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CHILDHOOD SEXUAL ABUSE: AN INVESTIGATION OF IT'S IMPACT ON CHILDREN'S COPING, SELF-EFFICACY, EMOTION REGULATION AND PERCEPTIONS OF SELF AND OTHERS

by

Lori Bast Thompson

A Dissertation Submitted to
the Faculty of the Graduate School at
The University of North Carolina at Greensboro
in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

Greensboro
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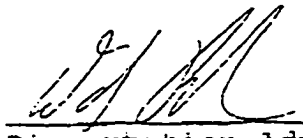
Approved by



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THOMPSON, LORI BAST, Ph.D. Child Sexual Abuse: An Investigation of its Impact on Children's Coping, Self-Efficacy, Emotion Regulation, and Perceptions of Self and Others. (1996) Directed by Dr. David L. Rabiner. 106 pp.

Sexually abused children frequently exhibit little or no psychiatric symptomatology when assessed during childhood, but it is important to examine what other consequences may result from the abuse, as sexual abuse is thought to be a major risk factor for a variety of adult mental health problems. It is possible that experiencing sexual abuse adversely effects important areas of children's functioning which contribute to the development of psychopathology later in life. The purpose of this study is to examine four areas of children's functioning, including coping, perceptions of helplessness, emotion regulation, and self-concept, in a group of twenty-two sexually abused, twenty-five psychiatric control, and twenty-seven normal control females between the ages of 6 and 12.

Using teacher report (The Child Behavior Checklist: Teacher Rating Form), results replicated previous findings of parental reports which indicate that sexually abused children are perceived as experiencing more psychological difficulties than a normal population but fewer difficulties than those manifested by nonsexually abused child psychiatric outpatient populations. Furthermore, results from a projective measure, designed to indirectly assess trauma-related schemas, revealed that compared to a normal

control group, sexually abused females have significantly more negative perceptions of themselves and others. Although sexually abused children also demonstrated more negative self concept on a self-report measure (the Piers-Harris Self-Concept Scale), these differences were not statistically significant. No significant differences between groups were found in regard to coping skills, as assessed by the Coping Scale for Children and Youth, or learned helplessness, as assessed by the Causal Attribution Measure. Significant differences were found in emotion regulation skills, as assessed by the Emotion Regulation Q-sort. However, results were against this study's predictions. The psychiatric control group demonstrated significantly more impaired emotion regulation skills when compared to the sexually abused children.

The fact that sexually abused children demonstrate more negative perceptions of themselves and others has long-term implications for their development of appropriate interpersonal relationships, and their ability to utilize support networks during times of distress.

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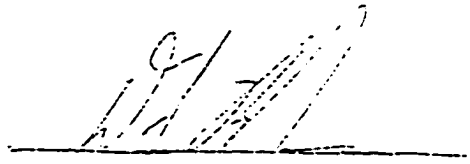
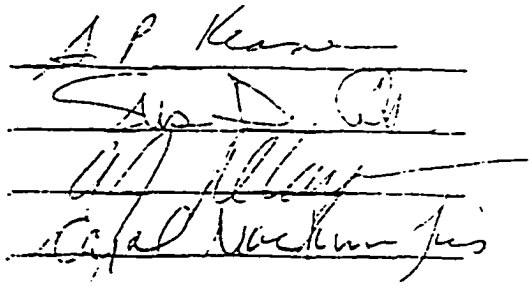
APPROVAL PAGE

This dissertation has been approved by the following committee of the Faculty of the Graduate School at The University of North Carolina at Greensboro.

Dissertation Advisor 

Committee Members 

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CHAPTER I

INTRODUCTION

Childhood sexual abuse is one of the most extreme public health problem facing children today. Recent reports estimate that 330,000 children are sexually abused each year (National Center on Child Abuse Prevention Research, 1994). Although childhood sexual abuse has been linked to a wide range of symptoms in children, the most common being fear, anxiety, depression, anger, aggression, and sexually inappropriate behavior (see Finkelhor and Browne for a review, 1985), researchers have noted that a substantial group of sexually abused children exhibit minimal or no symptomatology (Finkelhor, 1990; Hanson, 1990). This lack of symptomatology is not limited to externalizing problems, but also includes such internalizing symptoms as anxiety (Cohen & Mannarino, 1988; Grayston, DeLuca, & Boyes, 1992) and depression (Elliott & Tarnowski, 1990; Shapiro, Leifer, & Kassem, 1990). Furthermore, when sexually abused children are compared to a clinical psychiatric sample, children at all age levels (i.e. preschool, school-age, and adolescence) exhibit less overall pathology and fewer specific difficulties than a typical group of children receiving psychiatric services (Gomes-Schwartz, Horowitz, & Sauzier, 1985; Kendall-Tackett, Williams, & Finkelhor, 1993; Caffaro-

Rouget, Lang, & vanSanten, 1989; Tong, Oates, & McDowell, 1987; Mannarino & Cohen, 1986). Several studies have shown that although sexually abused children are perceived by their parents as experiencing psychological difficulties, these problems are not as severe as those manifested by nonsexually abused child psychiatric outpatient populations (Friedrich, Beilke, & Urquiza, 1987; Cohen et. al., 1988).

Kendall-Tachett, Williams, and Finkelhor (1993) provide three possible explanations for the relatively large amount of asymptomatic children who have been sexually abused. The first possibility is that the instruments used in these various studies were not sensitive enough to measure the children's symptoms accurately. Self-report measures may underestimate symptoms of sexually abused children, as these children may be more guarded or defensive than others. Furthermore, the children may have been symptomatic on dimensions which were not measured, but asymptomatic on the dimensions assessed in the study, as they note that in most individual studies, only a limited range of possible effects were examined. A second hypothesis is that the asymptomatic children are not as affected by the abuse. This could be due to the type of abuse the children were exposed to (i.e., limited frequency, less intensity, etc.), or the fact that these children were more resilient. The asymptomatic children may be blessed with large support systems, adequate coping skills, and appropriate

psychological treatment subsequent to the abuse. Finally, a third possibility mentioned in the Kendall-Tackett et. al. (1993) review is that asymptomatic children have yet to manifest their symptoms. They report "this could be either because the children are effective at suppressing symptoms or have not yet processed their experiences or because true traumatization occurs at subsequent developmental stages, when the children's victim status comes to have more meaning or consequences for them." (p. 170).

Retrospective studies of adults who were sexually victimized as children lends some support for this theory, as sexual abuse is thought to be a major risk factor for a variety of adult mental-health problems. For example, research has identified a number of disorders in which the incidence of childhood sexual abuse significantly exceeds the base rate. These conditions include borderline personality disorder (Bryer, Nelson, Miller, & Krol, 1987; Paris, Zweig, & Hallie, 1992; Herman, Perry, & VanderKolk, 1989), dissociative identity disorder (Bliss, 1984; Coons, Bowman & Milstein, 1989; Ross & colleagues, 1989, 1990, 1991; Putnam, Guroff, Silberman, Borban, & Post, 1986; Goodwin, 1989), substance abuse disorders (Briere, 1984; Herman, 1981; Goodwin, Cheeves & Connell, 1990; Brown & Anderson, 1991), depression (Bifulco, Brown, & Adler, 1991; Briere & Runtz, 1988, Sedney & Brooks, 1984) and somataform disorders (Briere & Runtz, 1988; Bryer, Nelson, Miller, &

Krol, 1987; Drossman, Leserman, Nachman, et. al., 1990; Loewenstein, 1990). In addition, large community surveys (e.g., Burnam, Stein, Golding, et. al., 1988) report a significantly increased risk of major mental disorders that are associated with sexual assault. Although longitudinal research is needed to clearly document a relationship between childhood sexual abuse and poor adult adjustment, it is reasonable to speculate that the trauma of sexual abuse may be associated with psychopathology in adulthood (Alpher, 1992; LaPorta, 1992; Fenton, 1993; Sheldon, 1988).

The preceding review suggests that although many sexually abused children do not display significant psychopathology during childhood, they may be at elevated risk to develop a variety of psychiatric problems later on. Although this may simply be due to delayed symptom presentation, it is also possible that experiencing sexual abuse adversely effects important areas of children's functioning which contribute to the development of psychopathology later in life, even though it does not immediately result in the development of psychiatric symptoms. Support for this theory was demonstrated by Gomes-Schwartz, Horowitz, Cardarelli, et. al. (1990) who found that 30% of their sample of sexually abused children who were asymptomatic during an initial assessment had developed symptoms by the time of the 18-month follow up.

Goals of Study

The majority of previous research on the consequences of sexual abuse has focused on how child sexual abuse contributes to the development of specific psychiatric symptoms. However, this approach may not be the most fruitful, as prior research has demonstrated that many sexually abused children are not highly symptomatic. Thus, in order to more fully understand the negative outcomes that many abuse victims experience, it is necessary to take a more comprehensive approach. As Cole and Putnam (1992) write: "research on the effects of incest or child sexual abuse needs to include assessment of the individual's sense of self, competence in the intellectual and social domain, self-regulatory and coping capacities, and the quality of interpersonal relationships with peers, teachers, and friends" (pg. 180). The goal of this study is to examine these domains by measuring four areas of dysfunction that have been relatively unexplored among child sexual abuse victims. These areas include coping mechanisms, perceptions of helplessness, emotion regulation, and perceptions of self and others. It is hypothesized that children who have been sexually abused will exhibit deficits in these four areas of functioning relative to groups of normal nonabused children and nonabused children receiving outpatient therapy.

Coping

One goal of this study is to examine the coping mechanisms of sexually abused children in order to determine whether these abilities may be negatively affected by sexual trauma. Most research in this area has focused on retrospective reports of childhood sexual abuse and the ways in which victims tried to cope with this difficult situation. Despite the retrospective nature of this research, the studies that have examined coping strategies of the sexually abused have demonstrated fairly consistent results. For example, Long and Jackson (1993) examined the coping mechanisms of college women who had been sexually abused in childhood. They found that these women relied on emotion-focused coping patterns (i.e. denial, dissociation, and minimization) during childhood to regulate their distress rather than strategies involving problem-focused actions (i.e. disclosing the abuse, finding ways to reduce or stop the abuse). Furthermore, their results suggest that higher levels of emotion-focused coping were associated with greater symptomatology. Using a sample of female registered nurses who reported previous childhood sexual abuse, Leitenberg, Greenwald, and Cado (1992) found that the coping mechanisms of emotional suppression and denial were used most frequently from the time the abuse ended until the present. In addition, although the women rated emotional suppression, denial, and avoidance as being the most helpful

coping mechanisms, results of the study suggest that these mechanisms were associated with poorer adjustment in adulthood.

Studies examining adolescent sexual abuse victims have provided similar results. Johnson and Kenkel (1991), using a population of adolescent incest victims, found that wishful thinking emerged as the most significant coping predictor of self-rated global distress. Furthermore, the adolescents who showed the poorest adjustment coped by means of detachment and distancing.

It appears that individuals faced with sexual abuse tend to avoid thoughts or feelings associated with the trauma. However, ideal coping, as defined by Dye and Roth (1991), includes the ability to gradually provide oneself with manageable amounts of emotional material. This gives the individual an opportunity to come to an emotional and cognitive understanding of the meaning of the trauma, and the impact it has had on one's life. This process should then lead to a reduction in symptoms and to successful integration of the trauma experience. Roth and Newman (1991) suggest that many sexual abuse victims are unable to utilize this ideal coping process, and tend to rely solely on emotion-reducing coping strategies, which allows them to permanently avoid the emotionally-laden material. However,

they report that:

> "...the cost of avoiding thoughts or feelings associated with the trauma can be great in the long run. In the case of sexual trauma, the trauma often continues to unconsciously affect the individual in maladaptive ways, as when there is an increased vulnerability to repeated victimizations and/or to symptoms of severe posttraumatic distress (Roth & Newman, 1991; pg. 280-281)."

Furthermore, the research on coping strategies (see Roth & Cohen, 1986, for a review) generally indicates that avoidance of stressful material does not lead to the most adaptive result, and long term consequences include the inability to adaptively regulate emotional experiences. Therefore, it is likely that the coping mechanisms of denial, minimization, and emotional suppression, which have been frequently utilized by adults and adolescents who were sexually abused as children, are also used by children who have experienced sexual abuse. These poor coping strategies are likely to compound the long-term adjustment of these children, leading to future problems with emotion regulation.

