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Online Sexual Abuse and Symptomatology in Chilean Adolescents: The Role of Peer Support

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Abstract

Several authors are studying sexual abuse via the Internet and its consequences. However, the available studies have not sufficiently detected factors that could help reduce the symptoms that victims may experience. Given the importance of peers during adolescence, especially in the online world, the objective of this study was to evaluate the relationship between online sexual abuse, perceived peer support, and internalizing and externalizing symptomatology. Three hundred and eighty Chilean adolescents (M = 16.12 years, SD = .52, 49.7% girls, 50.3% boys) responded to a set of self-report instruments. The results showed a relationship between online sexual abuse and depressive symptomatology, as well as self-injurious and antisocial behaviors. In turn, peer support was inversely associated with internalizing symptomatology. Results of the study highlight the relevance of peers as factors in intervention programs for adolescents dealing with online sexual abuse.

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Online sexual abuse (OSA) in children and adolescents corresponds to a type of technology-mediated sexual abuse (Quayle & Sinclair, 2012). The forms of OSA vary, from unwanted exposure to pornography to online grooming, whereby the aggressor uses different strategies (e.g., compliments, pressure, blackmail, and threats) to achieve online sexual interaction and eventually meet the child in person or obtain some type of sexual material (e.g., photos) of the minor (Jones et al., 2012). In Chile, estimates indicate that 14.7% of adolescents (11.5% in case of boys and 17.8% in case of girls) have been victims of sexual harassment via the Internet; moreover, 11% (9.2% of boys and 12.8% of girls) have received unwanted sexual proposals over the Internet (Pinto & Venegas, 2015).

Regarding the consequences of OSA, there is a belief that this type of abuse is harmless for its victims because there is no victimization outside the online world (Whittle et al., 2013). On the contrary, the findings of different studies suggest that even when victimization occurred exclusively in the online context, victims presented a series of internalizing symptoms, such as depression and post-traumatic stress (Nur Say et al., 2015; Wells & Mitchell, 2007), and externalizing symptoms, such as antisocial behavior, substance abuse, and academic and social maladjustment (Houck et al., 2014). This finding highlights the need to prevent OSA and treat its consequences (UNICEF, 2011).

The Role of Peer Support

Even during adolescence, the role of parents continues to be fundamental. In this stage, peers acquire greater prominence in people´s lives (Fuligni et al., 2001; Schönbucher et al., 2012). In fact, friendships can act as protective factors against the effects of offline sexual abuse, even though their role is secondary to that of parental support (Guerra & Castillo, 2016; Powers et al., 2009).

To our knowledge, there is no literature evaluating the relationship between peer support and the consequences of OSA. However, as will be discussed herein, there is evidence that suggests that relationships with peers are worth studying in the online context. Evidence supports that psychosocial problems, such as loneliness and social anxiety, can play a role in increasing the probability of experiencing online victimization (Guerra et al., 2019; van den Eijnden et al., 2014). The relevant literature also highlights that one of

the factors hindering the protective role of parents in terms of the Internet is the generation gap. Whereas adolescents socialize in a technological context as digital natives, their parents have learned the use of technology in the later stages of life (Ovelar et al., 2009). Therefore, it is reasonable to think that peers—also digital natives—could play an important role in supporting victims of OSA. Consistent with it, there is evidence that the social support from peers helps to cope with negative consequences of cyberbullying, include depression (Machmutow et al., 2012).

Without denying the importance of other sources of social support, such as parents or schools, in this brief report, we focus on the role of peer support, given the importance of peers in adolescents' lives, especially in the online world. The objective of the study was to evaluate the relationship between the frequency of OSA experiences, internalizing and externalizing symptoms, and the role of peer support. The hypothesis is that there is a direct association between OSA and symptoms, whereas peer support moderates the relationship between these variables. In other words, the relationship between OSA and symptomatology should be lower in adolescents who perceive high levels of peer support.

Methods

Participants

We requested collaboration from 27 secondary schools in the Valparaíso Region of Chile, and 12 agreed to participate in the study. In these 12 schools, we invited all third-year high school students to participate in the study. A total of 380 of them (45.6% of the total) participated. The participants are all adolescents aged 15–17 years (M = 16.12, SD = .59, 49.7% girls, 50.3% boys) participated in this study.

