Archives of Sexual Behavior, Vol. 26, No. 2, 1997

IN MEMORIAM

With great sadness, *Archives of Sexual Behavior* informs its readers of the death of a long-term member of its Editorial Board, Dr. Kurt W. Freund.

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Psychological Correlates of Male Child and Adolescent Sexual Experiences with Adults: A Review of the Nonclinical Literature

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Researchers have generally neglected sexual experiences of boys with adults, assumed them to be the same as those of girls, or tried to understand them by referring to clinical research while ignoring nonclinical research. A review of nonclinical research allows a more complete understanding of boys' sexual experiences with adults and the outcomes and correlates of those experiences. Research with nonclinical samples reveals a broad range of reactions, with most reactions being either neutral or positive. Clinical samples reveal a narrower, primarily negative, set of reactions. Comparison of the reactions of boys and girls shows that reactions and outcomes for boys are more likely to be neutral or positive. Moderator variables, including presence of force, perceptions of consent, and relationship to the adult, also relate to outcomes. Incestuous contacts and those involving force or threats are most likely to be negative. Problems in this field of research include broad and vague definitions of "abuse" and conflation of value judgments with harm. Effects of boys' early sexual experiences with older persons in general cannot be accurately inferred from clinical research alone or from girls' experiences.

KEY WORDS: sexual abuse; males; nonclinical; review.

INTRODUCTION

Ongoing concern over adult–nonadult sexual contacts and their consequences is reflected in the increase in literature and research in this area (Okami, 1990, 1992; Willis *et al.*, 1991a; Willis *et al.*, 1991b). A growing

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0004-0002/97/0400-0105$12.50/0

number of literature reviews on sexual abuse have appeared over the past 10 to 15 years (Beitchman *et al.*, 1991, 1992; Browne and Finkelhor, 1986; Constantine, 1981; Conte, 1985; Kendall-Tackett *et al.*, 1993; Kilpatrick, 1987; Mendel, 1995; Urquiza and Capra, 1990). For various reasons, however, each of these reviews is inadequate for fully addressing the issue of boys' reactions to early sexual experiences with adults and how these reactions might differ from those of girls. First, much of the available research has focused on the effects of such contacts on girls, with boys either ignored altogether (e.g., Russell, 1986), or assumed to have the same reactions and display the same outcomes as girls (e.g., Mendel, 1995; Nielsen, 1982). Numerous studies in relevant literature reviews include female subjects only: 14 of 30 studies reviewed by Constantine (1981), 20 of 34 in Kilpatrick (1987), and 16 of 25 in Conte (1985). Some researchers whose studies have included a small number of male subjects have failed to report outcomes separately for male and female (e.g., Adams-Tucker, 1982; Friedrich *et al.*, 1986). Finally, in the case of literature reviews, some reviews have specifically focused on females only (e.g., Browne and Finkelhor, 1986), and others that have included studies with male subjects have failed to discuss outcomes for male and female separately (e.g., Kendall-Tackett *et al.*, 1993).

A second major problem is that most reviews have an almost exclusive focus on clinical studies. For example, Kendall-Tackett *et al.* (1993) reviewed only studies of children and adolescents currently in sex abuse treatment programs. Similarly, the reviews of short- and long-term effects by Beitchman *et al.* (1991, 1992) cover clinical literature thoroughly but pay little or no attention to research based on nonclinical samples, such as the large number of reports based on college samples (e.g., Fromuth and Burkhart, 1987) or on convenience samples located in a variety of manners (e.g., Sandfort, 1984). In fact, Beitchman *et al.*'s 1991 review of short-term effects was based entirely on clinical studies. Literature reviews that focus primarily or exclusively on males (e.g., Bolton, 1989; Urquiza and Capra, 1990; Watkins and Bentovim, 1992) also rely mainly on clinical studies. For example, 16 of 22 studies listed by Urquiza and Capra (1990) were from clinical sources.

Reliance on research with female samples is problematic when conclusions from such research are extended to males. Possible sex differences in how early sexual experiences are interpreted, in how boys and girls feel about the experiences themselves, and in proportion of boys and girls who are asymptomatic, are typically not addressed. Some reviewers even specifically deny the presence of male–female differences (Black and DeBlassie, 1993; Mendel, 1995). However, direct comparisons of males and females from nonclinical populations are not discussed. There is ample evidence from other areas of research in sexuality to suggest the importance of such comparison. In a meta-analysis of research on sexual behavior and

attitudes, M. B. Oliver and Hyde (1993) identified a number of gender differences in behavior and attitudes. Adult and adolescent males report more masturbation, a greater incidence of homosexual experiences, and earlier age at first intercourse than do females. In addition, males report more accepting attitudes toward premarital and extramarital sex than do females, and also report less sex guilt and anxiety. Effect sizes were moderate to large for these differences. Sex differences in reactions to early sexual experience have also been found, with males reporting more positive reactions than females to first intercourse (Darling *et al.*, 1992); this difference has persisted for some time (e.g., Sorensen, 1973). Finally, sex differences in reactions to sexual encounters with adults have been previously noted. Fritz *et al.* (1981) reported that males were more likely to perceive their experiences as "sexual initiation" whereas females were more likely to perceive their experiences as "sexual violation." Such findings indicate the importance of systematically examining possible sex differences in reactions to early sexual experiences.

The focus on clinical samples in making general conclusions about the effects of early sexual experiences is also problematic for several reasons. Because most such contacts go unreported by the child or adolescent, these studies may not generalize beyond reported cases. Some reviewers (e.g., Urquiza and Capra, 1990) have noted that samples obtained from clinical sources may be skewed toward those suffering the most harm or distress associated with their experiences. Although some clinical reports include acknowledgement of this problem and note limitations on generalizations (e.g., Friedrich *et al.*, 1988), this is not always the case (e.g., Harper, 1993). In nearly all clinical studies, a broad array of symptoms has been reported in subjects identified as sexual abuse victims. Researchers studying child and adolescent males identified as sexual abuse victims, and adult males reporting earlier abuse, have found emotional problems including anxiety, anger, depression, guilt and shame, and low self-esteem (Mendel, 1995; Urquiza and Capra, 1990; Watkins and Bentovim, 1992). Behavioral problems have included aggressive behaviors, self-destructive behaviors, homicidal and suicidal ideation, and substance abuse problems (e.g., Mendel, 1995; Urquiza and Capra, 1990). Sexual problems reported for male children and adolescents include concerns over sexual identity and masculinity, sexualized behavior in children, and sexual victimization of younger adolescents or children; in adulthood, problems include relationship difficulties, compulsive sexual behaviors, sexual dysfunction, inhibited sexual desire, and sexual aversion (e.g., Bolton, 1989; Mendel, 1995; Urquiza and Capra, 1990; Watkins and Bentovim, 1992). Such problems often, however, do not appear in nonclinical samples such as student populations (e.g., Fromuth and Burkhart, 1987; Predieri, 1991). Research based on convenience sam-

ples (e.g., Okami, 1991) also reveals asymptomatic groups of subjects. This contrast indicates a need to focus separately on nonclinical research.

Because of the relative neglect of males' experiences and the various problems with the clinically oriented research and literature reviews, the need for a comprehensive review of nonclinical literature on the effects of early sexual contacts with adults on males is apparent. The purpose of the current review is to address shortcomings of previous reviews in several ways. First, the main focus is the experience of boys, because of the relative neglect of male experiences. Second, because of the strong emphasis on clinical research in previous reviews of effects on males, the present review is based on nonclinical and nonlegal samples. Findings from this literature are then compared with reviews of clinically based research. Third, a comparison is made between males' experiences and those of females, based on nonclinical studies which have included subjects of both sexes. This allows comparison of responses for males and females from similar populations. Finally, this review includes an examination of the variables that seem to act as moderators of outcomes, in order to begin explaining the range of effects.

METHOD

Location of Studies

Studies including males who had sexual contact with adults in childhood or adolescence were located using a variety of standard literature search techniques. First, reference lists of both clinical and nonclinical studies of adult–juvenile sexual contacts already known to one or both authors were reviewed. Second, reference lists and summary tables of the comprehensive reviews available to the authors were scanned for studies that included both male and female subjects or that included males only (Beitchman *et al.*, 1991, 1992; Bolton, 1989; Browne and Finkelhor, 1986; Constantine, 1981; Conte, 1985; Kendall-Tackett *et al.*, 1993; Kilpatrick, 1987; Mendel, 1995; Urquiza and Capra, 1990; Watkins and Bentovim, 1992). Third, computer database searches were used. The *PsycLit* database for the years 1974 to 1993 was searched utilizing the key words "sexual abuse" and "children" or "adolescents." Abstracts were read on-screen to determine if a particular article was a study of outcomes or effects and if the research population was nonclinical. The *Dissertation Abstracts International* database was also searched, utilizing the same key terms, for the years 1984 to 1993. This procedure located a number of unpublished dissertations that seemed potentially includable. Book or journal references to research with nonclinical samples were then located on shelf or via in-

terlibrary loan and examined in detail; unpublished dissertations were located on UMI microfilms.

