

AN ABSTRACT OF THE THESIS OF

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Sexual Offenses Involving Male Adolescents

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This study investigated the prevalence of sex abuse during a five-year period at two of the treatment centers within The Saint Francis Academy, Incorporated. The adolescents in this study ranged from 12 to 18 years of age and had been diagnosed with disruptive behavior disorder diagnoses. There were 242 records reviewed from 1990 through 1994. In this population, 29% of the males had been sexually abused. Of this 29%, 58% of the adolescents had been sexually abused by a male, 13% had been sexually offended by a female, 8% were abused by both male and females, and 21% did not list the sex of the offender in the files. Among the adolescent sex offenders, 68% had been sexually abused prior to their abuse of another individual. This study suggests that adolescent male sex offenders have a higher rate of being sexually abused than those who have not sexually abused others. Even though this rate is higher, clinicians cannot assume sexual offenders have been sexually victimized prior to their sexual offense.

AN EXPLORATION OF SEXUAL ABUSE
AND SUBSEQUENT SEXUAL OFFENSES
INVOLVING MALE ADOLESCENTS

A Thesis

Presented to

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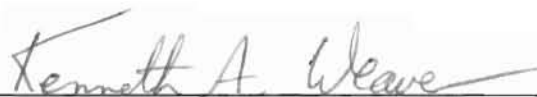
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TABLE OF CONTENTS

	<u>Page</u>
ACKNOWLEDGMENTS.....	i
TABLE OF CONTENTS.....	ii
<u>Chapter</u>	
1 INTRODUCTION.....	1
Literature Review.....	3
2 METHOD.....	13
Participants.....	13
Design.....	14
Procedure.....	15
3 RESULTS.....	17
Table 1.....	18
4 DISCUSSION.....	19
REFERENCES.....	23

Chapter I

Introduction

Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorders, and Conduct Disorder make up the subclassification of disruptive behavior disorders in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (American Psychiatric Association, 1994). These diagnostic labels are characterized by behaviors that are socially unacceptable and disruptive. Most often such behaviors present more problems to society than to the child or adolescent.

Disruptive behavior disorders include irresponsible or antisocial behaviors. The antisocial behaviors encompassed within the disruptive behavior disorder classification have frequently been referred to as "externalizing" symptoms. These antisocial behaviors tend to provide immediate gratification, some type of gain, or the infliction of injury, pain or loss of others' property (Loeber, 1982). These behaviors all involve crossing into another person's boundaries. Sexual abuse does invade another human being's boundaries, suggesting the need to determine the prevalence of sexual abuse among those diagnosed as having a disruptive behavior disorder.

Adolescents with externalized symptoms are frequently diagnosed as having a disruptive behavior disorder and

consequently placed within a character disorders treatment setting (Cozens & Force, 1991). Many adolescent sexual perpetrators are diagnosed as having a conduct disorder, which does not directly imply committing a sexual offense. Before 1990, adolescent sex offenders were typically diagnosed with Adolescent Adjustment Reaction (Ryan, Lane, Davis, & Isaac, 1987). This diagnosis provided a way to encompass a broad range of both sexual misconduct and prognoses based on the evaluator's discretion (Fagan & Wexler, 1988).

Externalizing symptoms common among male adolescent victims of sexual abuse include confrontation with or cruelty to individuals, animals, or property, lying, truancy, trouble focusing their attention, or distracting others in school. Other prevalent symptoms generally include hyperactivity, excitability or poor impulse control, phobias, nightmares, and crying spells. Defiance of authority figures in the home and the community is common. However, the aforementioned symptoms may reflect either normal adolescent growth or other forms of abuse, such as physical or emotional abuse, and other psychiatric disorders, including post-traumatic stress disorder, major affective disorder, and the anxiety disorders.

Male victims' and disruptive behavior disordered adolescents' behaviors generally suggest they are angry,

destructive individuals (Mayer, 1985). Ryan et al. (1987) found that such powerlessness and lack of control can begin a cycle of abuse to others. Untreated childhood sexual abuse problems may be expressed in adulthood through child or spouse abuse or other aggressively violent acts.

