AN ABSTRACT OF THE DISSERTATION OF

Nancy K. Hall for the degree of Doctor of Philosophy in Human Development and Family Studies on August 8, 2001. Title: The Impact of Maltreatment on Adolescent Substance Abuse.

Abstract approved: Redacted for Privacy

Patricia B. Moran

THE IMPACT OF MALTREATMENT ON ADOLESCENT SUBSTANCE ABUSE

While the general link between adolescent maltreatment and adolescent substance abuse is well established, questions remain regarding factors that may explain variability in the strength of this link. This study examines whether the link between maltreatment and substance abuse varies across three categories of maltreatment: physical, sexual and emotional. It also examines gender differences and timing of abuse (past or current). This study also examines the level of parental monitoring and what effect parental monitoring has on

maltreated adolescents and their use of substances.

Survey data were collected from six public schools in a rural Southwestern Oregon County on experience of maltreatment (emotional, physical and sexual) and use of substances (tobacco, alcohol and illicit drugs), gender differences and level of parental monitoring. Data were analyzed using t-tests and regression models.

Results indicated that youth who currently experienced emotional, physical or sexual abuse were significantly more likely to use tobacco, alcohol, and illicit drugs than were youth who had experienced abuse in the past. They also indicated a significant interaction between gender and physical abuse, sexual abuse and emotional abuse (past and present combined) in predicting illicit drug use with males using illicit drugs at a significantly higher rate than females. As predicted, a significant interaction was found between parental monitoring and maltreatment/no maltreatment in predicting drug use. Maltreated youth with low levels of parental monitoring were significantly

more likely to have high levels of substance use than were maltreated youth with high levels of parental monitoring.

These results give rise to the need for further research into this subject to aid counselors in helping youth, especially male youth, in substance abuse treatment.

Results of this study suggest a need for substance abuse treatment counselors to educate the parents of the treatment clients to closely monitor their adolescent as a possible means of reducing substance abuse.

THE IMPACT OF MALTREATMENT ON ADOLESCENT SUBSTANCE ABUSE

by

Nancy K. Hall

A DISSERTATION

submitted to

Oregon State University

in partial fulfillment of

the requirements for the

degree of

Doctor of Philosophy

Completed August 8, 2001

Commencement June 2002

Doctor of Philosophy thesis of Nancy K. Hall presented on August 8, 2001.

APPROVED:

Redacted for Privacy

Major Professor, representing Human Development and Family Studies

Redacted for Privacy

Head of Department of Human Development and Family Studies

Redacted for Privacy

Dean of Graduate School

I understand that my dissertation will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my dissertation to any reader upon request.

Redacted for Privacy

Nancy K. Hall, Author

ACKNOWLEDGMENTS

I would like to express by deepest gratitude to my major advisor Dr. Patricia Moran. I greatly appreciate her guidance and patience through my graduate studies. This work could not have been possible without my major advisor's input, inspiration and belief in me, and my life goals.

I would like to thank Dr. Sam Vuchnich, Dr. Alan Sugawara, Dr. Mina Carson and Dr. Cheryl Jordan for sharing their ideas and expertise with me through this process.

I would like to thank my husband, Darrell D. Hall, who knew what it took for me to put the pieces together and reminded me over and over again of that process. I thank my children, Derek and Shawna Hall, for their belief in me, and my ability to persevere. My dearest friend Gerry Golden has my undying gratitude for just being my dearest friend. My good friend Karen Salley who always believed in my abilities and tenacity, and I appreciate her so much. Without my dear friend Susan K. Matteson, the last days of this dissertation process would have been unbearable. I thank you all from the bottom of my heart.

TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

TABLE OF CONTENTS (continued)

LIST OF TABLES

THE IMPACT OF MALTREATMENT ON ADOLESCENT SUBSTANCE ABUSE

Chapter One

Introduction

According to the Substance Abuse & Mental Health Services Administration (SAMHSA) Office of Applied Studies (1999), among youths ages 12-17 years, eleven percent have used illicit drugs. SAMHSA also reports that 10.5 million youths between the ages of 12 and 20 use alcohol, and 6.8 million engage in binge drinking, including 2.1 million who would also be considered heavy drinkers. According to Debra Costa, (2000) the number one health problem in the country is substance abuse because it places an enormous burden on American society as a whole. Substance abuse harms health, family life, the economy and public safety. Substance abuse affects all segments of society and threatens the future of young people.

Like substance abuse, physical, emotional and sexual maltreatment is also a serious problem in the lives of many adolescents. According to the Council on Scientific Affairs

(1993), research suggests that adolescents may be at equal risk or even greater risk of family violence in comparison to younger children. In 1991, 2.5 million cases of child abuse were reported to child protective services. This equals a rate of 42 cases per 1000 children. Twenty-five percent of those cases were adolescents. In a report by the Florida Child Protective Services (1998), 192,666 children were identified as alleged victims of abuse in Florida and 35% of those children were ages 10 through 17.

Despite the fact that we consider and treat substance abuse and adolescent maltreatment as separate problems, research shows that, in fact, they are often linked. According to Kilpatrick, Acierno, Suanders, Resnick, Best and Schnurr (2000) adolescents who have been physically assaulted, who have been sexually assaulted or who have witnessed violence have increased risk for current substance abuse. A study by Luster and Small (1997) found a significant main effect between sexual abuse and binge drinking. Further, youth who had been both sexually and

physically abused, were almost twice as high as those who had been sexually abused only. The link between all types of abuse has been the focus of much research with the outcome showing a need for the abused to use substances as a way of avoiding their pain (Spear & Skala, 1998; Martin, 1996; Kaminer, 1999; Rotheram-Borus, 1996; Hussey, 1996; Singer, Song & Ochberg, 1994).

While the general link between adolescent maltreatment and adolescent substance abuse is well established, questions remain regarding factors that may explain variability in the strength of this link. This study examines whether the link between maltreatment and substance abuse varies across three categories of maltreatment: physical, sexual and emotional. It also examines gender differences and timing of abuse (past or current). This study also examines the level of parental monitoring and if monitoring effects substance abuse.

Chapter Two

Literature Review

The literature review begins with definitions of physical, sexual and emotional abuse. It then examines estimates of the incidence of adolescent abuse. The review then explores developmental issues pertaining to adolescent abuse. Characteristics of abusive families are then examined, followed by discussions of the impact of physical, sexual and emotional abuse. The review then examines research on the link between the experience of abuse and the use of substances during adolescence. It also examines the contribution of factors such as adolescent development, family issues, family structure, age, and gender in the relationship between maltreatment and substance abuse. Finally, the review examines the role that parental monitoring plays in reducing substance abuse among abused adolescents.

Defining Abuse

The Council on Scientific Affairs (1993) offered the following definitions for the major types of maltreatment:

Physical Abuse

Physical acts that caused or could have caused physical injury to the child.

Sexual Abuse

Involvement of a child in sexual activity to provide sexual gratification or financial benefit to the perpetrator, including contacts for sexual purposes, prostitution, pornography, or other sexually exploitative activities.

Psychological or emotional abuse

Acts or omissions that caused, or could have caused, conduct, cognitive, affective, or other mental disorders.

There is growing agreement that psychological maltreatment is the core issue in child maltreatment. The strength of this position rests on the widely supported

assumptions that (a) psychological maltreatment is inherent in all forms of child maltreatment; (b) the major negative effects of child maltreatment are generally psychological in nature, affecting the victim's view of self, others, human relationships, goals, and strategies for living; and (c) the concept clarifies and unifies the dynamics that underlie the destructive power of all forms of child abuse and neglect. Abuse conveys the message that those to whom the child looks for protection and nurturance are unreliable and indeed may be hurtful and therefore psychologically harmful (Hart & Brassard, 1987; Garbarino, 1980).

According to Cavaiola & Schiff (1988), while abused victims differ significantly from their nonabused counterparts in some ways, there are few differences that distinguish victims in regard to the type of abuse they experienced (i.e., physical abuse, sexual abuse, incest/physical abuse, and incest). This may relate to the common elements in all types of

abuse (i.e., victimization, powerlessness, and exploitation).

Incidence of Maltreatment

According to a Council Report in the Journal of the American Medical Association (1993) accurate estimates of the incidence of maltreatment are difficult to obtain. Reports of maltreatment are likely to be fewer than the actual incidence due to reluctance of victims to admit the occurrence of abuse and the likelihood that many cases are not identified or reported.

Adolescents are even less likely than younger children to be identified because they typically incur less serious physical injuries and so are less likely to require medical care or to be identified as abuse victims when care is sought (Council Report, 1993). Also, adolescent victims are more likely to be served by alternative youth-serving agencies, such as runaway centers, which are not surveyed for official reports and may not report abuse to child protective agencies due to beliefs that appropriate services for adolescents are not

available (Council Report, 1993). One study found that only 39% of the adolescent maltreatment cases were reported to child protective agencies compared to 76% for younger children (Garbarino, Sebes & Schellenbach, 1984).

According to the Council Report (1993), in the recent past there has been increased recognition of family violence and child maltreatment as problems that affect adolescents as well as younger children. Results of two national studies of child abuse and neglect (Council Report, 1993), indicated that recent increases in the number of reported cases of maltreatment have occurred disproportionately among older children and adolescents. The overall incidence of abuse and neglect in adolescents is either higher or the same as that of younger children.

Variations in state and local practices in reporting or substantiating reports of maltreatment also contribute to underestimates of the number of adolescent victims (Council Report ,1993). Substantiated cases are those in

which a child protective service agency finds enough evidence to prove that maltreatment has occurred. Cases may fail to be substantiated because a youth shows no physical injuries or recants his or her disclosure, both of which occur frequently for adolescents (Council , 1993). Failure to substantiate does not always indicate that no maltreatment occurred. Cases in which adolescents are abused by nonfamily members are not handled by child protective services and therefore not included in official reports (Council Report, 1993). Due to the funding criteria for child protective services, the cutoff age for helping children is age 11.

