

Poly-Victimization and Coping Profiles: Relationship With Externalizing Symptoms in Adolescents

Cristóbal Guerra ,¹ Noemí Pereda,² and Georgina Guilera² 

Abstract

Externalizing symptoms correspond to a set of behavioral problems related to aggressiveness and the violation of norms. These disorders are common during adolescence, especially in poly-victimized populations. However, not much is known about the mechanism underlying the relationship between poly-victimization and symptoms or about the factors that could play a protective role in this relationship. It is necessary to understand the factors that influence the development of these disorders to prevent them. The aim of this study was to evaluate the relationships among coping strategies, poly-victimization, and externalizing symptoms. The participants were 144 adolescent outpatients ($M = 14.31$, $SD = 1.48$) attending child and adolescent mental health services. The participants responded to three scales that examined their coping strategies, poly-victimization levels, and externalizing symptoms. The results showed that both poly-victimization and nonproductive coping were directly associated with externalizing symptomatology. In contrast, coping in reference to others and productive coping had inverse relationships with externalizing symptoms. Finally, the results of a cluster analysis revealed three groups of adolescents with different coping strategy profiles. The group with the least externalizing symptomatology was the “active-balanced” group (high use of coping in reference to others and productive coping combined with moderate use of nonproductive coping). The group with the greatest symptomatology was the “lonely” group (high use of productive and nonproductive coping but low use of coping in reference to others). The results suggest that poly-victimization and style of coping has an impact on the development of externalizing problems. These results may be useful for designing programs to prevent or treat externalizing disorders in adolescents.

Keywords

adolescence, clinical sample, coping strategies, externalizing, poly-victimization

Externalizing problems correspond to a category used in developmental psychopathology to describe disorders characterized by little emotional control during childhood and adolescence. This category includes behavioral problems related to aggressiveness, opposition or the violation of norms, and criminal behavior (Achenbach & Rescorla, 2001).

Several authors have indicated that externalizing problems are particularly prevalent during adolescence (Latimer & Zur, 2010; Neves, Xavier, Vieira, & Rubin, 2013). This finding is relevant because adolescence is a key period of development in which human beings consolidate the structural aspects of their personality and the way they establish interpersonal relationships with others (Berger, 2007). Consequently, several authors have expressed concern regarding adolescents who present externalizing behaviors as these symptoms are associated with social and academic adjustment problems in adolescence (Hinshaw, 1992) and with antisocial behaviors in adulthood (Moffitt, 1993).

Studies in various countries have found that male adolescents present a greater externalizing symptomatology than female adolescents (Rescorla et al., 2007; Verhulst et al., 2003). In particular, there is evidence that male adolescents are more predisposed to rule-breaking (Alarcón & Bárrig, 2015; Bartels, van de Aa, van Beijsterveldt, Middeldorp, & Boomsma, 2011) and aggressive behavior (Lacasa, Mitjavila, Ochoa, & Balluerka, 2015) than female adolescents.

It has also been noted that the externalizing symptomatology is frequent among adolescents who have suffered multiple experiences of different types of victimization on the relational plane. Finkelhor, Ormrod, and Turner (2007) proposed the term “poly-victimization” to refer to the cumulative victimization suffered by individuals who have been exposed to multiple types of violence. These authors argue that the negative effect of poly-victimization on the development of children and adolescents is greater than the adverse effect of exposure to a single type of traumatic experience or chronic exposure.

Several studies have shown a direct relationship between externalizing behaviors and the repeated experiences of different types of victimization among adolescents, both in community samples (Cudmore, Cuevas, & Sabina, 2017) and in clinical samples (Álvarez-Lister, Pereda, Abad, Guilera, & GReVIA, 2014; Boxer & Terranova, 2008; Ford, Connor, & Hawke, 2009; Ford, Wasser, & Connor, 2011).

However, authors such as Cyr, Clément, and Chamberland (2014) warned that not much is known about the mechanism underlying the relationship between poly-victimization and symptoms or about the factors that could play a protective role in this relationship. This is a problem when designing intervention programs to prevent the development of externalizing behaviors that may later constitute serious problems in adulthood for poly-victims, the people around them, and society in general (Manly, Oshri, Lynch, Herzog, & Wortel, 2013).

