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# A Preoccupation

I have been rushing around these past few weeks as Sylviane and I, after so many years together, have decided to get married early in October – only a few days from now actually.

No. No. I am not writing this to invite everyone who reads CYC-Net to our wedding – much as it would be lovely, I think we would run out of space very quickly.

I am writing about it because it has been so long since I was an intimate participant in a ritual ceremony of our own lives. And it has got me to thinking about and noticing certain things.

Like, how I am so involved in the preparation that I forget to stay in touch with my friends (sorry friends!). Or how I am simply so focussed on the preparations that I forget other important things in my life.

Why am I telling you this – because it got me thinking about kids and families dealing with important life events – like the crises in their lives. When you are heavily focussed on one thing, it is hard to remember to attend to other things.

And so I was thinking, for example, about a kid who has to go to court next week – and how we try to get her to focus on other things – but she just can't. Maybe we forget how all-consuming a particular event can be. Maybe we could

just focus on the 'main event' and leave the other issues for later. Maybe we could focus on *her* life rather than *our* agenda.

I think we forget sometimes whose life is at stake here. We get caught up in our 'therapeutic agendas' and fail to acknowledge the significance of a particular event in the life of a child or family.

Just a thought!

**Thom**



# Foster Care in Germany

Kiaras Gharabaghi



Last month I had an opportunity to attend a special symposium on foster care in Germany, organized by the Ministry responsible for children and youth services in Niedersachsen, one of the Bundeslander (provinces) of Germany. I was especially interested in doing so because after exploring child and youth services in Germany for several years now, and currently very intensely during my six months stay in Germany this year, I was curious to find out why foster care almost never comes up in discussions with colleagues or even during site visits of residential group care programs. Indeed, although nearly 50% of all children and youth living in out-of-home care in Germany live in foster care, the overwhelming emphasis of professional and academic discussions related to residential care is on

group care. Foster care has been chronically neglected both in terms of research and in terms of its development as a placement option for children and youth. Only in recent years has there been an increasing emphasis on examining foster care more closely, and even this only in a few of Germany's 16 provinces. One of the provinces that has taken the lead on developing this system further is Niedersachsen, one of the larger provinces in terms of area but a mid-sized province in terms of population (encompassing cities such as Hannover, Osnabruck, Braunschweig, Bielefeld and Hildesheim). To this end, the responsible Ministry in Niedersachsen recently published the second edition of a report entitled "Further Development of the Foster Care System", which outlines the



different types of Foster Care as well as the processes that support each of these types.

Foster care in Germany is covered by the same federal law as residential group care, and just like residential group care, it is administered and financed through the municipal or county-based Jugendamt (child and youth services office). Most foster care is offered through private-sector, not-for-profit organizations, many of which have religious affiliations. There are some private, for-profit organizations as well, however, there is relatively little discussion about the organizational form of foster care. Foster care homes overwhelmingly serve younger children, although a built-in assumption of the regular foster care system is that foster parents make a commitment to children for their entire journey to adulthood. As a result, most foster families have experience with only a few foster children, since they typically would provide a home for those children for many years, and there is considerable emphasis placed on fostering one child only.

Teenagers requiring out-of-home placements are almost always placed in group care, in part because most foster parents prefer not to start their fostering journey with teenagers, and also because it is generally assumed that the issues of teenagers may be greater than what can be accommodated in a foster home. Indeed, not unlike in other jurisdictions around the world, most foster care breakdowns occur at the time when young people reach puberty. Children placed in foster care are often not seen as particu-

larly challenging to care for, and foster care is often avoided when there are obvious and acute mental health issues involved.

There are six types of foster care placements that are identified within the Niedersachsen system. The first of these is “Short Term Foster Care”, typically limited to a three months period and geared toward providing additional and often relief support to families already receiving various forms of non-residential support. This type of foster care is not very frequently utilized, but to the extent that it does occur, it is usually limited to foster parents who have already existing social pedagogic qualifications and experience, and who are able and willing to work with the child’s family in order to strengthen family relationships upon reunification.

A second type of foster care is referred to as “On Call Foster Care”, which is essentially a crisis service for placing children who are in need of child protection measures. This type of foster care is seen as particularly unique because it is not defined by a specific time period for the placement. Foster parents providing this service are typically individuals with higher social service qualifications, and their role extends from care giving to intervention and even aspects of case management functions. In general, this type of foster care requires extensive collaboration with other professionals and service systems.

A third and relatively new type of foster care is called “Foster Care with the Option for Re-unification”. This is designed to provide greater focus on working with the families of children ex-



periencing various forms of neglect, and foster parents take an active role in the case planning and implementation of preparing for reunification. The time frame for this to happen is not specifically defined, and the expectation is that this process can take anywhere from several months to several years.

Fourth, there is “Regular Foster Care”, where the foster parents are typically middle class families wanting to assist children in need. These foster parents receive relatively low compensation (based on the real cost of raising a child) and where virtually no training or continuing education is provided. Indeed, an interesting feature of the German system is an explicit rejection of the idea of professionalizing foster carers; training or continuing education, so the argument goes, would inherently negate the very nature of family-based care, and render foster care as just a different manifestation of institutional care. This approach has resulted in multiple challenges to the foster care system. Particularly notable amongst these are the difficulties foster parents encounter when dealing with the families of origin of their foster children. Access for families of origin is frequently court-ordered to take place on a daily basis, with visits usually taking place in the home of the foster carers, who in turn are asked to supervise such visits and provide a range of assessments without any specific training for doing so. Another major challenge relates to issues of cultural competency, because a disproportionate number of children and youth living in out-of-home placements are children and youth with migration

backgrounds. So far, at least, migration backgrounds are under-represented amongst foster carers, resulting in many challenging scenarios related to the management of cultural diversity.

Aside from “Regular Foster Care”, there is also “Social Pedagogic Foster Care”, similar to what in North America might be referred to as Treatment Foster Care. In this form of foster care, at least one of the care givers is expected to be a qualified Social Pedagogue, whose role it is to develop a plan for the social and emotional development of the child long term. Children placed in this type of foster care often have diagnosed mental health or developmental challenges, and reunification, while not entirely ruled out, is not considered a likely outcome and therefore is not pursued within the Plan of Care to any substantial degree.

Regular Foster Care and Social Pedagogic Foster Care are the most common types of foster care placements, and both of these are seen as commitments to children from the time of placement until their transition to adulthood. Much of the focus on foster care in Germany is centered around these two types of foster care placements, and on-going support for such placements is offered through workers from municipally or county-based Children and Youth Services Offices (similar to Regional Authorities in the UK or Children’s Aid Societies in some parts of Canada).

Relatively new and precarious are two additional types of foster care that are still being developed in Germany. One of these is Kinship Care, which has, in prac-



tice, had a long and substantial role in the upbringing of children and youth who cannot live with their birth families, but where the specific organizational forms and issues of compensation are only now being articulated. German law provides for kinship care inasmuch as it specifically declares that kinship care givers cannot be disadvantaged relative to foster care givers in terms of compensation and support. Kinship placements have increased dramatically in recent years, and the formal system is just now catching up with designing appropriate processes and regulations for this kind of foster care. Perhaps most interesting is an entirely new kind of foster care referred to as “Sponsored Foster Care”; this is a specialized form of foster care whereby responsible adults (or families) from within the child’s familial or social circles provides relief care (during evenings or on weekends, but not overnight) specifically for children living with parents (or a single parent) impacted by significant mental health challenges. The care provider in this case receives compensation on an hourly basis, and there usually is a maximum number of hours per month designated for this kind of relief care. The thinking is that children living with parent(s) impacted by mental health may require respite from time to time, especially if the parent’s mental health challenges go through periods of acuteness which may compromise their capacity to parent. Consideration here is also given to the idea that children with parents impacted by significant mental health concerns often must fulfill

caregiving tasks for younger siblings or even for the parents, and therefore may not have their own developmental and everyday living needs met. At the same time, the parent’s mental health challenges are not, in and of themselves, reason for out-of-home placement, and maintaining the family unit is seen as a priority. This type of foster care is not frequently used in practice. The responsible child and youth services offices across Germany have different comfort levels with this type of foster care, and therefore, significant regional variations exist with respect to the frequency of this type of fostering arrangement.

The foster care system in Germany is developing very unevenly from province to province. Perhaps because of its strong position with respect to NOT professionalizing foster care, the German child and youth care research community has not engaged this system in any significant manner. As a result, national data about the effectiveness of the different forms of foster care, or even about outcomes for young people who grow up in foster care, is largely absent. Nevertheless, foster care is an important component of child and youth services here, and considerable efforts are underway (at least in some regions) to raise the profile of foster care and to engage researchers to collaborate with foster care providers on developing best practices and new and innovative models.



# Deferential Diagnosis: The Key to Mental Health Services

**Cedrick of Toxteth**

## **Session One**

Good morning Doctor.

Good Morning, er, let me see now ... ah yes, Mrs. Huddlewick. And what we can we do for you?

Well it's my son Frank, doctor. He just won't do as he's told.

Ah yes, the old ODD. There's lots of it going around these days. How can I help?

Well the people at the Mental Health Centre said they can't do anything until they have a diagnosis.

Quite right too. Nobody's going to pay professionals for just dealing with naughty boys are they? They can't do treatment if there's nothing to treat? They're not child and youth care workers you know... they're real para-professionals. Is that all?

Well I was hoping you might give me a diagnosis?

Oh very well. So how long have you been feeling this way?

What way?

Whatever way you've been feeling. I can't give you a diagnosis until I know the symptoms. I'm a psychiatrist not a magi-

cian Mrs. er ... what was your name again? Huddlelewick. Gladys Huddlelewick

Ah yes. Well Mrs. Muddlelewick let's get down to brass tacks, cut to the chase, as they say. You're not a private patient so the government is paying twenty dollars a minute for this little chat. So what do you think your problem is?

It's about my son Frank.

Ah yes. And how long have you had these negative feelings toward ... what's his name again.

Frank.

Yes. How long have you had this urge to kill Frank?

I don't want to kill him, I just want him to do as he's told.

Yes, of course you do, of course you do. It must be a terrible strain to be the mother of a monster like Hank.

His name is Frank and he's not really a monster. It's just that he makes me angry sometimes.

Angry eh, well that's a start. How about confused? ... depressed? ... suicidal? ... homicidal maybe? Come on Mrs. Cuddledick. You'll have to give me more





to work on if you want a diagnosis. We don't just hand them out to anybody who walks in here you know. This is a clinic, not a soup kitchen.

But it's not about me doctor, it's about Frank.

Yes, that's what they all say ... a typical avoidance reaction ... but unfortunately that's not a serviceable diagnosis. Come on, we have six minutes left. Cooperate and maybe I can cobble together a tentative diagnosis of PMS to get things rolling.

But I've never suffered from PMS

It's a psychiatric condition. It stands for Pervasive Maternal Psychosis.

But psychosis is spelt with a 'P', not at 'S'.

Is it? Well we can look into that later. Tell me about your mother.

Please leave my mother out of this.

Ah, so you have some feelings about this. Seems like early attachment problems. Were you breast fed?. Oh, sorry, I'm afraid we're out of time.

But that wasn't six minutes.

Sorry, my watch must have stopped. See my nurse for another appointment.

This is nuts. The Mental Health Centre sent me here to get a diagnosis for Frank, not for me. They can't see him until he has one.

Who's Frank?

He's my son.

But he's not here. I can't diagnose somebody I've never even seen. It's against the rules, strictly unethical.

He's in the waiting room. You're receptionist said she'd send him in when you were ready.

Ready? Of course I'm ready. We psychi-

atrists are always ready for whatever wretched disordered soul happens to walk through that door. I'll just ring this bell.

Can I stay with him? He's very uncomfortable with strangers.

Well you'll have to go out and come back in again. Then it would be a follow up consultation. Even psychiatrists have to make a living you know.

## Session Two

You must be ... er let me see now ...  
Brenda.

My name's Frank.

Are you sure? It says "Brenda" here.

It's Frank

My mistake. Well Frank, your mother tells me you're a bit of a monster, is that right?

*I didn't say he was a monster. You said that.*

Now Mrs Shuttlewick. Please don't interfere. I'm trying to conduct a diagnostic interview. My questions are psychiatrically formulated. Any more interruptions and I'll have to ask you to leave. So Frank, what do you have to say for yourself?

Nothin'

Well saying nothing means something to me. In fact, it means a lot to me. Do you want to know what it means.

No thanks.

Well, it means you're angry on the inside. Tell me what you're angry about and I'll understand ... I'm a psychiatrist. Do I remind you of your father?

Yes.

Good. Just think of me as you father.



No problem. He's dead.

