2004

A Comparison of Attitudes about Aggression, Sexuality and Social Support in the Peer Relationships of Sexually Abused and Nonabused Female Adolescents

Sherri R. Edelman
Philadelphia College of Osteopathic Medicine, sherriedelman@comcast.net

Philadelphia College of Osteopathic Medicine

A COMPARISON OF ATTITUDES ABOUT AGGRESSION, SEXUALITY AND SOCIAL SUPPORT IN THE PEER RELATIONSHIPS OF SEXUALLY ABUSED AND NONABUSED FEMALE ADOLESCENTS

Sherri R. Edelman

Submitted in partial fulfillment for the degree of
Doctor of Psychology in the
Department of Clinical Psychology

Philadelphia, Pennsylvania

November 2004

PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE
DEPARTMENT OF PSYCHOLOGY

Dissertation Approval

This is to certify that the thesis presented to us by SHERRI R. EDELMAN on the 10 day of MAY, 2004, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

Committee Members' Signatures:

Elizabeth Gosch, Ph.D., ABPP, Chairperson

Robert A. DiTomasso, Ph.D., ABPP

Esther Deblinger, Ph.D.

Robert A. DiTomasso, Ph.D., ABPP, Chair, Department of Psychology

Dedication

To Morton Awner, my grandfather, my guardian angel. You gave me the roots I needed to thrive: you planted the seed, then watered and nurtured it; then you gave me the wings I needed to take me here. Your spirit lives in me always.

Acknowledgments

There are many people I would like to thank for their guidance and support during the various stages of working on this dissertation. My internship experience at the Center for Children's Support at the University of Medicine and Dentistry (UMDNJ) in Stratford, New Jersey provided an opportunity to develop my research direction, while affording a rich learning environment. I would like to express my appreciation to several of the staff at the Center: Amy Hoch-Espada for her efforts during the initial stages to help me formulate my ideas, as well as for her support and encouragement; Christine Schroeder for her assistance with statistics, and her patience during the statistical analyses; Beth Cooper for her help with data entry; and a very special thank you to Dr. Esther Deblinger for her guidance, positive attitude, and encouragement. I extend a heartfelt thank you to her for allowing me to complete my research through the Center. I have great respect for her: she is a person of tremendous integrity, commitment, and personal and professional acumen. I would also like to thank Dr. Lori Winter for allowing me to utilize the Pediatrics department at UMDNJ to obtain my control group sample. In the midst of a very hectic professional life, she made time to meet with me and facilitate the research process.

I would also like to extend a heartfelt thank you to Dr. Elizabeth Gosch, my dissertation chairperson. I appreciate her time and attention to my work, her intelligent input and guidance during the conceptualization and formulation of my research ideas, as well as for her excellent organizational skills and attention to detail. In the midst of a

very busy professional and personal life, she made a consistent effort to make herself available to support my efforts.

Dr. Bob DiTomasso has been a source of support for me since I began the program at PCOM in 1996. I would like to extend my gratitude for his encouragement, compassion, intelligence and guidance throughout the years, with particular appreciation for his patience and willingness to listen.

To my children, Rachel and Andrew, I extend my appreciation for their understanding and patience when I was not able to be available for them during the seven years it took to complete my doctorate degree. I love them so very much, and thank them for supporting my professional and personal development. I hope I will make them proud of me always.

An extra special thank you to my partner personally and professionally, Dr. Jeffrey Sklar, for his unconditional love every step of the way during this process. His patience, understanding and encouragement are unparalled. I am blessed to take this journey with him by my side.

Abstract

There is a paucity of research examining whether adolescents with a history of sexual abuse develop different norms or standards for acceptable behavior in their peer relationships. The trauma literature suggests that intervening variables such as perceived social support, interpretations of violence, and interpersonal attitudes may be relevant to the study of sexual abuse. The goal of this study was to examine the relationship between a history of sexual abuse, relational attitudes about aggression and sexuality, and the interpersonal factors of social support and negative interaction in adolescent peer relationships. Two groups of female subjects between 13 and 17 years of age participated in the study: 28 had experienced sexual abuse; 33 had no known history of abuse and served as the control group. Information on the sexually abused group was obtained using initial assessment data from a child abuse treatment facility. Subjects for the control group were recruited from a medical clinic. Evaluation of both groups included the measurement of the study variables using the Network of Relationship Inventory (NRI) and the Relationship Attitudes Survey for Adolescents (RASA). Analysis of Variance (ANOVA), Analysis of Covariance (ANCOVA), and Semipartial and Pearson Correlations were conducted on the data. The major finding of this study revealed a difference in levels of dysfunctional sexual attitudes between the sexually abused and nonabused groups: results from an ANCOVA analysis showed a significant effect for abuse history ($p <$ .03). A second finding of this study revealed an inverse relationship between social support and tolerance of aggression in the nonabused group: results of a correlational analysis were statistically significant at the

$p <$ .02 level. Positive findings from the current study point to the importance of designing developmentally sensitive educational and clinical interventions for adolescents who may be at risk for becoming involved in coercive and maladaptive relationships. Raising awareness about sexuality, dating violence, elements of healthy and supportive friendships and dating relationships, and maladaptive relationship aggression are examples of possible directions for the implementation of educational protocols. In particular, girls who have been identified as endorsing dysfunctional relational attitudes may benefit from sexual violence prevention education.

Table of Contents

List of Tables, Continued

Appendices

List of Tables, Continued

Appendices

Chapter 1

Introduction

There is a growing body of research that provides evidence of the development of peer relationships as a central task of adolescence (Connolly, Furman, & Konarski, 1995; Furman, Brown, & Feiring, 1999). However, there is a paucity of existing empirical work examining how the experience of sexual abuse might impact adolescent peer and dating relationships. Investigators have proposed that the formation of attitudes and beliefs concerning interpersonal relationships, power, and control are particularly sensitive developmental tasks during adolescence (Wekerle & Wolfe, 1998). Furthermore, the trauma and stress literature suggests that intervening variables such as perceived social support, interpretations of violence, and interpersonal attitudes may be relevant to the study of child sexual abuse. This study, then, synthesizes evidence from several sources to create a framework for studying how cognitions self and other reflected in attitudes about aggression and sexuality affect interpersonal functioning in the peer and dating relationships of adolescents with a history of sexual abuse.

Specifically, this study addressed four topics in the general adolescent literature: sexual abuse, peer relationships, social support, and aggression. Although each individual topic would warrant a thorough review, the first chapter addresses only the most salient features of each. My overall goal is to consider the independent or interactive effects of each area, culminating in an integration of these broader theoretical concepts, which led to eight specific research hypotheses.

The first chapter is an overview of child sexual abuse, building a foundation for a comprehensive understanding of adolescent, abuse-specific interpersonal, cognitive and psychosocial functioning. Research reveals that youth with a history of sexual abuse are at risk for problems, placing them on several different psychosocial trajectories. In this

study, I consider these questions: What causes individual differences in abuse reactivity? Why do some adolescents go on to have greater impairments in their existing and future relationships? Abuse research and theory emphasize that abused children experience significant distress; that their responses contribute to dysfunctional adaptations to normal social and psychological functioning (Briere, 1992). Arguably, a history of sexual abuse alone may not lead to a negative interpersonal trajectory; it is a complex interaction of mediating cognitive, interpersonal and social factors.

In the second part of this chapter, social-cognitive, interpersonal and behavioral theory and research are discussed to provide a context for understanding adolescent relationships. The research and theoretical work from Furman and his associates (Furman & Feiring, 1999; Furman & Buhrmester, 1985) suggest that peer and dating relationships provide important opportunities to develop skills and competencies that contribute to the ability to form healthy relationships in adulthood. Moreover, they function as a source of support and an integral component for the development of social and emotional competence. Cognitive and attribution differences present before the occurrence of the abuse may contribute to post-abuse interpersonal and social functioning. While some victims of sexual abuse experience interpersonal difficulties, it is still unclear about the interaction of variables that lead to relationship dysfunction. It could be that within the abused adolescent population, attitudes and perceptions may moderate the peer pathways to interpersonal and social functioning.

Social support is reviewed in the third part of this chapter. It is generally agreed that social support is an important factor in healthy childhood and adult adjustment. Thus far there has been limited empirical investigation of the role social support plays in the interpersonal relationships of sexually abused adolescents. Runtz and Schallow (1997) found the relationship between child sexual abuse and adult adjustment to be strongly mediated by perceived social support. Gaining a greater understanding of how adolescent attitudes may interfere with normal adaptive processes for utilizing their interpersonal resources is a key focus of this formal investigation.

The area of conflict and aggression comprise the final part of this chapter.

Researchers suggest that aggressive adolescents are at risk for the development of poor relationships with friends and romantic partners (Feiring, Taska, and Lewis, 1998). A portion of the extant literature addresses negative interaction in adolescent peer relationships in normal samples, or examines the relationships of physically abused children, but relatively little has been studied about the sexually abused adolescent's peer relationships. With that in mind, I present this subject matter for investigation: that the maladaptive social cognitions of adolescents with a history of sexual abuse are related to that individual's perceptions of the social support and negative interactions in their peer and dating relationships.

Two caveats about the discussion that follows are important to consider. First, although this study will expand the existing database and advance understanding of social and cognitive factors in adolescent relationships, it is not meant to examine all possible intervening variables. Second, this study is not meant to be an investigation of abuse-specific variables, such as complexity and chronicity of abuse, or family-related and environmental influences. Instead, the goal is to expand the limited knowledge about the peer and dating relationships of adolescents who have been sexually abused by examining their cognitions and attitudes about aggression and sexuality, and to determine if there is a link to perceptions of social support and negative interaction.

Part 1

Sexual Abuse: Theory and Research

Definition of Sexual Abuse

A standard definition of child sexual abuse has not yet been determined. Some researchers limit their definition of child sexual abuse strictly to those who have endured sexual intercourse and penetration, while others have included a wider range of experiences, such as being fondled and witnessing sexual acts performed by others

(Paolucci, Genuis, & Violato, 2001).

For the present study, child sexual abuse is defined as any unwanted sexual contact, (ranging from genital touching and fondling to penetration), during the period in which the victim is considered a child by legal definition and the perpetrator is in a position of relative power vis a vis the victim (Violato & Genuis, 1993, p. 37). Child sexual abuse has been reported to have a prevalence rate of nearly 20 percent. The impact on human development that may result from child sexual abuse experiences continues to be a great concern to clinicians and researchers (see Kendall-Tackett, Meyer-Williams & Finkelhor, 1993, for a comprehensive review of theoretical conceptualizations of how child sexual abuse affects development).

Discussing abuse and abuse-related literature and research presents a formidable challenge for this author with regard to terminology. Literature on the subject included encountered variations in references to a "sexually abused" individual. For example, some authors use the term "victim" to describe someone who has been sexually, physically, or emotionally abused; others may use the word "maltreatment" to encompass these same types of child abuse. When authors use the term maltreatment interchangeably with abuse, this paper will do the same, when it is determined from the literature that it rigorously encompasses sexual abuse in the meaning and content of the material presented. In addition, some of the research and literature covered in the following chapter will focus on childhood in general, and not just adolescence. Sometimes use the term "youth" will be used; or the paper will refer to generally both children and adolescents, when discussing scientifically and theoretically sound concepts applicable to an age range from childhood through adolescence; at times, sexual abuse, regardless of type or chronicity, will be referred to generally. When this is the case, sound work founded on rigorous theory and scientific principles will be presented; and within this context, permit the occasional discussion of abuse-related interpersonal and psychosocial sequalae without separating out age or abuse-specific factors.

Prevalence of Child Sexual Abuse

True prevalence of sexual abuse is unknown, partly because such abuse occurs in secret, and because much of the incidents are not reported to authorities. Research does support an estimated 500,000 new cases of child sexual abuse each year in the United States alone (Finkelhor, 1994). Finkelhor's (1994) literature review revealed that one in five adult women experienced either contact or no contact sexual abuse during childhood in North America, consistent in international studies as well (Reece, 1998). Elliott & Briere (1995) find 13 percent of boys report a history of contact sexual abuse. Median age at time of abuse is reported as 9.9 years for boys and 9.6 for girls (Finkelhor, Hotaling, Lewis, & Smith, 1990), but sexual abuse occurs from infancy through adolescence (Gold, Hughes, & Swingle, 1996).

Impact of Child Sexual Abuse

As mentioned previously, psychological and interpersonal difficulties increase in prevalence as a result of sexual abuse experiences in comparison to those who have not been abused (Boney-McCoy & Finkelhor, 1995). Many researchers and clinicians have concluded that child sexual abuse is a major risk factor for a variety of problems, both in childhood and in terms of later adult functioning. Nonclinical adolescent samples of sexual abuse victims report more depression and anxiety (Gidycz & Koss, 1989). When sexually abused girls from dysfunctional families are compared with nonabused girls from comparison families, the abused girls have lower self-esteem and more internalized aggression (Hotte & Rafman, 1992). On standard assessments of child behavioral problems, parents report sexually abused children have more behavioral problems than nonabused children.

The effects of child sexual abuse create short-term as well as long-term problems (Finkelhor et al., 1990; Kendall-Tackett et al., 1993). Much information is available about the long-and short-term effects of CSA. (For long-term effects, see: Brier &

Elliott, 1994; Salter, 1995; Coffey, Leitenberg, Henning, Turner, & Bennett, 1996; Brier, 1992; Conte & Berliner, 1988; Kendall-Tackett et al., 1993; Mian, Marton, & LeBaron, 1996; Finkelhor & Browne, 1985; for short-term effects, see: Deblinger, Lippmann, & Steer, 1996; Kendall-Tackett et al., 1993; Mian et al., 1996). Longitudinal research investigating child sexual abuse concludes that early identification of children who may be at risk of forming long-standing problems is possible and needed (Calam, Horne, Cox, & Glasgow, 1998).

Numerous empirical studies examining the developmental impact of sexual abuse on children and adolescents indicate that maladaptation is frequently associated with experiencing sexual abuse (see Beitchman, Zucker, Hood, DeCosta, & Akman, 1991, and Beitchman, Zucker, Hood, DeCosta, & Cassavia, 1992, for a review). The most frequent symptoms reported by individuals who have been victims of child sexual abuse include: sexual maladjustment resulting from premature sexualization (Verduyn & Calam, 1999), interpersonal problems, educational difficulties, acute anxiety neuroses, self-destructive behavior, somatic symptoms, loss of self-esteem, prostitution, delinquent criminal behavior, depression, and suicide (Higgins & McCabe, 1994; Kendall-Tackett et al., 1993; Browne & Finkelhor, 1986). Fundamentally, the harm incurred is a result of the nonconsensual, developmentally inappropriate nature of the abuse, which interferes with normal developmental processes and increases later risk for maladjustment.

In a meta-analysis of the published research on the effects of child sexual abuse, the authors conclude that these analyses provide clear evidence confirming the link between child sexual abuse and subsequent negative short-and long-term effects on development. The impact on development that may result from child sexual abuse experiences continues to be a great concern to clinicians and researchers (see Kendall-Tackett et al., 1993, for a comprehensive review of theoretical conceptualizations of how abuse affects development).

Mediating abuse-related factors. Although the data reveals that child and adult survivors of sexual abuse have more problems than nonabused groups, there is no evidence of a uniform or predictable response for all individuals. Certain characteristics of the abuse and environmental factors influence the incidence of distress. Factors that may contribute to a more negative outcome include: a closer relationship with the offender; multiple offenders, longer duration; more frequent contact; penetration; and violence (Berliner & Elliott, 1996). As previously mentioned, investigation of these factors is well beyond the scope of this study, but important to consider as future grist for the mill.

Boney-McCoy and Finkelhor (1996) have data supporting the causal link between victimization and subsequent psychological distress, as well as the impact of victimization independent of social-family context. Nash, Neimeyer, Hulsey, and Lambert (1998) find that investigators vary in their opinions about the relative contributions of abuse with regard to the influence of family environment. Their own studies found that intrafamilial abuse is a significant factor when measuring symptomatology. However, they plead for taking into account both social and cognitive mediators, as the most reliable current evidence indicate that the event (e.g., sexual victimization), context (e.g., family context, type of abuse), and cognitive factors all may have an effect. Clearly, much more remains to be learned about their interaction.

Victimization and Psychosocial Factors

According to Briere (1992), abused children experience significant psychological distress. Unlike abuse experienced in adulthood, the trauma frequently occurs during the most critical developmental period during which assumptions about self, others, and the world are formulated. These responses may contribute to dysfunctional adaptations with regard to normal social and psychological maturation. As a result, it is important to understand not only the acute reactions to victimization, including posttraumatic stress and cognitive distortions, but also the individual's abuse-specific accommodations

(e.g. maladaptive coping strategies).

Sexually abused youth are believed to have difficulty coping with the myriad of challenges that the growth and centrality of friendships and romantic relationships in adolescence present (Wolfe & Feiring, 2000). It has been said "abused youth are more likely to view the central self as bad" (Wolfe & Feiring, 2000, p. 319). They suggest that, as a result of sexual abuse, adolescents may endorse more negative sexual attitudes, disclose less, cope less successfully, and endorse higher levels of aggressive attitudes with more negative interactions. The psychosocial sequelae of child abuse may be of great significance with regard to prevention of a large scope of societal dysfunction. According to the research of Widom (1989), Neumann, Houskamp, Pollock, and Briere (1990), and McCord (1983), it is possible that problems with violent crime, suicide, and alcoholism would be greatly decreased if child abuse were prevented or successfully treated.

The number of child sexual abuse victims who have experienced serious mental health problems in the United States and Canada are in the millions (Violato & Genuis, 1993). Kendall-Tackett et al. (1993) found that adolescent victims of sexual abuse are at greater risk for interpersonal and mental health problems compared to those who have not been sexually abused. Moreover, victims of child and adolescent sexual abuse are at greater risk for problems in later social and psychological functioning as well (Briere, 1992; Parker & Asher, 1987; Feiring, Taska, & Lewis, 1998; Mueller & Silverman, 1989).

Frequently, adults who have been abused as children experience ongoing difficulties in the areas of intimacy, relationships, trust and authority. Previous studies have demonstrated that childhood abuse was associated with interpersonal difficulties in adulthood (Ducharme, Koverola, & Battle, 1997; Mullen, Martin, Anderson, Romans, & Herbison, 1996). Capaldi and Crosby (1997) found that prior history of child maltreatment increases the likelihood of negative relationship formation in the absence of compensatory skill development.

The effects of child sexual abuse contribute to both initial and long-term changes in

social functioning. The very personal nature of sexual abuse itself (victims report knowing the perpetrator approximately 85 percent of the time), along with boundary violations and the betrayal of trust experienced in these relationships, can be deleterious to future interpersonal relationships (Briere, 1992). These problems often center on vulnerability and fear within the intimate framework of relationships. Research has found child abuse to be associated with adolescent dating violence (Malik, Sorenson, & Aneschensel, 1997; Smith & Williams, 1992), and a greater likelihood of multiple divorces and separations in adulthood (Widom, 1994). Adult literatures on outcomes for individuals with sexual abuse history suggest that survivors may have multiple superficial and sexual relationships that cease when interpersonal intimacy becomes a factor.

Victims of child abuse may experience difficulties in their interpersonal relationships that may be linked to cognitive and conditioned reactions to the victimization (e.g. concerns about abandonment, low self-esteem, problems with trust and intimacy); and cognitive responses, such as avoidance, adversariality, sexualization, and ingratiation. These abuse-related responses can create challenges to daily interpersonal interactions that may interfere with the normal development of social abilities in relationships, support, and ultimately, well-being and life satisfaction.

Often these interpersonal vicissitudes lead to social dysfunction, severely limiting friendships and successful, healthy dating relationships. Adult abuse survivors may have continued difficulties with relationships following maltreatment, manifested in either an avoidance of interpersonal intimacy completely, or a tendency to tolerate aggression in intimate relationships as normal and appropriate (Briere, 1992). Adolescents who have been sexually abused may develop different norms or standards for acceptable behavior in interpersonal relationships, which may have a significant effect on the nature of their peer networks.

It may be, however, that the experience of sexual abuse alone may not be the sole determinant of perceiving one's peer relationships as offering little social support and perceiving greater levels of negative interaction. These perceptions may result from a

combination of attitudes, specifically about aggression and healthy intimacy, in addition to the experience of abuse, which mediate these outcomes. Much more needs to be understood about the mediating factors contributing to the myriad of challenges to the interpersonal relationships of this population. This is what guides the direction of this research.

Abuse and social support. Social support appears to be an important mediator of the effects of life stress (Heller, Swindle, & Dusenbury, 1986; Kessler, Price, & Wortman, 1985; Pearlin, Menaghan, Lieberman, & Mullan, 1981). Conte and Schuerman (1987) found it to be a significant factor for the adjustment of children who have been sexually abused (cited in Feiring et al., 1998). Social support is an important resource for adults who have been sexually victimized as children (Gold et al., 1996; Testa, Miller, Downs, & Panek, 1992; Gold, 1986). There is evidence that adults who have experienced child sexual abuse may have less alternative sources of support (Grauerholz, 2000). Spaccarelli & Kim (1995) found parental support, but not cognitive appraisals or coping strategies, to be predictive of resilience. There is ample evidence that child-parent relationships are a major source of support for younger children. Within a developmental framework, however, adolescents and adults seek more support from peers with greater significance in their adjustment (Runtz & Schallow, 1997).

Runtz and Schallow (1997) found the relationships between child sexual and physical maltreatment and adult adjustment to be strongly mediated by perceived social support. They found virtually no evidence of a direct relationship between childhood maltreatment and adult adjustment. From their results they concluded that social support and coping strategies are two of the factors that differentiate between those who were maltreated and relatively healthy and those who remain burdened by the sequelae of child maltreatment. Part 3 will return to explore social support in the abused population in greater detail.

Aggression and abuse. Children and adolescents who are victims of sexual abuse have more problems with anger and aggressiveness toward others (Briere & Elliott, 1994), which can lead to several maladaptive outcomes. Briere and Elliott have found that children frequently externalize their trauma, expressed as fighting, bullying, or attacking other children, leading to social isolation. Minuchin (1974) found that these socially withdrawn children go on to have fewer experiences with close friendships, tending toward either avoidance of, or overly intensive, relationships. Much less had been studied about the extent of anger and aggression experienced in the relationships of adolescent and adult survivors of sexual abuse, but the data that is available reflects the existence of difficulties (Briere & Elliott, 1994). The investigators found one manifestation of abuse-related anger to be sexually aggressive behavior toward others.

There is evidence to support the relationship between maltreatment and the learning of aversive social strategies utilized in peer and dating relationships (Wekerle & Wolfe, 1998). George and Main (1979) found that maltreated children show higher levels of aggression and withdrawn behaviors toward their peers than comparison groups. They may be more likely to be rejected by peers, and report more conflict in close relationships (Wolfe et al., 1998). In addition, there is evidence that child sexual abuse victims are less likely than nonabused comparisons to feel emotionally supported by their partners (Mullen, Caldwell, & Hunter, 1994). This may be a result of avoidance of intimacy and relationships in general, which may leave survivors feeling socially isolated (Polusny & Follette, 1995).

Aversive adolescent partnerships have been predictive of adult intimate violence (O'Leary, Malone, & Tyree, 1994). Researchers have found that sexually abused adolescents do not view acts of aggression as destructive to their romantic relationships, and may in fact become "bullies" to compensate for emotional vulnerability (Wolfe & Feiring, 2000). This raises concern about risk factors for failure to create adaptive, healthy romantic relationships void of abuse and victimization. More needs to be understood about the nature of the attitudes and beliefs about aggression and intimacy that these adolescents are endorsing in their current relationships, which greatly guides

the direction of my study.

Brief Overview of Theories

There are several theoretical perspectives that examine the reason maltreated children may experience difficulty in forming and maintaining friendships (see Price & Ladd, 1986, for a comprehensive review of this body of work). A thorough examination of these theories is beyond the scope of this chapter. Certainly, many valid arguments could be presented with regard to finding a specific theoretical approach to incorporate into research on abuse-related interpersonal and psychosocial factors. Unfortunately, very few abuse-related interpersonal theories of relationships have been proposed to date. For the purposes of this study, a brief review will suffice to acquaint the reader with theoretical perspectives guiding theory and research on maltreated children.

Finkelhor and Browne's four traumagenic dynamics. One of the most widely recognized and cited theories about the effects of childhood sexual abuse is Finkelhor and Browne's (1985) Traumagenic Dynamics. The authors present ways in which sexual abuse may lead to traumatic betrayal, stigmatization, powerlessness, and traumatic sexualization; which in turn lead to negative short-and long-term consequences for survivors. These dynamics have implications for interpersonal functioning:

1) The process of traumatic sexualization, whereby the child's sexual feelings and attitudes are influenced in developmentally inappropriate and negative ways, may lead to problematic sexual interaction with others.

2) The betrayal of trust that is the result of sexual abuse also has implications for the survivor's later ability to trust others and make judgments about interpersonal relationships. Finkelhor and Browne (1985) suggest that such early betrayal may lead to great distrust of others, avoidance of intimacy, or in some cases, an overly trusting stance in relation to individuals who may be potentially harmful to the individual.

3) Powerlessness, experienced in an extreme form in child abuse, may lead to diminished self-protective strategies or trouble identifying and expressing interpersonal needs. The child is often unable to stop the abuse and has no control over the actions of the perpetrator. In this context, the survivor may have learned that she has little efficacy in relation to others and these victims may feel powerless to stop others from harmful or manipulative actions.

4) Stigmatization can occur as a result of the emotional and cognitive reactions to the experience of abuse. Some individuals experience shame and self-consciousness, and may form social and romantic attachments to individuals they consider similar to themselves.

For a thorough review of several perspectives that lead to similar conclusions about the link between child sexual abuse and interpersonal problems, the reader is referred to Messman and Long (1996). For the purposes of this study, this theory is presented as a sound theoretical foundation for further exploration of interpersonal relationship dynamics in victims' relationships.

Social learning theory. Social learning theory highlights the way in which early relationships may serve as a model for future interpersonal relationships. When there is a history of abuse, the experience of the abusive relationship models may link with the victim's existing social information processing style, leading to psychosocial and behavioral manifestations.

Crick and Dodge (1994) reviewed social information processing mechanisms in children's social adjustment. They find overwhelming empirical evidence that supports the relationship between characteristic processing styles and children's social adjustment. A number of social information processing models have emerged to offer significant contributions to the understanding of social adjustment (for a review and cites for this research, see Crick & Dodge, 1994).

Dodge and colleagues'(1986) model proposes that children engage in four mental steps when confronted with a social situational cue: 1) encoding of situational cues;

representation and interpretation of those cues; 3) mental search for possible responses to the situation; and 4) selection of a response. The role of emotion in social information processing is relatively unknown, with little research integrating the two perspectives. Dodge and colleagues have argued that some aspects of maladaptive social information processing may be affected by individual variations in context (Dodge, Pettit, McClaskey, & Brown, 1986). Nelson and Crick (1999) examined the social information processing of prosocial young adolescents. Results revealed that, in contrast to their comparison group peers, prosocial adolescents were less likely to attribute hostile intent or feel distressed in provocative situations; gave more negative evaluations of aggressive responses and more positive evaluations of prosocial responses to provocation; and were more likely to endorse relational rather than instrumental goals in dealing with provocation.

Developmental psychology theory. Also applicable to expanding the knowledge base in abuse-related theoretical orientations, well-supported explanations can also be found in developmental psychology theory (Rogosch, Cichetti, & Aber, 1995; Cicchetti, Toth, & Bush, 1988) for the connection between childhood maltreatment and subsequent problems in relationships. It has been suggested that child maltreatment influences children's subsequent relationship skills; and that this may be less about the abuse than a reflection of the transmission of relationship vulnerability to a number of negative variables (e.g. interactional style, acceptance of hostility in relationships, etc.)

Harry Stack Sullivan's theory of socioemotional development. Sullivan (1953) believed that individual preferences for specific types of interactions or relationships are derived from their social needs or integrative tendencies. Furman (1989) based the development of the Network of Relationships Inventory (NRI) used in this study to measure perceptions of social support and negative interaction partly on Sullivan's socioemotional theories, building on his theories about childhood and adolescent friendships. Sullivan (1953) hypothesized that social needs are biologically based

tensions, which are roughly equivalent to negative emotions, such as fear or loneliness; the tensions can be avoided or reduced by engaging in particular types of interactions. Sullivan hypothesized that there are five basic social needs: tenderness, companionship, acceptance, intimacy, and sexuality. Each developmental stage is characterized by a corresponding need (Furman, 1989, p. 154). Two of these social needs, intimacy and sexuality, are considered in the apparatus for the present study.

These theories lay the groundwork and provide a theoretical perspective for a clearer understanding of why individuals may have post-abuse differences in their interpersonal functioning, social information processing, and psychosocial development. Difficulties in these areas may contribute to challenges with forming and maintaining friendships. This paper attempted to find a broader context in which to view peer relationships, taking some of these theoretical principles into account. Consideration of this raises a question addressed in the present study; Do the interpersonal relational attitudes about healthy sexual intimacy and attitudes about tolerance of aggression of adolescents who have been sexually abused affect the perception of social support and negative interaction in their peer and dating relationships?