Instruments

A brief questionnaire regarding online sexual victimization experiences (Guerra et al., 2020) was disseminated to participants. This self-report instrument assesses the frequency of 12 different forms of online sexual victimization experienced within the past year (e.g., "An adult has pretended to be a minor to flirt with me"; "An adult has sexually harassed me through messages, calls, emails, etc."; "Someone has threatened or blackmailed me to send or show them images/videos of intimate parts of my body"). The instrument uses a four-point Likert scale (i.e., 0 = never to 3 = always). The total

score is the sum of scores for all items (higher scores indicate a greater frequency of OSA). Cronbach's α obtained in the present study was .87.

The peer support subscale of the Multidimensional Scale of Perceived Social Support (Zimet et al., 1988), validated for Chile (Arechabala & Miranda, 2002), assesses perceptions of peer support. It contains four items, such as, "I can count on my friends when I have problems" and "I can discuss my problems with my friends." The response options range from 1 (very strongly disagree) to 4 (very strongly agree). The total score is the sum of the scores for all items (higher scores indicate greater support). Cronbach's α was .91.

The Depression Self-Rating Scale (Birleson, 1981) was translated for Chile (Álvarez et al., 1986). It is a self-rating scale with 18 items that evaluate the frequency of depressive symptoms within the last week (e.g., "I feel so sad that I can hardly bear it; I think life is not worth living"). Response options range from 0 (never) to 2 (mostly). Regarding the total score—obtained from the sum of all answers after adjusting the reverse-scored items—, higher scores indicate greater depressive symptoms. Cronbach's α obtained in the present study was .82.

The Self-harm Scale for teenagers (Arriaza et al., 2011) is a self-applied scale containing four items that assess the frequency of self-injurious behavior among adolescents in the past two months (cutting, burning, or hitting themselves; generating voluntary wounds; interrupting wound healing; and removing hair). The Likert scale allows a response between 0 (never) and 5 (very frequent). Regarding the total score obtained from the sum of scores for all items, the higher the score, the higher the frequency of self-injurious behaviors (Cronbach's $\alpha = .78$).

We used a reduced version of the Antisocial and Criminal Behavior Scale in adolescents (Andreu & Peña, 2013) with 10 items from the original scale. The scale evaluates pre-criminal behavior, vandalism behavior, property infringement, violent behavior, and alcohol and drug use (e.g., "I have damaged or destroyed public property"). The rating scale is dichotomous (true/false). Teenagers responded regarding the presence of certain behaviors over a period of 12 months—the greater the number of true responses, the greater the frequency of antisocial behavior (Cronbach's $\alpha = .79$).

Procedure

The ethics committee of Universidad Santo Tomás approved the study. We requested authorization from the directors of schools to conduct the investigation. For the schools that agreed to participate, we requested informed consent from either parents or guardians and adolescents. Members of the research team applied the instruments in groups inside the participating

schools. Each teenager answered the instruments anonymously in printed form with paper and pencil. We assigned a numerical identification code without any participant identification data to completed instruments.

Given that the instruments included questions about experiences of victimization—which, on the one hand, can generate psychological distress and, on the other hand, encourage the disclosure of abuses suffered (Mudaly & Goddard, 2009)—an action protocol was created. Prior to applying the instruments, the subject of the study and its associated risks were explained to participating adolescents. At the end of the instruments' application, teenagers received contact information for institutions supporting victims of sexual abuse and an email from the investigation team (in case the students needed guidance). The research team encouraged adolescents to utilize school support systems if they needed to discuss personal issues. Coordination with the psychologists of each school ensured that pertinent actions were taken in response to any disclosure, including providing emotional support and referring participants requiring extra support to the protection system. After the study, each school received a report containing the main results of the study so that administrators could take additional actions aimed at preventing, detecting, and supporting potential victims.

Data Analysis

Using SPSS (IBM Corporation, 2012), we calculated descriptive statistics (mean, standard deviation, minimum, and maximum) and correlations between the study variables (Spearman's rho); additionally, we analyzed gender differences from responses to the study instruments (student's *t*-test and Cohen's *d*). Given the gender differences in levels of symptomatology, we performed a hierarchical multiple regression analysis controlling for gender using MPlus (Muthén & Muthén, 2012). We incorporated three dependent variables in the same equation. First, we entered into the equation the predictors (OSA and peer support) and the control variable (gender), and in the next step, we included the interaction, OSA × peer support (moderation). Since the variables did not follow the normal distribution, we used maximum likelihood as the method of estimation (with bootstrapping of 10,000 iterations). We used $p < .05$ as a criterion for considering statistical significance. Effect sizes were interpreted as follows (Cohen, 1988): Small ($d = .20$), medium ($d = .50$), and large ($d = .80$).