Rather than externalizing their reaction to the sexual trauma, some adolescent male sexual victims learn to internalize their symptoms, lowering self-esteem (Finkelhor, 1984). Self-destructive behavior such as obesity, anorexia, self-mutilation, suicide, self-medication, and other symptoms relating to depression also characterize male adolescent victims of sexual abuse (Mayer, 1985).

In studies within the last 15 years the prevalence of sexual abuse in nonclinical populations has ranged from 7.7% to 38% (Salter, 1988). These findings have impacted the increased need for treatment within this population, for both the victim and the offender. Increased clinical interest is also reflected by the number of published studies. Barbaree, Marshall, and Hudson (1994) reported only 9 major publications on adolescent sex offenders prior to 1970, 10 papers the next decade, and 88 papers in the 1980s.

Literature Review

Black and DeBlassie (1993) compared experiences of sexually abused boys from toddler age to adulthood. While

children may develop differing symptoms, they all possess an unusual amount of knowledge relating to sex and sexual activity. Black and DeBlassie were unable to determine, however, whether the boys externalized or internalized their trauma after the victimization occurred.

Psychosexual confusion, identity crises, and self-esteem issues were long-term effects experienced by male victims of sexual abuse, especially if the abuse was of a lengthy duration (Black & DeBlassie, 1993; Finkelhor, 1984; Mayer, 1985; Salter, 1988). In the past, society frequently has blamed the child after the victimization occurred. In some studies, the mother was seen as a co-perpetrator, since she did not protect her child (Finkelhor, 1984). Finkelhor and Hunter (1990) reported that society believed abuse of male children was offset by the male child's desire for sexual stimulation. This belief allowed the perpetrator to blame the child for the sexual abuse. As a result of this attitude, some male adolescents began to experience fears of homosexuality, creating further psychosexual confusion (Mayer, 1985).

Sexual abuse appears to be less damaging when the abuse is of short duration with no threat of harm. When the parent validates the child's self-worth by recognizing the boy is not at fault for the sexual abuse, feelings of guilt decrease. The victim must be comfortable within the family

and able to disclose the experiences to an adult. The victim also needs supportive adults to minimize any lasting negative effects of the sexual abuse (Finkelhor, 1984; Mayer, 1985).

Finkelhor (1984) found parent abuse usually occurred at a younger age for a male as opposed to a female child. Also, when a parent abuses a son, at least one other victim, usually a sister, is abused 60% of the time. The effect of parental abuse is complicated by the parent's possible return to the home and other factors such as sibling anger for reporting the abuse that resulted in the parent being removed from the home (Finkelhor, 1984; Mayer, 1985)

Researchers have attempted to determine the prevalence of male adolescent sexual abuse by surveying normal populations and juvenile offenders. The Finkelhor (1984) Boston Survey conducted from a random community sample found that 6% of the men reported some form of sexual encounter with a person who was not considered a peer and 3.2% of the men reported contact that was labeled abuse. Finkelhor's (1979) Student Survey of male college students in 1979 reported 8.7% of this population had a sexual experience prior to age 13 with a person 5 or more years older. Of the students in this college population, 4.1% had been sexually abused by an adult. Finkelhor estimates 2.5% to 8.7% of the

general adult male population had been sexually victimized as children.

Baltimore police referred sexual assault victims from four city districts to the hospital for physical examinations and to get a standardized history (Scherzer & Lala, 1980). Twelve males under the age of 14 were seen in 1978 as a result of the police referrals. This was 16.5% of the sexual assault cases for that year. Nine of the boys' families (75.7%) were receiving public assistance. Ten of the boys (82.5%) knew their perpetrators. Four of the assailants were adolescents themselves, and all were male.

Ellerstein and Canavan (1980) reviewed hospital records of sexual abuse from January 1, 1976, to December 31, 1978 in the Children's Hospital in Buffalo. This chart review included 154 female children, as well as 16 male children. In 1976, 4 of 50 cases were boys; in 1977, 3 of 52 cases were boys; and in 1978, 19 of 68 cases were boys. The age of these boys ranged from 3.3 to 16.4 years, and all perpetrators were males.