It is presumed that the coping strategies that adolescents use to manage stress could explain, at least in part, the relationship between poly-victimization and externalizing symptomatology. Lazarus and Folkman (1984) defined coping strategies as an individual's cognitive and behavioral efforts to handle the excessive demands caused by highly stressful situations. Meanwhile, Frydenberg and Lewis (1993) offered a categorization of coping strategies that is useful to try to explain the relationship between poly-victimization and externalizing problems. The first category they propose includes coping strategies that refer to others, which aim to gain support from agents in an individual's social network. The authors propose that these strategies can operate as a protective factor if they effectively mobilize social resources for help. The second category is productive coping, which refers to strategies that are expected to effectively reduce the emotional stress caused by stressful situations or, in this case, repeated experiences of victimization (e.g., solving problems, working hard, and focusing on the positive). The last category is nonproductive coping, in which the strategies are linked to avoidance and denial of the problem (e.g., not coping, ignoring the problem, keeping it to oneself, self-blaming) and are expected to be ineffective for preventing symptomatology.

Although few studies have tested the approaches of Frydenberg and Lewis (1993) in poly-victimized adolescents, there is some evidence to support the use of these approaches with this population. For example, Guerra, Pereda, Guilera, and Abad (2016) found that nonproductive coping strategies mediated part of the effect of poly-victimization on internalizing symptomatology among 144 Spanish adolescents with mental health problems. Specifically, these authors found that the greater the adolescents' poly-victimization, the greater the use of nonproductive coping strategies and the greater the symptomatology.

However, the other coping strategies and externalizing symptoms were not addressed in this study.

Meanwhile, Riley, Wright, Bokszczanin, and Essau (2017) found that the relationship between poly-victimization and emotional well-being (positive affect and life satisfaction) was moderated by coping strategies that aimed to solve problems in a sample of 454 adolescents from the general population in Poland. Specifically, the use of problem-solving strategies decreased the negative effect of poly-victimization. However, the authors found no moderating effect for coping strategies associated with searching for social support or distraction.

To our knowledge, the only study that has examined the relationships among poly-victimization, coping strategies, and externalizing symptomatology is that of Guerra, Ocaranza, and Weinberger (2016). These authors surveyed 78 Chilean adolescents treated in the child protection system and found that coping in reference to others moderated the relationship between poly-victimization and externalizing symptoms. Specifically, coping in reference to others decreased the negative effect of poly-victimization on externalizing symptoms.

Although the limited evidence available in the literature seems to support the approach of Frydenberg and Lewis (1993), some authors present a somewhat different view. Bonanno and Burton (2013) warned that it is risky to assume a priori that one coping strategy is in itself better or worse than another. These authors argue that the effectiveness or ineffectiveness of a specific coping strategy will depend on the characteristics of the context in which it is used and the existence of a broad repertoire of coping strategies that allows individuals to adapt to the different demands of their environment (Bonanno & Burton, 2013; Carver & Connor-Smith, 2010; Folkman & Moskowitz, 2004).

Following this idea, it is possible to presume that an individual uses different coping strategies or combinations of strategies depending on his or her context. Consistent with this assumption, Lam and McBride-Chang (2007) found that individuals who had a wide repertoire of coping strategies and used different strategies to confront traumatic experiences had better emotional adjustment than those with a more limited repertoire of coping strategies.

From this view, coping strategies that are referred to as nonproductive (e.g., ignoring the problem) may be directly related to externalizing symptoms when they are the only way for poly-victimized adolescents to cope with a stressful situation. However, it is valid to assume that these same strategies are not unproductive in a context in which the adolescent combines them with productive strategies (e.g., solving the problem, seeking social support).