The Relationship of Coping to Future Psychopathology - Poor coping relates closely to the adult criteria listed in many DSM-IV diagnoses. For example, Dissociative Identity Disorder (DID) is diagnosed in individuals who present with

two distinct identities or personality states (DSM-IV, 1994). Diagnosed individuals also display difficulty with integrating various aspects of identity, memory, and consciousness. This disorder may be the result of emotional avoidance (or coping responses of denial, minimization, or detachment) used by sexual abuse victims to minimize and control the negative affect associated with the abuse. Many clinicians believe that DID is a psychological adaptation to traumatic experiences in early childhood (Putnam, 1990; Ross, Anderson, Fleisher, & Norton, 1991), as it is hypothesized that children who are sexually abused learn to dissociate parts of themselves and develop alternative personalities to cope with their emotional pain (Greaves, 1980; Spiegel, 1984). Although the avoidance of aversive thoughts and feelings associated with sexual abuse may temporarily alleviate the pain, it may also lead to the development of personality traits that interfere with optimal levels of adult functioning (Follette, 1994; Roth & Newman, 1993). Poor coping strategies may also explain the association between childhood sexual abuse and somatic complaints in clinical samples of women (Hunter, 1991; Nash, Hulsey, Sexton et. al., 1993; Briere & Runtz, 1988; Springs & Friedrich, 1992). The common feature of the Somataform Disorders is the presence of physical symptoms that are not fully explained by a general medical condition (DSM-IV, 1994). Sexual abuse victims may be incapable of labeling

negative internal experiences because of their earlier coping strategies. These affective responses may be rechanneled and manifested in physical or medical difficulties (Polusny & Follette, 1995). Similarly, researchers have also suggested that addictive behaviors in trauma survivors may represent attempts at avoidance of the abuse-specific memories or affective material characteristic of Post Traumatic Stress Disorder (PTSD) (Briere & Runtz, 1991, 1993; Rodriguez, Ryan & Foy, 1992).

It is important to assess whether sexually abused children demonstrate the coping mechanisms of denial, suppression, and minimization during childhood, as it is possible that therapeutic techniques to alter negative coping strategies could be utilized during childhood to prevent future psychopathology.

Emotion Regulation

Emotion regulation is defined by Cole, Michell, and O'Donnell (1993) as "the ability to regulate positive and negative emotions along a number of dimensions in ways that support cognitive, behavioral, and social functioning..." (1993, p. 18), and has increasingly come to be viewed as a primary developmental task with wide-ranging implications for children's development (Cicchetti, Ganiban, & Barnett, 1991; Thompson, 1990).

The ability to regulate emotions includes the skill of integrating disparate emotions simultaneously. Splitting is a term derived from object relations theory to signify an individual's inability to simultaneously integrate dissimilar emotions in regard to relationships that are important to them (Blanck & Blanck, 1976). Calverley, Fischer, and Ayoub (1994) have examined the use of affective splitting in sexually abused adolescent inpatient girls ages twelve to seventeen. They hypothesized that sexually abused girls would have problems with emotion regulation, and attempted to examine this with an interview that focused on how the person thinks and feels about herself when she is with an important person in her life (i.e. mother, father, peer, etc.). They discovered that sexually abused adolescents were more likely than depressed inpatient adolescents to experience affective splitting of self in relationships, which included the inability to combine two discrepant emotions. These adolescents experienced either hatred or love toward the individual instead of finding an acceptable balance between these two emotions. Calverley et. al. (1994) determined that these sexually abused adolescents had significant difficulty managing conflicting emotions when involved in relationships, and tended to describe themselves in a particular relationship through a single affective script. For example, they would describe feelings of rage at one individual and affection for

another, but were unable to acknowledge that they could experience positive and negative emotions within both of these relationships.

In addition to utilizing splitting as a way to manage their emotional experiences, many sexually abused children may cut off or blunt negative sensations, or at times remove the emotions from their consciousness to protect themselves from the trauma that they are experiencing (Cole & Putnam, 1992). Support for this hypothesis has been demonstrated by Cicchetti and Beeghly (1987), who found that maltreated children use less negative emotion language than nonmaltreated children, suggesting that they are less willing or less able to admit to feelings of negative emotion. This emotional style may protect the individual from overwhelming, disorganizing emotion associated with the memories of the abuse. However, this pattern could have serious long-term consequences for adult functioning, as valuable emotions are inaccessible when needed, memory processes are restricted, and relationships are strained.

In support of this theory, adult sexual abuse victims are frequently described as having problems regulating their emotions, demonstrating both increased and uncontrollable affect, or a restriction in affect (Roth & Lebowitz, 1987). The ability to form satisfying interpersonal relationships also is hindered if one is unable to regulate one's emotions when involved in interpersonal conflicts (Cole & Putnam,

1992). Studies of maltreated toddlers have found that these children react in poorly regulated and situationally inappropriate ways to a peer's distress, showing more fear, anger, and aggression than empathy and concern (Howes & Eldredge, 1985; Main & George, 1985; Troy & Sroufe, 1987). Because many adult sexual abuse victims also experience difficulties in forming and sustaining intimate relationships (Courtois, 1988; Jehu, 1988; Finkelhor, Hotalking, Lewis et. al., 1989), and because there has not yet been any research examining the emotion regulation skills of sexually abused children, it is important to examine this area further.

The Relationship of Emotion Regulation to Future Psychopathology -

Patterns of unstable and intense interpersonal relationships (DSM-IV, 1994) are characteristic traits of Borderline Personality Disorder (BPD) and Dissociative Identity Disorder (DID). These adult difficulties may be related to poor emotion regulation skills which become more pronounced once the developmental task of establishing long-term interpersonal relationships is required. In support of this theory, there is a distinct similarity between the previously mentioned affective compartmentalization found in sexually abused adolescents, and the pattern described for Borderline Disorders and Dissociating Disorders (Calverly et. al., 1994). These types of deficits have proven very

difficult to treat in adulthood. It is important to determine whether sexually abused children have begun to develop emotion regulation patterns during childhood that could negatively impact their long-term adjustment. Because these deficits have been so difficult to treat in adulthood, it may be useful to assess and treat these deficits during childhood before they become firmly established.

Learned Helplessness

The results of the coping research presented above are not surprising, as it is relatively well established that emotion focused coping methods are more likely to be used in situations that are perceived as uncontrollable and where people feel powerless (Lazarus & Folkman, 1984). Child victims of sexual trauma have been exposed to situations where they have no control. Many have been repeatedly victimized, which leaves them feeling powerless. Furthermore, they are frequently subjected to abuse by authoritative figures who they have been taught to respect and obey, which likely compounds their sense of helplessness. It is possible that continued exposure to uncontrollable negative experiences leads sexually abused victims to believe that they have little control over other areas of their lives. The term "learned helplessness" describes this pattern of events.

In general, learned helplessness is defined as an acquired sense that one can no longer control one's environment, with the result that one gives up trying (Seligman, 1975). Learned helplessness has been proposed as one of the five categories of behavior in Summit's (1983) sexual abuse accommodation syndrome, and is included as one of the four traumagenic dynamics in Finkelhor and Browne's (1985) conceptualization of the core psychological injuries caused by sexual abuse. German, Habenicht, and Futcher's (1990) work on the personality and self-concept of the female adolescent incest victim demonstrated that the psychological profile of these adolescents indicated an orientation of learned helplessness, as they had begun to accommodate to the abuse. Finally, clinical case examples (Roth & Lebowitz, 1987; Roth & Newman, 1991) of sexually abused victims suggest that learned helplessness is a frequent consequence of sexual abuse. However, research has not yet examined whether sexually abused individuals begin to develop a pattern of learned helplessness in childhood.

The Relationship of Learned Helplessness to Future Psychopathology - If feelings of helplessness develop in children as a consequence of their victimization, it may contribute to the development of important symptoms later on. Finkelhor and Browne (1985) have hypothesized that many tragic symptoms of adult sexual abuse victims (such as despair, depression, and suicidal behavior) are connected to

their sense of helplessness. Several studies have confirmed that self-efficacy expectancies are correlated significantly with symptoms of depression (Kanfer & Zeiss, 1983; Devins, Binik, Gorman, et. al., 1982). This feeling of powerlessness may also lead to the high rate of revictimization (DeYoung, 1982; Herman, 1981; Briere, 1984) which is common among sexually abused victims. Because most sexually abused children are abused on more than one occasion, and were unable to stop the abuse each time, they may attribute the sexual abuse to stable, global factors (Kelley, 1986). Because of this, they may increasingly expect that victimization will recur across many situations, and no longer attempt to fight against the abuse when they encounter similar situations in the future. Furthermore, it may explain the tendency for adult victims to become involved and remain with partners who are controlling and abusive. This often perpetuates a cycle of abuse, as the children of such relationships are likely to become abused as well (Lowery, 1987). Therefore, given the long-term implications of learned helplessness, it is important to examine whether sexually abused children show signs of developing a learned helplessness orientation.

Schemas about Self and Others

The development of a secure sense of self is an important aspect of child and adult functioning. Sense of

self is a psychological construct that is derived from one's experiences, and involves the development of an internal awareness of personal existence that is relatively stable across contexts, experiences, and affects (Briere & Runtz, 1993). It is thought to be related to the formation of secure attachment relationships in childhood (Bowlby, 1973), the internalization of important others' perceptions and expectations (Putnam, 1990), and the extent to which internal processing is neglected because of the need to deal with external negative stressors (Briere, 1992). Therefore, it seems reasonable to speculate that sexual victimization during childhood can have a significant effect on one's self-concept, as these children frequently lack secure relationships with important individuals, either because of negative family characteristics or because they have been abused by someone they trusted. They also have to cope with significant external stressors, which reduces their ability to deal with internal processing demands.

Recent research has supported this hypothesis. On self-report measures, adolescent sexual abuse victims report significantly lower self-concepts when compared to national norms (German, Habenicht & Futcher, 1990; Orr & Downs, 1985), and to a normal control group (Tong et. al., 1987). When a group of sexually abused inpatient adolescents were compared with non-sexually abused inpatient adolescents, the sexually abused adolescents demonstrated a significant

negativity bias when describing their core self (Calverley, Fischer, & Ayoub, 1994). Furthermore, clinical and nonclinical subjects who reported previous sexual abuse scored higher on the impaired self reference subscales of the Traumatic Symptom Inventory when compared to a normal control group (Briere, Cotman, Harris et. al., 1992). The few studies which have examined self-concept among sexually abused children (Grayston, De Luca, and Boyes, 1992; Oates, O'Toole, Lynch, Stern, & Cooney, 1994) have found that these children have significantly lower self-concept than groups of children who have not experienced abuse. Furthermore, researchers using projective techniques (Leifer, Shapiro, Martone, & Kassem, 1991; Zivney, Nash, & Hulsey, 1988) have found indications of abuse-related self disturbance in the Rorschach responses of sexually abused girls.

Although research directly examining sexual abuse victims' perceptions of others has been lacking in the sexual abuse literature, the inability to trust others has been noted frequently as an important consequence of sexual abuse (Cahill, Llewelyn & Pearson, 1991), as has the difficulty sexual abuse victims have developing close interpersonal relationships (Courtois, 1988; Jehu, 1988; Finkelhor et. al., 1989). In work related to these issues, Jehu (1988) found high percentages of distorted beliefs when examining case studies of sexually abused children in therapy. Although he did not include a control group, Jehu

reports that 92 percent of his sample had negative perceptions of others, particularly the belief that it was dangerous to get close to anyone because of the likelihood that they would be betrayed, exploited, or injured by them. Wayland (1994), using a projective measure designed to elicit children's schemas about sexual trauma, found negative perceptions of others in 84 percent of her sample of sexually abused children. Unfortunately, Wayland's sample was small and did not include a control group. Further examination of this area is necessary to more fully understand the impact of negative interpersonal schemas on the long-term functioning of sexually abused children.

The Relationship of Schemas of Self and Other to Future Psychopathology - Briere and Runtz (1993) have hypothesized that the impairment of self in sexual abuse victims can lead to a variety of further problems, including problems regulating affect, developing stable relationships, and developing a stable sense of personal identity. Relationship difficulties in sexual abuse victims may also be related to their negative perceptions of others, as many individuals with Borderline Personality Disorders, in particular, experience an intense fear of abandonment, along with the expectation that their significant partner will be unable to meet their needs. Another characteristic of BPD includes an identity disturbance illustrated by "markedly and persistently unstable self-image or sense of self" (DSM-

IV, 1994). Low self-esteem during childhood, caused by the victimization that sexually abused individuals have experienced in their childhood, may manifest itself later in life in negative or evil images of self, or in the belief that they do not exist at all. Briere (1992) believes that revictimization is a probable consequence for these individuals, since they may be unable to critically evaluate the actions or demands of others because of their own impaired sense of self. Further examination of this area may promote the development of therapeutic strategies to increase the self-concept of sexually abused children, and thus prevent the future revictimization of these individuals.

Statement of Purpose

As discussed above, sexually abused children frequently exhibit little or no psychiatric symptomatology when assessed during childhood. Although the effects of childhood victimization may not initially show up as psychiatric symptoms, it is important to examine what other consequences may result from childhood sexual abuse, and whether these consequences disrupt healthy long-term development. The purpose of this study is to begin to explore these questions, which have been largely ignored in prior research on sexually abused children. It is hypothesized that although sexually abused children may not

display elevated levels of psychiatric symptoms, they will display impaired coping skills, perceptions of helplessness, problems with emotion regulation, and impaired perceptions of themselves and others. Although the long-term consequences of problems in these areas can not be examined in this study, it is suggested that difficulties in these core areas of functioning contribute to the psychiatric problems that many sexually abused children display as adults.