Abused Children-Social, Cognitive and Behavioral Factors

Up to now, studies investigating sexuality in adolescents who have been sexually abused have mostly examined variables that manifest in sexual activity (e.g. number of partners and age of first intercourse). The next logical step may be focusing on the underlying attitudes, cognitions and motivations about sex and relationships. For example, Beitchman, Zucker, Hood, DeCosta, & Cassavia, (1992) has linked revictimization and sexual promiscuity to the tendency of girls to have an impaired ability to assess trustworthiness and to cognitively over sexualize and idealize males in dating relationships.

There is some evidence that sexually abused youth exhibit certain social-cognitive and behavioral orientations that may interfere with their efforts to form and maintain

friendships. Examples of this would be experiencing difficulty with interpersonal trust (Bernath & Feshback, 1995), and difficulty conceptualizing peer relationships as reciprocal (Dean, Malik, Richards, & Stringer, 1986). For children who experience abuse, impairments in self-system processes, such as negative self-evaluations, deficits in self-esteem, and an inability to talk about their feelings, may interfere with relationship formation and maintenance, especially during adolescence, when intimate self-disclosure is a factor (Parker & Gottman, 1989).

There has been an association in this population with a number of problems in adolescence, including alcohol and drug use, depression, and low self-esteem, which in turn may accompany high-risk sexual activity and sexual permissiveness in adolescence. Finkelhor (1994) suggests that social detachment may isolate an abused individual from social supports, which may lead to sexually exploitative relationships in the future. However, having female peers has been positively related to healthy sexual development and more satisfying romantic relationships (Noll, Trickett, & Putnam, 2000). With this in mind, and in an effort to better understand what may interfere with adaptive peer relationship skills leading to the negative outcomes mentioned above for adolescents, I consider related questions: Do healthy relationship attitudes about sexual intimacy predict higher levels of social support in peer relationships? Do adolescents with a history of sexual abuse experience more negative interactions in their peer relationships than nonabused comparisons if they endorse attitudes that reflect a tolerance for aggression?

Wolfe and Feiring (2000) found the formation of attitudes and beliefs concerning interpersonal relationships and the abuse of power and control to be particularly sensitive developmental tasks during adolescence. Recently, there has been an increase in interest in the cognitive processing of abusive experiences. Recent examples of this research include: children's attributions about the abuse (for review see Special Focus Section in Child Maltreatment, February, 2002); feelings of stigma and self-blame in abuse victims (Wolfe & Feiring, 2000; Coffey et al., 1996; Wyatt, 1990); and the search to find meaning in the abuse experience (Roth & Newman, 1993). Findings from these

recent studies suggest that cognitive, social and environmental factors *may be more important than the abuse itself* in predicting adjustment from child sexual abuse.

There may be a complex intermingling of variables that contribute to either a positive or a negative outcome for maltreated individuals. Spaccarelli (1994) found that attributional styles and other cognitive differences that may have been present prior to the occurrence of the abuse may contribute to the victim's cognitive appraisal and coping styles. The negative impact of the maltreatment experience on subsequent interpersonal functioning may be a function of abuse-related cognitive and emotional deficits (Rogosch et al., 1995). Bowlby (1980) suggests that these maltreatment experiences lead to a negatively biased information processing style. However, some children have been found to be more resilient or able to tolerate these traumatic events (Spaccarelli & Kim, 1995), with little interpersonal or social sequelae. Moreover, positive mental health outcomes have been consistently linked to high levels of perceived social support (Barrera, 1986; Cohen &Willis, 1985).

Sexually abused youth may tend to approach interactions with a heightened tendency to process threat (Bugental, 1993), and compared to non-abused children, recall a larger number of distracting aggressive stimuli (Rieder & Cicchetti,1989). At the same time, this cognitive processing style may lead to overprotective, hypervigilant, and emotionally intense reactions in interpersonal relations, leading to a greater incidence of distorted interpretations and perceptions. Much still remains to be investigated empirically, and is addressed in this paper's central question: Do experiences associated with maltreatment, specifically sexual abuse, lead to the development of attitudes and behavioral patterns that may have an independent or interactive effect on these interpersonal and social factors?

Rationale of Study

Forming peer relationships and intimate partnerships raises important issues and presents many challenges for relationship-disrupted abused youth. Specifically, the

experience of sexual abuse is believed to place adolescents at risk for the development of poor relationships with friends and romantic partners (Feiring, Taska, & Lewis, 1998). Furthermore, the peer and dating relationships of abused youth may be fraught with affective disturbances (e.g. interpersonal sensitivity and hostility), with limited personal resources to deal with these challenges, including lower self-efficacy and distorted beliefs about relationships (Wekerle & Wolfe, 1998). Yet, perhaps as a result of the apparent significance for increasing our general understanding of adolescence as a crucial developmental passage, we have not yet given adequate attention to another important consideration: the unique interpersonal and social challenges for populations such as sexually abused adolescents. Although more recent attention has been directed at the role of close friendships and dating partnerships as central tasks in adolescence (for a complete review, see Special Edition on Adolescence in Child Maltreatment, 2000), investigations have been limited to children and adult survivors and sexual dysfunction (Wolfe & Feiring, 2000). The developmental stage of adolescence is a critical one, when abused adolescents are integrating their attitudes and beliefs about relationships and sexuality.

The following section, then, presents background and current issues relevant to the study of the peer relationships of abused adolescence as viewed from a psychosocial and cognitive perspective. Social-cognitive, interpersonal and behavioral theory and research are discussed to provide a context for understanding adolescent relationships.

Part 2

Adolescent Peer Relationships

In this part of the chapter, the expediency of developing a strong research base with a focus on relationship attitudes and cognitions that may converge on the interpersonal and social experiences of adolescents who have been sexually abused is explored. First,

adolescent peer relationships are discussed, including normal friendships and intimacy, and the impact of abuse on these relationships. Evidence is then presented regarding adolescent sexuality and revictimization, and the chapter concludes with important considerations for studying social, cognitive and behavioral abuse-related factors.

Peer Relationships and Friendships: Definition and Function

The term *peer relationship* is often associated with those relationships of similar age and gender without a sexual or romantic component (Furman, 1998), while *dating relationships* refers to those with sexual or romantic components. Furman (1998) posits that we are biologically predisposed to affiliate with known peers, and those interpersonal affiliative abilities extend into dating relationships. Asher and colleagues (1998) find friendship to be innately dyadic rather than group-related.

According to Brain (1977), friendship is nearly a universal characteristic of human society. Its function supercedes legal sanctions, social institutions, and family ties. It is not uncommon in many cultures for friendship to be valued more highly than kinship. Descriptions of friendships vary with age – expectations from youth to late adulthood change from providing pleasure and entertainment to providing greater instrumental aid. Ginsberg, Gottman, and Parker (1986) find that some of the aspects of friendship that remain consistent across developmental lines are: similarity, emotional supportiveness, shared activities, and confiding; and reciprocal liking, trust, and acceptance.

The nature of adolescent relationships is quite varied, including best friendships, close friendships, cliques or friendship groups, social crowds, and dating relationships (Urberg, Degirmencioglu,Tolson, & Halliday-Scher, 1995). Hartup (1996) also defines friendship as dyadic; specific attachments that involve maintaining contact with the other individual as well as exchanging affects, interest and information. Participation in friendships is volitional – they may be terminated at will. The volitional nature of these relationships sets them apart from family relationships, which are often more binding.

Sullivan (1953) found that friendships promote the development of interpersonal sensitivity, as well as serving as early models for later significant relationships. Moreover, developmental tasks often impact processes that are salient to friendship. A good example of this is self-disclosure, which is relatively infrequent until adolescence (Parker & Gottman, 1989).

Functions of friendships. Since Sullivan's (1953) original formulation of the benefits of friendship, there have been a number of additional attempts to present a comprehensive list of friendship functions. Asher and Parker (1989) synthesize this work as seven friendship functions: a) fostering the growth of social competence; b) serving as sources of ego support and self-validation; c) providing emotional security in novel or potentially threatening situations; d) serving as sources of intimacy and affection; e) providing guidance and assistance; f) providing a sense of reliable alliance; and g) providing companionship and stimulation. Parker and Gottman (1989) suggest that friendships contribute to skill development in managing emotions in interactions and sorting out internal emotional experiences. With each developmental stage (e.g. early childhood, middle childhood, and adolescence), Parker posits that there is a shift in role definition and behavioral expectations, changes in social networks, and a reorganization of social support and personal resources.

The importance of friendships in childhood. According to Ginsberg et al. (1986), a review of the literature on friendships reveals that they play a crucial role in meeting children's current and long-term psychological needs. Moreover, they contribute to the individual's mental, physical, and subjective well being in adulthood. There has been a great deal written about the positive, formative influence of peer interaction on children's current and long-term adjustment. Interaction with peers provides opportunities for cognitive (Piaget, 1962), social-cognitive (Selman, 1981), and moral (Kohlberg, 1963); and assume adaptive sex-role behavior (Fagot, 1977; Fine, 1981). Inclusion in social groups allows children access to learning about sexuality (Fine,

1980), while serving as a resource for support during episodes of acute and chronic stress (Ispa, 1981).

The importance of friendship in adulthood. Research has determined that adults have an inherent psychological drive to establish close, emotional bonds with others (Sullivan, 1953; Adler, 1927). Empirical data from studies done in several related areas converge to conclude that achievement of satisfying relationships may have significant positive psychological and physical consequences (Ginsberg et al., 1986). Ginsberg posits that in times of stress, these close relationships can be protective, while their absence can contribute to mental and physical health problems.

Peer Relationships in Adolescence

There have been a limited number of studies examining the same-sex and dating relationships of adolescents with a history of maltreatment. One study that did look at adolescent peer relationships examined the same-sex best friend and dating partners of adolescents who had been abused. The investigators found that the friendship qualities of intimacy, companionship and support were higher for same sex friends than for dating partners (Lempers & Clark-Lempers, 1993). In a study that examined friendship and social-emotional functioning of adolescents with close and cross-sex friendships, younger adolescent girls were found to report more prosocial support in the same-versus cross-sex friendships (Kuttler, La Greca, & Prinstein, 1999).

Girl's social relationships become a central component of their identity and a strong predictor of adjustment (Cross & Madson, 1997, cited in Feiring, Deblinger, Hoch-Espada, Hayworth, 2002). Because close relationships are a driving force in women's lives, it is predictable that many difficulties during adolescence involve these close relationships, particularly dating partners. Some of these problems may include dating violence, depression resulting from relationships, early childbearing, and sexually

transmitted diseases (Purdie & Downey, 2000). Dating relationships form as a result of an intricate balance of friendships, intimate dyad bonds, same-sex group affiliations, and mixed gender groups. Patterns that are healthy in normal peer relationships lay the foundation for the formation of intimate functioning (Collins & Sroufe, in press).

Findings from an investigation by Levesque (1993) of an ethnically and socioeconomically diverse sample of high-school students found adolescents' self-reported experiences of love and related emotions remarkably similar to the reported experiences of adults. Connolly, Pepler, Craig, and Taradash, (2000) find that romantic development seems to proceed most smoothly for adolescents whose peer relationships are based on reciprocity, intimacy, and mutual support. Adolescents who are abusive in their interactions with their peers may be at risk in their romantic development, and ultimately in future relationships throughout their lives.

Intimacy is often viewed as a significant feature of close friendships, associated with an experience of understanding, closeness, support and warmth. There may be a reciprocal association between friendship, intimacy and romantic relationships. Sharabany and Wiseman (1993) suggest that friendships may influence intimacy in later romantic relationships, while romantic relationships may at the same time influence intimacy in relationships with friends. Friendship also plays a role in the development of conflict resolution skills (Hartup, 1996), and may in fact be training ground for skill development to manage conflict in dating relationships.

It may be argued that for adolescents, attitudes and expectations may moderate the pathway to interpersonal and social functioning in their peer relationships. Furman and Buhrmester (1992) developed the Network of Relationship Inventory (NRI) to study intimacy in relationships. The development of intimacy was thought to play a key role in interpersonal relationships with best friends and romantic partners. The investigators found that dating relationships played a key role in adolescent's girls' well being in late adolescence. These researchers found an association between low intimacy in these relationships and latent, negative social cognitions.

Peers serve a variety of purposes in the development of healthy adults, including the

establishment of healthy, high-quality relationships with same-and-other-sex individuals as well as healthy sexuality; social competence versus interpersonal deficiency, and opportunities to build the skills necessary for intimacy, such as self-disclosure (Noll et al., 2000). The transition between adolescence and adulthood with regard to the formation of healthy relationships, sexual experiences and attitudes have not been fully grasped – what is known is that the development and maintenance of peer relations and romantic partnerships in adolescence lays the groundwork for adult sexual functioning and relationship satisfaction (Connolly et al., 2000).

Intimacy in Peer Relationships

Many authors regard intimacy as the quintessential feature of friendship. Intimacy is expressed through reciprocal self-disclosure: the ability to reveal private, personal experiences and strongly held thoughts and feelings. However, self-disclosure exposes personal vulnerabilities; it requires an existing foundation of trust. Asher et al. (1998) found that individual differences in the willingness to trust and to engage in self-disclosure are related to children's social success and adjustment with peers.

Sullivan (1953) is frequently cited as first drawing attention to the intimate, affectionate quality of friendship during adolescence. It is during this stage that intimate self-disclosure, in the form of sharing personal or private thoughts and feelings with friends, begins to emerge. There is a large body of research detailing adolescents' perceptions of intimacy in their friendships and how they vary by age and gender (Dolgin & Kim, 1994; Furman & Buhrmester, 1992; Sharabany & Wiseman, 1993, to name a few). A brief review of sound theoretical principles may be helpful to introduce these theories.

During adolescence, close friendships are increasingly characterized by intimacy. The salient, social process at this age is honest, intimate self-disclosure. This interpersonal process, organized around closeness and mutual exchanges of thoughts and feelings, provides the framework for self-disclosure and discussion of personal

information about sexuality, family problems and personal concern (Hartup, 1993). In his extensive work with adolescent friendships, Hartup found that intimacy assumes great significance between middle childhood and middle adolescence. Furman and Wehner's (1994) conceptualization suggests that the intimacy experienced with a close same-sex friend serves as a prototype, or is transferred to, dating relationships. Study results have found that females report similar levels on intimacy indexes in the romantic and same-sex close relationships (Shulman & Collins, 1997).

Intimacy supporting behaviors: Socioemotional functioning. Increased intimacy in adolescent friendship is usually believed to have important implications for both short- and long-term socioemotional functioning (Buhrmester & Furman, 1986; Hartup, 1992; Sullivan, 1953). Reis and Shaver (1988) suggest that the core process of intimate interactions is not necessarily disclosure, but more likely the experiences of feeling understood, validated, and cared for that accompany self-disclosure. Recent studies have documented that children's friendships become more intimate beginning in early adolescence as they increase in companionate exchanges, personal disclosure, and more frequent provisions of emotional support (see Steinberg, 1989, for a review).

Sullivan theorized that the importance of friendship intimacy to socioemotional functioning increases with age. If this need is left unsatisfied in adolescent friendships, it may lead to a dearth of important sources of social support and coping assistance (Buhrmester, 1990). Kuttler and colleagues (1999) investigated friendship qualities and social-emotional functioning of adolescents in grades 10 through 12. In general, adolescents reported more companionship in their same-sex versus cross-sex friendships. Burhmester (1990) investigated whether there are age differences between preadolescence and adolescence in the importance of intimacy on adjustment and growth of interpersonal competencies. Her study provided sound evidence that friendship intimacy is related to social adjustment for adolescents. Results also supported the contention that interpersonal competency is related to friendship intimacy

during adolescence.

Intimacy and self-disclosure. A longitudinal study examined intimate affect and intimate interactions in the social networks of adolescent same-sex relationships in grades 9, 10, and 11. Intimacy, based on discussion, self-disclosure, and the capacity for sustained intimacy, increased by grade level. Girls more frequently established intimacy through discussion and self-disclosure; boys were more likely than girls to establish intimacy through shared activities (McNelles & Connolly, 1999). Youniss and Smollar (1985) suggest that adolescents must be capable of appropriately disclosing personal information and providing emotional support to friends, while at the same time, honestly expressing their opinions and dissatisfactions with each other while managing conflicts. These interpersonal skills parallel those of adult romantic relationships.

Age and gender differences in intimate affect and behaviors. In the seminal work of Sharabany, Gershoni, and Hofman (1981), intimacy in early childhood friendships was characterized by shared activity, loyalty, and alliance; whereas, interpersonal sensitivity and disclosure of inner psychological states emerged during adolescence. Generally, girls' friendships have been considered more intimate that those of boys (Buhrmester & Furman, 1987; Jones & Dembo, 1989), but recent studies have begun to question these findings. Typically, gender differences have resulted from equating intimacy with self-disclosure; a result of failing to empirically investigate the unique male pathways to emotional closeness. These researchers placed a dual focus on both affective and behavioral indexes of intimacy, believing that boys and girls may differ in their preferred routes to intimacy due to the interplay between social roles and norms. In their view, affective closeness is viewed as an essential core feature of intimacy (Camarena, Sarigiani, & Peterson, 1990; Selman & Schultz, 1990).

Intimacy is a hallmark of adolescence, supporting growth and well-being. Buhrmester and Furman's (1987) findings underscore the role of intimate behaviors in facilitating sustained intimate affect. As adolescents begin to further understand the

processes that underlie intimacy in healthy relationships, they pave the way for further investigation in relationships in which intimacy fails to develop.

During adolescence and young adulthood, both females and males tend to express differences in the content of their relationships. Benenson (1996) suggests that it is likely that females' experiences with friendships and the exchange of empathy are transformed into a global attitude of mutual reciprocity with regard to the individual needs of others. Ideally, females form close relationships with other girls and women who value mutual sensitivity to feelings, express vulnerabilities, and emphasize the importance of mutual caring. For males, their experiences with assertiveness in groups translate into a global concern with justice, fairness, and objectivity.

Intimacy in the abused adolescent's peer relationships. Reis and Shaver (1988) suggest that intimacy is an interpersonal process that includes self-disclosure as well as verbal and nonverbal expressions of closeness, relatedness, appreciation, and affection. Parker and Herrera (1996) conducted a study of interpersonal processes in the friendships of 9-to 14-year old physically abused and 32 matched non-abused children. The authors focused primarily on intimacy, conflict and affective expression. Abused children displayed less overall intimacy and dyads experienced less positive interactions and greater conflict than comparisons.

Adolescent Sexuality

The quality and number of peer relationships, as well as the identity of one's peers, may have a direct effect on sexuality in dating relationships (Furman, 1998). Research on sexual behavior illustrates an association between age at first intercourse and peers' attitudes about sexual behavior and perceptions of friend's sexual activity. Caucasian adolescent females are more likely to have friends with a similar level of sexual activity, and female sexual behavior may be influenced by their friends' sexual activity.

The dating relationships of adolescents have been associated with both positive

self-esteem and prosocial skills (Neeman, Hubbard, & Masten, 1995). There are negative correlations as well, including risky sexual behavior, early parenthood, psychological problems, and poor academic achievement (Capaldi, Crosby, & Stoolmiller, 1996; Cauffman & Steinberg, 1996; Neeman et al., 1995). Because of the difficult nature of their socioemotional challenges and obstacles, it may be that the strong emotional highs and lows of romance may become the single largest source of stress for adolescents. Finally, adolescent romantic relationships are believed to be a major venue for working through issues of intimacy and autonomy (Connolly & Goldberg, 1999; Erikson, 1968), two fundamental interpersonal processes for future success in relationships.

Abuse history and adolescent sexuality. Several researchers have found evidence of a connection between sexual abuse and sexual problems in children and adolescents (Maltz, 1988; Friedrich, 1990; Briere, 1992; Briere & Runtz, 1990; Cohen, Deblinger, Maedel, & Stauffer, 1999; Wolfe & Feiring, 2000; Flanagan & Furman, 2000; Noll et al., 2000). Survivors of child sexual abuse are at relatively high risk of being revictimized sexually (Grauerholz, 2000; Mayall & Gold, 1995). Cohen et al. (1999) examined sex-related thoughts and feelings of sexually abused and nonabused children. Findings from their research supported the hypotheses that children with sexual abuse histories have problems in the area of sexuality, particularly greater levels of sexual anxiety than nonabused comparisons, supporting the idea that the psychosexual development of victims may be adversely affected by their victimization.

Deblinger (1991), a well-respected child abuse expert, suggests that premature exposure to information about sexuality in a confusing and traumatic framework may contribute to dysfunctional perceptions of sex and sexuality in general. Concerns with sexualized behaviors among sexually abused individuals are well founded. The developmental precociousness and tendency toward more adult-like sexuality may have a strong relationship to subsequent interpersonal rejection or stigmatization in adolescent peer networks. Cohen, et al. (1999) examined sex-related thoughts and

feelings of sexually abused and non-abused children, and addressed the challenges faced by this victimized population in the area of sexuality and psychosocial development. They found that children who have been sexually abused report significantly higher levels of sexual anxiety than non-abused comparisons. The authors posit that victimization experiences cause premature exposure to information about sexuality within a confusing and traumatic context, leading to dysfunctional perceptions about sex and sexuality.

Noll et al. (2000) believes that sexualized dating relationships in early adolescence may have a damaging effect on later sexual development. It may be prudent to examine maladaptive patterns of behavior related to victimization within the framework of normal developmental processes and healthy relationship patterns. But as research continues to examine normative development in peer and dating relationships, it is important to begin understand the developmental sequence, function and consequence of these relationships for victimized adolescents (Wolfe & Feiring, 2000). Abused adolescents report slightly more negative attitudes toward sex, and may be less capable of seeing their dating partner as a "buddy" or a friend.

Effects of child sexual abuse may include traumatic sexualization (Finkelhor & Browne, 1985), which contributes to the development of inappropriate and interpersonally dysfunctional sexuality, including a tendency for a victim of sexual abuse to be more sexually precocious than a nonvictim (Mayall & Gold, 1995). National data reveal that adolescents continue to have the highest rates of rape and other sexual assaults of any age group. Adult abuse survivors often have difficulty with relationships following maltreatment. This manifests in either avoidance of interpersonal intimacy completely, or a tendency to tolerate aggression in intimate relationships as normal or appropriate (Briere, 1992). This research attempted to prove that examining these variables in adolescence might prevent adult patterns from becoming established.

Problems with adolescent sexuality have been increasingly identified as a potential consequence of child sexual abuse. In a survey of middle and high school students, 18 percent of females and 12 percent of males reported having unwanted sexual

experiences (Erickson & Ripkin, 1991). Additional studies of female adolescents have found rape during childhood and adolescence to be associated with younger age of first voluntary intercourse, increased rate of pregnancy, higher depression, greater amounts of illegal drug use, as well as evidence of physical abuse and negative mental health states (Miller, Monson, & Norton, 1995). Heflin and Deblinger (1996) state that issues around dating and sexuality are of heightened concern for many adolescents. In addition, the relationship between child sexual abuse and adult revictimization is found among a variety of samples and studies (Messman & Long, 1996). Studies have demonstrated a greater risk of sexual or physical victimization for adult women, particularly in their sexual and romantic relationships (McCord, 1985; Briere & Runtz, 1987, Bullock & Russell, 1986). Empirical investigation during these years presents an opportunity to explore potential problem areas by gaining a more thorough understanding of the adolescent's beliefs and attitudes toward interpersonal relationships and sexuality in order to identify the pathways from these cognitions to their effects on behavior.

The authors review research pointing to a myriad of interpersonal difficulties individuals with a sexual abuse history endure into adulthood, including: a) greater fear of both sexes; b) greater likelihood of never marrying, or marriages ending in divorce; c) minimal satisfaction in their relationships; d) greater dysfunction in interpersonal patterns; and e) higher levels of discomfort, alienation, and sensitivity in their interpersonal relationships. Although intimate violence often first emerges in adolescent relationships, few studies have included adolescents.

Sexuality and revictimization. Research is consistent with the idea that there is a relationship between a history of childhood sexual trauma, and victim and offender behaviors. There is a need to empirically investigate the degree to which victims of abuse may have a greater endorsement of aggressive attitudes as a result of egregious assaults they may have endured that may contribute to the formation of beliefs, defenses, and coping strategies that are maladaptive compensatory strategies. This can

be accomplished by examining the attitudes and beliefs of adolescents, both abused and nonabused, that may mediate experiences of crucial components of relationships that are healthy, adaptive mechanisms promoting positive relationship satisfaction and outcome. For this study, social support and negative interaction are the two variables examined.

Related research can be found in an unpublished dissertation about adolescents who may be at risk to become perpetrators or victims of sexual violence (Hayworth, 2000). Relevant findings in this work revealed that: 1) girls who identified themselves as more socially capable and reported more extensive peer networks were less likely to endorse "Rape Supportive Beliefs" (RSB's), and may be at reduced risk for sexual violence and revictimization; 2) sexually abused females have an earlier onset of "sexual socialization", less same-sex relationships in middle adolescence, and a "lower status" peer group; 3) girls showed a positive correlation between initiating conflict in their dating relationships and the endorsement of RSB's; 4) girls showed an inverse relationship between social functioning and endorsement of RSB's; 5) girls who endorsed RSB's were significantly more likely to report initiating conflict with their romantic partners than girls who endorsed less RSB's; and 6) improvements of prosocial skills as a result of interventions that facilitate change toward more healthy attitudes and beliefs about the self (e.g. roles, expectations of their relationships) are the foundation for the prevention of revictimization. The author states that peer group composition and behavior have a relationship to sexual violence, and suggests that females with a larger social network and higher incidence of positive socialization experiences are less likely to endorse RSB's, possibly at lower risk to become victims of sexual violence. Girls who were victimized admitted to weaker peer relationships than non-victimized girls. These girls reported a greater proportion of same-sex peers who had engaged in sexual intercourse (p. 42), though there was low statistical significance to this data. In addition, boys in this sample spent more time with same-sex friends than girls, while girls who spent more time with boys were more likely to initiate conflict in these relationships. Across the studies surveyed, the author discovered that between 20

percent and 29 percent of adolescent females report forced sexual encounters (p. 38). There was clear evidence for further investigation intimate violent attitudes and gender socialization among adolescents.

Wekerle and Wolfe (1998) use the term "domestic violence coupling" to describe the activating of an early version of both victim and victimizer roles in relationships set from abusive childhood experiences. An understanding of the sequential nature of behaviors leading to the resulting dysfunctional interactions in subsequent relationships could be better understood by looking more closely at the interactional process. Flanagan and Furman (2000) found that between two-thirds and three-quarters of the victimized women surveyed in their study experienced multiple episodes of victimization. Wolfe and Feiring (2000) cited one study, which looked at victimized adolescents, finding them at greater risk for conflict in their romantic relationships and close friendships when compared with non-maltreated adolescents.

Sexualized behavior is an area of concern for sexually abused individuals. Child abuse has been associated with adolescent dating violence (Malik et al., 1997; Smith & Williams, 1992), but existing data on victimization in middle adolescence is limited (Flanagan & Furman, 2000). Wolfe and Feiring (2000) stress the importance of examining maladaptive patterns of beliefs associated with victimization in abused individuals relative to normal developmental patterns of beliefs. Early initiation of advanced forms of dating in this group of adolescents is reason for concern, as this may lead to premature experiences of "sexual intimacy", which in turn may lead to maladaptive patterns of coercion and aggression in interpersonal relationships. In her research with females who have been sexually abused, Noll et al. (2000) found a tendency for social withdrawal from certain categories of girls, resulting in membership in lower status or undesirable peer groups and sexualized dating relationships, which may have a damaging effect on later sexual development. Understanding how friendships may have a moderating role in lessening the probability of future victimization and fostering mental health, as well as investigating how friendship might mitigate the negative effects of maltreatment on romantic relationship development, has

been the interest of recent researchers (Wolfe & Feiring, 2000) and an important focus for future work.

Messman & Long (1996) discussed "learned expectancy" — that sexuality and intimate relationships are associated with pain and negative feelings—making it difficult to label *revictimization* experiences as abuse; as well as the phenomenon of "learned helplessness", in which active coping such as leaving the relationship or getting help from others, becomes difficult. Though these discussions focus on sexual revictimization, the theoretical models can be extended to other interpersonal functions.

New studies of adolescents are increasing our awareness that they may be both the perpetrators and the victims of romantic aggression, within the same relationship or from one relationship to another. The roles of girlfriend, boyfriend, and lover do not preclude those of perpetrator or victim. Romantic relationships involve coercive interactions in a significant minority of couples. This overlap of perpetrator and victim status may be a key factor in understanding the process of injurious romantic aggression. Peer relationships are an important source of influence on romantic development and can provide a context for learning both positive and negative attitudes and behaviors.

Impact of Abuse on Peer Relationships

It has been suggested that interpersonal struggles are a result of both immediate cognitive and conditioned responses to victimization that continue into the long-term (e.g. distrust of others; anger at and/or fear of those with greater power; concerns about abandonment; perceptions of injustice), along with cognitive responses such as avoidance, passivity, and sexualization (Briere et al., 1994, p. 61). Gamefski and Arends (1998) studied 745 adolescents with a history of sexual abuse and matched them with 745 adolescents without this history. This randomly selected community high school sample found adolescents who have been sexually abused to have a higher incidence of emotional, behavioral and suicidal problems than comparisons.

Buhrmester (1990) found an association between low intimacy with peers and depressive symptoms during adolescence. Herman-Stahl and Peterson (1996) found that poor quality peer relationships predicted depressive symptoms one year later in early adolescence. Research conducted by Monroe, Rohde, Seeley, and Lewinsohn (1999) found support for the significance of the role of romantic relationships in vulnerability to depression when a breakup with a romantic partner became a risk factor for the first episode of depression in adolescence.