Criteria for Inclusion

Because the focus of this review was effects on male adolescents and children of sexual contacts with adults, and the intent was to assess both the range of responses and variables that might account for that range, several criteria were established in addition to the obvious criterion that the studies had to include male subjects. First, when a study included both males and females, outcomes had to be reported separately on at least one measure. Reporting of results that did not distinguish males from females clearly precluded examination of outcomes for males alone. Second, a study had to include at least two males so that some comparison of a range of outcomes was at least possible. This criterion led to the exclusion of single-case studies, although such reports were typically from clinical sources anyway. Third, the study had to report some kind of psychological or behavioral outcome measure. Measures could include self-report or self-evaluation of the experience, scores on various standardized measures of personality or adjustment, or reports of clinical impressions or diagnoses. This criterion led to the exclusion of reports that only indicated the incidence of sexual contacts, but did not offer information on any outcome measures.

Based on the criteria outlined above, we located 35 nonclinical studies that could be included in the review. These studies included reports appearing as journal articles, book chapters or books, and unpublished dissertations. The included studies were published between 1956 and 1994 and are summarized in Table I.

Coding of Studies

All studies included in this review were coded for date of publication, country in which the study was conducted, sample type, sample size, age of subjects at time of the sexual experience or relationship, current age of subjects, the method(s) of assessing outcomes, and the range of outcomes. Each author coded a portion of the studies.

For sample type, samples were coded as "college" if the subjects were college students; as "convenience" if the researcher(s) used subjects found from several sources or from unusual sources such as print advertisements; and "general population" if the subjects were a random population sample from a specific area.

Table I. Summary of Nonclinical Outcome Research of Childhood and Adolescent Sexual Experiences[a]

Reference	Country	Sample type	N[b]	Age at experience	Current age	Measures	Range of outcomes[c]
Bagley (1991)	Canada	Community	200 M	NA	Range: 18–27	SM	–, — to –
Baker and Duncan (1985)	Great Britain	National	82 M, 124 F	M: $\bar{X}$ = 12.03 F: $\bar{X}$ = 10.74	Range: 15–65+	SR	M: 0, – to + F: –, — to +
Bernard (1981)	Netherlands	Convenience	7 M, 2 F	M: range 7–15 F: both age 12	NA	SR, SM	M: +, – to + F: +, 0/+
Condy *et al.* (1987)	U.S.	College	57 M	$\bar{X}$ = 12.5, range 6–15	$\bar{X}$ = 24.3	SR	+, – to +
Committe on Sexual Offences. (1984)	Canada	National	307 M, 538 F	Majority of all subjects: ages 12–18	≥16	SR	0, – to 0
Davis (1990)	U.S.	Convenience	20 M	$\bar{X}$ = 11.2, range: 3–16	NA	SM, SR	+, 0 to +
Doll *et al.* (1992)	U.S.	Convenience	369 M	$\bar{X}$ = 10, range: 2–17	$\bar{X}$ = 31, Range: 18–73	SR	–, – to +
Finkelhor (1979)	U.S.	College	23 M, 119 F	M: $\bar{X}$ = 11.2 F: $\bar{X}$ = 10.2	College age	SR	M: 0, – to + F: –, – to +
Finkelhor *et al.* (1989)	U.S.	National	169 M, 416 F	M: Mdn = 9.9 F: Mdn = 9.6	18 and over	SR	M: 0, – to 0 F: 0, – to 0
Fischer (1991)	U.S.	College	20 M, 41 F	Before puberty	College age	SR	M: NA, – to + F: NA, – to +
Fritz *et al.* (1981)	U.S.	College	20 M, 42 F	Before puberty	College age	SR	M: NA, – to 0 F: NA, – to 0
Fromuth and Burkhart (1987, 1989)	U.S.	College	87 M	Under 16	$\bar{X}$ = 20	SM, SR	0, – to 0
Goldman and Goldman (1988)	Australia	College	35 M, 166 F	M: $\bar{X}$ = 10.3 F: $\bar{X}$ = 9.8	$\bar{X}$ = 22	SR	M: +, – to + F: –, – to +
Hatfield (1987)	U.S.	College	213 M	NA	$\bar{X}$ = 21.6	SM, SR	0, NA
Haugaard and Emery (1989)	U.S.	College		$\bar{X}$ = 10.3	$\bar{X}$ = 19.2	SM, SR	M: NA, – to + F: NA, – to +
Ingram (1981)	Great Britain	Convenience	74 M	$\bar{X}$ = 9.2, Range: 6–14	NA	CI	0, 0 to +
Lauman *et al.* (1994)	U.S.	National	166 M, 289 F	Before puberty or by age 13	Range: 18–59	SR, SM	M: 0, – to 0 F: –, – to 0
Landis (1956)	U.S.	College	140 M, 360 F	<18	College age	SR	M: –, – to + F: –, – to +

Li *et al.* (1993)	Great Britain	College	182 M	≤16	81.9% < 30	SR	0, – to +
Li *et al.* (1993)	Great Britain	Convenience	22 M	≤16	Range: 16–44	SR	0, – to +
Money and Weinrich (1983)	U.S.	Convenience	2 M	12 and 13	>18	CI, SR	+, +
Nelson (1986)	U.S.	Convenience	16 M, 37 F	<18	NA	CI	M: NA, – to + F: NA, – to +
Okami (1991)	U.S.	Convenience	37 M, 33 F	NA	Range: 16–69	SM, SR	+ experiences only
O'Neill (1990)	Puerto Rico	College	43 M, 82 F	M: $\bar{X}$ = 10.0 F: $\bar{X}$ = 10.97	$\bar{X}$ = 22.2, range: 18–54	SR	M: –, – to + F: –, – to +
Predieri (1991)	U.S.	College	560 M	$\bar{X}$ = 10.8	$\bar{X}$ = 20.2	SM, SR	0, – to 0
Risin and Koss (1987)	U.S.	College	216 M	$\bar{X}$ = 9.8	$\bar{X}$ = 21.0	SR	0, — to 0
Sandfort (1984)	Netherlands	Convenience	25 M	$\bar{X}$ = 13.3, range: 10–16	Same	SM, SR	+, 0 to +
Sandfort (1992)	Netherlands	Convenience	123 M, 160 F	<16	Range: 18–23	SM, SR	M: 0, – to + F: –, – to +
Sarbo (1984)	U.S.	College	24 M, 62 F	<18	College age	SM, SR	0, – to 0
Schultz and Jones (1983)	U.S.	College	40 M, 70 F	M: $\bar{X}$ = 11 F: $\bar{X}$ = 10	M: $\bar{X}$ = 22 F: $\bar{X}$ = 26	SR	M: 0, – to 0 F: –, – to 0
Simari and Baskin (1982)	U.S.	Convenience	54 M, 29 F	Range: 5–14	M: $\bar{X}$ = 31, range: 22–56	SR	–, – to 0
Stein *et al.* (1988)	U.S.	Community	31 M, 51 F	M: $\bar{X}$ = 11.0	≥18	SM, SR	–, — to 0
Tindall (1978)	U.S.	Convenience	9 M	$\bar{X}$ = 13.8	$\bar{X}$ = 35, range: 25–46	CI	+, 0 to +
Urquiza (1988)	U.S.	College	53 M	$\bar{X}$ = 10.3	College age	SM, SR	+, – to +
Woods and Dean (1984)	U.S.	Convenience	65 M	NA	Adult	SR	0, + to –

[a]Abbreviations: NA = information not available or unclear from the report; for sex, M = male, F = female; for measure(s) used, SR = self-report, SM = standardized measure, CI = clinical impression.

[b]The listed *N* refers to the number of subjects in the study reporting early sexual contact(s) with adults. For national, community, and college samples the total study *N* is higher than that listed in the table due to the number of subjects in each study without such experiences.

[c]The most common outcome is reported first, followed by the range of outcomes (— = very negative, – = negative, 0 = neutral, + = positive).

Sample size is coded in Table I as the number of male and female subjects reporting childhood or adolescent sexual contact with an adult. Thus, for college and general population studies the total sample is larger than the figure listed because fewer than 100% of the subjects report such experiences. In some cases, reported results were based on the total number of experiences rather than the number of subjects reporting any experience(s).

Method of assessing outcome was coded as one of three possibilities. Studies were coded as "self-report" if subjects were asked to evaluate the impact of their experiences themselves. Self-report measures typically involved the subject rating the experience on a positive-to-negative scale, although self-report also included perceptions of being victimized or not victimized, or the presence or absence of perceived problems or harm. In cases in which the researchers used some form of standardized test to evaluate personal or social adjustment or mental health (e.g., the Hopkins Symptom Checklist), the study was coded as "standardized measure." Finally, in cases where reports of outcome consisted of the clinical diagnoses or impressions of the researcher(s), the study was coded as "clinical impression." Studies could receive more than one code if more than one type of outcome measure was used.

