RESPONSIBLE MANAGEMENT OF SEXUAL ACTIVITY AMONGST CLIENTS WITHIN A RESIDENTIAL TREATMENT CENTER FOR SEXUAL MINORITY YOUTH

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Bill is sixteen years old and is being screened for admission into one of the local residential treatment centers for youth. His collateral information indicates a youth in need of out-of-home care as he has been out of parental control for several months, dropping out of school, beginning to abuse alcohol, has had one run-in with the police, and has no community or family resources at his disposal. The interview with the agency treatment team goes well and Bill's caseworker believes that a place will be secured for Bill. During the post-interview staff debriefing, one of the child care workers asks how Bill's sexual orientation will affect the house? Bill is gay, and identified himself as such during the interview. The staff spend the rest of the debriefing session discussing the ramifications of having an openly gay adolescent in the house. While it is agreed that there will be some effects on the other youth, the staff are sure that they can handle any situation and that Bill deserves a place within the milieu. The decision to accept Bill is about to be made when the question of sleeping arrangements is raised, "all of the rooms are two person spaces, can we place a gay kid in a room with another boy?" The conversation is halted at this point. No one is sure how to address this issue.

If the above situation sounds absurd to you let me assure you that it takes place throughout the nation as Child and Youth Care Workers face the demands that homosexual youth may place on our service delivery system. The staff at the agency saw no reason not to admit Bill into their program; in fact, he seemed to be an excellent candidate for the services that they provide. However, the issue of sexual contact between clients is one which needed to be addressed. Would having a self-identified gay youth increase the likelihood of sexual activity within a bedroom? What about if all the clients within the facility were homosexual? The scope of this paper will be on the means necessary to provide responsible management of sexual activity in a residential treatment center with an exclusive sexual minority population.

Background

There is a lack of residential treatment centers (RTCs) in this country which can provide a safe and supportive environment for sexual minority youth to openly acknowledge and express their sexual orientation and

provide culturally sensitive treatment experiences for these youth. (Treatment is used not as a reference to treating the sexual orientation of these youth, but to those problems which become manifest with such an orientation in current society; and for those problems associated with youth in general.) For the majority of sexual minority youth, society does not offer the nurturance to openly express one's gay, lesbian and/or bisexual orientation (Coleman and Remafedi, 1989; Hetrick and Martin, 1987; Hunter, 1990; Hunter and Schaefer, 1987; Martin, 1982). The time has come in this country, for child, youth and family care workers to create safe and supportive RTCs for those clients in need of such a setting *and* who are of a sexual minority (McMillen, 1992).

Let me focus on Oregon for a moment. The Task Force on Sexual Minority Youth estimates that there are approximately 50,000 homosexual and bisexual youth in Oregon (McManus et al., 1991, p. 8) and that approximately 20% of homeless youth self– identify as exclusively homosexual or bisexual (p. 15). This report and my own clinical experience with sexual minority youth in Portland, Oregon, concur that many of these homeless youth and sexual minority youth in general (Hetrick and Martin, 1987; Remafedi, 1987; McMillen, 1992) have received some form of treatment within community and private social services (i.e. school counseling, foster placement, individual and family counseling, drug and alcohol prevention and addiction counseling, shelter care, detention and juvenile court, and placement within RTCs). However, with such a percentage of homeless youth being sexual minority and with suicide rates for sexual minorities being 2-3 times higher than those of their heterosexual peers (Remafedi, Farrow and Deisher, 1991; McManus et al., 1991, p. 12), it is time for professionals to question the effectiveness of treatment services provided.

Social Service Needs

> Group homes, emergency shelters, residential treatment facilities, and juvenile detention facilities can be dangerous places for sexual minority youth. Rape is a common form of violence against lesbian and gay youth in institutions. Lesbian and gay youth in institutions are frequently blamed by administrators for the fact that an assault occurs. They may be accused of "flaunting" their sexual orientation. Simply acknowledging one's sexual orientation may be viewed by some as "flaunting." A frequent institutional solution is to expel the victim from the facility or isolate the victim from others rather than confront the perpetrators and address the issues of homophobia (McManus et al., p. 15).