Study Objective

As mentioned, there is little evidence of the role that different coping strategies play, either individually or in combination, in the appearance of externalizing symptoms in adolescents. Therefore, the present study aims to evaluate this role. The objective is to construct empirical profiles of coping in adolescents and to evaluate their relationship with the presence of externalizing symptomatology after controlling for poly-victimization. It is expected that, when individually analyzed, coping strategies in reference to others and productive strategies will be inversely related to symptomatology (Guerra, Ocaranza, et al., 2016; Riley et al., 2017), while nonproductive strategies will be directly related to symptomatology (Frydenberg & Lewis, 1993; Guerra, Pereda, et al., 2016). In addition, it is expected that there will be groups of adolescents that use different combinations of coping strategies and that these groups will differ significantly in their level of externalizing symptomatology according to Bonanno and Burton (2013).

Method

Participants

The study included 144 adolescents (65.3% female and 34.7% male) aged between 12 and 17 years old ($M = 14.31$, $SD = 1.48$). The participants were mostly of Spanish nationality (80.3%), while a smaller proportion was born in Latin America (16.8%) or in other European countries (2.8%). At the time of the study, all the subjects were being treated at child and adolescent mental health centers in the northeastern region of Spain. The reasons for the consultation were related to adjustment disorders (20.8%), anxiety disorders (19.4%), attention deficit disorder and disruptive behavior (16.7%), mood disorders (7.6%), or eating disorders (6.3%). The remainder were being treated for other reasons (e.g., poor school performance or relationship issues).

Measurements

Youth Self-Report-11-18 (YSR). A Spanish version translated by the Epidemiology and Diagnosis in Developmental Psychopathology Unit of the Autonomous University of Barcelona was used. We applied the 119 items from the second part of the questionnaire, which evaluates various types of symptoms (e.g., anxiety, depression, or aggressive behavior). The response format for each item offered alternatives ranging from 0 = *not true* to 2 = *very true or often true*. The YSR provides information about levels of internalizing symptoms and externalizing symptoms and a total problem score (Achenbach & Rescorla, 2001). To interpret the results, raw scores were converted into *T*-scores according to the authors' suggestion. A higher score indicates greater severity of the symptoms. A *T*-score ≥ 65 was established as the cut-off for clinical severity. For the purposes of this investigation, only the scores referring to externalizing symptoms were used (22 items corresponding to rule-breaking behavior and aggressive behavior). In this study, a Cronbach's alpha of .81 was obtained for externalizing symptoms.

Juvenile Victimization Questionnaire (JVQ). We used a version translated into Spanish and Catalan by the University of Barcelona's Research Group on Child and Adolescent Victimization (GREVIA). This version included 36 forms of victimization grouped into six modules: conventional crimes (nine items), caregiver victimization (four items), sibling/peer victimization (six items), sexual victimization (six items), witness/indirect victimization (nine items), and electronic victimization (two items). The JVQ asks the adolescent whether he or she has been subject to various forms of victimization throughout his or her lifetime and during the past year (Finkelhor, Hamby, Ormrod, & Turner, 2005). In this study, only the information regarding the number of types of victimization the respondent experienced throughout his or her life was considered (36 items). This version of the instrument has shown good psychometric properties (Pereda, Gallardo-Pujol, & Guilera, 2016).

Adolescent Coping Scale (ACS). The ACS is a self-report instrument comprising 80 items, 79 of which are closed questions regarding the frequency of different coping behaviors (Frydenberg & Lewis, 1993). The response format is a 5-point Likert-type scale, where 1 = *never* and 5 = *very often*. The scale also includes an open question regarding any additional coping behavior not included in the closed questions. The 79 items are grouped into 18 subscales concerning specific coping strategies that, in turn, are divided into three different coping styles: coping in reference to others (17 items related to searching for social support; α in the present study = .83), productive coping (25 items related to active coping and positive thinking; α in the present study = .84), and nonproductive coping (37 items based primarily on avoidance and emotional discharge; α in the present study = .84). The total score is computed after adjusting and integrating the partial scores of the subscales. Thus, the possible scores for

the three different coping styles range between 20 and 100 points.