Did you kill him Hank. Was it your fault he died?

Oh for sure. He fell off a bike and got smoked by a semi.

And you feel a deep sense of grief and loss.

You bet. It was my fucking bike that got crushed.

Do you miss him Hank?

No, he never lived at our house. He just broke into our shed one night and stole my bike.

Ah, so you never really had a father like me. Someone you could talk to and rely on.

You've gotta be kidding.

It must be hard for a smart young lad like you not to have a Dad like me to talk to.

No, I'd sooner talk to a donkey's ass.

Hmm, a mixed metaphor. Could be Expressive Language Disorder. Tell me more about your dad. He really let you down didn't he? Tell me, do you sometimes have feelings of being alone, not seen or heard by adults?

Yes. I feel that right now.

Would you like to punch me in the face Roger?

Okay.

Well I won't let you, so there. Make one move and I'll call the cops. Now what do you feel?

Hungry, it's lunch time.

Oh my God, so it is. One more question, on the house. What's the square root of sixty nine?

Er ... 8.30662386922

No, you're wrong there smart ass. Run

along now and I'll meet with your mother again after lunch. We'll see if we can get you some help.

### Session Three. The Diagnosis

Come in and sit down Mrs. Fuddlewick. No not there, over here. There's nothing to be afraid of, just relax. Now, how have things being going since our last session? Have you been taking your medication?

It's only been two hours and I'm not taking any medication.

I didn't give you a prescription? Oh dear. What was your diagnosis?

I don't have a diagnosis doctor, I came to get one for my son. The people at the Mental Health Clinic told me ...

Oh yes, I remember now. It was Frank wasn't it?

Yes, Hank ... er... Frank

Very good. Well I made a few notes over lunch. Your son is a difficult case but I think we might have something to work with. He is suffering from a complex form of Conduct Disorder, with elements of Attention Deficit Hyper Activity Disorder, Oppositional Defiance Disorder and Mathematics Disorder.

Mathematics Disorder?

Yes, you remember I asked him a simple mathematical question and he got it wrong.

No, he was absolutely right. I checked.

Well, it could have been a lucky guess, now couldn't it? Never mind, we'll drop that and substitute Autistic Disorder. This is one of the most popular diagnoses these days - impaired development in social in-



teraction and markedly restricted repertoire of activities and interests. Yes, that should be enough to get him into treatment.

But that doesn't sound a bit like my Frank.

Listen Mrs. Butterwick, do you want to get him some treatment or not? If you continue to question my diagnostic skills I'll be very upset and that won't help you or your daughter, now will it? Without a diagnosis you might well end up at Social Services. They'll say that you're to blame and there's a good chance they'll put her in a group home somewhere. With a solid mental health diagnosis nobody is to blame. Now doesn't that sound better?

Oh I don't know what to do. I feel so helpless.

Yes, I understand. Now just sit back, relax and tell me how long you've been feeling this way.

*Before he was released from custody, Cedrick was a columnist with Relational Child & Youth Care Practice. He can be contacted through his Parole Officer Gerry Fewster ([fewster@shaw.ca](mailto:fewster@shaw.ca))*



“For instance, on the planet Earth, man had always assumed that he was more intelligent than dolphins because he had achieved so much — the wheel, New York, wars and so on — whilst all the dolphins had ever done was muck about in the water having a good time. But conversely, the dolphins had always believed that they were far more intelligent than man—for precisely the same reasons.”

— Douglas Adams  
*Hitchhiker's Guide to the Galaxy*



# The Task is always the same: Human Development

However varied the job, however different the responsibilities, the task is always the same — human development. A tragic, preventable “accident” shows the point. In the city of Minneapolis in the State of Minnesota there is a branch of an international, reputable youth serving agency. One aspect of program was group trips to athletic events. When a child died on a group trip apparently after she fell out of the van through a window which was pushed open during some “fooling around”. This was a tragic event for the child, the other children, the youthworker who was driving the van, the parents and the agency, among others. Even a cursory examination of the facts showed that the youthworker was driving a group of 10 to 12 year-olds; no other adult was aboard. The worker had driven to and from a city about 500 miles away. The round-trip was done in less than three days. The worker had no special training on how to plan a trip, how to supervise a group of children in a moving vehicle, how to do this for about sixteen hours of driving, etc. In short, the youthworker “drove the van” on “the trip” to a swimming meet. Neither she or her agency, it seems, understood that “the

trip” was the surface, a metaphor, for human development; an opportunity for the worker and their learning about their own possibilities as individuals and as a group. It was an opportunity to live “responsibility”, to learn how to plan and carry-out and evaluate a trip. It was a chance for the youth, along with an adult, to create, implement and assess expectations for the trip, including the roles each would play to maintain safety and order.

Because “the trip” was seen as a trip and not as an opportunity to learn, to be and become, a chance was lost. Youthwork never showed its possibilities.

Since we live in and through actions and deeds, it is in these that we must see and create opportunities to live justly, honourably and authentically – the ways of being human and human being. In that context, this tragedy would be meaningful.

It is senseless. It was not an “accident”; it is understandable and the result of poor work, poor supervision, poor vehicular design and construction; and lousy luck.

We can push the odds in our favour.

— Mike Baizerman



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# Crystal Meth

Olivia Lasting and Grant Charles

## Abstract

*Although not a drug of choice in all countries crystallized methamphetamine (crystal meth) is of concern in an increasing number of communities. While there is a growing body of knowledge about crystal meth as a relatively 'recent' drug that has not yet spread to all jurisdictions there is much that we do not know. In this article we provide an overview regarding what is known as well as identifying gaps in our knowledge. Specifically we discuss usage patterns, the physiological effects of this substance, treatment issues and some of the recent concurrent issues associated with crystal meth. We conclude with a discussion of the gaps in knowledge.*



## Epidemiology

Methamphetamine is an amphetamine-type stimulant (World Health Organization [WHO], 1997) with similar neuropsychological effects. It was first synthesized in the 1880s from ephedrine, but not widely used until World War II when governments on both sides of the conflict provided methamphetamine to military personnel so they could remain

awake and focused during missions (Anglin, Burke, Perrochet, Stamper, & Dawud-Noursi, 2000). Historically, the first “meth epidemic” in Japan can be traced to the release of major amounts of surplus methamphetamine to the general public after WWII (WHO, 1997). Both amphetamine and methamphetamine were commonly used in the 1950s and 1960s to treat narcolepsy, depression, and



obesity (Anglin et al., 2000). Recreational use of methamphetamine or “speed” became popular along the West Coast of the United States during the 1960s although usage dropped in subsequent years (Anglin et al., 2000). Recently it has made somewhat of a comeback since the synthesis of a smokeable form of crystallized methamphetamine (d-methamphetamine hydrochloride) or “crystal meth” in the 1980s (Nathoo, 2003).

Crystal methamphetamine, also known as meth, crystal, tina, jib, gak, ice, speed, crank, and shards, can be found in several different forms. It may appear as slightly transparent crystals, brownish granules, or beige, white, or pink powder. It is sold in paper flaps, plastic baggies, tablets, or capsules. Crystal meth is most commonly injected, snorted, or smoked in a pipe but it can also be mixed into a beverage (often coffee or another caffeinated drink) (Meredith, Jaffe, Ang-Lee, & Saxon, 2005) or ingested in pill or capsule form (Murray, 1998). “Booty bumping,” or dissolving crystal meth in water and then inserting it into the rectum, is used almost exclusively within the “party n’ play” (i.e., meth and sex) gay scene (Specter, 2005, May 23).

Amphetamines are the second most widely used class of illicit drugs in the world after cannabis. The most recent World Drug Report published by the United Nations (Chawla & le Pichon, 2006a) estimated that 0.6% of the global population used amphetamines during 2004 while 3.9% used cannabis during that same time period. Methamphetamine use is highest in South East Asia, Oceania, and North America. Historically, Thailand

has reported the highest levels of use, but its recent crackdown on drug trafficking in 2003 has put the Philippines in the lead (Chawla & le Pichon, 2006a). Most countries report stable or decreasing rates of amphetamine use since 2000, most noticeably in Thailand and Australia. Notable exceptions are China, South Africa, and New Zealand, which reported large increases between 2003 and 2004 (Chawla & le Pichon, 2006a). In 1998, Ireland reported the highest use of illicit amphetamines in Western Europe (Chawla et al., 2003) but by 2003 rates had fallen significantly (Chawla & le Pichon, 2006b). Currently, the United Kingdom is the largest consumer of amphetamines in Europe. Some sources of data indicate that methamphetamine is beginning to appear in the UK club scene (Chawla & le Pichon, 2006b). Elsewhere in Europe, rates remain low. Meth use is negligible in South America and most of Latin America and Africa, although Costa Rica, the Dominican Republic, and some Western African countries report rates similar to those in North America (Chawla & le Pichon, 2006b).

Crystal methamphetamine is known for its association with the rave or club culture, but users also include a wide range of groups including students, professionals, blue-collar workers, men who have sex with men, and street youth (Nathoo, 2003). People use crystal methamphetamine for many different reasons. Some people use crystal meth recreationally at parties or clubs with friends. Others, especially young women, seek meth’s anorectic effect as an aid to dieting. Stu-



dents may use crystal meth to help them stay alert and focussed on their studies (WHO, 1997). Some men use meth to enhance sexual sensation and stamina (Halkitis, Parsons, & Stirratt, 2001). Perhaps the most common reason that people around the world use methamphetamine is as a tool to increase work productivity and performance (e.g., truck drivers, shift workers, labourers) (Chouvy, 2005; WHO, 1997). In Bungay et al.'s (2006) sample of Canadian street youth, the most common reasons given for using methamphetamine were to help them stay awake, maintain vigilance, socialize, and bolster their self-confidence, thereby enabling them to cope with the dangers of street life. Researchers in Asia (Chouvy, 2005) and in the UK (Boys, Marsden, & Strang, 2001) report similar reasons for using meth as found in North America.

### **Physiological Effects**

Methamphetamine acts on several neurotransmitter systems in the brain. Without going into the neurobiological details, methamphetamine acts to increase the amounts of the neurotransmitters dopamine, noradrenalin and serotonin in the central nervous system. It is these elevated dopamine levels in the brain that are mainly responsible for the feelings of euphoria and increased energy (Barr et al., 2006). As with other psychoactive drugs, the onset of effects is dependent on the route of ingestion. When smoked, users usually begin feeling the effects within 3–5 seconds, and the high may last 8–16 hours (Nathoo, 2003). Initially, the user experiences intense feelings of euphoria and

feels energized, alert, talkative, happy, and self-confident (Hart, Ward, Haney, Foltin, & Fischman, 2001).

The short-term physiological effects of meth use include racing heartbeat, increase in blood pressure, dilated pupils, dry mouth, nausea, muscle spasms, and decreased interest in eating or sleeping (Meredith et al, 2005). A binge user on a 'meth run' may use from two days to two weeks, sometimes longer, with minimal food or sleep, resulting in dehydration, extreme weight loss, and symptoms of psychosis (Bungay et al., 2006). Meth use decreases the production of saliva which leads to increased bacteria in the mouth. In turn, higher bacteria levels lead to multiple caries and tooth loss, a phenomenon commonly referred to as "meth mouth." Bruxism (tooth-grinding) commonly associated with stimulant use exacerbates this tooth damage (Donaldson & Goodchild, 2006). High doses of methamphetamine can cause death from cardiac arrest, cerebral haemorrhage, or hyperprexia (high body temperature) (Ellinwood, King, & Lee, 2001; WHO, 1997). Meth use can also impact health indirectly when intoxication impairs a user's ability to make good judgments about risky behaviours like unprotected sexual contact or injection drug use (Halkitis et al., 2001; Semple, Patterson, & Grant, 2004).

### **Effects on Mental Health**

Long-term methamphetamine use has been shown to cause neurochemical changes to the brain's dopamine system and structural alterations to the brain visible under magnetic resonance imaging



(MRI) and proton magnetic resonance spectroscopy (MRS) (Barr et al., 2006). Regular use of meth has also been associated with memory loss and difficulty completing complex tasks (Simon et al., 2000), depressive symptoms (Meredith et al., 2005; Volkow et al., 2001), movement disorders (Harris & Batki, 2000), mood swings (Vincent, Shoobridge, Ask, Allsop, & Ali, 1998) paranoia, and drug-induced psychosis (Harris & Batki, 2000; Srisurapanont, Jarusuraisin, & Kittirattanapaiboon, 2001; Zweban et al., 2004). Long-term use of crystal methamphetamine damages the brain's dopamine receptors, though preliminary research suggests they may recover with extended abstinence (Volkow et al., 2001).