Impact of Abuse During Adolescence

Difficulties in adolescence and adulthood often have earlier precursor patterns (Zahn-Waxler, 1996). Problems become increasingly evident during adolescence when previous supports are no longer present and new developmental tasks are imposed for which the individual is not prepared (Zahn-Waxler, 1996). Zahn-Waxler (1996) believes this may

particularly be the case for vulnerable individuals who have experienced early adversity, stress, and trauma.

In a study of Vietnam veterans, Van der Kolk (1985) found that combat exposure during adolescence was more likely to result in Post Traumatic Stress Disorder (PTSD) than exposure as an adult. Similarly, studies by Kaplan, Salzinger, and Weiner, (1994) found that adolescents who were raped were more likely to have enduring psychological difficulties than were older rape victims. These findings are not surprising in light of the impact that trauma is likely to have on the major developmental tasks of adolescence: identity formation, separation from one's family of origin, and emerging sexuality.

One major developmental change during adolescence is the transition from concrete to abstract thinking. With the increasing power of abstract thought, adolescents begin to conceptualize each other's inner thoughts and feelings, and adolescent friendships involve considerable self-revelation. Self-understanding

develops an introspective quality. It includes a more articulated sense of self as a stable personality and involves an integration of aspects of self into a whole (Cole & Putnam, 1992). During these developmental changes, youths experience multiple levels of themselves as they strive to identify and like whom they really are throughout adolescence. The task of identity formation requires the adolescent to integrate complex self-related features and consolidate them into a unified, continuous sense of self that is compatible with the self-view and the view of others (Cole & Putnam, 1992). These tasks are complex transitions the adolescent must go through to become a whole contributing member of society.

According to Brooks (1985), emotional disturbances in adolescence are heightened by developmental changes in cognitive ability, by physical growth and sexual maturation—particularly, the onset of menstruation, and by psychological factors. In real life there is no way to keep these three powerful sources of influence separate. Deep psychodynamic concerns

influence the adolescent's cognitive and physical responses to the world; the adolescent's cognitive description of the world shapes the adolescent's emotional response; and the adolescent's biological processes further shape psychological concerns.

When sexually abused adolescents search within and without for personal identity, the need to maintain one's parents/guardians as "good persons" must necessarily come into conflict with the growing sense of self. Consequently, adolescents with abuse experiences are left with a need for repression and denial on the one hand, and a need for the "truth" about their parent's/guardian's behavior on the other. The strength of the repression and denial associated with a history of sexual abuse frequently has the effect of inhibiting or terminating the adolescent's search for "Truth" (Brooks, 1985).

Mouzakitis (1984) believes the effects of chronic abuse on children once they become adolescents usually are manifested by antisocial behavior. Offenses may include minor status

actions, but as a rule they are nonstatus actions such as armed robbery, breaking and entering, forgery, and use and possession of drugs. Interpersonal relationships of the chronically abused are characterized by aggression, hostility, mistrust, and inability to establish meaningful relationships with peers and adults. Children feel dehumanized and discounted by their own parents and others with whom they come in contact. Their self-concept is poor adding to their inability to relate to others and to achieve academically. Their unpredictable attachments result in dysfunctional attempts to resolve their adolescent developmental difficulties. They deal unsuccessfully with their need for a new identity, with their efforts to become independent, and with their sexual maturation through actions that contribute little to the resolution of these problems. Many are found to be sexually promiscuous, are unreliable in assigned duties, use drugs, and have poor ties with their peer group.

At one level, the abused adolescent is at an advantage in comparison to the abused child because of a greater ability to defend himself or herself both physically and verbally. The abuse, however, may affect the adolescent's ability to integrate past, present, and future expectations into a lasting sense of identity (Kaplan et al., 1994). This may have particular impact on the adolescent's ability to plan constructively for the future.

A sexualized relationship with the father, represents a highly deviant social experience at a time when the adolescent is trying to absorb his/her changing sexual identity and to explore opposite-sex peer relationships. The continuing developmental task of integrating the multiple and changing aspects of self into a coherent whole is significantly jeopardized. If the victim has had to rely on coping through denial and dissociation, the risk for severe psychopathology is heightened. Reliance on relatively immature coping strategies increases the likelihood of acting impulsively when frustrated, depressed, or anxious (typically by

engaging in misconduct, such as substance abuse, sexual acting out, running away, and other self-destructive behaviors). The incest experience interferes with these necessary developmental transitions in a manner that increases the risk of serious psychopathology (Trolley, 1995; Cole & Putnam, 1992).

In a study of sexually abused adolescents, Aiosa-Karpas, Karpas and Pelcovitz, (1991) found that, compared with matched psychiatric and "normal" controls, abused adolescents had career expectations well below their potential. Similarly, at an age when peer relationships are a crucial force in facilitating individuation from parents, abuse victims are at particular risk for impaired ability to rely on peers as a source of support.

Kaplan, et al (1994) say adolescent abuse is frequently found to be associated with the normal developmental efforts of adolescents toward separation and autonomy from parental control; 90% of incidents that preceded adolescent abuse involved an adolescent disobeying or arguing with a parent. Adolescents

may not even recognize their abuse as being more than usual discipline because there are negative societal attitudes toward adolescents regarding parental and other authority control issues. Adolescent abuse is further complicated by the developmental level of both the teenager and the family. The adolescent's appropriate need for greater independence and explorative behavior by definition implies that the adolescent must begin to separate from the family (Kaplan, et al, 1994).

Parents who demonstrate insufficient knowledge and understanding of normal child development, who accept the belief that corporal punishment is necessary in child rearing, and who have weak inhibitions against aggression toward children do not accept the changes their adolescents are going through. The possibility of both parent and teenager entering a transitional developmental phase, with the child becoming an adolescent and the parent entering midlife, may also subject the family to greater strain (Kaplan, et al, 1994).

Characteristics of Abusive Families

Brassard, Germain, and Hart, (1987) summarized the multiple factors of maltreatment that contribute to maltreatment. Abusing parents can enter the family with developmental histories that may predispose them to be abusive to their children. Stress-promoting events or forces within the immediate family increase the likelihood that parent-child conflict will occur. When a parent's response to such conflict and stress takes the form of child maltreatment the response is seen as the result of both the parent's own experience as a child and of the values and childrearing practices that characterize the society or subculture in which the individual, family, and community are embedded.

There are certain general characteristics in individuals and families who have violent as well as chemical dysfunctions; while none are invariably predictive of present family violence, their presence merits consideration. They are as follows: (1) a family which can come to no common agreement on reality, on what

actually happened or when it happened, whatever the incident being discussed, (2) a family in which one or more members demonstrate a pronounced inability to handle anger or fear appropriately, or a family in which several members show this inability in relation to another specific family member, (3) a family which deals with all feelings angrily, such as showing love by painful tickling or ridicule, showing sadness with hostility, showing resentment by use of the "silent treatment", (4) a family which gives any one member a great deal of extra space, and appears to act upon that member's verbal or nonverbal communication cues immediately, whatever those cues may be, (5) a family which engages in both revenge-based interaction and secret keeping (Potter-Efron & Potter-Efron, 1985).

According to Potter-Efron and Potter-Efron (1985), there are four attitudes toward parenting that can be indicative of parents who are more likely to be or become abusive with their children: (1) low empathy; (2) strong

belief in corporal punishment; (3) inappropriate age expectations; and (4) role reversal.

Abusive families have been reported to demonstrate poor communication skills, recurrent family or marital stress, inappropriate behavioral expectations of the victim, role confusion or reversal, stepfamily relationships, overreliance on physical punishment for disciplining, and inadequate knowledge of child rearing and nurturing (Kaplan, et al, 1994). Kaplan reports these families exhibit less communication with their children, more inconsistency and intrusiveness in their reactions to their children, and a greater proportion of negative interactions with others in the family. Moreover, they have also demonstrated a greater use of aversive discipline (Kaplan, et al, 1994).

According to Gabarino, et al (1984), high-risk families are characterized by a formidable set of enduring potentiating factors (e.g., chronic internalized developmental problems, positive values and attitudes concerning coercion, and a "chaotically enmeshed"

interpersonal system) and are thus vulnerable as the child enters adolescence. Low-risk families, on the other hand, are characterized by more protectors (e.g., a "flexibly connected" family system, a disavowal of coercion, and a more supportive, less punishing style of parenting) and more buffers (e.g., greater adolescent social competence). It appears that many low-risk families can absorb adolescent psychopathology without precipitating maltreatment.

While parenting style alone is not sufficient to predict if or when maltreatment will occur, it may influence the resolution of parent-adolescent conflicts and the way in which discipline is exercised. Use of physical force as a means of discipline may pose a high risk of abuse in the case of adolescents (Council Report, 1993).

In a study by Pelcovitz, Kaplan, Goldenberg, Mandel, Lehane, and Guarrera, (1984) abusers in authoritarian type families portrayed their families of origins as having had harsh and rigid expectations and reported

complying with their parent's rules and regulations even when they considered them unjust. The abusive parent in these families reported little awareness of any feelings of anger or resentment which had been harbored against their parents as a result of this child-rearing pattern. Typically the thoughts or feelings of these parents were seen as either all good or all bad. This cognitive style is particularly troublesome in dealing with adolescent issues. The abuse seen in this group was often a result of the inability of these parents to acknowledge differences or to develop skills essential in negotiating with adolescents. Since adolescence coincides with the achievement of more mature reasoning ability, for the first time children in these families challenged their parents at the cognitive level of an adult. These parents were unprepared for this developmental stage.

Janus, Archambault, Brown, and Welsh, (1995), suggested that the nature of the abusive parent-child interaction itself rather than the number and nature of occurrences was most

directly related to negative behaviors and emotional dysfunction on the part of the adolescent. They noted that duration of abuse may not be as salient a factor as the presence of abuse itself, in that those who were abused on only one occasion showed the same behavioral and emotional sequelae as those abused on multiple occasions.