There are many social service needs (Remafedi, 1987; Schneider, 1991; Martin, 1992) for sexual minority youth of which residential treatment centers are only one. In creating such RTCs the program manager would face many of the same obstacles which all RTCs face (namely, financial and

community support), but there would be added pressures. Society as a whole may have difficulty accepting RTCs which endorse and support sexual minorities. The RTCs would be subject to public and professional scrutiny of an intense nature. Policies regarding the admission of clients, selection of staff, treatment plans, treatment modalities, family and community involvement, education, and sexual relations between clients would be examined.

This paper will examine the policy of management for sexual activities between clients within a group home for sexual minority youth. It is the position of this paper that sexual activity exists between youth and that homosexual sexual activity is a healthy form of sexual expression. It is also assumed that, as adolescence is a time of sexual exploration (either mentally, physically or both) (Hetrick and Martin, 1987; Juhasz and Sonnenshein-Schneider, 1980; Schneider and Tremble, 1986; Striar and Ensor, 1986; Troiden and Goode, 1980), adolescent clients within RTCs are, as with their peer counterparts, looking for opportunities to express their sexuality (Striar and Ensor, 1986; McMillen, 1992). The question of whether there can be consensual sexual experiences between peer youth is a strong one, and one in which there is little agreement. While this paper does not directly address this issue, it needs to be noted that the sexual experiences being discussed here are consensual in nature, with the assumption being that youth are capable of (and, in fact, are) making such decisions with other peers.

Within a group home for sexual minority youth, as within any form of RTCs (Striar and Ensor, 1986), it is crucial that client physical contact be minimized. It is possible to examine this need to limit sexual contact within the RTCs from several vantage points, including the moral and developmental needs of the client and society. However, the point of this paper is that sexual expression between clients leads to the disintegration of the therapeutic milieu in that: 1) the physical and emotional well-being of <u>all</u> the client population is placed in jeopardy when a sexual component is thrust upon the center; 2) energy used in the expression and maintenance of sexual relations detracts energy which children and youth need to have focused on the issues which brought them into care, and; 3) it is often difficult to discern the consensual nature of sexual relations between clients and therefore every contact has the possibility of being abusive. Therefore, policies dealing with such behavior must be created and successfully implemented (Striar and Ensor, 1986; McMillen, 1992).

Even with such a concern about client sexual contact, staff need to be aware of the sexual development needs of the youth in their care. McMillen (1992) notes that many of those youth in current RTCs will be dealing with sexual orientation issues. While he states that the reason for this is due to the clinical population's exposure to and victimization from sexual abuse and the over-representation of sexual minority youth in treatment, I believe that the reason has more to do with the development of sexual identities within adolescents as opposed to response to trauma. However, McMillen

does denote some compelling evidence for the over-representation of sexual minorities within treatment facilities and states that, "If a therapeutic relationship can be developed which lessens the stigma of homosexuality, residents will be more willing to reveal and deal with their history of sexual victimization (1992, p.9)." It should be added, that such an environment would also allow clients to openly express and develop positive sexual identities.

Current Policy

As reported by Striar and Ensor (1986), residential treatment centers have a policy against clients engaging in sexual activity with one another. This policy may be an informal one, or may actually be written; regardless, it is composed of various practices designed to discourage sexual conduct. The reasons for such a policy are numerous, but seem focused around three main issues: liability, individual treatment needs and milieu morale.