The coding of outcomes was performed so that the most commonly noted outcome was put first, followed by the range of reported outcomes. Positive outcomes were claimed in a study only if at least one of the following criteria was met: (i) some of the subjects evaluated their sexual experience with an adult as positive, (ii) the author of the report claimed that some subjects benefitted, or (iii) standardized measures indicated better adjustment in some fashion compared to controls. The first two of these criteria are similar to those used by Constantine (1981). In nearly all cases, claims of positive outcomes were from the subjects themselves. Because it is possible that claims of positive outcomes might be misinterpreted as justifying sexual exploitation or abuse, or as inappropriate for other reasons (cf. Okami, 1992), it should be noted that most such claims stem from the individuals who would be labeled "victims." In effect, positive outcomes were defined as either personal perception that the experience was beneficial or as better psychological adjustment compared to controls without early sexual contact with adults. Neutral outcomes were claimed if at least one of the following criteria was met: (i) some of the subjects evaluated their experiences as neutral, (ii) authors reported that some subjects were asymptomatic, or (iii) standardized tests revealed no significant differences between "abused" and control groups. In many studies "mixed" outcomes (in which experiences were claimed by subjects or researchers to have both positive and negative effects) could not be disentangled from the idea of truly "neutral" outcomes (in which subjects' adjustment did not significantly differ from that of controls in either a positive or neutral direction). In

practice, both types of experiences were included under the neutral category. Finally, negative outcomes were coded based on (i) self-evaluations by subjects, (ii) clinical diagnoses or judgments, and (iii) poorer adjustment on standardized tests compared to controls. Very negative outcomes were coded to indicate variations in the number and severity of symptoms among subjects. If a study provided such information, then it was coded as including both negative and very negative outcomes.

RESULTS

Overview of Studies

Of 35 nonclinical studies located, 16 were based on college samples. In most of these studies, the sample included students enrolled in specific undergraduate courses at one or a few schools (e.g., Fischer, 1991); one study was based on a national sampling of male undergraduates (Risin and Koss, 1987). These studies have some broad generalizability, at least in comparison to clinical studies, in that nearly half the population of the United States experiences some college-level education (U.S. Bureau of the Census, 1995). The remaining studies involved samples obtained with a wide variety of methods. National population samples included Baker and Duncan (1985) in Great Britain; Committee on Sexual Offences Against Children and Youths (1984) in Canada; and Finkelhor *et al.* (1989) and Laumann *et al.* (1994) in the United States. The Canadian study and the Finkelhor *et al.* (1989) study, however, only asked subjects about unwanted sexual contacts or contacts they considered abusive, thereby excluding experiences regarded as neutral, positive, or consensual. Two other reports were based on community samples from specific cities (Bagley, 1991, in Calgary, Canada; Stein *et al.*, 1988, in Los Angeles); however, in both of these studies subjects were again asked only about contacts considered unwanted or abusive. Other sample sources included print advertisements (e.g., Nelson, 1986; Okami, 1991); personal contacts and referrals (e.g., Bernard, 1981; Sandfort, 1984); a mixture of various sources (e.g., Ingram, 1981); and computer bulletin board users (Davis, 1990). Such samples are clearly not generalizable, but they do provide information on the range of experiences, associated outcomes, and variables related to those outcomes.

Outcomes

Outcomes are discussed according to the types of measures used (self-reports, standardized measures, and clinical impressions). Findings from reviews of clinical studies are cited for comparison purposes. Variables found

to play a moderating role in outcomes (i.e., increasing or decreasing the likelihood of specific reactions and outcomes) are also discussed. Finally, reactions and outcomes for males are compared to those of females drawn from the same samples. Results of college studies (nearly half the total) are reported first, followed by the results of nonclinical studies drawn from other sources. Table II provides a more comprehensive summary of findings from the college studies.

College Study Results: Self-Report

College males' self-evaluations of their early sexual experiences with adults ranged from positive to negative, but were mainly neutral or positive. Nine college studies provided full breakdowns of positive, neutral or mixed, and negative assessment. For short-term reactions (those occurring at or around the time of the actual experience), positive assessments ranged from 6 to 68% of experiences. If Landis (1956) is set aside, the range was between 38% (Urquiza, 1988) and 68% (Schultz and Jones, 1983) of all experiences. Neutral or mixed ratings varied from 8% (O'Neill, 1990) to 33% (Landis, 1956) of all experiences. Negative ratings ranged from 8% (Schultz and Jones, 1983) to 46% (Landis, 1956). Some college studies did not include a detailed breakdown of reactions. For example, Haugaard and Emery (1989) found that 33% of their male respondents regarded their experience as "very positive" both then and now, but did not report a breakdown of positive or neutral responses; Risin and Koss (1987) found that between 26.1 and 55.6% of their subjects reported feeling "not at all victimized," depending on the most intimate sexual act which they experienced. Despite these incomplete reports, what emerges is a consistent picture of males reporting predominantly neutral or positive feelings about their early sexual experiences with older persons at the time they occurred, with negative reactions in the minority. This statement should not be interpreted as minimizing negative reactions, but rather as pointing out what may seem a surprisingly high percentage of positive or neutral self-evaluations.

For males' self-reports of long-term reactions, i.e., current feelings about their experience(s), long-term negative feelings ranged from 9% (Schultz and Jones, 1983) to 47% (Urquiza, 1988). Two studies reported average ratings on 5-point positive-to-negative scales for long-term feelings (Finkelhor, 1979; Goldman and Goldman, 1988). Finkelhor (1979) reported an average rating of 3.2 by males for experiences with acquaintances or friends at least 5 years older, almost exactly on the neutral midpoint; experiences with strangers were evaluated negatively, at an average rating of 4.0. Goldman and Goldman (1988) reported an average rating of 3.0 for experiences with persons 5 to 10 years older and 3.3 for experiences with those at least 10 years older,

Table II. Correlates and Reactions for Early Sexual Contacts with Adults—College Samples

Study	Types of contacts reported[a]				Short-term reactions		Long-term reactions	
	Mm	Fm	Mf	Ff	Boys	Girls	Boys	Girls
Condy *et al.* (1987)	–	57[b]	–	–	Good = 51% Mix = 12% Bad = 25%	–	Good = 37% None = 28% Mixed = 9% Bad = 16%	–
Finkelhor (1979)	19[b]	4	112	7	Pos & neut = 62% Neg = 38%	Pos & neut = 34% Neg = 66%	Ratings = 3.2 (friend), 4.0 (stranger)[d]	Ratings = 4.0 (friend, stranger)[d]
Fischer (1991)	15[c]	10	59	0	–	–	Liking = 28%; no stress then or now = 21%	Liking = 5%; no stress or now = 7%
Fritz *et al.* (1981)	8[b]	12	38	4	–	–	10% reported problems	23% reported problems
Fromuth and Burkhart (1987)	26[c]	76	–	–	Pos = 53% Neut = 30% Neg = 18%	–	Pos = 39% Neut = 46% Neg = 15%	–
Goldman and Goldman (1988)	19[c]	21	179	9	Pos = 39% Neut = 32% Neg = 30%	Pos = 17% Neut = 16% Neg = 68%	Rating = 3.3[d]	Rating = 4.2[d]
Hatfield (1987)	5[b] (w/both = 2)	19	–	–	–	–	No difference vs. controls	–
Haugaard and Emery (1989)	Both 21[b]		Both = 80		–	–	Very pos then and now =33%	Very pos then and now = 4%
Landis (1956)	181[c]	35	523	8	Pos = 6% Neut = 33% Neg = 46%	Pos = 2% Neut = 15% Neg = 76%	No harm = 81% Temporary = 19% Permanent = 0%	No harm = 66% Temporary = 30% Permanent = 3%

Li *et al.* (1993)	45[b]	33	–	–	Pos, neut: Mm = 59%, Fm = 83%	–	Hardly any reported lasting effects (only 1 or 2)	–
O'Neil (1990)	39[c]	10	76	9	Pos = 41% Neut = 8% Neg = 45%	Pos = 10% Neut = 6% Neg = 82%	Pos & neut = 56% Neg = 44%	Pos & neut = 31% Neg = 69%
Predieri (1991)	13[b] (w/both = 4)	14	–	–	Felt victimized: not at all = 48%; quite/very = 35%	–	No difference vs. controls	–
Risin and Koss (1987)	115[b] (w/both = 9)	92	–	–	–	–	Felt victimized: no/a little = 43 to 81%; quite/very = 6 to 41%	–
Sarbo (1989)	Both = 24[b]		Both = 62				No difference vs. controls for males or females	
Schultz and Jones (1983)	Both = 40[b] (at least 35 with males)		Both = 70 (9 or less with females)		Pos = 68% Neut = 24% Neg = 8%	Pos = 28% Neut = 19% Neg = 52%	Pos = 61% Neut = 30% Neg = 9%	Pos = 25% Neut = 28% Neg = 47%
Urquiza (1988)	35[b] (w/both = 2)	16	–	–	Pos = 38% Neut = 26% Neg = 32%	–	Pos = 15% Neut = 34% Neg = 47%	–