A significant body of international research confirms that long-term use and/or high dosages of methamphetamine can produce symptoms of acute psychosis (Barr et al., 2006; Curran, Byrappa, & McBride, 2004; Srisurapanont et al., 2001). An Australian study of 302 methamphetamine users in Sydney (McKetin, McLaren, Lubman, & Hides, 2006) found the prevalence of psychotic symptoms to be eleven times higher among regular meth users than in the general population. A large-scale study of methamphetamine users conducted in Taiwan found that more severe symptoms of meth-induced psychosis were correlated with earlier age at first use and higher doses of methamphetamine (Chen et al., 2003). Most instances of meth-induced psychosis resolve within a few days of cessation of use (Ali et al., 2006; Baker & Dawe, 2005) although some users suffer psychosis for

months or years. Some may never recover completely (Srisurapanont et al., 2001). Researchers have found evidence for a sensitization effect where individuals who have experienced one instance of meth-induced psychosis are more likely to experience subsequent breaks, even at reduced levels of meth use (Ellinwood et al., 2001). Yui, Goto, Ikemoto, Ishiguro, and Kamata (1999) found that former methamphetamine users were more vulnerable to psychotic breaks when subjected to elevated stress levels, even years after cessation of meth use.

The link between methamphetamine use and psychosis is not yet clear. Numerous studies confirm that large doses of methamphetamine may produce a brief psychotic state similar to schizophrenia (Barr et al., 2006; Curran et al., 2004; Harris & Batki, 2000; Meredith et al., 2005; Zweban et al., 2004). In their review of 43 studies on stimulant psychosis, Curran et al. (2004) found some evidence for a 'kindling' or sensitization effect in which repeated lower doses of meth increase the likelihood of a later psychotic break. Meth may act to precipitate a psychotic break by potentiating an underlying genetic vulnerability (Chen et al., 2003), although rates of psychosis have been found to be significantly higher even in individuals with no histories of psychotic disorders (Harris & Batki, 2000; McKetin et al., 2006). Other researchers have found that psychiatric symptoms may precede the onset of substance use (Curran et al., 2004). Indeed, some users report using illicit substances as a means of self-medication to treat their pre-existing





psychiatric symptoms (Bungay et al., 2006). Alternatively, methamphetamine abuse and a co-occurring disorder may be independent from one other but related to some other underlying genetic and/or environmental factor (Glantz & Leshner, 2000). When people using methamphetamine are also using other illicit and prescription drugs concurrently, it becomes extremely difficult to tease out the effects of one particular substance on mental health. These issues and relationships are complex, transactional, and multifactorial in nature.

### **Treating Methamphetamine-Related Disorders**

Extended use of crystal methamphetamine can result in dependence and methamphetamine abstinence syndrome upon cessation of use (McGregor et al., 2005; Newton, Kalechstein, Duran, Vansluis, & Ling, 2004). Typical withdrawal symptoms include fatigue, increased appetite, depression, anxiety, and intense cravings (McGregor et al., 2005; WHO, 2004). Withdrawal symptoms peak around 24 hours after last use and mostly subside after seven to ten days (McGregor et al., 2005; Newton et al., 2004). In some cases, depressive symptoms may persist for weeks or even longer (Volkow et al., 2001). Some users, particularly women (Kalechstein et al., 2000) may experience suicidal ideation in the first few days of withdrawal and warrant increased monitoring (Zweban et al., 2004).

Sensationalistic media reports have depicted crystal methamphetamine as the most addictive drug on the market with

the highest relapse rate of any addiction (see for example CBC News, 2006, September 16). However, the research does not support these assertions. Rawson et al. (2000) did not find significant differences in treatment outcomes between meth and cocaine users. Several large-scale studies show minor if any differences in the treatment success rates between those who use crystal meth and those who use other substances (Bishop, 1999; Luchansky, 2003).

Cognitive behavioural therapy (CBT) and contingency management strategies have been shown to be most effective with methamphetamine users (Baker & Dawe, 2005; Rawson et al., 2006). CBT techniques focus on helping the client change his or her beliefs or cognitions and, by extension, his or her behaviours through teaching and coaching relapse prevention techniques, helping the client identify and avoid trigger situations, and increasing the client's capacity to cope with daily stressors. Contingency management strategies use operant reinforcing principles to reinforce positive behaviours. These approaches can be tailored to help the client achieve his or her specific treatment goal, whether that be abstinence, moderation, or harm reduction. Traditional psychotherapy has not been shown to be useful (Baker & Lee, 2003), and most practitioners recommend motivational interviewing techniques as more effective tools for developing insight and motivation for change (Nathoo, 2003).

Another intervention that has shown moderate success is the Matrix Model based out of the University of California in



Los Angeles in the United States (Rawson, Gonzales, & Brethen, 2002). The Matrix Model Program is a manualized and integrated intervention that provides CBT, family education, twelve-step groups, and urine testing on an outpatient basis. While the program has demonstrated short-term positive outcomes for meth users (Rawson et al., 2002), participants are expected to attend counselling sessions twice a week for four months in addition to other programming. This can be a prohibitively lengthy and costly treatment for many consumers. Additionally, the program's emphasis on abstinence is likely to exclude clients who do not wish to stop using drugs altogether, but who would still benefit from some form of treatment or support.

Many programs include a peer support group or twelve-step group as part of their treatment protocol. One example of an innovative peer support model is the Crystal Clear Peer Support Training Project, a street outreach initiative conceived by the Methamphetamine Response Committee in Vancouver, Canada. Street-involved youth who have experience with methamphetamine use are recruited to attend 12 weeks of paid training and receive ongoing consultation to enable them to support and educate their peers around harm reduction techniques, mental health issues, and resources for meth users in general (Vancouver Coastal Health, 2005). While the initial results have been promising this program is still in its early stages and has not yet been systematically evaluated for its efficacy in meeting its goals of reducing harms and

connecting street youth with formal services. Successful peer support initiatives in other areas of health promotion (see Broadhead et al., 1998 for an example of a successful HIV prevention program) provide support for the anticipated effectiveness of this intervention.

In cases that involve methamphetamine-induced psychosis, current research indicates that the most effective treatments combine psychosocial and pharmacological interventions in order to treat substance abuse and mental illness in an integrated fashion (Mangrum, Spence, & Lopez, 2006). Psychosocial interventions ideally should begin once acute psychotic symptoms have begun to wane (Barr et al., 2006). Antipsychotic medications are typically used to treat the acute symptoms of methamphetamine-induced psychosis with benzodiazepines as needed for anxiety (Barr et al., 2006). There is some experimental evidence that regular low doses of antipsychotic medications taken by an individual even while he or she is actively using crystal can have a protective effect on the brain by reducing the sensitization or priming effect of meth use for later psychosis (Curran et al., 2004). There have not been any controlled large-scale studies of the newer antipsychotics although Risperidone (Misra & Kofoed, 1997), olanzapine (Misra, Kofoed, Oesterheld, & Richards, 2000), and quetiapine (Dore & Sweeting, 2006) have all shown some success in treating symptoms of meth induced psychosis. Haloperidol, a conventional antipsychotic medication, has also been effective at treating the symptoms of methamphet-



amine-induced psychosis but its serious and potentially fatal side effects make it the least favoured option for treating meth-induced psychosis (Sato, Chen, Akiyama et al., 1983 cited in Curran et al., 2006).

### Concurrent Issues

Apart from the direct impact upon users there are a number of issues related to meth use that are also problematic. For example, an area of increasing concern is the manufacture of methamphetamine in so-called “mom and pop” home meth labs. Using recipes for crystal meth easily found on the Internet and with basic ingredients readily available in most chemist shops or other commercial outlet stores, these small scale manufacturing plants are increasing in number throughout North America. Unfortunately, these ingredients are often toxic or flammable, and the refining process required to produce meth carries a significant risk of explosion, fire, or poisoning (Caldicott, Pigou, Beattie, & Edwards, 2005). Small-time producers are unlikely to have chemistry degrees or access to appropriate equipment thus increasing the likelihood of mistakes. Up to five pounds of toxic waste are produced for every pound of product. These chemicals are typically dumped down the drain or outside on the ground thereby creating unknown environmental hazards for any who may come in contact with them (Office of National Drug Control Policy [ONDCP], 2005). Some jurisdictions have responded by restricting access to certain key ingredients (e.g. pseudoephedrine or hypophosphorous acid)

and/or instituting mandatory reporting requirements on sales of these chemicals. For example, as of September 30, 2006, chemists in the United States are required to keep medications that contain pseudoephedrine (e.g., decongestants) behind the counter. They must also limit the amount that can be purchased at any one time. In addition they are also supposed to check the buyer’s identification and keep a record of customers and their purchases for two years (Bren, 2006). Canada, Australia, and New Zealand have similar controls on medications containing pseudoephedrine (Proprietary Association of Great Britain, 2007, March 07). The effectiveness of these measures has not been established although indirect indicators, such as hospital admissions (Cunningham & Liu, 2003) and arrests related to meth use (Cunningham & Liu, 2005), show some short-term efficacy.

In North America, child protection concerns have increasingly come to the forefront of this discourse. As more clandestine drug labs are detected and seized so do authorities come into contact with increasing numbers of children in these homes. Media coverage of children living in “meth houses” or with meth-using caregivers has contributed to the publicization of this issue (Biberica, 2004, December 12). Children in homes containing meth labs are at risk in several different ways. They are more likely to be abused or neglected by drug-using parents or their drug-using associates. They are at risk of ingesting any of the toxic precursor chemicals, the methamphetamine itself, or the toxic wastes produced



during the manufacturing process, whether orally, through dermal exposure (e.g., from crawling on the floor or playing in the back yard), or via second-hand smoke. Obviously, meth lab fires or explosions also put children in the home at high risk (Messina, Marinelli-Casey, West, & Rawson, 2007). These issues are unlikely to disappear in the near future, and may become more publicized in countries outside of North America, particularly in Asia and Oceania where meth use and manufacture rates are highest.

## Discussion

While there is a growing body of research on crystal meth there is still a great deal we do not know. As with most addiction and mental health services we have not yet developed a full understanding of the specific effectiveness of our interventions (Charles & Alexander, 2007). There are a great many intervention strategies that are untested or unproven in terms of their efficacy. Even in the programs that seem to make a difference we are not clear on what components of the interventions are effective. Much of our current research examines programs as a whole rather than attempting to understand which aspects of them may be having a positive impact (Charles & Alexander, 2007). We also need to learn more about what is not working. It is rare that we look at the potential negative impact of the interventions that we use that do not work. We have seen with other forms of substance misuse that some interventions may be more harmful than helpful. For example, there is a growing body of

research that suggests that group counseling can be detrimental to certain clients (Cho, Halifors & Sanchez, 2005; Rhule, 2005).

Crystal meth has become a 'hot button' issue in many jurisdictions in North America. As usage has spread into the middle classes, especially among young people, there has been increasing pressure for 'something to be done.' The result is the development of interventions and strategies that are politically or ideologically driven rather based upon specific needs or proven interventions. As we have seen in reference to other forms of substance abuse the consequence of this can be the development of a piecemeal rather than a coordinated response that results in a defused or ineffective intervention strategy that is wasteful of the often limited available funds and resources (Charles & Alexander, 2007).

We also need to better understand the dynamics and process of usage. We do not have a clear understanding of who is using crystal and why they are using it. While, as we have mentioned, there is some research in this area we do not have a full grasp of why certain people are more at risk than others. We also need to know more about the usage patterns and impact among diverse groups. This knowledge may lead to the development of prevention and intervention strategies that are more focused and effective and away from the 'one size fits all' approaches so often used in many jurisdictions (Charles & Alexander, 2007). In addition, as with all substance abuse we need to better understand the interplay between neurobiology,



the social environment and any resulting addictive behaviours (Charles & Alexander, 2007).

## Conclusion

Crystal meth is an amphetamine-type stimulant that affects the brain's dopamine and serotonin systems. Users run the gamut from street youth to truck drivers to students. There are many reasons for using meth, although as far as we yet know, instrumental use is by the most common. Long-term methamphetamine use can impact a user's physical as well as mental health. One of the most severe mental health consequences is meth-induced psychosis. Cognitive behavioural and contingency management strategies are the standard treatment for methamphetamine addiction, and peer support groups can be a useful adjunct although their effectiveness still needs to be fully proven. While there is a growing body of knowledge regarding crystal meth there is much that we still do not know. Filling in the gaps in our knowledge will lead to the development of the types of prevention and intervention programs that will help us deal effectively with devastating impact crystal meth can have on people.

