"Don't Shoot, We're Your Children": Have We Gone Too Far in Our Response to Adolescent Sexual Abusers and Children With Sexual Behavior Problems?

Fifteen years ago, when we first began working with adolescent sex offenders, treatment providers faced many obstacles. There were no treatment models uniquely designed from scratch for this population. No true experimental research had been used to evaluate the effectiveness of either customary or specialized interventions. There were no prospective data on the natural course of behavior in these youngsters. And there were no prospective data on the risk factors for developing the behavior. No empirically derived typologies existed. No actuarial risk assessment was available. Of course, the need to respond to social problems cannot and does not wait for better data. So, like our colleagues, we proceeded with some trepidation, knowing that we were largely working in the dark, and borrowed treatment models used with other populations and for other problems. We mixed and matched. We used informed guesswork, tried to remain guided by theory and professional standards, and hoped.

Now, 15 years later, things have changed. Unfortunately, much of what has changed has not been the state of our knowledge about many of the central questions needed to intelligently design interventions. Certainly, we have much more information about many important questions—general psychological characteristics, program descriptions, behavior patterns, relapse rates following intervention, family characteristics, and so forth. However, not one of the basic critical questions described above has been answered more than tentatively, if at all. There are still no true experimental studies comparing outcomes of treated versus untreated adolescents and no prospective data on either risk factors or the natural course of the behavior; there are only the beginnings of empirical typologies and no actuarial risk assessment. Largely, the field is still using treatment models and assumptions borrowed and adapted from programs developed for incarcerated adult pedophiles. These things have not changed.

Disturbingly, what has changed is the conviction that we have found the right track. The field has evolved conventional wisdoms that, like all conventional wisdoms, became accepted as fact when repeated and reinforced often enough. In some cases, they may shade into dogma. These might include beliefs, for example, that sex offender–specific treatment is the only acceptable and effective approach and that all teens and children who have performed inappropriate sexual behaviors must receive it; that a history of personal victimization is usually present, is a direct cause of abusive sexual behavior, and must be a focus of treatment; that denial must be broken; that hard, in-your-face confrontation is synonymous with good therapy; that treatment must be long term and involve highly restrictive conditions; that deviant arousal, deviant fantasies, grooming, and deceit are intrinsic features; that parents and families of offenders are generally dysfunctional; that long-term residential placement is commonly required; that the behaviors always involve an offense cycle or pattern that must be identified; that these teenagers and their parents must face the fact that they have a compulsive, incurable, life-long disorder; and that these youngsters are such dangerous predatory criminals that neighborhoods must be notified of their presence. Despite their wide acceptance, it is our opinion that clear, empirical scientific support for each and every one of these conventional wisdoms is either minimal or nonexistent.

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The origins of many of these conventional wisdoms are fairly clear. They evolved from work with adult sex offenders and pedophiles, often in penal settings. And, they evolved from clinical impressions. However, we should recall that our clinical impressions are often the products of our belief systems and are vulnerable to confirmatory biases. Certainly, we have seen individual cases in which some or many of these conventional wisdoms seemed to be true. But how well they apply to adolescent offenders in general, to as yet unspecified subgroups, or to any individual teenager remains open to serious question. And, it seems reasonable to assume that these conventional wisdoms become increasingly strained as one moves further down the developmental ladder and further away from the adult sex offenders and pedophiles on which the beliefs are based. Is a 12-year-old who has experimentally touched a child on a single or a small number of occasions suddenly transformed into a predatory pedophile for life? We would suggest, "No." Should all teenagers who have engaged in inappropriate or abusive sexual behaviors receive treatment heavily based on an adult pedophilia model? In considering these questions, it may be useful to remind ourselves that we have an obligation first, to do no harm to our patients and second, to practice within the limits of our knowledge base. These principles are especially important in circumstances involving mandated or coerced treatment and in circumstances in which treatments may involve aversive procedures, negative social labeling, restrictions on freedom, embarrassment, or shame.

It is time for potentially harmful practices that are used in well-intentioned efforts to intervene with these children and adolescents to engage our professional attention. We should be on guard against the potentially punitive, aversive, and absolutist tone inherent in some of our treatment beliefs. Punitive or aversive treatment approaches must be considered within the context of a current political climate that exaggerates our fear of juvenile crime and energizes corresponding movements to punish children and youth as we would hardened adults (what some commentators have termed the *war on children*). This, combined with the emotionality and zeal surrounding sexual abuse and sex offenders as well as with the positions of power we assume in treating coerced patients under the auspices of official authority, should alert us to the potential for harming youthful patients by swatting flies with sledge hammers.