According to Chandy, Blum, and Resnick, (1996), numerous investigators have identified the stepfamily as a high-risk setting for abuse, particularly for adolescents. Living with biological parents seems to be a protective factor. Other studies have reported that a larger proportion of abused children come from single or reconstituted families and that having a stepfather and living without a natural parent are risk factors (Chandy, et al, 1996). Sociobiological principles (less parental investment in children not having a genetic connection) and social-psychological phenomena (interpersonal challenges of complex, multiple, and often competing patterns of interaction, reinforcement histories, and cognitive

attributions) come together to predict that stepfamilies will be a higher risk context for maltreatment, particularly when the adolescent is malfunctioning (Garbarino, et al 1984).

In Garbarino's, et al (1984) study the pathology of adolescents in stepfamilies was seen as greater than adolescents in other high-risk groups. The stepfamily situation illustrates that the overall developmental impact of psychopathology depends in large measure on the context established by the family as a social system, and that adolescence is a special challenge in its own right. According to Garbarino, et al (1984), stepfamilies having enduring protectors (e.g. a "flexibly connected" family system, lack of coercion, and a more supportive, less punishing style of parenting) can absorb adolescent psychopathology without precipitating maltreatment.

The Impact of Physical Abuse

According to Straus and Kantor (1994), one of the reasons so few parents and social scientists question the wisdom of "spare the rod

and spoil the child" and few researchers have investigated the potential adverse effects of physical punishment is because, in legal terms, it is permissible. In terms of informal cultural norms, physical punishment is expected of parents when a child persists in misbehaving. Both the law and the informal culture assume that, when done "in moderation," corporal punishment is harmless and sometimes necessary.

Physical abuse of 12-18 year olds in the United States comprises 43% of the legally documented cases of the physical abuse of female children younger than age 18 and 28% in males younger than age 18 (US Dept. of Health and Human services, Children's Bureau, 1994).

According to Kaplan, Pelcovitz, Salzinger, Mandel, and Weiner, (1997) physical abuse is considered both a traumatic stressful event and a chronic stressor because it often occurs within the context of conflict over parental control and adolescent individuation, which are prominent characteristics of adolescent family

life. Both physical abuse and suicide attempts are often precipitated by disciplinary crises (Pelcovitz et al., 1984)

Kiser, Heston, Millsap, and Pruitt, (1991) studied the relationship between physical abuse and sexual abuse with post-traumatic stress disorder saying that children who have experienced physical and/or sexual abuse tend to show heightened anxiety as evidenced by hypervigilance, impaired impulse control, enuresis, sleep disturbances, and socially inappropriate behaviors. They cope with the trauma through repetition of the assault in dreams, fantasy, aggressive play, self-destructive behaviors, and delinquency. Symptoms of depression are also common and include depressive affect, impaired self-concept, and feelings of helplessness.

A study by Barber, McParland, O'Malley, Pope and Coyne (1994), of abused children and adolescents, looked at the difficulties of treating this population. Their treatment facilitators saw physically abused youth as both more self-destructive and more accepting of

intervention than other patients. These findings are consistent with clinical observations that, even in the context of severe behavioral and emotional problems, many physically abused children are quite engaging. Barber, et al (1994) go on to say the youth may engage with supportive adults in order to win the attention they miss in their families, or, for some, this pattern of interacting in an engaging way may develop in attempts to mollify the abusing adult and stave off further abuse.

Cases of adolescent abuse remain hidden because there is a belief that adolescents can take care of themselves and because they usually deserve the punishment they get. These are sentiments that may be shared by the physically abused adolescent himself or herself: they are bad, worthless, and deserving of punishment. Hence, not only are others predisposed not to report adolescent abuse, adolescents are themselves unlikely to self- report abuse they believe is deserved (Janus et al., 1995).

In a study on Post Traumatic Stress Disorder in physical abuse, Pelcovitz's et al.,

(1994) suggested that physically abused adolescents may be more at risk for emotional, behavioral, and social difficulties than for PTSD. Child mental health professionals, in designing accurate assessment and treatment strategies for physically abused adolescents need to screen carefully for depression, conduct disorder, and social difficulties.

According to Pelcovitz et al (1994) clinicians need to be aware that even when adolescents show no trauma-specific symptomatology and deny that the abuse had any impact on their functioning, these disorders may be present. Mental health professionals also need to be aware that the absence of PTSD in adolescence does not rule out the possibility that the adolescent was physically abused. Physical abuse often occurs as an extension of child discipline that relies on the use of corporal punishment. In a culture that often condones such disciplinary practices, the adolescent may not view more severe physical punishments as something unique and out of the "ordinary." Physically abused adolescents, in

contrast to sexual abuse survivors, showed little embarrassment and/or secrecy in their discussions regarding beatings they received at the hands of their parents. In fact, they often appeared surprised that anyone would make such an issue of a process they considered "normal" and not worthy of anyone's interest.

The Impact of Sexual Abuse

Studies of children and adolescents have reported greater disturbance in children sexually abused during the pre-teen and teenage years compared to children abused at younger ages. Children who were first sexually molested between the ages of 10 and 15 received more severe diagnoses and were more likely to be referred for inpatient treatment compared to children first molested prior to age 10 (Beitchman, Zucker, Hood, DaCosta, & Akman, D. 1991).

Most incest victims must cope with multiple aspects of the experience: (a) physical and psychological trauma in the form of the actual sexual experiences, including violation of one's

body; (b) extended periods of apprehension, guilt, and fear between sexual contacts; and (c) the loss of a trusted relationship with an emotionally significant person (Cole & Putnam, 1992).

Cole and Putnam (1992) regarded the specific effects of the pervasive, sustained stress of incest to be most pronounced in domains of self-development, specifically in terms of the development of physical and psychological self-integrity, and the development of self-regulatory processes, particularly regulation of affect and impulse control. Moreover, the development of self is integrally related to social development and a sense of others; sexual abuse by a parent violates the child's basic beliefs about safety and trust in relationships, disturbing both the sense of self and the ability to have satisfying relationships in which one feels loved and protected. In fact, the typical child's social supports in incestuous families are the source of distress. Parental authority and societal standards, which value the privacy of the

family, limit the likelihood of successful disclosure (Cole & Putnam, 1992).

According to Barber, et al (1994), sexually abused youngsters show a pattern of behaviors which overlaps with that of physically abused patients but shows some important differences. Both sexually and physically abused patients were rated as more self-destructive than patients without known abuse history. In contrast to physically abused patients, sexually abused patients tended to be seen as having an infantile, demanding style of relating to others, and were not seen as particularly accessible to treatment. Both sexually and physically abused patients were rated as more self-destructive than patients without known abuse history.

Many activities used to cope with the pain of sexual abuse are problematic because they tend to be self-destructive or lead to further problems or both. Avoidance behaviors used by victims of sexual abuse include the use of alcohol and other drugs, indiscriminate sexual behavior, and bulimia (Luster & Small, 1997).

Caffaro-Rouget, Lang, and vanSanten, (1989) say the closer the relationship of perpetrator and child, the greater the trauma suffered by the child. Duration of abuse, especially if genital penetration occurs and, secondly, severity of abuse, use of force or threatening gestures, result in more trauma for the child.

Finkelhor and Browne (1985) proposed a framework for a more systematic understanding of the effects of child sexual abuse. Four traumagenic dynamics---traumatic sexualization, betrayal, stigmatization, and powerlessness --- were identified as the core of the psychological injury inflicted by abuse.

Traumatic sexualization refers to a process in which a child's sexuality (including both sexual feelings and sexual attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse (Finkelhor & Browne, 1985).

Betrayal refers to the dynamic by which children discover that someone on whom they were vitally dependent has caused them harm. This may

occur in a variety of ways in a molestation experience. For example, in the course of abuse or its aftermath, children may come to the realization that a trusted person has manipulated them through lies or misrepresentations about moral standards. Children who are disbelieved, blamed, or ostracized undoubtedly experience a greater sense of betrayal than those who are supported (Finkelhor & Browne, 1985).

Powerlessness refers to the process in which the child's will, desires, and sense of efficacy are continually hindered. Many aspects of the sexual abuse experience contribute to this dynamic. The theory is that a basic kind of powerlessness occurs in sexual abuse when a child's territory and body space are repeatedly invaded against the child's will. Powerlessness is then reinforced when children see their attempts to halt the abuse frustrated. It is increased when children feel fear, are unable to make adults understand or believe what is happening, or realize how conditions of

dependency have trapped them in the situation (Finkelhor & Browne, 1985).

Stigmatization, the final dynamic, refers to the negative connotations---*e.g.*, badness, shame, and guilt--- that are communicated to the child around the experiences and that then become incorporated into the child's self-image. These negative meanings are communicated in many ways. They can come directly from the abuser who may blame the victim for the activity, demean the victim, or convey a sense of shame about the behavior. Pressure for secrecy from the offender can also convey powerful messages of shame and guilt. But stigmatization is also reinforced by attitudes that the victim infers or hears from other persons in the family or community. Stigmatization may grow out of the child's prior knowledge or sense that the activity is considered deviant and taboo, and it is certainly reinforced if, after disclosure, people react with shock or hysteria, or blame the child for what has transpired. Children may be additionally stigmatized by people in their environment who now attribute other negative

characteristics to the victim (loose morals, "spoiled goods") as a result of molestation (Finkelhor & Browne, 1985).

Finkelhor and Browne (1985) say these four traumagenic dynamics account for their view of the main sources of trauma in child sexual abuse. They are best thought of as broad categories useful for organizing and categorizing the understanding of the effect of sexual abuse.

The Impact of Emotional Abuse

While emotional abuse cannot directly kill, its effects are insidious. Instead of murdering the child, the result is a destruction of the spirit, a loss of the sense of self, a loss of belief that one can succeed, and a barrier to interactions with people. This form of abuse focuses on denial of life experiences, a discounting of the child, an invalidation of feelings, and a displacement of blame for adult and family problems, leaving the child without the normal experiences that produce feelings of

being loved, wanted, capable, and secure (Keith-Oaks, 1990).

These children begin to believe they negatively affect everything. They assume responsibility for all feelings and become so involved in their parent's needs, they have no real sense of their own feelings and needs. They live in an environment that lacks consistency and is very unpredictable. The child is confused because the parent is the one who is supposed to express love, yet the parent is inflicting maltreatment. Because the child is not allowed culturally to be angry with the parents, the message to the child may be "don't feel." Feelings, therefore, must be denied. Emotionally abusive parents often feel guilty about their inability to be consistent with their children and may switch from being overly rigid to overly permissive. The result is constant tension, "walking on eggshells" by the child, with no idea of what can be expected next (Keith-Oaks, 1990).