[a]Type and number of contacts are listed as follows: Mm = boys' contacts with adult men, Fm = boys' contact with adult women, Mf = girls' contacts with adult men, Ff = girls' contacts with adult women.
[b]Number of participants reporting experiences.
[c]Number of experiences reported by participants.
[d]Ratings: 1 = positive, 5 = negative.

again almost exactly on the neutral midpoint. When current feelings are distinguished from feelings at the time of the experience, some studies indicate that perceptions shift toward neutral evaluations and away from either positive or negative evaluations. Condy *et al.* (1987), Fromuth and Burkhart (1987), and O'Neill (1990) all reported decreases in negative or positive evaluations or both and increases in neutral evaluations. In contrast, Urquiza (1988) reported an increase in both negative and neutral evaluations and a decrease only in positive evaluations.

College Study Results: Standardized Measures

Standard measures of adjustment or functioning used in college studies included measures of social functioning, such as the Texas Social Behavior Inventory (e.g., Haugaard and Emery, 1989); sexual behavior and adjustment, such as the Derogatis Sexual Functioning Inventory (e.g., Predieri, 1991); and clinical symptoms or problems, such as the Hopkins Symptom Checklist (e.g., Fromuth and Burkhart, 1988). In most cases, the researchers used subjects who did not report early sexual experiences with adults as controls to make comparisons with the abused group.

Personality Measures

Several researchers have used measures of personality and behavior characteristics not directly involving sexual or clinical problems. Fromuth and Burkhart (1988) used locus of control and the Rosenberg Self-Esteem Scale among their measures. Neither measure correlated with a history of abuse in male undergraduates. Haugaard and Emery (1989) used the Comrey Personality Scales and the Texas Social Behavior Inventory to compare control subjects with a broadly defined group of abused subjects, including those who rated their experiences as "very positive" at the time and in retrospect. The controls seemed slightly better adjusted in their same-sex relations in emotional stability, but no differences were found on most subscales from the two measures. When abuse groups were more narrowly defined so as to exclude the positive responders, more differences emerged and the magnitude of the differences increased. Predieri (1991) used the masculinity–femininity scale from the MMPI and found no differences between abused and control groups. Finally, Urquiza (1988) compared abused and nonabused groups of males on the Tennessee Self-Concept Scale and a Self and Family History Questionnaire. There were no differences between groups on the TSCS, although the abused group reported more problems on the Self and Family History Questionnaire. In short, studies using varied personality measures with college-

based samples have found no differences between abused and nonabused groups on most scales and subscales, but significant differences indicating better adjustment for nonabused subjects appear on a minority of measures. In addition, researchers typically failed to compare positive and negative responders separately with the control subjects. This leaves open the possibility that no differences exist for positive responders while significant differences exist for negative responders, and combining the two groups into a single "abuse" category obscures these differences. Haugaard and Emery's (1989) study supports this interpretation, with the exclusion of "positive responders" leading to increases in significant differences.

Sexual Adjustment

Fromuth and Burkhart (1987) found no differences between abused and nonabused males using Finkelhor's (1984) Sexual Self-Esteem Scale. Finkelhor (1984) analyzed data from his 1979 subjects on this scale and reported that the sexually abused group had lower sexual self-esteem. Finkelhor (1984) also noted that male subjects in his college study who had such early experiences were four times more likely than other males to be currently engaged in homosexual activities. However, the other studies cited here did not report on sexual orientation, so this finding is tentative. Predieri (1991) found no differences in sexual dysfunctions or other sexuality-related problems on either the Sexual Experiences Survey or the Derogatis Sexual Functioning Inventory. Urquiza (1988) did find some differences on a Sexual Adjustment Questionnaire, with the abused group being less well adjusted. Fritz *et al.* (1981) used a questionnaire on sexual satisfaction, sex problems, and the subject's perceived need for sex therapy, and found that 10% of males in their abused group reported such problems. Unfortunately, similar data were not reported for the subjects with no such contacts, so no control group comparison was possible. Despite the fact that early sexual experiences that are presumed to be harmful could reasonably be expected to produce later sexual problems, the various studies were inconsistent in their results, with differences reported in some but not others. Even in those case where differences emerged, it is once again an open question as to whether this finding applies to all the abused subjects, or primarily or exclusively to those whose experiences were negative.

Clinical Measures

Fromuth and Burkhart (1989) used the Symptoms Checklist (SCL-90) and the Beck Depression Inventory (BDI), and found no differences on

the BDI. For the SCL-90, no differences were found for one of their two college samples, but some appeared for the second sample, indicating that the abused subjects were "slightly less well-adjusted" (p. 536). Once again, however, no attempt was made to separate positive versus negative responders. Hatfield (1987) also used the SCL-90 and found no group differences. Sarbo (1989) used the Clinical Analysis Questionnaire (CAQ) and found no overall difference between molested and nonmolested groups. Some differences did appear on subscales, indicating poorer adjustment for the molested group. Finally, Urquiza (1988) used Briere's Trauma Symptom Checklist (TSC-33) and found no overall differences between the abused and nonabused groups. Again, no group differences emerged on most scales, although the differences that did occur indicated better adjustment for nonabused subjects.

In general, researchers using standardized measures with college samples consistently find few or no differences between abused and nonabused groups. Differences that do appear are typically present on one or a few scales or subscales out of many used. In addition, researchers have typically failed to compare control groups separately with those who report positive versus negative evaluations of their experiences. This problem can potentially both obscure the magnitude of symptoms for negative responders, and lead to exaggeration of differences or symptoms for positive responders.

Noncollege Study Results: Self-Report

Self-report findings in other nonclinical samples are similar to those in the college reports. Among national population samples, Baker and Duncan (1985) found that 57% of males in their British sample felt their experience had no effect; 6% felt that it had improved their life; 33% felt it was harmful at the time, but had no lasting effect; and 4% felt they had suffered permanent harm. In the U. S., Laumann *et al.* (1994) found that 45% of their male subjects who were sexually touched by adults during childhood reported that the experience affected them. Nearly all these reports of effects were negative. This leaves 55% of the males who indicated no effects, suggesting that the majority did not feel negatively affected. In the Canadian national sample (Committee on Sexual Offences Against Children and Youth, 1984), only 6.8% of abused males reported emotional or psychological harm from the unwanted experience. With subjects recruited from computer bulletin boards, Davis (1991) found 58% regarded their experience as positive and 27% regarded their experience as negative. Woods and Dean (1984) sampled males from the Knoxville, Tennessee, area and found that 36% regarded their experience as positive and 24% as neutral. A total of 34% reported an overall negative effect on their current

life. As seen in Table I, most other convenience samples indicate primarily neutral or positive self-evaluations. The main exception is Doll *et al.* (1992), who used predominantly homosexual males recruited from sexually transmitted disease clinics. In this study, 58% felt the experience was negative when it occurred and 54% felt so in retrospect. However, a very high number of the experiences involved force (approximately 50%), which may account for the high rate of negative evaluations. In a unique self-report study, Sandfort (1984) reported on 25 boys aged 10–16 in the Netherlands who were engaged in ongoing sexual relationships with older males. Using the Self-Confrontation Method, in which subjects report on their emotional responses to experiences and also provide ratings of how they would like to feel, Sandfort found that 24 of the 25 boys reported predominantly positive emotions about the sexual contacts and all felt predominantly positive about the relationship as a whole. Although it is unclear to what population such findings can be generalized, Sandfort's study is unique in that it is the only study of children and adolescents in ongoing relationships in which the subjects had not experienced legal, clinical, or other interventions.

Noncollege Study Results: Standardized Measures

Bernard (1981) reported that his subjects did not differ from population norms on the ABV, a measure of personality standardized on the Dutch population. Okami (1991) devised several scales of general and sexual adjustment and found that subjects reporting positive experiences were better adjusted than those reporting negative experiences. Sandfort (1992) reported on a group of young male adults who had early, self-defined consensual experiences with adults. These subjects were just as well-adjusted on sexual measures, such as sexual satisfaction, as were those with no early sexual experiences with adults. In contrast, adjustment problems did appear for those who had early experiences self-defined as nonconsensual. In their U.S. national sample, Laumann *et al.* (1994) found differences between sexually touched and nontouched males on 6 of 11 items measuring sexual adjustment. For the data presented, however, the average effect size was small (r = .07). These findings are consistent with the results from the college studies, with few or no differences typically reported.