Hypotheses

It is predicted that sexually abused children, relative to both nonsexually abused psychiatric controls and normal controls, will: (1) demonstrate more cognitive and behavioral avoidance coping techniques when asked to rate how they would cope with interpersonal stressors; (2) be more likely to attribute failure to stable internal factors (i.e. incompetence) when presented with scenarios of interpersonal rejection; and (3) have more negative schemas of self and other when presented with a self-report self concept measure and with a series of projective stories used to elicit schemas about self and other. Finally, it is hypothesized that teachers will: (4) rate sexually abused children as demonstrating more overt behavioral difficulties than a group of normal children, but less difficulties than a group of outpatient psychiatric children; and (5) rate

sexually abused children as demonstrating more emotional disregulation than the clinical or normal control samples.

CHAPTER II

METHOD

Subjects

A total of 74 females participated in this study (22 sexually abused children, 25 clinical psychiatric controls, and 27 normal controls.) The samples of sexually abused children and clinical controls were drawn from referrals provided by local Mental Health and private outpatient facilities. Normal controls were obtained from local YMCA summer camps. An age range of 6-12 was used, as it was felt that children needed to be at least 6 years of age in order to respond reliably to the questionnaires. A cut off age of 12 was chosen arbitrarily so that the sample included primarily children who had not yet reached adolescence.

The sexually abused group consisted of children who had disclosed sexual abuse to a social worker in the North Carolina Department of Social Services and/or their outpatient clinician. For this study sexual abuse was defined as any type of unwanted sexual activity. This included being forced to observe others involved in sexual acts, fondling, and penetration. A very small percentage of this sample (5%) had experienced attempted sexual contacts only or had been the victims of exhibitionism or voyeurism without bodily contact. Fifty-four percent of the children

were exposed to fondling and forty-one percent of the sample were victims of intercourse, either vaginal or anal. The primary perpetrator was a neighbor, or family friend/acquaintance (41%), followed by the father (32%), and then other male relatives (27%), such as an uncle or older cousin. Twenty-three percent of the sample had been abused by more than one person. Although most of the sexual abuse sample (77%) lived with a family member, twenty-three percent were moved to a foster family or a group home after the abuse was discovered.

The psychiatric control group consisted of 25 children who were being seen in treatment at various outpatient mental health facilities. The individual therapist of each child in this group was asked to provide the primary diagnosis of the child they were treating, as it was not possible to evaluate each child using standardized diagnostic procedures. Because of this, it is likely that clinicians used different procedures in determining their client's diagnosis, and it is thus impossible to rate the accuracy of these diagnoses. Nonetheless, twelve of the twenty-five girls (48%) were diagnosed with an externalizing disorder by their outpatient therapists. These diagnoses included Oppositional Defiant Disorder (50%), Attention Deficit Hyperactivity Disorder (33%), Adjustment Disorder with Disturbance of Conduct (8%), and Adjustment Disorder with Mixed Emotions and Disturbance of Conduct (8%). The

other thirteen girls (52%) were diagnosed with an internalizing disorder, including Adjustment Disorder with Mixed Emotional Features (23%), Dysthymia (15%), Generalized Anxiety Disorder (15%), Major Depression (8%), Anorexia Nervosa (8%), Post-traumatic Stress Disorder (8%), Dissociative Identity Disorder (8%), Dissociative Disorder NOS (8%), and Psychotic Disorder NOS (8%). Only four percent of the psychiatric control group were living with a foster family or in a group home.

The normal control group consisted of twenty-seven children, all of whom lived with a family member and who had not been involved in mental health treatment, either currently or in the past.

The three groups were relatively similar in regard to age and race (Sexual abuse group - 71% white, 23% other; Psychiatric control group - 68% white, 32% other; Normal control group - 81% white, 19% other). However, as will be discussed later, efforts made to obtain samples comparable in terms of social class and intelligence were unsuccessful. Efforts were also made to screen the clinical and normal control groups for sexual abuse.[1]

Measures

The Child Behavior Checklist: Teacher Rating Form:

This measure was included to determine whether our sample was representative of previous samples of sexually abused

children who display more behavioral problems than normal controls, but exhibit less symptomatology than clinical controls (Friedrich, Beilke, & Urquiza, 1988; Cohen & Mannarino, 1988). The Parent Form of the CBCL was not used because many of the children from our clinical samples were temporarily placed in foster homes or group homes. Teacher ratings, therefore, were felt to provide more reliable assessments of children's behavioral difficulties. The Teacher's Report Form (TRF; Edelbrock & Achenbach, 1984), which is presented in a four-page format, gathers background information and assesses 118 items related to classroom behavior. The scoring profile includes four general scores for adaptive characteristics, eight behavior problem scales, internalizing and externalizing problems, and total problem scores.

For the purpose of this study, only the total problem score and the adaptive functioning factor scores were used. The total problem score includes 118 behavior problem items relating to difficulties within the areas of anxiety, social withdrawal, popularity, self-destructive behavior, obsessive-compulsiveness, inattention, nervousness, and aggression. The adaptive functioning scale is obtained by summing ratings on all four adaptive functioning items, which include: how hard the child is working, how appropriately s/he is behaving, how much s/he is learning, and how happy s/he is. The reliability and validity of this

measure has been well documented (Achenbach & Edelbrock, 1986).

The Coping Scale for Children and Youth (CSCY): Because sexually abused children were hypothesized to exhibit widespread impairment in coping, the CSCY (Brodzinsky, Elias, Steiger et. al., 1992) was included to assess the general coping skills of the children in our sample (see Appendix A). This scale is comprised of 29 items which assess 4 general strategies of coping: assistance seeking, cognitive-behavioral problem solving, cognitive avoidance and behavioral avoidance. Because of time constraints, only 21 or the 29 items were used. The eight items removed were selected because they were felt to have poor face validity or because they were repetitive with other items on the measure. Furthermore, although the original scale requests children to think of one problem that has upset them in the past few months, children were presented with two problem scenarios, one involving a dilemma with a peer, and the second involving a dilemma with a parent. This was done to obtain a broader range of situations that children are exposed to and are expected to cope with. They were then instructed to rate the frequency with which they would use the particular coping behaviors to deal with the identified stressor.

For example, the family version included the scenario "You feel like you often get picked on and teased by one of

your parents. Sometimes they really hurt your feelings. You'd like them to stop but you are not sure what you should do." The child was then provided with a series of 21 statements, such as "I would try to pretend that the problem didn't happen" or "I would decide to stay away from people and be by myself." A four-point Likert scale (0=never, 1=sometimes, 2=often, 3=very often) was used for the ratings.

An acceptable level of internal reliability has been established for each category (i.e. assistance seeking, r=.72; cognitive-behavioral problem solving, r=.81; cognitive avoidance, r=.80; and behavioral avoidance, r=.70), and the test-retest reliability of this measure has also been shown to be adequate (e.g. r's ranged from .70 to .83 over a one-week period)(Brodzinsky et. al., 1992).

The Behavioral Avoidance and Cognitive Avoidance Factors were of primary interest in this study because they show the most similarity with the emotion-focused coping patterns of denial, dissociation, and minimization that have been displayed by adults and adolescents who experienced sexual abuse during childhood. For example, items within the Cognitive Avoidance factor included "I tried not thinking about the problem," and "I pretended the problem wasn't very important to me." Items within the Behavioral Avoidance factor included "I went to sleep so I wouldn't have to think about it." and "I tried not to be with anyone who

reminded me of the problem." All of these items reflect emotion-reducing coping strategies, which are hypothesized to create difficulties for individuals when they confront developmental tasks that require the management of emotion laden material. The reliability of the Cognitive and Behavioral Avoidance factors within this sample, as assessed via Cronbach's alpha, were as follows: (cognitive avoidance - peer, r=.53; behavioral avoidance - peer, r=.70; cognitive avoidance - family, r=.72; behavioral avoidance - family, r=.77).

Causal Attribution Measure: This measure (see Appendix B) was included to assess whether sexually abused children attribute social rejection to stable internal versus unstable external factors, thereby suggesting an orientation toward learned helplessness. The Causal Attribution Measure was developed by Goetz and Dweck (1980), and focuses primarily on response to rejection, with some instances of acceptance included to reduce the tendency of subjects to assume that all questions are basically alike. Rejection attributions were assessed for four vignettes describing common rejection scenarios that children would be exposed to in the course of their daily lives (i.e. Suppose someone stops telling you her secrets. Why would this happen to you?). Following each vignette, children were asked to indicate the extent to which they endorsed each of the five explanations for the rejection, which included, 1)

incompetence attribution ("Because it's hard for me to make friends."), 2) rejector attribution ("Because she's not very nice."), 3) incompatibility attribution ("Because she doesn't like something about me."), 4) misunderstanding attribution ("Because she got the wrong idea about something I did."), or 5) chance mood attribution ("Because she was in a bad mood."). As noted above, only the incompetence attribution was of interest in this study.

For each attributional response, children were asked to rate on a scale from 0 ("that's not the reason") to 3 ("for sure that's the reason") how likely was the reason for their rejection. The incompetence attribution ("Because it's hard for me to make friends"), indicates a feeling of personal incompetence at making and keeping friends.

Goetz and Dweck (1978) identified this response as the one most likely to imply a learned helplessness orientation because of past research indicating that the failure attributions of helpless children focus on causes that are not easy to change, especially causes that are internal and relatively stable, such as lack of ability. This is consistent with Kelley's (1986) review of learned helplessness within a sexually abused population. Kelley proposes that sexually abused children attribute the abuse to internal stable factors, because of the closeness of the relationship between the victim and the offender and because of the ongoing nature of the problem. Furthermore, Kelley

believes that victims of child sexual abuse tend to attribute their experience to global factors because they expect that victimization will recur across many situations.

Because this study was unable to assess learned helplessness as it related specifically to sexual abuse (see endnote 1), looking at the attributions associated with social rejection was felt to be the most appropriate option. Therefore, the score used for the analyses included the child's rating from 0 ("that's not the reason) to 3 ("for sure that's the reason") of how likely they felt the incompetence attribution was the reason for their rejection. Because children were asked to rate the incompetence attribution across four separate vignettes, their total score on this measure was the summation of these four scores.

Reliability of the incompetence attribution within our sample, as assessed via Cronbach's alpha, was .58. It is important to note that this is only a marginally acceptable level of reliability.

Schemas of Self/Other:

The Piers-Harris Self-Concept Scale (Piers & Harris, 1969) was used to replicate previous findings (Oates et. al., 1994) demonstrating a lower self-concept in sexually abused children when compared to normal controls. This scale is an 80-item self report measure which yields a total score as well as scores on six subscales: behavioral, anxiety, popularity, intellectual and school status, physical

appearance and attributes, and general happiness and satisfaction. Children responded to first person declarative statements, such as "I am a happy person," with a yes or a no. Roughly half of the statements were worded to indicate a positive self-concept, and half to indicate a negative self-concept. Because the total self-concept score is the single most reliable score on the Piers-Harris Self-Concept Scale (Piers & Harris, 1969), this was the score used for subsequent analyses. The reliability and validity of this measure has been well-documented (Crandall, 1973; Shavelson Hubner & Staton, 1976).

Wayland's Projective Measure: Because self-report measures of self-concept sometimes fail to differentiate sexually abused from nonabused children (Elliott & Tarnowski, 1990), a projective measure (Wayland, 1994) was included to examine schemas of self and other in sexually abused children (see Appendix C). Wayland's measure is designed to indirectly assess trauma-related schemas and affects. Children were presented with six hypothetical vignettes about threatening and conflictual situations (i.e. There is a grown-up in Janice's life she feels afraid of who does scary things. She worries about it at home and at school), and were asked to create stories about these hypothetical situations. Each story was then coded on two dimensions.

The first dimension included schemas about self. This dimension is scored either as positive ("Mary has friends

who want her to smoke, but she knows that's not right. She tells them why they shouldn't smoke and is a really good friend to them because she helps them stay good."), ambivalent ("Sally's parents were getting a divorce. It was hard for her to keep the secret but she did all school year."), or negative ("Kim is a girl with freckles, glasses, and buck teeth. She thinks she's ugly and sometimes wants to die."). The second dimension included schemas about others. Again, this dimension was coded as positive ("Susie's parents aren't getting along. Susie's friend notices that Susie is sad and helps her figure out how to solve her problems."), ambivalent ("Janice is always afraid of her uncle because he beats on her. One day the cops took her out of the home and put her in a foster home with nice people and she was never scared of anyone else again."), or negative ("Jenny has some problems at home. She tells her friend about it and soon the whole neighborhood knows. Jenny learns not to trust others with her secrets."). More detailed scoring examples of these dimensions can be found in Appendix C.