According to Garbarino (1980), a child has a rightful claim to 1) a responsive parent, one

who recognizes and responds positively to socially desirable accomplishments; and 2) a parent who does not inflict on the child the parent's own needs at the expense of the child's. Thus, an emotionally abusive parent may reject the infant's smiling, the toddler's exploration, the schoolchild's efforts to make friends, and the adolescent's privacy and autonomy. Such a parent demands that the infant gratify the parent's needs ahead of the child's, that the child take care of the parent, and that the adolescent subjugate herself to the parent's wishes in all matters (including, perhaps, sexual relations).

While emotional maltreatment occurs in the absence of physical abuse and neglect, the two are associated. What makes most physical assault abusive is its emotional significance. Physical harm per se does not necessarily imply developmental damage and certainly does not imply abuse. Physical injury derives its meaning (except in those cases where permanent impairment is produced) from the context in which it occurs. The behaviors of the parent

require interpretation by the child, and by "significant others." Indeed, one of the problems facing abusive parents is their isolation from the normal channels of feedback about the significance of their behavior (Garbarino, 1980).

According to Hart and Brassard (1987) there are two related theoretical explanations for the adverse developmental impact of psychological maltreatment on children: the coercion model and the organizational model. The coercion model emphasizes the influence of chains of actions and reactions among parents and children that progressively influence the quantity and intensity of hostile behavior. The organizational model emphasizes the importance of developmental psychosocial stages.

Psychological maltreatment is the core issue in child maltreatment. The concept clarifies and unifies the dynamics that underlie the destructive power of all forms of child abuse and neglect. In addition, it incorporates individual cases, as well as institutional and cultural practices, that would otherwise be

ignored. Most importantly, there is mounting evidence that psychological maltreatment per se is associated with the development of the severest forms of behavior disorders and developmental delays in children. These developments and findings indicate that psychological maltreatment, as well as child maltreatment in general, is a serious mental health threat that should be brought to the forefront of psychology's efforts in policy development, research, prevention, and intervention (Hart & Brassard, 1987).

The Link Between Physical Abuse and Substance Abuse

The link between physical abuse and substance abuse during adolescence has been studied by many researchers (e.g. Chandy, Blum & Resnick, 1996; Dembo, Dertke, Borders, Washburn, & Schmeidler, 1988; Dembo, Williams, Wish, Dertke, Berry, Getreu, Washburn, & Schmeidler; Singer,Petchers & Hussey, 1989; Rotheram-Borus, Mahler, Koopman, & Langabeer, 1996; Luster & Small, 1997; Harrison, Hoffman,&

Edwall, 1989; Baer, Garmezy, McLaughlin, Pokorny, & Wernick, 1987; Kaminer, 1999; Spear & Skala, 1998; Martin, 1996; Schiff & Cavaiola, 1991).

In a study by Baer, et al (1987), the researchers looked at alcohol as a stress reducer. They found that among older adolescents, alcohol use reduced stress, while younger adolescents were more inclined to use alcohol for the demarcation of developmental milestones and to gain social acceptance. In a family where the adolescent is abused, these mild uses of alcohol may develop into abuse as a way of escape.

In a study of physical abuse and suicide attempts, adolescent problems were assessed in terms of school failure, perception of inadequate peer and family, social and emotional support, and adolescent feelings of hostility, hopelessness, and lowered self-esteem. These vulnerabilities were expected to increase adolescent risk for mental disorders, especially depression, conduct disorder, and substance abuse, which then raised the probability of

self-destructive and risk-taking behavior. All the abused attempters had a history of disruptive disorders (conduct disorder or oppositional defiant disorder), and five of the eight were either alcohol-dependent or alcohol-abusing (Kaplan, Pelcovitz, Salzinger, Mandel, & Weiner, 1997; Kaplan, Pelcovitz, Salzinger, Weiner, Mandel, Lesser, & Labruna, 1998).

Furthermore, in the Kaplan et al., (1997) study on physical abuse and suicide attempts, all the abused attempters had various comorbid combinations of depression, disruptive behavior disorders (including conduct disorder attention-deficit hyperactivity disorder, and oppositional disorder), and substance abuse or dependence. Further study supported the hypothesis that physical abuse during adolescence is associated with greater risk for developing adolescent psychiatric disorders. After other important risk factors which were more prevalent in the abuse group were accounted for, physical abuse raised the risk for the occurrence of unipolar depressive disorders, disruptive disorders, drug abuse, and cigarette use (Kaplan et al., 1998).

The Link Between Sexual Abuse and Substance Abuse

Luster, et al (1997) believe there are marked individual differences in how victims of sexual abuse function. Some victims of abuse engage in self-destructive coping behaviors, and others seem to cope successfully with this trauma and experience few adverse effects.

Despite the fact that some youths cope successfully, evidence of drug use occurs more frequently among youths who have experienced sexual abuse. Rotheram-Borus, et al (1996), examined the relationship between sexual abuse and risk behavior early in the participants' lives, relatively soon after the abuse had occurred. Nearly a quarter of the youths reported at least weekly substance use prior to the study.

Hussey (1996) said that the altering of one's internal experience is a primary reason for using mood-altering substances. One of the implications suggested by these research findings is that there might be a progression in coping strategies that would predispose a

victimized child to seek out the "consoling" effects of mood-altering chemicals during adolescence. Thus, their style of coping with overwhelming sexual experiences, learned as a child, is replicated and transformed in a developmental manner through substance abuse emerging during adolescence. Earlier strategies of escaping psychological distress through dissociation and distancing tactics interact developmentally to predispose some sexually abused children to later alcohol and drug abuse.

In both a first study and a replication study, Dembo, et al, (1988), found that child abuse, either sexual or physical, was positively related to high rates of illicit drug use.

Watts and Ellis (1993) gave a self-report 109 closed-ended question survey to 670 females. The study found sexual abuse to be associated with both drug use and delinquency for a normal, school-attending population.

The Hussey, Strom, and Singer (1992) study of male victims of sexual abuse, found that abused adolescent males showed significant differences in several areas: they used drugs

more frequently, were more depressed, had lower self-esteem, were more hopeless about the future and had more difficulty controlling sexual feelings.

Chandy, Blum and Resnick (1996) looked at gender-specific outcomes for sexually abused adolescents and substance abuse. In the case of alcohol, a larger proportion of female teenagers reported frequent use of alcohol. However, male teenagers reported more extreme use of alcohol. A higher proportion of males reported consuming five or more drinks at a time when they drink, as well as drinking before and during school. For marijuana use, a larger proportion of males reported more frequent use and use before and during school than females.

Harrison, Edwall, Hoffman, and Worthen (1990), in a discussion of a chemical treatment population, said that boys who admit to histories of sexual abuse are characterized by a number of psychological and social problems similar to those experiences both by abused girls and by abused male runaways. Specifically, they and other family members have

been variously physically and sexually abused; they have abused alcohol and other chemicals regularly and from a very young age, at least in part to self-medicate their distress; and they have been in more and more serious trouble with the law than their peers. In short, these boys appeared to be suffering the effects of traumatization described by Finkhelhor and Browne (1985), and they were attempting to deal with the resulting negative feelings in ways which exacerbated both their emotional and social problems.

Not only is there a large percentage of abused adolescents with substance abuse problems, but as Edwall, Hoffman & Harrison (1989) found in their study of adolescents in chemical dependency treatment, the groups who reported sexual abuse, and particularly the incest group, tended to be younger at the time of admission to chemical dependency treatment than the remainder of this population. While previous studies of sexual abuse and drug use have been based on samples of men and women seeking clinical treatment, youth in juvenile

detention facilities, or alcoholic women in AA, the Edwall, et al (1989) study found sexual abuse to be associated with both drug use and delinquency for a normal, school-attending population. Girls who had been sexually molested were found to have significantly higher rates of drug abuse with almost all drugs.

A significantly more frequent use of both alcohol and stimulants on the part of incest victims allowed them to become fundamentally detached from their physical experiences and feelings in order to reduce their pain. Such persons may simultaneously attempt to sedate themselves, as with heavy alcohol use, and also to escape into the transient high produced by stimulants, which may be the only safe and predictable way to have any experience of feeling (Auerbach-Walker, 1988).

The generalizations made by Dembo and others that childhood sexual abuse is a primary cause of drug use, delinquency, and other problem behaviors appear to be true. Studies show clear differences between groups of sexually abused adolescents and adolescents

without a history of sexual abuse with respect to frequency of drug use and frequency of alcohol use. In Singer et al's study, 44% of the abuse group reported being drunk at least three times in the past two months, compared with 16% of control group members reporting this level of drunkenness. Of the abuse group, 43% indicated being high on drugs three times or more in the past two months, with 13% of the control group reporting such drug use. Statistically significant between-group differences were also found across the following measures of drug and alcohol abuse: frequency of drinking, frequency of drug use, times drunk, and times high on drugs. Overall, the chemical abuse levels of youth known to have been sexually abused were significantly higher than their nonabused counterparts (Watts and Ellis, 1993; Singer, Petchers & Hussey, 1989).

Functionally, adolescent delinquency may serve a number of purposes. Some consider "acting-out" to be forms of escape and social avoidance in sexually abused adolescents. Such behaviors include running away, truancy,

prostitution and drug and alcohol use. These behaviors most obviously function to enable the adolescent to remove herself from a painful environment (Runtz & Briere, 1986; Simons & Whitbeck, 1991).