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# The Value and Practice of Self Care

**James Freeman**

*This article provides a brief reflection on the practice of caring for self in the field of child and youth care. Examples of stressors and wellness practices are provided from residential care workers as a means of sampling ideas and encouraging the incorporation of self care in daily practice. Questions for reflection and discussion by individuals and groups are included.*

**Key words:** *Child and youth care, self care, wellness, occupational stress*



In the transition from the events of a wonderful summer, I've found myself adjusting to the routine of work and the new school year. Things have quickly become busy with a number of demanding projects. It has been a good struggle to maintain balance and keep my focus on relationships, connection, and engagement. My aim in this reflection is to review some important features on the practice of caring for ourselves. This may be for you, as it is for me, especially important during these times of transition.

## **The value of self care**

Self care is a core competency in our work which includes incorporating wellness practices into own lifestyle, practicing stress management, and building and using a support network (Mattingly, Stuart & VanderVen, 2010). It is also an ethical responsibility which includes self-awareness and the maintenance of our own well-being.

The primary value of self care is that it reinforces the dignity and value of the person. When we fail to take care of ourselves, we are "not caring adequately for either [our self] or the other, [we] are lowering the dignity of both" (Wren, 1973). Child and youth care requires self-awareness and the ability to be present in the context of relationship. In my own experience my ability to do these well increases dramatically when I am taking good care of myself.

## **Awareness of personal stressors**

I recently facilitated a refresher workshop on our crisis intervention curriculum



for some of the staff in the residential care programs where I work. The focus of the session was on the habits and routines we incorporate into our lives to maintain our own well being. Some of the stressors the group identified for themselves include:

- Not getting enough sleep
- Spending extended time with youth in crisis
- Dealing with aggressive behavior
- Taking on extra shifts to help my co-workers
- Witnessing the effects of abuse, neglect, and bullying.

It is not surprising that the occupational stress in our field is high. We work in the subtle, delicate, and at times dark areas of life. As young people and families recover and move toward more positive and fulfilling places in their lives, we often find ourselves at that very point moving into relationship with a new young person or family at a crisis point in their life. This stress can “severely hamper the ability of the helping professional to best serve his or her clients [and] can rapidly increase as [we transition] to the next issue and realizing that there is never really an end point in sight” (Kostouros & McLean, 2006). If we are not both careful and intentional we can find ourselves missing out on rhythms of recovery and balance in life.

### **Incorporating wellness practices**

In the workshop we also explored the ways in which the group incorporated wellness practices into their lifestyles. There were a range of answers including:

- Working out at the gym
- Camping
- Playing with my kids
- Going on long runs
- Spending time with family
- Grilling on the barbecue with friends
- Eating healthy and taking walks
- Painting
- Making sure to get enough sleep
- Approaching every day as a brand new day

Each one of us has a unique path to self-care. What works for one of us may not work for another.

[M]editation, or a continuing relationship with a deeply respected person, or group experience which contributes to positive feedback are essential.... You as a person deserve some attention. This may mean a little solitude, time in which to reconsider goals and regroup activities. It may mean music, reading, worship, some companionship with nature.

Refurbishing your self means something different to each person. (Wren, 1973)

Although our strategies may be different, what we do share is the need to be intentional about making time for renewal and re-energizing. The challenge is to find out what works for us and make it part of the rhythm of our life.

### **Knowing your purpose**

A final topic on which we polled participants was on their purpose and what keeps them going in their work. Some of



the responses included:

- Knowing that I make a difference mentoring and guiding youth
- Being valued and supported by my colleagues
- Advocating for and empowering young people
- Seeing a young person make a good choice after a time of difficulty
- The friendships I have built with young people and colleagues
- Seeing people achieve more of their potential
- Giving hope to those who need it most.

Remembering what keeps us engaged - and focusing on what gives our work meaning can be a helpful strategy to incorporate in our self care.

### Take action

Our effectiveness with today's young people depends on our own health and well being. It is a responsibility for each of us as "there is no helping professional who will go through a career and not need to step back and invest in quality time and care for him or herself" (Kostouros & McLean, 2006). In my career I have witnessed individuals staying in a specific role too long, knowing that were unhappy. I have also seen practitioners who are skilled at self care and know exactly what they need to stay sharp in their work.

Perhaps you find yourself in a place where you feel burned out or tired from all you have invested in others. You may even find yourself in an organization that

doesn't seem to care or provide support you need. You are worth it. The young people you are in relationship with are worth it. Make a plan today that will improve your care for self and for others.

### Questions for reflection and discussion

What stressors cause you to feel worn or burned out? What wellness practices do you incorporate into your lifestyle? What keeps you motivated and engaged in your work with young people? What can you add or subtract from your life to increase your well being?

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# Friendship and Hope

John Digney and Maxwell Smart

*When true friends meet in adverse hour; 'Tis like a sunbeam through a shower.  
A watery way an instant seen. The darkly closing clouds between.*  
– Sir Walter Scott (Scottish poet, novelist and playwright)

*Even if the hopes you started out with are dashed, hope has to be maintained.*  
– Seamus Heaney, Irish Poet (1939-2013 – R.I.P. dearest friend of the Irish people)

## ‘Peering’ at Friendship

‘We may be touched by many people in these ways, but our relationships with friends impact us immensely’ (Searcy Overton, 2006). In the same article by Searcy Overton, it is stated, ‘The ability of young people to develop healthy friendships with peers is critical to their emotional development and success’. This is an assertion which will echo the experience of many CYC’s – including ourselves. Indeed in our collective 50 plus years in Child and Youth Care we can agree that we have commonly used the label ‘friendships’ and possibly more frequently the term ‘peer’ (like most other CYC folk). But why bring it up?

In our everyday life, with our own kids, our nephews and nieces, our neighbour’s kids, we talk with them about their friends; what did you and your friends do today? Are your friends coming over later? How you getting on with your friends? Yet, when we speak with (or about) our kids in work, we talk about their peers. How is Mary

getting along with her peers? Does wee Jimmy have a good relationship with many of his peers? So, what’s the difference – is there an issue worth debating here? Or are we making an issue out of nothing?

## Friendly Adult Rethinking

Wee Jimmy has some peers but does he have any friends? After all we hear it is friends who are the people who will ‘impact him immensely’? Is it the case that we have some ‘elitist’ definition of what a friend actually is? To paraphrase Oscar Wilde, if you have one true friend, you are over your quota!

Friends come and friends go, but during these journeys of relationship we learn so much, indeed we often get our greatest sense of belonging from friends. So, and it’s just a question to ponder, we are wondered why it is that kids in the various care systems are only permitted to have ‘peers’ ... such an impersonal and almost clinical term!

Maybe it is our responsibility as adults



to rethink how we consider the notion of friendship for 'troubled youth'. It is reasonable to believe that friendships benefit children, so is it not reasonable for us, as the architects of the kids living space, to assume responsibility for focusing better on assisting in creating friendships (and all that goes along with this) and not only 'peerships' and to assess the impact of having (or not) friends?

We're sure some readers of this article are likely to have had their internal monologue stating from time to time things such as; 'What can I really do? I only have them for a few hours each day. Their family or friends have more influence on them than I do' (Hewitt, 1999). Well, maybe we need to reconsider some of these issues.

### **Gravitational Pull and Relational Poverty**

Could it be that our adult concern with the issue of friendship comes from the anecdotal observations about how so many kids at risk seem to gravitate to other kids at risk? Perhaps we, the "ever caring" carers, become so entrapped in seeing risk in the banding together of troubled youth, seeing this as whole heartedly unhealthy for all concerned. Maybe we do not recognise these relationships akin to those we had when we were youngsters, starting out in our novice navigation of relationships with 'peers'.

Consequently we as adults can become hostile to connections made by youth in our charge and disregard or deny the learning opportunities that can occur. This negative lens says more about us than troubled youth. Maybe we should be the

party to pause and ask why our 'kids at risk' band together in the first place?

Troubled youths are thought to group together because of their commonality of life experience. It might even be because we adults group them together in group homes. Like planets in orbit, troubled youth seem to be pulled towards each other as if pulled by the gravity of their combined emotional turmoil.

Whilst fitting in with groups is the expected 'adolescent norm', when troubled youth lack this belonging, or find it with other kids or groups that have been historically problematic for them (such as those with rage or in rebellion) – we wonder what we are doing wrong. Should we be asking though, why it is that these groups have enormous appeal for the kids without approval of more conventional groups? Why is it that these are not considered friends, indeed they are not even peers – they are 'inappropriate peer groups'?

When kids encounter 'relational poverty' in their lives (often reinforced by our own regimes), like the ache of a belly lacking food or an unquenched thirst in drought, this relational poverty impacts in devastating ways. Connection in friendship, whether approved of by adults or not, is often a way to gain acceptance and meet needs to belong.

Troubled kids clearly need as much love and affection in their lives as everybody else. 'Positive human relationships are essential to healthy lives ... they serve to protect and help us ... to sustain us in difficult times. We may be touched by many people in these ways, but our relationships with friends impact us



immensely, (Searcy Overton, 2006).

As resilience research has evolved an inconvenient truth has emerged, gangs have sometimes facilitated more powerful belonging than our homes, schools or communities. Cairns (2002) notes, 'although [some] children continue to struggle hard to find a way to be true to themselves and still be part of society, it is often an unavailing struggle for children who are so different from the norm' (p.65). So, let them have friends – whatever a friend is and try as helping adults to assist youth make sense of what makes a good friend and what doesn't.

### **Hoping for Hope**

'If youth is the season of hope, it is often so only in the sense that our elders are hopeful about us' – George Elliott.

Maria Montessori professed, far from receiving adult condemnation; troubled kids must be admired for their resilience, for their rebellion and for their fight against an 'unfair world'. To alleviate these struggles helping adults need evoke hope in youngsters, to inspire them to believe in their strengths, and for us to focus our interventions on effective ways for youth to also find the hope which we see for them.

The word hope had recently re-entered our vernacular; along with developments in the fields of neurology and epigenetics. The Child and Youth Care profession, along with its individual workers, have started to begin to believe that there is always hope and it's never too late. We have a role in instilling hope in our youth, their families and the on-lookers, busy gawking and see a bunch of no-hopers. Kohl (2000) wrote, 'we cannot

teach hope unless we ourselves are hopeful, not merely in a general sense but in specific ways ... teaching hope involves focusing on strengths...' In our care settings for instance we could start with the mantra, "start each day or shift with fresh hope".

Perry (2009) talks about hope as a cognitive experience, in essence a positive mental construct, in his quote, 'hope is the internal representation of a better world; essentially a belief that things can be better. It is, in essence, a memory'. When talked about in this manner, it seems to be something more attainable. We can do something to help bring about this 'internal construct'. This sound much better than us saying something like, 'Peter has no hope of doing well' or 'we hope things will get better'. So now we should be able to take up and believe in a starting position that hope is about instilling the internal belief (via creation of opportunities for new memories) that a young person can always turn the corner onto the safer road.

In order to instil hope in our youth; the adults, the professional, the carers must have hope and must be supported to have hope. However, in recent times in countries such as Ireland and Scotland where there has been 'service developments' (arising out of funding cuts and risk avoidance), there have been draconian reactions to troubling behaviours being exhibited by our troubled youth. Increases in the level of bureaucratic red tape, searches for standardisation and power being given to people who don't understand much about the important aspect of the CYC job seems to have caused some



backward motion.

When we only have administrators and politicians who do not know or understand, we then lack the necessary support to make the system work for troubled youth. Where regulators aren't aware of contemporary thinking and don't think into the long term, where the importance of relationship, risk and friendship are downplayed, at time it is not hard to understand why some hope is being lost. But what happens when the carer loses hope? As noted by Brendtro & Ness (2005) "troubled youth often are frightening or repugnant to adults unable to understand or manage them... untrained adults who are insecure in their ability to [change] these youths are highly motivated to get rid of them", p11.

"Getting rid of them" is the opposite of hope and converts hope into no hope and to the notion that troubled youth are disposable. We bring up the notion of hope this month as a discussion topic anticipating that others will add their own reflections and understandings. However as we chatted between ourselves on this theme of our article, we could quickly acknowledge that our own feelings of and belief in, the power of hope were fundamental driving forces that has kept us going all these years. Obstacles are there to be overcome, and as Alessi (2004) states:

In addition to keeping an open mind regarding the multitude of therapeutic interventions, you have to maintain a sense of hopefulness ... it is easy to get swept away in a sense of hopelessness. We must maintain a sense of hope if we at all want to help ... we should not come to

rapid conclusions ... about the fate of these children or adolescents and their families. It is only with hope and openness to a broad range of [therapeutic] interventions that these individuals can be helped.

We must never give up hope and for the sake of all we love and hold dear, we must not let our youth lose hope either!