In 1983, a three-year survey was completed to determine the prevalence of physical sexual abuse among boys who entered a children's hospital servicing urban and rural communities in Ohio and West Virginia (Showers, Farber, Joseph, Oshins, & Johnson, 1983). A total of 637 sexually abused children were seen during this time period; 81 or 13%

were boys. Among the boys, 38% had been sexually victimized repeatedly. The perpetrator was usually a male teenager known to 79% of the victims. However, Showers et al. (1983) reported that boys 12 years of age or older were most often victimized by a stranger.

The Juvenile Sexual Offenders Program associated with the Adolescent Clinic of the University of Washington in Seattle surveyed 450 male juvenile sexual offenders from November, 1976, through October, 1983 (Smith, 1988). This program was designed to treat juvenile sexual offenders and their families. The adolescents referred to the Juvenile Sexual Offenders Program represented a group of sexual offenders where verbal or physical aggression may have been used, although they had not committed truly violent sexual crimes, such as rape that included sexual penetration. In this study, rapists had a lower number of previous sexual offenses when compared to the total sex offender population, 50% compared to 67.5% respectively. However, the Juvenile Sexual Offenders Program did not attempt to connect rape with the prevalence of being sexually victimized.

Smith (1988) divided the sample into two groups, one for the period from November, 1976, to January, 1981 (N = 305), and the other for the period from January, 1981, through October, 1983 (N = 145). In the two groups, 19% and 32% respectively of the boys had been sexually victimized

prior to their sexual victimization of another individual. This significant difference may be a result of better reporting, better enforcement, better questioning, or the smaller sample for the second time period (Smith, 1988).

Based upon their research at the Adolescent Clinic at the University of Washington, Fehrenbach, Smith, Monastersky, and Deisher (1986) indicated that between 1976 and 1981, 100 of the 286 boys interviewed, or 35%, had experienced some form of abuse, 11 of which were sexual only and 7 of which were sexual and physical. Sexual offenders who engaged in only exhibitionism or voyeurism were less likely to have a history of having been sexually abused. This was based upon self-report from the adolescents. Most victims of these adolescent sexual offenders were under the age of 12, with the victim's modal age being 6, suggesting most victims of adolescent perpetrators are very young (Fehrenbach, Smith, Monastersky, & Deisher, 1986). Since the majority of past research has been based upon self-reporting of sexual abuse among non-offenders, adjudicated juvenile sexual offenders, and adult sexual perpetrators, these rates may tend to be inflated, especially among admitted adolescent sexual perpetrators having a disruptive behavior disorder.

Connecting the prevalence of male adolescent sexual abuse and the history of child sexual abuse to disruptive

behavior disorders may provide further direction toward understanding child sexual abuse, which has slowly emerged as a societal problem. Even into the 1980s researchers (see, for example, Barbaree, Marshall, & Hudson, 1993; Finkelhor, 1984; Mayer, 1985) reported society felt child sexual abuse was only a minor threat to the physical and emotional development of the child.

Salter (1988) found some researchers placed the responsibility for the sexual abuse on the child and the child's mother. Finkelhor (1984) reported the child protection movement and the women's movement joined forces to help bring attention to the problem of child sexual abuse, and in the late 1970s sexual abuse reporting increased substantially. Initial efforts focused on female sexual abuse, resulting in clinicians seeing in therapy a higher portion of female versus male children who had been sexually abused (Finkelhor, 1984). In the late 1970s and early 1980s, clinicians noted increased disclosure of sexually abused male children, although defining abuse of boys was complicated by the unsubstantiated assumptions that boys tended to initiate the sexual activity and boys relative to men were affected less negatively by the sexual contact (Finkelhor, 1984).

Lack of disclosure by the child and the parent and the frequency rates of abuse in college populations and clinical

settings made it difficult to determine the prevalence of sexual abuse of boys until the early 1980s (Finkelhor, 1984). Some of this research (e.g., Salter, 1988; Mayer, 1985) led to the belief that sexually abused boys became sexual perpetrators. Other research disproved this belief (Awad & Saunders, 1991).