Procedure

Prior to its implementation, the study was approved by the Institutional Review Board at the University of Barcelona and by an external ethics committee linked to the participating centers. Once the study was approved, we contacted a convenience sample of child and adolescent mental centers across the region of Catalonia. We recruited the adolescent sample from the centers that agreed to participate in the study (70%). We requested informed consent from both the guardians and the adolescents, who were in the diagnostic phase prior to mental health treatment. The research interview was conducted in the health care setting during each adolescent's diagnostic assessment. The admission criteria for the study required participants to be aged between 12 and 17 years and to have sufficient cognitive and language abilities to understand the interviewer's questions. All adolescents who sought assessment and met the inclusion criteria were asked to participate by their referee at the center. All the participants were informed that their participation was voluntary and that refusal to participate would have no adverse consequences. No compensation was offered to any of the participants. The instruments were administered by either a research assistant or a professional from the center in question; in both cases, the interviewer had received training in developmental victimology and in collecting data on violence against children (United Nations Children's Fund, 2012). Following the interview, the results were written up in a report that was filed in each adolescent's chart.

Data Analysis

First, we performed a descriptive analysis of the study variables (range, mean, and standard deviation) and an analysis of the relationships among them using Spearman's correlation coefficient. Second, we conducted a hierarchical cluster analysis using the standardized scores of the three different coping styles: in reference to others, productive, and nonproductive. As a measure of the similarity of the different clusters, we used the Euclidean distance square, and as a grouping procedure, we used the method of Ward. Third, we described each cluster based on its mean ACS scores for each style of coping. We evaluated the statistical significance of the differences among the clusters with a one-factor ANOVA. Finally, to compare the levels of externalizing symptomatology of the resulting clusters, after verifying that the application conditions were met, we performed an ANCOVA. In the ANCOVA, we decided to include poly-victimization (i.e., the number of types of victimization experienced throughout the respondent's life) as a covariate for two reasons: first, because of evidence that it is highly associated with externalizing symptomatology; second, because in this study, this relationship was well established ($\rho = .44$; $p < .01$).

Although there were differences in the number of males and females in each cluster, $\chi^2(2) = 9.266$; $p < .05$, we did not include gender in the analysis as the difference in externalizing symptoms between males and females was not statistically significant for the whole sample, 59.30 vs. 57.90 ; $t(142) = .403$; $p = .40$. The analyses were performed with SPSS (IBM Corporation, 2012).

Table 1. Descriptives of and Correlations Between Externalizing Symptoms, Poly-Victimization, and ACS Subscale Scores ($N = 144$).

	range	<i>M</i> (<i>SD</i>)	2	3	4	5
Externalizing symptoms	0-83	(9.50)	.14**	.18*	*	
Poly-victimization	0-18	4.05)	—	.11		
Coping in reference to others	0-77	(11.78)		—	.64**	
Productive coping	0-89	(11.94)		—	—	
Nonproductive coping	0-77	(9.93)		—	—	

Note. Spearman's rho. ACS = Adolescent Coping Scale.

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

Results

Description of and Relationships Among Externalizing Symptomatology, Poly-Victimization, and Coping Strategies

As Table 1 shows, the adolescents presented an average externalizing symptoms *T*-score that was lower than

the cutoff point of 65 points. Regarding poly-victimization, they reported between 0 and 18 episodes of victimization during their lifetime ($M = 6.22$; $SD = 4.05$). Considering the range of possible variation in the ACS (from 20 to 100 points), it can be observed that, on average, the adolescents reported a moderate use of coping in reference to others (approximately 48 points) and nonproductive coping (close to 50 points) and a greater use of productive coping (over 63 points).

Table 1 also shows that the participants' externalizing symptomatology was directly related to poly-victimization and to nonproductive coping and was inversely related to coping in reference to others and to productive coping. Furthermore, coping in reference to others and productive coping were directly related to each other, but neither was associated with nonproductive coping, leaving open the possibility that some adolescents use more than one coping strategy simultaneously. Finally, poly-victimization was directly related to the use of nonproductive coping in the adolescents.

Table 2. Mean and Standard Deviation of the ACS Subscales in Each Cluster.

	Cluster 1 Passive <i>n</i> = 45	Cluster 2 Lonely <i>n</i> = 51	Cluster 3 /Balanced <i>n</i> = 48	(2, 141)
coping in reference to others	40.20 (9.21)	(8.87)	(7.53)	4.878**
productive coping	55.69 (9.91)	(8.28)	(8.50)	8.541**
nonproductive coping	42.42 (5.22)	(6.67)	(6.71)	39.146**

Note. ACS = Adolescent Coping Scale.