A study by Wolfe et al. (2001) examined the connection between child maltreatment experiences and clinically significant mental health problems in adolescence, particularly relationship formation and interpersonal problems. The authors results revealed that females with a history of maltreatment were almost twice as likely to report being victims of sexual abuse by a dating partner and about three times as likely to report threatening behavior. Moreover, these females reported significant adjustment problems in adolescence, including emotional distress such as anger, depression, and anxiety, posttraumatic stress-related symptoms, and acts of violent and non-violent delinquency.

The interpersonal relationships of victims are compromised by multiple factors, including social withdrawal, fear of intimacy, and distrust of others (Conte & Schuerman, 1987). Findings from a study by Parker and Herrera (1996) indicate that low-accepted children viewed their friendships as less supportive and as less trustworthy and loyal. They also reported problems with conflict resolution and less overall satisfaction with their friendships than comparison groups. Relationships characterized by coercion would be expected to lead to dissatisfaction with the relationship and its dissolution. However, the consequences of abusive behavior for relationships are not uniform, and the meaning of such behavior for different dyads is not the same. Perhaps factors relating to resiliency, and possibly to psychosocial trajectories, play a role in these variations in outcome. In light of these complexities, the need to examine individual differences in the peer dynamics of sexually abused youth becomes even more prominent.

Some adolescents do not view acts of aggression as destructive to their romantic

relationships. In fact, these relationships may be viewed as satisfying, and, in some cases, abuse is perceived as improving the relationship (Gray & Foshee, 1997; O'Keefe, Brockopp, & Chew, 1986). Some youth report remaining in abusive relationships despite their coercive nature (Jezl, Molidor, & Wright, 1996). Parker and Herrera (1996) examined the peer relationships of abused children to find that, unlike comparisons, the close friendships of these children were characterized by greater conflict and disagreement between the partners. Such findings indicate that the typical predictors of relationship satisfaction are not always applicable, alerting us that we need to understand why such seeming conundrums occur.

Gaining a greater understanding of how sexual abuse experiences translate into dysfunctional interpersonal patterns, or interfere with normal adaptive processes for utilizing interpersonal resources, is paramount for developing a comprehensive theory of adolescent relationship dynamics. Interventions at this level of development may have important implications in redirecting maladaptive trends in relationship formation, which may occur as a result of prior victimization. There is need to increase the knowledge base of adolescent development subsequent to child sexual abuse, and put that knowledge to use to prevent lifelong difficulties that result in negative outcomes and a compromised quality of life.

The question still remains to be answered: do adolescent relationships play a protective role in preventing the development of problem behaviors in child abuse victims? Wolfe and Feiring (2000) believe that examining the role friendship, as a moderator for the effects of maltreatment on relationships is an important focus of future work. But broadening our view of the correlates of child sexual abuse beyond measures of intrapersonal functioning demands an examination of many of the interpersonal facets in dating and intimate relationships.

Resiliency. Studies on resilient children have determined that peer relationships provide them with emotional support and comfort in times of crises (Werner, 1993).

Further research could examine social support in a non-abused population to determine if there are differences from the abused sample. A more incisive awareness of the manner in which adolescents who have experienced sexual abuse cope with the challenging social demands in their peer relationships is needed. At present, there are three different psychosocial trajectories for youth who have been sexually abused: 1) some appear relatively normal; 2) some become socially isolated and sexually withdrawn; and 3) others become hypersexual and promiscuous (Noll et al., 2000).

Social, cognitive and behavioral factors. Adolescence marks the onset of formal operational thought. It is during this stage when individuals can begin thinking about abstract possibilities and ideals, and are ready for deliberate, self-accusatory introspection. Adolescents can now utilize objectivity when assessing themselves and their relationships, can assume the unique position of offering compassion and help to their friends, while viewing themselves, their friends, and their problems from a long-term perspective (Parker & Gottman, 1989). Presently, research has not fully grasped the transition between early and late adolescence with regard to the formation of healthy relationships, sexual experiences and attitudes. What is known is fundamental for this investigation: that the development and maintenance of peer relations and romantic partnerships in adolescence is the groundwork for adult sexual functioning and relationship satisfaction (Wyatt, Newcomb, & Riederle, 1993).

Clearly, the challenges and developmental tasks of adolescence are a tall order. Certainly, having ample opportunity for optimal support and utilization of available resources during this developmental period would be ideal for the adolescent. However, victims of sexual abuse experience particular challenges with socialization and difficulties developing the skills necessary to contend with the myriad of interpersonal and social demands in their peer relationships.

Part 3 of this chapter begins with a brief overview of social support, with particular attention to theory and research in peer relationship. It concludes with a plea to expand our basic foundation for understanding the role of social support in the peer

relationships of abused adolescents by directing more research toward the cognitions and interpersonal perceptions associated with specific relationships that may influence the adolescents' social behavior and relationship satisfaction.

Part 3

Social Support

There has been an increase in interest in the study of social support in the last 25 years. Interested readers are encouraged to review areas of focus, which include: 1) social support as a protective factor for life stress (Vaux, 1988; Cohen & Wills, 1985), physical health (Kennedy, Kiecolt-Glaser & Glaser, 1990), and emotional well-being (Gottlieb, 1988; 2) the link between social network and perceptions of support (Cutrona, 1986); and 3) cognitive processes that may mediate between support and well-being (Lakey, Mornequ & Drew, 1992).

The hypothesis that there is a link between stressful life events and the occurrence of both physical and mental illness has been the target of a considerable amount of research (Ginsberg et al., 1986). These authors found that variability in the stressfulness of certain life events may be mediated or buffered by social support. They suggest that people who can depend on the support of friends during adversity decrease their risk of negative physical or emotional consequences more than people who are unable to do so. Ginsberg et al. (1986) reviewed evidence finding that, throughout life, we can predict better outcomes when we can have social support, share intimacy, and can replace the loss of social support through major life transitions.

Social support became an area of research interest by increasing the evidence of a relationship between the social milieu and health as portrayed in two seminal papers by Cassel (1976), who has identified three general types of social support assessment: 1)

network measures that focus on the individual's report of social integration into a group, and the interconnectedness of those within that group; 2) measures of received support that focus on support reported as having actually been given by others in some specified time period; and 3) measures of perceived support that focus on the support the person believes would be available if needed. Of the three, measures of perceived support have yielded the strongest positive associations with health outcomes (Sarason, Pierce, & Saranson, 1990), and have been incorporated into this study. The authors find this approach reinforced by the present empirical focus on cognitions, as well as the impact that schemas or personal models may exert over behavior.

Social Support in Normal Peer Relationships

Generally, a "sense of support" (Saranson et al., 1990) reflects the individual's overall feelings of acceptance by others, and belief that others will generally be helpful in times of difficulty. The availability of social support from various sources within the social network has been less frequently studied (Procidano & Heller, 1983). Lately there has been more attention paid to assessing the support provided by relationships in childhood and adolescence, particularly by Furman and colleagues (1999).

Furman and Buhrmester (1985) built on social theory and research when they developed the Network of Relationship Inventory (NRI), a measure used in this study. They incorporated the idea that people seek six types of social support in their relationships: 1) attachment, including affection, security, and intimate disclosure; 2) reliable alliance – a lasting, reliable bond; 3) enhancement of worth; 4) social integration (e.g., companionship); 5) guidance – tangible aid and advice; and 6) opportunity for nurturance of others.

Research demonstrates that adolescents who report having supportive relationships with their close friends also report having supportive dating relationships (Connolly & Johnson, 1996; Shulman, Levy-Shiff, Kedem, & Alon, 1997). Research on adolescent friendship found social support in friendships to be predictive of support in romantic

relationships a year later, with a similar pattern evident for negative interactions (Connolly et al., 1995).

Consistent with previous findings, Connolly et al. (2000) found that perceptions of support and negative interactions in friendships are associated with similar characteristics in romantic relationships. Results from their research found social support to be relationship-specific as well as global. They suggest placing it within a broad relational framework that encompasses relationship-specific conflict as well as support, which is also a goal for the present study.

Social Support and Maltreatment

Studies of the long-term consequences of childhood maltreatment have demonstrated that victims of abuse benefit from the social support that is provided to them both in childhood and adulthood. Empirical studies that have investigated social support in survivors of the long-term consequences of childhood maltreatment have demonstrated that abuse victims fare better as a result of social support they receive both as children and adults (Muller, Goh, Lemieux, & Fish, 2000).

In a study of social support and children and adolescents' adaptation to sexual abuse, Feiring et al. (1998) found evidence of the importance of examining victim perception of support received and available. However, studies of social support have rarely examined survivors of abuse (Brock, Saranson, Saranson, & Pierce, 1996; Werner, 1993). Those that have found that greater levels of current perceived social support are associated with better psychological adjustment (Runtz & Schallow, 1997).

A study conducted by Muller et al. (2000) examined the elements of social support reported as most significant by high-risk maltreated survivors. Their findings suggest that friends are considered more important support providers than mothers in adolescence, particularly for emotional support. They found some additional support for these findings in the literature, including studies that found a greater likelihood of women and men with a history of abuse to confide in friends (Muller et al., 2000;

Mahlstedt & Keeny, 1993; Stets & Pirog-Good, 1989).

Social support and adult survivors of sexual abuse. The role of social support in moderating the impact of childhood sexual abuse on adult psychological adjustment was examined in a study by Testa and colleagues (1992). Women who experienced supportive reactions following disclosure of childhood sexual abuse had fewer psychological symptoms and higher self-esteem relative to those who did not receive support. Muller et al. (2000) examined the specific components of social support reported as most significant by high-risk maltreated adult survivors of abuse. The abused sample rated emotional support from friends as higher in importance than what they received from mothers. Clearly, a more thorough understanding of social support in peer friendships and dating partnerships would be valuable to help understand its' significance for adolescent victims of sexual abuse.

Social behavior in peer relationships: Individual abuse-related differences. A limited amount of studies have investigated the partner relationships of childhood abuse survivors (Ducharme et al., 1997; Roche, Runtz, & Hunter, 1999; Whiffen, Judd, & Aube, 1999). Abused children are less likely than comparison groups to approach unfamiliar peers, and when they do, their interactions are often less successful, reciprocal, and positive than those of other children (Camras & Rappaport, 1993).

Polusny and Follete (1995) developed a theoretical model that investigates the long-term correlates of child sexual abuse. In their model, individuals with histories of sexual abuse attempt to reduce negative thoughts, affective states, and memories of the abuse with coping behaviors that include avoidance of intimate relationships and casual sexual relationships. The authors suggest that these behaviors are meant to relieve emotional pain associated with the abuse. However, using them may result in long-term negative effects, such as feeling socially isolated, dissatisfaction with relationships, sexual dysfunctions, and revictimization.

Wolfe et al. (2001) found violence and abuse toward intimate partners a common

occurrence among high school students, with prevalence rates in excess of 25 percent of dating relationships. Wolfe and Feiring (2000) suggest that there has been little emphasis on the study of adolescence in terms of its developmental importance in establishing a pattern of healthy, nonviolent relationships with intimate partners and future family members (p. 362). Social supports that involve dependable relationships and shared values play a role in the promotion of adolescent health. Based on empirical findings that support the belief that the function of social support in the friendships of maltreated children acts as a protective factor for later pathology, adolescents who have been sexually abused (who are unable to form friendships and receive social support at a developmental period when they withdraw from parental support) may be at great risk for negative outcomes.

Perceived social support is conceptualized by Sarason et al. (1990), p. 309:

> In a sense, perceived social support is a cognitive adaptation that the individual makes given the constraints and opportunities, both real and imagined, created by a history of experiences. This history molds personal working models of self and others and incorporates self-identity and expectations about the nature of relationships (for example, what individuals offer others and what others have to offer them). Perceived social support is not an isolated perception that comes into play only when individuals are confronted by a stressful situation. It is part of a constellation of cognitions that derive from a history of social interactions and account for differences in interpretations of situations, the motives of others and beliefs about what others are 'really like'. Attention to the wide range of social and cognitive phenomena related to perceived social support may contribute to a better understanding of social behavior.

Social Support in the Peer Relationships of Abused Adolescents

Victims of sexual abuse experience particular challenges developing the social skills

necessary to cope with the myriad of demands in their peer relationships. Studies of the long-term consequences of childhood maltreatment have demonstrated that victims of abuse benefit from the social support that is provided to them both in childhood and adulthood. In a study of social support and children and adolescents' adaptation to sexual abuse, Feiring et al. (1998) found evidence of the importance of examining victim perception of support received and available. However, studies of social support rarely examined survivors of abuse (Brock et al., 1996; Werner, 1993). A related study conducted by Muller et al. (2000) examined the elements of social support reported as most significant by high-risk maltreated survivors. Their findings suggest that friends are considered more important support providers than mothers, particularly for emotional support. Muller and colleagues (Muller et al., 2000; Mahlstedt & Keeny, 1993; Stets & Pirog-Good, 1989) found some additional support for these results in the extant literature, including studies that found a greater likelihood of women and men with a history of abuse to confide in friends.

Testa et al. (1992) examined the role of social support in moderating the impact of childhood sexual abuse on adult psychological adjustment. Women who experienced supportive reactions following disclosure of childhood sexual abuse had fewer psychological symptoms and higher self-esteem relative to those who did not receive support. Muller et al. (2000) examined the specific components of social support reported as most significant by high-risk maltreated adult survivors of abuse. The abused sample rated friends as higher than mothers (mothers were second highest) for receiving emotional support.

Social support: Social and interpersonal factors. A limited amount of studies have investigated the partner relationships of childhood abuse survivors (Ducharme et al., 1997; Roche et al., 1999; Whiffen et al., 1999), finding that abused children are less likely than comparison groups to approach unfamiliar peers, and when they do, their interactions are often less successful, reciprocal, and positive than those of other children (Camras & Rappaport, 1993). Briere and colleagues found that adults with a

history of sexual abuse experience decreased satisfaction in relationships, greater incidence of marital difficulties, and more frequent marital breakup colleagues (Briere & Runtz, 1988; Fleming, Mullen, Sibthorpe, & Bammer, 1999).

Bugental (1993) believed that maltreated individuals may be more likely to approach social interactions with a heightened tendency to process threat, which may then lead to overprotective, hypervigilant, and emotionally intense reactions in their interpersonal relations. At the same time, abuse-related difficulties with social cognitions may lead to distorted interpretations and perceptions of their social interactions. One must stress not only how developmental context shapes the adolescents' ability to negotiate tasks, but also how the impact of abuse-related sequelae affects both prosocial and deviant components.

In the final part of the chapter, conflict and aggression in peer and dating relationships is examined. Conflict and aggression is defined; a summary of the existing literature in this area for both normal and abused populations is presented; and theoretical perspectives are presented. A portion of the extant literature addresses negative interaction in adolescent peer relationships in normal samples, or examines the relationships of physically abused children, but relatively little has been studied about the sexually abused adolescent's peer relationships.

Part 4

Negative Interaction

Review of the literature provides evidence that maltreatment increases the probability that adolescents will be interpersonally challenged with regard to negative interaction in peer and social dating relationships (Capaldi & Crosby, 1997; Wolfe, Scott, Reitzel-Jaffe et al., 2001). Wolfe and colleagues (1998) concur with empirical evidence for a maladaptive interpersonal trajectory for maltreated children, wherein a

violent interactional dynamic in adolescent close relationships may be setting the stage for violence in intimate partnerships. Peer and social dating relationships among maltreated youth may be fraught with affective disturbances such as interpersonal sensitivity and hostility, with limited personal resources (i.e. lower self-efficacy) and distorted beliefs about relationships (Wolfe et al., 1998). With this in mind, I begin by presenting the literature on conflict and aggression in adolescent relationships, with specific attention to child maltreatment, relational and indirect aggression, and social-information processing is presented.

Definitions of Conflict and Aggression

Conflicts – disagreements and oppositions – are inevitable whenever people interact. Both conflict instigation and conflict management are important determinants in the exploration of interpersonal conflicts. Unfortunately, there is considerable confusion about the difference between conflict and aggression. Conflicts of an aggressive nature frequently gain attention as a result of the associated risk of aggression to child and adolescent development. However, many arguments among youth are resolved without aggression.

Conflict is most often related to opposition or resistance among people; one individual behaves in an objectionable manner in the opinion of another (Hartup, 1993). Conflict is often the context in which aggression manifests. Aggression is defined as behavior directed at hurting another person or thing the other lays claim to, as one of many possible tactics for winning a disagreement (Shantz & Hartup, 1992).

Shantz and Hartup (1992) suggests that conflict is both a determinant and an outcome of adolescent peer interaction. Conflicts can be defined from a temporal perspective: short-term versus long-term disagreements. Disagreements that are ongoing, more intense and consequential are usually considered conflictual in nature. In Hartup's (1993) view, disagreements, arguments, or fights could all be considered conflicts.

Theoretical Perspectives on Conflict

There are multiple theoretical perspectives on conflict, running the gamut from developmental psychology to the social sciences. These theoretical models can be found in the writings of Sigmund Freud (1936/1965), B.F.Skinner (1938), Jean Piaget (1980, 1985), and the "Sturm and Drang" formulations of G. Stanley Hall (1904). Some of the meanings and applications in different content domains of psychology include: motivation (Lewin, 1935); personality and psychopathology (Freud, 1936/1965); cognitive development (Piaget, 1962); behavioral biology (Hinde, 1966); and interpersonal conflict in social and child psychology (Duncan, 1991; Kolominskii & Zhiznevskii, 1990).

Interest in interpersonal conflict in social and child psychology has been vast, with formidable research literature on the social relations of children. Much of the focus has been on interactional conflict between peers and how adults may handle these conflicts. However, the literature is more data-focused than theoretically grounded, largely as a result of a lack of integration of systematic psychological and developmental theory.

Social-cognitive theories of conflict. Theories of cognitive development portray conflict as a poor fit between the existing schemata of the person and the perceptual challenges of external events and objects (Shantz & Hartup, 1992, p. 17). Social-cognitive theory posits that aggressive responses are not absolute, but are affected by particular thoughts and patterns of processing information. Studies of aggressive children have focused on the relationship between perception and action, but much more needs to be understood (Dodge & Crick, 1990). Research during the past several decades in attribution, decision-making, and information processing has led to theoretical and empirical advances in the area of aggressiveness in peer social interaction.

Conflict in Normal Relationships

Conflict is expected in the normative development of youth. Laursen (1990) found that during the course of an average day, a typical high school student is involved in about seven disagreements. Moreover, conflict has been linked to characteristics of psychosocial development, including identity formation, development of social-cognitive skills, and ego development (Laursen & Collins, 1994). Effective conflict management skill is interpersonally adaptive, brought on by the social and cognitive changes of adolescence (Paikoff, Brooks-Gunn, & Warren, 1991; Steinberg, 1991; as cited in Collins & Repinski, 1994).

In normal relationship development, children learn to master aggressive drives within the peer group milieu, developing appropriate aggressive behaviors and rehearsing regulating mechanisms for modulating aggressive affect. Peer interaction affords opportunities to experiment aggressively with one's age mates, whose cognitive and social skills are comparable to their own (Hartup, 1996). Hartup cites that the nature of the relationship determines the effect of conflict on subsequent interactions, with social interaction between friends and dating partners most likely to continue despite disputes; the strategies utilized by friends and dating partners seem to lessen the disruptive potential of conflict.

According to equity theory, individuals with rewarding social exchanges work toward maintaining the positive rewards of these relationships by reducing distress and inequity. In longitudinal studies of friends by Berndt and Keefe (1992), it was found that relationship bonds deteriorate with ongoing conflict. However, conflicts that include constructive engagement may stimulate positive adaptation (Laursen & Collins, 1994). Furman and Buhrmester (1992) and Miller (1993) find that beginning in mid adolescence, conflict with same-sex friends declines, but increases in relationships with dating partners.

Longitudinal studies reveal that childhood aggression is the best-known behavioral predictor of future social adjustment problems (see Coie, Dodge, & Kupersmidt, 1990,

for a review). Findings from studies of children's social adjustment suggest that future social adjustment may be affected by a number of skills. These include the ability to obtain helping, caring responses from peers (e.g., support), conflict management skills, and the ability to avoid aggressive overtures (Crick & Grotpeter, 1996).

Conflict in Adolescent Peer Relationships

There are a number of writings that deal with a broad range of topics related to conflicts (For review, see Shantz and Hartup, 1992). In a review of interpersonal conflict during adolescence, Laursen and Collins (1994) examine the pervasiveness of conflict in adolescent social relationships, placing emphasis on a social relationship perspective. Their definition of conflict is defined as a dyadic, interpersonal, behavioral event involving opposition that includes negatively charged affective exchanges (e.g. quarrels and antagonism). Furthermore, adolescents with coercive friendships are more likely to report difficulties in their romantic relationships (Connolly et al., 2000).

Difficulties in peer relationships generally arise from two distinct social styles: withdrawal from social interaction and aggressiveness in social interaction (Parker & Asher, 1987). Either pattern would present challenges to the development of romantic relationships. In the case of withdrawn adolescents, their social behaviors are usually associated with exclusion from peer groups and difficulty initiating and maintaining friendships. Excluded from the experience of same and mixed gender peer groups, they may lack the opportunity to benefit from the normative and skill-building informal dating relationships that form early on within these friendship groups. Missing the chance to learn the necessary skills of intimate interaction, socially withdrawn adolescents may find it difficult to develop intimacy, often leading to too little or too much of it. Moreover, missing opportunities to formulate a conceptual framework for understanding romance in same-sex friendships, socially withdrawn youth may rely more on media and popular images of romantic relationships, resulting in greater levels

of dissatisfaction based on the development of distorted perceptions and expectations (Connolly & Goldberg, 1999).

Youth with an aggressive behavioral social style may have friendships with individuals similar to themselves (Connolly, McMaster, Craig, & Pepler, 1998). Connolly and her colleagues suggest there may be an increased risk that aggressive behavioral styles within the peer group will be extended to dating relationships. Adolescence is often viewed as a bridge in relationship style through to adulthood, so it is most disturbing to discover incidence studies of violence in adolescent partnerships showing a range from 30 percent to 50 percent of all high school youth (Suderman & Jaffe, 1993). Adults reporting relationship violence often have memories of violence in their adolescent relationships (Dutton, 1994). Aggressive patterns of social interaction may be linked to the quality of the interactions in these relationships as well (Capaldi & Crosby, 1997; Quinton, Pickles, Maughan, & Rutter, 1993).

In normal relationship development, children learn to master aggressive drives within the peer group milieu, developing appropriate aggressive behaviors and rehearsing regulating mechanisms for modulating aggressive affect. As previously mentioned, peer interaction affords opportunities to experiment aggressively with one's age mates, whose cognitive and social skills are comparable to their own (Hartup, 1996). Hartup suggests that the nature of the relationship determines the effect of conflict on subsequent interactions; social interaction between friends and dating partners most likely continue despite disputes, while the strategies utilized by friends and dating partners seem to lessen the disruptive potential of conflict. Many adolescent conflicts do not ultimately affect the relationships, with disagreements reportedly improving the relationship as much as having little or no effect.

Individual differences in conflict: Gender, developmental, and individual issues. Gender differences manifest in several ways. In early childhood, disagreements are more common for boys than girls; disagreements for boys often involve power, while girls disagree about interpersonal matters. Moreover, approaches to conflict resolution vary as well, with boys using power assertion and girls indirect approaches, bargaining

and negotiation. Male adolescents report more often than females that disagreements have little effect on their relationships, while females show greater concern with long-term implications, both positive and negative (Hartup, 1993; Putallaz & Sheppard, 1992).

Research on developmental issues for conflict and friendship relations is methodologically flawed and inconsistent. Individual differences are apparent, such as number of friends, stability of friendship, and behavioral organization of friendships. While studies of conflict in dyadic relationships are in their nascent stages, other variations need to be investigated, such as individual differences in variation in intensity, exclusivity, security, commitment, and the saliency of reciprocity and complementarity. Presently, studies of conflict in adolescent populations are scattered, with limited attention to abuse samples.

Relational/Indirect Aggression or Victimization

There is substantial evidence that peer victimization is a relatively common and destructive characteristic of children's peer relationships (Boulton & Underwood, 1992; Olweus, 1993; Crick & Bigbee, 1998). Peer maltreatment contributes to parallel maladjustment, such as peer rejection, in addition to difficulties with adult depression (Crick & Bigbee, 1998). Understanding of aggression has been advanced by the study of relational aggression. However, there is still relatively little empirical information available regarding the nature of relational aggression in adolescence and adulthood (Werner & Crick, 1999). Research on indirect aggression reveals that adolescents and adults do employ relationally aggressive behavior in their social interactions (Bjorkqvist, Osterman, & Lagerspetz, 1994).

Previous research has determined that males are usually more aggressive than females (see reviews by Eagly & Steffen, 1986), but considered only overt forms of physical and verbal aggression. More recently, there has been increased interest in more indirect forms of aggression (i.e., spreading false stories about others, isolating)

(Crick, 1995; Crick & Bigbee, 1998). Researchers consider this style a result of the overall relational nature of girls; they tend to use forms of aggression that will damage the relationship, such as breaking confidences or ostracism. Unlike girls, boys tend to be characterized by greater instrumental and physical dominance goals, resulting in more overt forms of aggression (e.g., hitting, kicking).

Crick and Grotpeter (1995) define relational aggression as "harming others through damage to their peer relationships or the threat of such damage" (p. 313). Crick and Bigbee (1998) discovered that relational aggression includes behaviors in which relationships specifically serve as the vehicle of harm. Owens (1996) reports that during adolescence, girls exceed boys in the use of indirect aggression, and are more often victimized (Crick & Bigbee, 1998). Moreover, Crick states that relationally aggressive children often under report their use of relationally aggressive behaviors, making it more difficult to identify and study.

Intimacy and relational aggression. Grotpeter and Crick (1996) assessed the degree of intimacy and support reported within the friendships of 9 to12 year old girls. Results of this pilot study indicate that relationally aggressive girls report more aggression in their friendships, as well as greater levels of perceived intimacy. Furthermore, the friends of these girls report higher levels of conflict and betrayal in these relationships, with greater levels of relational aggression and higher levels of exclusivity than girls reported about friendships with nonaggressive girls. These girls also reported engagement in relatively high levels of self-disclosure. However, Grotpeter's results showed that this type of intimacy (which includes divulging secrets and private feelings and usually considered a positive characteristic of friendship) might actually be elicited as a means to gain control over friends (e.g., by threatening to betray confidences if the friend disobeys their commands).

Social-information processing in relational and overt aggression. Children's social behavior, including aggression, has been seen as a function of sequential

social-information processing steps. (i.e., biased processing contributes to deviant social behavior such as aggression.) These processing steps, including encoding of internal and external social cues and interpretation of the encoded cues, contribute to and motivate children's involvement in aggressive acts (Crick & Bigbee, 1998). The researchers discover that, relative to their nonaggressive peers, aggressive children more frequently misinterpret social cues in a hostile way, eventually believing that there are positive outcomes from their aggressive behavior.

Impact of relational/indirect aggression or victimization. Aggressive children do have friends, but they often belong to peer networks containing similarly aggressive children (Grotpeter & Crick, 1996). Grotpeter cites research demonstrating that victims of relational aggression experience significant difficulties with social-psychological adjustment. As a result of a high correlation between relational forms of aggression and victimization, relational victims have an increased likelihood that they will retaliate through relational aggression. The authors state we are still forming an empirical base of understanding about aggressive children and adolescent friendships are still forming. Therefore, it is unclear whether these relationships offer the positive, supportive functions that usually exist in normal friendships (Grotpeter et al., 1996).

Owens, Shute, and Slee (2000) used a qualitative investigation of adolescent girls and their teachers to explore explanations for adolescent girls' indirect aggression (defined as spreading false rumors and excluding peers from a group). Results revealed the key explanation for their indirect aggression: a desire to create excitement, coupled with a need for inclusion in the peer group, and a desire for close, intimate relationships. Additional explanations include: alleviating boredom; jealousy; revenge and retaliation; competition over boys; threats to relationship (e.g., possible loss of partner); and threats to self-esteem (e.g., from being rejected by a partner).

Galen and Underwood (1997) examined social aggression among 7th and 10th graders. Social aggression was defined as an attempt to damage another's self-esteem, social status, or both. Behaviors used to manipulate these factors include verbal

rejection and negative facial expressions, and more indirect methods, such as slanderous rumors or social exclusion. Galen & Underwood found that gender differences in social aggression are not significant and have been decreasing in recent study findings. Results of their study on social aggression confirmed that girls view both socially and physically aggressive behaviors as equally damaging. Moreover, adolescent participants' reports suggested that incidences of overt expressions of anger are on the rise. Reviews of the literature on social aggression confer with their findings (Schlossman & Cairns, 1993; Viemero, 1992, as cited in Galen & Underwood, 1997). Unfortunately, the authors conclude by stating that these maladaptive patterns of coping with anger and aggression could remain long-standing; that is, they may go on to interfere with future friendships and work relationships, disrupt romantic relationships, and interfere with effective parenting.