In a study on sexual abuse correlates, Singer, et al, (1994) found significant differences between victim and nonvictim participants in self-reported motivations for drug or alcohol use. Victims were more likely than non-victims to report using drugs or alcohol to reduce tension, to get to sleep, to relieve pain or discomfort, and to escape family problems. One reason for the use of mood-altering substances by sexually abused adolescents was the perception that they would derive benefits from such use. Sexually abused adolescents, more than their non-sexually abused counterparts, believed that alcohol or drug use helped them to relax, to forget their problems, to be friendlier or to make friends, and to feel better about themselves. These convictions served to intensify their patterns of substance abuse. Sexually victimized adolescents used

mood-altering substances as coping mechanisms and as means of modifying tension, addressing problems, and fraternizing. Coping strategies children use may be dissociative or contain regressive elements. These strategies serve to help children distance themselves from overwhelming traumas for which they are unprepared. The child victim often has few effective options in altering the overwhelming external reality of the stronger, more powerful perpetrator's advances. (Hussey, 1996; Hussey & Singer, 1993).

According to Lindberg and Distad (1985), a child is helpless when incest occurs. Inherent in that helplessness is rage toward the abuser as well as other family members who have left the child unprotected and unsupported, fear of physical harm, verbal abuse, or family disintegration, isolation in sustaining the incest secret, and enormous stress. The adolescents in Lindberg & Distad's (1985) study responded to their experiences through distinguishable types of "acting out" behavior, some being primarily overt and others less

obvious. Overt behaviors included explosive anger, alcohol and drug abuse, suicide attempts, self-mutilation, running away, seductiveness and/or promiscuity. In this study of 27 adolescent victims, 21 abused alcohol and 20 used illegal drugs.

According to Moran, Davies & Toray (1994), counselors in drug treatment programs should be aware of the high probability of physical or sexual abuse in the history of drug-addicted adolescents, especially females. The overall incidence of maltreatment in this study was 35%, which is similar to the rates of maltreatment reported in other studies of the incidence of maltreatment in drug treatment programs.

According to Spear & Skala, (1998), the chemically dependent male with a history of physical and/or sexual abuse is likely to: indicate that at least 2-3 other family members are chemically dependent, have started using drugs by the time he was 10 years old, have been referred for chemical dependency treatment by age 15, be a multi-drug user, and describe his

communication with his parents as poor or abusive.

The chemically dependent female with a history of physical and/or sexual abuse is likely to: be a multi-drug user, have a chemically dependent maternal grandfather, have a chemically dependent father, and describe communication with parents as poor or abusive (Spear & Skala, 1998).

The literature suggests that in most populations studied, female victims outnumber male victims of sexual abuse, but the specific ratio is not easy to determine and may vary significantly between different samples. Some have argued that the admission of victimization is at odds with sex-role stereotyped masculinity so powerful in adolescence. Because males likely perpetrate most sexual abuse of male adolescents, avoiding the appearance of homosexuality imposes a significant constraint on boys reporting their abuse. Others have commented that society is more sensitized to girls being victims because of the perception of boys as strong and girls as weak and that victim

status and role are "reserved" for females, whereas males are not permitted to express vulnerability and helplessness. Clearly, there are many unanswered questions regarding male victimization (Gonsiorek, et al, 1994).

The McClellan and Adams (1995) study showed that a history of any sexual abuse was associated with symptoms related to dissociative symptoms, substance abuse, mood changes, and self-injurious behaviors. Further, youth with sexual abuse histories were more likely to be female, and have higher rates of physical abuse histories, family disruption, lower socioeconomic status, and out-of-home placements. Diagnostically they had higher rates of substance abuse than their non-abused peers.

In a study of sexual abuse history and associated multiple risk behavior Rotheram-Borus, et al (1996) showed that a history of sexual abuse was significantly associated with self-esteem. Runaway youths who had been sexually abused after age 13 had lower self-esteem than did youths who were not abused or abused before age 13. One explanation for this

finding is youths who were abused after age 13 felt more responsible for the abuse than youths who were abused before age 13. Low self-esteem is a commonly reported outcome of sexual abuse in adolescent samples.

Gomes-Schwartz, Horavitz and Sauzier (1985) found that teenagers are especially vulnerable psychologically to sexual exploitation, and asked the intriguing question of whether specific characteristics of the adolescent life stage may exacerbate symptoms. One hypothesis is that older victims are more cognizant of the meaning of sexual approaches (Brooks, 1985; Gomes-Schwartz, Horavitz & Sauzier 1985).

Luster, et al (1997), in a study involving victims of abuse who were 18 years old or younger, concluded that the symptoms displayed by minors may depend on their age. The symptoms that were commonly found in adolescents who had been abused included depression, withdrawal, self-injurious behaviors, somatic complaints, illegal acts, running away, and substance abuse.

The Link Between Emotional Abuse and Substance Abuse

Cavaiola & Schiff's (1989) study of chemically dependent adolescents showed that, while alcohol and drugs may play a self-enhancing role in chemical dependence, it appeared that for the abused chemically dependent adolescent, the self-enhancement or self-medicating role of these chemicals is short-lived. In these adolescents the chemical dependence is the first layer of defense; it must be removed before an attempt can be made to work through the repetitive trauma of abuse of any kind.

For anyone in substance abuse treatment, denial of feelings is a core issue. Identifying feelings is one of the first exercises those in treatment are asked to do. This exercise is difficult for most substance abuse patients but especially so for emotionally abused patients. They may not believe they were abused because they were not physically hit or sexually abused. The physically and/or sexually abused patient has something tangible, in the mind of the

emotionally abused patient, to be angry about. It is very difficult for them to grasp the abuse they have endured.

Gender and Substance Abuse

A disturbing trend observed by Hart and Brassard, (1987) is the steady increase in the numbers of youth who use illicit drugs. According to Kaminer (1999), in general, adolescent males use substances of all kinds more than do adolescent females.

As has been found in other studies, Spear & Skala (1998), found that both abused adolescent males and abused adolescent females used a greater number of different drugs than non-abused adolescent males and females. Abused adolescent males used a significantly greater amount of drugs with greater frequency than abused adolescent females. Chandy, et al (1996) found that male adolescents who have been sexually abused reported more extreme use of alcohol and more frequent use of marijuana than female adolescents.

Parental Monitoring

According to Karen DeBord (1999), parental monitoring means establishing guidelines and limits for a child/adolescent in order to keep track of what is going on in his or her social world. It means knowing: where your kids are, who they are with, what kinds of activities have been planned, and how they will get there and back again. Parental monitoring also means making expectations clear with the child/adolescent about what to do in an emergency. While children/adolescents may complain that parents "don't trust them" or that they are being unreasonable, there is security in knowing that parents care enough to ask.

High levels of parental monitoring (i.e., knowing where children are and what they are doing) can deter adolescents from deviant behavior, including drug use (Steinberg, et al, 1994).

According to Luster, et al (1997) the family context of a victim of abuse is likely to be an important factor in how well children cope with a history of abuse. The research on

stressors and protective factors, generally, and the abuse literature, specifically, suggest that having a supportive relationship with at least one parent can do much to ameliorate the effects of stress on children. The Luster and Small (1997) study examined two family processes, having a high level of support from at least one parent and parental monitoring of the adolescent's behavior. The findings in Luster and Small's study showed that victims of abuse are less likely to experience problem outcomes if they have supportive relationships and are closely monitored.

According to Litterick (1998), parental monitoring is directly effective in both preventing drug use and the amelioration of drug use. The more parental involvement in an adolescent's life, the less likely the adolescent is to form associations with deviant peers. Further, a study by Luster and Small (1997) showed lower scores on binge drinking if the teens were closely monitored by parents, regardless of sexual abuse history.

Hypotheses

This study will address the following eight hypotheses:

Hypothesis 1

Youth who have experienced emotional abuse will report higher levels of alcohol, tobacco and illicit drug use than youth who have not experienced emotional abuse.

Hypothesis 2

Youth who are currently experiencing emotional abuse will report higher levels of alcohol, tobacco and illicit drug use than youth who have experienced emotional abuse in the past but not currently.

Hypothesis 3

Youth who have experienced physical abuse will report higher levels of alcohol, tobacco and illicit drug use than youth who have not experienced physical abuse.

Hypothesis 4

Youth who are currently experiencing physical abuse will report higher levels of alcohol, tobacco and illicit drug use than youth who have experienced physical abuse in the past but not currently.

Hypothesis 5

Youth who have experienced sexual abuse will report higher levels of alcohol, tobacco and illicit drug use than youth who have not experienced sexual abuse.

Hypothesis 6

Youth who are currently experiencing sexual abuse will report higher levels of alcohol, tobacco and illicit drug use than youth who have experienced sexual abuse in the past but not currently.

Hypothesis 7

The impact of abuse will be greater on level of illicit drug use for males than for females.

Hypothesis 8

Parental monitoring will buffer the relationship between maltreatment and drug use.

Chapter Three

Methods

Sample

Respondents of this study were 1,042 10th to 12th graders from a rural county from Oregon attending six public high schools. Forty-six percent were female and fifty-four percent were male. Approximately 72% of the students at the six high schools participated in this study. The other 28% were students who were absent on the day of surveying or whose parents refused to consent.

Seventy-nine percent of the respondents were Caucasian, seven percent Native American, six percent Hispanic, two percent African American, two percent Asian American, and four percent reported other ethnicities. Fifty-three percent lived with both biological parents; 22% lived with one biological parent and a stepparent; 17% lived with one parent; the remaining 8% had other living arrangements such as with relatives or in a foster home.

Procedure

The data were collected by the Teen Assessment Project in Oregon. Stephen Small (1991) at the University of Wisconsin developed the Teen Assessment Project (TAP). It is a community-based program designed to assess youths' needs through research as well as program planning and implementation. The implementation of TAP requires both community involvement and research resources. Each community forms a steering committee that includes professionals and people who hold influential positions in the community, concerned citizens, and adolescents. TAP "taps" into the concerns of local adolescents and makes this information available for problem resolution. The steering committee proposes concerns and questions, which are translated by researchers into appropriate questionnaires. Patricia Moran, Oregon State University, and Sue Doescher, Oregon State University Extension Child Development and Parent Education Specialist adapted the survey instrument for this study. This process is mutually beneficial

to both the community and researchers because it stimulates concern for adolescents so the community can take action after reviewing the results.