Results

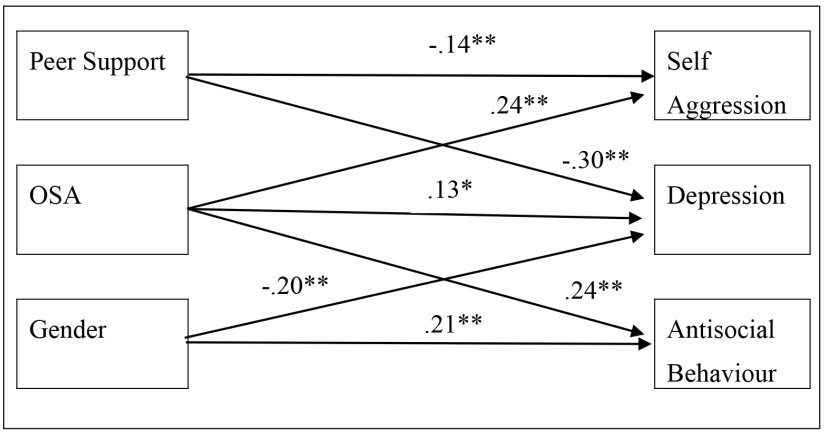
Table 1 shows descriptive statistics and relationships between variables. The adolescents in the study had, on average, a low score on the OSA scale (2.21

points out of a possible 36 points). However, the frequency analysis showed that 53.5% of them had experienced at least one episode of OSA during the past year. There are differences attributable to gender in most of the variables. Girls reported higher scores for OSA (Cohen's d = .48) and depression (Cohen's d = .50), as well as more self-aggression (Cohen's d = .26) than boys. Boys had higher scores for antisocial behaviors (Cohen's d = .30) than girls. The OSA score was directly associated with scores for depression, self-aggression, and antisocial behavior. The peer support score was inversely associated with depressive and self-aggressive symptoms.

A regression analysis, performed in a single model, assessed the effect of OSA and peer support on symptoms (including gender as a control variable). Even though the effect size was small, OSA was a significant predictor of the three types of symptoms. Furthermore, as expected, peer support predicted low levels of depression and self-injurious behavior. Peers' social support showed no association with antisocial behavior. This model explained 17% of the variance in depression, 9% of the variance in self-aggression, and 8% of the variance in antisocial behavior (Table 2).

In the second step, we repeated the analysis, including analysis of the interaction effect between peer support and OSA. However, moderation was not statistically significant in any of the cases. Figure 1 shows the standardized regression coefficients that were statistically significant in Step 1.

Figure 1. Standardized regression coefficients that were statistically significant.



Note. *p < .05. **p < .01.

Table 1. Descriptive Statistics in the Total Sample and Divided by Gender, and Relations (Spearman's rho) between the Study Variables.

	Min-Max	Total *M* (DT)	Female *M* (DT)	Male *M* (DT)	*t*(378)	Cohen's *d*	rho OSA	rho Peer Support
OSV	0–26	2.21 (3.70)	3.08 (4.23)	1.34 (2.83)	4.726**	.48	–	–
Peer support	4–16	11.59 (3.67)	11.48 (3.73)	11.71 (3.60)	–.627	.06	–.02	–
Self-aggression	0–20	3.59 (4.94)	4.24 (5.44)	2.95 (4.33)	2.554*	.26	.17**	–.17**
Depression	0–32	13.76 (6.12)	15.30 (5.98)	12.30 (5.93)	4.824**	.50	.17**	–.29**
Antisocial behavior	0–50	9.74 (8.91)	8.42 (8.34)	11.04 (9.27)	–2.900**	.30	.19**	–.08

Note. *$p < .05$. **$p < .01$.

Table 2. Regression Coefficients Associated with Externalizing Symptoms.