Wayland obtained adequate reliability for these dimensions. The internal consistency of perception of self and perception of other within this sample was computed using the alpha statistic. The alphas obtained were .55 and .74, respectively.

Subjects responses were independently coded by two raters who were blind to the subject's group affiliation (i.e., sexual abuse, psychiatric control, or normal control). Twenty-five percent of the protocols were coded by both raters so that inter-rater reliability could be assessed. Cohen's Kappa values of .84 and .85 were obtained for perception of self and perception of other, respectively.

The Emotion Regulation Q-sort: In order to assess the emotion regulation skills of children in the three groups, the Emotion Regulation Q-sort (Shields & Cicchetti, 1995) was utilized (see Appendix D). This measure is designed to assess what Shields and Cicchetti describe as "optimal emotion regulation," which they report to be "the capacity to effectively moderate one's emotional arousal, such that an optimal level of engagement with one's environment is fostered (Calkins, 1994) and goal-directed behavior is supported (Thompson, 1994)."

The Q-sort methodology is an ipsative procedure for assessing personality characteristics by sorting a standard set of descriptors into piles ranging from most to least descriptive of an individual (Block, 1978). This pattern of descriptors, arranged by raters familiar with a child, is designed to generate a profile that provides a comprehensive portrait of an individual's personality functioning. Shields and Cicchetti, using the definition of optimal

emotion regulation described above, asked 16 raters -- Ph.D. psychologists who are noted experts in the study of emotional development -- to complete California Child Q-sort profiles (Block & Block, 1969). These expert raters were asked to compile a personality profile reflective of an optimally well-regulated child; their ratings then served as the foundation for the criterion Q-sort. This criterion Q-sort is the prototype of what an optimally regulated child's pattern of scores should be on the Emotion Regulation Q-sort (see Appendix D for the rating assigned to each of the 100 items within the Q-sort).

The Q-sort is completed after observing the subject for several weeks. Because it was not possible to observe each subject for the extensive amount of time required to score the Q-sorts accurately, teachers were asked to complete the Q-sort, as they had extended contact with the children. Teachers were presented with a group of 100 cards with short descriptions, such as: This child gets along well with other children; This child is open and straightforward; This child is stubborn, etc. They were then to asked sort the cards into nine groups of 5, 8, 12, 16, 18, 16, 12, 8, and 5 cards, respectively, ranging from Extremely Uncharacteristic to Extremely Characteristic of the child. To generate an individual's score for emotion regulation using this methodology, each of the 100 items that the teacher sorted (into the nine groups) was then given a score of 1 through

9, based on which of the nine piles the item was placed in. This creates a forced distribution for each child, which relates to the forced distribution already formulated for the "optimally regulated" child. Each item within the forced optimally regulated profile has a previously assigned number between 1 and 9 (see Appendix D for the numbers assigned to each item), which was generated based on the ratings provided by the expert raters. The higher the number of the item, the more indicative it is of optimal regulation skills. This procedure produces 100 observations for each child. In order to measure the association between how well <u>each</u> individual child's profile correlated with the optimal profile, a Pearson Product Correlation was computed for each child. This was done by using the ratings provided by the teacher and the ratings of the optimally regulated profile. More specifically, each of the 100 cards within the child's Q-sort was compared with the optimally regulated respected card, whereby the two ratings for a given card count as 1 observation. These 100 observations were then used as the basis for the correlation, which then provided a correlation coefficient signifying how well that child's profile correlated with the optimal profile. A child's profile that is highly correlated with the optimal profile is indicative of a well regulated child, whereas a child's profile that has a low or negative correlation with the

optimal profile is indicative of a poorly emotionally regulated child.

Shields and Cicchetti attained correlations between the expert individual raters' Q-sort definitions of an optimally well-regulated child and the Composite Emotion Regulation Criterion Q-sort, which ranged from .76 to .93.

It is important to note that this is a new measure and data on the reliability and validity of this measure is only now being examined. However, it was chosen because no other measures of emotion regulation in this age group have been developed. Alternative measures to assess the construct of emotion regulation are currently under development, but Cicchetti and Shield's emotion regulation Q-sort was the best alternative available at the time.

Wechsler Intelligence Scale for Children - III: The vocabulary subtest of the Wechsler Intelligence Scale for Children - III (WISC-III; Wechsler, 1991) was administered to determine whether the three samples varied in terms of verbal intelligence. The vocabulary subtest was used instead of the complete WISC-III because it is known to be the single best measure of general intelligence (Wechsler, 1991), and time considerations did not permit administration of the entire test.

Socioeconomic Status: In order to determine if the three samples varied in regard to SES, the Hollingshead (1975) index was used to obtain socioeconomic information on

all subjects. This information was obtained from the parent or guardian of each subject.

Procedure

Those facilities (i.e DSS, mental health facilities, private outpatient settings, or summer camps) that agreed to refer children who fit the criterion for this study were provided with consent forms (see Appendix E) describing the study to the child's parent or legal guardian. Only those parents or legal guardians who signed and returned the consent forms were contacted by phone to schedule a time to participate. They were told that this study was being conducted to examine children's behavioral problems and competencies, their coping ability, their perception of control over their environment, their self-concept, and their ability to regulate their emotions in interpersonal situations. They were notified that information from teachers would be collected, and permission to contact their child's teacher was requested. They were also assured that no information about their child would be provided to the teachers or referral site.

Each subject and caregiver was met at the local Mental Health Center or summer camp facility by the primary researcher or a graduate assistant. All efforts were made to ensure that the examiner was blind to the child's group affiliation (i.e. sexual abuse, clinical psychiatric, or

normal) until after the child was interviewed. It was often not possible to be blind to the normal children's group affiliation, however, as most of the normal control children were interviewed at the summer camp facility. This was unlikely to introduce bias into the scoring, however, because most of the measures administered used a multiple choice format and there was little room for bias by the examiners. However, there are still demand characteristics which must be considered. The child's group affiliation was not included on those measures that were later scored by the examiner (e.g. projective stories), and which therefore had room for potential bias.

The caregiver was asked to provide SES information while she waited for the child to complete her section of the study, or, if the child was met at the summer camp, this information was obtained over the phone. The examiner or research assistant then asked the child to follow her into a separate room in order to administer the Coping Scale for Children and Youth (CSCY) - peer version, the Weschsler Vocabulary Subtest, the Social Attribution Measure, the CSCY - family version, the Piers-Harris Self Concept Scale, and the Wayland Projective Measure. These were presented in a standard order for all children, as order effects were not expected. The Wayland Projective Measure was chosen as the last measure administered because of the possibility that some children would find this measure to be more threatening

than the others. Therefore, it was felt that rapport should be well established before the Wayland Measure was administered.

After the parent or legal guardian and child completed their respective measures, both were debriefed and any questions or concerns they had were answered before they left. At this time the children were also provided with fast food coupons and toys to thank them for their help. Teachers were then contacted and asked to complete the Teacher Rating Form and the Emotion Regulation Q-sort. The research assistant scheduled a time to meet with each teacher in order to assist them in completing these tasks. However, it should be noted that one of the school districts within the catchment area where subjects were recruited did not allow their teachers to participate in this research study. Therefore, the measures which requested teacher participation were only completed on approximately 35 of the 74 children who participated in this study.

CHAPTER III

RESULTS

Preliminary Analyses

One-way Anovas which compared the three groups on SES and IQ were significant, $F(2,71)=6.34$, $p<.002$, and $F(2,71)=7.53$, $p<.001$, respectively. As seen in Tables 1 and 2, the sexually abused group clearly contained children from lower SES backgrounds who had lower estimated IQ's. Therefore, in all of the group statistical procedures described below, SES and IQ were included as covariates. Furthermore, the three groups also differed in the Number of Treatment Sessions (SA $M=13.9$, PC $M=8.6$, NC $M=0$) attended while in therapy. However, this factor was not used as a covariate because it was not significantly correlated with any of the dependent measures.

As a preliminary look at the data, correlations were computed both for the sample overall and within the three different groups (see Table 3,4,5 and 6). Although there were a number of correlations where variables appeared very different from one another, only those which were tested and were significant at the .05 level will be discussed. For example, some of the within-subject correlations involving the PC group were not in the expected direction. More

specifically, there were significant differences in regard to the correlations between the Child Behavior Checklist Sum of Behavioral Problems and Wayland's Perception of Other (SA -.2931, PC .2270, NC -.8809). These correlations suggest that the more behavioral problems that the PC group exhibited, the more positive was their perception of others. This pattern was also demonstrated by the correlations between the Emotion Regulation Q-sort and Wayland's Perception of Other (SA .4549, PC -.3508, NC .4335) and between the Emotion Regulation Q-sort and Wayland's Perception of Self (SA .6504, PC -.2820, NC .6589). Again, these correlations suggest that the more negative the PC group's emotion regulation skills, the more positive their perception of themselves and others.

Overview of Analyses

To determine whether sexually abused children differed from psychiatric and normal control children in the ways predicted, a series of univariate analyses of covariance (ANCOVA's), followed by planned comparisons between sexually abused children and children in the other two groups. Differences between normal and psychiatric controls were not examined as this was not the focus of the study. Preliminary analyses of differences in behavioral difficulties and adaptive functioning were examined first, followed by analyses that examined group differences in the

areas of coping, learned helplessness, self-esteem, and emotion regulation (see Tables 7 and 8).[2]

The Child Behavior Checklist: Teacher Rating Form - Two ANCOVAs using the dependent variables of the Total Behavior Problem Scale and the Sum of Adaptive Functioning Scale were conducted on the Achenbach Teacher Rating Form in order to determine if our sample was representative of previous samples in terms of behavioral difficulties and adaptive functioning (see Table 7). As predicted, there were significant differences between the three groups in regard to their Total Behavior Problem Scale scores, $F(2,30)=5.59$, $p<.009$, $r^2=.42$, and the Sum of their Adaptive Functioning, $F(2,30)=7.05$, $p<.003$, $r^2=.34$. In both cases, the SA group demonstrated less difficulties than the PC group, but more difficulties than the NC group. Planned comparisons indicated that the Adaptive Functioning scores of the SA group ($M=16.5$) were significantly lower than the Adaptive Functioning scores of the NC group ($M=24.17$), $t(28)=2.67$, $p<.01$, differences between the SA group ($M=16.5$) and the PC group ($M=13.9$), $t(28)=-1.41$, $p<.17$, were in the predicted direction, but were not significant. Furthermore, Planned Comparisons revealed a trend for the SA group ($M=57.86$) to demonstrate more behavioral problems on the Total Behavior Problem Scale than the NC group ($M=47.86$), $t(28)=-1.83$, $p<.07$, but less behavioral problems than the PC group ($M=64.07$), $t(28)=1.76$, $p<.09$. This is consistent with

previous research (Friedrich, Beilke, & Urquiza, 1988; Cohen & Mannarino, 1988) which indicates that although sexually abused children are described as experiencing psychological difficulties, these problems are typically not as severe as those manifested by nonsexually abused child psychiatric outpatient populations.

Coping Ability - It was hypothesized that sexually abused children would demonstrate more cognitive and behavioral avoidance coping techniques when asked to rate how they would cope with two types of interpersonal stressors (i.e. a problem that occurred with a family member and with a peer). Because the Cognitive Avoidance Factors of the peer and family versions of the Coping Scale were highly correlated ($r=.64$), as were the Behavioral Avoidance Factors for the two versions of the Coping Scale ($r=.70$), the Cognitive Avoidance measures were combined, as were the Behavioral Avoidance measures. This yielded a combined score for Cognitive Avoidance, and a combined score for Behavioral Avoidance. An ANCOVA was conducted with these two factors (cognitive avoidance and behavioral avoidance) as the dependent variables. No significant results were found for the Cognitive Avoidance factor, $F(2,69)=1.94$, $p<.152$, $r^2=.09$, or the Behavioral Avoidance factor, $F(2,69)=1.67$, $p<.195$, $r^2=.10$ (see Table 8).

Learned Helplessness - To test the second prediction (i.e. that sexually abused children will attribute failure

to internal stable factors), the incompetence factor of the attribution questionnaire ("Because it's hard for me to make friends.") was used as the dependent variable in a one-way ANCOVA. Although the means were in the predicted direction (SA $\underline{M}$=5.23, PC $\underline{M}$=4.04, NC $\underline{M}$=3.33), no significant group effects were found, $\underline{F}(2,69)=.34$, $\underline{p}<.71$, $r^2=.14$ (see Table 8).

Negative Schemas of Self and Other - In order to test the prediction that sexually abused children have more negative schemas of self on the Piers-Harris Self-Concept Scale, an ANCOVA was conducted using the total score of the Piers-Harris as the dependent variable. Group means were in the predicted direction (see Table 8), but no significant group effects were found, $\underline{F}(2,69)=1.80$, $\underline{p}<.17$, $r^2=.20$.