A passive consent form was sent to all parents (guardians) prior to the survey administration date. Parents were requested to contact the school if they didn't want their children to participate in TAP. At the time of the survey, students were told that participation in TAP was voluntary and their responses would be anonymous. There would be no right or wrong answers and students could stop at any time. A Spanish version of the questionnaire was also provided for those who wanted it. Teachers were instructed to provide 45 minutes for students to complete the survey in a classroom setting.

Measures

The survey contained 176 items which included several established scales, developed items and demographic information, such as age, gender and family structures.

Maltreatment

Three items specifically asked about the experience of emotional, sexual, and physical abuse by adults. A brief description of each type of abuse was also provided. Emotional/verbal abuse was described as "where someone is intentionally trying to hurt you emotionally with words or actions." Physical abuse was described as "beat up, hit with an object, kicked, or some other form of physical force." Sexual abuse was described as "when someone in your family or another person does sexual things to you or makes you do sexual things to them that you don't want to." These three items were coded as: "0 = no", "1 = was abused, but the abuse has stopped" and "2 = currently being abused" (Appendix A).

In this sample, out of the 1,042 surveyed, 14% (n = 143) reported current emotional abuse; 21.5% (n = 218) reported past experience and 64.5% (n = 655) reported no emotional abuse. For physical abuse, 3.7% (n = 38) reported current physical abuse; 15.9% (n = 162) reported past physical abuse and 80.4% (n = 820) reported no

physical abuse. About two percent (1.7%, n = 17) reported current sexual abuse; 8.2% (n= 83) reported past sexual abuse, and 90.1% (n = 916) reported no sexual abuse.

Substance Abuse

Substance abuse includes alcohol and illicit drugs.

The Use of Tobacco variable was constructed by combining both chewing and smoking tobaccos. These two items asked: "please indicate how often you have used smoking tobacco (chewing tobacco and snuff.)" The responses were coded on a four-point scale from "never" to "often." The sum of the two uses were used as an indicator of tobacco use (Appendix B).

The Consumption of Alcohol variable was measured by the frequencies of wine, beer, and hard liquor use. The participants were asked to respond to items about their use of alcohol, such as "please indicate how often you have used wine." The responses were coded on a four-point scale from "never," to "often." The sum of these

three items was used as an indicator of alcohol use (Appendix C).

Use of illicit drugs such as marijuana and heroin, was measured by a sum of nine items, (Appendix D). The participants were asked to answer the questions such as "please indicate how often you have used cocaine (coke)." The responses were coded on a four-point scale from "never" to "often." The sum of these items was used as an indicator of use of illicit drugs.

Parental Monitoring

Twelve items specifically asked about parental monitoring. The participants were asked to respond to items such as "my parents usually know what I am doing after school." The responses were coded on a five-point scale from "never," to "always." The sum of these 12 items will be used as an indicator of parental monitoring (Appendix E).

Chapter Four

Results

This chapter presents the results of each hypothesis.

Hypothesis 1

Hypothesis 1 predicted that youth who have experienced emotional abuse will report higher levels of alcohol, tobacco and illicit drug use than youth who have not experienced emotional abuse. Table One shows mean tobacco, alcohol and illicit drug scores for youth who reported no emotional abuse, past emotional abuse and current emotional abuse. Results of t-tests indicated that youth who had experienced emotional abuse were significantly more likely to use tobacco ($t = 9.46$; $df = 2197$; $p<.0001$), alcohol ($t = 11.75$; $df = 2189$; $p<.0001$), and illicit drugs ($t = 12.82$; $df = 2162$; $p<.0001$) than were youth who had experienced no abuse.

Table 1

Mean Values and Standard Deviations for Tobacco, Alcohol and Illicit Drug Use Among Youth Who Have Experienced No Abuse and Youth Who Have Experienced Emotional Abuse in the Past

	NO ABUSE N=1559	PAST ABUSE N=369
Tobacco	.98(1.52)	1.62*(1.74)
Alcohol	2.54(2.64)	3.91*(2.97)
Illicit Drugs	.83(2.94)	2.76*(5.61)

Note: *indicates p<.0001

Hypothesis 2

Hypothesis 2 predicted that youth who are currently experiencing emotional abuse will report higher levels of alcohol, tobacco and illicit drug use than youth who have experienced emotional abuse in the past but not currently. Results of t-tests indicated that youth who had experienced current emotional abuse were not significantly more likely to use tobacco or alcohol, but were significantly more likely to use illicit drugs (t = 4.58; df = 2162; p<.0001)than were youth who had been emotionally abused in the past.

Table 2

Mean Values and Standard Deviations for Tobacco, Alcohol and Illicit Drug Use Among Youth Who Have Experienced Past Emotional Abuse and Youth Who Have Experienced Current Emotional Abuse

	NO ABUSE N=1559	CURRENT ABUSE N=272
Tobacco	.98(1.52)	1.79(2.02)
Alcohol	2.54(2.64)	4.22(2.97)
Illicit Drugs	.83(2.94)	4.42*(8.51)

Note: *indicates p<.0001

Hypothesis 3

Hypothesis 3 predicted that youth who have experienced physical abuse will report higher levels of alcohol, tobacco and illicit drug use than youth who have not experienced physical abuse. Table Three shows mean tobacco, alcohol and illicit drug scores for youth who reported no physical abuse, past physical abuse and current physical abuse. Results of t-tests indicated that youth who had experienced physical abuse were significantly more likely to use tobacco (t = 11.05; df = 2210; p<.0001), alcohol (t = 11.15; df = 2203; p<.0001), and

illicit drugs (t = 18.45; df = 2176; p<.0001) than were youth who had experienced no abuse.

Table 3

Mean Values and Standard Deviations for Tobacco, Alcohol and Illicit Drug Use Among Youth Who Have Experienced No Abuse and Youth Who Have Experienced Physical Abuse in the Past

	NO ABUSE N=1839	PAST ABUSE N=300
Tobacco	1.04(1.56)	1.85*(1.97)
Alcohol	2.70(2.69)	4.13*(2.95)
Illicit Drugs	1.01(3.24)	3.59*(6.42)

Note: *indicates p<.0001

Hypothesis 4

Hypothesis 4 predicted that youth who are currently experiencing physical abuse will report higher levels of alcohol, tobacco and illicit drug use than youth who have experienced physical abuse in the past but not currently. Results of t-tests indicated that youth who experienced current physical abuse were significantly more likely to use tobacco (t = 4.18; df = 2210; p<.0001), alcohol (t = 3.87; df

= 2189; $p<.0001$), and illicit drugs (t = 10.72; df = 2176; $p<.0001$)than were youth who had been physically abused in the past.

Table 4

Mean Values and Standard Deviations for Tobacco, Alcohol and Illicit Drug Use Among Youth Who Have Experienced Past Physical Abuse and Youth Who Have Experienced Current Physical Abuse

	PAST ABUSE N=300	CURRENT ABUSE N=74
Tobacco	1.85(1.97)	2.74*(2.37)
Alcohol	4.13(2.95)	5.51*(3.41)
Illicit Drugs	3.59(6.42)	9.80*(12.91)

Note: *indicates p<.0001

Hypothesis 5

Hypothesis 5 predicted that youth who have experienced sexual abuse will report higher levels of alcohol, tobacco and illicit drug use than youth who have not experienced sexual abuse. Table Five shows mean tobacco, alcohol and illicit drug scores for youth who reported no sexual abuse, past sexual abuse and current sexual abuse. Results of t-tests indicated that

youth who had experienced sexual abuse were significantly more likely to use tobacco (t = 12.76; df = 2203; p<.0001), alcohol (t = 9.87; df = 2196; p<.0001), and illicit drugs (t = 22.35; df = 2169; p<.0001) than were youth who had experienced no abuse.

Table 5

Mean Values and Standard Deviations for Tobacco, Alcohol and Illicit Drug Use Among Youth Who Have Experienced No Abuse and Youth Who Have Experienced Sexual Abuse in the Past

	NO ABUSE N=2011	PAST ABUSE N=157
Tobacco	1.10(1.59)	1.69(1.77)
Alcohol	2.84(2.75)	3.97(2.99)
Illicit Drugs	1.21(3.64)	3.43(6.18)

Note: *indicates p<.0001

Hypothesis 6

Hypothesis 6 predicted that youth currently experiencing sexual abuse will report higher levels of alcohol, tobacco and illicit drug use than youth who have experienced sexual abuse in the past but not currently.

Results of t-tests indicated that youth who experienced current sexual abuse were significantly more likely to use tobacco (t = 9.08; df = 2203; p<.0001), alcohol (t = 5.63; df = 2196; p<.0001), and illicit drugs (t = 17.25; df =2169; p<.0001)than were youth who had been sexually abused in the past.

Table 6

Mean Values and Standard Deviations for Tobacco, Alcohol and Illicit Drug Use Among Youth Who Have Experienced Past Sexual Abuse and Youth Who Have Experienced Current Sexual Abuse

	PAST ABUSE N=157	CURRENT ABUSE N=38
Tobacco	1.69(1.77)	4.34*(2.03)
Alcohol	3.97(2.99)	6.79*(2.78)
Illicit Drugs	3.43(6.18)	16.71*(13.92)

Note: *indicates p<.0001

Hypothesis 7

Hypothesis 7 predicted that the impact of physical, sexual and emotional abuse will be greater on level of tobacco, alcohol and illicit drug use for males than for females. For this

analysis, current and past abuse categories were collapsed. Two-way ANOVA's between gender of subject and each type of maltreatment in predicting tobacco, alcohol & illicit drug use indicated significant interactions between gender and physical abuse ($F(2)=8.88$, $p<.0001$), sexual abuse ($F(2)=22.49$, $p<.0001$) and emotional abuse ($F(2)=13.67$, $p<.0001$) in predicting illicit drug use. No significant interactions were found for physical, sexual and emotional abuse in predicting tobacco or alcohol use.

