



CHAPTER ONE

Moving Forward: A Rolling Stone Gathers No Moss

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Introduction

Professionals come to this work for many reasons. Twenty-five and thirty years ago, we joked about the “drift theory”... it was work that many of us drifted into with no predetermined thoughts or biases. It was a job. Today, however, many undergraduate and graduate students as well as young professionals enter this field because they had an inspiring professor, worked under a university researcher, or had a colleague who was a specialist in working with young people with sexual behavior problems.

Many dilemmas exist now that were unimaginable 30 years ago. The state of our knowledge has evolved dramatically, while our ability to apply it has lagged far behind. Where there was once a presumption that juvenile courts would close case records upon the adolescent turning 18, juveniles are now increasingly being transferred to adult courts, having to register as sex offenders in perpetuity, becoming subject to public web sites, and generally growing up in an unhelpful public eye. This might become less objectionable if there were empirical evidence to show that it works to reduce the harm and likelihood of sexual abuse. Few people want safer communities more than the professionals who work in the wake of sexual harm; our field has yet to find a way to use its knowledge to inform our public policies.

In our first volume, *Current Perspectives: Working with Sexually Aggressive Youth and Youth with Sexual Behavior Problems* (2006), there were many important things to say about a field that was at one level stagnating, but at another level expanding its horizons, increasing its understanding, and slowly thinking out of the “traditional box” to look into new and challenging directions.

Even trying to keep up with the science in the world of children and adolescents can feel overwhelming at times. The worlds of medical and mental health have explained to us, as well as helped us to understand there is much to consider in the body–mind connection. As was discussed in *Current Perspectives*, many of the young people who enter the doors of our private practices, community-based programs, residential programs, and youth detention centers are not simple case studies. It seems that an increasing number come from backgrounds that may include child abuse (i.e., physical abuse, emotional abuse, sexual abuse and/or neglect); traumatic experiences in addition to or in lieu of

abuse (i.e., traumatic brain injuries, witnessing the death of others, natural disasters); family dysfunction (i.e., divorce, domestic violence), and stress/anxiety-induced illnesses (headaches, digestive problems, physiological complaints). Co-morbid and/or dual diagnosed clients and patients have become more common, and may have become the norm.

We have been forced to look at young people holistically if we are to do good service to them by providing quality care and treatment. Intake histories must go well beyond looking at family history and sexual history. Below are just a few examples of recent scientific findings that affect children and thus reflect the level of information we can attempt to keep up with and use in our respective practices:

*Childhood Abuse Increases Risk for Later Sexually Coercive Behavior In Some Men*¹. “Boys who experienced childhood physical and sexual abuse are more likely to use sexually coercive behavior against an unwilling female partner when they are adolescents and young adults.”

*Childhood Trauma Weakens Gene Response to Stress*². “Childhood abuse appears to permanently change a person’s response to stress possibly making them more susceptible to suicide, new research suggests... This impacts directly on how the brain develops and the stress regulation mechanism.”

*Antisocial Behavior May Be Caused by Low Stress Hormone Levels*³. “...Adolescents with severe antisocial behavior do not exhibit the same increase in cortisol levels when under stress as those without antisocial behavior. These findings suggest that antisocial behavior, at least in some cases, may be seen as a form of mental illness that is linked to physiological symptoms (involving a chemical imbalance of cortisol in the brain and body).

*Children with Concussions Require Follow-up Care Before Returning to Play, Say Researchers*⁴. “...Head injuries that occur during regular activities, such as riding a bike or in a car crash, are more common than sports injuries and yet the same issues arise — the children want to go back to sports, or to school, or outside to play... Mild traumatic brain injury, commonly referred to as a concussion, is a head injury that typically does not cause any visible physical damage, but frequently has symptoms such as headache, vomiting, loss of consciousness, or fatigue. Mild traumatic head injury is a common injury in children yet only about 12 percent of those resulting in hospitalization occur during athletic activities”

*Concussions Linked to Weakened Brain Functioning Years Later*⁵.

*ADHD Linked to Sleep Problems In Adolescents*⁶. “A new study shows that adolescents with a childhood diagnosis of ADHD are more likely to have current and lifetime sleep problems and disorders, regardless of the severity of current ADHD symptoms. Authors suggest that findings indicate that mental health professionals should screen for sleep problems and psychiatric comorbidities among all adolescents with a childhood diagnosis of ADHD.”

*Inadequate Sleep Leads to Behavioral Problems, Study Finds*⁷. A recent Finnish study suggests that children's short sleep duration even without sleeping difficulties increases the risk for behavioral symptoms of ADHD... The children whose average sleep duration as measured by actigraphs was shorter than 7.7 hours had a higher hyperactivity score and impulsivity score and a higher ADHD score..."

*Adolescent Insomnia Linked to Depression and Substance Abuse During Adolescence and Young Adulthood*⁸. "... Adolescent insomnia symptoms are associated with depression, suicide ideation and attempts, and the use of alcohol, cannabis, and other drugs such as cocaine... increases the risk of developing mental health problems and also may increase the severity of these problems."