In order to determine if the schemas of self and other in sexually abused children were more impaired than those of nonsexually abused psychiatric controls and normal controls when presented with projective stories relating to self and other, separate ANCOVAs were conducted, with the two dimensions (i.e. schemas about self and schemas about others) of the Wayland projective stories as the dependent variables (see Table 7). Analyses demonstrated significant group effects for Perceptions of Self, $\underline{F}(2,68)=3.31$, $\underline{p}<.04$, $r^2=.10$, with Planned Comparisons yielding a significant difference between the SA group ($\underline{M}$=11.05) and the NC group ($\underline{M}$=12.04), $\underline{t}(68)=2.57$, $\underline{p}<.01$, but no significant difference

between the SA group (M=11.05) and the PC group (M=11.54), $t(68)=1.44$, $p<.15$. Significant results for Perception of Other $F(2,68)=3.20$, $p<.04$, $r^2=.14$, were obtained, with Planned Comparisons demonstrating differences between the SA group (M=10.55) and the NC group (M=12.26), $t(68)=2.39$, $p<.01$, but no significant difference between the SA group (M=10.55) and the PC group (M=10.92), $t(68)=.69$, $p<.49$. These results suggest that the sexually abused children have more negative perceptions of themselves and others than a group of normal control children, which is consistent with this study's predictions.

Emotion Regulation - Finally, an ANCOVA was conducted to test the hypothesis that the sexually abused group would demonstrate less adaptive emotion regulation skills than the clinical or normal control samples. However, before statistical analyses could be completed, the Q-sort data was correlated with the optimally regulated Q-sort profile, which yielded a Pearson Product correlation for each subject. Because correlations are not normally distributed, each correlation was then transformed using Fischer's r to z transformation. The transformed observations were then used as the dependent variable in an ANCOVA analysis. Results of this analysis were significant $F(2,30)=8.41$, $p<.001$, $r^2=.53$, but in a direction that was contrary to our hypothesis (see Table 8). The PC group demonstrated the most impaired emotion regulation skills, with Planned Comparisons showing

significant differences between the SA group (M=.35) and the PC group (M=-.021), t(30)=-2.78, p<.009, but no differences between the SA group (M=.35) and the NC group (M=.682),t(30)=1.49, p<.14. These results indicate that based on teacher report, the emotion regulation skills of sexually abused girls are not noticeably more impaired than those of normal children and of psychiatric controls. In fact, results demonstrate significant deficits in the emotion regulation skills of non-sexually abused psychiatric control children.

CHAPTER IV

DISCUSSION

Prior studies of children and adults who have been sexually abused during childhood indicates that a paradox exists within this area of research. More specifically, because research has identified a number of disorders in which the incidence of childhood sexual abuse significantly exceeds the base rate, some have suggested that the trauma of sexual abuse may be associated with the emergence of psychopathology in adulthood (Alpher, 1992; LaPorta, 1992; Fenton, 1993; Sheldon, 1988). However, sexually abused children, as a group, have been noted to demonstrate less overall pathology and fewer specific difficulties than typical groups of children receiving psychiatric services (Gomes-Schwartz et. al., 1989; Tong et. al., 1987; Mannarino & Cohen, 1986). This has led researchers to hypothesize that a latency often occurs between the termination of the abuse and the emergence of psychiatric symptomatology.

One possible explanation for this paradox is that childhood sexual abuse adversely affects significant areas of functioning which contribute to the development of psychopathology later in life, even though it does not immediately result in the development of psychiatric symptoms during childhood. This study was designed to

extend prior work on the behavioral symptomatology (or lack thereof) of sexually abused children, and examine four areas of functioning which may contribute to the development of later symptomatology, but which do not cause significant overt psychiatric symptoms shortly after the abuse. These areas include coping skills, perceptions of helplessness in regard to managing their environment, negative schemas of self and others, and poor emotion regulation skills.

These areas of functioning were chosen because of research and clinical case studies demonstrating the emergence of these difficulties within adults who had been sexually abused as children. For example, research on adults who had been sexually victimized as children indicate that the coping mechanisms of denial, dissociation, and minimization may have been utilized to help them cope with the trauma of the abuse. In addition, because sexually abused children are frequently exposed to uncontrollable negative experiences in childhood, it has been hypothesized that many sexually abused victims believe they have little control over other areas of their lives when they become adults. Finally, poor self esteem and negative perceptions of others in childhood may lead to long-term problems regulating affect, developing stable relationships, and developing a stable sense of personal identity.

Results Which Supported Hypotheses

Overall, support for our hypotheses was relatively modest. As predicted, analyses which examined overt behavioral symptomatology, through the use of teacher rather than parental report, was consistent with what has been reported by other researchers. More specifically, within our sample, the sexually abused children tended to demonstrate more behavioral problems and less adaptive functioning than a group of normal controls, but less behavioral problems and greater adaptive functioning than a group of outpatient psychiatric controls. Previous research has primarily examined parental assessment of their child's behavioral problems and level of adaptive functioning. By using teacher reports rather than parental reports, we have added strength to this finding.

In regard to the four areas of functioning that are believed to affect later adjustment, significant results were found on the responses children provided for Wayland's projective measure. More specifically, results indicated that sexually abused girls have more negative perceptions of themselves and of others when compared to a group of normal children.

Having a negative perception of oneself has often been thought to be a risk factor for children, as it is believed to be a central feature of social-emotional adjustment. Low

self-esteem, for example, is often linked with a host of other problems, including poor mental health (Swanson, Bratrude, & Brown, 1971) and self-destructive behavior (Furnham, 1988). Furthermore, some researchers (Briere, 1992) have suggested that low self-esteem in children who have been sexually abused increases the likelihood that revictimization will occur, since they may be unable to critically evaluate the actions or demands of others because of their own impaired sense of self.

In addition to having a poor self-image, one could speculate that having negative perceptions of others would make it more difficult for these individuals to develop appropriate interpersonal relationships. This is significant in regard to child and adolescent development. Children and adolescents frequently rely on the guidance and support of important individuals around them to help them manage the difficult task of growing up. Having negative perceptions of others would make it more difficult for these children to get through subsequent developmental stages, as they would feel it necessary to cope and adjust to difficult times in their lives by themselves, tasks which they may be unable to manage at their present cognitive and emotional level of functioning.

Many adult disorders, including Borderline Personality Disorder, and to some extent, Dissociative Identity Disorder, include a pervasive pattern of instability of

interpersonal relationships, and an identity disturbance characterized by a markedly unstable self-image or sense of self. Both of these disorders are difficult to treat during adulthood. Developing ways to alter these children's negative perceptions of themselves and others during childhood may prove to be an important preventative treatment goal for clinicians, and may help to preempt later difficulties that these children may experience in these areas.

Results In Predicted Direction

The sexually abused group also demonstrated more negative self concept on a self-report measure (the Piers-Harris Self-Concept Scale). However, these differences were not statistically significant. This is noteworthy because significant results about children's self-esteem were obtained through a projective measure within this sample, but not found when using a self-report instrument. There could be several explanations for this discrepancy.

First, many of the children within our sexual abuse group were identified shortly after the abuse occurred. Therefore, it is possible that we are only seeing the early stages of low self-esteem. More specifically, it is possible that the trauma of being sexually abused may not fully affect the self-esteem level of many of these children until they are faced with subsequent developmental challenges which make the trauma more noteworthy. One

example might include the developmental task associated with having more emotionally demanding relationships, both with same-sex and opposite-sex peers. Difficulties within this area may exacerbate their feelings of incompetence. Tracking these children across time may be quite clarifying in regard to determining whether these types of developmental tasks intensify their feelings of incompetence.

Although prior studies have found differences in self-esteem using self-report measures, a second, more speculative, theory is that projective measures are more sensitive in detecting differences within a sexually abused population. Projective techniques may give children a chance to reveal aspects of themselves that they may generally be resistant to expose because they feel threatened by the direct approach of self-report measures.

Furthermore, children's responses to this type of projective measure provide a rich description of the multitude of difficulties sexually abused children experience daily, descriptions that are impossible to obtain from typical self-report measures. Future research may find it useful to code responses to Wayland's Projective Measure, and other projective measures, along dimensions that are applicable to the long-term functioning of sexually abused children. As noted previously, many other methods of assessment (i.e. self-report) have frequently been

unsuccessful in discerning differences between children who have and have not been abused.

In regard to children's perceptions of control within their environment, we had predicted that the children who had been sexually abused would attribute social rejection to stable internal factors (i.e. incompetence), thereby suggesting an orientation toward learned helplessness. Although the means of the three groups were in the predicted direction (with the sexual abuse group demonstrating the most deficits in helplessness), results of the learned helplessness measure did not demonstrate significant differences between the groups.

Although this lack of results may be due a lack of true differences between the three groups, it is also possible that the self-report measure used was not sensitive enough to capture any differences between the three groups, or that the sexually abused children were unwilling to report difficulties within these areas. In addition, because of our small sample size and large variability within this measure, the power of this study was low, which limited our ability to find significant differences on these measures. Furthermore, the large variability within our sample caused a great deal of overlap between the three groups.

The lack of clear differences may be the result of the fact that many of these children had recently been identified by the Department of Social Services as being

abused. In order to keep them safe, some of the children were placed with another family member, or placed in a group or foster home setting. In other situations, the children were able to stay within their home, but steps were taken to keep the abuser away from the child. It is possible that there are strong and reliable differences between these three groups in regard to their feelings of helplessness, but that these results were minimized because of the fact that social workers, therapists, and, at times, teachers, were providing assistance to the child. This would reduce the child's tendency to feel that they could do nothing to stop the abuse, as mechanisms were in place to do just that. In fact, many of these children may have been experiencing a new found sense of control over their lives, as they discovered that they were able to stop the abuse by discussing it with a teacher or adult friend.

In addition, it is possible that our sample of sexually abused children was too diverse to obtain clear differences between the three groups. For example, it is possible that children abused regularly by a close relative would be more likely to develop learned helplessness than those who have been abused on one occasion by a stranger. In addition, children who were readily believed by a parent or teacher when they disclosed the abuse would be less likely to develop a learned helplessness orientation than children who had not been supported. These factors were not accounted

for or controlled for within this study. Although these factors were believed important to assess, it was not possible to account for all of these variables within this study.

Furthermore, it is also likely that the learned helplessness measure was relatively ineffective in accurately tapping into this construct. As noted previously, the internal consistency of this measure was only marginally acceptable. In addition, intelligence level was highly correlated to this dependent measure, and appeared to account for a large portion of the variance within the model.

Results Against Predictions

We had predicted that children who had experienced sexual abuse would demonstrate more cognitive and behavioral avoidance coping strategies than a normal control group or psychiatric control group. Self-report measures utilized within this study did not find any significant group differences. More specifically, the means of the coping measure were not in the predicted direction, as the PC group demonstrated slightly more cognitive and behavioral avoidance techniques. This is surprising, given past research which has suggested that SA adults use more avoidance techniques of denial, dissociation, and minimization.

One possible explanation for this discrepancy is that many of the sexually abused children within this study had recently been identified by the Department of Social Services as being abused, and immediate action had been taken to deal with this abuse. At times, this included being removed from the unsafe environment, and being referred for services at the Mental Health Center. Because of this, it is possible that these children were unable to defend against their abuse through the use of denial and minimization, since the social worker and therapist involved in the case were frequently addressing the issue with the child, and making necessary changes within her environment to protect her.

Individuals who participated in previous studies which have examined the coping skills of adults had often not received services for the abuse, or did not tell anyone about the abuse until years after the incidents occurred. Individuals who attempted to deal with this type of abuse on their own, without the assistance of social workers or therapists, may be more likely to have used the defense mechanisms of denial and minimization. The children who participated in this study were generally encouraged to discuss the abuse with Social Service's investigators in order for Social Services to confirm the abuse allegations and consequently remove them from the abusive situation. Therefore, it is possible that our sexual abuse sample, when

compared to other groups of sexually abused children, were coping quite well because of the external support which they were receiving.

Significant differences were found in regard to the emotion regulation skills of the three groups, but they were inconsistent with this study's prediction. More specifically, results indicated that the psychiatric control group demonstrated significantly more impaired emotion regulation skills than the sexually abused group. Several factors may help to explain these findings.

First, the results of this measure are consistent with the results of the Achenbach TRF, in that the psychiatric group tended to exhibit more behavioral difficulties and more externalizing symptoms than the sexually abused group or the normal control group. It is important to realize that both measures (the Q-sort and the TRF) were completed by teachers. As stated previously, sexually abused children tend to exhibit less overt psychopathology than a group of clinical controls. The completion of the Q-sort method relied on teachers to assess overt behavioral portrayals of poor regulation skills (outward portrayals of anger, emotionality, etc.). For example, some of the items within this measure which were indicative of poor regulation skills included "Is unable to delay gratification," "Is aggressive," and "Reverts to immature behavior under stress." All of these items would likely be more noticeable within a

psychiatric control group, who typically would be receiving services for these types of difficulties. It is possible that sexually abused girls manifest more subtle emotion regulation difficulties, such as withdrawing from a negative peer interaction only to cry once she gets into the girl's bathroom. Unfortunately, assessing these types of emotion regulation problems is challenging.