In some studies, subjects were asked only about experiences they considered unwanted or abusive, thereby excluding experiences seen as neutral or positive. In these cases, more relationships do emerge between sexual abuse experiences and later symptoms. In community samples, both Stein *et al.* (1988) in the U.S. and Bagley (1991) in Canada reported that abuse history in males was associated with increased psychological symptoms and disorders. Finkelhor *et al.* (1989) found in their U.S. national sample that

abuse experiences were associated with more marital disruption and lower religiosity (but not sexual satisfaction) among males. Effect sizes were small and Finkelhor *et al.* noted that these results must be regarded with caution because most victims reported no problems. Because these reports only examined experiences seen as unwanted or abusive by the respondents, they provide no information on how experiences with adults defined as neutral, positive, or voluntary might relate to observed symptoms.

Noncollege Study Results: Clinical Impressions

Several noncollege studies relied on clinical impressions or diagnoses (e.g., Ingram, 1981). Included were some collections of case reports that provided detailed descriptions of long-term sexual relationships, the younger person's perceptions, and current adjustment (Money and Weinrich, 1983; Tindall, 1978).

Ingram (1981) reported on a group of boys, ages 6 to 14 at the time of their experiences, who had been involved in sexual contacts with older males. Although some were referred specifically for counseling because of their sexual contacts, in other cases the contacts were discovered accidentally or during counseling for other concerns. After reviewing the types of experiences the boys had, their home life, and their relationships with the men, Ingram concluded that there was no evidence from his study that any of the boys were worse off as a result of the experience. Money and Weinrich (1983) reported on two males who as boys had become sexually involved with men. The men had voluntarily referred themselves for counseling and therapy. Both boys regarded the relationships positively, saw their older partners as close friends, set limits on the sexual interaction, and were currently pursuing heterosexual relationships. Tindall (1978) reported in detail on nine case histories of boys whose sexual experiences with older men had been discovered by Tindall in his work as a school psychologist (none had been referred for sexual reasons). These cases were those with the most complete follow-up data out of a larger pool of 200. In some cases follow-up data extended into the subjects' 40s. All developed heterosexual adult patterns of behavior, displayed successful adjustment in other areas such as education and careers, and in several cases maintained friendships with the men with whom they had been involved. Tindall concluded that "in sexual relationships between males beyond puberty where force is not involved many have no deleterious effects" (p. 381).

These case reports and clinical impressions involved, in some cases, follow-up information that extended for years or even decades after the sexual contacts stopped occurring. The findings indicate that long-term sexual contacts with older persons can be seen as positive by the younger par-

ticipants and are not clearly associated with adult impairments or dysfunction.

Moderators of Outcomes

A wide range of responses by boys to sexual contacts with adults has been documented, from very negative to very positive. The next logical step is to attempt to account for this range, identifying moderator variables that may serve to increase or decrease the likelihood of specific outcomes. In nonclinical studies, researchers have identified a number of variables related to the sexual contact which play a role in how boys respond to their sexual contacts with adults. Reviews of the clinical literature also indicate the importance of moderator variables, often consistent with nonclinical findings. For each variable, findings from nonclinical literature are discussed first, followed where possible by relevant findings from clinical reviews.

Force Versus Willingness

The presence or absence of force, and subjects' evaluations of their willingness or consent in the sexual contact, have been examined in numerous nonclinical studies. These studies are consistent: When physical force or threats of harm are present, responses of boys to the sexual contact are typically negative. This finding is true for both college studies (Condy *et al.*, 1987; Haugaard and Emery, 1989; O'Neil, 1990; Predieri, 1991; Sarbo, 1984; Urquiza, 1988) and noncollege studies (Doll *et al.*, 1992; Okami, 1991). In those studies in which the most positive cases of sexual contacts with adults were reported, these contacts without exception were reported with no mention of threat or force (Bernard, 1981; Money and Weinrich, 1983; Sandfort, 1984; Tindall, 1978). The boys studied by Sandfort (1984) reported that current sexual contacts took place primarily as a result of mutual initiative with the adult or on the boys' own initiative (although the first contacts in the relationship typically took place as a result of the adults' initiative). Tindall (1978) reported that the boys in his cases did not feel pressured or forced to participate. Finally, in the cases reviewed by Money and Weinrich (1983), the boys set limits on the types of sexual activity and reported that they were not pressured.

The issue of force leads to the larger issue of assent or consent. In the studies reviewed, a number of subjects defined themselves as willing or consenting participants in their sexual contacts with adults. This self-defined consent seems to refer to a willingness to participate, and does not necessarily indicate the level of sexual knowledge or awareness of possible

consequences needed to meet the more stringent criteria of informed consent. Self-defined consent, like absence of force, is in all studies associated with positive outcomes or evaluations. Condy *et al.* (1987) found that subjects who reported that they initiated the sexual contact with an older female, or who agreed to the females' advances, identified their experiences as predominantly positive. Subjects who reported being forced identified their experiences as negative. Haugaard and Emery (1989) found that subjects who reported greater pressure to participate reported more negative responses. Sandfort (1992) asked subjects to define their early experiences with adults as consensual or nonconsensual; subjects who reported nonconsensual experiences with adults were less well-adjusted on various measures of sexual problems and sexual satisfaction than those who defined their experiences as consensual. Okami (1991) reported that consent versus coercion was strongly associated with evaluations of experiences as positive versus negative.

Findings from the clinical literature are consistent with the nonclinical literature on the impact of force. In their reviews, both Mendel (1995) and Urquiza and Capra (1990) reported that the presence of force or threats is typically associated with increased symptoms. It is noteworthy that in many clinical samples, which might be expected to include the most disturbed individuals, force continues to emerge as a major predictor of outcome.

Relationship to the Older Person

The most consistent finding in terms of the relationship between the boy and the adult is that contacts involving relatives are associated with more negative outcomes. Among college studies, Condy *et al.* (1987), Fischer (1991), and Urquiza (1988) all found contacts with relatives to be more negative. On the other hand, Predieri (1991) and Sarbo (1984) did not find relationship with the adult to be associated with outcomes. In other nonclinical studies, Baker and Duncan (1984) found that contacts within the family were regarded as more harmful, and Okami (1991) found that incest was present in a greater percentage of negative as opposed to positive experiences.

Clinical and nonclinical research again seem reasonably consistent: incestuous relationships are associated with more negative outcomes. Reviews focused on males (Mendel, 1995; Urquiza and Capra, 1990) and on females only or both males and females (Beitchman *et al.*, 1991; Browne and Finkelhor, 1986) reported this conclusion.

Sex of Older Person

Surprisingly, a number of studies failed to examine boys' experiences with men separately from boys' experiences with women. One possible reason for this failure is that the adults have been commonly assumed to be male. This assumption is fairly accurate for the experiences of girls; in the studies in Table I, the proportion of older males involved in girls' experiences ranged from 90 to 100%. However, experiences reported by boys involve older females far more often than those of girls. From Table I, the proportion of older females reported as partners (in those studies including experiences with both older males and older females) ranged from 40% (Goldman and Goldman, 1988) to 75% (Fromuth and Burkhart, 1987). Because negative attitudes toward homosexual behavior persist in our society, and such attitudes could be expected to influence a boy's reaction to a sexual contact with a man, the sex of the older partner may be an important variable.

In a few studies, experiences with older males versus older females were studied separately. Experiences with older females were consistently rated in a more positive fashion than experiences with older males (Finkelhor, 1979; Fischer, 1991; O'Neill, 1990; Predieri, 1991). This difference is unsurprising in view of the continuing stigmatization of homosexual behavior. However, not all experiences with older females are regarded positively, and not all experiences with older males are regarded negatively. Condy *et al.* (1987) found that 25% of their male respondents had a negative immediate reaction to their experiences with older females, and 16% felt the experience had a negative long-term effect. Also, many of the studies describing the most positive examples of adult–nonadult sexual relationships included man–boy relationships only (Money and Weinrich, 1983; Sandfort, 1984; Tindall, 1978). In short, both heterosexual and homosexual contacts with adults involve the full range of responses, from negative to positive.

Type of Sexual Activity

For this variable, an interesting pattern emerges: In a number of studies, fondling and/or penetration as the most intimate sexual behavior seem to be associated with more negative outcomes. Contacts involving oral sex as the most intimate behavior seem more positive. Risin and Koss (1987) noted higher levels of negative emotions (such as guilt and anger) for both fondling and penetration as the most intimate activity, compared to oral sex. However, high levels of positive emotions were also associated with penetration, which the authors suggested could be due to subjects reacting positively to penetrating an older partner. Urquiza (1988) also reported fondling and penetration to be associated with more negative outcomes. Predieri (1991) found

that males who were symptomatic on the various measures of adjustment were more often those with fondling as the most intimate contact.