*Childhood Sleep Problems Persisting Through Adolescence May Affect Cognitive Abilities*⁹.

*Learning from Mistakes Only Works After Age 12, Study Suggests*¹⁰. "...Twelve-year-olds are better able to process negative feedback, and use it to learn from their mistakes..."

*Anti-social Behavior in Girls Predicts Adolescent Depression Seven Years Later*¹¹.

*One in Seven U.S. Teens Is Vitamin D Deficient*¹².

*Bullied Kids More Likely to Become Psychotic Preteens*¹³. Children who are bullied are more likely to develop psychotic symptoms in early adolescence — and there is a dose effect, with repeated bullying associated with greater risk.

These headlines represent a fraction of the studies and science, ranging from physical health to mental health, focused on youth. However, these 13 headlines are both alarming and sobering. They encourage us to consider, or remind us, that youth are complex — as are their actions. Sexually abusive youth are equally complex, and their sexually abusive behaviors emanate from a variety of causes that must be understood and addressed. We cannot assume that traditional sex offender specific treatments will assist these youth in healing, especially when many of these treatments are based in adult sex offender treatment methods and models. Further, many of the professionals delivering these adult methods and models have employed a harsh, confrontational approach towards their clients that research has shown is often far less effective than a warm, empathic, rewarding, and directive one.

A primary concern of our historical approaches has been our field's failure to take into consideration that in almost all cases the strongest forces in the direction of change are within our clients themselves. It is only in recent years that professionals working with adolescents who have sexually abused have found that the most enduring treatment progress happens when the clients themselves make the case for change. Adults' efforts in compelling and cajoling change are rarely enough to result in long-term success. While there is no question that the legal system has a crucial role to play, we cannot expect that we can simply punish crime away. The real task in our work is to set agreed-upon goals for treatment in a way that taps the internal motivation of the client.

Each of us has to examine our skills and deficits and decide which population we want to work with. We must be cognizant of the biases and prejudices that exist in all of us. As we enter this work there are many questions we can ask ourselves and the colleagues with whom we work. Do we have the patience to work with developmentally delayed youth or the stamina to maintain our focus when challenged by a young person who is conduct disordered? Are we willing to give up our bias towards group therapy when some youth will improve more so with individual therapy? How do I justify labeling a youth as high risk when the risk tools of our field are not yet valid and/or reliable? Am I able to challenge my colleagues' work in a residential setting when my observations are that they are not skilled enough to accurately and effectively perform their job?

As we lecture throughout this country and abroad, we continually find professionals, some new to the field and others with years of experience, who continue to hang onto outdated concepts and ideas regarding young people with sexual behavior problems. The myths and misconceptions as to who these young people are continue to prevail possibly due to the strong influence of the media, or perhaps because some are closed to new ideas. For example, many emphasize the notion of holding adolescents accountable when it would likely be more appropriate to guide them towards an understanding of what accountability actually is.

Fortunately, we have found that the majority of colleagues and professionals we have met in the past decade are in tune to the changing treatments and models. The majority are eager to learn and validate the ideas we offer. Like our previous volume, *Current Perspectives*, this volume continues to put forth new ideas and ways of working with this population.

Moving Forward

The saying, "the only thing that is constant, is change" applies to most disciplines, and it is especially true of ours. Given the high stakes involved in preventing further sexual harm, professionals cannot afford to engage in practice based on the common knowledge of even 10 years ago. We should find inspiration in moving forward, even when it requires us to give up established traditions. This includes finding the strength to adopt empirically sound practice at a time when popular opinion is in the direction of approaches proven not to work. Having worked with both adults and juveniles, we can readily agree that working with youth is a challenge, and in many instances a greater challenge than working with adults. Why is this so?

Youthful development is fluid and, therefore by definition, ever changing. Emotional abilities and capacities evolve as the brain grows and develops. Their cognitive abilities become more advanced and sharper. Physiologically they are changing and hormones become a driving force. Parental guidance yields to peer influence. Sexuality is developing and changing, such that what is apparent one day, can be very different six months later. The media and technology provide ever growing sources of information and can readily shape opinion. Good sportsmanship becomes competition. Bad information goes in one ear and out the other. Identity is emerging. Relationships become paramount.

Our strategies for working with sexually aggressive youth and youth with sexual behavior problems must follow what we know about physiological and psychological development, as well as the environments in which these occur. In our opinion, one of the

greatest honors of working with this population is the amount of reciprocal teaching that occurs between patient and clinician. While we take our knowledge and use it to help the young people we work with, a vast amount of our knowledge comes not only from books and lectures, but from our clients themselves.

Kevin Powell's chapter, notes that:

"Strengths-based concepts and interventions that can assist evaluators and treatment providers in effectively working with youth who have sexual behavior problems... Any intervention, which emphasizes strengths and the exceptions to problems and deficits, can be classified as 'strengths-based'... [an] approach [that] emphasizes the importance of forming positive therapeutic relationships and creating an environment in which youth will be actively engaged in treatment... it is an approach that confronts their problematic behaviors in a non-antagonistic manner."