Conflict and Child Maltreatment

A seminal study examined maltreated adolescents and found they are prone to more conflict with dating partners and close friends compared with non-maltreated adolescents (Wolfe, Wekerle, and Reitzel-Jaffe et al., 1998). In a paper examining data on peer relations in maltreated children, Mueller, Ernst, & Thiel (1987) found a theme of heightened aggressiveness in peer interaction. A second characteristic that emerged in this analysis of maltreated adolescents was an excessive degree of withdrawal and avoidance of interaction with peers. The authors hypothesize that those who do evidence heightened aggressiveness in relationships with peers may be re-enacting their abuse experience, placing themselves in the more powerful role of aggressor. It is in this way, the authors believe, that adolescents may manage to avoid feelings of helplessness and traumatic sequelae associated with having been abused. These kind of interactions, which may be harsh and comfortless, offer a predictability and familiarity that may minimize the psychological pain associated with seeking support and finding little, and instead offer the predictable rejecting or abusive response.

Bowlby (1973) suggests that both examples of responses, aggressiveness or withdrawal, stem from a view of the world as comfortless and unpredictable, to which they respond by either retreating from or striking out. They conclude that research reviewed suggests that the development of egalitarian and trusting relations between peers may be negatively affected in several ways by a history of maltreatment. Furthermore, they suspect that maltreatment may also interfere with an additional area of development of peer relations – the gradual transfer of the functions of support, security, and intimacy from parents to peers. They offer three predictions about the causal relationship: 1) maltreating relationships do not offer a good model of trust and intimacy; 2) the experience of maltreatment may lead the youth to look to peers prematurely to fulfill unmet needs; and 3) the gradual transfer of functions from parents to peers may become accelerated or distorted as they hope to find much needed emotional support. Following a thorough examination of peer relations in both the context of a normal developmental framework and that of maltreated children's peer relationships, the author concludes that peer relationships are a particularly vulnerable area for abused children.

Following an exhaustive perusal of the extant literature and research, it is noted that there is a need for future studies to look at these predictions more systematically, as the present understanding of the relationship between a history of maltreatment and adolescent social functioning is still quite global. This includes utilizing the growing body of research focused on normal children's peer relations, as well as exploring the mental representations of maltreated children. This research was inspired in part by the premise of earlier work done by Wolfe, Wekerle, and Reitzel-Jaffe et al., 1998, suggesting that relationship problems in adolescence can be viewed as part of a pattern of behavior that emerges from an attempt to adapt to inappropriate circumstances. Related research findings from Wolfe's seminal study on factors associated with abusive relationships found more hostility and interpersonal sensitivity in adolescents with a history of maltreatment.

Pawlby, Mills, and Quinton's (1997) prospective study found that adolescent girls

who had been removed from maltreating families perceived their relationship with their current boyfriend as the most important part of their entire social group. They viewed themselves as easily influenced by their boyfriends; subsequently, as adults they experienced lower interpersonal functioning than a comparison group. These authors cite maltreatment as the forerunner to an increase in dependence on romantic relationships with troubled partners, and that this overdependence on a romantic partner may lead to a tendency to overlook partner abuse, dishonesty, unfaithfulness, and drug and alcohol abuse. Formulations for this study was also inspired by the recent work of a group of researchers who have built on studies such as those described above, focusing their efforts on increasing our limited understanding adolescents and their friendships (Special Edition of Child Maltreatment, November 2000; Noll et al., 2000).

Research and theoretical understanding of adolescent peer and romantic relationships is in the nascent stages, particularly with regard to the study and treatment of victim and victimizer behavior. Presently, there are a great deal of questions remaining about how maltreatment in childhood impacts adolescents and their friendships and peer relationships, and in what way this affects the quality of their relationships and future satisfaction and well-being into adulthood (Noll et al., 2000). It is a goal to in some small way advance the empirical work of Noll, who discovered differences in how social functioning relates to sexual attitudes (and activity) for sexually abused and comparison girls. Because there are many adolescent girls who do not have these problems, it is important to investigate individual differences; ways in which the adolescent who has been sexual abused may be vulnerable to relationship-centered difficulties, including vulnerability for revictimization or victimizer behavior. Noll's results lend additional support to the assumption that a history of maltreatment as a risk factor in adolescent relationships will contribute to negative outcome beyond adolescent peer and dating relationships, forming lasting patterns of violent and maladaptive dynamics in adult intimate partnerships.

Interpersonal conflict and social interactions. Though some adolescent relationships are healthy and supportive, there is often a high frequency of coercive and aggressive behaviors. More than one-third of high school students report engaging in one or more abusive acts toward a dating partner in any given year, including behavior such as verbal harassment and intimidation, to more severe acts like slapping, choking, punching and forced sex (Wolfe, Scott, Reitzel-Jaffe et al. 2001). Jackson, Cram, and Seymour (2000) and Wolfe and colleagues (1998) believe that long-term patterns of abuse in intimate relationships are the result of accumulated risk factors for abusive behavior that begin during the critical period of adolescence. Briere (1996) states that sexually abusive relationships may teach adolescents to be hypervigilant of the needs of the other, often at the expense of the self, in order to protect themselves and be valued. When relationships become too close and threatening, knowing no other means of self-protection, the adolescent survivor withdraws to regulate intimacy. Caught between the desire to be connected and the fear of being connected to others, the adolescent may cycle through relationships, which often leads to a further sense of loss (Briere, 1996). Davis et al. (1997) suggests that adult women with histories of childhood sexual and physical abuse have much higher rates of problems with intimacy, empathy, trust, and sexual anxiety, which can interfere with sustaining healthy relationships.

Cultural messages and gender stereotypes. Wekerle and Wolfe (1998) believe there may be particular vulnerabilities in this group to cultural messages about gender stereotypes (e.g. male dominance, competitiveness, uncommunicativeness; female submissiveness and passivity), which may later translate into hyper vigilance for signs of aggression. Wolfe suggests that when adolescents engage in new partnerships, they may begin to expect to encounter and ultimately accept hostility from who they view as "powerful others" (Bugental, 1993), misconstrue hostile intent when others become oppositional, and adopt maladaptive beliefs that aggression is a feasible method to use to resolve conflict.

Conclusion

As detailed in the above review, forming peer relationships and intimate partnerships raises important issues and presents formidable challenges for relationship-disrupted populations such as adolescent victims of sexual abuse. Current knowledge about sexual abuse, and the interpersonal and psychosocial correlates of adolescent development, continue to expand. However, research on the social and emotional sequelae of maltreatment has only recently been directed at increasing understanding of the known reciprocal influences of maltreatment and peer relations. Unfortunately, what is known from existing research documents a profile of abused youth consistent with theoretical formulations that predict pervasive negative effects of abuse on their relationships with peers.

This paper points out the need to expand scientific understanding of the interpersonal and social processes for the abused adolescent by investigating from within a broader context than the abuse itself; one that includes attitudes and beliefs about conflict and abuse, interpretations of violence and maltreatment, and perceptions of available resources, such as social support. It has been suggested that perspectives and understanding of what is known about normative paths for interpersonal relationships be integrated to shed more light on abuse-related interpersonal destructive influences. Indeed, understanding and preventing negative interaction, maladaptive relationship attitudes, and inadequate social support in the peer relationships of adolescents with an abuse history will require informed attention to these processes.

Recent studies cited in this work reveal a wide array of psychological and interpersonal problems, which occur more frequently among individuals who have been sexually abused. Many of these adolescents face huge obstacles, including negative self-views and conflict and uncertainty, as they struggle to develop relationships in the absence of social supports at school, home and in the community. Could it be that abused adolescents have greater difficulty recognizing their own abusive relationship

attitudes? Victimized adolescents must develop the competencies necessary to negotiate their relationships. This process may begin with recognizing maladaptive relational attitudes and difficulties with interpersonal conflict and social support in their peer and dating relationships as an index of poor social functioning. Overall, there is widespread consensus on recommendations for future research that examines how friendship, such a predominant force in the lives of our children and adolescents, may act as a moderator for mitigating the effects of maltreatment on peer and dating relationship development. However, research is only beginning to address some important, provocative questions with regard to the intermingling of variables that converge with a history of sexual abuse and the development of healthy peer relations.

This study posed several questions related to peer relationships: Do adolescents who have been sexually abused perceive less available social support in same-sex and/or dating relationships? If so, is this related to dysfunctional aggressive sexual attitudes? Do adolescents with a history of sexual abuse experience more negative interactions in their peer relationships than non-abused comparisons if they endorse more tolerance of aggression? Do adolescents with a history of sexual abuse have greater dysfunctional sexual attitudes than their nonabused comparisons?

These are questions that encourage a closer look at the multi-faceted network of individual factors that contribute to the experience of the adolescent victims of abuse within their social environment. There are many twists and turns on the road to understanding the interpersonal and psychosocial processes of the abused adolescent; this study does not intend to address the breadth of topics raised earlier. At best, it attempts to embark on an initial examination of the relational attitudes of adolescents with a sexual abuse history in an effort to determine if problems related to the sexual abuse create greater challenges for interpersonal functioning. This step is taken with a look beyond dysfunction toward healthy interpersonal intimacy and emotional interaction, and with a continuation of these healthier patterns well into adulthood. There are many challenges for adolescents today, as well as concerns with bullying,

victimization and high-risk sexual behavior, to name but a few. These problems do not appear to be vanishing anytime soon. The possible consequences remain a very serious concern.

List of Hypotheses:

The following eight hypotheses were addressed in this research:

Hypothesis 1 – Adolescents who have been victims of sexual abuse would endorse lower levels of social support and higher levels of negative interaction in their same-sex relationships when compared to the non-abused group.

Hypothesis 2 – Adolescents who have been victims of sexual abuse would endorse lower levels of social support and higher levels of negative interaction in their dating relationships when compared to the non-abused group.

Hypotheses 3 – There would be a difference in levels of dysfunctional sexual attitudes between the sexually abused and non-abused comparison groups.

Hypothesis 4 – There would be a difference in levels of tolerance of aggression between the sexually abused and non-abused comparison groups.

Hypothesis 5 – There would be a negative correlation between social support and dysfunctional sexual attitudes in the relationships of adolescent victims of sexual abuse.

Hypothesis 6– There would be a positive correlation between negative interaction and dysfunctional sexual attitudes in the dating and same sex relationships of adolescents.

Hypothesis 7 – There would be a negative correlation between social support and tolerance of aggression in the dating and same sex relationships of adolescents.

Hypothesis 8 – There would be a positive correlation between negative interaction and tolerance of aggression in the relationships of adolescent victims of sexual abuse.

Chapter 2

Method

Institutional Review Board for the use of Human Subjects in Research Approval

This research project was reviewed and approved by the Human Subjects Committee at the University of Medicine and Dentistry of New Jersey, School of Oseteopathic Medicine (UMDNJ-SOM) and the Philadelphia College of Osteopathic Medicine.

Participants

Subjects in the present study were female between 13 and 17 years of age. Sample size is $N = 61$. There are two groups of subjects: Group 1 was comprised of 28 adolescents who have been sexually abused; Group 2 was comprised of 33 adolescents who had no known history of sexual abuse. Inclusionary Criteria for Group 1, the sexually abused adolescent, included: female; ages 13 - 17; abuse validation as described below; and signed consents by parent or legal guardian and adolescent. Exclusionary Criteria for Group 1 included: existence of Mental Retardation (<70 IQ); a diagnosis of Pervasive Developmental Disorder, Psychotic Disorder, or a serious medical illness (functional impairment); and expression of intent to hurt self or other. Inclusionary and exclusionary criteria for Group 2, the non-abused adolescent sample, was identical to Group 1, with the exception of abuse status, which was: reports no known history of sexual abuse.

The adolescents range in age from 13 to 17 years with a mean age of 15.06 years. The following demographic data describing the sample characteristics are presented in Tables 1 - 9: race/ethnicity, school placement, relationship of parent to adolescent,

parent marital status, parent highest grade, parent highest degree, parent employment, head of household occupation, and family income.

Procedure

Group 1 - Sexually abused adolescent clinical sample. This group consists of 28 adolescent females with a substantiated history of sexual abuse. The New Jersey Division of Youth and Family Services (DYFS) and the New Jersey Prosecutor's Office conduct investigations: subjects who have been referred to the Center for Children's Support (CCS) at the University of Medicine and Dentistry, School of Osteopathic Medicine's (UMDNJ-SOM) Specialty Care Center in Stratford, New Jersey for treatment by the above mentioned agencies, as well as by the Center's medical staff following forensic medical examinations, are included in the clinical sample.

Parents or legal guardians and children who have met screening criteria worked with a therapist at the CCS to review the purpose of the study and what they were expected to do, including potential risks, benefits, and confidentiality procedures. They have reviewed, signed and received copies of consent forms.

A therapist and a psychology intern worked together to collect baseline pretreatment assessment data from a standardized set of measures routinely given to all youngsters and non-offending caregivers before beginning treatment at the CCS. The therapist conducted a structured background and diagnostic interview with the non-offending parent; a psychology intern and/or the therapist administered the self-report measures to the adolescent. Two of these measures as described below were used in the current investigation for comparison to the matched non-abused group, who also completed the same two study measures. The completed measures are stored in a locked file cabinet in the CCS by ID number, and were blind entered into the CCS's confidential database by this ID number and then returned to their secure location for storage.

Group 2 - Nonabused adolescent control sample. This group consists of 33 adolescents with no known history of sexual abuse who are medical patients at the Department of Pediatrics, Division of Adolescent Medicine, at the University of Medicine and Dentistry of New Jersey-School of Osteopathic Medicine (Primary Care Center) in Stratford, New Jersey. Medical records were generated randomly by computer to derive a sample of adolescents who met basic eligibility criteria (gender and age) and selected for inclusionary and exclusionary criteria. They were then recruited for the study by a structured telephone screening conducted by the researcher. Telephone calls were made to the parent or legal guardian of youngsters who met the basic eligibility requirements (see Appendix D). A brief introduction to the study was offered to determine interest in participation, and an initial eligibility screening was conducted. At that time, known history of sexual abuse was ruled out, confirming the possible omission of any history of abuse that was not given to the primary care physician and recorded in the problem list of the medical chart. If no history of abuse was acknowledged, the parent/guardian was then informed that the procedures for the study were expected to take approximately 30 minutes, and that they would receive $20 for participation at the completion of the procedure. If the parent/guardian expressed interest in allowing his or her adolescent to participate in the study, both were willing to participate, and the adolescent met the screening criteria, the researcher and participant arranged to meet at a convenient day and time in the Department of Pediatrics, Division of Adolescent Medicine at the UMDNJ-SOM Primary Care Center. The researcher met the participants at the arranged day and time in the main reception area; all of the study procedures and data collection were then conducted in the adolescent waiting room in that department.

When a parent/guardian and adolescent arrived for their scheduled research appointment, the researcher met with both of them to review the study and explain what they would be expected to do, as well as any potential risks, confidentiality and consent procedures. Questions pertaining to the study or its procedures were addressed. Each parent/guardian was permitted to peruse measures if they requested. The consent

was reviewed and explained to all adolescents; the parent/guardian was then given a consent form to read and it was reviewed (Appendix B). It was requested that both forms be signed and dated by the study participants when they agreed to participate. There were no individuals who declined participation. The researcher recorded a witness signature and date, and one copy each of the signed and dated consent forms were given to all parent/guardians and their adolescents to retain for their records and future reference.

The parent/guardian then responded to a demographic interview Appendix C) given verbally by the researcher. Following the completion of this brief interview, the researcher then administered the two self-report study measures to the adolescent: The Network of Relationship Inventory-Short Form (NRI-S) (Appendix E); and the Relationship Attitude Survey for Adolescents (RASA) (Appendix F). These were completed in the same room, but out of view of the parent/guardian. Approximately ten to 15 minutes were required to complete this part of the procedure. The researcher remained seated between both the parent and adolescent, available for any questions or concerns that either of them may have had at any time during the procedure.

Upon completion of the measures, the researcher collected the data from the parent and adolescent, and provided them with the agreed upon financial reward. They were thanked for their contribution to the study, and reminded to retain and refer to their copy of the consent form for contact or any other information they may need either now or anytime in the future. The completed measures were then taken by the researcher to the CCS in the Specialty Care Services building of UMDNJ-SOM and placed securely in the locked file cabinet, where they remained stored: the data was later blind entered into the CCS's confidential database by ID number, then returned to the locked file cabinet.

Demographic variables. There is a standard demographic interview given to all patients beginning treatment at the CCS prior to completion of the pretreatment measures. This demographic instrument was utilized to gather demographic data for the

Group 1 sample. Group 2 was given a structured demographic interview that had been designed to guide the investigator in the collection of demographic and abuse information that corresponds to that collected from Group 1 (Appendix C). Details pertaining to the demographic variables for both study groups are listed in Tables 1-9 (pp. 80-88). Additional information on the demographic variables pertaining to statistical analyses is presented in Chapter 3, Part 2 (p. 75).

Instruments

Independent and Dependent Variables

Interpersonal factors: Social support and negative interaction. The 24-item Network of Relationship Inventory-Short Form (NRI-S; Furman & Buhrmester, 1985) (Appendix E) was utilized to measure support and negative interaction. It was derived from a longer version of the Network of Relationship Inventory (NRI; Furman & Buhrmester, 1985). The NRI-S examines two dimensions of adolescent peer relationships; one assessing perceptions of Social Support, and a second assessing perceptions of Negative Interaction. Adolescents are asked about features of their relationships with same-sex friends and boy/girlfriends. This self-report measure consists of 24 items and yields one overall mean score for Support and one overall mean score for Negative Interaction for each of the two relationships. A Summary Score can be computed by averaging the scores for both. Respondents rate items on a 5-point Likert-type scale ranging from 1 (Little or None) to 5 (The Most). Averaging the following items scores the Social Support factor: 6, 7, 8, 9, 11, 12, and 15. The Negative Interaction factor is the average score of items 4, 5, 10, 13, 14, and 16. Psychometric analyses revealed that the internal consistency of the total scale scores were satisfactory, *M* Cronbach's Alpha = .80. Alphas of the individual scale scores were greater than .60 (Furman & Buhrmester, 1985).

Relational attitudes: Dysfunctional sexual attitudes and tolerance of aggression. A measure of relational attitudes was derived from the Relationship Attitudes Survey for Adolescents (RASA; Feiring, Deblinger, Hoch-Espada, & Hayworth, 2002) (Appendix F). This 31-item scale is under development at the Center for Children's Support to measure adolescent attitudes about intimate relationships and sexual interactions. Based on factor analysis, the RASA has three reliable subscales: 1) Tolerance of Aggression (alpha = .86), which taps the endorsement of attitudes suggestive of aggression as acceptable. This 6-item scale targets attitudes such as "It is okay for a woman to be verbally aggressive in a relationship" and "It is okay for a man/woman to be physically aggressive in a relationship;" 2) Dysfunctional Sexual Attitudes (alpha = .83), a 13-item scale taps the endorsement of attitudes that justify the use of sexual aggression, such as "If someone dresses in a sexy way, it means he or she wants to have sex;" and 3) Healthy Relationship Attitudes (alpha = .80), a 6-item scale that assesses the endorsement of attitudes that describe positive relational or intimate attitudes, such as "I think it is important for couples to talk about how they feel about sex" and "You can express love and caring without having sex." Respondents rate items on a 5-point Likert-type scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). For the purposes of this study, this self-report measure will yield one overall mean score for only two of the three relational attitudes subscales: Dysfunctional Sexual Attitudes and Tolerance of Aggression. Corresponding item numbers on the RASA for Tolerance of Aggression are: 4, 8, 12, 20, 24, 28, and 31. Corresponding item numbers on the RASA for Dysfunctional Sexual Attitudes are: 2, 3, 6, 9, 10, 13, 14, 17, 18, 22, 25, 26, and 29.

Chapter 3

Results

This chapter presents the results of the statistical analysis for this study, which examined whether Relational Attitudes (dysfunctional sexual attitudes and tolerance of aggression) and Interpersonal Factors (social support and negative interaction) differ in the same-sex and dating relationships of abused and nonabused female adolescents. In the first part of this chapter, I present the statistical analysis used for the study and the main study variables was presented. Part 1 concluded with a summary of the statistical analyses for the eight main research hypotheses.

In Part 2 of this chapter, a detailed description of the demographic characteristics of the clinical and control group samples was presented and displayed in Tables 1 – 9. Next, each hypothesis is analyzed: for each hypothesis, there is a description of how it was tested, the results of the major analyses presented, and the immediate implications of the findings was discussed. Finally, Analysis of Variance (ANOVA) data for Hypotheses 1 - 4 is presented in Tables 10 – 15.

Part 1

Statistical Analysis and Main Study Variables

This study examined whether Relational Attitudes — dysfunctional sexual attitudes and tolerance of aggression — and perceptions of Interpersonal Factors — social support and negative interaction—differ in the same-sex and dating relationships of abused and nonabused female adolescents. Data were entered, managed and analyzed

using SPSS programs on a personal computer at the Center for Children's Support by a research coordinator blind to the study hypotheses. To protect the data and insure its accuracy, range and validity checks were conducted during data entry, and back-ups were routinely performed. The analytical techniques employed in the present investigation included Analysis of Variance (ANOVA), Analysis of Covariance (ANCOVA), Semipartial Correlational analyses, and Pearson Correlations.

Independent variables for Hypotheses 1 – 4 are: 1) History of Abuse-the clinical sample has a substantiated history of sexual abuse; the control group has no known history of abuse; the dependent variables measured were 1) Relational Attitudes-dysfunctional sexual attitudes and tolerance of aggression, derived from the Relationship Attitudes Survey for Adolescents (RASA) (Appendix F); and 2) Interpersonal Factors: level of perceived social support, and level of perceived negative interaction in the adolescent's same-sex and dating relationships. Data was derived from the Network of Relationship Inventory-Short Form (NRI-S) (Appendix E). Independent variables for Hypotheses 5 – 8 are Interpersonal Factors: level of perceived social support, and level of perceived negative interaction in the adolescent's same-sex and dating relationships; and dependent variables are the Relational Attitudes-dysfunctional sexual attitudes and tolerance of aggression.

To examine the eight hypotheses, Analysis of Variance (ANOVA), Analysis of Covariance (ANCOVA), and Semipartial Correlations were performed. ANOVAs were conducted when the dependent variable was continuous and the independent variable was categorical (e.g., Hypothesis 1). ANCOVAs were performed when the dependent variable was continuous and the independent variable was categorical, and the covariate was used when the covariate (e.g., age) affected the dependent variable (e.g., Hypotheses 2 - 4). Semipartial Correlations were conducted to examine the relationship between two variables, to control for (or partial out) the variance of the controlled for variable (e.g. Hypotheses 5 - 8). Pearson Correlations were used when there were no "control" variables.

Summary of Statistical Analysis for Eight Main Research Hypotheses

Hypothesis 1: Adolescents who have been victims of sexual abuse will endorse lower levels of social support and higher levels of negative interaction in their same-sex relationships when compared to the nonabused group

Independent Variable: History of abuse
Dependent Variables: Social support and negative interaction in same-sex relationship
Analysis: ANOVA; test of between-subjects effects
Results: Do not support hypothesis 1 for either of the dependent variables

Hypothesis 2: Adolescents who have been victims of sexual abuse will endorse lower levels of social support and higher levels of negative interaction in their dating relationships when compared to the nonabused group

Independent Variable: History of Abuse
Covariates: Age is used as a control variable for social support in dating relationship. Parent marital status and school placement were used as control variables for negative interaction in dating relationships
Dependent Variables: Social support and negative interaction in dating relationship
Analysis: ANCOVA test of between-subjects effects
Results: Do not support hypothesis 2 for either of the dependent variables

Hypothesis 3: There will be a difference in levels of dysfunctional sexual attitudes between the sexually abused and nonabused comparison groups

Independent Variable: History of abuse
Covariate: Parent respondent (biological/not biological parent) included in the dysfunctional sexual attitudes analysis.
Dependent Variable: Dysfunctional sexual attitudes
Analysis: ANCOVA test of between-subject effects
Results: Significant, dysfunctional sexual attitudes are higher in the clinical group, $F(1,55) = 5.029$, $p < .03$.

Hypothesis 4: There will be a difference in levels of tolerance of aggression between

the sexually abused and nonabused comparison groups

Independent Variable: History of abuse
Covariates: School placement and parent marital status
Dependent Variable: Tolerance of aggression
Analysis: ANCOVA test of between-subjects effects
Results: Do not support hypothesis 4 for tolerance of aggression

Hypothesis 5: There will be a negative correlation between social support and dysfunctional sexual attitudes in the relationships of adolescent victims of sexual abuse

Independent Variable: Social Support
Covariates: Age as a control for social support in dating relationships; parental relationship to adolescent as control for dysfunctional sexual attitudes
Dependent Variables: Dysfunctional sexual attitudes
Analysis: Semipartial Correlation (dating); Pearson Correlation (same sex)
Results: Do not support hypothesis 5 for dysfunctional sexual attitudes

Hypothesis 6: There will be a positive correlation between negative interaction and dysfunctional sexual attitudes in the relationships of adolescents

Independent Variable: negative interaction
Covariates: school placement and parent marital status for negative interaction in dating relationships; parental relationship (bio/not bio) of adolescents for analyses of dysfunctional sexual attitudes
Dependent Variable: dysfunctional sexual attitudes
Analysis: Semipartial Correlation (dating); Pearson Correlation (same sex)
Results: Do not support hypothesis 6 for dysfunctional sexual attitudes

Hypothesis 7: There will be a negative correlation between social support and tolerance of aggression in the relationships of adolescents

Independent Variable: Social support
Covariate: Age as a control for social support in dating relationships
Dependent Variable: tolerance of aggression
Analyses: Semipartial Correlation (dating); Pearson Correlation (same sex)
Results: A significant negative correlation between social support and tolerance of aggression was found for the dating relationships of the nonabused group, $r\,(25) = -0.45$, $p < .02$; hypothesis 7 was partially supported

Hypothesis 8: There will be a positive correlation between negative interaction and tolerance of aggression in the relationships of adolescents

Independent Variable: Negative interaction
Covariates: School placement and parent marital status for negative interaction in dating relationships
Dependent Variable: Tolerance of aggression
Analyses: Semipartial Correlation (dating); Pearson Correlation (same sex)
Results: Do not support hypothesis 8 for either of the dependent variables

Part 2

Demographic and Statistical Analyses for Main Study Hypotheses

In this chapter, demographic data is described, the eight hypotheses are restated, the statistical analysis utilized to test each hypothesis is reported, and a statement is given on whether the hypothesis was supported or not. Variables were used as covariates when the variable was: 1) significantly related to sexual abuse history; 2) significantly related to one or more of the "variables of interest"; or 3) marginally related to both.

Description of Demographic Information

All demographic information that was collected is presented in Tables 1 - 9. Table 1 presents the frequency and percent of race by abuse history. Table 2 shows the frequency and percent of school placement by abuse history. Table 3 describes the frequency and percent by relationship of the parent to adolescent and abuse history — most were biological mothers. Table 4 shows the frequency and percent by parental marital status and abuse history. Table 5 presents the frequency and percent by parent highest grade and abuse. Table 6 shows frequency and percent by parent highest degree and abuse.

All demographic information that was collected is presented in Tables 1 - 9. Table 1 presents the frequency and percent of race by abuse history. Table 2 shows the frequency and percent of school placement by abuse history. Table 3 describes the frequency and percent by relationship of the parent to adolescent and abuse history — most were biological mothers. Table 4 shows the frequency and percent by parental marital status and abuse history. Table 5 presents the frequency and percent by parent highest grade and abuse. Table 6 shows the frequency and percent by parent highest degree earned and abuse history. Table 7 describes the frequency and percent by parent employment status and abuse history. Table 8 shows the frequency and percent by head of household occupation (Hollingswood-type scale) and abuse history. Table 9 describes the frequency and percent by family income and abuse history.

Age did not differ across the two groups: however, it correlated significantly with social support in dating relationships, so it was included as a control in any analyses with that condition. Descriptive statistics for age in this study sample are as follows:

1) Group 1: $N = 33$; minimum age 13, maximum age 17; $M = 15.06$, ($SD = 1.14$)
2) Group 2: $N = 28$; minimum age 13, maximum age 17; $M = 14.96$, ($SD = 1.32$)

For both Groups 1 and 2, the background characteristics obtained, but considered through background variable and confound analyses as unnecessary to factor into statistical analyses, are described:

a) Legal custody of child: all respondents, except one, had legal custody; therefore, there was not enough variability to control for statistically.

b) Highest year of parent education: somewhat higher in the control group, and there were missing data in the clinical group. Results of statistical analyses confirmed that this was unrelated to variables of interest in this study, so it was not used as a control variable.

c) Parental employment status: when parents were classified as working FT/PT versus not working FT/PT, the clinical and control groups were highly similar and variables of interest do not differ; therefore, it was not included as a control variable.

d) Head of household occupation: did not differ significantly by clinical and control

groups; therefore, it was not included as a control variable.

It is important to note that there are two valid concerns in the data set for family income. First, family income is higher for the nonabused controls (see Table 9); second, there are some missing data for family income for the clinical abused group. As a result, it is important to keep in mind that this is a potential weakness of the study. There is the possibility that the results may have varied had the complete data set been available for family income for the abused group, and if both groups had been more closely matched on this variable.

Description of Main Findings by Individual Hypothesis

Hypothesis 1. Hypothesis 1 stated that adolescents who have a history of sexual abuse (Group 1) would endorse lower levels of social support and higher levels of negative interaction in their same-sex relationships when compared to the nonabused group (Group 2). This hypothesis was tested with an ANOVA. The data pertaining to this hypothesis are presented in Table 10 (social support) and Table 11 (negative interaction). The results showed no statistically significant difference in same-sex relationships on social support and negative interaction, respectively, by abuse history. Therefore, this hypothesis was not supported.