Type of sexual activity might be confounded with other variables, such as willingness or force. For example, Risin and Koss (1987) reported that contacts with fondling as the most intimate behavior involved more force and less initiation by the boy himself. In Sandfort's (1992) study, boys' consensual contacts involved more "advanced" sexual activities than the nonconsensual ones, but the reverse was true for females. Another possible confound is the failure to distinguish between boys' experiences of penetrating their partner versus being penetrated (e.g., Risin and Koss, 1987). Being the recipient or oral sex, or penetrating an older female partner, may be associated with more sexual pleasure and more positive emotional reactions than being orally or anally penetrated.

Duration/Repetition of Sexual Contacts

Most nonclinical researchers reporting on these variables found no relationship (e.g., Finkelhor, 1979; O'Neill, 1990; Sarbo, 1984). However, Urquiza (1988) reported that repetition was associated with more symptomatology. This variable could be confounded with others, such as consent and force. For example, voluntary relationships might involve repeated contacts over an extended period but so might involuntary experiences characterized by force or by unwilling acquiescence to the adult's demands. This situation could be especially true in the case of incestuous contacts. Reviews of clinical literature do not clarify the possible impact of duration and repetition; Urquiza and Capra (1990) found no clear relationship of duration to impact.

Age Difference/Age of Older Person

These variables do not seem clearly related to outcomes, at least for boys. Goldman and Goldman (1988), O'Neill (1990), and Sarbo (1984) all found these variables unrelated to outcomes for boys. Predieri (1991), however, did report that greater age difference was associated with more negative outcomes. Also, males and females might differ in how this variable is associated with outcome: Both Finkelhor (1979) and Goldman and Goldman (1988) reported that greater age difference was associated with more negative outcomes for females. As for clinical research, Urquiza and Capra (1990) reported that there were no conclusive findings on the impact of age at the time of the experience.

Age of Boy at Time of Experience

Although it could be argued that experiences in adolescence are more likely to involve consent and hence less likely to have negative consequences, results on this variable have been inconsistent and inconclusive as well. For college-based studies, Condy *et al.* (1987), Fromuth and Burkhart (1987), and Goldman and Goldman (1988) found no significant relationship between age at time of the experience and immediate (short-term) reaction. For current evaluations, however, Fromuth and Burkhart found that younger age was associated with more negative ratings; Condy *et al.* found a nonsignificant trend for younger age to be associated with more negative ratings; and Goldman and Goldman found no association with retrospective evaluation. In research based on convenience samples, Nelson (1986) and Okami (1991) both found that experiences at younger ages were associated with more negative evaluations, but these results cannot be generalized to other samples. Although the college study results suggest a tendency for younger age to be associated with more negative long-term reactions, replication of such results in additional college- and population-based samples is clearly needed.

Previous reviews have reached inconsistent conclusions about the effects of age at the time of the experience as well. In reviews focused on effects on males, Urquiza and Capra (1990) argued that there was no conclusive relationship, but Watkins and Bentovim (1992) concluded that impact was greater at younger ages. In reviews of research with both males and females, Kilpatrick (1987) concluded that older age at time of the experience was associated with greater maladjustment; Constantine (1981), Conte (1985), and Haugaard and Repucci (1988) all concluded that the findings were equivocal. Once again, the effects of age may be confounded with other variables such as consent. For example, younger children may be less able than adolescents to avoid or resist unwanted sexual contacts; as a result, research based on college or community samples may indicate that younger age is associated with worse reactions and outcomes.

Secondary Consequences

Secondary consequences include reactions of others, such as parents and peers, to the sexual contacts. Feelings of guilt and shame regarding the sexual contacts, which are based on perceived violation of one's own and others' norms, are also addressed here.

Emotional responses of guilt were related to outcomes, with greater guilt associated with more negative responses. Haugaard and Emery (1989) and Okami (1991) both reported guilt feelings to be associated with negative evaluations of experiences. Stein *et al.* (1988), in their study of un-

wanted experiences in a community sample, noted that feelings of guilt and shame were common. Risin and Koss (1987) reported that guilt feelings were more common in experiences involving fondling, which were also associated with more force and greater levels of other negative feelings. Finally, Sandfort (1984) reported that when the boys interviewed in his study were asked about negative aspects of their relationships, many cited concerns about possible negative reactions from others, such as parents, peers, and authorities. The role of socialization in these reactions may be very important. Finkelhor (1979) and Fritz *et al.* (1981) both suggested that boys' reactions may be more positive than those of girls because boys are socialized to regard sex in a more positive fashion, whereas girls receive more negative messages. Fritz *et al.* (1981) stated that although girls typically regarded their experiences as sexual violation, boys often regarded their experiences as sexual initiation.

Clearly, feelings of guilt and shame and concerns about negative reactions from others are associated with negative responses to early sexual contacts with adults. These responses, however, are not inherent in the sexual contact per se but rather stem from social taboos and condemnation (cf. Constantine, 1981). To the extent that boys receive more positive messages regarding sexuality, they are less likely to experience these negative emotions and to react negatively to sexual contacts.

Comparison of Males' and Females' Responses

A number of the nonclinical studies reviewed included both male and female subjects and in all cases, as part of the inclusion criteria, reported at least some results separately. Consequently, responses of males and females drawn from the same populations can be compared directly on a number of measures.

Self-Report

A clear, consistent, and large difference emerges in the college studies between male and female self-evaluations of their early sexual experiences with adults. Most female respondents rates their experiences as having been negative both at the time and in retrospect. In contrast, male respondents report predominantly neutral or positive ratings of their experiences. This difference is so consistent that, without a single exception, females rated their experiences more negatively than males did in every study that included both sexes. Immediate reactions for females ranged from 66% negative (Finkelhor, 1979) to 82% negative (O'Neill, 1990). Retrospective

evaluations were also consistently more negative than those of the males. Fischer (1991) reported that only 7% of females claimed no stress then or now from their experience, versus 21% of males; 4% of the females in Haugaard and Emery's (1989) study, versus 33% of the males, rated the experience as very positive both then and now; and 69% of females in O'Neill's (1990) study rated the experience as negative in retrospect, versus 44% of males. Fritz *et al.* (1991) found that 23% of females, versus 10% of males, reported sexual problems. Table II reveals similar differences in studies reporting results in a variety of other formats as well.

Noncollege samples revealed similar differences. In Baker and Duncan's (1984) British sample, 13% of female respondents versus 4% of males reported permanent harm from their experiences. In Laumann *et al.*'s (1994) U.S. national sample, 70% of female subjects versus 45% of male subjects reported effects of their experience (almost entirely negative). In the Canadian national sample, in which subjects were asked only about experiences they considered abusive (Committee on Sexual Offences, 1984), 24% of female subjects versus 6.8% of males reported psychological or emotional harm from their unwanted sexual experience. Eighty-six percent of Nelson's (1986) female respondents, versus 25% of male respondents, regarded their experiences as negative. Okami's (1991) female respondents also, in general, viewed their experiences more negatively than did the males. Thus, male–female differences consistently appear across many types of nonclinical samples.

In short, nonclinical research indicates that females are far more likely than males to evaluate their early sexual experiences with adults as negative, and are more likely to experience problems, especially sexual ones, associated with their experiences. These differences are consistent across a wide variety of sample types (college, national, and convenience).

DISCUSSION

The nonclinical research on boys' sexual contacts with adults supports several basic conclusions. First, a wide range of responses to such experiences occurs, with reactions that range from very negative to very positive and psychological correlates that range from severe emotional and behavioral problems to a lack of any symptoms. The research findings do not support the view that sexual contacts between boys and adults are typically experienced as negative or that they are invariably harmful. In contrast, results from both college-based samples and general population samples indicate that the majority of such experiences are evaluated by males as neutral or positive. Results from standardized measures of adjustment are consistent with

self-reports, with most researchers finding either no differences in overall adjustment or a few differences out of a large number of scales. Again, the real difficulties of many male victims of sexual abuse should not be denied or minimized by these findings; rather, they are emphasized as a counterpoint to the assumption that all such contacts must be experienced as abusive or negative and typically produce long-lasting harm.

Second, a number of moderator variables are consistently and logically related to these reactions and correlates. Force or coercion in particular is closely linked to perceptions of the experience as negative and to the presence of psychological and behavioral problems. Other moderators (e.g., relationship to the adult) appear to be important as well. In short, these moderator variables can potentially account for the full range of reactions and correlates of boys' sexual experiences with adults, indicating that sexual contact per se is not intrinsically harmful.

