Residential Child and Youth Care Practitioner Training

Welcome to Module 2, Part 1 of the Residential Child and Youth Care Practitioner Training.
Module 2 Objectives

This module covers material about child and adolescent growth and development. Specifically, you will learn about:

1. Physical, cognitive, social and emotional, sexual, and moral development at all stages, beginning in infancy and continuing through adolescence. Additionally, you will learn about . . .
2. Attachment
3. Parenting styles
4. Children with special needs
5. Attention Deficit Hyperactivity Disorder, or ADHD
6. Autism Spectrum Disorders
7. Learning Disabilities
8. Learning Style Differences
9. Depression and suicide
10. Bipolar disorder
11. Anxiety disorders
12. Sexually acting out
13. Family violence
14. The impact of loss, separation, and out-of-home placement on youth
15. Lesbian, Gay, Bisexual, Transgender, and Questioning -- or LGBTQ -- youth, and
16. Developmentally appropriate programming for at-risk youth
Why Child & Adolescent Development?

So why learn about child and adolescent development?

The answer is simple. Who we are as people is the result of our biology, as well as our relationships and our environment — both nature and nurture. By understanding the developmental needs and important milestones in children’s and adolescents’ lives, you will be able to work with them more successfully and be better able to offer support and guidance to their families and communities.
Development

Development is usually divided into 3 broad categories: physical development, cognitive development, and social and emotional development.

Physical development is concerned with children’s bodies and how they change over time as a result of the normal process of maturing.

Cognitive development addresses children’s mental process, including how they think and what they think about.

Social and emotional development pertains to how children manage relationships, including their ability to express needs, feelings, and desires within relationships.
Development: Things to Consider

Some things to consider with regard to development include the following:
• Change is multi-directional. That is to say that change does not always occur in a straight line. It can have lags and spurts. A child might go through a period of quick change – for example, a growth spurt, plus learning to walk and learning to talk -- as well as a period where there is very little change for a while.
• Development occurs within multiple contexts, including one’s family, one’s community, and one’s culture. For example, growing up in an abusive family environment has a significant impact on a child’s social and emotional development.
• Human development is plastic in the sense that individuals can be molded through time by their circumstances, efforts, and unexpected events; at the same time, however, people maintain a certain amount of identity that is resistant to change.

In this section we will explore the developmental milestones for children and adolescents in the following domains: physical development (including sexual development), cognitive development (including moral development), and social and emotional development.
The First 2 Years (0-2): Physical Development

The first two years of a child’s life are characterized by rapid growth in body, mind, and social relationships.

In terms of physical development, growth is rapid. For example, infants double their birth weight by 4 months and triple it by age one. Two year olds are approximately half of their adult height and about one fifth of their adult weight. Gains of weight and height are monitored closely by pediatricians.

Brain development is also rapid at this age. The brain increases dramatically in size and complexity. Experience and normal stimulation by parents and caregivers help to foster this very important brain development. For example, talking to babies, playing games like peek-a-boo, and singing all help brain development.

Infants gradually improve their motor skills as they begin to grow and the brain begins to mature.

Good physical health for infants is significantly influenced by health care and caregiving, proper nutrition, immunizations, and sleep. Throughout childhood, regular and ample sleep correlates with normal brain maturation, learning, emotional regulation, academic success, and
psychological adjustment. That is to say, getting enough good sleep is extremely important for proper development. On the other hand, lifelong sleep deprivation can lead to health problems.
In terms of cognitive development, infants are smart and active learners, adapting to experience. They are like “little scientists.” Infants first react to their own bodies, then respond to other people and things. Eventually, infants become more goal-oriented, creative, and experimental. Infants gradually develop an understanding of objects. Researchers have found impressive intellectual capacities for infants by about 6 months of age.

Language learning might be the most impressive cognitive accomplishment of infants. Eager attempts to communicate are apparent in the first weeks and months of a baby’s life, through crying and cooing. Infants begin to babble at about 6 to 9 months, understand words and gestures by 10 months, and speak their first words at about one year. Vocabulary begins to build very slowly until the infant knows approximately 50 words. Toward the end of the second year, toddlers put words together, showing that they understand the basics of grammar.
The First 2 Years (0-2): Social and Emotional Development

In terms of social and emotional development, within the first two years of a child’s life, babies progress from reactions primarily revolving around pain and pleasure to more complex patterns of social awareness and emotional responsiveness. Initially, newborns seem to have only two simple emotions: distress and contentment; either they are crying and fussing or peaceful. Soon, other emotions become recognizable, like social smiling, or smiling in reaction to interaction with others; laughter; and curiosity. By 4 to 8 months, infants start to express some additional negative emotions, such as anger in response to frustration (for example, when strapped into their car seats when they want to be exploring instead), and eventually, they start to express sadness and fear.
The First 2 Years (0-2): Social and Emotional Development

Infants in particular have two dominant types of fear: stranger wariness, which is fear in response to a stranger, and separation anxiety. Babies may begin to cry or act distressed, even exhibiting anger, if a familiar caregiver leaves.

Click on the video link at the bottom of the page to see what separation anxiety looks like: http://www.youtube.com/watch?v=Y6QtU1L_A8 (separation anxiety video)
The First 2 Years (0-2): Social and Emotional Development

By their second year of life, toddlers have developed emotions that take on a new complexity and strength. There is more awareness of themselves and their interactions with others. Toddlers experience self-awareness, disgust, pride, shame, guilt, and embarrassment. Anger and fear become less frequent and more focused toward infuriating or terrifying experiences.