	B	β	95% CI
Step 1			
Self-aggression			
Gender	–.69	–.07	[–1.71, .33]
OSA	.32**	.24**	[.12, .51]
Peer support	–.19**	–.14**	[–.33, –.05]
R^2	.09		
Depression			
Gender	–2.45**	–.20**	[–3.58, –1.32]
OSA	.22*	.13*	[.02, .41]
Peer support	–.50**	–.30**	[–.66 –.34]
R^2	.17		
Antisocial behavior			
Gender	3.65**	.21**	[1.94, 5.36]
OSA	.57**	.24**	[.27, .86]
Peer support	–.15	–.06	[–.39, –10]
R^2	.08		
Step 2			
Self-aggression			
Gender	–.68	–.07	[–1.68, .33]
OSA	–.03	–.02	[–.59, .54]
Peer support	–.27**	–.20**	[–.41, –.12]
OSA × peer support	.03	.28	[–.01, .08]
R^2	.10		
Depression			
Gender	–2.44**	–.21**	[–3.56, –1.31]
OSA	–.15	–.09	[–0.63, .33]
Peer support	–.58**	–.35**	[–.77, –.39]
OSA × peer support	.03	.24	[–.01, .07]
R^2	.17		
Antisocial behavior			
Gender	3.65**	.21**	[1.93. 5.37]
OSA	.58	.24	[–.32, 1.48]
Peer support	–.14	–.06	[–.43, .15]
OSA × peer support	–.00	–.00	[–.08, .08]
R^2	.08		

Note. B = unstandardized beta weight; β = standardized beta weight; CI = confidence interval.
*$p < .05$.

Discussion

The objective of this study was to evaluate the relationship between the frequency of OSA, symptomatology in adolescents, and the possible moderating role of peer support. The results showed generally low scores on the OSA scale; however, the frequency analysis revealed that more than 50% of the participants experienced at least one episode of OSA during the past year. This figure exceeds that of the previous Chilean study (Pinto & Venegas, 2015), probably because we considered 12 types of OSA whereas the previous study referred to a single item to evaluate OSA. In addition, the results of this study showed higher rates for internalizing symptoms in females and higher rates for externalizing symptoms in males, which are consistent with previous evidence in the context of offline sexual abuse (Coohey, 2010; Gauthier-Duchesne et al., 2017). This result may be attributable to cultural factors that favor the acquisition of different patterns of emotional expression in boys and girls (Aláez et al., 2000). We believe that such gender differences should be considered when planning interventions for adolescents in countries where gender stereotypes are more prevalent (e.g., Chile).

Consistent with previous evidence, the results of this study showed that the more frequent the OSA, the greater the symptomatology exhibited by affected adolescents in all measures provided (Houck et al., 2014; Nur Say et al., 2015; Wells & Mitchell, 2007). This finding reinforces the significance of preventing OSA, given its impact on adolescents despite the absence of physical contact with the perpetrator. Contrary to our expectations, peer support did not act as a moderator of the relationship between OSA and the symptoms. However, the results still make it possible to highlight peer support as an important factor negatively correlated with depression and self-aggression, which is consistent with findings of previous studies regarding offline sexual abuse (Guerra & Castillo, 2016; Powers et al., 2009). Results of this study confirmed the importance of considering peers as potential protective agents for combatting the consequences of OSA. Previous studies documented the preponderant importance of peer groups during adolescence (Davison & Jago, 2009), which could be more relevant even in the context of online experiences, given the aforementioned generational gap in Internet competence that exists between parents and children (Ovelar et al., 2009). Future studies should analyze how peer support is related to family support, given the fundamental role of both in the prevention of symptoms following offline sexual abuse (Guerra & Castillo, 2016).

Finally, the limitations of the study are noteworthy. First, the sampling method and size suggest that the results may not be generalizable. Second, the cross-sectional design employed does not guarantee the causality of the proposed relationships. Third, the levels of victimization in the sample were

generally low, which raises the likelihood that adolescents who have experienced more OSA did not participate in the study (i.e., their participation rate was just 45.6%). Fourth, the focus of this study was on older adolescents; thus, the results do not represent the experiences of much younger children who may also have access to the Internet. Finally, the survey used in this study only measured OSA experiences that occurred in the past year and did not account for OSA trauma that might have occurred more than 12 months ago. In future studies, researchers should consider the experiences of younger children and adolescents who have experienced more online victimization (ideally by longitudinal approaches) in order to provide further evidence about the effects of OSA and peer support. It will also be important to work with larger and more representative samples that allow results to be generalized and include a greater number of predictors (e.g., family support, school support, and experiences of offline victimization). This approach will allow us to explain a larger amount of the variance in symptomatology.

Despite the limitations, in this study, it was possible to explain 17% of the variance in depression, 9% of the variance in self-aggression, and 8% of the variance in antisocial behavior based on a model with only three predictors highlighting the importance of gender, OSA, and peer support in the explanation of symptoms in adolescents. These factors should be considered in intervention programs for victimized adolescents.

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Declaration of Conflicting Interests

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