RTCs are always concerned with the liability factor of the treatment within the agency. As there are risks involved in grouping together large numbers of emotionally and behaviorally disturbed children and youth, it is important to avoid any situations which can lead to legal and/or financial actions against the agency and its personnel. Sexual activity amongst clients is such a situation in that parents, the community, and the clients themselves may file suit on charges of sexual misconduct, rape, lack of supervision of children and youth, a host of medical concerns (including STDs, and AIDS), and pregnancy. There is also the concern that when there is sexual activity amongst clients that it may not be consensual in nature, but rather a manifestation of offender/victim roles. Even those clients not directly involved with the event may experience a re-traumatization and/or a lack of safety within RTCs where client sexual activity is occurring. It is also speculated that sexual contact between clients can lead to a disintegration of morale within RTCs. Such an event would obviously risk damaging the effectiveness of milieu treatment which relies on the team support of all staff and clients (it needs to be noted that this author has yet to find research on the impact of consensual sexual activity amongst adolescent clients).

Staff working within RTCs will attest to the concerns around client fraternization and the difficulties involved in implementing a successful policy against such a practice (Striar and Ensor, 1986; McMillen, 1992). There appear to be at least two main problems in such a policy implementation. The first involves the sexual urges of children and youth. Whether this manifestation of overt sexuality is a result of maturation or a response to the abuse and life events of the clients, it is difficult to quell such feelings. Children and youth will, as do adults, find outlets for sexual expression. The second barrier is the combination of heterosexism and sexual fear which prevail in society. As many agencies only treat one gender, and those that are co-gendered have rules against both males and females within the same sleeping quarters, there is a belief that no sex will take place as there is no opposite gender to mingle with. This is a heterosexist bias in that it

implies 1) that all children and youth are heterosexual and, 2) that all children and youth have a fixed sexual identity that they will not deviate from. If this were the case then there would be no need for such a policy in the first place (not to mention the fact that there would also be no homosexuals). However, those of us who work within RTCs know that sexual activity between clients does take place, notwithstanding their stated (or assumed) sexual orientation. There is also the societal idea that children are not sexual beings; that sexuality is latent until puberty. The majority of the children in our care are survivors of abuse, and many of sexual abuse. This, along with the sexualization of children and youth as manifested within media and society, allows for those in our care to become sexualized at early ages. It is simply absurd and negligent to state that those children and youth in care will not have sex with one another. That is why effective RTCs have several practices in place to diminish the sexual activity of clients.

Of concern for this paper are the RTCs designed for self-identified gay, lesbian and bisexual youth. In order to implement effective practices against sexual activity amongst these clients, let's first examine those techniques already utilized to curb such activity, and note their effectiveness. This may allow us to generalize and therefore transfer these practices into RTCs for sexual minority youth who have found that societal phobia of their sexual identity has hindered treatment in current RTCs.

Current Practices

There is nothing written on the proactive steps taken to ensure the absence of sexual relations between clients. There was only one article which was reviewed for this paper (Schneider, 1991) which even asked the question of whether homosexual youth should be allowed to share rooms with other youth (a question which was never answered). I have been able to identify four practices which are believed to diminish this sexual activity. These are night supervision, absence of locks on bedroom doors, one client per bed, and separated bedrooms by gender. These practices are not designed solely for the purpose of decreasing sexual interactions, as there are other primary concerns which they each address. In fact, I do not believe that they truly address the issue at hand. However, I have noted that these are cited by staff of RTCs as the proactive measures taken to curb sexual interactions between clients. The fact that these do not adequately address the issue suggest that sexual activity between clients is little studied and underconceptualized. However, as these are reported as the interventions on this issue, their effectiveness in decreasing sexual activity will be the focus of examination. It needs to be noted that sexual activity *between* clients is discouraged while private masturbation is often allowed.

It is imperative within RTCs that the children and youth be under supervision at all times. This enables the facility to promote the physical and mental well-being of those in care and increases the therapeutic milieu. It is assumed that through adequate supervision there will be a decrease in negative client interactions. However, the success of supervision is limited

to the skill level of those doing the supervision. With budget restraints and the decrease in client activity levels during sleeping hours, the staff-client ratio is usually at its lowest during these night hours. Many agencies allow their night staff to be involved with other agency functions (such as paperwork and house cleaning) and therefore further diminish the effectiveness of night supervision.