Our unfortunate experience has been that these are not abstract concerns. For example, we have been concerned to see children as young as 10 or 12 subject to sex-offender registration laws and neighborhood notification; to have seen a 10-year-old coercively interrogated by police without parents or attorneys present, shackled and chained, and then placed in lockup facilities where he was beaten and sexually assaulted by older inmates until becoming suicidal; or to see parents told that their 7-year-old child could never return home again after two incidents of genital fondling of a 5-year-old sibling—all in the name of controlling sex offenders and all based on behavior involving single or very few incidents.

Fifteen years ago, our battle was getting the system to take cases seriously. We may have been too successful. Where we previously encountered public reluctance to identify the problem, we now sometimes encounter not only willingness but also zeal. We see the labels of *offender* and *perp* placed on preschoolers. In many instances, this has extended to affixing the label of *sex offender*, even in advance of any actual inappropriate behavior. Youngsters discovered to have abusive family members, a personal abuse history, or innocuous sexual behaviors such as masturbation may be seen as candidates to begin perping. For example, in at least one state, legislation has been proposed that would mandate that some sexually abused children be labeled as posing a risk to other children and segregated away from other children in foster care and other placements.

Moreover, related practices extend into treatment settings. We have encountered young teenagers (13 to 15) who, as part of their treatment, have been compelled to recite daily lay-outs or creeds including phrases such as "I am a pedophile and am not fit to live in human society. . . . I can never be trusted . . . everything I say is a lie. . . . I can never be cured." We have encountered residential programs where teenage boys were sanctioned if they looked at girls, were required to look at the floor when they passed females in the hall, and where the message was conveyed that all forms of teenage sexuality were offending. We have listened to teenage boys hesitantly confess that they admitted to offense histories and deviant fantasies they did not have, simply because it was expected and required before they would be eligible for release from residential programs. Our impression is that these incidents cannot be dismissed as isolated examples of overly zealous practice but are directly derived from an uncritical application of prevailing treatment models. Additional practices of concern for children and teenagers include the overly broad application of techniques such as fantasy journals, addiction/compulsion programs, shame therapy, or aggressive victim empathy techniques.

The available treatment outcome research suggests that detected sexual relapse rates among teenage

offenders who have been in treatment programs are typically modest (around 5%-15%), despite widespread public and professional assumptions to the contrary. However, we do not know if this represents any difference from relapse rates of untreated adolescents. Empirically, we cannot say whether treatment helps, hurts, or makes no difference. Furthermore, the available data do not support any one type of treatment over another with the exception of tentatively supporting the delinquency-focused multisystemic treatment over individual counseling. One thing the data does support is the fact that nonsexual problems appear to be vastly more common than do sexual ones for these teenagers. The Association for the Treatment of Sexual Abusers (ATSA; 1997) has endorsed the position that "poor social competency skills and deficits in self-esteem can best explain sexual deviance in juveniles, rather than the paraphilic interests and psychopathic characteristics that are more common in adult offenders" and that "there is little evidence to support the assumption that the majority of juvenile sexual offenders are destined to become adult sexual offenders, or that these youths engage in acts of sexual perpetration for the same reasons as their adult counterparts" (pp. 1-2). Given this, perhaps it is time to emphasize some flexibility and compassion in which treatments we choose and to which individual youngsters we apply them and to realize that individual need, not dogma, should dictate what must be accomplished.

The potential benefit of intervening with youthful sexual abusers is a real one. The fact remains that a significant amount of child sexual abuse and related behaviors are committed by children and teenagers. The fact remains that some currently unknown, but probably not insignificant, proportion of youthful abusers continue abusive behavior into adulthood and that adult abusers who have adolescent onsets may be responsible for a higher-than-usual number of events. To the extent that we can identify those truly at risk and work productively with them, our communities will be safer. But in the process, we should not forget that these are our children. And, as professionals committed to children's rights and welfare, we should think carefully about their rights and welfare before responding to their behavior.

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REFERENCE

Association for the Treatment of Sexual Offenders (1997, November). *Position on the effective legal management of juvenile sexual offenders.* Beverton, OR: Author.