Adolescents who become sexual perpetrators may be diagnosed with a disruptive behavior disorder, or more specifically, conduct disorder. One of the possible criteria for receiving a diagnosis of conduct disorder is that the adolescent has used coercion or forced sexual activity upon another individual (American Psychiatric Association, 1994). At this time the DSM-IV lacks a category that pertains to sexual assault or sexual dysfunction of an adolescent. As research on male adolescent sexual dysfunction continues, a new category may be needed, especially since most adolescents are not willing to acknowledge sexually deviant fantasies or preferences (Awad & Saunders, 1991) during the assessment stage of treatment. Subgroups within adolescent sexual offenders possess sexually deviant traits, though they do not meet criteria for a diagnosis of paraphilia (Saunders & Awad, 1991), leaving the clinician to judge whether the adolescent meets the criteria for a conduct disorder.

If the conduct disorder subclassification lists as one of its criteria forced sexual activity, and some clinicians believe adolescents who are sexually abused will sexually abuse others, then connecting prior sexual abuse to a diagnosis of conduct disorder must be studied. A high prevalence of sexual abuse among adolescents diagnosed with disruptive behavior disorders may demonstrate the need for further evaluation of sexual dysfunction, especially if they engage in some form of sexual misconduct.

Knowing the prevalence of sexual abuse may also improve assessment of sexual dysfunction, therapeutic intervention, and psychiatric treatment (Stenson & Anderson, 1987). Successful assessments and interventions can be based upon having knowledge of trends and symptomatology of problem areas in order to ask the right questions. Such knowledge may help break the cycle of the sexual abuse victim eventually becoming a sexual perpetrator.

Clinicians should question whether male adolescent sexual offenders have previously been sexually abused. Ascertaining the truth of past sexual abuse is difficult, especially since some sexual perpetrators may lie in order to escape the consequences of their behavior. One of the criteria listed among disruptive behavior disorders is lying (American Psychiatric Association, 1994). The disclosure of

past sexual abuse has provided sexual perpetrators an excuse for their behavior.

Salter (1988) suggests a higher prevalence of sexual abuse among sexual perpetrators than other clinical populations. In other research, sexual perpetrators stated they were sexually abused to prevent receiving consequences for their behavior. Since most adolescents who sexually offend are likely to be diagnosed with a disruptive behavior disorder, the prevalence of determining sexual abuse among disruptive behavior disordered adolescents should be investigated. Such investigation must first determine if a higher prevalence of sexual abuse exists among sex offenders versus those without a history of sexual abuse. Therefore, this research study will determine whether the adolescent males with a disruptive behavior disorder are likely to have been sexually abused as children.

A further look at the gender of the individual abusing the victims may provide insight into this population and the continuous cycle of sexual abuse. Thus this study will attempt to answer which gender most frequently abuses those boys who subsequently become sex offenders.

Chapter II

Method

Participants

The Saint Francis Academy with facility locations in Salina and Ellsworth, Kansas, provided the sample population, consisting of male adolescents with disruptive behavior and allied disorders from all regions of the country and socioeconomic levels. These adolescents were referred by clinicians, parents, or the Kansas Department of Social and Rehabilitation Services (SRS). Those adolescents referred by SRS were adjudicated as juvenile offender or as a child in need of care.

This sample consisted of 242 clients who were released in 1990, 1991, 1992, 1993, and 1994. The average length of stay for each adolescent depended upon the program to which he was admitted, but the programs usually ranged from 10 days to 24 months. These males were 12 to 18 years of age.

As low intellectual ability may impair the adolescent's understanding of sexual abuse, adolescents with an intellectual level below 85 were excluded from this research. This low average level was selected as a cutoff score to prevent participants from being included who may have had a borderline or mentally retarded intellectual level (Wechsler, 1991) as determined by a standardized intelligence test.

The Shipley Institute of Living Scale is one of the standardized tests used to assess intellectual ability at Saint Francis. The Shipley Institute of Living Scale tends to underestimate the intelligence of an adolescent who has limited verbal abilities or has had a chaotic school history causing limited educational learning opportunities (Zachary, 1986). All adolescents had an intellectual quotient of 85 or higher ($M = 102.70$, $SD = 22.34$).