Third, the experiences of boys in general are not the same as those of girls. Both college studies (e.g., Finkelhor, 1979) and national population studies (Baker and Duncan, 1984; Laumann *et al.*, 1994) demonstrate that the majority of boys see their experiences as positive or neutral, but the majority of girls see their experiences as negative. Also, the experiences of girls are overwhelmingly heterosexual in nature whereas the experiences of boys are much more evenly divided between homosexual and heterosexual encounters with older persons. The element of homosexuality in the case of boys' sexual contacts with male adults has been viewed by some clinical authors as creating unique concerns for boys, such as concern over sexual orientation (e.g., Rogers and Terry, 1984). However, the nonclinical literature shows that such problems do not necessarily occur (e.g., Money and Weinrich, 1983; Tindall, 1978). Reasons for the male–female differences are unclear and need to be examined; for example, females may be more vulnerable to force or coercion. Regardless of the reasons for gender differences in reactions, however, the differences themselves are clear. It is inappropriate to use studies or reviews of the early sexual experiences of females, particularly those based on clinical samples, as a guide to understanding the experiences of males in general.

Fourth, the findings in nonclinical studies contrast sharply with those of clinical researchers, who report a broad range of emotional, behavioral, and sexual problems (e.g., Mendel, 1995; Urquiza and Capra, 1990). Reasons for this contrast need to be explored.

Clinical and Nonclinical Findings Differ

Clearly, by whatever measures of effects are used, the nonclinical research findings reviewed here differ consistently from clinically based studies

of the correlates of early sexual experiences. Reviews of clinical literature on experiences of both boys (e.g., Urquiza and Capra, 1990) and girls (e.g., Browne and Finkelhor, 1986) document an enormous range of problems associated with early sexual contacts with adults. In addition, male and female experiences in clinical studies appear much more similar in terms of outcome, although externalizing symptoms (behavior problems, sexual aggression) and concerns about sexual identity appear more common among males, and internalizing symptoms (depression, lowered self-esteem) among females (e.g., Urquiza and Capra, 1990). Contrary findings do exist in the clinical literature. Some researchers report few or no emotional or behavioral problems for some males, both as children (e.g., Lukianowicz, 1972; Baurmann, 1983) and as adults (e.g., Bender and Grugett, 1952). Clinical research also has identified a minority of subjects who do not appear to be symptomatic (e.g., Friedrich *et al.*, 1986; see Finkelhor, 1990, for a discussion). Despite these exceptions, clinical research clearly documents a wide array of problems associated with early sexual contact with adults.

We do not propose that the differences between findings from the nonclinical and clinical literatures mean that one set of literature is somehow right and the other wrong. Rather, the different sets of literature focus on different groups of individuals, with a target population for clinicians that by definition is disturbed in some way. There are also potential confounds and biases in the clinical literature that may maximize findings of harm, including confounding variables; iatrogenic harm; and, in some cases, a failure to distinguish actual harm from value judgements.

Disturbed Target Population for Clinicians

The wide range of outcomes reported in this review contradicts other literature reviews (e.g., Mendel, 1995) that emphasize the extent of harm found among boys. Previous reviews, however, rely almost exclusively on clinical and legal samples. To the extent that clinical studies tap into the population of persons most disturbed and affected by their sexual experiences, negative outcomes are unsurprising. First, adult individuals who are functioning well and do not feel disturbed by their experiences are unlikely to come to clinical attention. Second, those children or adolescents who show the most behavioral disturbance are the ones most likely to be brought to clinical attention by the concerns of parents, teachers, or other adults. Thus, clinical studies are biased towards those individuals most negatively affected by their experiences (Okami, 1991). Another potential problem is that clinicians may tend to attribute problems to sexual experiences, when other risk factors such as physical abuse or family disruption

are present, because of the recent focus on child sexual abuse in the therapeutic community and in society at large (Higgins and McCabe, 1994).

Confounding Variables

Because all research (clinical or otherwise) on the effects of early sexual experiences is by nature correlational, the possibility of confounding variables must be considered. One important confound is physical abuse. In some clinical studies (Burgess *et al.*, 1987; Dimock, 1988; Harper, 1993), a third or more of all subjects reported physical abuse. In addition, other family problems, such as substance abuse, occurred. Such experiences make it difficult to determine to what extent observed problems are due to sexual experiences themselves. Recent research shows the importance of examining multiple types of abuse or mistreatment (Higgins and McCabe, 1994; Ney *et al.*, 1994). For example, Ney *et al.* (1994) examined experiences of sexual abuse, physical abuse, emotional abuse, and neglect, and found that a combination of physical and emotional abuse and neglect was associated with the worst outcomes. Clearly, other abuse and neglect variables and family dysfunction must be controlled before specific effects of sexual contacts can be identified.

Iatrogenic Harm

The possibility that some symptoms for some individuals are the result of the intervention itself (e.g., iatrogenic harm), rather than the sexual experience, must also be examined. Interventions may be carried out by authorities in such a way that they exacerbate problems created by the sexual experience or even produce problems not previously present (Baurmann, 1983; Okami, 1990). Some research provides anecdotal accounts of individuals stating they were disturbed by reactions of authority figures but not the sexual contact itself (e.g., Bernard, 1981; Brunold, 1964). Other researchers have cautioned against the risks of overreaction by parents, police, and others when the young person shows little concern or distress over the sexual experience (e.g., Ingram, 1981). Unfortunately, little direct research has been carried out. In one investigation, Elwell and Ephross (1987) found that intervention by larger numbers of professionals was associated with more behavioral disturbance in boys and girls identified as abused—especially interventions that the parents perceived as unhelpful. Discussion of iatrogenesis should not be misinterpreted as a suggestion that professional intervention is typically insensitive and harmful, but instead as acknowledging that intervention can be mishandled in potentially harmful ways.

A related issue is the effects of family and other social reactions following disclosure of adult–nonadult sexual contacts. Researchers have noted the pressures of social condemnation and blame on adolescents and children. Burgess *et al.* (1984) reported that prior to exposure to sexual contacts the children and adolescents in their study had "vague symptoms" and "unspecified complaints"; following exposure, 49 of 66 subjects developed new symptoms. Rather than attributing the new symptoms to the sexual experience, as Burgess *et al.* did, a plausible alternative explanation is that much of the new symptomatology was due to pressure and/or ridicule from friends and family and the stresses of intervention by legal authorities (Rind and Bauserman, 1993). Elwell and Ephross (1987) also found that the more neighbors and family became involved, the worse the symptoms in the children were. Social condemnation of adult–nonadult sexual contacts and of homosexual behavior creates additional pressures for boys with sexual contacts with adults in general and with older males in particular, and these socially induced concerns have been noted by clinicians (e.g., Rogers and Terry, 1986). Appropriate emotional support by the family is now widely acknowledged as an important factor in successful coping with abuse experiences. Actions of police, therapists, family, friends, and others in the social network must all be considered when attempting to explain the problems observed in children and adolescents.

Problems in Separating Symptoms From Value Judgments of Harm

Some symptoms discussed in the clinical literature may represent a failure to distinguish harm from value judgments (Kilpatrick, 1987). Two major examples exist in the current literature: sexualized behavior in children or adolescents, and sexual orientation. The symptom of sexualized behavior in children or adolescents is reported frequently (Friedrich *et al.*, 1986, 1988; Harper, 1993; White *et al.*, 1988) and is noted in reviews of clinical literature (Beitchman *et al.*, 1991; Kendall-Tackett *et al.*, 1993; Urquiza and Capra, 1990) as one of the predominant symptoms setting sexually abused children and adolescents apart from their peers. Sexualized behavior as a "symptom" must, however, be examined critically. Constantine (1981) argued that "whether and to what extent 'precocious sexually' is problematic will depend on the social and familial values with which the child lives" (p. 239). In short, sexual interaction with peers may in no way be harmful (unless they involve elements of coercion or unwillingness), but parents and others who feel such behavior is inappropriate may interpret it as a symptom or problem. Measures of sexualized behavior and other problems, such as the Child Behavior Checklist or CBCL (Achenback and Edelbrock, 1983), are vulnerable to such value judgments. On the CBCL,

parents respond to such questions as whether the child "plays with own sex parts too much" or "asks about sex too much." Responses to such items, however, seem likely to be influenced more by parental values than by some objective standard of just how much masturbation or inquiry about sex is problematic. Clinicians may also display a confirmation bias in their own judgements; if sexual abuse is suspected in a child or adolescent, the clinician may carefully look for sexual interest and behaviors and then interpret these behaviors as a reaction to the sexual contact. In one study, "sexual advances toward other children" was listed as a sex problem (Friedrich *et al.*, 1988). Vague, broad definitions like this could result in almost any form of childhood sex play being labeled pathological or a symptom if the clinician so chooses. Although some information on the frequency of various sexual behaviors in childhood is available, there is no standard of what might be "normal" in the sense of healthy or within the expected range of behaviors (Okami, 1992). Cross-cultural research on child and adolescent sexual behavior reveals tremendous variation in terms of what sexual behaviors are viewed as normal or appropriate for children and adolescents (cf. Currier, 1981; Ford and Beach, 1951). Recent definitions of "child perpetrators" already seem to go beyond coercive behaviors and potentially label any type of childhood sex play as an indicator of abuse (Okami, 1992). The issue becomes even more difficult to resolve with adolescents. Interest in sex and overt sexual activity are a normal part of adolescence in that they form part of the experience of most adolescents (Gullotta *et al.*, 1993). To label any manifestation of adolescent sexuality a "problem" cannot be accepted as valid. Even if specific sexual behaviors displayed by children or adolescents are a problem, the issue of causality arises. It is possible that adolescents and children who are more sexually active than average are also more likely to come into contact with adults who are predisposed to engage in sexual behaviors with them.