With the absence of locks on bedroom doors, which clients can utilize, the RTCs promote the values of clients to have free movement and physical safety. The absence of locked bedroom doors allows the client to still have the privacy of a closed door, yet without the restrictions of being locked within a room. There is a contradiction here in that while a child or youth is allowed easy escape routes in times of danger, other children and youth are allowed easy access to any room. Will an absence of locks actually prevent clients from having consensual sexual experiences? Will it allow for those clients who are labeled as "victims" to leave a room when being preyed upon by "offenders"?

All RTCs allow only one child per bed; and in doing so they promote the cultural values of individuality, personal space, and appropriate boundaries. These values are neither positive or negative in-and-of-themselves. The correlation between single bed arrangements and a decrease in sexual activity is difficult to research due to ethical considerations and research concerns regarding criteria for causality.

The value present in separating rooms by gender as a means of decreasing sexual activity is heterosexist in origin. The belief that sexual contact will not exist between same sex clients is manifest with this practice. By not opening up to the fact that homosexuality exists and is a healthy form of sexual expression, the RTCs are blinding themselves to the sexual activities that may be taking place within their facilities.

Evaluation

> There are inherent difficulties in enforcing policy. Such factors as staff-patient ratio, the degree of control over the patient's movements on and off the milieu, and the staff's level of commitment and understanding of the policy position will influence its implementation (Striar and Ensor, 1986, p. 62).

It is clear that the current practices do not curb sexual activity in-and-of themselves, and that two (the night supervision and lack of locked doors) may even, due to their inherit flaws, promote this event. Therefore, what positive aspects do they promote? The absence of locks allows easy access to children and youth in times of need, and allows for clients to be free of restricted movement. Night supervision can promote the sense of security which is often needed to allow for peaceful slumber. The limitation of one client per bed does reinforce an accepted cultural norm and can foster security in clients who have experienced past abuse.

The central focus of this paper is the same–sex bedroom arrangements (the focus in that one will need to examine the effectiveness of such a practice within a group home for sexual minority youth where clients are openly attracted to peers of the same gender). While this does not hamper sexual activity, it does promote several important things: an endorsement of cultural norms and the building of gender identification within clients. As many of our clients are survivors of abuse, they may experience difficulty in achieving positive self identification, ego development, and gender identification. As child and youth care workers we must strive to create an environment which will foster the healthy developmental growth of our clients.

It is, therefore, clear that these four practices do provide positive clinical interventions. However, if they are not completely successful in stopping sexual relations between clients, one must ask what does hinder the incidence rate of these sexual relations. (Incidence is difficult to assess in that events need to be either reported by clients or seen by staff in order to be documented.) These four practices do deter such activity, albeit their effectiveness is suspect. I would postulate that the elements which play the greatest role on limiting sexual activity are the values modeled by agency staff in regards to relationships between individuals and those consequences set in place for sexual relationships between clients.

Values

Child and youth care workers who work within the milieu of RTCs utilize their individual selves as treatment tools. Through modeling, the clients (it is hoped) will learn a wide range of skills. These include, but are not limited to: nutrition, socialization, problem solving, task completion, hygiene, study habits and effective communication. Staff model the various means by which these can be attained through our actions and comments. Healthy and responsible sexual expression is another aspect which can be modeled to our clients through our stance on this issue. How we respond to client questions and actions will impart our values on any sexual situation (Anderson, 1987; Carrier, 1989; Friedrich, 1990; Savin-Williams 1989; Tremble, Schneider, and Appathurai, 1989). Instead of being reactive we are able, through the milieu, to be proactive as well. In this sense, our daily interactions can be viewed as interventions and need to be honored as such by staff. We must not be hesitant to discuss sexual expression, sexual activity, and sexual relations between clients with those in our care (Anderson, 1987; Coleman and Remafedi, 1989; Hunter and Schaefer, 1987; Martin, 1982; Striar and Ensor, 1986). We must not only utilize life-space interviewing (Redl, 1966), but also create opportunities to discuss sex prior to finding out that this activity is already taking place under our roof.