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# Teaching Hard-to-Reach Youth

Allen Mendler

*Working with students who have behavioral problems requires that professionals immunize themselves against burnout. Continuous, daily work with such children and youth can be extremely stressful. And stress leads to a fight or flight response.*

*Unfortunately, neither of these two common built-in responses to stress is productive when working with hard-to-reach youth. One leads to power struggles, while the other leads to indifference. We know that healthy adult mentoring is probably the most salient human factor that helps at-risk youth make better choices. It is the development of trust through bonding that enables such youth to leave the safety of their self-defeating but predictable thoughts and behaviors.*

You are in the classroom and you ask Joe a question related to the lesson. Joe flashes a smirk and says, “Who the hell cares —this class sucks!” Fred, who can’t concentrate for more than 3 minutes, decides to take a mid-class cruise. His cruise includes visiting with others while you are trying to teach. Sally is polite, friendly, and even occasionally participates in the class lesson. The problem is that she never brings materials, is usually late, and doesn’t do homework. Jose has an extremely short



fuse. You never know how he will react. There are hours and even days in which he is calm and focused. With no warning, he may suddenly freak out and throw a chair or challenge someone to a fight.

In order to create resilient conditions for at-risk youth, we must move beyond our own natural responses to stress that are counterproductive to the process of change. There are several things that we can do both attitudinally and behaviorally to immunize ourselves against the harmful consequences of anger and indifference.





By far, the most important aspect is to develop the kind of attitude with obnoxious, defiant, rebellious, difficult youth that enables us to remain personally caring and involved with them without personalizing their offensive behaviors.

Our observations suggest that approximately 70% of all school misbehavior has to do with things other than the teacher's behavior. Obvious to all who have worked with difficult students are the many family and social issues that confront most of them. Many students misbehave as a way of gaining attention and notice; these same students are angry, even enraged at the rejection they experience from those who are supposed to love them. It is not uncommon for this anger to be displaced onto the educator.

Such students cannot be reached unless the educator learns how to keep caring despite angry, hostile behavior. Caring always has been important, but contemporary realities make it a requirement. Without it, there are growing numbers of students who do not learn and, worse, who disrupt others. Success with such students requires an attitude that enables the adult to stay personal with the student without becoming personally offended at the student's behavior. It can help if the adult realizes that hostile students are receiving at least as much hostility in their own lives, that students who make others miserable are being made at least as miserable themselves!

I am reminded of a situation in which Ed, an early adolescent, was regularly a challenging, foul-mouthed, aggressive student who frequently disrupted his classes.

Understandably, his teachers often became frustrated and kicked him out of class. Either the same day or the next, Ed returned with revenge in mind. Power struggles were common. As we met to discuss how to handle this situation, it was clear that his teachers were both frustrated and angry at Ed because of his excessive needs and frequent classroom disruption. The key issue was: How do we keep caring for Ed, a hurting student, and at the same time maintain the integrity of the class and find a way to respond to Ed with dignity? The solution was to find ways of staying personal with Ed without personalizing his miserable behavior. His teachers were helped to see that when he called them SOB's, they didn't have to become offended. If they chose, they could attribute his offensive behavior to an expression of pain in his own life rather than a personal statement directed toward them. Caring educators understand that the problem resides in the child.

It is possible to not become offended. Imagine that if instead of Ed calling his teachers SOB's, he called them a chair, or a chalkboard, or an eraser. Immediately, there would be a different reaction. We must learn to make these substitutions so that things that are irritating, offensive, inappropriate, and even outrageous are viewed in a neutral way. We must recognize that offensiveness is almost always a child's protest to the harsh, abusive treatment she or he has received. We may need to implement consequences; but we must do so in a manner that teaches the child, rather than react in a manner that simply reinforces the belief that all adults



are mean and hurtful. In order to hear the message of despair from children, we must separate ourselves from the child's misery without separating ourselves from the child.

Shortly after our "brainstorming" conference, one of Ed's teachers was verbally assaulted by him. Upon being referred to as the waste product that comes out of a horse's rear end, she reminded herself to hear the words "chalkboard" and "eraser." She reported that she began laughing at the incongruence between his words and her thoughts. After choosing to hear his words in neutral tones, she was able to defuse the moment by saying, "Ed, I may not smell very good, but the odor is not coming from me. When you find out where it is actually coming from, let me know." She then went on with the class. Later, she dealt privately with him in a manner that enabled her to identify some of his anger, which led to a changed relationship.

In order to persist in making a difference with difficult youth, we must be tougher at refusing to reject the child than the child is at delivering methods of rejection. It can help to take a temporary emotional vacation from the child. Occasionally, you may need to send the child to the administrator or a fellow teacher for a breather. You must keep your sense of humor and use such stress-reducing activities as deep breathing, exercise, meditation, and positive thoughts in order to accomplish this goal. Difficult students can be masterful in knowing exactly which of our hot buttons to press. So be forgiving of yourself when you get angry and

upset. Use "I-Messages" to convey your upset, frustrated feelings with such youth in a manner that identifies the real issues. For example, "I am so upset when you call me nasty names, and that tells me that you are hurt. It is the fact that you are so hurt which upsets me the most. If you want to talk, I am available." Most important, refuse to give up on the child despite the child's best efforts to get you to throw in the towel!

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The Twitter logo, consisting of the word "twitter" in a lowercase, blue, sans-serif font, followed by a blue silhouette of a bird in flight.

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# Absorption

Part I

**Laura Steckley**

**A**t the World CYC Conference in June of this year, I had the great pleasure of attending a presentation on hanging in with young people and the important parallel of hanging in the with staff who work with them. A team of CYC practitioners and managers spoke about their journey of working with young people who have very complex needs, the related impact on the direct CYC practitioners who try to meet these needs, and the implications for the management (or indirect CYC practitioners). It was a delight to hear this group of people talk about containment – not in the usual disparaging way the term is often used, but in a way that appeared to guide their work. And I must say, I was really impressed by the work they described.

I've been banging the drum about containment theory for some time now, but if it is new to you, here are a few pieces from previous CYC-Online issues that introduce the concept:

<http://www.cyc-net.org/features/ft-containment.html>

<http://www.cyc-net.org/cyc-online/cyconline-nov-2010-steckley.html>

<http://www.cyc-net.org/cyc-online/cyconline-dec-2010-steckley.html>

The presentation back in June really got me thinking about the role of absorption in containment. Put simply, the basic tenet of containment theory is that the parent, counsellor, carer or therapist – or in our case, the CYC practitioner – absorbs the unmanageable and gives it back in a more manageable form.

So what, exactly, is it that is being absorbed? Some of the speakers in the presentation referred to absorbing issues. I have always thought of it as absorbing feelings. I've come across descriptions of group processes where dynamics are described as being absorbed by teams. People commonly refer to picking up on a vibe, whether positive or negative, from another person or group.

I've also been wondering whether this notion of absorption is simply a metaphor, or whether we are actually physically absorbing something from someone else.

So I've been doing a bit of reading to feed my curiosity. In the May 2009 issue of CYC-Online, Bruce Perry discusses the neurobiological dimension of absorption:

A central aspect of [your neural] network is the capacity to read and respond to the emotional and social



cues that are being projected by people you interact with. If they are distracted and distressed, you will feel dismissed; you essentially will feel the way they feel – distressed ... We have the neurobiological capacity to absorb and be influenced by the emotions of those around us .

So our senses absorb emotional and social cues, giving information to our brains, and something physiological happens as a result of that absorption. I would venture that each of us has experienced the effect of someone else's intense feelings such that we felt the same way, and it's not too difficult to recognise the physical effect this sometimes has. But absorption of even subtle social/emotional content has a tangible impact because thoughts and emotions are "electrochemical signals that affect the chemistry and electricity of every cell in the body" Indeed, sub-disciplines of neurobiology are beginning to explain how human beings send out a variety of electrical signals, or vibrations, based on what they are thinking and feeling – much of which is absorbed by others.

We are wired this way to enable the formation and maintenance of relationships. The desire to be understood is innate and deeply instinctive. As newly born infants, we needed our carers to understand what we were feeling – hungry, tired, frightened, wet – so that they could meet our needs. On a very primitive level, we were getting others to feel something as a result of what we were feeling. Often and throughout life, we get

people to feel what we are feeling. Sometimes this is conscious and deliberate, for instance when a political activist gives a speech designed to stimulate the righteous indignation of an audience. Very much of the time, however, it is an unconscious process.

It is helpful, then, to think of absorption as received communication. In terms of containment theory, what is being communicated and absorbed are the feelings, thoughts and experiences that are unmanageable, unbearable, uncontainable. Much of the time they are so intolerable that it isn't possible to allow them into conscious awareness; the threat of psychological destruction is just too great. So in essence, we are sometimes feeling what a child or young person (or even colleague) simply cannot bear to feel, though, paradoxically, the feeling is still present in his or her subconscious. And sometimes we are the ones projecting the unmanageable, unbearable, uncontainable. These feelings might be fear, helplessness, hopelessness, despair, rage, jealousy, overwhelm, betrayal, worthlessness, loss, or loneliness. Our job is not to take these feelings away, much as we might feel tempted to, but to help children and young people (and even colleagues, for that matter) begin to be able to work with and manage them. This is done in a variety of ways and has been discussed elsewhere, but I was particularly struck by one of the speakers at the above-mentioned presentation who emphasised the importance of empathic acknowledgement. I suspect that this is the first and most important step in the process of containment. If absorption is



received communication, then empathic acknowledgement is the initial response – a form of communication that conveys that we’ve ‘heard’. The empathic component necessarily involves feeling. Sometimes it involves naming a feeling the other person was previously not fully aware of, bringing about a sense of clarity, validation or relief. Other times this may be too threatening or difficult, and we may need to be the only one who acknowledges a particularly painful feeling. And it must be acknowledged that sometimes we may simply get it wrong. Whatever the case, empathic acknowledgement can facilitate communication and reduce feelings of isolation, both of which are key ingredients of containment.

So back to the original question – what exactly is being absorbed? On a literal level, we are absorbing energy and vibrations. This may seem like a bit of trivia, but it has profound implications for practice and this leads me to the next question raised by the presentation. I’ve been wondering about why we might not ‘give back in a more manageable form’ that stuff we absorb in our work and what the consequences of this might be. This will be the focus of my next column.

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# In Praise of a Volatile Child and Youth Work

Hans Skott-Myhre

In a recent interview with Tony Taylor<sup>1</sup> on the web site *In Defense of Youth Work*, he makes a compelling case against the imposition of outcome based standards of care in the U.K. In the course of making his case against this horrendous bureaucratic intrusion into the work of youth/child and youth care workers, he makes a number of cogent arguments and assertions that I think have broader implications for all of us engaging with young people in our work.

Let me begin with his assertion that working with young people should be “volatile and voluntary, creative and collective – an association and conversation without guarantees.” This is a compelling vision for the work we do at all levels of our field. Whether, we are academics, administrators or direct line workers, the call for a level of volatility is provocative. As academics, this is a call for us to be willing to engage methodologies and theoretical perspectives that have the capacity

to unsettle long- standing beliefs and practices. To critically assess and challenge the claims of dominant scientific and cultural paradigms in ways that produces them as unstable. As administrators, this would imply a willingness to step aside from the common wisdom that stability and continuity are the hallmarks of a successful organization. It would call on administrators to promote and support ongoing small and large insurrections and to celebrate bottom up innovations and challenges to organizational common sense. For direct line workers, this would be call to accept the fact that human relations are unstable and unpredictable. That engaging young people in circumstances not of their choosing under adverse social conditions is inherently volatile. Such an acceptance would argue against the artificial production of “safety” and the quiet, well behaved, docile and emotionally malleable “client.” Instead, workers would welcome the struggle with justifiably

1 <http://www.indefenceofyouthwork.org.uk/wordpress/?p=384>



angry, unsettled and labile young people entering their care.

Taylor's call for the work to be voluntary is also provocative, in that there is an increasing tendency to mandate young people into our care in a whole range of different ways. In the most obvious we have the court mandated young person. If we are to take Taylor seriously, we need to challenge the right of the court to dictate the terms of care at every opportunity. Rather than colluding with the inherently unjust system of justice that sentences young people to "treatment," we would seek to collude with young people in challenging their incarceration, through overt legal means, collective political action to change unjust laws and regulations, or through refusal by staff to be minions of the court. Instead workers would seek a relationship on our own terms, rather than that imposed by the legal system. As academics, we would work to provide the theoretical and empirical grounds for challenging the very notion of involuntary treatment or care. First and foremost here is the necessity to repudiate and refute all research or theory that conceptualizes young people as a social category that is biologically differentiated in ways that require adult or social control or modification. As administrators, our job would be to structure our institutions so as to maximize the range of free access and freedom from constraint within the institution. This would mean open conversations with staff and youth that negotiate the parameters, norms and expectations of institutional life together. Such conversations would need

to be fundamental exercises in direct democracy and might well draw on the work of Franco Basaglia in his construction of the *assemblies* in the asylums of Italy in the 1970's.