Hypothesis 2. Hypothesis 2 states that adolescents who have been victims of sexual abuse would endorse lower levels of social support (controlling for age) and higher levels of negative interaction (controlling for parent marital status and school placement) in their dating relationships when compared to the nonabused group. This hypothesis was tested with an ANCOVA. The data pertaining to Hypothesis 2 are presented in Table 12 (social support) and Table 13 (negative interaction): they revealed no statistical differences in dating relationships on social support and negative interaction, respectively, by abuse history. Therefore, this hypothesis was not supported.

Hypotheses 3. Hypothesis 3 stated that there would be a difference in levels of dysfunctional sexual attitudes between the sexually abused and nonabused comparison groups. This hypothesis was tested using ANCOVA, controlling for parent relationship (biological/not biological). Data pertaining to this hypothesis are presented in Table 14. Results revealed that differences do exist between the two groups. There was a significant effect for abuse history, $F(1,55) = 5.029$, $p < .03$. As hypothesized, those who were abused had higher levels of dysfunctional sexual attitudes ($M = 26.82$, $SD = 1.08$, $N = 28$) than those who were not abused ($M = 23.59$, $SD = .94$, $N = 33$). Therefore, Hypothesis 3 was supported.

Hypothesis 4. Hypothesis 4 stated that there would be a difference in levels of tolerance of aggression between the sexually abused and nonabused comparison groups. This hypothesis was tested using an ANCOVA, controlling for school placement and parent marital status. Data for this hypothesis are presented in Table 15, and show no statistically significant difference on tolerance of aggression between the two groups. Thus, Hypothesis 4 is not supported.

Hypothesis 5. Hypothesis 5 stated that there would be a negative correlation between social support and dysfunctional sexual attitudes in the relationships of adolescent victims of sexual abuse. Two correlational analyses were conducted to examine this hypothesis. For those without a history of abuse, the correlation between social support and dysfunctional sexual attitudes, controlling for age and parent relationship, was not statistically significant, $r(24) = .02$, $p = .91$. For those with a history of abuse, the correlation between social support and dysfunctional sexual attitudes, controlling for age and parent relationship, was not statistically significant, *rsp* $(21) = .29$, $p = .17$. Therefore, Hypothesis 5 was not supported.

Hypothesis 6. Hypothesis 6 stated there would be a positive correlation between negative interaction and dysfunctional sexual attitudes in the adolescent's relationships.

Two correlational analyses were conducted to examine this hypothesis. For those without a history of abuse, the correlation between negative interaction and dysfunctional sexual attitudes (controlling for age, school placement, and parent marital status) was not statistically significant, r (23) = -.02, p = .93. For those with a history of abuse, the correlation between negative interaction and dysfunctional sexual attitudes (controlling for age, school placement, and parent marital status) was not statistically significant, *rsp* (17) = .03, p = .89. Therefore, Hypothesis 6 was not supported.

Hypothesis 7. Hypothesis 7 stated there would be a negative correlation between social support and tolerance of aggression in the adolescent's relationships. Two correlational analyses were conducted: for those with no history of abuse, the data supported the hypothesis. A correlation conducted of social support and tolerance of aggression, controlling for age, was statistically significant, *rsp* (25) = -0.45, p< .02. The hypothesis was not supported for those with a history of abuse; the correlation between social support and tolerance of aggression, controlling for age, was not statistically significant, *rsp* (25) = 0.14, ns. Therefore, Hypothesis 7 was partially supported: when the nonabused adolescents endorsed higher levels of social support, they had lower levels of tolerance of aggression. No such inverse relationship existed for the abuse group: in fact, there was scarcely a statistical difference at all, which may be qualitatively significant.

Hypothesis 8. Hypothesis 8 stated there would be a positive correlation between negative interaction and tolerance of aggression in the relationships of adolescent victims of sexual abuse. Two correlational analyses were conducted, controlling for school placement and parent marital status. For those without a history of abuse, the correlation between negative interaction and tolerance of aggression was not statistically significant,r (24) = .28, p = .16. For those with a history of abuse, the correlation between negative interaction and tolerance of aggression, controlling for school placement and parent marital status, was also not statistically significant, r (18) = -.05, p = .84. Therefore, Hypothesis 8 was not supported

Table 1

Frequency and Percent by Race and Abuse

Race	Abuse history			
	No		Yes	
	Freq	Percent	Freq	Percent
African-Am	6	18.2	5	17.9
Caucasian	22	66.7	14	50.0
Hispanic	2	6.1	4	14.3
Biracial	3	9.1	2	7.1
Asian	0	0.0	2	7.1

Table 2

Frequency and Percent by School Placement and Abuse

School Placement	Abuse history			
	No		Yes	
	Freq	Percent	Freq	Percent
Regular	13	39.4	19	67.9
Regular with remedial	1	3.0	1	3.6
Regular with scholars	18	54.5	0	0.0
PT Special Ed	1	3.0	1	3.6
FT Special Ed	0	0.0	5	17.9

Table 3

Frequency and Percent by Relationship of Parent to Adolescent and Abuse

Relationship	Abuse history			
	No		Yes	
	Freq	Percent	Freq	Percent
Bio Mom	27	81.8	19	67.9
Bio Dad	3	9.1	1	3.6
Adopt Mom	2	6.1	0	0.0
Grandmother	1	3.0	2	7.1
Foster Parent	0	0.0	1	3.6
Other	0	0.0	2	7.1

Table 4

Frequency and Percent by Parent Marital Status and Abuse

Marital Status	Abuse history			
	No		Yes	
	Freq	Percent	Freq	Percent
Single	0	0.0	3	10.7
Married	24	72.7	11	39.3
Separated	4	12.1	3	10.7
Divorced	5	15.2	4	14.3
Widowed	0	0.0	1	3.6
Living w/ partner	0	0.0	1	3.6

Table 5

Frequency and Percent by Parent Highest Grade and Abuse

	Abuse history			
Highest Grade	No		Yes	
	Freq	Percent	Freq	Percent
10	1	3.0	2	7.1
11	1	3.0	3	10.7
12	12	36.4	9	32.1
13	2	6.1	3	10.7
14	6	18.2	1	3.6
15	2	6.1	2	7.1
16	7	21.2	0	0.0
17	1	3.0	0	0.0
18	0	0	0	0.0
19	1	3.0	0	0.0

Table 6

Frequency and Percent by Parent Highest Degree and Abuse

Parent Degree	Abuse history			
	No		Yes	
	Freq	Percent	Freq	Percent
None	18	54.5	16	57.1
Vocational	1	3.0	3	10.7
Associate	5	15.2	1	3.6
Bachelors	9	27.3	20	71.4

Table 7

Frequency and Percent by Parent Employment Status and Abuse

Employ. Status	Abuse history			
	No		Yes	
	Freq	Percent	Freq	Percent
Full-time	19	57.6	9	32.1
Part-time	8	24.2	4	14.3
Unemployed	1	3.0	5	17.9
Retired	1	3.0	1	3.6
Homemaker	2	6.1	1	3.6
Disabled	2	6.1	2	7.1

Table 8

Frequency and Percent by Head of Household Occupation (Hollingswood type scale) and Abuse

	Abuse history			
HH/Oc	No		Yes	
	Freq	Percent	Freq	Percent
1	1	3.0	2	7.1
2	1	3.0	1	3.6
3	8	24.2	1	3.6
4	2	6.1	0	0.0
5	6	18.2	3	10.7
6	4	12.1	4	14.3
7	8	24.2	0	0.0
8	3	9.1	0	0.0

Note. Hollingswood scale can be found in Appendix C

Table 9

Frequency and Percent by Family Income and Abuse

	Abuse history			
Income	No		Yes	
	Freq	Percent	Freq	Percent
1	0	0.0	0	0.0
2	0	0.0	1	3.6
3	1	3.0	3	10.7
4	0	0.0	0	0.0
5	1	3.0	0	0.0
6	3	9.1	0	0.0
7	1	3.0	1	3.6
8	1	3.0	1	3.6
9	2	6.1	1	3.6
10	2	6.1	0	0.0
11	22	66.7	4	14.3

Note. Values for Income can be found in Appendix C

Table 10

ANOVA on Social Support by Sexual Abuse History (Victims vs. Non-Victims)

Source	*df*	*F*	*p*
History	1	.08	.78
Error	59	(86.44)	

Note. The value enclosed in the parenthesis represents the mean square error.

Table 11

ANOVA on Negative Interaction by Sexual Abuse History (Victims vs. Non-Victims)

Source	*df*	*F*	*p*
History	1	.00	.97
Error	58	(18.53)	

Note. The value enclosed in the parenthesis represents the mean square error.

Table 12

ANOVA on Social Support by Sexual Abuse History (Victims vs. Non-Victims)

Source	*df*	*F*	*p*
History	1	.25	.60
Error	53	(61.14)	

Note. The value enclosed in the parenthesis represents the mean square error.

Table 13

ANOVA on Negative Interaction by Sexual Abuse History (Victims vs. Non-Victims)

Source	*df*	*F*	*p*
History	1	.70	.41
Error	46	(30.17)	

Note. The value enclosed in the parenthesis represents the mean square error.

Table 14

ANOVA on Dysfunctional Sexual Relationship Attitudes by Sexual Abuse History (Victims vs. Non-Victims)

Source	*df*	*F*	*p*
History	1	153.78	.05
Error	55	(28.68)	

Note. The value enclosed in the parenthesis represents the mean square error.

Table 15

ANOVA on Tolerance of Aggression by Sexual Abuse History (Victims vs. Non-Victims)

Source	*df*	*F*	*p*
History	1	.70	.41
Error	46	(30.17)	

Note. The value enclosed in the parenthesis represents the mean square error.

Chapter 4

Discussion

It was a major goal of this study to create a framework for examining the relationship between a history of sexual abuse, relational attitudes about aggression and sexuality, and the interpersonal factors of social support and negative interaction in the peer and dating relationships of female adolescents. Specifically, the research was designed with an eye toward opportunities to inform clinical treatment planning, applied programs like violence prevention education, and in some small way, contribute to the limited body of existing theory and research in this area.

This final chapter begins with a review of the background literature for the study. The main findings are then summarized and integrated. Next, the major implications of the study findings are presented, including theoretical, research and applied implications. Finally, the methodological and conceptual limitations of the study are discussed, and the paper concludes with directions for future research in this area.

Background and Main Hypotheses

Longitudinal research investigating sexual abuse concludes that early identification of youngsters who may be at risk of forming long-standing problems is possible (Calam et al., 1996) and well needed. Youngsters react and cope with their victimization in many different ways. Some show only minimal effects, whereas others develop more severe repercussions (Conte & Schuerman, 1987). The results of this study may make a small contribution to our knowledge about the peer and dating relationships of adolescents with a history of sexual abuse.

It is well documented that the development of relationships is a central task of

adolescence (Connolly et al., 1995). The trauma and stress literature suggests that intervening variables such as perceived social support, interpretations of violence, and interpersonal attitudes may be relevant to the study of sexual abuse. Only recently, however, have researchers begun to chart the course of adolescent peer relationships by reviewing cognitive differences and their relationship to post-abuse interpersonal and social functioning. While we know that some victims of sexual abuse experience interpersonal difficulties, we are still unsure about the interaction of variables that lead to relationship dysfunction. This study explores how victims of sexual abuse might experience difficulties in their peer relationships that are expressed through abuse-related attitudes and cognitive responses. From the interactional perspective, two research parameters often treated peripherally in other studies became central to the research process: the link between relational attitudes (sexuality and aggression) and interpersonal factors (conflict and social support).

There is currently a paucity of research examining whether adolescents who have been sexually abused develop different norms or standards for acceptable behavior in their friendships and dating relationships. Up to now, studies investigating sexuality in adolescents have mostly examined variables that manifest in sexual activity (e.g. number of partners and age of first intercourse). Studies examining aggression have been predominately limited to aggressive behavior, rather than examining attitudes that reflect aggression. I have argued thus far that the next logical step is to focus on the underlying relational attitudes, cognitions and perceptions about sex and aggression in relationships, with the link as bidirectional — in that relational attitudes are viewed simultaneously as a cause and effect of interpersonal difficulties. Process-oriented research is emphasized, with attitudes underlying the peer relations of abused adolescents the primary grist for investigation.

Specifically, eight research questions were posed: Do adolescents who have been victims of sexual abuse endorse lower levels of social support and higher levels of negative interaction in their same-sex relationships when compared to a nonabused comparison group? Do adolescents who have been victims of sexual abuse endorse

lower levels of social support and higher levels of negative interaction in their dating relationships when compared to a nonabused group? Will there be a difference in levels of dysfunctional sexual attitudes between the sexually abused and nonabused comparison groups? Will there be a difference in levels of tolerance of aggression between the sexually abused and nonabused comparison groups? Will there be a negative correlation between social support and dysfunctional sexual attitudes in the relationships of adolescent victims of sexual abuse? Will there be a positive correlation between negative interaction and dysfunctional sexual attitudes in the relationships of these adolescents? Will there be a negative correlation between social support and tolerance of aggression in the relationships of these adolescents? Will there be a positive correlation between negative interaction and tolerance of aggression?

Summary of the Main Findings

Literature reviewed earlier revealed that adolescence is an important and sensitive period for the formation of attitudes concerning sexuality in relationships and the expression of intimacy, power and control (Wekerle & Wolfe, 1999). One important goal of this study was to find out if there were differences in the endorsement of dysfunctional sexual attitudes between a group of adolescent females with no known history of abuse and those with a substantiated history of sexual abuse. This is an important area to direct empirical investigation, as the endorsement of dysfunctional attitudes that may promote or inhibit the use or acceptance of aggressive behavior in adolescent romantic relationships is related to negative outcomes. For example, acceptance of aggression as a means to solve conflicts is viewed as a contextual factor related to an increased likelihood of relationship violence (Riggs & O'Leary, 1989). This study replicates other findings suggesting differences in the area of sexuality between abused and nonabused comparisons (Cohen, 1995).

The major finding of this study confirmed that there is a difference in levels of dysfunctional sexual attitudes (DSA's) between the sexually abused and nonabused

comparison groups. As expected, adolescents with an abuse history endorsed more DSA's than the comparison group. Females in the sexually abused group more frequently endorsed items on a self-report questionnaire entitled Relationship Attitudes Survey for Adolescents (RASA). On the RASA, DSA's tap the endorsement of attitudes that justify the use of sexual aggression. The 13 items on this scale index attitudes such as: "Women secretly enjoy being forced to have sex; If someone dresses in a sexy way, it means he or she wants to have sex; If the person does not fight back, it means yes to having sex; If both people are drunk, then neither of them is responsible for his or her sexual behavior; If your date touches you or kisses you, then it means he or she wants to have sex with you; If the person does not say no, it means yes to having sex".

Another finding of this study revealed that there was an inverse relationship between social support and tolerance of aggression in the nonabused group. I expected that there would be a negative correlation between social support and tolerance of aggression in the relationships of adolescents, based on the work of researchers such as Connolly et al. (2000), who suggest placing social support within a broad relational framework that encompasses relationship-specific conflict. In the nonabused sample, the female adolescents who endorsed greater levels of social support in their relationships had lower levels of tolerance of aggression.

It is interesting that when comparing these results with the abused group, there is no inverse relationship between social support and tolerance of aggression. There are several possible explanations for this finding. First, it was expected that individuals without a history of abuse who are in relationships that they perceive as supportive would be generally less tolerant of aggression from peers. Therefore, results supporting an inverse relationship in Group 1 converge with the normative research, reflecting more healthy relationship attitudes. However, when considering the between-group differences, it may be that adolescents with a history of abuse have a different style of social-information processing, particularly with regard to relational and overt aggression. When considering the theoretical implications discussed in Chapter 1, social behavior (including aggression) has been seen as a function of sequential social-

information processing steps (i.e., biased processing contributes to deviant social behavior such as aggression). These processing steps, including encoding of internal and external social cues and interpretation of the encoded cues, contribute to and motivate involvement in aggressive acts. Researchers have discovered that, relative to their nonaggressive peers, aggressive youth more frequently misinterpret social cues in a hostile way, eventually believing that there are positive outcomes from aggressive behavior. In addition, researchers have found that *sexually abused adolescents do not view acts of aggression as destructive to their romantic relationships, and may in fact become "bullies" to compensate for emotional vulnerability* (Wolfe & Feiring, 2000). With this in mind, it raises the possibility that the norms and expectations are very different for social support and tolerance of aggression in the relationships of adolescents with an abuse history.

The lack of support for the remainder of the research questions, particularly for the dependent variables of social support and negative interaction, was surprising in light of the existing research. The first consideration of this would necessitate a discussion of power and sample size. When performing T-tests for the first four hypotheses, for example, in order to detect a medium effect size at the .05 level with 95 percent power, I would have needed 111 people. Therefore, the sample size of $N = 61$ did not fully allow for the detection of an effect for the dependent variables. The same lack of power was an issue for the correlational analyses, where there was insufficient power to detect a strong enough relationship between the dependent and independent variables

Perhaps another explanation for the lack of supported findings has to do with mediating abuse-related factors. The betrayal of trust that is the result of experiencing sexual abuse may affect the survivor's ability to make judgments about interpersonal relationships. Finkelhor & Browne (1985) suggest that experiencing betrayal may lead to great distrust of others, avoidance of intimacy, or in some cases, the opposite, an overly trusting stance in relation to individuals who may be potentially harmful to the individual. Moreover, victims of child abuse may experience difficulties in their interpersonal relationships that may be linked to cognitive and conditioned reactions to

the victimization (e.g., concerns about abandonment, low self-esteem, problems with trust and intimacy); and problematic cognitive responses, such as avoidance, adversariality, sexualization, and ingratiation. These abuse-related responses can create challenges to daily interpersonal interactions that may interfere with the normal development of social skills, social support, and ultimately, well-being and life satisfaction in their relationships.George and Main (1979) found that it is more likely that peers will reject maltreated youth, and they report more conflict in close relationships (Wolfe et al., 1998). In summary, results from the clinical sample on the dependent variables may reflect the presence of some of these mediating abuse-related factors.

Furthermore, in trying to understand the unsupported findings of a study like this one, particularly in light of the small sample size, it is important to acknowledge that adolescent reports are very likely to be underestimates, and that adolescents have an admitted reluctance to report relationship aggression (Davis, Peck, & Storment, 1993; Wekerle & Wolfe, 1999). Moreover, studies on resiliency have determined that peer relationships provide individuals with emotional support and comfort in times of crises (Werner, 1993) (e.g., the timing of the administration of the study measures). Another important consideration relates to the several different psychosocial trajectories for youth who have been sexually abused, in that some abused individuals appear to follow a relatively normal path of psychosocial development (Noll et al., 2000).

Perhaps there may have been some possible biases that influenced the data response set, particularly within the abused sample (e.g., social desirability). Moreover, it may be possible that the measures were not reliable enough to detect true effects, particularly with such a small sample size (limiting statistical power and making it more difficult to detect anything but the strongest effects). In addition, on the RASA, there are fewer items for the dependent variable "tolerance of aggression" (seven), for example, than for "dysfunctional sexual attitudes" (thirteen). This might explain the lack of support for Hypothesis 4.

There are two additional possibilities for the lack of support for some of the study

hypotheses: both have to do with the timing of the administration of the measures. Often a concerned, non-offending caretaker brings adolescents who are referred following abuse to the CCS for assessment and treatment. At this time, they are given a tremendous amount of support directly following the abuse incident, or in some cases, when the abuse incident(s) are finally discovered or disclosed. Besides a very caring and supportive medical staff who are often their first contact with abuse-related services and treatment, they work with a very experienced and competent group of psychologists, staff and interns who are trained to provide expert care and support during their visits to the CCS. Often many of the adolescents who have been abused begin treatment soon after the abuse incident: could it be that they are still too numb to really integrate the post-abuse trauma sequelae — that the effects of the abuse on their social interactions in peer relationships has yet to be manifested? At the time of assessment they may actually feel very supported by the treatment team and the caregiver(s) who have allowed them to pursue support and treatment. I believe that if these measures were administered a year or more postabuse-related treatment, the manifestations of the traumagenic factors would evidence more broadly in socioemotional and interpersonal functioning.

Although the research in the field clearly reflects child and adult survivors of sexual abuse with more interpersonal problems than non-abused groups, there is still no evidence of a uniform or predictable response for all individuals (re: internal validity). It has been suggested that child maltreatment influences children's subsequent relationship skills: in other words, it may be less about the abuse than a reflection of the transmission of relationship vulnerability to a number of negative variables (e.g. interactional style, acceptance of hostility in relationships, etc.). Certain characteristics of the abuse and environmental factors influence the incidence of experiencing distress. Factors that may contribute to a more negative outcome include: a closer relationship with the offender; multiple offenders; longer duration; more frequent contact; penetration; and violence (Berliner & Elliott, 1996). As I previously mentioned, investigation of these confounding factors is well beyond the scope of my study, but nonetheless important considerations when evaluating study outcomes.

With this in mind, I would like to consider one final possibility for the unsupported study hypotheses. Youth with an aggressive behavioral social style may form friendships with individuals similar to themselves (Connolly et al., 1998). Connolly and her colleagues suggest there may be an increased risk that aggressive behavioral styles within the peer group will be extended to dating relationships. In light of the tendency of abused youth to have difficulty with the healthy management of aggression, I posit that perhaps the norms, expectations and standards that adolescents with an abuse history bring to their relationships precludes them from having well-grounded perceptions about the difference between healthy and dysfunctional interpersonal interactions.

Presently, there are still a great deal of questions that remain about how abuse impacts adolescents and their friendships and dating relationships. Research and theoretical understanding is still in the nascent stages, particularly with regard to the study and treatment of victim and victimizer behavior. However, what we do know is important: that adolescents who have been sexually abused may develop different norms or standards for acceptable behavior in interpersonal relationships, which may have a significant effect on the nature of their peer networks and their judgments and perceptions about their relationships. In fact, adult abuse survivors have been found to experience continued difficulties with relationships following maltreatment, manifested in either an avoidance of interpersonal intimacy completely, or a tendency to tolerate aggression in intimate relationships as normal and appropriate (Briere, 1992). It is with this in mind that I look toward continued research in this area.

Major Implications of the Results

A number of empirical studies examining the developmental impact of sexual abuse on adolescents indicate that maladaption is frequently associated with experiencing sexual abuse (see Beitchman et al., 1991, 1992 for a review). Sexual maladjustment resulting from premature sexualization is among the long list of symptoms of victims of

sexual abuse (Verduyn & Calam, 1999). Moreover, maltreatment has been said to directly impact on peer relationships (Wekerle & Wolfe, 1998). Wolfe and Feiring (2000, p. 319) suggest that, as a result of sexual abuse, "adolescents may endorse more negative sexual attitudes, disclose less, cope less successfully, and endorse higher levels of aggressive attitudes with more negative interactions." The significant findings of the study support the early theories of researchers who have begun to focus more attention on peer relationships in adolescence (see Feiring et al., 1998; Furman, 1998; and Connolly & Goldberg, 1999): that some adolescents with a history of sexual abuse may harbor dysfunctional attitudes and assumptions about sexuality and relational aggression reflected in their peer and romantic relationships.

There is a dearth of information available in the clinical literature on how healthy relationship attitudes about sexuality and aggression, such as taking into account the partner's feelings about sex, might be related to a lower risk for experiencing coercion in relationships (Feiring et al., 2002). However, there are a few studies documenting the deleterious effects of the endorsement of unhealthy attitudes about aggression. Feiring (p. 2) cites several researchers who found that adolescents who endorse the use of sexual or physical aggression have a greater likelihood of coercive behavior in dating relationships. Early investigations such as these were the foundation on which my research questions were built; the positive findings here will hopefully offer an incentive for future researchers to pursue this area of investigation with a larger sample size and more sophisticated methodology. Expanding this literature could be useful for assessment and clinical practice, as well as encouraging the application of new violence prevention education protocols in settings where large, unidentified abuse populations are probable (e.g., high schools).

As mentioned earlier, review of the literature provides ample theoretical and empirical evidence that maltreatment increases the probability that adolescents will be interpersonally challenged with regard to peer and social dating relationships (Capaldi & Crosby, 1997; Wolfe, Scott, Reitzel-Jaffe et al., 2001). The work of Wolfe et al (1998) concurs with the empirical evidence, finding the existence of a maladaptive

interpersonal trajectory for abused children, wherein a violent interactional dynamic in adolescent close relationships may be setting the stage for violence in intimate partnerships. Peer and dating relationships among maltreated youth may be fraught with affective disturbances such as interpersonal sensitivity and hostility, with limited personal resources (i.e. lower self-efficacy) and distorted beliefs about relationships (Wolfe et al., 1998).

The literature investigating sexual violence and aggression in dating relationships is alarming. In their survey, Koss, Gidycz, and Wisniewski (1987) found that more than one in four women (27 percent) reported experiences that met the legal definition of rape or attempted rape. Fifty-four percent of these college women described experiences of sexual victimization other than rape, including coercion, verbal abuse, and physical assault. These findings are robust, with between 27percent and 77 percent of young women studied reporting some form of sexual violence invading their intimate lives (see Hayworth, 2000, for a complete review). Davis and colleagues (1993) reported that females between the ages of 16 and 19 are most "at risk" to be the victims of date and acquaintance rape. Following a perusal of the literature, the portrait of the increased risk for sexual victimization and violence is clear — females from around sophomore year in high school through college graduation are at significantly higher risk for sexual victimization. With statistics like these for the general adolescent population, one can expect that adolescents with a history of abuse may be at greater risk than nonabused adolescent populations.

Despite the extensive literature assembled regarding sexual aggression and victimization among college students, comparatively little is known about adolescents with an abuse history and their attitudes about sexuality and aggression in their dating relationships. National surveys have indicated that by the age of 15, 25 percent of girls and 33 percent of boys have engaged in sexual activities. Middle adolescence (15 to 16 years) has been described as the beginning of the age range when many young women have reported sexual violence in dating situations (Frintner & Rubinson, 1993; Davis et al. 1993; Koss, 1988). Across studies, between 20 percent and 29 percent of adolescent

girls have reported forced sexual activities by their dating partners. With the incidence and prevalence of sexual victimization in low-risk populations at the rates we see above, it is time to bridge the gap and consider more research with questions like the ones I posed here, directed toward abused adolescent samples.

The main findings in this study support ideas and theories that have previously been proposed by researchers in the sexual abuse field. As Deblinger (1991) explains, sexually abused youth are often prematurely introduced to information about sexuality and in a way that is traumatizing, which may distort their perceptions of sex and sexuality. Finkelhor and Browne (1985), in their Traumagenic Dynamics Model, incorporate "traumatic sexualization" as a trauma-inducing factor. The most frequent symptoms reported by individuals who have been victims of child sexual abuse include: sexual maladjustment resulting from premature sexualization (Verduyn & Calam, 1999); interpersonal problems; educational difficulties; acute anxiety neuroses; self-destructive behavior; somatic symptoms; loss of self-esteem; prostitution; delinquent criminal behavior; depression; and suicide (Higgins & McCabe, 1994; Kendall-Tackett et al., 1993; Browne & Finkelhor, 1986).

Researchers, such as Noll et al., 2000, who looked at social functioning and sexual attitudes in sexually abused and comparison girls, as well as researchers who found that child abuse is associated with adolescent dating violence (Malik et al., 1997; Smith & Williams, 1992), demonstrate the importance of investigating the relationships of abused adolescents. Building on the existing body of scholarly work with additional studies in this area would continue to increase our knowledge about the ways in which adolescents who have been sexually abused may be vulnerable to relationship-centered difficulties, including vulnerability in the areas of focus in this study: sexuality, aggression, and social functioning. In this way, we will become better informed for clinical practice, facilitating well-informed treatment and clinical interventions that will help prevent adolescents from forming lasting patterns of violent and maladaptive dynamics that will carry on into their adult intimate partnerships.

Adult literature on outcomes for individuals with a history of sexual abuse suggests

that survivors may have multiple superficial and sexual relationships that cease when interpersonal intimacy becomes a factor (Wolfe & Feiring, 2000). Moreover, childhood victimization has been associated with an increased likelihood of subsequent offending and victimization (Widom, 1994). My research has built on the theories that view abuse-related sequelae as less about the abuse specifically, but more likely a reflection of an aversive interactional and/or violent relationship style. As a result, it is important to better understand not only the acute reactions to victimization (e.g., post-traumatic stress and cognitive distortions and attributions), but also the individual's interpersonal and cognitive accommodations.

The most unexpected result of this study is the lack of support for differences in levels of social support and negative interaction in adolescent peer relationships by abuse history. Musings about possible reasons for this finding provide caveats for researchers when conceptualizing and designing future studies in this area. Cichetti & Rogosch found maltreatment to be linked with difficulty in correctly perceiving emotional reactions in others. Moreover, researchers have found that adolescents have difficulty conceptualizing peer relationships as reciprocal (Dean et al.,1986). For children who experience abuse, impairments in self-system processes, such as negative self-evaluations, deficits in self-esteem, and an inability to talk about their feelings, may interfere with relationship formation and maintenance, especially during adolescence, when intimate self-disclosure is a factor (Parker & Gottman, 1989). Abused children are more likely to learn to inhibit or deny negative feelings, remain negative and resistant, and have lower social competence than non-abused children (Cichetti & Rogosch, 1994). Just as aggressive kids find aggressive friends, adolescents who have been the victims of sexual abuse may tend to perceive interpersonal factors from a perch of vulnerability and fear within the intimate framework of their relationships.