In addition, the adolescents were diagnosed as having a disruptive behavior disorder, as determined by a psychologist or psychiatrist, based upon DSM-III-R criteria. The DSM-III-R diagnoses that are a subclass of the category of disruptive behavior disorders include Attention Deficit Hyperactivity Disorder, Conduct Disorder, and Oppositional Defiant Disorder. Each of these disruptive behavior disorders is characterized by socially disruptive behaviors that frequently affect other individuals more than the adolescent diagnosed with the disruptive behavior disorder (American Psychiatric Association, 1994).

Design

In order to determine whether adolescent males with disruptive behavioral disorders who are known sexual perpetrators have a higher rate of being sexually offended than non-sexual offenders, a 2 (sexual victim: yes or no) x 2 (sexual perpetrator: yes or no) chi square design was

used. The sample population was divided accordingly into four groups: sexually victimized and a sexual perpetrator, sexually victimized but not a sexual perpetrator, not sexually victimized but a sexual perpetrator, and not sexually victimized and not a sexual perpetrator. In addition, a 1 x 4 chi square was used to determine whether the abuser's gender (male, female, both sexes, and not listed in the file) was equivalent for the subset of the sample that had been abused.

Procedure

Past records of adolescents admitted to Saint Francis Academy at Salina and Ellsworth between 1990 and 1994 were reviewed to determine the prevalence of sexual abuse among disruptive behavior disordered adolescents. The scientific hypothesis suggests that sexual perpetrators within this population would have a higher frequency of previous sexual victimization than the adolescents who were not adolescent sexual perpetrators.

Each adolescent's sexual conduct was classified into one of the four groups. The classification of each adolescent sexual offender and victimization of the adolescent was determined by documentation from a psychiatrist, psychologist, social worker, psychotherapist, or from actual court records. This helped to prevent inflated statistics based upon self-report.

A Data Collection Worksheet for each adolescent was completed at the time of the review of each case file. The worksheet included: (a) the case number to protect each adolescent's anonymity in order to maintain his confidentiality; (b) DSM-III-R Diagnoses; (c) IQ; (d) the group into which the adolescent fits, either 1, 2, 3, or 4; (e) date of completion of the Worksheet; and (f) the sex of the perpetrator who had offended the adolescent.

Within the medical community, sexual abuse has been defined as the result of exposure to sexual activity or stimulation that is inappropriate for the child's age and stage of psychosocial development (Ellerstein & Canavan, 1980). For the purpose of the present research, sexual abuse is defined as any sexual contact involving coercion (Smith, 1988) or with a perpetrator three or more years older. Sexual exploration with consenting peers was not included. The term sexual perpetrator will label the individual who initiates sexual contact through the use of coercion.

Chapter III

Results

There were 242 male participants in this study, 29% of whom had been sexually abused. Among just the adolescent sex offenders, the prevalence of having been sexually abused was 68%, and 32% had not been sexually abused.

In this study, 150 males had not been sexually victimized and were not sexual perpetrators; 21 had not been sexually victimized, but were sexual perpetrators; 27 had been sexually victimized, but were not sexual perpetrators; and 44 participants had been sexually victimized and were also sexual perpetrators. The chi square was significant, $\chi^2(1, N = 242) = 108.06, p < .01$ and the phi correlation coefficient was .51. If the adolescent had not been victimized, he is likely not to be a perpetrator, but the adolescent victim has a moderate tendency for being a perpetrator.

Among the 71 participants who had been sexually victimized, 58% were victimized by men or boys; 13% were victimized by women or girls (see Table 1); 8% were molested by both genders; and 21% of the cases did not list the perpetrator's gender. A higher prevalence $\chi^2(1, N = 71) = 42.97, p < .05$ of men or boys than women or girls were the victimizers of the sexually abused children.

Table 1

Gender of the Perpetrator who Sexually Victimized the Adolescent

Gender of Perpetrator	Victimized, Not a Sex Offender		Victimized, Sex Offender		Total Adolescents Victimized	
	N	%	N	%	N	%
	Males	14	52	27	62	41
Females	4	15	5	11	9	13
Both	1	3	5	11	6	8
Not Listed	8	30	7	16	15	21
Total	27	100	44	100	71	100

Chapter IV

Discussion

The prevalence of sexual abuse among the participants ranging in age from 12 to 18 who had a disruptive behavior disorder was investigated at The Saint Francis Academy. The prevalence of sexual abuse was 29%. The remaining 71% of participants had not been sexually abused or at least there was no documentation by a professional in the case records.