Although the Emotion Regulation Q-sort may be an appropriate measure for the assessment of outward portrayals of emotion regulation deficits, it may not be the most appropriate measure to use for a sexually abused population. Unfortunately, it was the only measure available at the time. Finding a way to assess the more internal and less overt instances of poor emotion regulation is an important area of future research.

Also of interest are the correlations demonstrated by the PC group which were against the expected direction. More specifically, these correlations indicated that the more behavioral problems exhibited by the PC group, the more positive their perception of others. Furthermore, the more impaired the emotion regulation skills of the PC group, the more positive their perceptions of themselves and others.

One potential explanation for this pattern of correlations includes the recent theoretical position that violence or outward and unregulated responses may be a result of threatened egotism--that is, highly favorable

views of self that are disputed by some person or circumstance. Because inflated, unstable, or tentative beliefs in one's superiority may be most prone to encountering threats, one is likely to react quickly and emotionally as a way of avoiding a downward revision of the self-concept (Baumeister, Smart, & Boden, 1996). Although this is a recent theoretical position, and has yet to be substantiated, it may help to make these inconsistent correlations more easily understood. More specifically, many children who demonstrate poor emotion regulation skills and behavioral problems within the school setting may not always be suffering from low self-esteem, but instead, are reacting emotionally and quickly to supposed threats to their self-esteem.

Summary

In general, the results of this study provide useful information to the field of sexual abuse. First, teacher reports of children's behavioral difficulties are consistent with previous parental reports which indicate that sexually abused children do not demonstrate as many behavioral difficulties as typical groups of children receiving outpatient mental health services. This finding is noteworthy because it highlights the importance of utilizing multiple methods to assess sexually abused children, given the research indicating that the long-term adjustment of sexually abused children is poor. It is apparent that these

children do not display overt symptomatology, but difficulties within important areas of functioning may be more readily accessible through the use of measures which examine the internal processes of sexually abused children. Although it is possible that these children truly are not experiencing as much distress as children who are diagnosed with a mental health disorder, it is also possible that their distress has not yet become manifest in easily observable.

Because of the possible latency between time of abuse and overt symptomatology, a more economical and beneficial therapeutic approach to the treatment of sexual abuse might include sporadic therapy sessions over a longer period of time. This might allow therapists to be more available to this population when specific difficulties do appear. At the present time, it is plausible that sexually abused children either do not receive mental health services or receive too few services because of the lack of overt symptomatology.

Second, the finding which suggests that sexually abused children demonstrate more negative perceptions of themselves and others has significant research and treatment implications. More specifically, it is possible that increased negative perceptions of self and others may play some role in such long-term outcomes as Borderline Personality Disorder, Depression, or revictimization because

the lack of a secure sense of self is a core area of difficulty within these populations during adulthood. At present, Borderline Personality Disorder is increasingly difficult to treat during adulthood. Longitudinal research of treatment strategies that could be utilized during childhood in the hopes of the prevention of BPD, Depression, or revictimization is an important area to assess.

For example, treatment for sexually abused children frequently consists of supportive therapy focusing on the removal of blame. One could speculate that it might also be helpful to utilize cognitive-behavioral therapy which focuses directly on altering the negative attributions of self and other that these children possess. More direct approaches which require children to initiate positive peer interactions or assertive behaviors, first within the therapy session and then within their natural environment, may also be useful approaches to improve long-term adjustment. Longitudinal analyses examining the treatment efficacy of these different approaches may be a useful area of future research.

Despite the additional information this study provides to the field of sexual abuse, there are multiple limitations of the current study. First, it would have been optimal if the three groups had been equated on SES and IQ. Although this issue was addressed through statistical covariation,

the amount of variance accounted for by these factors was notable.

Second, generalization of our findings is limited by the fact that our subject sample only included girls. Studies have suggested that one quarter to one third of all victims are boys, which indicates that this is an important area to examine. However, because of the small sample size within this study, it was difficult to obtain enough sexually abused males to examine whether they react differently to the trauma of abuse. Future research should examine this area more thoroughly.

Third, it is important to note that the abused subjects and psychiatric controls received treatment of some type. However, the nature of these interventions was not clearly specified nor was there any attempt to study their impact on the dependent variables. Future studies should attempt to minimize the impact of these factors by assessing these children before they have participated in treatment.

Fourth, although the severity of abuse was obtained from the sexually abused population, the length of abuse was not. These are both important variables, as a review of the sexual abuse literature (Kendall-Tackett et. al., 1993) indicates that molestations that included a long duration of abuse and oral, anal, or vaginal penetration led to a greater number of symptoms for victims.

Finally, because of the difficulties that arose with this study, it seems important that we continue to examine the areas of vulnerability associated with sexual abuse, using long-term follow-up, multiple methods of assessment (projective measures, self-report, behavioral observations), and multiple assessors (child, parent, teacher, peer). Without this comprehensive approach, it is difficult to obtain an accurate estimate of the short and long-term implications of sexual abuse.

In spite of its limitations, this study adds useful information to the sexual abuse literature for the following reasons. The addition of teacher data on the behavioral difficulties sexually abused children experience confirmed parental reports of difficulties which were more severe than a normal population, but less severe than an outpatient mental health population. The projective data demonstrated more negative perceptions of self and others within a sexually abused population. The self-report data on children's self-concept and perceptions of helplessness indicate that sexually abused children may be in the beginning stages of developing deficits in these areas of functioning.

In conclusion, research in this area would benefit from utilizing a developmental approach which not only focuses on the behavioral and emotional symptoms of sexual abuse, but also the cognitive and social development of these children.

This can be accomplished through the use of longitudinal studies which allow for the examination of these areas across developmental phases. Without this type of systematic, theory driven study, the role of how sexual abuse affects children's functioning will continue to remain a mystery.

ENDNOTES

1. It was not possible to directly question the clinical and normal control subjects about previous sexual abuse, as mental health administrators and YMCA summer camp officials were concerned about the sensitivity of this issue and felt it inapropriate to discuss this subject with children. Therefore, an item was included on the Teacher Behavior Checklist concerning sexual acting out behavior, as sexualized behavior is often considered the most characteristic symptom of sexual abuse (Kendall-Tackett, et. al., 1993). This allowed for the opportunity to remove a child from the normal or clinical control group if a teacher reported that a particular individual demonstrated a large amount of sexual acting out behaviors. The outpatient therapists of the children in the psychiatric control group were also questioned about sexualized behavior demonstrated by their clients. However, no teacher or therapist responded positively to this question for any child from the psychiatric control group or normal control group, and therefore no one needed to be excluded from these two groups.

2. Data was also initially examined using a four-group approach, and post-hoc analysis utilizing a two-group approach was conducted. The four-group approach was analyzed once the psychiatric control group was split into

an internalizing group (n=13) and an externalizing group (n=12) based on the primary diagnosis provided by the child's outpatient therapist. However, there was no way to determine whether these groups were dually diagnosed with both an internalizing and an externalizing disorder, as only the primary diagnosis was requested from the outpatient therapist. Because of the lack of confidence in the purity of the diagnosis, and the small number of subjects in these goups, these results were not reported.

Post-hoc analyses utilizing a two-group approach (i.e. the sexual abuse group and the normal control group) were conducted to determine whether the psychiatric control group's variability (in regard to diagnoses) was minimizing significant differences between the SA group and the NC group. However, significant results obtained were consistent with the results obtained using a three group (SA, PC, and NC) approach.

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APPENDIX A

COPING SCALE FOR CHILDREN AND YOUTH (CSCY)
PEER VERSION

All children and teenagers have some problems they find hard to deal with and that upset them or worry them. We are interested in finding out what you do when you try to deal with a hard problem. I will describe a problem that I want you to think about.

A friend at school told your teacher that you did something you really didn't do in order to keep herself out of trouble. Your friend's been in trouble before and you think she could get kicked out of class if you told the teacher the truth. But, you really like this teacher and don't want her to think badly of you.

Listed below are some ways that children and teenagers try to deal with their problems. Please tell us how often each of these statements would be true for you if you tried to deal with the problem I described above.

1. I would take a chance and try a new way to solve the problem.

0	1	2	3
never	sometimes	often	very often

2. I would get advice from someone about what I should do.

0	1	2	3
never	sometimes	often	very often

3. I would try to pretend that the problem didn't happen.

0	1	2	3
never	sometimes	often	very often

4. I would keep my feelings to myself.

0	1	2	3
never	sometimes	often	very often

5. I would go on with things as if nothing were wrong.

0	1	2	3
never	sometimes	often	very often

6. I would decide to stay away from people and be by myself.

0	1	2	3
never	sometimes	often	very often

7. I would ask someone in my family for help with the problem.

0	1	2	3
never	sometimes	often	very often

8. I would think about the problem and try to figure out what I could do about it.

0	1	2	3
never	sometimes	often	very often

9. I would put the problem out of my mind.

0	1	2	3
never	sometimes	often	very often

10. I would make a plan to solve the problem and then follow the plan.

0	1	2	3
never	sometimes	often	very often

11. I would figure out what had to be done and then do it.

0	1	2	3
never	sometimes	often	very often

12. I would try to not think about the problem.

0	1	2	3
never	sometimes	often	very often

13. I would share my feelings about the problem with another person.

0	1	2	3
never	sometimes	often	very often

14. I would go to sleep so I wouldn't have to think about it.

0	1	2	3
never	sometimes	often	very often

15. I would try to figure out how I felt about the problem.

0	1	2	3
never	sometimes	often	very often

16. I would pretend the problem wasn't very important to me.

0	1	2	3
never	sometimes	often	very often

17. I would try to get away from the problem for a while by doing other things.

0	1	2	3
never	sometimes	often	very often

18. I would hope that things would somehow work out so I wouldn't do anything.

0	1	2	3
never	sometimes	often	very often

19. I would try not to feel anything. I would want to feel numb.

0	1	2	3
never	sometimes	often	very often

20. When upset about the problem, I would be mean to someone even though they didn't deserve it.

0	1	2	3
never	sometimes	often	very often

21. I would try not to be with anyone who reminded me of the problem.

0	1	2	3
never	sometimes	often	very often

COPING SCALE FOR CHILDREN AND YOUTH
(FAMILY VERSION)

All children and teenagers have some problems they find hard to deal with and that upset them or worry them. We are interested in finding out what you do when you try to deal with a hard problem. I will describe a problem that I want you to think about.

You feel like you often get picked on and teased by one of your parents. Sometimes they really hurt your feelings. You'd like them to stop but you're not sure what to do.

Listed below are some ways that children and teenagers try to deal with their problems. Please tell us how often each of these statements would be true for you if you tried to deal with the problem I described above.

1. I would take a chance and try a new way to solve the problem.

0	1	2	3
never	sometimes	often	very often

2. I would get advice from someone about what I should do.

0	1	2	3
never	sometimes	often	very often

3. I would try to pretend that the problem didn't happen.

0	1	2	3
never	sometimes	often	very often

4. I would keep my feelings to myself.

0	1	2	3
never	sometimes	often	very often

5. I would go on with things as if nothing were wrong.

0	1	2	3
never	sometimes	often	very often

6. I would decide to stay away from people and be by myself.

0	1	2	3
never	sometimes	often	very often

7. I would ask someone in my family for help with the problem.

0	1	2	3
never	sometimes	often	very often

8. I would think about the problem and try to figure out what I could do about it.

0	1	2	3
never	sometimes	often	very often

9. I would put the problem out of my mind.

0	1	2	3
never	sometimes	often	very often

10. I would make a plan to solve the problem and then follow the plan.

0	1	2	3
never	sometimes	often	very often

11. I would figure out what had to be done and then do it.

0	1	2	3
never	sometimes	often	very often

12. I would try to not think about the problem.

0	1	2	3
never	sometimes	often	very often

13. I would share my feelings about the problem with another person.

0	1	2	3
never	sometimes	often	very often

14. I would go to sleep so I wouldn't have to think about it.

0	1	2	3
never	sometimes	often	very often

15. I would try to figure out how I felt about the problem.

0	1	2	3
never	sometimes	often	very often

16. I would pretend the problem wasn't very important to me.

0	1	2	3
never	sometimes	often	very often

17. I would try to get away from the problem for a while by doing other things.

0	1	2	3
never	sometimes	often	very often

18. I would hope that things would somehow work out so I wouldn't do anything.

0	1	2	3
never	sometimes	often	very often

19. I would try not to feel anything. I would want to feel numb.

0	1	2	3
never	sometimes	often	very often

20. When upset about the problem, I would be mean to someone even though they didn't deserve it.

0	1	2	3
never	sometimes	often	very often

21. I would try not to be with anyone who reminded me of the problem.

0	1	2	3
never	sometimes	often	very often

APPENDIX B

CAUSAL ATTRIBUTION MEASURE

1. Suppose someone stops telling you her secrets. Why would this happen to you?

A. Because it's hard for you to make friends.

0	1	2	3
that's not the reason	that might be the reason	that's probably the reason	for sure that's the reason

B. Because she's not very nice.

0	1	2	3

C. Because she doesn't like something about you.

0	1	2	3

D. Because she got the wrong idea about something you did.

0	1	2	3

E. Because she was in a bad mood.

0	1	2	3

2. Suppose a new girl in class always wants to sit next to you during lunch and at school. Why would this happen to you?

A. Because it's easy for you to make friends.

0	1	2	3
that's not the reason	that might be the reason	that's probably the reason	for sure that's the reason

B. Because she is a nice person.

0	1	2	3

C. Because she likes you.

0	1	2	3

D. Because she likes something you did.

0	1	2	3

E. Because it was a good day for her.

0	1	2	3

3. Suppose you move to a new neighborhood. A girl you meet does not like you very much. Why would this happen to you?

A. Because it's hard for you to make friends.

0	1	2	3
that's not the reason	that might be the reason	that's probably the reason	for sure that's the reason

B. Because she is a mean person.

0	1	2	3

C. Because she doesn't like the way you are.

0	1	2	3

D. Because she got the wrong idea about something you did.

0	1	2	3

E. Because it was a bad day for her.

0	1	2	3

4. Suppose someone in your neighborhood keeps calling you to ask you to do things with her. Why would this happen to you?