** $p < .01$.

Identification of Coping Profiles Through Cluster Analysis

To explore whether there were groups of adolescents using different combinations of coping strategies, we conducted a hierarchical cluster analysis. We decided to retain three clusters, following the suggestions of previous studies (Álvarez-Lister et al., 2014; Ford et al., 2011; Guerra, Plaza, & Farkas, 2017). Thus, each cluster included more than 10% of the sample. The clusters had a similar number of subjects, and there were significant differences in the use of coping strategies among the three groups (see Table 2). Moreover, the three-cluster solution gave parsimony to the analysis. To characterize the adolescents in the three clusters in terms of the coping strategies they employed, we calculated the mean scores for the ACS subscales (coping in reference to others, productive coping, and nonproductive coping) and compared them among clusters; in all cases, we obtained statistically significant differences (see Table 2).

Cluster 1 consisted of 45 adolescents (51.1% male vs. 49.9% female). Compared with the other two groups, it presented the lowest values in the three types of coping; for this reason, this cluster was called "passive" (see Table 2).

Cluster 2, which consisted of 51 adolescents (21.6% males vs. 78.4% females), was characterized by low coping in reference to others and relatively high values (over 60 points) for both productive coping and nonproductive coping. Productive and nonproductive coping strategies were both implemented by the adolescent him- or herself (at the cognitive or behavioral level), without requests for direct support from others. For this reason, this cluster was called "lonely".

Cluster 3 comprised 48 adolescents (33.3% males vs. 66.7% females) with high levels of coping in reference to others and high productive coping levels.

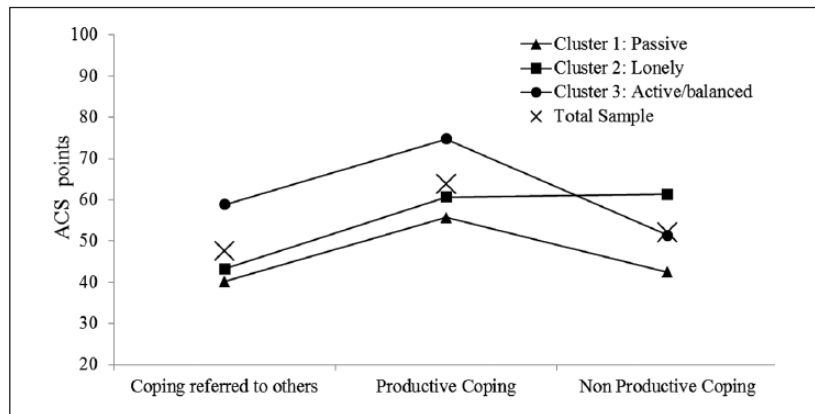


Figure 1. Coping strategies (ACS scores) of the three clusters.
Note. ACS = Adolescent Coping Scale.

In addition, this cluster included adolescents with moderate nonproductive coping. We decided to call this cluster “active and balanced” as these adolescents reported frequent use of the two coping styles inversely related to symptomatology and, in a complementary way, moderate use of strategies oriented toward evasion (nonproductive). Figure 1 schematically shows the differences among the three groups in the coping strategies they used.

Externalizing Symptoms in the Three Clusters

A statistically significant difference in externalizing symptomatology was observed among the adolescents in the three groups after controlling for poly-victimization (see Table 3). In particular, both poly-victimization, $F(2, 141) = 27.788$; $p < .01$; $\eta^2 = .17$; power = .99, and the combined use of coping strategies, $F(2, 141) = 5.701$; $p < .01$; $\eta^2 = .08$; power = .86, were related to externalizing symptomatology.