The actual intervention which is implemented to curb sexual contact between clients is the stance the agency takes on the issue. However, it is the staff which will determine whether this is reactive or proactive in nature.

It is important to remember that RTCs are very similar to family life. The terminology of group **homes** and group **parents** reflects this aspect. The reliance on a close knit grouping of individuals through which norms, security, friendships, and values are created is reminiscent of the family unit. Therefore, it is possible that the means in which values are placed upon children within a family can be utilized within RTCs. Parental and, in this case, staff influence on the development of sexual mores cannot be overstated.

RTCs For Sexual Minority Youth

McMillen (1992) reported on several aspects of current RTCs which foster homosexual activities. First, there is the usual separation of clients by gender within RTCs. This absence of the opposite sex could enhance homosexual activity. Second, as treatment centers are designed for observation as opposed to privacy, opportunities for physical sexual expression are limited. Even masturbation is often difficult to arrange. This lack of privacy and sexual outlet can lead to an increase in sexual desires. Third, there is an emphasis on the sharing and exploration of feelings with groups of relatively unknown persons. As McMillen states:

> Thus, adolescents, many already concerned about homosexual issues, are given limited access to masturbation and opposite sex peers and combined in close living quarters with an accent on sharing emotions and being honest. This situation can be particularly difficult for youths fully aware of same-sex desires, regardless of whether they have identified themselves as gay or lesbian (1992, p. 10).

However, what about those youth who have self-identified as gay, lesbian or bisexual? Should one assume that client sexual desires and relationships within RTCs for sexual minority youth are different than in other RTCs? It is true that those within these RTCs will have already self-identified their sexual orientation and may have acted upon that orientation. It is also true that placing homosexual children and youth within bedrooms with others of the same sex can lead to sexual activity between roommates. However, separating clients due to gender has not always been effective in stopping these relationships. Therefore, how will these RTCs implement a policy of no sexual activity between clients? When asked how they assure that sexual relations do not occur between clients, the Los Angeles–based Gay & Lesbian Adolescent Social Service (GLASS, the only agency in the country to offer RTCs for sexual minority youth) Executive Director, Terry de Crescenzo, reported (personal communication, August 1993) that this is, "a staffing issue." The statement reinforces the concept of client supervision, agency policy, and modeling of values.

There appear to be two answers: 1) continue with the practices already in place or, 2) allow only one client per bedroom. It would be wonderful to have RTCs with resources for each client, regardless of sexual orientation,

to have a private room; but the likelihood of such an event is rare. Should clients be denied the positive socialization and identification aspects of a roommate just because of their sexual orientation? If this were to happen, and clients were denied privileges solely on their sexual orientation, this would only reinforce the cultural judgments that homosexuals are to be defined only by their stereotypically assumed deviant and promiscuous sexual expression. By doing so, the RTCs would damage the well-being of the clients, the clinical treatment, and destruct the positive aspects of the milieu. Even if such a living situation were affordable, would it necessarily decrease sexual activity?

By utilizing the current practices already used by the profession, and strengthening them in regard to the flaws as noted in this paper, it will be possible to create RTCs for sexual minority youth that will allow for a positive growth of sexual identity and minimize sexual contact between clients. Ultimately, regardless of the practices in place, the effectiveness of such a policy rests within the values as modeled by agency personnel.

On-line staff are the most powerful and most overlooked tool in this type of policy formation and implementation. As direct-line child care workers have the most immediate contact with the children in care, they carry the responsibility of manifesting agency philosophy, rules and guidelines. If the agency values and respects the sexual orientation of all those within its care and understands the role that sexual expression plays within human development, staff response to many types of sexual expression within the RTCs can be viewed within a nonpunitive, normative and therapeutic manner.

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