The call for creativity, in Taylor's vision seems sensible and straightforward, but in actuality runs contrary to much of common practice. Indeed, too often we all seek formulaic theories, practices and administrative structures in the vain hope of producing a predictable, calm and well ordered work environment. Creativity, as I read it here, is not about the staff coming up with creative "interventions" that change "client" behavior. Instead, taken in concert with the terms of volatility and voluntary engagement, creativity would imply a joint set of projects between young people and adults in which, everyone's creative energies are engaged in meaningful interventions in our common cultural and social climate at the individual, institutional, community, national and global level. This would require a joint analysis by young people, staff and administrators regarding the actual material conditions that have led to the creation of the institution in which we are all embedded, as well as the conditions of exploitation and oppression that have led to the young person engaging with us at all. This analysis, would replace the facile and deceptive analysis of the young person's problems, biological exceptionalities, psychiatric abnormalities as well as their perceived strengths and factors of resilience.

If we take all of this seriously, we begin to move towards Taylor's vision of our



work as collective. In this, our work might well be founded more in what we hold in common, both as exploited and oppressed subjects under capitalism, as well as what we hold in common as living creative and dynamic sources of social and cultural change. To truly work collectively, we would need to challenge the artificial constructions that divide us by age, class, gender, sexuality, privilege and socially assigned hierarchies of discipline. This is not to attempt to eradicate difference, but to found difference functionally on our idiosyncratic and unique capacities and an analysis of the ways those capacities are restrained or restricted by socially and culturally imposed hierarchies and modes of exclusion. This cannot be a move towards any kind of post-feminist, post-racial attempt to avoid the painful realities of our complex social realities under capitalist rule. Our ability to work collectively requires ongoing reflection and deconstruction of the ways in which we all participate in perpetuating the rule of the dominant social within ourselves and among ourselves. Similarly, to work collectively, while sustaining volatility, voluntary participation, and creativity means that there can be no establishment of an overarching structure or set of beliefs to which we must adhere if we are to belong. Collective action needs to be based on the common struggle to continuously reshape our social and cultural environment so that it serves us all.

Of course, this all runs against the drive towards regulation, certification, standards of care, evidence based and outcome based approaches imposed and

promoted on the basis of neo-liberal imperatives, often implemented by well meaning youthwork/child and youth care advocates in the name of quality care or saving the field in these austere times. Taylor warns against any approach to our work that does not take into account the actualities of contemporary historical moment. He suggests, and I concur, that any attempt to shape or structure our work as though it were free from the profound and powerful influences of capitalism is without merit and in fact puts the integrity of the field and its history at risk. He states,

The product of the [neoliberal] framework is to be the 'emotionally resilient' young individual, who through the planned interventions of youth workers, will shrug their shoulders at adversity. Utterly in tune with government policy this manufactured individual will have less need for public services such as health and social welfare and will be willing to work for whatever wages, zero-hour contracts or indeed benefits are on offer. This is the self-centred, compliant young person of neo-liberalism's dreams. The last thing such an obedient cipher would do is to ask, "how come this is happening to me, my mates, to thousands of others?" Nowhere ... is there an acknowledgement that to talk of personal change demands an engagement with the social and political circumstances underpinning young people's lives.





Unfortunately, many of us working in the field, as academics, administrators and front line workers, have tacitly and almost unconsciously accepted this monstrous vision what Foucault called a docile body, as the ideal future for our young people. Worse, we have accepted it as an ideal for ourselves as employees and social actors. We seemingly wish to belong to the regimes of capitalism in hopes that it will provide the security and stability it has promised. This is an absolute chimera and delusion of the worst sort.

As Taylor points out, capitalism is an inherently exploitative and oppressive system that has never had a period in its brief history of a few hundred years, where it did not structurally require suffering and subjugation in the name of the profit and the economy. To suggest that the best we can hope for is to produce young people resilient enough to survive the vicissitudes of brutal global capitalist rule is cynical at best and irresponsible at worst.

We can do better than this. Taylor is promoting a vision of youth work/child and youth care that holds within it the possibility of re-claiming the world for the benefit of the living subjects that inhabit it, instead of the abstract system of rule defined only by the accretion of money and power. Of course, he tells us that the dominant system of rule, “wishes to confine to the scrapbook of history the idea that Youth Work is volatile and voluntary, creative and collective – an association and conversation without guarantees.” He tell us that “We need to continue to think, improvise and organise against this

threat and its illusions.”

To do this we need to be very careful about how we think about what we do. We swim in a sea of common sense and un-reflective beliefs heavily disseminated and promoted by the logic of capitalism. On a daily basis we are assaulted, through every medium possible, with the logic that the economy is the most valuable and important aspect of society and must be sustained and promoted at all cost. We are told, that all of our personal actions and social institutional behavior should be directed towards securing the economy. It is a message that is increasingly being adopted without question as the simple reality of our lives.

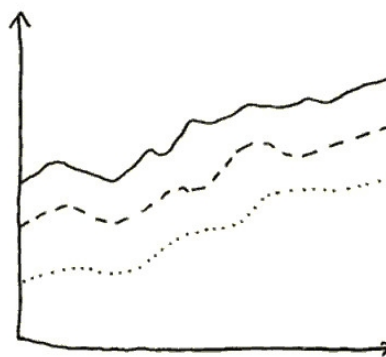
On the basis of it we are told there are no choices about the organization of our schools, homes, labor, or communities. Austerity must, regrettably be imposed. There is no other way. And like dreamers in a nightmare, we know something is amiss but it all seems so real we simply respond in ways that we hope will allow us to survive. But, to truly survive, we need to awaken from the nightmare and re-engage the actuality of our lived experience. Youth work/child and youth care has a long and powerful history of just such an engagement through the encounter between young people and adults as lived experience. As Taylor points out, “Its starting point is that both youth worker and young person are involved in a critical dialogue grounded in their shared and differing experiences, learning from each other in the process.” He cites the work of Dana Fusco and her work on what Taylor calls democratic educators. Fusco calls



for practitioners who work to sustain,

moral intuitiveness, self-critical openness, thoughtful maturity, a tactful sensitivity towards the child's subjectivity, an interpretive intelligence, a pedagogical understanding of the child's needs, improvisational resoluteness in dealing with young people, a passion for knowing and learning the mysteries of the world, the moral fibre to stand up for something, a certain understanding of the world, active hope in the face of prevailing crises and, not the least, humour and vitality.

Such qualities are not to be found in the marketplace. They are developed through living struggle in common with other living beings. If there is a politics pertinent to and appropriate for our field, I would suggest is not one of accommodation, but one of revolt. But a joyful revolt founded in our capacities for living as fully and completely as possible through unconditional care for one another and of an acceptance the beautiful uncertainty and volatility such care entails.



..... HOW BAD THINGS ARE  
- - - - HOW BAD THINGS SEEM  
— THE 'HOW BAD THINGS ARE'  
LINE REVIEWED IN THE  
LIGHT OF SOME EVIDENCE  
THAT HAD HITHERTO  
GONE UNNOTICED

Jack Phelan Comment

# On Social Pedagogy

I have been reading both Mark Smith and Kiaras Gharabaghi as they explore the complex similarities between social pedagogy and CYC practice (see Sept. *CYC-Online*). I would like to add some of my thinking to the discussion.

CYC practice, when it is done well, is both developmental and relational. That is, it requires an understanding of the ability and social maturity of the other person and it also requires a safe mutuality between both people usually developed slowly through a process of trust building and caring on the part of the CYC practitioner.

It is very hard to learn how to think developmentally, because it requires you to stop assuming that others think the same way that you do. Complex descriptions such as “meaning making” (Garfat, 1998, p.21) are built on the basic task of thinking developmentally. An example may help; every child between 2 and 5 years old thinks like a sociopath, not able to care for anyone but himself, yet we do not label them as such, we see it as a developmental stage that will change as they mature. When we are confronted by a teenager who is stuck in the developmental processes of a three-year-old, it is not easy to think developmentally and support her to

move forward into four- and five-year-old thinking; instead we often see pathology.

When the two-year-old shouts “NO” to every request, we are mildly challenged, but see it as a developmental stage that is not going to be helped by fining him a dollar every time he does this, yet we often deal with profanity (an immature teen’s way of saying NO) in this way.

The basic difference between people who need life space interventions, an intense method of treatment, and people who can be helped by once a week therapeutic conversations, is developmental. The less socially aware and mature you are, the more developmental support you need and life space work will be more helpful for you.

Simply put, people who are developmentally stuck at lower stages are more ego-centric and unsafe in the world. We have no problem thinking about young children this way, but it requires skill and training to think about teens and adults this way.

So where does relational practice fit into this?

Skilled CYC practitioners know that there is no opportunity for change and growth without building a safe relationship first. Yet this relationship alone does not create real change, even when sometimes it creates imitative behaviour, which was described 40 years ago in *The Other 23 Hours* as a form of role modelling. Using relational approaches to focus on behavioural change is not really helpful, unless there is a developmental shift also occurring.

Creating a safe relationship with some-



one, supports him/her to begin to see beyond him/herself, to become less ego-centric and more able to explore the world of other people safely. As a safe relationship develops, the CYC practitioner is able to discuss how she thinks and feels when the youth behaves different ways, and the youth is learning to take other people into consideration, to become more socially aware. This builds a social logic into the youth's critical thinking which is less ego-centric. This can only happen after the youth is able to be vulnerable (safely) in the relationship. As the youth begins to acquire a socially aware logic about how to behave, he/she starts to consider what impact he is having on others, which is what 5-8 year olds typically are becoming more aware of.

Recent CYC literature on relationship building emphasizes the creation of an *In-Between* space that brings the helper out of his usual personality and opens up a common ground place called the interpersonal in-between, which is a safe meeting area where both the adult and the youth can join together (Garfat, 2008). This is not asking the youth to think like you do, or a place of role modelling, but a risky yet useful joining of both people's world views without judgement.

So the adult is comparing his experience in the life space with the youth and hopefully expanding the youth's awareness of what the social ramifications might be. Mark Smith describes social pedagogy work as social education, the promotion of social functioning. In my formulation of the CYC practitioner's work, it is very important to avoid judging, advising, or

moralizing, yet the adult is hopefully creating a zone of proximal development by being a more knowledgeable other (Vygotsky) so he needs to have both a clear ethical stance and autonomy (see Smith) without needing to argue with the social logic of the youth.

Kiaras describes the realm of social pedagogy as outside both the family and the school, really the public domain (Gharabaghi, Sept. 2013), which fits nicely into this life space experiential framework. The belief that the agency of the youth is very essential is also confirmed in this process of meaning making. He claims that in social pedagogy work, diagnosis is suspect, behavior mod is rejected, and there is a deliberate search for patterns (Muster) that may allow for new approaches to challenges. When CYC practitioners work developmentally and relationally, they can create real experiences that support youth to grow in social awareness and complexity without diminishing the agency or authority of the youth over his story or beliefs.

There is some nice congruity here that might lead to further exploration.

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# Ignoring

*“When a child does or says something offensive I simply ignore him. Some of my colleagues say that is wrong, but it always works for me. Who is right?”*

As with most of these things, you could both be right and you could both be wrong. It is not enough to have a blanket “ignoring” rule. Generally, there are three clear reasons for us wanting to ignore a child’s behaviour, and all of these require conscious decisions on our part.

## **1. We ignore when we don’t want to reinforce negative behaviour.**

We are all familiar with the child who uses inappropriate ways of relating to others, perhaps in order to establish his dominance in the group or to divert a group from some constructive activity which he finds threatening or irrelevant to his present interests or needs. Alan may be clumsy or awkward in company and have difficulty with normal social skills. He may choose to make his presence felt by playing the clown or by passing ribald comments in order to draw others’ attention. By responding, we confirm for him that this method of engaging others “works”, so we choose rather not to respond — not to reward his approach. But there are some cautions ...

We must first have decided that this behaviour is ineffective and negative, not just offensive to our personal taste. The behaviour in question might be the way in which his family members relate to each other; it might be a common behaviour within his particular culture.

We must also be consciously working on improving this negative behaviour before we target it with our ignoring response. In other words, the behaviour must first have been discussed with the child, he or she must know that we want to reduce the behaviour.

It also helps if we have tried to understand the “benefit” he has gained from the inappropriate behaviour so that we can try to meet this need in better ways. It is a common, and tragic, feature of deprived children that they will seek attention from others, even if all they get is negative attention. We truly help when we make sure that a child receives legitimate rewards and attention without paying too high a price.