The literature informs future research: it may be that self-report measures present a challenge for the investigation of abused populations. Careful consideration of the complex intermingling of abuse-related variables when designing methodology would

help guide our direction when approaching future research with this population. However, this is a worthwhile effort, knowing that survivors of child sexual abuse are at relatively high risk of being revictimized sexually (Grauerholz, 2000; Mayall & Gold, 1995). Moreover, aversive adolescent partnerships have been predictive of adult intimate violence (O'Leary et al., 1994). This raises concern, and inspires us to facilitate adaptive, healthy romantic relationships void of abuse and victimization. But much more needs to be understood about the nature of the attitudes and beliefs about aggression and intimacy that these adolescents are endorsing in their current relationships. I have explored some of the possible abuse-related variables, with the hope of advancing this work.

The major findings of this study support more research like Noll's et al. (2000), who found that sexualized dating relationships in early adolescence might have a damaging effect on later sexual development. She found that abused adolescents report slightly more negative attitudes toward sex, and may be less capable of seeing their dating partner as a "buddy" or a friend. If female adolescents with a confirmed history of abuse endorse higher levels of dysfunctional sexual attitudes than their non-abused comparisons, we may have a guidepost for future research. Of course, implications of my research are offered with some caveats, to which I will now turn.

Major Limitations of the Study

Although this study does make a minor contribution to our understanding of relational attitudes and interpersonal factors in the sexually abused female adolescent's peer and dating relationships, it raises more questions than it answers. First and foremost, there are important limitations to generalizability. These limitations stem from a variety of sources, and each will be discussed in turn: method of assessment, sampling, and subject matter.

The results are limited by the method used for collecting data. Self-report instruments are subject to the personal biases of the reporter, and they do not necessarily

capture situational variability in behavior as well as multimethod assessment procedures do (Achenbach, Howell, Quay, & Conners, 1991). These include the possibility of underestimates of socially unacceptable behavior and reluctance to report aggression. Observational investigations of interactions would provide different information.

The results are limited by the timing of the administration of the measures. For the abused sample, the self-report instruments were administered at a time shortly after the occurrence of the abuse incident, when the adolescent may be experiencing a great deal of support from his or her caregiver in allowing the pursuit of treatment. Adolescent perceptions of their relationships may not fully correspond with their objective patterns of interaction. There may be a distinction between overt self-report and their internal working models of relationship (i.e. attachment theory). Further research is needed to determine the relationship between perceptions and actual patterns of interaction in various relationships.

Another fundamental limitation of this study is that the unique characteristics of the sexually abused sample make the generalizability of the results to other populations limited. The sample is comprised of adolescents who disclose their abuse and the cases are substantiated. Many individuals never decide to disclose their sexual abuse. It would be difficult to determine if the symptoms highlighted in this particular sample would be found in the other samples. Moreover, the somewhat sensitive nature of this study may influence the self-selection process that occurs during subject recruitment. Access to participants may be affected by differences in attitudes toward sexual issues.

There are also developmental confounds that may affect the saliency of the data. Developmental changes are significant in the characteristics of adolescent relationships. Ratings for intimacy with friends (same-sex relationships) and romantic relationships may increase markedly as children grow older. Same-sex friendships are increasingly supportive between late childhood and early adolescence, but this may taper off and be replaced by dating partnerships as a source of both intimacy and support as they move into middle and late adolescence. Data analysis in general is a

static picture, always one step removed from the dynamic reality it represents. Fortunately, this study controlled for age with a well-matched sample.

This work is cross-sectional, presenting difficulty with direction of effects. The study design does not allow us to separate age from cohort effects and does not allow for causal conclusions. Results may be complicated by changes over time in friendships themselves (e.g., friendships are thought to become more supportive as they develop). When comparing different adolescent's friendships that vary in length, results can be affected. A longitudinal study design would provide a broader data set reflecting change and continuity of perceptions across different relationships, while more effectively controlling for any cohort effects.

Finally, this study does not address abuse-specific variables such as complexity and chronicity of abuse or family-related and environmental influences, which also may have had an impact on the results, as well as on the generalizability of significant findings.

Future Directions

Despite the limitations, my study emphasizes the need for further research in this area. The trauma and stress literature suggests that intervening variables such as perceived social support, interpretations of violence, and interpersonal attitudes may be relevant to the study of child sexual abuse. I have argued that attitudes about aggression and sexuality and interpersonal factors in the peer and dating relationships of adolescents have important implications for research, and have raised some questions that may be worthy of further investigation.

With consideration of the limited nature of my research and significant findings, the results do have implications for clinical and school-based interventions. The findings point to the importance of designing developmentally sensitive educational and clinical interventions for adolescents who may be at high risk for becoming involved in coercive and maladaptive relationships. Raising awareness about sexuality, dating violence, the

elements of healthy and supportive dating and peer relationship, and defining maladaptive relationship aggression are just a few examples of possible directions for educational protocols in any setting where adolescents have the opportunity to learn. In particular, girls who have been identified as endorsing dysfunctional relational attitudes may greatly benefit from sexual violence prevention education.

The existing body of literature could benefit from more research identifying patterns of behavior and social functioning related to the risk of sexual violence and coercion in both abused and non-abused populations of adolescents, with a focus toward reducing relationship aggression (both direct and indirect). There is a limited number of studies about the nature and extent of anger and aggression experienced in the relationships of adolescent and adult survivors of sexual abuse, but the data that is available reflects the existence of difficulties (Briere & Elliott, 1994). More studies in this area would be beneficial. All of the areas of focus identified for females could be applied to male adolescents with a history of sexual abuse as well.

With the knowledge that adolescents with a history of sexual abuse may be more likely to endorse dysfunctional relational attitudes about sexuality and aggression, research on whether these attitudes are direct predictors of future sexual coercion and violence would be valuable. I also emphasize the need for further investigation of general sexuality development in adolescents with a history of sexual abuse. Finally, research identifying whether healthy relational attitudes, such as taking into account the partner's feelings about sex, are related to a lower risk for experiencing coercion in relationships would facilitate a better understanding of the links between attitudes and behavior in adolescent dating relationships. There are many paths from which to choose, but with a positive eye toward the future, and the possibility of less violence and negativity in relationships, we can actively work together with hope for a less violent society as a whole — even if we have to do it one child or adolescent at a time.

References

Achenbach, T., Howell, C., Quay, H. & Conners, C. K. (1991). National survey of problems and competencies among four-to sixteen year-olds. *Monographs of the Society for Research in Child Development, 56(3),* No. 225.

Adler, A. (1927). Understanding human nature. *International Zeitschrift fuer Individual Psychologie Beihette.*

Asher, S. R., & Parker, J. G. (1989). The significance of peer relationship problems in childhood. In B. H. Schneider, G. Attili, J. Nadel, & R. P. Weissberg (Eds), *Social competence in developmental perspective* (pp. 5-23). Amsterdam: Kluwer Academic.

Asher, S. R., Parker, J. G., & Walker, D. L. (1998). Distinguishing friendship from acceptance: Implications for intervention and assessment. In W. M. Bukowski, & A. F. Newcomb (Eds.), *The company they keep: Friendship in childhood and emotional Development* (pp. 366-405). New York: Cambridge University Press.

Barrera, M. (1986). Distinction between social support concepts, measures, and models. *American Journal of Community Psychology, 14(4),* p. 413-445.

Beitchman, J. H., Zucker, K. J., Hood, J. E., deCosta, G. A., Ackman, D. (1991). A review of the short-term effects of child sexual abuse. *Child Abuse and Neglect,* 15, 537-556.

Beitchman, J. H., Zucker, K. J., Hood, J. E., DeCosta, G. A., & Cassavia, E. (1992). A review of the long-term effects of child sexual abuse. *Child Abuse and Neglect,* 16, 101-118.

Benenson, J. F. (1996). Gender differences in the development of relationships. In G. G. Noam, K.W. Ed, & E. Fisher, *Development and vulnerability in close relationships* (p. 263-286). Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.

Berliner, L., & Elliott, D. M. (1996). Sexual abuse of children. In Briere, J., Berliner, L., Bulkley, J. A., Jenny, C., & Reid, T. *The APSAC handbook on child*

maltreatment (pp. 51-71). Thousand Oaks, CA: Sage Publications.

Bernath, M.S., & Feshback, N. D. (1995). Children's trust: Theory, assessment, development and research directions, *Applied & Preventative Psychology, 4(1),* 1-19.

Berndt, T. J., & Keefe, K. (1992). "Influences of friends' characteristics and friendship features on adolescents behavior and adjustment". Unpublished manuscript, Department of Psychology, Purdue University, 1992.

Bjorkqvist, K., Osterman, K., & Lagerspetz, K. M. (1994). Sex differences in covert aggression among adults. *Aggressive Behavior, 20(1),* 27-33.

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

Boney-McCoy, S., & Finkelhor, D. (1996). Is youth victimization related to trauma and depression after controlling for prior symptoms and family relationships? *Journal of Consulting and Clinical Psychology,* 61, 276-283.

Boney-McCoy, S., & Finkelhor, D. (1998). Psychopathology associated with sexual abuse: A reply to Nash, Neimeyer, Hulsey, and Lambert (1998). *Journal of Consulting and Clinical Psychology,* 66 (3), 572-573.

Boulton, M. J., & Underwood, K. (1992). Bully/victim problems among middle school children. *British Journal of Educational Psychology, 62(1),* 73-87.

Bowlby, J. (1973). *Attachment and loss: Separation, anxiety and anger.* New York: Basic Books.

Bowlby, J. (1980). *Attachment and loss: Vol. 3, Loss, Sadness and Depression.* New York: Basic Books.

Brain, P. F. (1977). Hormones and aggression. *Annual research reviews: Hormones & Aggression,* p. 126.

Briere, J. (1992). *Child abuse trauma: Theory and treatment of the lasting effects.* Newbury Park: Sage.

Briere, J. (1994). Assessing and treating victims of violence: New directions for mental

health services (No. 64), p. 107. San Francisco: Jossey-Bass.

Briere, J. (1996). *Trauma symptom checklist for children.* Odessa: FL: Psychological Assessment Resources.

Briere, J., & Elliott, D. M. (1994). Immediate and long-term impacts of child sexual abuse. *The Future of Children: Sexual abuse of Children*, 4, 54-69.

Briere, J., & Runtz, M. (1987). Post-sexual abuse trauma: Data and implications for clinical Practice. *Journal of Interpersonal Violence, 2(4),* 367-379.

Briere, J., & Runtz, M. (1988). Multivariate correlates of childhood psychological and physical maltreatment among university women. *Child Abuse and Neglect*, 12, 331-341.

Briere, J., & Runtz (1990). Differential adult symptomatology associated with three types of child abuse histories. *Child Abuse and Neglect*, 14, 357-364.

Brock, D. M., Sarason, I. G., Sarason, B. R., & Pierce, G. R. (1996). Simultaneous assessment of perceived global and relationship-specific support. *Journal of Social and Personal Relationships*, 13, 143-152.

Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. *Psychological Bulletin*, 99, 66-77.

Bugental, D. B. (1993). Communication in abusive relationships: Cognitive constructions on interpersonal power. *American Behavioral Scientist,* 36, 288-308.

Buhrmester, D. (1990). "Intimacy of friendship, interpersonal competence, and adjustment during preadolescence and adolescence". *Child Development*, 61, 1101-1111.

Buhrmester, D., & Furman, W. (1986). The changing functions of friends in childhood: A neo-Sullivan perspective. In V. J. Derlega & B. A. Winstead (Eds.) *Friendship and social interaction* (pp. 41-62). New York: Springer-Verlag.

Buhrmester, D., & Furman, W. (1987). The development of companionship and intimacy. *Child Development,* 58, 1101-1103.

Bullock, M., & Russel, J. A. (1986). Concepts of emotions in developmental psychology (p. 203-237). *Measuring emotions in infants and children, Vol 2.* New

York: Cambridge University Press.

Calam, R., Horne, L., Cox, A., & Glasgow, D. (1998). Psychological disturbance and child sexual abuse: A follow-up study. *Child Abuse and Neglect*, Vol. 22 (9), p. 901-913.

Camarena, P. M., Sarigiani, P. A., & Peterson, A. C. (1990). Gender specific pathways to intimacy in early adolescence. *Journal of Youth and Adolescence, 10(2),* 19-32.

Camras, L. A., & Rappaport, S. (1993). Conflict behaviors of maltreated and nonmaltreated children. *Child Abuse and Neglect, 17(4),* 455-464.

Capaldi, D. M., & Crosby, L. (1997). Observed and reported psychological and physical aggression in young, at-risk couples. *Social Development*, 6, 184-206.

Capaldi, D. M., Crosby. L., & Stoolmiller, M. (1996). Predicting the timing of first sexual intercourse for at-risk adolescent males. *Child Development, 67(2),* 344-359.

Cassel, J. (1976). The contribution of the Social Environment to Host Resistance. *American Journal of Epidemiology*, 104, 107-123.

Cauffman, E., & Steinberg, L. (1996). Maturity of judgement in adolescence: Psychosocial factors in adolescent decision making. *Law & Human Behavior, 20(3),* 249-272.

Cichetti, D., & Rogosch, F. A. (1994). The toll of child maltreatment on the developing child: Insights from developmental psychopathology. *Child and Adolescent Psychiatric Clinics of North America, 3(4),* 759-776.

Cichetti, D., Toth, S., & Bush, M. (1988). Developmental psychopathology and incompetence in childhood: Suggestions for intervention. In B. B. Lahey & A. E. Kazdin (Eds.), *Advances in clinical child psychology* (Vol. 11, pp 1-77). New York: Plenum.

Coffey, P., Leitenberg, H., Henning, K., Turner, T., & Bennett, R. T. (1996). Mediators of the long-term impact of child sexual abuse: Perceived stigma, betrayal, powerlessness, and self-blame. *Child Abuse and Neglect*, 20, 447-455.

Cohen, J. B. (1995). *Understanding the thoughts and feelings of sexually abused and nonabused children.* Unpublished doctoral dissertation, Yeshiva University,

New York.

Cohen, J. B., Deblinger, E., Maedel, A. B., & Stauffer, L. B. (1999). Examining sex-related thoughts and feelings of sexually abused and nonabused children. *Journal of Interpersonal Violence*, 14 (7), 701-712.

Cohen, S. & Willis, T. A. (1985). Stress, social support, and buffering hypothesis. *Psychological Bulletin*, 96, 310-357.

Coie, J. D., Dodge, K. A., & Kupersmidt, J. (1990). Peer group behavior and social status. In S. R. Asher & J. D. Coie (Eds.) *Peer Rejection in childhood* (pp. 17-59). New York: Cambridge University Press.

Collins, W. A., & Repinski, D. J. (1994). Relationships during adolescence: Continuity and change in interpersonal perspective. In R. Montemayor, G. Adams, and "T. Gullotta (Eds.), *Personal relationships during adolescence. Advances in adolescent development* (vol. 6, pp. 7-36). Thousand Oaks, CA: Sage.

Collins, W. A., & Sroufe, L. A. (in press). Capacity for intimate relationships: A developmental construction. In W. Furman, B. B. Brown, & C. Feiring (Eds.), *Contemporary perspectives on adolescent romantic relationships.* Cambridge, England: Cambridge University Press.

Connolly, J., Furman, W., & Konarski, R. (1995). The role of social networks in the emergence of romantic relationships in adolescence. Paper presented at the Society for Research in Child Development. Indianapolis, IN, March.

Connolly, J., & Goldberg, A. (1999). Romantic relationships in adolescence: The role of friends and peers in their emergence and development. In Furman, W., Brown, B.B., & Feiring, C., (Eds.), *Contemporary Perspectives on Adolescent Romantic Relationships*, New York: Cambridge University Press.

Connolly, J., & Johnson, A. (1996). Adolescents' romantic relationship and the structure and quality of their close interpersonal ties. *Personal Relationships*, Vol. 2, 185-195.

Connolly, J. A., McMaster, L., Craig, W., & Pepler, P. (1998, February). *Romantic relationships of bullies in early adolescence.* Paper presented at the biennial

meeting of the Society for Research on Adolescence, San Diego, CA.

Connolly, J., Pepler, D., Craig, W., & Taradash, A. (2000). Dating experiences of bullies in early adolescence. *Child Maltreatment*, Vol. 5 (4), 299-310.

Conte, J. R., & Berliner, L. (1988). The impact of sexual abuse on children: Empirical findings. In E. A. Walker (Ed.), *Handbook on sexual abuse of children: Assessments and treatment issues* (pp. 72-93). New York: Springer.

Conte, J. R., & Schuerman, J. R. (1987). Factors associated with an increased impact on child sexual abuse. *Child Abuse and Neglect*, 11, 201-211.

Crick, N. R. (1995). Relational aggression: The role of intent attributions, feelings of distress, and provocation type. *Development and Psychopathology*, 7, 313-322.

Crick, N. R., & Bigbee, M. A. (1998). Relational and overt forms of peer victimization: A multi-informant approach. *Journal of Consulting and Clinical Psychology*, Vol. 66 (2), 337-347.

Crick, N. R., & Dodge, K. A. (1994). A review and reformulation of social information processing mechanisms in children's social adjustment. *Psychological Bulletin*, Vol. 115 (1), 74-101

Crick, N. R., & Grotpeter, J. K. (1995). Relational aggression, gender, and social psychological adjustment. *Child Development*, 66, 710-722.

Crick, N. R., & Grotpeter, J. K. (1996). Children's treatment by peers: Victims of relational aggression. *Development and Psychopathology*, 8, 367-380.

Cutrona, C. E. (1986). Objective determinants of perceived social support. *Journal of Personality and Social Psychology,* 50, 349-355.

Davis, T., Peck, G., & Storment, J. (1993). Acquaintance rape and the high school student. *Journal of Adolescent Health, 14,(3),* 220-224.

Dean, A. L., Malik, M. M., Richards, W., & Stringer, S. A. (1986). Effects of parental maltreatment on children's conceptions of interpersonal relationships. *Developmental Psychology, 22(5),* 617-626.

Deblinger, E. (1991). *Cognitive behavioral interventions for treating sexually abused children suffering post-traumatic stress: Preliminary manual.* Unpublished

manuscript.

Deblinger, E., Lippmann, J., & Steer, R. (1996). Sexually abused children suffering post-traumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment,* 1 (4), 310-321.

Dodge, K. A., & Crick, N. R. (1990). Social information processing bases of aggressive behavior in children. *Personality and Social Psychology Bulletin,* 16 (1), 8-22.

Dodge, K. A., Pettit, G. S., McClaskey, C. L., & Brown, M. (1986). Social competence in children. *Monographs of the Society for Research in Child Development,* 51 (2, Serial No. 213).

Dolgin, K. G., & Kim. S. (1994). The effects of gender and topic intimacy. *Social Development, 3(2),* p. 14 p. 146-157.

Ducharme, J., Koverola, C., & Battle, P. (1997). Intimacy development: The influence of abuse and gender. *Journal of Interpersonal Violence, 12(4),* 590-599.

Duncan, P. T. (1991). Discipline strategies for pupil control at the middle school level in an urban setting. *Dissertation Abstracts International, 51(7A),* 2317.

Dutton, D. G. (1994). The origin and structure of the abusive personality. *Journal of Personality Disorders, 8(3),* 181-191.

Eagly, A. H., & Steffen, V. J. (1986). Gender and aggressive behavior: A meta-analytic review of the social psychological literature. *Psychological Bulletin,* 100, 309-330.

Elliott, D. M. (1994). Impaired object relations in professional women molested as children. *Psychotherapy,* 31, 79-86.

Elliott, D. M., & Briere, J. (1995). Posttraumatic stress associated with delayed recall of sexual abuse: A general population study. *Journal of Traumatic Stress Studies,* 8, 629-648.

Erickson, P. I., & Ripkin, A. J. (1991). Unwanted sexual experiences among middle and high school youth. *Journal of Adolescent Health, 12(4),* 319-325.

Fagot, B. I. (1977). Consequences of moderate cross-gender behavior in preschool

children. *Child Development*, 48, 902-907.

Feiring, C., Deblinger, E., Hoch-Espada, A., & Hayworth, T. (2002). Romantic relationships and aggression attitudes in high school: The role of gender, grade, and attachment and emotional styles, *Journal of Youth & Adolescence, 31(5),* 373-385.

Feiring, C., Taska, L., & Lewis, M. (1998). The role of shame and attributional style in children's and adolescents adaptation to sexual abuse. *Child Maltreatment*, 3, 129-142.

Fine, G. A. (1980). The natural history of preadolescent friendship groups (p. 293-320). In H. C. Foot & A. J. Chapman (Eds.), *Friendship and social relations in children.* New Brunswick, NJ: Transactions Publisher.

Fine, J. T. (1981). Sex similarities in behavior in a seventh grade classroom. *Journal of Early Adolescence, 1(3),* 233-243.

Finkelhor, D. (1990). Early and long-term effects of child sexual abuse: An update. *Professional Psychology: Research and Practice*, 21, 325-330.

Finkelhor, D. (1994). The international epidemiology of child sexual abuse. *Child Abuse and Neglect*, 18, 409-417.

Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization . *American Journal of Orthopsychiatry*, 55, 530-541.

Finkelhor, D., Hotaling, G., Lewis, I., & Smith, C. (1990). Sexual abuse in a national survey of men and women: Prevelance, characteristics, and risk factors. *Child Abuse and Neglect*, 14, 19-28.

Flanagan, A. S., & Furman, W. (2000). Rejection sensitivity and adolescent girls' vulnerability to relationship-centered difficulties. *Child Maltreatment*, 5, 338-349.

Fleming, J., Mullen, P. E., Sibthorpe, B., & Bammer, G. (1999). The long-term impact of child sexual abuse in Australian women. *Child Abuse and Neglect, 23(2),* 145-159.

Freud, S. (1936). Contribution to the psychology of the love life. *Revue Francaise dePsychanalyse, 9,* 2-21.

Freud, S. (1965). *New introductory lectures on psychoanalysis* (trans. James Strachey).

Oxford, England: Strachey.

Friedrich, W. N. (1990). *Psychotherapy of sexually abused children and their families.* New York: Norton.

Friedrich, W. N., Beilke, R. L., & Urquiza, A. J. (1987). Children from sexually abusive families: A behavioral comparison. *Journal of Interpersonal Violence*, 2, 391-402.

Frintner, M., & Rubinson, L. (1993). Acquaintance rape: The influence of alcohol, fraternity membership, and sports team membership. *Journal of Sex Education and Therapy, 19, (4),* 242-284.

Furman, W. (1989). The development of children's social networks. In D. Belle (Ed.), *Children's social networks and social supports* (pp. 151-172). New York: Wiley.

Furman, W. (1998). Friends and lovers: The role of peer relationships in adolescent peer relationship. In Collins, W. A. and Laursen, B. (Eds.), *Relationships as developmental contexts: The 29th Minnesota Symposium on Child Development.* Erlbaum, Hillsdale, NJ.

Furman, W., Brown, B. B., & Feiring, C. (1999). Love is a many-splendored thing: Next steps for theory and research. *Child Development, 71(3),* 707-720.

Furman, W., & Buhrmester, D. (1985). Children's perceptions of the personal relationships in the social networks. *Developmental Psychology*, 21, 1016-1022.

Furman, W., & Buhrmester, D. (1992). Age and sex differences in perceptions of networks of personal relationships. *Child Development*, 63, 103-115.

Furman, W., & Wehner, E. A. (1994). Romantic views: Toward a theory of adolescent romantic relationships. In Montemeyer, R., Adams, G., & Gullotta, T. (Eds.), *Advances in Adolescent Development,* Vol. 3: *Personal Relationships During Adolescence.* Beverly Hills, CA: Sage.

Galen, B. R., & Underwood, M. (1997). A development investigation of social aggression among children. *Developmental Psychology*, 33, 589-599.

Gamefski, N., & Arends, E. (1998). Sexual abuse and adolescent maladjustment: Differences between male and female victims. *Journal of Adolescence, 21(1),*

99-107.

George, C., & Main, M. (1979). Social interactions of young abused children: Approach, avoidance and aggression. *Child Development*, 50, 306-318.

Gidycz, C. A., & Koss, M. P. (1989). The impact of adolescent sexual victimization: Standardized measures of anxiety, depression and behavioral deviancy. *Violence & Victims*, 4 (2), 139-149.

Gil, E., & Johnson, T. C. (1993). *Sexualized children: Assessment and treatment of sexualized children and children who molest*. Rockville, MD: Launch.

Ginsberg, D., Gottman, J. M., & Parker, J. G. (1986). "The importance of friendship". In J. M. Gottman an J. G. Parker (Eds.), *Conversations of Friends*. New York: Cambridge University Press.

Gold, E. R. (1986). Long-term effects of sexual victimization in childhood: An attributional approach. *Journal of Consulting and Clinical Psychology*, 54, 471-475.

Gold, S. N., Hughes, D. M., & Swingle, J. M. (1996). Characteristics of childhood sexual abuse among female survivors in therapy. *Child Abuse & Neglect, 20(4)*, 323-335.

Gottlieb, B. H. (1988). Marshaling social support: The state of the art in research and practice (p. 11-51). Marshaling social support: Formats, processes, and effects, Thousand Oaks, CA: Sage.

Grauerholz, L. (2000). An ecological approach to understanding sexual revictimization: Linking personal, interpersonal, and sociocultural factors and processes. *Child Maltreatment*, Vol 5 (1), 5-17.

Gray, H. M., & Foshee, V. (1997). Adolescent dating violence: Differences between one-sided and mutually violent profiles. *Journal of Interpersonal Violence*, 12, 126-141.

Grotpeter, J. K., & Crick, N. R. (1996). Relational aggression, overt aggression, and friendship. *Child Development*, 67, 2328-2338.

Hall, G. S. (1904). *Adolescence: Its psychology and its relation to physiology,*

anthropology, sociology, sex, crime, religion and education. D. Appleton & Company.

Hartup, W. W. (1992). Friendships and their developmental significance. In H. McGurk (Ed.), *Contemporary Issues in childhood social development* (pp. 175-205). London: Routledge.

Hartup, W. W. (1993). Adolescents and their friends. In Laursen, B. (Ed.), *Close Friendships in Adolescence.* Jossey-Bass. San Francisco.

Hartup, W. W. (1996). The company they keep: Friendships and their developmental significance. *Child Development*, 67, 1-13.

Hayworth, T. F. (2000). Adolescents "at risk" to be perpetrator or victim of sexual violence. Unpublished dissertation submitted to the Department of Psychology, Bryn Mawr College.

Heflin, A. H., & Deblinger, E. (1996). Treatment of an adolescent survivor of child sexual abuse. In Reineke, M. A., Dattilio, F. M., & Freeman, A. (Eds.), *Cognitive therapy with children and adolescents: A casebook for clinical practice* (pp.199-226). New York: Guilford.

Heller, K., Swindle, R. W., & Dusenbury, L. (1986). Component social support processes: Comments and integration. *Journal of Consulting & Clinical Psychology, 54(4),* 466-470.

Herman-Stahl, M., & Peterson, A. C. (1996). The protective role of coping and social resources for depressive symptoms among young adolescents. *Journal of Youth & Adolescence, 25(6),* 733-753.

Higgins, D. J., & McCabe, M. P. (1994). The relationship of child sexual abuse and family violence to adult adjustment: Toward an integrated risk-sequelae model. *Journal of Sex Research, 31(4),* 255-266.

Hinde, R. A. (1966). *Animal behavior: A synthesis of ethology and comparative psychology.* New York: McGraw Hill.

Hotte, J. P., & Rafman, S. (1992). The specific effects of incest on prepubertal girls from dysfunctional families. *Child Abuse and Neglect*, 16, 273-283.

Ispa, J. (1981). Peer support among Soviet day care toddlers. *International Journal of Behavioral Development*, 4, 255-269.

Jackson, S. M., Cram, F., & Seymour, F. W. (2000). Violence and sexual coercion in high school students' dating relationships. *Journal of Family Violence*, 15, 23-36.

Jezl, D. R., Molidor, C. E., & Wright, T. L. (1996). Physical, sexual and psychological abuse in high school dating relationships: Prevalence rates and self-esteem issues. *Child and Adolescent Social Work Journal, 13(1),* 69-87.

Jones, G. P., & Dembo, M. H. (1989). Age and sex role differences in intimate friendships during childhood and adolescence. *Merrill-Palmer Quarterly,* 35, 445-462.

Kelley, D. S. (1994). Family victimization: An application of lifestyle and routine activity theory. *Dissertation Abstracts International Section A: Humanities & Social Science, 54(7A),* p. 72-86.

Kendall-Tackett, K. A., Meyer Williams, L., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin,* 113, 164-180.

Kennedy, S., Kiecolt-Glaser, J. K., & Glaser, R. (1990). Social support, stress, and the immune system, p. 253-266. *Social support: An interactional view,* Oxford, England: Wiley.

Kessler, R. C., Price, R. H., & Wortman, C. B. (1985). Social factors in psychopathology: Stress, social support, and coping processes. *Annual Review of Psychology, 36,* 531-572.