A second example of confusion between "harm" and "abuse" occurs when sexual orientation is discussed as an outcome. Some researchers note a higher prevalence of homosexual or bisexual orientation among those with early sexual contacts with adults (e.g., Johnson and Shrier, 1985), and state or imply a causal connection. This assumption is problematic for two reasons. First, such an approach imputes pathology to orientations other than exclusive heterosexuality. The implication that homosexual or bisexual interests in males are a symptom of sexual abuse may further imply that, as with any other symptoms, they are a problem to be treated and cured. If sexual orientations other than exclusive heterosexuality are not inherently pathological, such implications are inappropriate. Second, even if a connection between early sexual experiences of boys with adult males and later sexual orientation does exist, there is an equally plausible alternative ex-

planation: A developing homosexual or bisexual orientation may lead to the sexual contacts. The male child or adolescent with the homosexual or bisexual orientation may either deliberately seek sexual contacts with older males or more readily accept sexual advances. Research on the development of sexual orientation indicates that homosexual interests or feelings of "being different" typically occur before actual homosexual activity (Savin-Williams, 1995). Alternatively, such youth may simply seek out more contact in general with male adults and consequently be more likely to encounter an adult who makes sexual advances.

In short, harm to individuals must be distinguished from violations of social norms or moral codes (Kilpatrick, 1987). A behavior may be a violation of legal or social norms, but not necessarily cause harm to the individuals involved. This issue is often overlooked when sexual issues are involved, but it must be recognized and dealt with in order to obtain valid information about the effects of adult–nonadult sexual contacts.

Taken together, the above issue leads to the conclusion that generalizing from the findings of clinical studies to nonclinical populations is invalid. This lack of generalizability to nonclinical populations is now acknowledged by many clinical researchers (e.g., Friedrich *et al.*, 1988). In a recent meta-analysis, Jumper (1995) found that studies based on student samples consistently reported smaller effects sizes of abuse on psychological symptoms than did studies based on clinical sources. Although most of the studies in Jumper's meta-analysis included primarily or exclusively female subjects, the current review suggests similar outcomes for clinical versus nonclinical male samples.

Constantine's (1981) Model of Outcomes

Results of both nonclinical and clinical studies fit the model of outcomes proposed by Constantine (1981). Constantine argued that outcomes of early sexual experiences are shaped by two dimensions, consent and sexual knowledge. "Consent" here refers to the freedom to participate perceived by the individual, not informed consent in the sense of a given level of knowledge or awareness of possible consequences. Nonclinical research clearly shows that boys (at least those in adolescence or around puberty) may perceive their sexual experiences with older persons as voluntary (e.g., Money and Weinrich, 1983; Sandfort, 1984; Tindall, 1978), and the importance of perceived consent versus force or coercion is clear from the study results discussed above.

As for sexual knowledge, Constantine (1981) proposed that an adolescent or child involved in a voluntary sexual contact who was also sexually knowledgeable, but had not absorbed "conventional moral negatives,"

would experience the best outcome. The positive outcome would largely be due to a lack of negative feelings such as guilt or shame regarding the sexual contact. However, a child or adolescent who was relatively sexually ignorant but had absorbed negative beliefs regarding sexuality (e.g., "sex is dirty") would have a worse outcome because of confusion, guilt, and shame. Guilt and shame might even intensify the negative outcome of nonconsensual contacts because of the adolescent or child's awareness of the taboo nature of the sexual activity. Constantine noted that unfortunately this condition "describes the typical American child, who is told that sex is dirty, but not what it is" (p. 240).

Constantine's model is consistent with the observation that social condemnation and pressure are associated with more negative outcomes. In the absence of social taboos and moral condemnation, negative feelings such as guilt and shame and doubts or conflicts about masculinity should not arise for children and adolescents who experience such contacts. The cross-cultural and historical literature provides examples of societies where sexual contacts between boys and adults, rather than being condemned and pathologized, instead were approved of, encouraged, or even regarded as necessary for healthy development. In ancient Greece, sexual relations between men and adolescent boys from about 12 to 17 were widely accepted and were seen as facilitating the boys' educational development (Cantarella, 1992). Up until the mid-19th century, sexual relations between men and boys were also accepted and widely practiced in premodern Japan (Saikaku, 1990; Watanabe and Iwata, 1989). The samurai warriors engaged in sexual relations with boys in a way that paralleled the form practiced by the ancient Greeks in terms of function and ages of the boys involved (Schalow, 1989). In less structured forms, sexual relations between men and boys were common and widely practiced in numerous Islamic societies in Africa and the Middle East (Burton, 1935), and were an acceptable alternative to heterosexual relations during many periods of dynastic China (Hinsch, 1990). Numerous preindustrial societies have had institutionalized age-stratified sexual relations between boys and older males, including groups in Melanesia, Australia, Africa, and South America (Herdt, 1987). Other cultures have accepted heterosexual contacts between women and boys. For example, on the island of Mangaia in Polynesia, female adults instructed boys in sexual techniques and in intercourse when they reached puberty (Marshall, 1971). Similar practices between women and pubertal boys occurred in other parts of Polynesia, such as in the Marquesas Islands (Suggs, 1966), the Hawaiian Islands (Diamond, 1990), and Tahiti (D. L. Oliver, 1974). These historical and cross-cultural examples imply that shame, guilt, and doubts about one's sexuality are not inherent in sexual contacts between boys and adults, but depend on cultural views of these behaviors.

Future Research

The present review indicates several important directions for future research. First, given the range of reaction found, researchers should allow individuals to indicate their personal reactions and own evaluation of their experience(s). This point may seem obvious, but Okami (1990) noted that some recent research has in fact structurally disallowed the possibility of subjects reporting positive outcomes. Constantine (1981) also noted that much of the research simply asked "how bad was it" rather than asking about the full range of possible responses. Asking about a full range of possible outcomes does not mean that claims of harm are to be minimized or denied; rather, it allows those who do not feel that they were harmed, or who feel that they may have benefitted, to indicate this perception. Measures of perceived consent, sexual knowledge, and sexual values would also be useful in predicting reactions and correlates (cf. Constantine, 1981).

Participants should also be grouped compared on the basis of their self-evaluations of their experiences—that is, positive, neutral, and negative responders should all be compared to each other and to control groups. This separation would allow researchers to examine consistency between self-evaluations and observed problems, and how characteristics of the experiences are associated with different responses. It would also eliminate the risk that effects on positive responders are exaggerated, and those on negative responders are minimized, by combining these groups indiscriminately.

Finally, researchers should use standardized measures of adjustment and control groups as standard practice, but should also measure potential confounding variables (e.g., family disruption, physical abuse, and socioeconomic status). Such measures can be instrumental in examining cause and effect. Without controlling for background factors such as physical abuse that may lead to problems in and of themselves, researchers may mistakenly assume that observed problems are due to the sexual experiences of their subjects (Higgins and McCabe, 1994). It is important that researchers not assume cause and effect, but instead carefully test this assumption.

Summary

The nonclinical research literature supports the conclusions that boys experience a wide variety of reactions and outcomes following sexual contacts with adults; outcomes reported in nonclinical research are readily explained by moderator variables such as the presence of force or coercion; the experiences of males and females in nonclinical samples are different, and it is inappropriate to generalize from females to males or vice versa; and generalization from clinical to nonclinical samples is invalid. These con-

clusions may contradict those of other reviewers, but are in fact based on the findings of the nonclinical research literature neglected in previous reviews. To claim that boys' sexual experiences with adults may be associated with neutral or positive outcomes should under no circumstances be misinterpreted as an effort to deny the difficulties encountered by those males truly abused or to minimize the problems they experience. Rather, it should be recognized as an effort to obtain a more complete and accurate understanding of the sexual experiences of boys with adults in the general population. Labeling all such experiences as "abuse" without any further distinction obscures the range of responses that actually occur (Kilpatrick, 1987; Okami, 1990) and may distort perceptions by exaggerating effects on those who regard their experience as positive while simultaneously underestimating effects on those with negative experiences. Inaccurate generalizations about abuse and its effects do a disservice to all those who have such early sexual experiences—both those with nonnegative experiences and those with negative experiences.

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