Table 7

Mean Values and Standard Deviations for Tobacco, Alcohol and Illicit Drug Use for Male and Female Adolescents Who Have Experienced Sexual Abuse

	NO ABUSE	SEXUAL ABUSE
MALES	1.50(4.11)	7.58*(10.08)
FEMALES	.90(3.04)	2.61*(4.71

Note: *indicates $p<.0001$

Hypothesis 8

Hypothesis 8 predicted that parental monitoring will buffer the relationship between youth who have been maltreated and drug use. In other words, parental monitoring will have significantly greater impact on level of drug use for youth who have been maltreated than for youth who have not been maltreated. For this analysis, all 3 types of abuse were collapsed into 1 category and all 3 types of substances were collapsed into 1 category. Results of a regression analysis showed a significant main effect for parental monitoring in predicting drug use ($B = -.320$, $p<.0001$. As predicted, a significant interaction was found between parental monitoring and maltreatment in predicting drug use ($B = .186$, $p<.0001$). This indicated that parental monitoring was a stronger deterrent to drug use for maltreated youth.

Chapter Five

Discussion

This study explored relationships between adolescent maltreatment (physical, sexual and emotional) and alcohol, tobacco and illicit drug use. Consistent with other research, the results for hypotheses one, three and five indicated that youth who had experienced emotional, physical or sexual abuse were significantly more likely to use tobacco, alcohol, and illicit drugs than were youth who had experienced no abuse.

Numerous other studies have found a significant relationship between physical or sexual abuse and substance abuse. For example, Baer, et al (1987) said that in a family where the adolescent is physically abused, mild uses of alcohol may develop into alcohol abuse as a way to escape. Of the eight physically abused adolescents in a study by Kaplan et al (1997, 1998) five were either alcohol-dependent or alcohol abusing. According to Kaplan, et al (1997, 1998) physical abuse raised the risk for the occurrence of drug use and cigarette use.

Similarly, studies have found that the chemical abuse levels of youth known to have been sexually abused were significantly higher than their non-abused counterparts (Watts and Ellis, 1993; Singer, Petchers & Hussey, 1989).

Only one other study has examined the connection between emotional abuse and substance abuse. Caviola & Schiff's (1989) found that substances were used by emotionally abused adolescents to self-medicate. It is not surprising that emotional abuse is linked to substance abuse since it is the emotional component of all types of abuse that is at the core of the psychological harm that results from abuse (Hart & Brassard, 1987) and abused adolescents may turn to substances in order to escape from emotional pain.

Hypotheses two, four and six predicted that youth who were being emotionally, physically and sexually abused currently would be more likely to use tobacco, alcohol, and illicit drugs than were youth who had been abused in the past but not currently. Results for physical and sexual abuse were consistent with the hypotheses for

all three substances. However, for emotional abuse, there were no significant differences for alcohol and tobacco use but adolescents who reported present emotional abuse reported significantly higher levels of illicit drug use than adolescents who reported past emotional abuse.

It is notable that for all three types of abuse, illicit drug use was very much more prevalent for those experiencing current abuse in comparison to past abuse. One explanation is that the need to numb the emotional pain of current abuse is so strong that adolescents turn to substances that provide dramatic escape.

Consistent with other research, the results for hypothesis seven indicated a significant interaction between gender and physical abuse, sexual abuse and emotional abuse (past and present combined) in predicting illicit drug use. According to Kaminer (1999), in general, adolescent males use substances of all kinds more than do adolescent females. Spear & Skala (1998) found that both abused adolescent males and females used a greater number of different

drugs than non-abused adolescent males and females. In addition, abused adolescent males used a significantly greater amount of illicit drugs with greater frequency than abused adolescent females.

Consistent with other research, the results for hypothesis eight showed a significant main effect for parental monitoring in predicting drug use. For this analysis, all 3 types of abuse were collapsed into 1 category and all 3 types of substances were collapsed into 1 category. As predicted, a significant interaction was found between parental monitoring and maltreatment/no maltreatment in predicting drug use. Maltreated youth with low levels of parental monitoring were significantly more likely to have high levels of substance use than were maltreated youth with high levels of parental monitoring. These results are consistent with other findings on the impact of protective factors such as parental monitoring for at-risk (maltreated) and not at-risk (non maltreated) youth. These studies in general have found that the impact of protective factors is

greater for at-risk populations than for not at-risk populations

One limitation of this study is that the social geographical characteristics of the surveyed northwest region may be different from other locations. The participants of this study are tenth through twelfth graders in a northwest rural community. The outcome for higher levels of illicit drug use in males could be less dramatic in a more urban setting where gender roles may be less defined. This is a question for further research.

Another limitation is that the data are anonymous self reports and therefore the accuracy of the information reported is unknown. However, the fact that information was gathered from a non-clinical sample is perhaps its greatest strength. Relatively few studies have gathered information on such sensitive topics from such a population.

Defining the differences of emotional, physical and sexual abuse gives strength to this study but the definitions are not perfect. Interpretation differences still exist due to

specific wording such as, for emotional abuse, "*intentionally* trying to hurt you emotionally with words or actions". The adolescents may not report abuse if the abuser's action was perceived as unintentional.

In conclusion, the data from this study showed a very strong positive relationship between maltreatment and substance abuse. Further, this study showed that those currently experiencing abuse of any kind were far more likely to use illicit drugs than were those who had never experienced abuse or who had experienced abuse in the past but not currently. Results also indicated that male adolescents are at the greatest risk for illicit drug use. These results give rise to the need for further research into this subject to aid counselors in helping youth, especially male youth, in substance abuse treatment.

An unusual feature of this research was the opportunity to learn the effect of parental monitoring on substance abuse in abused and non-abused adolescents. Results of this study suggest a need for substance abuse treatment

counselors to educate the parents of the treatment clients to closely monitor their adolescent as a possible means of reducing substance abuse.

Bibliography

Auerbach-Walker, L. E. (1988). Handbook on sexual abuse of children: Assessment and treatment issues. New York, NY:Springer Publishing Company, Inc.

Baer, P. E., Garmezy, L. B., McLaughlin, R. J., Pokorny, A. D. & Wernick, M. J. (1986). Stress, coping, family conflict, and adolescent alcohol use. Journal of Behavioral Medicine, 10, 449-466.

Barber, C. C., Colson, D. B., McParland, M. Q., O'Malley, F., Pope, K. K., & Coyne, L. (1994). Child abuse and treatment difficulty in inpatient treatment of children and adolescents. Child Psychiatry and Human Development, 25, 53-64.

Beitchman, J. H., Zucker, K. J., Hood, J. E., DaCosta, G. A., & Akman, D. (1991). A review of the short-term effects of child sexual abuse. Child Abuse & Neglect, 15, 537-555.

Brassard, M. R., Germain, R. & Hart, S. (1987). Psychological maltreatment of children and youth. New York: Pergamon Press.

Brooks, B. (1985). Sexually abused children and adolescent identity development. American Journal of Psychotherapy, 39, 401-410.

Caffaro-Rouget, A., Lang, R. A. & vanSanten, V. (1989). The impact of child sexual abuse on victims' adjustment. Annals of Sex Research, 2, 29-47.

Cavaiola, A. A. & Schiff, M. (1988). Behavior sequelae of physical and/or sexual abuse in adolescents. Child Abuse & Neglect, The International Journal, 12, 181-188.

Cavaiola, A. A. & Schiff, M. (1989). Self-esteem in abused chemically dependent adolescents. Child Abuse & Neglect, 13, 327-334.

Chandy, J. M., Blum, R. W., & Resnick, M. D. (1996). Gender-specific outcomes for sexually abused adolescents. Child Abuse & Neglect, 20, 1219-1231.

Cole, P.M. & Putnam, F.W. (1992). Effect of incest on self and social functioning: A developmental psychopathology perspective. Journal of Consulting and Clinical Psychology, 60, 174-184.

Costa, D. (2000) Adolescent substance abuse. VersaCare Child and Family Outpatient Clinic, 1-2. Retrieved October 19, 2001 from http://www.communitycareservices.org/help/adolsa.html

Council on Scientific Affairs, American Medical Association (1993). Adolescents as victims of family violence. Journal of the American Medical Association, 270, 1850-1856.

DeBord, K. (1999). Parenting Teens. National Network for Child Care. Raleigh, NC: North Carolina Cooperative Extension Service. Retrieved October 19, 2000.

Dembo, R., Dertke, M., Borders, S., Washburn, M., & Schmeidler, J. (1988). The relationship between physical and sexual abuse and tobacco, alcohol, and illicit drug use among youths in a juvenile detention center. The International Journal of the Addictions, 23, 351-378.

Dembo, R., Williams, L., Wish, E. D., Dertke, M., Berry, E., Getreu, A., Washburn, M., & Schmeidler, J. (1988). The relationship between physical and sexual abuse and illicit drug use: A replication among a new sample of youths entering a juvenile detention center. The International Journal of the Addictions, 23, 1101-1123.

Department of Children and Families (1998). Annual statistical report of the Family Safety and Preservation Office.

Edwall, G. E., Hoffman, N. G., & Harrison, P. A. (1989). Psychological correlates of sexual abuse in adolescent girls in chemical dependency treatment. Adolescence, 24, 279-288.

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

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

Florida Monitor (2000). Key statistics on child protective services in Florida, (1999). Retrieved October 20, 2000 from http://www.oppaga.state.fl.us/profiles/5016/04/right.asp?programmum=5016

Garbarino, J. (1980). Defining emotional maltreatment: The message is the meaning. Journal of Psychiatric Treatment and Evaluation, 2, 105-110.

Garbarino, J., Sebes, J. & Schellenbach, C. (1984). Families at risk for destructive parent-child relations in adolescence. Child Development, 55, 174-183.

Gomes-Schwartz, B., Horowitz, J. M. & Sauzier, M. (1985). Severity of emotional distress among sexually abused preschool, school age, and adolescent children. Hospital and Community Psychiatry, 36, 503-508.

Gonsiorek, J. C., Bera, W. H. & LeTourneau, D. (1994). Male sexual abuse: A trilogy of intervention strategies. Thousand Oaks, CA: Sage Publications, Inc.

Harrison, A. H., Edwall, G. E., Hoffman, N. G. & Worthen, M. D. (1990). Correlates of sexual abuse among boys in treatment for chemical dependency. Journal of Adolescent Chemical Dependency, 1, 53-67.