Kohlberg, L. (1963). The development of children's orientations toward a moral order. *Vita Humana, 6(1),* 11-33.

Kolominskii, I. L., & Zhiznevskii, B. P. (1990). A sociopsychological analyses of conflicts among children during play. *Journal of Russian & East European Psychology, 30(5),* 72-86.

Koss, M. (1988). Hidden rape: Sexual aggression and victimization in a national sample in higher education. In A. W. Burgess (Ed.), *Rape and Sexual Assault II*

(pp.3-25). New York: Garland

Koss, M., Gidycz, C., & Wisniewski, N. (1987). The scope of rape: incidence and prevalence of sexual aggression and victimization in a national sample of higher education students. *Journal of Consulting and Clinical Psychology, 55, (2),* 62- 170.

Kuttler, A. F., La Greca, A. M., & Prinstein, M. J. (1999). Friendship qualities and social-emotional functioning of adolescents with close, cross-sex friendships. *Journal of Research on Adolescence,* Vol. 9 (63), 339-366.

Lakey, B., Mornequ, S., & Drew, J. B. (1992). Perceived social support and individual differences in the interpretation and recall of supportive behaviors. *Journal of Social & Clinical Psychology, 11(4),* 336-348.

Laursen, B. (1990). Relationships and conflict during adolescence. *Dissertation Abstracts International (March), 50 (9-B),* p. 4245-4246.

Laursen, B., & Collins, W. A. (1994). Interpersonal conflict during adolescence. *Psychological Bulletin,* Vol. 115 (2), 197-209.

Lempers, J. D., & Clark-Lempers, D. S. (1993). A functional comparison of same-sex and opposite sex friendships during adolescence. *Journal of Adolescent Research,* 8, 89-108.

Levesque, R. J. R. (1993). The romantic experience of adolescents in satisfying love relationships. *Journal of Youth and Adolescence,* 22, 219-251.

Lewin, K. (1935). *A Dynamic Theory of Personality,* New York: McGraw Hill.

Mahlstedt, D., & Keeny, L. (1993). Female survivors of dating violence and their social networks. *Feminism & Psychology,* 3 (3), p. 319-333.

Malik, S., Sorenson, S., & Aneschensel, C. (1997). Community and dating violence among adolescents: Perpetration and victimization. *Journal of Adolescent Health,* 21, 291-302.

Maltz, W. (1988). Identifying and treating the sexual repercussions of incest: A couples therapy approach. *Journal of Sex & Marital Therapy, 14(2),* 142-170.

Mayall, A., & Gold, S. R. (1995). Definitional issues and mediating variables in the

sexual revictimization of women sexually abused as children. *Journal of Interpersonal Violence, 10(1), p. 26-42.*

McCord, J. (1983). A forty-year perspective on effects of child abuse and neglect. *Child Abuse and Neglect, 7(3),* 265-270.

McCord, J. (1985). Long-term adjustment in female survivors of incest: An exploratory study. *Dissertation Abstracts International, 46(2-B),* 650-657.

McNelles, L. R., & Connolly, J. A. (1999). Intimacy between adolescent friends: Age and gender differences in intimate affect and intimate behaviors. *Journal of Research on Adolescence, 9(2),* 143-159.

Messman, T. L. & Long, P. J. (1996). Child sexual abuse and its relationship to revictimization in adult women: A review. *Clinical Psychology Review, 16(5),* 397-420.

Mian, M., Marton, P., & LeBaron, D. (1996). The effects of sexual abuse on 3-5-year-old girls. *Child Abuse & Neglect, 20(8),* 731-745.

Miller, J. B. (1993). Learning from early relationships (p. 1-29). In S. Duck (Ed.) *Learning About Relationships,* Thousand Oaks, CA: Sage.

Miller, B. C., Monson, B. H., & Norton, M. C. (1995). The effects of forced sexual intercourse on white female adolescents. *Child Abuse & Neglect, 19(10),* 1289-1303.

Minuchin, S. (1974). *Families and Family Therapy.* Harvard University Press, Cambridge, MA.

Monroe, S. M., Rohde, P., Seeley, J. R., & Lewinsohn, P. M. (1999). Life events and depression in adolescence: Relationship loss as a prospective risk factor for first onset of major depressive disorder. *Journal of Abnormal Psychology, 108(4),* 606-614.

Mueller, E., & Silverman, N. (1989). Peer relations in maltreated children. In D. Cicchetti & V. Carlson (Eds.), *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect* (pp. 529-578). Cambridge: Cambridge University Press.

Mueller, G. F., Ernst, G., & Thiel, L. (1987). Training and changes in social skills for conflict reduction in interpersonal control situations. *Psychologie und Praxis, 31(4),* 144-151.

Mullen, P. E., Martin, J. L., Anderson, J. C., Romans, S. E., & Herbison, E. (1996). The long-term impact of the physical, emotional, and sexual abuse of children: A community study. *Child Abuse & Neglect, 20(1),* 7-21.

Muller, R. T., Caldwell, R. A., & Hunter, J. E. (1994). Factors predicting the blaming of victims of physical child abuse or rape. *Canadian Journal of Behavioral Sciences*, 26, 259-279.

Muller, R. T., Goh, H. H., Lemieux, K. E., Fish, S. (2000). The social supports of high-risk, formerly maltreated adults. *Canadian Journal of Behavioral Science*, 32 (1), p.1.

Nash, M. R., Neimeyer, R. A., Hulsey, T. L., & Lambert, W. (1998). Psychopathology associated with sexual abuse: The importance of complementary designs and common ground. *Journal of Consulting and Clinical Psychology*, 66, 568-571.

Neeman, J., Hubbard, J., & Masten, A. S. (1995). The changing importance of romantic relationship involvement to competence from late childhood to late adolescence. *Development and Psychopathology*, 7, 727-750.

Nelson, D. A., & Crick, N. R. (1999). Rose colored glasses: Examining the social information-processing of prosocial young adolescents. *Journal of Early Adolescence*, 19 (1), p. 17-38.

Neumann, D. A., Houskamp, B. M., Pollock, V. E., & Briere, J. (1990). The long-term sequelae of childhood sexual abuse in women: A meta-analytic review. *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children, 1(1),* 6-16.

Noll, J. G., Trickett, P. K., & Putnam, F. W. (2000). Social network constellation and sexuality of sexually abused and comparison girls in childhood and adolescence. *Child Maltreatment,* 5, 323-337.

O'Keefe, N. K., Brockopp, K., & Chew, E. (1986). Teen dating violence. *Social Work,*

31(6), 465-468.

O'Leary, K. D., Malone, J., & Tyree, A. (1994). Physical aggression in early marriage: Pre-relationship and relationship effects. *Journal of Consulting and Clinical Psychology*, 62, 594-602.

Olweus, D. (1993). *Bullying at school: What we know and what we can do.* Oxford, England: Blackwell Publishers.

Owens, L. D. (1996). Sticks and stones and sugar and spice: Girls' and boys' aggression in schools. *Australian Journel of Guidance and Counseling*, 6, 45-55.

Owens, L., Shute, R., & Slee, P. (2000). "I'm in and you're out": Explanations for teenage girls' indirect aggression. *Psychology, Evolution & Gender*, 2 (1), 19-46.

Paikoff, R. L., Brooks-Gunn, J., & Warren, M. P. (1991). Effects of girls' hormonal status on depressive and aggressive symptoms over the course of one year. *Journal of Youth and Adolesence, 20(2)*, 191-215.

Paolucci, E. O., Genuis, M. L., Violato, C. (2001). A meta-analysis of the published research on the effects of child sexual abuse. *Journal of Psychology*, Vol 135 (1), 17-37.

Parker, J. G., & Asher, S. R. (1987). Peer relations and later personal adjustment: Are low-accepted children "at risk"? *Psychological Bulletin*, 102, 357-389.

Parker, J. G., & Gottman, J. M. (1989). Social and emotional development in a relational context: Friendship interaction from early childhood to adolescence. In T. J. Berndt (Ed.), *Peer relationships in child development* (pp. 95-131). New York: Wiley.

Parker, J. G., & Herrera, C. (1996). Interpersonal processes in friendship: A comparison of abused and nonabused children's experiences. *Developmental Psychology*, Vol. 32 (6), 1025-1038.

Pawlby, S. J., Mills, A., & Quinton, D. (1997). Vulnerable adolescent girls: Opposite-sex relationships. *Journal of Child Psychology & Psychiatry & Allied Disciplines, 38(8)*, p. 909-920.

Pearlin, L. I., Menaghan, E. G., Lieberman, M. A., & Mullan, J. T. (1981). The stress

process. *Journal of Health & Social Behavior, 22(4),* 337-356.

Piaget, J. (1962). *Play, dreams and imitation in childhood.* New York: Norton.

Piaget, J. (1965). *The Moral Judgement of the Child.* New York: Free Press (originally published 1932).

Piaget, J. (1980). *Adaptation and intelligence.* Chicago: University of Chicago Press.

Piaget, J. (1985). *The equilibration of cognitive structures.* Chicago: University of Chicago Press. (Original work published 1975).

Polusny, M. A., & Follette, V. M. (1995). Long-term correlates of child sexual abuse: theory and review of empirical literature. *Applied and Preventive Psychology*, 4, 143-146.

Price, J. M., & Ladd, G. W. (1986). Assessment of children's friendships: Implications for social competence and adjustment. In R. J. Prinz (Ed.), *Advances in behavioral assessment of children and families* (pp. 121-149). London: JAI.

Procidano, M., & Heller, K. (1983). Measures of perceived social support from friends and from family: Three validational studies. *American Journal of Community Psychology*, 11, 1-24.

Purdie, V., & Downey, W. C. (2000). Sexual victimization and perceptions of close relationships in adolescence. *Child Maltreatment*, 5, 350-359.

Putallaz, M., & Sheppard, B. H. (1992). Conflict managememt and social competence (p. 330- 355). In C. Uhlinger, E. Shantz, & E. Hartup (Eds.), *Conflict in Child and AdolescentDevelopment.* New York: Cambridge University Press.

Quinton, D., Pickles, A., Maughan, B., & Rutter, M. (1993). Partners, peers, and pathways: Assortative pairing and continuities in conduct disorder. *Development and Psychopathology*, 5, 763-783.

Reece, R. M. (1998). "Behavioral manifestations of child sexual abuse": A response. *Child Abuse & Neglect, 22(6),* 533-535.

Reis, H. T., & Shaver, P. (1988). Intimacy as an interpersonal process. In Duck, S. (Ed.) *Handbook of Personal Relationships: Theory, Relationships, and Intervention.* Chichester, England: Wiley.

Rieder, C., & Cicchetti, D. (1989). Organizational perspective on cognitive control Functioning and cognitive-affective balance in maltreated children. *Developmental Psychology,*25, 382-393.

Riggs, D. S., & O'Leary, K. D. (1989). A theoretical model of courtship aggression. In M.A. Pirog-Good & J. E. Strets (Eds.), *Violence in Dating Relationships* (pp. 53-71). New York: Prager.

Roche, D. N., Runtz, M. G., & Hunter, M. A. (1999). Adult attachment: A mediator between child sexual abuse and later psychological adjustment. *Journal of Interpersonal Violence, 14(2),* 184-207.

Rogosch, F. A., Cicchetti, D., & Aber, J. L. (1995). The role of child maltreatment in early deviations in cognitive and affective processing abilities and later peer relationship problems. *Development and Psychopathology,* 7, 591-609.

Roth, S., & Newman, E. (1993). The process of coping with incest for adult survivors: Measurement and implications for treatment and research. *Journal of Interpersonal Violence, 8(3),* 363-377.

Runtz, M. G., & Schallow, J. R. (1997). Social support and coping strategies as mediators of adult adjustment following childhood maltreatment. *Child Abuse and Neglect,* 21, 211-226.

Salter, A. C. (1995). *Transforming trauma: A guide to understanding and treating adult survivors of child sexual abuse.* Thousand Oaks, CA: Sage.

Sarason, I. G., Pierce, G. R., & Saranson, B. R. (1990). Social support and interactional processes: A triadic hypothesis. *Journal of Social and Personal Relationships,* 7, 495-506.

Schlossman, S., & Cairns, R. B. (1993). Children in time and place: Developmental and historical insights (p. 110-130). *Problem Girls: Observations on Past and Present.*

Selman, R. L. (1981). The development of interpersonal competence: The role of understanding in conduct. *Developmental Review,* 1, 401-422)

Selman, R. L., & Schultz, L. H. (1990). *Making a friend in youth.* Chicago: University

of Chicago Press.

Shantz, C. U., & Hartup, W. W. (Eds.), (1992). *Conflict in child and adolescent development.* Cambridge, England: Cambridge University Press.

Sharabany, R., Gershoni, R., & Hofman, J. A. (1981). Girlfriend, boyfriend: Age and sex differences in intimate friendship. *Developmental Psychology*, 17, 800-808.

Sharabany, R., & Wiseman, H. (1993). Close relationships in adolescence: The case of the kibbutz. *Journal of Youth and Adolescence*, 22, 671-695.

Shulman, S., & Collins, A. (1997). Romantic relationships in adolescence: Developmental perspectives (p. 117). In *New Directions for Child Development,* No. 78, San Francisco: Jossey-Bass.

Shulman, S., Levy-Shiff, R., Kedem, P., & Alon, E. (1997). Intimate relationships among adolescent romantic partners and same-sex friends: Individual and systemic perspectives. In S. Shulman & W. A. Collins (Eds.), *Romantic Relationships in adolescence: Developmental perspectives* (pp. 37-51). San Francisco: Jossey-Bass.

Skinner, B. F. (1938). *The behavior of organisms: An experimental analysis.* Oxford, England: Appleton-Century.

Smith, J. P., & Williams, J. G. (1992). From abusive household to dating violence. *Journal of Interpersonal Violence*, Vol 7 (2), p. 153-165.

Spaccarelli, S. (1994). Stress, appraisal, and coping in child sexual abuse: A theoretical and empirical review. *Psychological Bulletin*, 116, 340-362.

Spaccarelli, S., & Kim, S. (1995). Resilience criteria and factors associated with resilience in sexually abused girls. *Child Abuse & Neglect, 19(9),* 1171-1182.

Special Edition on Adolescence (2000). *Child Maltreatment*, Vol. 5 (4), November. Sage Publications.

Steinberg, L. (1989). Pubertal maturation and parent-adolescent distance: An evolutionary perspective. In G. Adams, R. Montemayor, & T. Gullotta (Eds.), *Biology of adolescent behavior and development* (pp. 82-114). Newbury Park, CA: Sage.

Stets, J. E., & Pirog-Good, M. A. (1989). Patterns of physical and sexual abuse for

women and men dating relationships. *Journal of Family Violence*, 4, 63-76.

Suderman, M., & Jaffe, P. (1993). Dating violence among a sample of 1,567 high school students. In D. Wolfe (Chair), *Violence in adolescent relationships: Identifying risk factors and prevention methods.* Symposium conducted at the annual convention of the American Psychological Association, Toronto.

Sullivan, H. S. (1953). *The Interpersonal Theory of Psychiatry.* New York: Norton.

Testa, M., Miller, B., Downs, W., & Panek, D. (1992). The moderating impact of social support following childhood sexual abuse. *Violence and Victims*, 7, 173-186.

Urberg, K. A., Degirmencioglu, S. M., Tolson, J. M., & Halliday-Scher, K. (1995). The structure of adolescent peer networks. *Developmental Psychology, 31(4),* 540-547.

Vaux, A. (1988). *Social support: Theory, research, and intervention.* New York: Praeger.

Verduyn, C., & Calam, R. (1999). Cognitive behavioral interventions with maltreated children and adolescents. *Child Abuse & Neglect, 23(2),* 197-207.

Violato, C., & Genuis, M. (1993). Problems of research in male child sexual abuse: A review. *Journal of Child Sexual Abuse,* Vol. 2 (3). p. 33-54.

Wekerle, C., & Wolfe, D. A. (1998). The role of child maltreatment and attachment style in adolescent relationships. *Development and Psychopathology*, Vol. 10 (3), 571-586.

Werner, E. E. (1993). Risk, resilience, and recovery: Perspectives from the Kauai longitudinal study. *Development and Psychopathology,* 5, 503-515.

Werner, E. E., & Crick, N. R. (1999). Relational aggression and social-psychological adjustment in a college sample. *Journal of Abnormal Psychology*, 108 (4), 615-683

Whiffen, V. E., Judd, M. E., & Aube, J. A. (1999). Intimate relationships moderate the association between childhood sexual abuse and depression. *Journal of Interpersonal Violence,*14 (9), p. 940-954.

Widom, C. S. (1989). Does violence breed violence? A critical examination of the literature. *Psychological Bulletin,* 106 (3), 3-28.

Widom, C. S. (1994). Childhood victimization and adolescent problem behaviors. In R.

D. Ketterlinus & M. E. Lamb (Eds.), *Adolescent problem behaviors: Issues and research* (pp. 127-164). Hillsdale, NJ: Erlbaum.

Wolfe, D. A., & Feiring, C. (2000). Dating violence through the lens of adolescent romantic relationships, *Child Maltreatment, 5(4),* 360-363.

Wolfe, D. A., Scott, K., Reitzel-Jaffe, D., Wekerle, C., Grasley, C., & Straatman, A. (2001). Development and validation of the conflict in adolescent dating relationships inventory. *Psychological Assessment*, Vol. 13 (2), 277-293.

Wolfe, D., Scott, K., Wekerle, C., & Pittman, A. (2001). Child maltreatment: Risk of adjustment problems and dating problems in adolescence. *Journal of the American Academy of Child and Adolescent Psychiatry.*

Wolfe, D., Wekerle, C., Reitzel-Jaffe, D., & Lefebvre, L. (1998). Factors associated with abusive relationships among maltreated and nonmaltreated youth. *Development and Psychopathology,* 10, 61-85.

Wyatt, G. E. (1990). Changing influences on adolescent sexuality over the past forty years. In J. Bancroft, J. Machover, & E. Reinisch (Eds.), *Adolescence and Puberty*, London: Oxford University Press.

Wyatt, G. E., Newcomb, M. D., & Riederle, M. H. (1993). *Sexual abuse and consensual sex: Women's developmental patterns and outcomes.* Thousand Oaks, CA: Sage.

Youniss, J., & Smollar, J. (1985). *Adolescent relations with mothers, fathers, and friends.* Chicago: University of Chicago Press.

Appendix A

HUMAN SUBJECTS PROTOCOL: CONSENT TO PARTICIPATE IN A RESEARCH PROJECT. Title of Study: History of Abuse and Interpersonal Attitudes as Predictors of Social Support in Adolescent Female Peer Relationships

Investigators: **Esther Deblinger, Ph.D., Clinical Director, Associate Professor of Psychiatry, Center for Children's Support**
Lori Feldman-Winter, M.D., Associate Professor of Pediatrics Department of Pediatrics, Division of Adolescent Medicine

Address: **42 East Laurel Road**
Stratford, NJ 08084
(856) 566-7036

Co-Investigator: **Sherri Edelman, M.S., Psychology Doctoral Candidate**
Philadelphia College of Osteopathic Medicine

Consent for Participation in a Study

Group 1 - Parent Form

DESCRIPTION: The purpose of this study is to learn about how sexual abuse may affect girls peer relationships, as well as how thoughts and feelings affect their interactions with their peers. In this study, we will compare the thoughts and feelings of sexually abused and nonabused females. We are asking you and your daughter to participate because you have identified that to your knowledge she has not been a victim of child sexual abuse. The purpose of this study is to look specifically at the areas of female adolescent peer relationships, interpersonal and sexual attitudes. We are asking you to allow us to enter you and your daughter's responses to three questionnaires into a computer database for research purposes.

PROCEDURES: If you decide to be in the study, we will ask you to complete some questionnaires during your initial appointments with your daughter's counselor that are part of the standard pretreatment assessment given to all individuals entering into treatment at the Center for Children Support, but are being used here for research purposes. The study questionnaire you will complete asks about adolescent sexual behavior; the two questionnaires for the study that your daughter are asked to complete will help us learn about their friendships and/or dating relationships and sexual attitudes. These forms will focus on her thoughts, feelings and behavior. You are both welcome to

IRB APPROVED: From: 3/20/03 (Date) To: 3/19/04 (Date)

look at these questionnaires before agreeing to participate; they have been used before with many other adolescents. We will inform you of anything your daughter indicates, either verbally or in writing, that may be cause for concern, including an intention to harm themselves or someone else; otherwise, the questionnaires will be considered confidential.

RISKS OR DISCOMFORTS: There are no procedures that would result in long-term social, emotional, and/or physical harm to participants. The questionnaires do not ask about sexual abuse; they ask about attitudes and opinions about hypothetical abusive situations, as well as about relationships. Trained mental health professionals administer the questionnaires, and will appropriately offer support if a participant demonstrates any emotional discomfort during the assessment process. Any previously undisclosed child abuse and/or neglect that are discovered will be reported to the appropriate state agency as required by law.

POTENTIAL BENEFITS: The information provided will help us to better understand adolescents like yours. The more we learn, the more we can help if there is a problem or an adolescent feels confused. The assessment information is valuable as it is used by your counselors to determine how to best help your daughter.

ALTERNATIVE TREATMENTS: If you choose not to participate in the research study, it will in no way affect the treatment or services you or your youngster receives at the Center.

CONFIDENTIALITY ISSUES:

Privacy: If you choose to participate in the study, we want to assure you that the information you provide will be kept private. To ensure your privacy, only the research staff, counselors, University officials and the Institutional Review Board (IRB) will be able to obtain your names or other identifying information and/or have access to your medical and/or research records. The IRB is a committee sponsored by the university that reviews research studies to help protect people who participate in research. To protect your privacy, all the research records will be kept in a secure, locked file by number, not name. In addition, we will not use any information that would identify you when we report the findings of this research in papers, professional journals, or at professional meetings.

To protect your confidentiality and the confidentiality of your research records, in most circumstances we will not disclose information about you and your adolescent without first obtaining your consent. If you provide us with permission to disclose your research information, you may revoke that permission, in writing, at any time. Please write to Esther Deblinger, Ph.D. at UMDNJ-SOM, 42 East Laurel Rd., Suite 1100B, Stratford, New Jersey 08084 to revoke your permission. If you revoke your permission, we will no longer disclose research information about you, although we will be unable to take back the disclosures we made with your permission.

NJ State Law: The investigators and his/her collaborators will consider your records confidential to the extent permitted by law. However, there are certain exceptions that

you should know about. According to State law, the researcher must contact appropriate local or state authorities:

(1) If you disclose an intent to harm yourself or someone else;

(2) If you report having been involved in physical or sexual abuse or neglect of a minor;

and/or

(3) If we receive a court order signed by a Judge to release your records to the courts.

We will inform you if any of these limits of confidentiality arise during the course of the study.

NONPARTICIPATION: YOUR RIGHTS TO SAY NO AND WITHDRAW: You have the right to refuse to participate in the study or withdraw from the study at any time without penalty. If you choose not to participate, there will be no prejudice with regard to the care or services provided by the Center, the Division of Youth and Family Services (DYFS), and/or the Prosecutor's office.

If you have any questions concerning your rights as a research subject, or you feel you have been pressured to participate in this study against your wishes, you may contact the Institutional Review Board at (856) 566-2712.

I have read the consent form or it has been read to me. The purpose and methods of the study, and what I will be asked to do, have been explained to me. Signing this form means I have made my own decision and agree to participate in the study described. My signature also means that this information may be used and disclosed for the research purposes described in this form. You also understand that you are giving personnel involved in this research permission to have access to your research records and those of your adolescent, which may include protected health information about you and your child. Your signature also means that this information may be used and disclosed for the research purposes described in this form. At this time, my questions concerning this research have been answered, and I have received a copy of this consent form. If I have any questions or concerns about the research study later, I may contact Esther Deblinger, Ph.D. at (856) 566-7036 between the hours of 9:00 a.m. and 5:00 p.m.

_____ _____

Date Signature of Participant

PROJECT COORDINATOR OR INVESTIGATOR'S CERTIFICATION: I certify that I have explained to the above individual the nature and purpose, the potential benefits, and possible risks associated with participating in this research study, have answered any questions that have been raised, and have witnessed the above signature.

IRB APPROVED: From: 3/20/03 3/19/03
Date Date

HUMAN SUBJECTS PROTOCOL: CONSENT TO PARTICIPATE IN A RESEARCH PROJECT. Title of Study: History of Abuse and Interpersonal Attitudes as Predictors of Social Support in Adolescent Female Peer Relationships

Investigators: **Esther Deblinger, Ph.D., Clinical Director, Associate Professor of Psychiatry, Center for Children's Support**
Lori Feldman-Winter, M.D., Associate Professor of Pediatrics, Department of Pediatrics, Division of Adolescent Medicine

Address: **42 East Laurel Road**
Stratford, NJ 08084
(856) 566-7036

Co-Investigator: **Sherri Edelman, M.S., Psychology Doctoral Candidate**
Philadelphia College of Osteopathic Medicine

Consent for Participation in a Study

Group 1 – Female Adolescent Assent Form

DESCRIPTION: Relationships are an important part of a girl's life. We are doing a study to learn more about girls' thoughts and feelings about their peer relationships. Each adolescent thinks and feels different things about their friendships and/or dating relationships; we are asking you to complete questionnaires that ask about these thoughts and feelings, and to allow us to enter the responses into a computer database for research purposes.

PROCEDURES: If you decide to be in the study, we will ask you to complete two questionnaires that will help us learn about how you view your friendships and/or dating relationships and your attitudes towards these relationships. They are part of the standard pretreatment assessment given to all individuals entering into treatment at the Center for Children Support, but are being used here for research purposes. You are welcome to look at these questionnaires before agreeing to participate; they have been used before with many other adolescents. Our intention is for the questionnaires that you complete to be considered confidential; possible exceptions include anything verbal or written that may be cause for concern, including an intention to harm yourself or someone else.

RISKS OR DISCOMFORTS: There are no procedures that would result in long-term social, emotional, and/or physical harm to participants. The questionnaires do not ask about sexual abuse; they ask about attitudes and opinions about hypothetical abusive

IRB APPROVED: From: 3/20/03 3/19/04
Date Date

situations, as well as about relationships. Trained mental health professionals administer the questionnaires, and will appropriately offer support if a participant demonstrates any emotional distress during the assessment process. Any previously undisclosed child abuse and/or neglect that are discovered will be reported to the appropriate state agency as required by law.

POTENTIAL BENEFITS: The information provided will help us to better understand youngsters like you. The more we learn, the more we can help if there is a problem or an adolescent feels confused. In addition, assessment information is valuable as it is used by your counselors to determine how to best help you.

ALTERNATIVE TREATMENTS: If you choose not to participate in the research study, it will in no way affect the treatment or services you or your parent receives at the Center.

CONFIDENTIALITY ISSUES:

Privacy: If you choose to participate in the study, we want to assure you that the information you provide will be kept private. To ensure your privacy, only the research staff, counselors, University officials and the Institutional Review Board (IRB) will be able to obtain your names or other identifying information and/or have access to your medical and/or research records. To protect your privacy, all the research records will be kept in a secure, locked file by number, not name. In addition, we will not use any information that would identify you when we report the findings of this research in papers, professional journals, or at professional meetings.

NJ State Law: The investigators and his/her collaborators will consider your records confidential to the extent permitted by law. However, there are certain exceptions that you should know about. According to State law, the researcher must contact appropriate local or state authorities:

(1) If you disclose an intent to harm yourself or someone else;

(2) If you report having been physically or sexually abused or neglected;

and/or

(3) If we receive a court order signed by a Judge to release your records to the courts.

We will inform you if any of these limits of confidentiality arise during the course of the study.

NONPARTICIPATION: YOUR RIGHTS TO SAY NO AND WITHDRAW: You have the right to refuse to participate in the study or withdraw from the study at any time without penalty. If you choose not to participate, there will be no prejudice with regard to the care or services provided by the Center, the Division of Youth and Family Services (DYFS), and/or the Prosecutor's office.

IRB APPROVED: From: 3/20/03 To: 3/19/04
Date Date

If you have any questions concerning your rights as a research subject, or you feel you have been pressured to participate in this study against your wishes, you may contact the Institutional Review Board at (856) 566-2712.

I have read the consent form or it has been read to me. The purpose and methods of the study, and what I will be asked to do, have been explained to me. Signing this form means I have made my own decision and agree to participate in the study described. My signature also means that this information may be used and disclosed for the research purposes described in this form. At this time, my questions concerning this research have been answered, and I have received a copy of this consent form. If I have any questions or concerns about the research study later, I may contact Esther Deblinger at (856) 566-7036 between the hours of 9:00 a.m. and 5:00 p.m.

Date	Signature of Participant
Witness Name	Signature

PROJECT COORDINATOR OR INVESTIGATOR'S CERTIFICATION: I certify that I have explained to the above individual the nature and purpose, the potential benefits, and possible risks associated with participating in this research study, have answered any questions that have been raised, and have witnessed the above signature.