Significance beyond the .01 level suggests there may be a relationship between being a victim of sexual abuse and being a sexual perpetrator. The phi correlation coefficient of .51 indicates there is a relationship between sexual victimization and being a sexual perpetrator. A phi correlation of .51 suggests there is only a moderate chance of the participant who is a sexual perpetrator having been sexually abused, but if the adolescent is not a sexual offender, he is most likely not to have been sexually victimized. As a result of this relationship, clinicians may place importance on collecting background information from family members and others. This may help determine whether treatment of the sexual abuse is a factor when treating adolescent sexual offenders.

The significance of this relationship has not been influenced by inflated rates of abuse reports. Only documented cases, and no self-reported cases were accepted

in this study to prevent inflated statistical results of sexual offenders claiming to have been victimized as an excuse for their victimization of others. The significance of the relationship between sexual abuse and sexual victimization may actually be higher, since male children are more hesitant to report their own sexual victimization. In addition, most males are sexually abused at a younger age than females. Because of this, it is more difficult for adult care givers to believe the abuse has occurred, and it is more difficult for them to respond to the situation.

Eleven years ago, the Juvenile Sexual Offenders Program in Washington found that between 19% and 32% of their sample population had been sexually abused. In the present study, the percent of sexual abuse among the offenders was 68%. One reason for the increase of sexual abuse rates may be a result of programs designed to teach children to tell adults of people who have harmed them. These types of early prevention programs found in child care centers and nursery schools may promote reporting of abuse at a young age.

A second reason for the increased sexual abuse rates may have resulted from parents feeling more comfortable telling professionals of the abuse to their children. Previously, mothers were thought of as co-abusers (Salter, 1988) because they did not prevent the abuse. Mothers may have begun to realize that when a baby-sitter or a boyfriend

has abused their child, the perpetrator and not the mother is to blame. Women who have been victimized are generally more likely to discuss their own sexual abuse (Finkelhor, 1984). It may be easier for mothers to report the sexual abuse of their child as a result of memories of their own past trauma.

The correlation between the age of the adolescent sex offender when sexually abused and the age of the person this adolescent sexually abused may help further determine whether the sexual offense is tied to issues of power, trauma, and homosexuality. More males than females sexually abused the adolescent, although whether the perpetrators were homosexuals, pedophiles, or past victims is unclear. Continued investigation of these issues is indicated.

Continued research with this group could further provide information about peer relationships among adolescent sex offenders, especially if the adolescent has few age-appropriate friends and socializes better with younger children. Relationships with adults may present a different factor. Isolation from peers and adults may result in their need to interact or gain acceptance by younger children.

This population of sex offenders with disruptive behavior disorders could provide more information about sexual dysfunction. The Saint Francis Academy,

Incorporated, is in a key position through their Research Department to further investigate sexual abuse, especially within dysfunctional families. Determining a prevalence of sexual abuse or victimization among the adolescent's family members through longitudinal studies would be informative. The gender of the person who was abusive to the child or adolescent in this sample population may be appropriate, as well.

Parenting practices have changed as a result of divorce and the increase of unwed or single parents raising children. Single parents are required to depend more on others to help care for their children, which creates more opportunities for perpetrators to abuse children without parental knowledge.

Societal change has allowed for more flexible sexual mores, such as living together out of wedlock. These flexible sexual mores can also create a situation that may promote sexual abuse through deviant individuals or change in what society considers acceptable behavior. This may actually encourage what is presently considered deviant sexual behavior with children. Such change allows for more open discussion of sexual activity. Hopefully this openness will allow children and adolescents more freedom to safely report abuse, thus breaking the sexual abuse cycle.

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An Exploration of Sexual Abuse and
Subsequent Sexual Offenses Involving
Male Adolescents

Title of Thesis/Research Project

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May 8, 1995

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