A. Because you're so friendly.

0	1	2	3

B. Because she is a cool person.

0	1	2	3

C. Because she likes the way you act.

0	1	2	3

D. Because you did something that she thought was neat.

0	1	2	3

E. Because she was in a good mood.

0	1	2	3

5. Suppose someone goes away from you whenever she can. Why would this happen to you?

A. Because it's hard for you to make friends.

0	1	2	3
that's not the reason	that might be the reason	that's probably the reason	for sure that's the reason

B. Because she is not a friendly person.

0	1	2	3

C. Because she doesn't like the way you are.

0	1	2	3

D. Because she got the wrong idea about something you did.

0	1	2	3

E. Because it was a bad day for her.

0	1	2	3

6. Suppose you go to a new school. It is recess time. A girl you want to play with does not want to play with you. Why would this happen to you?

A. Because it's hard for you to make friends.

0	1	2	3

B. Because she's mean.

0	1	2	3

C. Because she doesn't like you.

0	1	2	3

D. Because she got the wrong idea about something you did.

0	1	2	3

E. Because it was a bad day for her.

0	1	2	3

7. Suppose you were voted "Most Popular" by your class. Why would this happen to you?

A. Because it's easy for you to make friends.

0	1	2	3
that's not the reason	that might be the reason	that's probably the reason	for sure that's the reason

B. Because they are nice people.

0	1	2	3

C. Because they like you.

0	1	2	3

D. Because they like something you did.

0	1	2	3

E. Because it was a good day for them.

0	1	2	3

APPENDIX C

WAYLAND PROJECTIVE MEASURE

1. Sally is a girl who has a secret she doesn't like to talk about because she worries that bad things could happen to her or her family if she talks about it. It has to do with something that happened to her. Make up a story about Sally with a beginning, a middle, and an end.

2. There is a grown-up in Janice's life she feels afraid of who does scary things. She worries about it at home and at school. Tell a story about what is happening to Janice with a beginning, a middle, and an end.

3. Kim is a girl who feels different from other kids. And sometimes she feels bad about herself. Make up a story about Kim with a beginning, a middle, and an end.

4. Jenny does things she feels bad about and she worries about them. She doesn't want anyone to know about these things. Make up a story about Jenny with a beginning, a middle, and an end.

5. Susie is worried something bad could happen between her parents. She thinks that somebody could feel upset or get hurt. Make up a story about Susie with a beginning, a middle, and an end.

6. Mary feels like other people don't like her. Make up a story about Mary with a beginning, a middle, and an end.

Scoring examples for Wayland's Projective Measure

Perception of Self:

Positive - Kim meets other people who are like herself and who read books and see movies about people she can relate to. She realizes, yes, she is different, but that is a good thing and she becomes proud of who she is.

Ambivalent - Someone in Sally's family maybe did something to her. Maybe she tells somebody. She finally talks with her parents about it.

Negative - Kim feels different because she has no friends. She feels bad about herself and she's always lonely and she has to play with barbie dolls because they are her only friends.

Perception of Others:

Positive - Kim worries about her looks. And some girls from school show her some neat things about herself. Now she doesn't feel different anymore.

Ambivalent - One day Jenny was playing with her friends. She did something on purpose. She felt really bad about herself.

Negative - Her parents beat on her. And she won't tell anybody because her parents tell her that if she tells, she'll get a whooping. She finally tells a social worker and she gets in trouble and has to live with foster parents.

APPENDIX D

THE EMOTION REGULATION Q-SORT

This set of 100 "Q-Sort" cards can be used to describe a particular child. Each card has on it one item which may be more or less descriptive of any child. These cards are to be divided into 9 categories placing in one extreme pile those cards you consider most characteristic of this particular child and in the other extreme pile those cards you believe to be most uncharacteristic with regard to this child. Naturally, the items will fall into middle categories depending on how characteristic they are of the child you are rating.

Please divide up the items with this question in mind: How characteristic of the child is the behavior or attitude described in the item? Do not rate the child relative to his/her peers. For example, a child does not have to be "happier" than most children for such an item to be placed in a high category; if all children are characteristically happy, this item would be placed in a high category for all of them. Similarly, if very few children are depressed, then this item would be placed in a low category for most children. Place items in middle categories to indicate that the item is neither characteristic nor uncharacteristic of this child. Do not use the middle categories to indicate that a child does not differ from his/her peers.

As you look through the 100 cards sorting them into piles keep a picture of the child in your mind. A convenient method of sorting is to first form 3 stacks of cards--those items deemed characteristic being placed on one side, those items deemed uncharacteristic being placed on the other side, and those cards remaining falling in between. You do not need to pay attention to the number of cards falling into each of these 3 initial groupings. The next step is to divide these piles into the final 9 categories. As shown in the table below, each category must end up with a particular number of cards. For example, category 9 (extremely characteristic or salient) will have 5 items in it, these 5 items out of the 100 being the most characteristic and descriptive of the child.

The number of cards to be placed in each category are:

Category	No. of Cards	Label of Category
9	5	extremely characteristic
8	8	quite characteristic
7	12	fairly characteristic
6	16	somewhat characteristic
5	18	relatively neutral or unimportant
4	16	somewhat uncharacteristic
3	12	fairly uncharacteristic
2	8	quite uncharacteristic
1	5	extremely uncharacteristic

Nine category cards have been provided to make the final sorting into piles easier. On each category is noted the category number, the number of cards to be placed in that category, and a description of just how characteristic of the child items in the category should be.

You may find it difficult to sort the items into the exact numbers required for each category. We recognize this, but ask that you do so because this particular method has proven most reliable and valuable in the past. Thank you very much for your cooperation.

CCQITEMS		EMOTREG
1.	Prefers non-verbal communication	4.4
2.	Is considerate of other children	7.4
3.	Is warm and responsive	8.1
4.	Gets along well with other children	7.7
5.	Is admired by other children	7.1
6.	Is helpful and cooperative	7.1
7.	Seeks physical contact with others	5.4
8.	Tends to keep thoughts/feelings to self	4.3
9.	Develops genuine and close relationships	8.1
10.	Has transient interpersonal relationships	3.4
11.	Attempts to transfer blame to others	3.1
12.	Reverts to immature behavior in stress	2.6
13.	Characteristically try to stretch limits	4.3
14.	Is eager to please	5.6
15.	Shows concern for moral issues	7.1
16.	Tends to be proud of accomplishments	6.3
17.	Behaves in a sex-typed manner	5.4
18.	Expresses negative feelings openly	6.5
19.	Is open and straightforward	7.1

20.	Tries to take advantage of other	3.4
21.	Tries to be the center of attention	3.9
22.	Tries to manipulate others by ingratiation	3.8
23.	Is fearful and anxious	2.6
24.	Tends to brood and ruminate or worry	2.7
25.	Uses and responds to reason	7.3
26.	Is physically active	5.1
27.	Is visibly deviant from peers	3.9
28.	Is vital, energetic, lively	6.5
29.	Is protective of others	6.1
30.	Tends to arouse liking in adults	6.9
31.	Shows a recognition of others feelings	8.1
32.	Tends to give, lend, share	7.1
33.	Cries easily	2.9
34.	Is restless and fidgety	4.0
35.	Is inhibited and constricted	2.9
36.	Is resourceful in initiating activities	7.0
37.	Likes to compete; tests self against others	5.4
38.	Has unusual thought processes	4.1
39.	Tends to be rigidly repetitive in stress	1.4
40.	Is curious and exploring	7.1
41.	Is persistent in activities	6.6
42.	Is an interesting, arresting child	6.1
43.	Can recover after stressful experiences	8.9
44.	When in conflict, tends to give in	4.4
45.	Tends to withdraw when under stress	3.1
46.	Tends to go to pieces under stress	1.5
47.	Has high standards of performance	5.8
48.	Seeks reassurance about worth/adequacy	4.4
49.	Shows specific mannerisms	3.9
50.	Has bodily symptoms of tension/conflict	2.6
51.	Is agile and well coordinated	5.4
52.	Is physically cautious	4.6
53.	Tends to be indecisive and vacillating	3.9
54.	Has rapid shifts in mood	1.7
55.	Is afraid of being deprived	3.4
56.	Is jealous and envious of others	3.1
57.	Tends to dramatize/exaggerate mishaps	3.9
58.	Is emotionally expressive	7.2
59.	Is neat and orderly in dress/behavior	5.4
60.	Becomes anxious in unpredictable environments	2.8
61.	Tends to be judgmental of others behavior	3.9
62.	Is obedient and compliant	5.8
63.	Has rapid personal tempo	4.9
64.	Is calm and relaxed, easy-going	7.5
65.	Is unable to delay gratification	2.3
66.	Is attentive and able to concentrate	7.0
67.	Is planful, thinks ahead	7.4
68.	Appears to have high intellectual capacity	5.6
69.	Is verbally fluent	5.6
70.	Daydreams, gets lost in reverie	4.4

71.	Looks to adults for help/direction	5.1
72.	Has a readiness to feel guilty	3.6
73.	Responds to humor	6.9
74.	Becomes strongly involved in tasks	6.1
75.	Is cheerful	7.6
76.	Can be trusted, is dependable	7.0
77.	Appears to feel unworthy	2.8
78.	Is easily offended	2.6
79.	Tends to be suspicious/distrustful	2.9
80.	Teases other children	3.4
81.	Can acknowledge unpleasant experiences	8.4
82.	Is self-assertive	6.4
83.	Seeks to be independent/autonomous	6.4
84.	Is a talkative child	5.1
85.	Is aggressive (physically or verbally)	2.2
86.	Likes to be by him/her self	5.0
87.	Imitates behaviors of admired others	5.1
88.	Is self-reliant, confident	7.4
89.	Is competent, skillful	6.5
90.	Is stubborn	3.7
91.	Is inappropriate in emotive behavior	1.2
92.	Is physically attractive	5.1
93.	Behaves in dominating manner	3.7
94.	Tends to be sulky or whiny	2.5
95.	Overreacts to minor frustration	1.8
96.	Is creative in perception, thought/work	6.1
97.	Has an active fantasy life	5.5
98.	Is shy, makes social contact slowly	4.4
99.	Is reflective, thinks before speaking	7.1
100.	Is easily victimized by other children	3.0

APPENDIX E

CONSENT FORM FOR RESEARCH

I am studying how children handle difficult problems and how they control their feelings. I am also interested in how children from different backgrounds feel about themselves and feel about how much control they have over things that happen in their life. I plan to use this information to help kids become better able to deal with various problems in their lives, and I would be thankful if you and your child would be in this study.

This study asks your child to fill out several forms. The first form your child will be asked to fill out includes two made-up stories about a problem that has happened at school and at home. The questions on the form will then ask her how she would handle these events if they really happened to her. She will then be asked how she would feel when given made up stories about kids not getting along with her. She will also be given a form which will ask questions about how she feels about herself (for ex. "I think I am attractive."). Finally, she will be presented with made-up stories involving problems that other children sometimes have, and she will be asked to finish the stories herself. Some of these questionnaires may cause your child to become momentarily anxious or sad, particularly if she doesn't feel good about herself. If this does happen, I will contact her therapist at this facility to let them discuss these concerns. However, most children who have been in this study have reported that they enjoyed the experience.