The group with the greatest symptomatology was Cluster 2 (lonely), followed by Cluster 1 (passive) and Cluster 3 (active/balanced). However, the post hoc analysis (Bonferroni) noted that the differences in externalizing symptomatology were significant only between Cluster 2 (lonely) and Cluster 3 (active/balanced; $M_{diff} = 5.60$; $p < .01$). Specifically, the adjusted mean score for externalizing symptomatology among the adolescents in Cluster 2 (lonely) was close to the cutoff point of the YSR, while that of the adolescents in Cluster 3 (active/balanced) was well below it.

Table 3. Adjusted Mean, Standard Error, and CI of Externalizing Symptoms in Each Cluster.

	Cluster 1 Passive <i>n</i> = 45	Cluster 2 Lonely <i>n</i> = 51	Cluster 3 Active/Balanced <i>n</i> = 48	<i>F</i> (2, 141)
<i>M</i>	57.61	61.46	55.86	5.701**
<i>SE</i>	1.24	1.17	1.21	
95% CI	[55.17, 60.06]	[59.13, 63.79]	[53.48, 58.24]	

Note. CI = confidence interval.

** $p < .01$.

Discussion

The objective of the study was to evaluate the relationship between coping strategies, considered both individually and as a group, and externalizing symptomatology among adolescents from a clinical sample, controlling for the number of victimization experiences the participants had in their lifetime. This issue has received little attention and is highly relevant for planning effective future interventions with the most victimized youth.

First, the results show that poly-victimization is directly related to externalizing symptomatology in adolescents. Several authors have already highlighted the negative relationship between poly-victimization and psychological adjustment indicators in children and adolescents (Álvarez-Lister et al., 2014; Boxer & Terranova, 2008;

Cudmore et al., 2017; Ford et al., 2009; Ford et al., 2011). This study reaffirms the relationship between this construct and the level of externalizing symptomatology.

Second, nonproductive coping was directly related to externalizing symptomatology, while coping in reference to others and productive coping were inversely related to it. These results are consistent with the theory of Frydenberg and Lewis (1993) and with the few previous studies that account for the adverse effect of nonproductive strategies (Guerra, Pereda, et al., 2016) and the protective role of productive coping (Riley et al., 2017) and coping in reference to others (Guerra, Ocaranza, et al., 2016) in poly-victimized adolescents. It should be noted that the cross-sectional nature of this study does not allow us to confirm that the identified relationships are causal. Thus, it is necessary to allow for the possibility that the externalizing symptomatology itself has an influence on the coping strategies that adolescents use. It is highly necessary to perform longitudinal studies to clarify these types of issues.

Third, contrary to what most previous studies show (Alarcón & Bárrig, 2015; Lacasa et al., 2015), externalizing symptomatology did not vary according to the gender of the participants. However, there is evidence that males are more predisposed to rule-breaking (Alarcón & Bárrig, 2015; Bartels et al., 2011) and aggressive behavior (Lacasa et al., 2015), while other studies show that female adolescents have a similar or greater tendency to engage in different forms of indirect violence compared with male adolescents (Card, Stucky, Sawalani, & Little, 2008). Therefore, gender could be related to the type of externalizing symptoms to be evaluated, but this differentiation was not analyzed in this study. Another possible explanation for the absence of differences in externalizing symptomatology between male and female participants is related to the fact that the rate of externalizing symptoms in this sample was below clinical significance (*T*-score less than 65). Therefore, it could be that this difference appears in samples with higher levels of externalization.

In addition, it should be noted that, in this study, males and females reported similar levels of poly-victimization, which could mean that in young people, poly-victimization annuls the gender differences in externalizing behavior that have been found in the general populations of several countries (Rescorla et al., 2007; Verhulst et al., 2003). In this case, males and females presented similar levels of symptomatology, as in previous studies of poly-victims (Ford et al., 2011; Guerra et al., 2016).

Fourth, the results show that it is possible to group adolescents according to how they combine the use of different coping strategies. Thus, we identified three groups of adolescents and labeled them “passive,” “lonely,” and “active/balanced” according to their use of the different coping strategies that were evaluated. In addition, the results of this study showed that adolescents with a wider coping repertoire have the lowest levels of externalizing symptomatology, as was previously observed in the study by Lam and McBride-Chang (2007). This is probably because adolescents presenting this broader repertoire can adjust the coping strategies they use in different contexts, in line with the suggestion of Bonanno and Burton (2013). Indeed, in this study, the group that presented the lowest level of symptomatology was the active/balanced group, which comprised adolescents who presented high coping in reference to others and high productive coping while allowing themselves some evasion spaces.