## **2. We ignore when the unwanted behaviour is not high on our list of treatment priorities.**

We do not have to intervene in every minor negative behaviour. There is a danger that we will come across as very disapproving or rejecting if we go about like Miss Manners, picking up on everything less than perfect.

The kids will very soon get to feel that we are “getting on their case”. If a child is struggling to be able to trust a new environment with its new people and strange routines, it doesn’t help for us ‘to be nit-



picking about the way she eats or sits in a chair. We ignore these things, but ...

We must first have assessed this child, and have established a clear set of treatment priorities, knowing which problems are urgent and serious, which can wait until later, and which are really not important. Without this level of planning, we can find ourselves being irritated by things which shouldn't even be on our agenda.

We must also have on our teams a working knowledge of relevant developmental and clinical models which we can use to pace ourselves in our work with the child.

We are often working with the social and psychological parallels of road accident victims. In the early stages we need to stabilise patients and get them slowly back on their feet; we don't expect good ballet or rugby skills from the time they are admitted! So, in child and youth care, we set goals, and then carefully plan our route towards these goals

### **3. We ignore behaviour which is not our business.**

When we spend so much time with the young people in our care, we are so often tempted to over-identify with them, to incorporate them in our "family", to want to make them PLU's (people like us!) So we want to mess with their table manners, their accents, their religion and their politics. Masud Hoghghi, who developed the well-known MCAT approach in child care, was very clear about this when he reminded us that our aim in treatment is to enhance what is good, reduce what is damaging, and conserve what doesn't

need changing — and indeed contributes to a sense of continuity.

### **Other reasons**

There are other reasons which may make us want to ignore certain behaviours or certain children, which have much to do with our own self-awareness which is always a crucial element of good child care practice. Ignoring to protect ourselves: There is no doubt that work with troubled youngsters brings us face to face with issues of our own — issues with which, as ordinary humans, we continue to have difficulty, or which we have not completely resolved for ourselves. Kids will push some of our buttons which we would rather not have pushed — and many will say that these youngsters have an uncanny sense of what is sensitive stuff for us. We all have had to come to terms with issues around such things as, authority, power, sexuality, rejection, loss, fear, failure, guilt ... and it is in the nature of child care work that these things will confront us anew in the children and families we work with. Be aware that one way of dealing with anxiety is to repress it, to ignore it. Be aware that when we choose to use ignoring as a technique in our work, we may unconsciously be refusing to deal with material which is painful for us, and therefore being unhelpful to the child. Ignoring to punish or reject: The withdrawal of attention and affection is one of humanity's cruellest punishments, probably because it was one of the most frightening experiences we endured when we were vulnerable children. Even as adults we still use this way to punish our friends and



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partners when we withdraw or sulk in our hurt or exasperation. One thing you can count on in your work with troubled children is that they will hurt you and exasperate you, and when you find yourself out of ideas, out of energy or out of resources, you may well find yourself withdrawing from the engagement, giving up, ignoring.

These two examples of other reasons why we ignore, illustrate powerfully the need for supervision in your child and youth care work. There may well be good reasons for you to ignore the behaviour of children, but these must be good reasons, well thought out reasons, and when they are opened up as elements of treatment

planning with our colleagues, or well understood in supervision, they have a better chance of being safe and effective for the kids.

### Conclusion

With children and youth at risk there may be unexpected triggers — terrors and vulnerabilities about loss, separation and rejection — and for this reason we are always extremely cautious about using ignoring as a way of managing young people. We will only use ignoring when it is part of a well thought out plan and we are sure it will be safe.

— B.G.



a feature from this journal six years ago

# Connecting

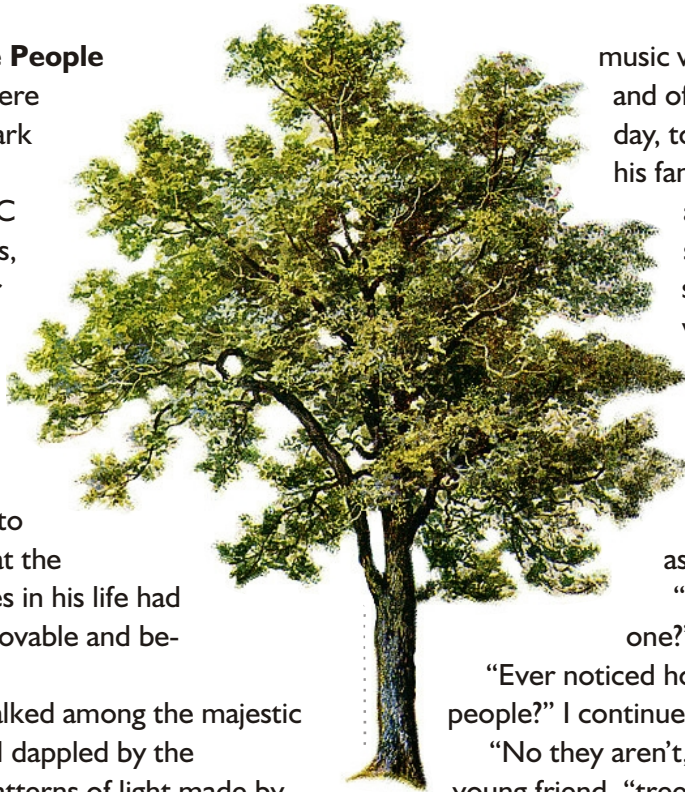
Frank Eckles

*In our work with youth, there are special moments of connection where our understanding, sensitivity and helping potential release us. Drawn by the other person's developmental readiness and the demands of the moment, an opportunity emerges for heightened relationship and communication. This is when we are at our best as CYCs.*

## Trees Are Like People

Brian and I were walking in the park one day. I had been Brian's CYC for some months, now. During our time together I had come to realize how alienated and alone Brian felt. He often spoke to me of feeling that the early experiences in his life had left him ugly, unlovable and beyond repair.

Today, we walked among the majestic trees on the trail dappled by the ever-changing patterns of light made by the gentle wind upon the tree leaves. We walked aimlessly, enjoying each other's company. We talked of baseball games, of



music we both enjoyed, and of Brian's wish, one day, to be reunited with his family. We came upon a clearing with a small stone bench. I sat on the bench while Brian lay down on a grassy mound.

"Brian, have you ever noticed how trees are?" I asked.

"Sure, hasn't everyone?" he replied.

"Ever noticed how trees are like people?" I continued.

"No they aren't," rebutted my young friend, "trees aren't at all like people!"

I swept my hand in an arc indicating the trees around us and said,





“Look at all these trees. Are any two exactly the same?”

“No,” he replied.

“And what makes them different?” I asked.

He puzzled for a moment and replied,

“Some are oak. Some are pine. And some of them, I don’t really know what kind they are.”

“Right you are,” I said, “and what else do you notice?”

“Well, some are tall and some are short. Some with piney branches, others with broad fingery leaves.”

“Yes, I see that also. Now notice something else.” I pointed to an oak tree that was noticeably bent and distorted. “What do you notice about that tree?”

Brian considered the tree for a moment and replied, “Looks like it might have been struck by lightning or maybe broken apart in a storm long ago.”

“Notice how the tree responded,” I said, “that bent trunk will always be there as a reminder of something that happened to the tree. The tree will always be marked by the event in the tree’s life. That tree was probably very young when its trunk was bent. But it has continued to grow these many years. Does that tree seem ugly to you, Brian?”

“No,” replied Brian, “not really.”

“It’s simply different and unique, isn’t it? Notice that none of the trees are exactly alike,” I continued, “No pine is exactly like any other pine. No oak exactly like any other oak. Each is changed by the events of its life; the place that it grows, the trees that surround it, the good years, the bad years. Just like people. We all are

marked by the events of our lives. It seems to make each of us more unique and valuable for there is no other exactly like us.”

We sat quietly for a long time. Neither of us speaking, listening to the wind whispering through the leaves, Brian pensively inspecting the trees. Eventually we continued our walk through the woods—each of us taking something away: Brian, a new awareness of his own uniqueness and value; me, an affirmed sense of myself as a child care worker and person. I doubt if either one of us will ever forget that day.

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# Jan's story

## From home to secure unit in eight moves

**M**y name is Jan. I am 15 and have been in the Gardener Unit in Manchester for the last few months. It is the only National Health secure unit built especially for teenagers. I am not sure what my future is. I was raised in Staffordshire. My first few years were alright. I got on with my sister and went to a catholic primary school for 7 years. Then my stepdad moved in. We didn't get on. He used to shout at me "You'll go where I say!" and beat me. My mum was scared of him; he beat her too. He adopted me but even so just after that I was put into care. I lived in a Family Centre. I kept away from my family and was going to school but doing no work.

Then I was sent to a clinic in Birmingham but came back to the Family Centre at the weekend. I caused some mischief so they refused to keep me. I was sent to another Family Centre in Burton but there was no school to go to. The other kids and I got each other into trouble. I used to set fire to things; once it was a lorry. By the age of 12, I was wild and out of control. After several more moves, I was sent to the Corvedale Care Crisis Intervention Centre in Shropshire. It was an Outward Bound (adventure training) place. I stayed two months and enjoyed it. I liked canoe-

ing, abseiling and rock climbing. It helped to keep me out of trouble. Then I went to a boarding-school in Wales. It was snobby and boring. I stayed about three months but they didn't want me there.

Finally, I came here and have stayed in Manchester for nine months. This is my longest home for some time. I am not bothered about its being a secure unit. I have been ice skating and swimming and am still working on my problems. Being in one place has helped me with my education. I was never very good at reading, having missed so much school. The Gardener Unit has a school called Cloughside and I have passed an exam in English. I never thought I could do this. It is called SAIL (Staged Assessment in Literacy), Stage One. I have also taken a word-processing exam and will do a spreadsheet test soon. I will get a school certificate in basic maths.

Some of my art has been shown in the unit. We can use computers in art and do colour printing. We make birthday cards for people. I feel better in myself for doing well in school. I hope to go to college and work on computers. I have also found that I am good at music. My key workers applied for a grant from the Prince's Trust. I wrote a letter myself too and a couple of days later a cheque arrived; it was for £210, to buy a keyboard. I thought it was brilliant, getting something I'd always wanted.

I enjoyed playing it, making up my own music. Rachael, the Music Therapist, has taught me how to read music. I hope to carry on with my music when I am older. Looking back on my life, I do feel angry





sometimes. I haven't seen my real dad for a couple of years. I wish I could have been kept in one place and not moved around so much. When I used to walk out of my class because everything just got on top of me, the teachers didn't try to find out what was wrong. My mum couldn't tell the social workers about all that was going on at home because she was afraid.

I know it is hard for kids in care to find good jobs. How can we get a good education when we move around so much? I know I have not finished moving. I shall be going somewhere else in the New Year and I'm not sure where. I know I will not have an easy future, but at least my education and my exams make me feel good about myself — and I really love my keyboard.

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From a long-ago issue of *Who Cares?* — the UK magazine for young people in care

“All you need is love. But a little chocolate now and then doesn't hurt.”

— Charles M. Schulz

“Whenever I feel the need to exercise, I lie down until it goes away.”

— Paul Terry

“We don't see things as they are, we see them as we are.”

— Anaïs Nin

“Life is what happens to you while you're busy making other plans.”

— Allen Saunders

“Always forgive your enemies; nothing annoys them so much.”

— Oscar Wilde

\* \* \*



If the brain is mostly made of fat, then gaining weight in college will only make you smarter!

# Our work undervalued?

**H**ello, I am a second year in the CYCC program and I am doing my practicum at a non-profit organization. I am thoroughly enjoying the work that I am involved with at this organization; however, it is frustrating to me to see people who are passionate about helping youth, but who are unable to keep their programs running due to budget cuts.

I think the core problem that I see as a society is that social work is undervalued. Counsellors, nurses, social workers and not-for-profit employees are all required to do the work that they do because they love it but they should not expect financial rewards for it. We can pay millions to a young man who can fire a rubber puck across the ice into a net for a goal but somebody working with youth in trouble with the law will be paid little. It is also hard to “prove” that working with a youth and keeping them out of jail will pay off in the end and so people often are not willing to invest in someone willing to make the effort.

This lack of appreciation and undervaluing translates into funding cuts. Whenever a government wants to cut funding it will be the not-for-profit sector that gets mangled. Social support agencies and schools face funding cuts on a daily basis. These organizations are an important source of support, resources and employment throughout communities.

The loss of income and educational funds has a huge impact on communities of all sizes.