Harrison, P. A., Hoffman, N. G. & Edwall, G. E. (1989). Sexual abuse correlates: Similarities between male and female adolescents in chemical dependency treatment. Journal of Adolescent Research, 4, 385-399.

Hart, S. N., & Brassard, M. R. (1987). A major threat to children's mental health: Psychological maltreatment. American Psychologist, 42, 160-165.

Hussey, D. L. (1996). Adolescent substance abuse and sexual abuse. Child and Adolescent Psychiatric Clinics of North America, 5, 29-43.

Hussey, D.L. & Singer, M. (1993). Psychological distress, problem behaviors, and family functioning of sexually abused adolescent inpatients. Journal of the American Academy of Child & Adolescent Psychiatry, 32, 954-961.

Hussey, D. L., Strom, G. & Singer, M. (1992). Male victims of sexual abuse: An analysis of adolescent psychiatric inpatients. Child and Adolescent Social Work Journal, 9, 491-503.

Janus, M. D., Archambault, F. X., Brown, S. W., & Welsh, L. A. (1995). Physical abuse in Canadian runaway adolescents. Child Abuse & Neglect, 19, 433-447.

Kaminer, Y. (1999). Addictive disorders in adolescents. The Psychiatric Clinics of North America, 275-288.

Kaplan, S. J., Pelcovitz, D., Salzinger, S., Mandel, F., & Weiner, M. (1997). Adolescent physical abuse and suicide attempts. Journal of the American Academy of Child and Adolescent Psychiatry, 36, 799-808.

Kaplan, S. J., Pelcovitz, D., Salzinger, S., Weiner, M., Mandel, F. S., Lesser, M. L., & Labruna, V. E. (1998). Adolescent physical abuse: Risk for adolescent psychiatric disorders. American Journal of Psychiatry, 155, 954-959.

Kaplan, S. J., Salzinger, S., & Weiner, M.(1994). Adolescent physical abuse. Child and Adolescent Clinics of North America, 3, 695-711.

Keith-Oaks, J. (1990). Emotional abuse: Destruction of the spirit and the sense of self. The Clearing House, 64, 31-35.

Kilpatrick, D. G., Acierno R., Suanders B., Resnick H. S., Best C.L. & Schnurr P.P. (2000). Risk factors for adolescent substance abuse and dependence: data from a national sample. Journal of Consulting Clinical Psychology, 68, 19-30.

Kiser, L. J., Heston, J., Millsap, P. A., & Pruitt, D. B. (1991). Physical and sexual abuse in childhood: Relationship with post-traumatic stress disorder. Journal of the American Academy of Child and Adolescent Psychiatry, 30, 776-783.

Lindberg, F. H., & Distad, L. J. (1985). Survival responses to incest: Adolescents in crisis. Child Abuse & Neglect, 9, 521-526.

Litterick, J. (1998). Family factors associated with levels of adolescent substance abuse. Dissertation submitted to Temple University Graduate Board.

Luster, T., & Small, S. A. (1997). Sexual abuse history and problems in adolescence: Exploring the effects of moderating variables. Journal of Marriage and the Family, 59, 131-142.

Martin, G. (1996). Reported family dynamics, sexual abuse, and suicidal behaviors in community adolescents. Archives of Suicide Research, 2, 183-195.

McClellan, J. & Adams, J. (1995). Clinical characteristics related to severity of sexual abuse: A study of seriously mentally ill youth. Child Abuse & Neglect, 19, 1245-1254.

Moran, P. B., Davies, M. K., & Toray, T. (1994). Behavioral, emotional, and psychological outcomes among adolescents in a drug treatment program: A comparison of maltreated and non-maltreated youth. Journal of Child & Adolescent Substance Abuse, 4, 17-33.

Mouzakitis, C. (1984). Characteristics of abused adolescents and guidelines for intervention. Child Welfare, 63, 149-157.

Pelcovitz, D., Kaplan, S. J., Goldenberg, B., Mandel, F., Lehane, J., & Guarrera, J. (1994). Post-traumatic stress disorder in physically abused adolescents. Journal of the American Academy of Child and Adolescent Psychiatry, 33, 305-312.

Pelcovitz, D., Kaplan, S., Samit, C., Krieger, R. & Cornelius, D. (1984). Adolescent abuse: Family structure and implications for treatment. Journal of the American Academy of Child Psychiatry, 23, 85-90.

Potter-Efron, R. T. & Potter-Efron, P. S. (1985). Family violence as a treatment issue with chemically dependent adolescents. Alcoholism Treatment Quarterly, 2, 1-16.

Rotheram-Borus, M. J., Mahler, K. A., Koopman, C., & Langabeer, K. (1996). Sexual abuse history and associated multiple risk behavior in adolescent runaways. American Journal of Orthopsychiatry, 66, 390-400.

Runtz, M., & Briere, J. (1986). Adolescent "acting out" and childhood history of sexual abuse. Journal of Interpersonal Violence, 1, 326-334.

Schiff, M. M. & Cavaiola, A. A. (1991). The education of the adolescent chemical dependence worker in the field of child abuse. Journal of Adolescent Chemical Dependency, 1, 3-10.

Singer, M. I., Petchers, M. K., & Hussey, D. (1989). The relationship between sexual abuse and substance abuse among psychiatrically hospitalized adolescents. Child Abuse & Neglect, 13, 319-325.

Singer, M. I., Song, L. & Ochberg, B. (1994). Sexual victimization and substance abuse in psychiatrically hospitalized adolescents. Social Work Research, 18, 97-103.

Spear, S. F. & Skala, S. Y. (1998). Adolescents in treatment for chemical dependency: Profiles associated with a history of physical and sexual abuse. Alcoholism Treatment Quarterly, 16, 31-43.

Steinberg, L., Fletcher, A. & Darling, N. (1994). Parental monitoring and peer influences on adolescent substance use. Pediatrics, 93, 1060-1064.

Straus, M. A. & Kantor, G. K. (1994). Corporal punishment of adolescents by parents: A risk factor in the epidemiology of depression, suicide, alcohol abuse, child abuse, and wife beating. Adolescence, 29, 543-560.

Substance Abuse & Mental Health Services Administration (SAMSHA), Office of Applied Studies (1999). National household survey on drug abuse.

Trolley, B. (1995). Group issues and activities for female teen survivors of sexual abuse. Child and Adolescent Social Work Journal, 12, 101-118.

U.S. Department of Health and Human Services, Children's Bureau, (1994). Child maltreatment 1994: Reports from the states to the national child abuse and neglect data system. Washington, D.C.: Children's Bureau, U.S. Department of Health and Human Services.

Van der Kolk, B. & Fisler, R. (1994). Childhood abuse and neglect and loss of self-regulation. Bulletin of the Menninger Clinic, 58, 145-168.

Watts, W. D., & Ellis, A. (1993). Sexual abuse and drinking and drug use: Implications for prevention. Journal of Drug Education, 23, 183-200.

Zahn-Waxler, C. (1996). Environment, biology, and culture: Implications for adolescent development. Developmental Psychology, 32, 571-573.

APPENDICES

Appendix A: Experience of Abuse

EXPERIENCE OF EMOTIONAL ABUSE

Have you ever been emotionally or verbally by an adult? (Verbal and emotional abuse is when someone is intentionally trying to hurt you emotionally with words or actions).

0 = No

1 = I am currently being emotionally or verbally abused.

2 = I was emotionally or verbally abused, but the abuse has stopped.

EXPERIENCE OF PHYSICAL ABUSE

Have you ever been physically abused by an adult? (e.g. beat up hit with an object, kicked, or some other form of physical force).

0 = No

1 = I am currently being physically abused.

2 = I was physically abused, but the abuse has stopped.

Appendix A: Experience of abuse (continued)

EXPERIENCE OF SEXUAL ABUSE

Have you ever been sexually abused by an adult? (Sexual abuse is when someone in your family or another person does sexual things to you or makes you do sexual things to them that you don't want to do).

0 = No

1 = I am currently being sexually abused.

2 = I was sexually abused, but the abuse has stopped.

Appendix B: Use of Tobacco

Please indicate how often you have used:

	Never	Once/ Twice	Some- Times	Often
1. Smoking Tobacco	0	1	2	3
2. Chewing tobacco or snuff	0	1	2	3

Appendix C: Use of Alcohol

Please indicate how often you have used:

	Never	Once/ Twice	Some- Times	Often
1. Beer	0	1	2	3
2. Wine	0	1	2	3
3. Hard Liquor	0	1	2	3

Appendix D: Use of Illicit Drugs

Please indicate often you have used:

	Never	Once/ Twice	Some-times	Often
1. Marijuana (grass,pot)or hashish (hash)	0	1	2	3
2. Stimulants(uppers, diet pills, speed)	0	1	2	3
3. Quaaludes downers (reds,(ludes,soapers) blues, yellows, barbs,etc.)	0	1	2	3
4. Cocaine (coke)	0	1	2	3
5. PCP (angel dust, peace pill),LSD (acid),mushrooms, or other psychedelics	0	1	2	3
6. Heroin(horse,smack) or other opiates (methadone, morphine, codeine, etc.)	0	1	2	3
7. Tranquilizers (valium, librium, etc.)	0	1	2	3
8. Amphetamines (crank, meth, crystal)	0	1	2	3
9. Something to get high without knowing what it was.	0	1	2	3

Appendix E: Parental Monitoring

Please answer the following questions:

1. My parents usually know what I am doing after school.

2. My parents usually know how I am spending my money.

3. My parents know the parents of my friends.

4. My parents know who my friends are.

5. My parents know where I am after school.

6. If I am going to be home late I am expected to call my parents to let them know.

7. I tell my parents whom I am going to be with before I go out.

8. When I go out at night my parents know where I am.

9. I talk to my parents about the plans I have with my friends.

10. When I go out my parents ask me where I am going.

11. I tell my parents I am doing one thing when I am really doing something else.

12. I am honest with my parents about what I do, where I go, and who I am with.

Possible answers to the above questions:

Never=0, Rarely=1, Sometimes=2, A lot of the time=3, Always=4