A Therapist's Perspective on the Compliant Child Victim

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This issue of the "compliant" child victim of sexual abuse brings into our awareness many difficult and uncomfortable aspects of current social policy and practice in our field. I am going to join this discussion primarily from the perspective of psychotherapy. A few introductory thoughts may set the context for how I see this complex issue.

Which Cases Shall We Include?

Shall we include in this discussion only those adolescents who report or behave as compliant victims as Ken Lanning defines them? If so, we really do not know how widespread this phenomenon might be. It might constitute a relatively small proportion of cases or encompass most child sexual abuse situations. Certainly, periodic news stories relate the most extreme versions of these types of cases. A typical media story is that of a young woman who marries the man who abused her when she was a teen, often after he was released from prison. In clinical offices, we encounter, with relative and perhaps increasing frequency, teens who had some role in placing themselves in such compliant situations or in on-going relationships, or who failed to disclose grooming or initial sexualized encounters with older persons.

As Lanning well describes, these are troubling cases and more information about them would be very useful. On the other hand, we always worry in our field that the sensational but rare case will divert attention away from more widespread yet deserving cases. Clearly, there is a lot we do not know about the treatment of children who are sexually abused.

Issues of Consent

Lanning also points out that the issue of victim consent is critical in the law as well as in our understanding. As a therapist, I think this subject is particularly complex and have observed that most cases, even those occasionally of stranger assault (rape), involve victims who perceive that they have given some degree of consent. The child who did not say "no" when the back of her head was touched may feel she gave consent to subsequent victimization. The child who did not actively resist may perceive that failure as a form of consent. The child who did not disclose after the first incident may feel he gave consent to the second occurrence. This notion that victims genuinely feel they have given some degree of consent, albeit often an irrational belief, challenges us to define what *consent* actually means in this context.

As a field, we have never been comfortable with the idea that children can consent or believe they can consent to sexual contact with older persons. One of our leading scholars, David Finkelhor (1979), long ago noted that children cannot consent because often they do not understand what it is that they are consenting to and do not have the power to say "no" (the basis of informed consent).

The very idea that children would, could, or should be allowed to consent to sexual contact with older persons is deeply troubling. We rarely allow ourselves to consider this possibility and act (from assessment through treatment to termination) on the premise that, regardless of the child's behavior, true consent could not have been given. This perspective leads to a therapist stance that the offender is always one hundred percent responsible, that the victim should hate the abuse, and that the victim should feel no responsibility for the abuse. Feelings of self-blame, no loyalty to the offender, and even ambivalence, although widely recognized as common, are generally feelings that are considered pathological. Therefore, a goal of treatment is to assist the victim in evaluating and often rethinking beliefs.

In many cases, it is true that what child victims perceive as consent is really simply a function of offender exploitation of children's youth, inexperience, and dependence and in no way realistically represents informed consent. This is especially the case when the victim clearly did not want or like the sexual contact or was so needy and vulnerable that he or she could not assert real interests. This is always the case with prepubescent children and almost always the case with teenage victims of incest.

There is, however, a difference for some teen compliant victims. Teenagers—because of their age, developmental capacities (e.g., ability to maintain a view independent of and different from the views of adults), and at times their adaptation and reaction to life circumstances—are more able to make informed decisions. This does not mean that their decisions are always well thought out or mature. But the fact is that at a certain arbitrarily defined age, the law presumes teenagers can give informed consent to sexual relationships. There is no societal consensus about what this age is because laws vary from state to state, but we do set an age after which a teenager can engage in sex with a person no matter how much older.

This means, for example, that if the age of consent is 16, then it is perfectly legal for an adolescent and a 50-year-old to have a sexual relationship. Yet, the day before the teenager's sixteenth birthday, this relationship is a crime. Does the capacity to consent change overnight? Should we therapists treat such situations completely differently? Should our views about consent strictly adhere to the law, or should they be based on some individualized assessment of the child and circumstances?

What children can consent to and what they should consent to might be very different things. Most critically, it is not our views that should have the primary influence over the therapy but rather our clients' views, balanced against principles of development, mental health, and freedom as well as balanced with their capacity to make informed judgments about long-term consequences.

One of the biggest problems with this strongly held set of attitudes on the part of therapists concerning children's inability to consent is that it may deny the experience and perception of many victims. Even with very young victims, when it is clear they could not consent, they may feel a sense of responsibility. The reasons for this vary. For some, the idea that they somehow gave consent provides a feeling of control (i.e., attribution of control). For many, it flows from having not said "no," having gone along with or even initiated the relationship, from having wanted some aspect of the relationship (e.g., the affection, support, or attention), or from some highly personalized thought process (e.g., I am keeping my family together by not telling them what is happening to me because they could not handle it).