In places where the cuts do not completely eradicate a service the trouble becomes that the volunteers and paid staff use their own bodies to bridge the gaps in services, ironically proving the idea that “see, you could have done this with less all along.” This sets up a vicious cycle so that when the organization has no more “fat” to trim, people get burnt out and have nothing left to give, groups go under.

At the heart of all of this is ideology. The political parties that value social services, that do not believe you should make a profit off health care, that believe marginalized and troubled people can contribute and be part of society do not get elected because of all the political in-fighting. All in all, if we cannot change the political view, what can we change so that we have a chance to help our youth back into our communities? It seems we may have to do the advocating ourselves to keep the non-profit organizations afloat. The work of advocating for the non-profit organization becomes equally as important as fulfilling the stated mission statement of the organization.

**Jennifer Bell**  
Calgary, Alberta



# C.D.D.

Andy Leggatt

William Faulkner wrote –

*“... I believe that man will not merely ENDURE, he will PREVAIL ... He is immortal ... NOT because he, alone among the creatures, has an inexhaustible voice ... but because he has a SOUL ... a SPIRIT ... capable of compassion and sacrifice and endurance ...”*

Now many of you are now thinking that you have been somehow magically transported to a “Criminal Minds” episode ... what’s with the jet in that show anyway ... clearly those guys don’t work in the Youth and Family Services field ... it wouldn’t be the same having six people touring across the country jammed in a rusted out, noisy, used Grand Caravan!

While others of you are probably wondering how I would know anything about William Faulkner ... “Hey, Andy, what do you know about William Faulker? ...” “Aaahhh ... wasn’t he a pitcher for the Toronto Blue Jays? ...”

OK ... Grisham maybe ... But *Faulkner*?

Good thing my amazing wife Darlene is well read!

And although I admit that, other than perhaps “The Sound and The Fury”, I could not name one other work by the man ... which clearly speaks volumes to MY ignorance as opposed to HIS immense talent ... clearly Faulkner had the soul of a CYW.

Because I truly do believe that Compassion is one of the most important qualities that we as workers or carers can possess.

I also think he speaks to the incredible resiliency of the human spirit when Faulkner states that we are all CAPABLE of compassion ... excepting, of course, anyone who has appeared on “Big Brother”!

And they call that show “Reality TV”? ... I suppose it is ... if you live in a Narcissistic Cesspool! ...

Oops ... Oh yeah ... Compassion ... I forgot ... Sorry!

Like so many other equally important qualities, there is not, as many of us believe or perhaps allow ourselves to believe, some “automatic refill” setting for our compassion that we can access regardless of life’s circumstances.

In fact, we must strive to fiercely protect and nurture our compassion ... as our compassion is vulnerable, and often insidiously so, to such influences as fatigue ... despair ... complacency ... disappointment ... distraction ... fear ...

“... Fear grows out of things we THINK and lives in our MINDS ...  
... Compassion grows out of things we ARE and lives in our HEARTS ...”

— Barbara Garrison



And therefore we as CYW's or carers in the field are particularly prone to C.D.D. ... or Compassion Deficit Disorder.

Symptoms include ...

Feeling jaded ... bitter ... spiteful ... resentful ... entitled ...

We take other people's actions or statements personally ...

We become invested in being right ... as opposed to being helpful ...

We become resistant to suggestion ... or change ... or new ideas ... often militantly so ...

But, as Faulkner so powerfully stated, we are ALL capable of compassion ...

Including the youth with whom we work whose belief that they matter to anyone has been destroyed ... and whose ability to form any sort of healthy, reciprocal relationship has been hugely impaired ...

Including the families who have frequently experienced generation after generation of dysfunction, pain, and abuse ...

Including the colleague who insists on eating his/her meals in the staff room or ignores a weeping youth during "Quiet Time" because he/she is "attention-seeking" ...

So what is the treatment plan for C.D.D.? ...

Frequent acts of random kindness ...

Regular exercise of our curiosity ...

A healthy diet of generosity ...

Generous doses of humility ...

And regular monthly checkups with

your mentor in the field ...

We work daily with our youth to nurture, develop, and value these same qualities ...

Do we not owe it to our youth and families to have no



less expectations of ourselves? ...

Theodore Isaac Rubin wrote:

"... Compassion and Kindness are more important than wisdom ... and the recognition of this is the beginning of wisdom ..."

We have a responsibility to have the wisdom to help our youth find the "inexhaustible voice" that Faulkner speaks so eloquently about ...

Don't we? ...

"... OK ... Let's pull the Grand Caravan over at the next gas station ... This van's suspension sucks ..."



## Post Card from Leon Fulcher

Air Mail

**H**i Everyone! The regional *School Kapa Haka Festival* took place last week at St Joseph's Primary School in Wairoa. That's the nearest town to where we live alongside the North Island's *Urewera National Park*. Primary and secondary school kids from around our region gathered for this event, supported by grandparents and family members for a great festival. This event gathered together far more people from around the region than any local sporting event might attract. Where we live, cultural performing arts are cool!

formed into changing rooms. A special 'drop zone' was created just off Queen Street for elders who were personally escorted to their seats! Stalls offering sausage sizzles, cakes, scones and coffee, tea and soft drinks were doing a roaring trade – well before the performances started.



*Kapa Haka* or Traditional Maori Performing Arts begins with Children

The first school group made a real impression. A mixture of younger and older children, this group also highlighted the extent to which any child interested in *kapa haka* can participate in this traditional Maori activity in our part of the world, with the blonde lad at the left offering a lovely example! The girls had made their



Primary School *Kapa Haka* Group Preparing for their Performance

Classrooms and offices throughout the St Joseph's School complex were trans-

'poi' – white soft-filled ball on tether – to use in some performances.



Anyone who is interested can join the Kapa Haka team!

A young man with Down's Syndrome captured my attention in the first group. He knew that he'd be moving to the front row when the boys did their haka. When finally his opportunity came, he performed his haka with gusto. And it was nice to see how he was accepted by all of his peers.

As school groups finished their performances, family members in the audience commonly rose to perform their own haka responses, acknowledging and giving recognition or *mana* to the efforts of their *tamaraki*/children. *Kapa haka* isn't just a performance; it's about family, extended family and tribal efforts!

We had of course come to support our local primary school – *Te Kura o Waikaremoana* – and our kids were stunning! The younger children could be seen following the older children in their group,



Whanau/Family respond to the children's performance with haka!



Te Kura o Waikaremoana Kapa Haka Team

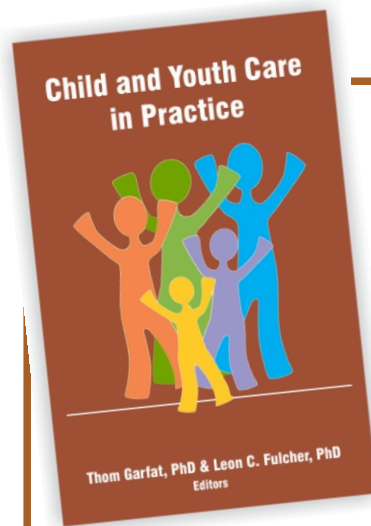
learning and refining their moves at each stage of the performance. I was reminded again of how the '**zone of proximal development**' operates in situations like this. Learning is shaped and reinforced through relationships that have meaning for each child, as seen with the young man challenged with Down's Syndrome.





Young children watch peers who're more confident with their performance!

Sitting there in the audience, you couldn't miss the large photograph of Saint Mary of the Cross MacKillup. It featured prominently behind the St Joseph's School stage. Google helped me identify that Saint Mary MacKillup is the only Australian to have been canonised as a Saint. Born in South Australia of Scottish ancestry, Mary MacKillup went on to establish the Order of Saint Joseph. At one stage she was declared a heretic for taking a stand about assisting children and the poor. It made me think that Mary was probably an early child and youth care worker, committed to hanging in with children when they needed it. We have a lot of Saints in our field!



## Child and Youth Care in Practice

Thom Garfat & Leon Fulcher - editors

*Child and Youth Care in Practice* brings together some of the best of contemporary writings on Child and Youth Care practice. Starting with an updated version of the characteristics of a CYC approach and ranging from practice-based evidence that informs evidence-based Outcomes that Matter through to direct care, supervision and management, through education to creative arts, *Child and Youth Care in Practice* demonstrates the application of a Child and Youth Care approach across many areas of our work.

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miscellany

# EndNotes



The amplitude of young peoples' feelings ranges further in all directions than that of us older folk.

Their heights of joy and depths of despair  
Their energetic activity and intractable moods  
Their rewarding enthusiasms and depressing unwillingnesses.

Happy is the moment when we catch them in an up and resist the infectiousness of their downs!

---

“Whatever you are, be a good one.”  
— **Abraham Lincoln**

“I believe that imagination is stronger than knowledge. That myth is more potent than history. That dreams are more powerful than facts. That hope always triumphs over experience. That laughter is the only cure for grief. And I believe that love is stronger than death.”

— **Robert Fulghum**

*All I Really Need to Know I Learned in Kindergarten*

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“The saddest aspect of life right now is that science gathers knowledge faster than society gathers wisdom.”

— **Isaac Asimov**



The first little pig built his house from straw ... and it still came in \$50,000 over budget!

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“It is our choices, Harry, that show what we truly are, far more than our abilities.”

— **J.K. Rowling**

“Here's to the crazy ones. The misfits. The rebels. The troublemakers. The round pegs in the square holes. The ones who see things differently. They're not fond of rules. And they have no respect for the status quo. You can quote them, disagree with them, glorify or vilify them. About the only thing you can't do is ignore them. Because they change things. They push the human race forward. And while some may see them as the crazy ones, we see genius. Because the people who are crazy enough to think they can change the world, are the ones who do.”

— **Apple Inc.**



Fred runs away now and then, but the bartenders always get tired of him and send him home.

### **Seven Deadly Sins**

Wealth without work  
Pleasure without conscience  
Science without humanity  
Knowledge without character  
Politics without principle  
Commerce without morality  
Worship without sacrifice.

— **Mahatma Gandhi**

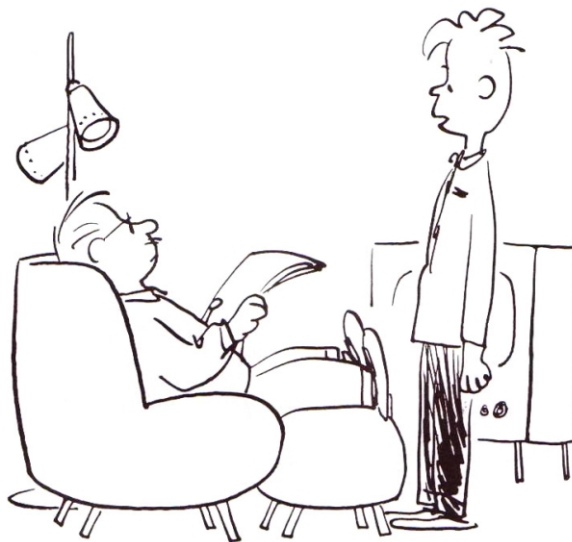
“Reading is one form of escape. Running for your life is another.”

— **Lemony Snicket**

“For instance, on the planet Earth, man had always assumed that he was more intelligent than dolphins because he had achieved so much — the wheel, New York, wars and so on — whilst all the dolphins had ever done was muck about in the water having a good time. But conversely, the dolphins had always believed that they were far more intelligent than man—for precisely the same reasons.”

— **Douglas Adams**

*The Hitchhiker's Guide to the Galaxy*

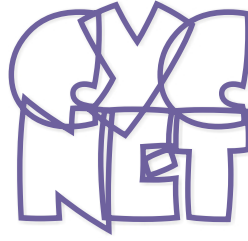


“I've decided to go on to college, Dad, and then, after that, try to become a ‘prophet of doom!’”

“Instead of being presented with stereotypes by age, sex, color, class, or religion, children must have the opportunity to learn that within each range, some people are loathsome and some are delightful.”

— **Margaret Mead**





THE INTERNATIONAL CHILD AND YOUTH CARE NETWORK

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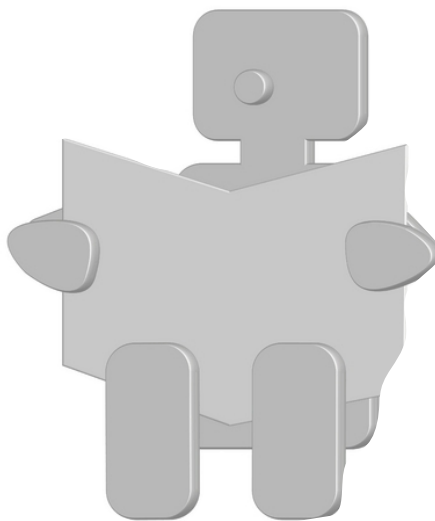
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