Date	Project Coordinator or Investigator Signature

IRB APPROVED: From: 3/20/03 To: 3/19/04
Date Date

ter for Children's Support

Appendix B

HUMAN SUBJECTS PROTOCOL: CONSENT TO PARTICIPATE IN A RESEARCH PROJECT. Title of Study: History of Abuse and Interpersonal Attitudes as Predictors of Social Support in Adolescent Female Peer Relationships

Investigators: **Esther Deblinger, Ph.D., Clinical Director, Associate Professor of Psychiatry, Center for Children's Support**
Lori Feldman-Winter, M.D., Associate Professor of Pediatrics, Department of Pediatrics, Division of Adolescent Medicine

Address: **42 East Laurel Road**
Stratford, NJ 08084
(856) 566-7036

Co-Investigator: **Sherri Edelman, M.S., Psychology Doctoral Candidate**
Philadelphia College of Osteopathic Medicine

Consent for Participation in a Study

Group 2 - Parent Form

DESCRIPTION: We are doing a study to compare the thoughts and feelings of sexually abused and nonabused girls. We are asking you and your daughter to participate because you have identified that to your knowledge she has not been a victim of child sexual abuse. The purpose of this study is to look at the areas of female adolescent peer relationships, interpersonal and sexual attitudes. We are asking you to allow us to enter you and your daughter's responses to three questionnaires into a computer database for research purposes.

PROCEDURES: If you and your daughter agree to participate in this study, we will ask you to complete a brief interview and a questionnaire about her sexual attitudes and behavior. Your daughter will be asked to complete two questionnaires that will help us learn about how she views her friendships and/or dating relationships and her sexual attitudes towards these relationships. You are welcome to look at these questionnaires before you or your daughter agrees to participate; they have been used before with many other adolescents. We will inform you of anything she may indicate, either verbally or in writing, that may be cause for concern, including an intention to harm themselves or someone else; otherwise, the survey instrument will be considered confidential. The procedures will take place in one session that will last approximately 30 to 45 minutes. At the completion of the study procedure, you and your daughter will receive a total of $20.00 cash for your participation.

IRB APPROVED 3/20/03 To: 3/19/04 Date

RISKS OR DISCOMFORTS: There are no procedures that would result in long-term social, emotional, and/or physical harm to participants. The questionnaires do not ask about sexual abuse; they ask about attitudes and opinions about hypothetical abusive situations, as well as about relationships. However, some of the questions you or your daughter are asked may cause mild discomfort. If at any time you do become uncomfortable, or you have any questions, the person talking with you can offer support and assistance. Both you and your daughter may choose to not answer individual questions, or choose to stop completing the questionnaires at any time.

POTENTIAL BENEFITS: The information provided will help us to better understand adolescents like yours. The more we learn, the more we can help if there is a problem or an adolescent feels confused.

ALTERNATIVE TREATMENTS: If you choose not to participate in this research study, it will in no way affect any treatments or services you receive at UMDNJ.

CONFIDENTIALITY ISSUES:

Privacy: If you choose to participate in the study, we want to assure you that the information you provide will be kept private. To ensure your privacy, only the research staff, University officials and the Institutional Review Board (IRB) will be able to obtain your names or other identifying information and/or have access to your medical and/or research records. The IRB is a committee sponsored by the university that reviews research studies to help protect people who participate in research. To protect your privacy, all the research records will be kept in a secure, locked file by number, not name. In addition, we will not use any information that would identify you when we report the findings of this research in papers, professional journals, or at professional meetings.

To protect your confidentiality and the confidentiality of your research records, in most circumstances we will not disclose information about you and your adolescent without first obtaining your consent. If you provide us with permission to disclose your research information, you may revoke that permission, in writing, at any time. Please write to Esther Deblinger, Ph.D. at UMDNJ-SOM, 42 East Laurel Rd., Suite 1100B, Stratford, New Jersey 08084 to revoke your permission. If you revoke your permission, we will no longer disclose research information about you, although we will be unable to take back the disclosures we made with your permission

NJ State Law: The investigators and his/her collaborators will consider your records confidential to the extent permitted by law. However, there are certain exceptions that you should know about. According to State law, the researcher must contact appropriate local or state authorities:

(1) If you disclose an intent to harm yourself or someone else;

(2) If you report having been involved in physical or sexual abuse or neglect of a minor.

IRB APPROVED: From: 3/20/03 To: 3/19/04
Date Date

We will inform you if any of these limits of confidentiality arise during the course of the study.

NONPARTICIPATION: YOUR RIGHTS TO SAY NO AND WITHDRAW: You have the right to refuse to participate in the study or withdraw from the study at any time without penalty. If you choose not to participate, there will be no prejudice with regard to the care or services provided to you or your adolescent by the Department of Pediatrics at the UMDNJ-SOM Primary Care Center.

If you have any questions concerning your rights as a research subject, or you feel you have been pressured to participate in this study against your wishes, you may contact the Institutional Review Board at (856) 566-2712.

I have read the consent form or it has been read to me. The purpose and methods of the study, and what I will be asked to do, have been explained to me. Signing this form means I have made my own decision and agree to participate in the study described. My signature also means that this information may be used and disclosed for the research purposes described in this form. You also understand that you are giving personnel involved in this research permission to have access to your research records and those of your adolescent, which may include protected health information about you and your child. Your signature also means that this information may be used and disclosed for the research purposes described in this form. At this time, my questions concerning this research have been answered, and I have received a copy of this consent form. If I have any questions or concerns about the research study later, I may contact Esther Deblinger, Ph.D. at (856) 566-7036 or Lori Feldman-Winter, M.D. at (856) 566-7032 between the hours of 9:00 a.m. and 5:00 p.m.

_____ _____

Date Signature of Participant

PROJECT COORDINATOR OR INVESTIGATOR'S CERTIFICATION: I certify that I have explained to the above individual the nature and purpose, the potential benefits, and possible risks associated with participating in this research study, have answered any questions that have been raised, and have witnessed the above signature.

_____ _____

Date Project Coordinator or Investigator Signature

IRB APPROVED: From: 3/20/03 To: 3/19/04
Date Date

HUMAN SUBJECTS PROTOCOL: CONSENT TO PARTICIPATE IN A RESEARCH PROJECT. Title of Study: History of Abuse and Interpersonal Attitudes as Predictors of Social Support in Adolescent Female Peer Relationships

Investigators: **Esther Deblinger, Ph.D., Clinical Director, Associate Professor of Psychiatry, Center for Children's Support**
Lori Feldman-Winter, M.D., Associate Professor of Pediatrics, Department of Pediatrics, Division of Adolescent Medicine

Address: **42 East Laurel Road**
Stratford, NJ 08084
(856) 566-7036

Co-Investigator: **Sherri Edelman, M.S., Psychology Doctoral Candidate**
Philadelphia College of Osteopathic Medicine

Consent for Participation in a Study

Group 2 – Female Adolescent Assent Form

DESCRIPTION: Relationships are an important part of a girl's life. We are doing a study to learn more about thoughts and feelings about peer relationships. Each girl thinks and feels different things about their friendships and/or dating relationships: we are asking you to complete questionnaires that ask about these thoughts and feelings, and to allow us to enter the responses into a computer database for research purposes.

PROCEDURES: If you decide to be in the study, we will ask you to complete two questionnaires that will help us learn about how you view your friendships and/or dating relationships and your attitudes towards these relationships. You are welcome to look at these questionnaires before agreeing to participate; they have been used before with many other adolescents. Our intention is for the questionnaires that you complete to be considered confidential: exceptions include anything verbal or written that may be cause for concern, including an intention to harm yourself or someone else. The procedures of the study will take place in one session that will last approximately 30 to 45 minutes.

RISKS OR DISCOMFORTS: There are no procedures that would result in long-term social, emotional, and/or physical harm to participants. The questionnaires do not ask about sexual abuse; they ask about attitudes and opinions about hypothetical abusive situations, as well as about relationships. However, some of the questions you are asked

IRB APPROVED: From: 3/20/03 To: 3/19/04
Date Date

may make you feel mildly uncomfortable. If at any time you experience discomfort, or you have any questions, the person talking with you can offer support and assistance. You may choose to not answer individual questions, or choose to stop completing the questionnaires at any time.

POTENTIAL BENEFITS: The information provided will help us to better understand other female adolescents like you. The more we learn, the more we can help if there is a problem or an adolescent feels confused.

ALTERNATIVE TREATMENTS: If you choose not to participate in this research study, it will in no way affect any treatments or services at UMDNJ which may be appropriate for you and your parent.

CONFIDENTIALITY ISSUES:

Privacy: If you choose to participate in the study, we want to assure you that the information you provide will be kept private. To ensure your privacy, only the research staff, University officials and the Institutional Review Board (IRB) will be able to obtain your names or other identifying information and/or have access to your medical and/or research records. To protect your privacy, all the research records will be kept in a secure, locked file by number, not name. In addition, we will not use any information that would identify you when we report the findings of this research in papers, professional journals, or at professional meetings.

NJ State Law: The investigators and his/her collaborators will consider your records confidential to the extent permitted by law. However, there are certain exceptions that you should know about. According to State law, the researcher must contact appropriate local or state authorities:

(1) If you disclose an intent to harm yourself or someone else;

(2) If you report having been physically or sexually abused or neglected.

We will inform you if any of these limits of confidentiality arise during the course of the study.

NONPARTICIPATION: YOUR RIGHTS TO SAY NO AND WITHDRAW: You have the right to refuse to participate in the study or withdraw from the study at any time without penalty. If you choose not to participate, there will be no prejudice with regard to the care or services provided to you or your parent by the Department of Pediatrics at the UMDNJ-SOM Primary Care Center.

If you have any questions concerning your rights as a research subject, or you feel you have been pressured to participate in this study against your wishes, you may contact the Institutional Review Board at (856) 566-2712.

IRB APPROVED: From: 3/20/03 To: 3/19/04

I have read the consent form or it has been read to me. The purpose and methods of the study, and what I will be asked to do, have been explained to me. Signing this form means I have made my own decision and agree to participate in the study described. My signature also means that this information may be used and disclosed for the research purposes described in this form. At this time, my questions concerning this research have been answered, and I have received a copy of this consent form. If I have any questions or concerns about the research study later, I may contact Esther Deblinger, Ph.D. (856) 566-7036 or Lori Feldman-Winter, M.D. at (856) 566-7032 between the hours of 9:00 a.m. and 5:00 p.m.

_____ _____

Date Signature of Participant

PROJECT COORDINATOR OR INVESTIGATOR'S CERTIFICATION: I certify that I have explained to the above individual the nature and purpose, the potential benefits, and possible risks associated with participating in this research study, have answered any questions that have been raised, and have witnessed the above signature.

_____ _____

Date Project Coordinator or Investigator Signature

IRB APPROVED: From: 3/20/03 To: 3/19/04
Date Date

INTERVIEW WITH PARENT/LEGAL GUARDIAN

Appendix C

1. **SUBJECT ID (ASSIGNED AFTER THE INTERVIEW IS COMPLETED)** _____

2. **DATE FORM COMPLETED**___/___/___

3. **How old is she right now?**_____**years** _____**months**

4. **What is your relationship to the adolescent?** _____

5. **Do you have legal custody of the adolescent? Y**_____**N**_____

6. **How long has the adolescent lived with you?** _____

7. **What is her race or ethnic group?**

   1. African-American
   2. Caucasian
   3. Hispanic
   4. Asian
   5. Bi-Racial
   6. Other (_____)

8. **What grade is she currently in at school?** _____

9. **Which of the following best describes her school placement?**
   0. Regular classes
   1. Regular classes with additional remedial instruction
   2. Regular classes with additional scholars placement
   3. Special education classes (part-time)—for the behaviorally/ emotionally/learning handicapped (specify:_____)
   4. Special education class or special school (full time)—for the behaviorally/emotionally/learning handicapped (specify:_____)
   5. Advanced placement (full time for the gifted)
   6. Other/not in school
   7. Unknown

10. **What is your current marital status?**

    1. single/never married
    2. married
    3. separated
    4. divorced
    5. widowed
    6. living with partner

Continue on P. 2

11. What is the highest grade in school or year of college you have completed?

none	0
elementary school	1 2 3 4 5 6 7 8 9 10 11 12
college	13 14 15 16
graduate/professional	17 18 19 20+

12. What is the highest degree that you have completed?

0. none (or part college)
1. vocational certificate
2. Associate (A.A., Jr. college)
3. Bachelor's (B.A., A.B., or B.S.)
4. Master's (M.A., M.S., M.S.W., e
5. Doctoral (Ph.D., Psy.D., M.D. J.D., D.D.S., etc.

13. Which best describes your employment status?

1. employed full-time
2. employed part-time
3. unemployed
4. retired and not working
5. student
6. homemaker
7. disabled or too ill to work
8. other (specify)_____

14. What is the occupation of the head of the household? _____

DO NOT ASK THE FOLLOWING QUESTION (For DATA ENTRY ONLY)

History of Sexual Abuse NO_____YES_____

Continue on P. 3

19. **Now I want you to think about your family's total income, before taxes. Do you know how much it was last year? (If not sure, ask PER MONTH or PER WEEK. If needed, help the informant focus on the appropriate column.**

	PER YEAR	PER MONTH	PER WEEK
1.	Less than $5,000	Less than $417	Less than $96
2.	$5,000 - $10,000	$418 - $833	$97 - $192
3.	$10,000 - $15,000	$834 - $1250	$193 - $288
4.	$15,000 - $20,000	$1251 - $1666	$289 - $384
5.	$20,000 - $25,000	$1667 - $2083	$385 - $480
6.	$25,000 - $30,000	$2084 - $2500	$481 - $576
7.	$30,000 - $35,000	$2501 - $2916	$577 - $673
8.	$35,000 - $40,000	$2917 - $3333	$674 – $769
9.	$40,000 - $45,000	$3334 - $3750	$770 - $865
10.	$45,000 - $50,000	$3751 - $4166	$866 - $961
11.	More than $50,000	More than $4167	More than $962

TELEPHONE SCREENING

Appendix D

May I please speak with _____? My name is_____. I am working in collaboration with Dr. Lori Feldman-Winter at the UMDNJ-SOM Department of Pediatrics doing research which is designed to help all youngsters, especially sexually abused females. Sexual abuse is a widespread problem in our society today. We are doing a study which will look at female adolescents thoughts and feelings about their friendships and/or dating relationships, because the more we know, the better we can help if they have a problem or feel confused. In order to do this, we need to know how nonabused girls think and feel about their friendships and dating relationships, sexual attitudes, and other issues. Participation in this study is voluntary on the part of both parent and adolescent. If you choose not to participate, this will in no way affect the care or services provided by the Department of Pediatrics or any of the other departments at the UMDNJ. Agreeing to participate at this time does not obligate you in case you change your mind later. Should you change your mind later, although personal information about you will be collected, it will be kept confidential. If you do participate, you will be asked to sign a consent form that explains the confidentiality procedures in greater detail.

We are asking you to participate because your daughter has been identified as being female, between 13 and 17 years of age, and having never been a victim of sexual abuse. For our study, we need a group of females with no history of abuse; just to be sure we are identifying a nonabused group, I need to inform you that if you or your daughter disclose now, or at any time during this research, that she has in fact been sexually or physically abused, we are obligated to report this information to the Division of Youth and Family Services. By continuing, you confirm that your daughter has no known history of abuse. May we continue?

1. **Are you the legal guardian of _____? Y____N____**
2. **Does your child have any pervasive developmental delays (e.g. Autism, Asbergers, or Retts)? Y____N____**
3. **Is your child currently behaving in a way that would make her dangerous to herself or others? Y____N____**
4.

We would arrange to meet at a convenient time for you right in the Department of Pediatrics. Are you due for an annual checkup? We can schedule your Health Maintenance Assessment at the same time if you would like. It is anticipated that this process will take approximately 30 - 45 minutes. You and your daughter will receive $20.00 for participating in this study. The purpose of the study and what we will do will first be explained to you in detail and you will sign the consent forms. The parent/caregiver is then given a brief interview and a questionnaire to complete asking about their adolescents' relationships and sexual behaviors, and your daughter will be asked to complete two questionnaires related to friendships and

sexual attitudes. You are welcome to look over the questionnaires you and your youngster will be asked to complete before you consent to participate. I will be there to address any questions or concerns you or your daughter may have as you participate in this study. Do you have any questions or concerns? What day/time would work best for you?

Name_____ Date_____ Time_____

Appendix E

The following questions ask about your relationships with each of the following people: a boy/girl friend, a same-sex friend, and an other-sex friend. If you have not had a romantic dating relationship, please skip those questions.

1. We would like you to choose a **boy/girl friend** whom you are dating or dated. You may choose someone you are seeing now, or someone you went out with earlier in high school. If you choose a past boy/girl friend, please answer the questions as you would have when you were in the relationship.

   Boy/Girl Friend's First Name _____
   How long is/was the relationship? _____Years _____Months
   Are you seeing this person now? (Circle One) A. Yes B. No

2. Please choose the most important **same-sex friend** you have had in high school. You may select someone who is your most important same-sex friend now, or who was your most important same-sex friend earlier in high school. **Do not choose a sibling**. If you select a person with whom you are no longer friends, please answer the questions, as you would have when you were in the relationship.

   Same-Sex Friend's First Name _____
   How long is/was the friendship? _____Years _____Months
   Are you close friends now? (Circle one)
   A. Yes B. Friends-but not as close as before C. No

3. Please choose the most important **other-sex friend** you have had in high school. You may select someone who is your most important other-sex friend now, or who was your most important other-sex friend earlier in high school. **Do not choose a sibling, relative, or boy/girl friend—even if she or he is or was your best friend.** If you select a person with whom you are no longer friends, just answer the questions, as you would have when you were in the relationship.

   Other-Sex Friend's First Name _____
   How long is/was the friendship?_____Years_____Months
   Are you close friends now? (Circle one)
   A. Yes B. Friends-but not as close as before C. No

Now we would like you to answer the following questions <u>about the people you have selected above</u>. Sometimes the answers for different people may be the same but sometimes they may be different.

4. How much do you and this person get upset with or mad at each other?

	Little or None	Some-what	Very Much	Extre-mely Much	The Most
Boy/Girl Friend	1	2	3	4	5
Same-Sex Friend	1	2	3	4	5
Other-Sex Friend	1	2	3	4	5

5. How much do you and this person get on each other's nerves?

	Little or None	Some-what	Very Much	Extre-mely Much	The Most
Boy/Girl Friend	1	2	3	4	5
Same-Sex Friend	1	2	3	4	5
Other-Sex Friend	1	2	3	4	5

6. How much does this person treat you like you're admired and respected?

	Little or None	Some-what	Very Much	Extre-mely Much	The Most
Boy/Girl Friend	1	2	3	4	5
Same-Sex Friend	1	2	3	4	5
Other-Sex Friend	1	2	3	4	5

7. How sure are you that this relationship will last no matter what?

	Little or None	Some-what	Very Much	Extre-mely Much	The Most
Boy/Girl Friend	1	2	3	4	5
Same-Sex Friend	1	2	3	4	5
Other-Sex Friend	1	2	3	4	5

8. How much do you play around and have fun with this person?

	Little or None	Some-what	Very Much	Extre-mely Much	The Most
Boy/Girl Friend	1	2	3	4	5
Same-Sex Friend	1	2	3	4	5
Other-Sex Friend	1	2	3	4	5

9. How much does this person help you figure out or fix things?

	Little or None	Some-what	Very Much	Extre-mely Much	The Most
Boy/Girl Friend	1	2	3	4	5
Same-Sex Friend	1	2	3	4	5
Other-Sex Friend	1	2	3	4	5

10. How much do you and this person get annoyed with each other's behavior?

	Little or None	Some-what	Very Much	Extre-mely Much	The Most
Boy/Girl Friend	1	2	3	4	5
Same-Sex Friend	1	2	3	4	5
Other-Sex Friend	1	2	3	4	5

11. How much do you share your secrets and private feelings with this person?

	Little or None	Some-what	Very Much	Extre-mely Much	The Most
Boy/Girl Friend	1	2	3	4	5
Same-Sex Friend	1	2	3	4	5
Other-Sex Friend	1	2	3	4	5

12. How much does this person really care about you?

	Little or None	Some-what	Very Much	Extre-mely Much	The Most
Boy/Girl Friend	1	2	3	4	5
Same-Sex Friend	1	2	3	4	5
Other-Sex Friend	1	2	3	4	5

13. How much do you and this person argue?

	Little or None	Some-what	Very Much	Extre-mely Much	The Most
Boy/Girl Friend	1	2	3	4	5
Same-Sex Friend	1	2	3	4	5
Other-Sex Friend	1	2	3	4	5

14. How much do you and this person hassle or nag each other?

	Little or None	Some-what	Very Much	Extre-mely Much	The Most
Boy/Girl Friend	1	2	3	4	5
Same-Sex Friend	1	2	3	4	5
Other-Sex Friend	1	2	3	4	5

15. How much do you take care of this person?

	Little or None	Some-what	Very Much	Extre-mely Much	The Most
Boy/Girl Friend	1	2	3	4	5
Same-Sex Friend	1	2	3	4	5
Other-Sex Friend	1	2	3	4	5

16. How much do you and this person disagree and quarrel?

	Little or None	Some-what	Very Much	Extre-mely Much	The Most
Boy/Girl Friend	1	2	3	4	5
Same-Sex Friend	1	2	3	4	5
Other-Sex Friend	1	2	3	4	5

17. How often does this person point out your faults or put you down?

	Not at All	Some-what	Very Much	Extre-mely Much	The Most
Boy/Girl Friend	1	2	3	4	5
Same-Sex Friend	1	2	3	4	5
Other-Sex Friend	1	2	3	4	5

18. How often does this person criticize you?

	Not at All	Some-what	Very Much	Extre-mely Much	The Most
Boy/Girl Friend	1	2	3	4	5
Same-Sex Friend	1	2	3	4	5
Other-Sex Friend	1	2	3	4	5

19. How often does this person say mean or harsh things to you?

	Not at All	Some-what	Very Much	Extre-mely Much	The Most
Boy/Girl Friend	1	2	3	4	5
Same-Sex Friend	1	2	3	4	5
Other-Sex Friend	1	2	3	4	5

20. How satisfied are you with your relationship with this person?

	Not at All	Some-what	Very Much	Extre-mely Much	The Most
Boy/Girl Friend	1	2	3	4	5
Same-Sex Friend	1	2	3	4	5
Other-Sex Friend	1	2	3	4	5

21. Do you see your relationship as being good with this person?

	Not at All	Some-what	Very Much	Extre-mely Much	The Most
Boy/Girl Friend	1	2	3	4	5
Same-Sex Friend	1	2	3	4	5
Other-Sex Friend	1	2	3	4	5

22. How happy are you with the way things are between you and this person?

	Not at All	Some-what	Very Much	Extre-mely Much	The Most
Boy/Girl Friend	1	2	3	4	5
Same-Sex Friend	1	2	3	4	5
Other-Sex Friend	1	2	3	4	5

23. Please fill in the **number of friends** you have in each category (within the **past year**).

Boy/Girl Friend _____
Same-Sex Friend _____
Other-Sex Friend _____

24. Please circle who of the following people is your **best friend**. Please write the name of that person in the blank next to it.

A. Boy/Girl Friend_____
B. Same-Sex Friend_____
C. Other-Sex Friend_____
D. I don't have a best friend

Appendix F

RASA

ID#_____

Please complete the following information about yourself either by circling the correct answer or writing it in. Do not put your name on this paper.

1	2	3	4	5
strongly disagree	disagree	neutral/don't know	agree	strongly agree

A. Male Female

B. Caucasian African-American Hispanic Asian Other _____

C. Age: _____ D. Grade: _____

E. Number of Brothers: _____ F. Number of Sisters: _____

Please complete the following information about yourself by writing the correct number for your answer on the line.

How much do you agree with the following statements?

1	2	3	4	5
strongly disagree	disagree	neutral/don't know	agree	strongly agree

_____1. It is all right to have sex with someone when he or she is drunk.

_____2. It is the woman's job to prevent pregnancy and sexually transmitted diseases.

_____3. Women secretly enjoy being forced to have sex.

_____4. It is okay for a woman to be physically aggressive in a relationship.

_____5. Extreme jealousy means that your partner really loves you.

_____6. If someone dresses in a sexy way, it means he or she wants to have sex.

_____7. Under some circumstances, it is okay for an adult to have sex with a child.

_____8. It is okay for men to be sexually aggressive.

_____9. Men secretly enjoy being raped.

_____10. If the person does not say no, it means yes to having sex.

_____11. If your partner really loved you he or she would not pressure you to have sex.

_____12. It is okay for women to be verbally aggressive.

_____13. If the person does not fight back, it means yes to having sex.

_____14. Some people deserve to be raped.

_____15. People should be free to choose who they want to have a relationship with.

_____16. Men should take the lead in relationships.

_____17. People often cry rape after having sex because they feel guilty later.

_____18. Children sometimes are to blame for their own sexual abuse because they flirt with adults.

_____19. You can express love and caring without having sex.

_____20. Verbal aggression is okay.

_____21. Men can not help being aggressive in a sexual manner sometimes.

_____22. People act like they do not want to have sex when they actually do want to have sex.

_____23. It is my responsibility to treat others as I would want to be treated.

_____24. It is okay for men to be verbally aggressive.

_____25. If your date kisses you and touches you, then it means he or she wants to have sex with you.

_____26. If both people are drunk, then neither one of them is responsible for his or her sexual behavior.

_____27. It is okay for you to change your mind about what kind of sexual activity you want to have.

_____28. It is okay for women to be sexually aggressive.

_____29. If your partner really cared about you, he or she would have sex with you whenever you wanted.

_____30. I think it is important for couples to talk about how they feel about sex.

_____31. It is okay for a man to be physically aggressive in a relationship.

UMDNJ
SCHOOL OF OSTEOPATHIC MEDICINE
University of Medicine & Dentistry of New Jersey

Appendix G

Office of Research and Sponsored Programs
Phone: (856) 566-6066

Clinical Trials Management
Phone: (856) 566-7148

Research Animal Facility
Phone: (856) 566-6119

INSTITUTIONAL REVIEW BOARD
NOTICE OF APPROVAL

IRB Protocol Number: 2079-I-01
Sponsor/Protocol #: Internal

Principal Investigator: Deblinger, Esther, Ph.D
Institution/Dept.: Psychiatry

Protocol Title: "History of Abuse and Interpersonal Attitudes as Predictors of Social Support in Adolescent Female Peer Relationships"

Items approved in this action:

- Study Protocol
- Parental Consent Form
- Female Adolescent Assent Form
- Telephone Screening Script
- Interview with Parent/Legal Guardian Form

Date of Approval:	Continuing Review Report Due to IRB Office:	Approval Expiration Date:
March 20, 2003	January 2, 2004	March 19, 2004

Amendments: It is the Principal Investigator's responsibility to keep the IRB apprised of any and all modifications to the approved study, changes in status of the study agent/device or funding, not limited to those noted above. You must have IRB approval before initiating action on any changes to the study. Please call the IRB office at 856-566-2712 if you have questions about what or when to report.

Consent Forms: Only the consent form(s) approved by the IRB for this study may be used to document informed consent of study subjects. Revised forms must be approved before using them. The IRB office will write approval and expiration dates on each consent form that may be duplicated for your study. Signed original consent forms must be retained in a safe location by the Principal Investigator during the study and for a post-study period that will be stated on the closure notice.

Adverse Events: If any medical events, significant protocol deviations or adverse reactions should occur to any enrolled subject (or a study subject within 30 days of end of participation) in this study, whether or not the incidents are study-related, you are required to notify the IRB. If an on-site adverse event is serious and/or unexpected, call the IRB Director at 856-566-6463 within 48 hours and follow up with a written report to the IRB within 5 calendar days. As Principal Investigator, you may have other reporting obligations to the federal government, sponsor, or other site investigators. If you receive safety reports from the FDA or sponsor, evaluate them for possible changes to the consent form and send copies of the safety reports under a cover letter to the IRB, who will notify you if consent form changes are required. You must also send copies of Data Safety Monitoring Board and Data Monitoring Committee reports, and reports from the sponsor's site monitors to the IRB.

Continuing Review: Please note the study expiration date above. Federal regulations stipulate that research involving human subjects be reviewed at least every 365 days, but the IRB has the authority to require more frequent reviews. Please turn in review materials for this study to the IRB office two months before the expiration date to ensure a timely review. Research that is not reviewed before the expiration date must be suspended until IRB re-approval. Forms for continuing review reporting will be sent to you and are also available from the IRB office. Neither study closure by the sponsor or the investigator nor administrative oversight remove the obligation for timely continuing review.

Thank you for your cooperation with the Institutional Review Board.

T. Ruth Ison, M. Div., S.T.M., CCRC, Director
Office of the Institutional Review Board

Gilbare T. Gecys, D.O., Chair
Institutional Review Board

June 10, 2003

Elizabeth Gosch, Ph.D.
Department of Psychology
Philadelphia College of Osteopathic Medicine
4190 City Avenue
Philadelphia, PA 19131

RE: **History of abuse and interpersonal attitudes as predictors of social support in adolescent female peer relationships** - protocol approved by an outside IRB

Dear Dr. Gosch:

The study materials and outside IRB approval to your above-referenced study was reviewed by me as Chairman of the Philadelphia College of Osteopathic Medicine Institutional Review Board under expedited review procedures. I have determined that the approval of UMDNJ's IRB can be accepted by the PCOM IRB.

Good luck with your study and please remember to report any adverse events to the Board immediately. Any proposed modifications to the protocol or informed consent, including changes in study personnel, the number of subjects to be enrolled or ancillary study documents such as questionnaires, must be approved by the Institutional Review Board before they can be implemented.

Sincerely,

John Simelaro, D.O.
Chairman

cc: S. Edelman