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Often the victim's sense that he or she has given permission for the sexual contact flows directly from the manipulations, rationalizations, or other "mind games" that offenders are expert in using. On the other hand, from an objective perspective, it is true that some acts by child victims have contributed to their victimization. By failing to acknowledge that many victims feel they they have in some way given consent for their acts, however, we deny their experience and deprive them of our assistance with troubling thoughts and feelings.

Social Construction of Sexual Relationships

It is often hard for us to remember that modern opposition to adult-child sexual contact is a social construction. Laws against such contact, the elements making such contact a crime, and what kind of crime it represents are all matters of social policy and social construction. Historically, adult-child sex has been allowed or condoned under a variety of circumstances. Even today, in some societies, adults can have sex with or marry children of an age that we might consider unacceptable. With whom and under what circumstances sexual relationships are legitimized is influenced not just by laws but also by community standards, religious tenets, and psychiatric perspectives. For example, the older readers among us will recall a time when same-sex sexual attraction and behavior was considered a diagnosable condition. Most of us no longer feel this is a proper view.

The arguments for why sexual contact between adults and children should be forbidden, against the law, and cause for bringing children into contact with therapists are old and have not been revisited for some time. They partly flow from concerns about the effects of sexual abuse on children, although we also recognize that not all children are negatively affected and those who are affected are not impacted in the same way. Some argue that it is the fact that sexual contact between older persons and children is inherently for the pleasure of the older person that makes it objectionable. Some argue that sex outside of marriage is wrong and thus should be prohibited. Many therapists hold their views about sexual contact between children and older persons from a developmental perspective, which argues that children do not have the capacity to manage, understand, or process sexual contact, especially with developmentally more advanced older persons.

My point here is not to reopen this discussion, although fundamentally I think it bears reopening. Rather, I wish to remind us that these views about the "wrongfulness" of sexual contact between children and older persons are social constructions. Further, I want to suggest that the more our cognition is unconscious, the greater risk there is that we will negatively impact how we view clients, how we approach our work with them, and hence, the extent to which we make it possible or not for the young to express their own attitudes toward their experiences.

More critically, however, I want to remind us that cases of compliant teen victims challenge and trouble our underlying assumptions about childhood and sexuality. To the extent that we are unaware of these fundamental beliefs, and to the degree to which our beliefs are inconsistent with those of our clients, we set up an extremely difficult clinical situation. In subtle and sometimes not so subtle ways, we cut off communication with our clients. And, when we negatively impact their process of identifying, articulating, and potentially revising their own beliefs, we potentially negatively impact the therapeutic relationship.

Sexual Object Choices

I think it is helpful to remember that from a clinical perspective, all sexual object choices are clinical phenomena, as is any aspect of behavior or any psychological process. This is as true for teenagers as it is for adults. Our motivations for seeking out certain kinds of relationships (e.g., the transferences that impact partner selection, the types of sexual behaviors we prefer, interpersonal attraction in general, and many other aspects of who we want to engage with what kinds of behavior) are all matters in part of our histories, psychologies, and opportunities. In varying degrees—given capacity, interest, motivation, and opportunity—the nature of these factors are knowable.

From a clinical perspective, one of the goals for therapy with compliant victims is to engage in a process through which the historical, developmental, and psychological reasons for their apparent object choice become self-evident. It is our fundamental belief as therapists that once such factors become known, clients are in a better position to make more conscious decisions about future behavior. This is the essence of informed choice.

What troubles me personally is that typically the teen compliant victim has no awareness of the bases in her (sometimes his) own life for why a particular sexual relationship has been chosen. It is hardly a choice when one is driven or manipulated into a certain kind of relationship. Although many sexual object choices made by adults might involve elements of manipulation or exploitation about which they have little appreciation, we may approach these choices differently than we do with adolescents.

It is my basic stance that all relationship and sexual object choices are matters of complex interactions among multiple factors, such as motivation, history, attraction, need fulfillment, and so forth. Our approach with adults who make object choices that are hurtful, not satisfying, destructive, or otherwise problematic is to help them to identify factors that underlie their object choices and come to new or renewed decisions about their life. Although we usually have limited information about the object choice factors of adolescent victims, I think our stance should be basically the same as with adult clients.

In fact, some of the factors underlying the object choices of the complaint victim are known. Rebellion and acting out may be reasons for some teens. Attention seeking, support, and nurturance, albeit often sexualized, are reasons for others. Search for lost, idealized, or never-experienced parental relationships may underlie other cases. The desire to be older and seen as more mature than one is can be another factor. The individual reasons are no doubt as varied as there are cases.

My basic point is that clinically our goals should be to help the client understand these factors, not to pass conscious or unconscious judgment on acts that have their origins in historical, developmental, or other psychological processes.

Managing Our Own Feelings

The adult world has determined, for complex reasons (many of which I personally endorse), that adult-child sexual contact is to be avoided. However, these cases involve elements or dynamics that are deeply disturbing and often get confused in our thinking. At the most basic level, they involve an older person and a younger person being sexual. Often the participants are involved at high levels of sexual-

ity, highly frequently, and in nontraditional places (e.g., church sanctuaries, classrooms, or family homes while other family members are in adjacent rooms). These cases also involve issues of "proper" object choice, acting out sexual fantasies, impulse control, sexualization of idealized- and culturally-based views of childhood (e.g., innocence or incest taboos), and other repressed impulses and ideas.