This wisdom is often overlooked and in fact is contrary to a basic relapse prevention model, which often emphasizes weaknesses, deficits, and what the patient should 'not' do. He goes on to say:

"... rather than just focusing on a youth's problem behaviors and what NOT to do, this approach focuses on a youth's positive behaviors and educates them on 'What To Do'. It is solution-focused in that it directs services towards helping youth to be sexually healthy, pro-social citizens within our communities, which is the ultimate goal of sex offense-specific services... Youth are more likely to form trusting therapeutic relationships and be open, honest, and engaged in assessment and treatment when the focus is on their strengths. When youth feel unsafe, socially alienated, rejected and/or have failure experiences on a daily basis, we cannot expect them to be positive and pro-social. Youth will respond with defensiveness, dishonesty, irritability, aggression, and/or social withdrawal, depression, and possibly suicidal behaviors. From an evolutionary perspective, it makes sense that if a youth is placed in an environment that is unsafe, it is only natural and adaptive that their responses will be more defensive, and sometimes aggressive in order to survive."

In order to learn, however, we must remain open-minded. We further our learning by applying that which we have learned already as we become open to new concepts and ideas. Very often, the most effective means for growing professionally is to ask our clients how well we're listening and helping. As writers and lecturers, we have both had the experience of having a colleague or professional approach us and say, "That's not what you said five years ago!" Often our response is, "That's right... I'm glad that my position on that has changed"... or... "the newest science/research doesn't support that concept any longer."

Beyond our own rigidity and resistance to change, professionals in our field face fierce external pressures. In their chapter in this volume, Lambie, Robson, and Barriball remind us:

"In today's world we are fed by the media an ever-increasing menu of fear-driven tasty morsels. This huge amount of fear in our society today brings high levels of anxiety about the uncertain times upon us out there and that things "just

aren't right." There is economic insecurity, what does the future hold? What is happening to our planet? And fear of the 'other' with an influx of refugees, terrorists and criminals into our communities. This leads to increasing demands on governments to 'crack down' on these ever-present threats and to 'control' the 'out of control crime statistics' with 'boot camps' for adolescents and longer, harsher prison sentences."

Likewise, Marx and Richards remind us of the often bizarre legal framework we work in:

"The (Washington) Community Protection Act failed to differentiate between juvenile and adult offenders. Juvenile sexual abusers, aged 12 to 18, were absorbed into the same criminal cohort on the supposition they were equally predatory. This inclusion negated juvenile justice as a separate and distinct justice system designed to protect delinquents from their adult counterparts."

The failure to view sexual abuse by twelve-year-olds as different from that of more persistent adult offenders is, in our view, offensive.

Charles Flinton's chapter on engaging resistance speaks to an age-old problem in working with youth. He notes:

"Sometimes, in hopes of increasing accountability, therapists and clients lose sight of the fact that change (and its accompanying disclosure) is painful. Resistance is present in any process of change, but we must keep in focus that... resistance is correctly attributed sometimes to the person and sometimes to the situation. This perspective is consistent with a systems approach to resistance which acknowledges that resistance is an interaction of the components in the system. In order to overcome resistance, one must understand this relationship, and provide a holding environment that adequately supports its expression, exploration, and finally, its extinction... Disagreeing with a therapist is not necessarily resistance to change; it may reflect healthy self-preservation. Some clients have been labeled resistant when in fact they are unable to participate because they do not comprehend information due to cognitive or neurological deficits. This is not resistance."

Inasmuch as we have to learn how to work with our patients' resistance, we must also learn how to work with our own!

For professional growth and development, we offer several questions for readers to consider as they move forward through these chapters:

- How does each chapter fit into your past practice? How about your current and future practice?
- What is one thing that you can take from each chapter and apply to your work tomorrow?
- How can you use the information in this book to invite young people to change rather than compel them to do so?
- Given what you read in each of these chapters, what are three things from your current practice that you realize you would do better to abandon?

- How can you use what you read in these chapters to assist efforts to prevent sexual abuse from happening in the first place?
- What is one thing in each chapter that you didn't know?
- What is the number one lesson you can take away from each chapter?

We hope these perspectives can inform the practice of others.

Endnotes

¹ University of Washington (2008, October 24).

² Carter, Helen ABC Science Online. (2009, February 13).

³ University of Cambridge (2008, October 5).

⁴ Children's Hospital of Philadelphia (2009, May 5).

⁵ University of Illinois (2009, March 3)

⁶ American Academy of Sleep Medicine (2009, May 6).

⁷ University of Helsinki (2009, April 28).

⁸ American Academy of Sleep Medicine (2008, October 5).

⁹ American Academy of Sleep Medicine (2009, March 3).

¹⁰ Science Daily (2008, September 27).

¹¹ University of Washington (2009, February 18).

¹² Cornell Medical College (2009, March 12).

¹³ Medscape Today (2009, May 8).

<http://www.medscape.com/viewarticle/702560?src=rss>