The group with the greatest symptomatology was the one that presented a high use of individual strategies (both productive and nonproductive) to the detriment of coping strategies related to seeking support from others (the lonely cluster). It is striking that this cluster and not the passive cluster had the worst psychological adjustment. However, this finding is not so surprising considering the participants’ developmental stage. During adolescence, individuals have relatively little control over their context to cope with complex situations such as victimization experiences. At this stage, it is parents (or other adults in the adolescent’s support network) who have the power and resources to take protective measures against relational trauma (such as denouncing the abuser or bringing the adolescent to therapy) that are necessary to create a context in which the adolescent’s own coping strategies become effective (Vanistendael & Lecomte, 2002).

Consistent with the above findings, there is ample evidence that social support generates a protective context that reduces the risk of developing symptomatology for people who have been victimized during childhood and adolescence through exposure to violence inside the family (Kliewer, Murrelle, Mejia, Torres de, & Angold, 2001), child maltreatment (Evans, Steel, & DiLillo, 2013), sexual abuse (Murthi & Espelage, 2005), or poly-victimization (Guerra et al., 2016).

Conclusion, Limitations, and Clinical Implications

Based on the results, it can be concluded that both poly-victimization and coping strategies have a strong relationship with externalizing symptomatology in adolescents. The way in which adolescents combine the coping strategies they use in different contexts helps explain, at least in part, their externalizing symptomatology. In particular, it seems that the most adaptive action combines the search for social support with active coping and spaces for distraction and avoidance. Meanwhile, the least adaptive alternative entails coping alone without seeking

support from others. However, we must recognize the complexity of the development of symptomatology as there are multiple factors not included in this study that need to be assessed in future research.

The combination of coping strategies accounts for only 8% of the variance in externalizing symptomatology. The size of the effect is less than 17%, which explains the poly-victimization. For this reason, it is concluded that having lived through varied experiences of violence remains one of the most relevant factors in explaining symptomatology in young people (Finkelhor et al., 2007). Despite the benefit of a flexible repertoire of coping strategies, when the number of victimization experiences is too high, adolescents are still likely to develop symptoms. Hence, it is important to consider the mobilization of sources of social support that stops the victimization and then, in a safe context, allows the adolescent to properly use coping strategies.

This study has some limitations that need to be highlighted. First, the sample is small and was intentionally obtained only from a clinical context. Therefore, it is not possible to generalize the results, although some conclusions may be useful for other clinical samples. Second, the size of the sample did not allow us to perform a differentiated analysis among adolescents with different diagnoses. It would be relevant to initiate more specific studies with more delimited clinical samples. Third, the cross-sectional nature of the study does not allow causal relationships to be established between factors. Fourth, we included a limited number of factors that may be associated with externalizing symptomatology. Future studies should include other factors that may play an important role, such as parenting styles (Reitz, Deković, & Meijer, 2006) and the adolescent's relationship with his or her peer group (Buist & Vermande, 2014).

Despite these limitations, we believe that this study provides greater knowledge regarding the factors involved in the presence of externalizing symptomatology. This information may be useful when designing specific treatment programs for adolescents with externalizing symptomatology (Cyr et al., 2014; Manly et al., 2013) to enhance protective factors that can reduce the level of symptoms.

From this point of view, before starting psychotherapy with adolescents with externalizing problems, it is necessary to assess both their victimization experiences and the coping strategies they have used. With this information, clinicians will be able to treat different profiles of adolescents with externalizing problems. In particular, if the adolescent has experienced victimization throughout his or her life, it is necessary to include these experiences in psychotherapy. In the same way, it is necessary to help the adolescent expand his or her repertoire of coping strategies to make it more flexible. Finally, these results suggest that adolescents need external support to cope with difficult or traumatic life experiences. For this reason, to help these adolescents overcome externalizing problems, it is important to evaluate and strengthen their support network.

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