Moreover, many compliant victims have been engaged in developmentally premature, frequent, and highly sexual interactions over time and present with a highly sexually charged demeanor and interactive style. Even when not so sexualized, the fact of their experiences creates in the minds of others a view of these teens as highly sexual. Their very presence in our communities challenges deeply held, albeit irrational, myths that children are nonsexual, that adults do not violate role expectations, and that those in power can be trusted.

The presence of compliant victims can also trigger the vicarious expression of deeply held fantasies, fears, and anxieties. Whether these are about sex with adolescents (as in the Lolita books and films) or about other impulses and ideas is a matter of some debate and beyond the scope of this article. However, compliant teens do represent the possibility that defended-against impulses and ideas might be acted out and brought into action. When issues of sex are added, it is not hard to understand why adults and whole communities have to protect themselves from acknowledging the existence of such cases. Faced with this reality, law enforcement or other child protection systems and the public are prone to take immediate, even if often unconscious, action to blame the victim, prosecute the adult person, and push any accompanying feelings back into our own unconscious.

The Therapeutic Response

The ideas outlined above bring me to comment on our basic stance as therapists when confronted with compliant victims. One of the first questions we should ask is whether to accept these cases in therapy and, if so, what should be the treatment goal.

Children do not usually volunteer for treatment; their parents bring them. In most cases with children, we do not expect them to be able to make decisions about whether they need treatment. However, in the case of a compliant victim, the child, who is the client, may fundamentally disagree with the premise for therapy made by his or her parents or other adults—that what happened was wrong, that there has been harm, and that professional assistance is needed. With all clients of all ages, especially with complaint victim cases, a successful outcome depends upon the formation of an alliance and some agreement about the purpose and goals of treatment. This can be very tricky in these types of cases.

Managing Counter Transference

It will be no surprise to my many child abuse colleagues that my first recommendation is to be aware of our own powerful counter transferences when it comes to these cases. As outlined previously, I believe strongly that our own feelings, cognitions (beliefs), and fantasies play a critical role in how open and neutral we remain while approaching clients. We must provide the best conditions possible for them to discover their own deeply held and often unconscious ideas about their behavior.

Clinical Material

All behavior, experience, feeling, belief, and other aspects of living— whether expressed, presented, or hidden from the therapy—constitute the "stuff" out of which therapy takes place. The reactions of others, whether present in the client's life today or in the past or existing as generalized impressions of "the other" and whether real or expressions of aspects of one's own superego, are all relevant aspects of clinical process. The therapeutic goal for all clinical material, especially in assessment, is to understand the meaning, origins, and nature of the client's experience. When the client's experience is as troubling as that of the compliant victim, extraordinary caution and neutrality are required. The goal is to assist clients in understanding not just the extent to which they were compliant but, more importantly, the nature, developmental and historical foundations, motivations, and dynamics of the "choice" as well as the extent to which the sexual relationship really was in fact a "choice."

Neutrality

The therapist has a responsibility to provide a fundamentally different experience from that which the compliant victim has with parents, prosecutors, significant others, and even the older person with whom he or she has been involved. But, the notion of therapeutic neutrality is often misunderstood, especially by our nontherapeutic colleagues.

As Chessick (1993) pointed out, "The great value of neutrality is that it encourages the patient's free association and expression of many embarrassing and very private thoughts and fantasies" (p. 258). Managing our own counter transference to the client's experiences, apparent choices, and actions; avoiding imposing or supporting predominate views about their behavior; and noncontingent regard, warmth, and acceptance create the therapeutic conditions in and through which compliant victims can come to understand more fully their own experience.

Even so, some compliant victims may remain emotionally attached to the older person with whom they were sexually involved. Our ability to create a therapy process that allows for such an outcome is the challenge we face. My experience, although as limited as most therapists I suspect, is that usually such a stance allows teens to understand the extent to which their compliance was in fact not a free choice. They are then able to move beyond the experience with greater capacity for free choice in the future.

At its most basic level, our field seems to seek a world in which individuals, children, and adults are not manipulated, coerced, tricked, or unconsciously led to act in ways that are potentially not in their best interests. At least at the beginning of therapy, compliant victims do not agree with our view of their circumstance. How do we apply our ideas about development, history, and psychological processes to help children and youth understand the bases upon which they and others act? How can we facilitate alternative decisions for them about how to behave and be that can make all the difference?

Chessick, Richard.1993. *A Dictionary for Psycho-Therapists*, New York:Jason Aronson.

Finkelhor, David. 1927. What's wrong with sex between adults and children? *American Journal of Orthopsychiatry, 49*(4), 692-697.