In addition your child's involvement, I will also be asking teachers to fill out a checklist about your child's behavior in school, and how she relates to other children in her class. The teacher will be given no information about your child, aside from stating that they are participating in a research study conducted through the University of North Carolina at Greensboro. If this is okay, please sign the teacher consent area listed below.

It will take approximately 1 hour for your child to complete the questionnaires that she will be given. There is no cost for participating, aside from the cost of transporting your child to this facility. In return for her help, she will receive gift certificates to fast food restaurants and toys to thank her. In addition, your name will be entered in a raffle, with the first prize being $100.00, the second prize $50.00, and the third and fourth

prizes $25.00. Before beginning, I will explain to her what she will be doing, and remind her that she can stop at any time if she wishes. She will receive the gift certificates and toys even if she decides to discontinue with the study, and your name will still be entered in the raffle regardless of whether she completes the study.

Finally, it is also important that you know that all of your daughter's responses will be kept private. The confidentiality of this study's records identifying your daughter will be maintained within the principal investigator's locked file cabinet. Her identity will remain confidential if material from the record is used for publication or for educational purposes. However, her therapist will be contacted if your daughter appears to be distressed by the research experience. In addition, if your daughter reports that she is being physically, sexually, or psychologically abused, this will be reported to the Department of Social Services. Finally, no information will be given to her teacher or her school, and they will not be told that your daughter is a client at this facility.

Although personal benefit may not result from taking part in this study, knowledge may be gained that will benefit others. If you decide that you would like your child to participate in this study, please sign your name in the space provided. Thank you for your attention to this matter.

Sincerely,

Lori Thompson, MA

I give my child, _____, permission to be in this study.

Signature: _____ Date: _____

CONSENT FORM FOR RESEARCH FOR MINOR

As I mentioned to your parents, I would like you to help me in a study about how children handle difficult problems and how they control their feelings. I am also interested in how children from different backgrounds feel about themselves and about how much control they feel they have over things that happen in their life. I would be thankful if you would be in my study by filling out a few forms. You will be given gift certificates to fast food restaurants and toys to thank you for your help.

One important thing to remember is that your participation in this project is completely voluntary. That means that even if you decide to help us, you will be able to stop at any time during the experiment if you want, and you will still get the fast food coupons and toys. It also means that if you decide you don't want to help, no one will be upset with you.

You should also know that none of the information you give to me today will be given to your parents or anybody else. So you should feel free to answer the questions knowing that your answers will be kept confidential. The only time I would talk to your therapist is if you tell me that somebody is trying to hurt you or you are planning to hurt somebody else, or if you seem to be very upset with the questions I'll be asking you. However, most kids that I've talked to so far seemed to have enjoyed the study.

If you think you would like to help me by filling out a few forms, please sign the line below. Thanks.

Sincerely,

Lori Thompson, MA

I, _____, would like to be in this study.

Date: _____

CONSENT FOR RELEASE FOR TEACHER'S PARTICIPATION

I give my child's teacher, _____,
at _____ School permission to
fill out questionnaires about my child,
_____ for a research study being
conducted by Lori Thompson, MA., a graduate student at the
University of North Carolina at Greensboro.

Signature: _____ Date: _____

TABLE 1

MEANS AND STANDARD DEVIATIONS TABLE
COVARIATES BY GROUP

	Group 1 (SA)	Group 2 (PC)	Group 3 (NC)
SES	M=29.318 SD=6.924	M=33.440 SD=14.110	M=41.519 SD=13.805
IQ	M=6.000 SD=3.729	M=8.200 SD=3.571	M=9.741 SD=2.795

TABLE 2

CORRELATION TABLE
SES AND IQ WITH DEPENDENT MEASURES

	SES	IQ
Adaptive Functioning	.0963 (33) p=.594	.3535 (33) p=.042
Sum of Behavioral Problems	-.1073 (35) p=.540	-.3015 (35) p=.078
Coping Cognitive Avoidance	-.0100 (74) p=.890	-.1000 (74) p=.3790
Coping Behavioral Avoidance	.0500 (74) p=.650	-.1200 (74) p=.284
Social Attribution Incompetence	-.2044 (74) p=.081	-.3594 (74) p=.002
Piers-Harris Total	.3638 (74) p=.001	.3163 (74) p=.006
Wayland Perception of self	.0126 (73) p=.916	-.0879 (73) p=.460
Wayland Perception of other	.2374 (73) p=.043	.0514 (73) p=.666
Q-sort	.2131 (35) p=.219	.3026 (35) p=.077

TABLE 3

CORRELATION TABLE FOR WHOLE SAMPLE

	AFSUM	TRSUM	COGAVODS	BEHAVODS	INCOMPET	OTHER	SELF	QSORT	PHARRIS
AFSUM	1.000 (33) P=.	-.8071 (33) P=.000	-.1505 (33) P=.403	-.2655 (33) P=.135	-.1533 (33) P=.394	.2156 (33) P=.228	.2879 (33) P=.104	.8289 (30) P=.000	.2457 (33) P=.168
TRSUM		1.000 (35) P=.	.2086 (35) P=.229	.3404 (35) P=.045	.2046 (35) P=.238	-.2550 (35) P=.139	-.3472 (35) P=.041	-.8515 (35) P=.000	-.0964 (35) P=.582
COGAVODS			1.000 (74) P=.	.6327 (74) P=.000	.2549 (74) P=.028	-.1847 (73) P=.118	-.1913 (73) P=.105	-.2170 (35) P=.210	-.0827 (74) P=.483
BEHAVODS				1.000 (74) P=.	.2357 (74) P=.043	-.3266 (73) P=.005	-.2266 (73) P=.054	-.3603 (35) P=.034	-.3095 (74) P=.007
INCOMPET					1.000 (74) P=.	-.0802 (73) P=.500	-.1200 (73) P=.312	-.0658 (35) P=.707	-.3442 (74) P=.003
OTHER						1.000 (73) P=.	.6431 (73) P=.000	.1208 (35) P=.489	.1551 (73) P=.190
SELF							1.000 (73) P=.	.2828 (35) P=.100	.0768 (73) P=.518
Q-SORT								1.000 (35) P=.	.2860 (35) P=.096
PHARRIS									1.000 (74) P=.

TABLE 4

CORRELATION TABLE FOR SEXUALLY ABUSED GROUP

	AFSUM	TRSUM	COGAVOBS	BEHAVOBS	INCOMPET	OTHER	SELF	QSRTRAN	PHARRIS
AFSUM	1.000 (14) P=.	-.7116 (14) P=.004	.2688 (14) P=.356	-.2370 (14) P=.415	-.1926 (14) P=.509	.5413 (14) P=.046	.2938 (14) P=.308	.7380 (12) P=.006	.1373 (14) P=.640
TRSUM		1.000 (14) P=.	-.0528 (14) P=.858	.4121 (14) P=.145	.4165 (14) P=.138	-.2931 (14) P=.309	-.2164 (14) P=.458	-.7552 (12) P=.005	-.0615 (14) P=.834
COGAVOBS			1.000 (22) P=.	.4570 (22) P=.032	.4183 (22) P=053	.1874 (22) P=.404	.1275 (22) P=.572	.0078 (12) P=.981	-.1661 (22) P=.460
BEHAVOBS				1.000 (22) P=.	.4863 (22) P=.022	-.1533 (22) P=.496	-.0681 (22) P=.763	.3703 (12) P=.236	-.4230 (22) P=.050
INCOMPET					1.000 (22) P=.	-.0666 (22) P=.768	-.0336 (22) P=.882	-.0426 (12) P=.896	-.5866 (22) P=004
OTHER						1.000 (22) P=.	.5729 (22) P=.005	.4549 (12) P=.137	-.0339 (22) P=.881
SELF							1.000 (22) P=.	.6504 (12) P=.022	.0094 (22) P=.967
QSORTRAN								1.000 (12) P=.	-.0513 (22) P=.874
PHARRIS									1.000 (22) P=.

TABLE 5

CORRELATION TABLE FOR PSYCHIATRIC CONTROL GROUP

	AFSUM	TRSUM	COGAVODS	BEHAVODS	INCOMPET	OTHER	SELF	QSRTRAN	PHARRIS
AFSUM	1.000 (13) P=.	-.8023 (13) P=.001	.0308 (13) P=.920	-.2381 (13) P=.443	-.0414 (13) P=.893	-.2145 (13) P=.482	-.1426 (13) P=.642	.8804 (12) P=.000	.4798 (13) P=.097
TRSUM		1.000 (14) P=.	.0729 (14) P=.804	.2982 (14) P=.300	.1999 (14) P=.493	.2270 (14) P=.435	.0775 (14) P=.792	-.8547 (13) P=.000	-.3217 (14) P=.262
COGAVODS			1.000 (25) P=.	.6709 (25) P=.000	.1083 (25) P=606	-.2400 (24) P=.259	-.4126 (24) P=.045	.0987 (15) P=.726	.0455 (25) P=.829
BEHAVODS				1.000 (25) P=.	.0807 (25) P=.701	-.3901 (24) P=.059	-.3207 (24) P=.127	-.2255 (15) P=.419	-.2801 (25) P=.175
INCOMPET					1.000 (25) P=.	-.3266 (24) P=.119	-.3556 (24) P=.088	-.0811 (15) P=.774	-.2186 (25) P=918
OTHER						1.000 (24) P=.	.5632 (24) P=.004	-.3508 (15) P=.200	.1449 (24) P=.449
SELF							1.000 (24) P=.	-.2820 (15) P=.308	-.0836 (24) P=.698
QSORTRAN								1.000 (15) P=.	.5201 (15) P=.047
PHARRIS									1.000 (25) P=.

TABLE 6

CORRELATION TABLE FOR NORMAL CONTROLS

	AFSUM	TRSUM	COGAVODS	BEHAVODS	INCOMPET	OTHER	SELF	QSRTRAN	PHARRIS
AFSUM	1.000 (6) P=.	-.2626 (6) P=.615	.1443 (6) P=.785	.0712 (6) P=.893	.5148 (6) P=.296	.0253 (6) P=.962	.2084 (6) P=.692	-.1901 (6) P=.718	-.5893 (6) P=.218
TRSUM		1.000 (7) P=.	.0408 (7) P=.931	.0798 (7) P=.865	-.3512 (7) P=.440	-.8009 (7) P=.030	-.8732 (7) P=.010	-.6908 (7) P=.086	.4320 (7) P=.333
COGAVODS			1.000 (27) P=.	.7945 (27) P=.000	.1036 (27) P=607	-.2457 (27) P=.217	-.2461 (27) P=.216	-.1060 (8) P=.803	.1234 (27) P=.540
BEHAVODS				1.000 (27) P=.	.1208 (27) P=.548	-.3127 (27) P=.112	-.2489 (27) P=.211	-.4747 (8) P=.235	-.0584 (27) P=.772
INCOMPET					1.000 (27) P=.	.2675 (27) P=.177	.0802 (27) P=.691	-.2939 (8) P=.480	-.4566 (27) P=217
OTHER						1.000 (27) P=.	.6734 (27) P=.000	.4335 (8) P=.283	.0141 (27) P=.944
SELF							1.000 (27) P=.	.6589 (8) P=.076	-.0760 (27) P=.706
QSORTRAN								1.000 (8) P=.	.3276 (8) P=.428
PHARRIS									1.000 (27) P=.

TABLE 7
MEANS AND STANDARD DEVIATIONS TABLE
CBCL (TRF) FACTORS BY GROUP

	Group 1 (SA)	Group 2 (PC)	Group 3 (NC)
Adaptive Functioning	M=16.500 SD=3.737	M=13.923 SD=6.020	M=24.167 SD=3.312
Sum of Behavioral Problems	M=57.857 SD=8.969	M=64.071 SD=9.849	M=47.857 SD=6.517

TABLE 8

MEANS AND STANDARD DEVIATIONS TABLE
DEPENDENT MEASURES BY GROUP

	Group 1 (SA)	Group 2 (PC)	Group 3 (NC)
Coping Cognitive Avoidance	M=13.409 SD=8.770	M=14.240 SD=6.815	M=10.407 SD=7.582
Coping Behavioral Avoidance	M=7.500 SD=5.162	M=8.800 SD=6.745	M=6.037 SD=4.345
Social Attribution-Incompetence	M=5.227 SD=3.841	M=4.040 SD=2.922	M=3.333 SD=2.760
Piers-Harris Total	M=54.000 SD=12.976	M=55.080 SD=13.115	M=63.667 SD=9.648
Wayland Perc-self	M=11.045 SD=1.558	M=11.542 SD=1.351	M=12.037 SD=2.028
Wayland Perc-other	M=10.545 SD=1.625	M=10.917 SD=2.062	M=12.259 SD=2.640
Q-sort	M=.354 SD=.388	M=-.021 SD=.376	M=.682 SD=.151