By age 2, children can display the entire spectrum of emotional reactions. They have been taught what is acceptable in their family and culture. For example, some cultures might encourage pride, while others might discourage pride and cultivate modesty and shame.
The First 2 Years (0-2): Social and Emotional Development

A child’s temperament – that is, the inborn differences between one person and another in emotions, activity, and self-regulation – plays a role in emotional development as well. For example, traits such as shyness and aggression are generally thought to be part of one’s temperament. Temperament is not the only component of a baby’s emotional development, however. Personality traits such as honesty and humility, for example, are considered learned. Thus, babies grow into people whose genetic traits are shaped by their experiences – the result of parenting, culture, and learning.

Most important to the development of emotion is the relationship between parent and baby, or caregiver and baby. Let’s turn now to a discussion of attachment.
Congratulations!
You have completed Part 1 of the RCYCP Module 2 Training. Please use the navigation below to open the next section of the training.

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Welcome to Module 2 of the Residential Child and Youth Care Practitioner Training.
Attachment

The concept of attachment is critical to understanding children – especially children who are mistreated or experience trauma. Attachment will be discussed here in module 2, but will be brought up again in module 7 when you learn about trauma.

Let’s get started.

Attachment is a lasting bond between people. It begins before birth, solidifies by age 1, and influences relationships throughout life. Our attachment to our parents, formed when we were children, affects our behavior with our own children, as well as our relationship with our partners. Attachment is a universal trait that is important from an evolutionary standpoint to ensure the survival of the species. Historically, proximity-seeking - that is, staying near a caregiver - and contact-maintaining, or staying in physical contact with a caregiver, fostered the survival of the species by keeping toddlers near their caregivers and keeping caregivers constantly aware of potential outside danger.
The quality of attachment that an infant develops with a specific caregiver is largely determined by the caregiver’s response to the infant. By response, we are referring to how the caregiver reacts to and treats the infant when the infant’s feelings of safety and security are threatened: for example, how the caregiver reacts when the infant is ill, physically hurt, emotionally upset, or frightened.

A pattern then develops: Baby is distressed, caregiver responds, baby reacts to caregiver. So by about 6 months of age, and based on these patterns, infants begin to anticipate their caregivers’ responses to their distress, and their behavior adjusts accordingly. Let’s look at how this works.
Types of Attachment

There are 4 types of infant-parent attachment: secure, insecure-avoidant, insecure-resistant, and disorganized.
Secure Attachment

When infants are distressed, caregivers who consistently respond in sensitive or “loving” ways, such as picking the infant up promptly and reassuring the infant, make infants feel secure in the knowledge that when they cry, they will then be comforted by their caregiver.
They also seek proximity, or physical closeness, to the caregiver, and maintain contact with the caregiver until they feel safe. These infants are “secure” in their attachment to their caregiver. For example: a toddler might scramble down from the caregiver’s lap to play with an interesting toy, but occasionally look back, vocalize a few syllables, or return for a hug. Or, a caregiver’s departure may cause distress, but the caregiver’s return elicits a positive reaction, like smiling, hugging, and then more playing.

Securely attached infants will be concerned but not completely overwhelmed by a caregiver’s leaving.
Research has shown that having a loving primary caregiver and developing a secure attachment to that primary caregiver help to protect children from social and emotional difficulties.

The attachment has a lifelong effect, too. Securely attached infants are more likely to become secure toddlers, socially competent preschoolers, high-achieving schoolchildren, and capable parents.

About two-thirds of infants are securely attached. The remaining one-third of infants fall into the insecure attachment categories that will be discussed next.
Insecure-Avoidant Attachment

When caregivers consistently respond to distress in insensitive or rejecting ways, such as ignoring, ridiculing, or becoming annoyed, infants develop a strategy for dealing with distress that is “insecure and avoidant.” Essentially, they avoid their caregiver when distressed and try not to show negative emotion in the presence of the caregiver, because they don’t want to be rejected. This happens even though there is still a deep desire to get the kind of comfort that securely attached infants receive from their caregivers. As you might guess, this avoidance strategy is a poor one and increases the risk for developing adjustment problems.
Insecure-Resistant Attachment

When infants have caregivers who respond in inconsistent, unpredictable, and/or ‘involving’ ways, such as expecting the infant to worry about the caregiver’s own needs, or increasing the infant’s distress, they develop a strategy that is “insecure and resistant.” They tend to display extreme negative emotion to draw the attention of their inconsistently responsive caregiver. Essentially, by exaggerating anger and distress, they are hoping that they can elicit a response from the inconsistently responsive caregiver. This attachment style is also associated with an increase in the risk of developing social and emotional maladjustment.
Insecure Attachment: Video Example

Click on the links to see some examples of insecure attachments:
Secure, Insecure, Avoidant, & Ambivalent Attachment in Mothers & Babies:
http://www.youtube.com/watch?v=DH1m_ZMO7GU

Developing Attachment: Inconsistent Response to a Baby’s Distress:
http://www.youtube.com/watch?v=8BA8CcEUP84
Disorganized Attachment

Finally, infants who are exposed to unusual parenting and to caregiver behaviors that are ‘atypical,’ such as frightening, frightened, dissociated, sexualized, or otherwise out of the ordinary behaviors, exhibit “disorganized” attachment. This type of attachment is also considered “insecure.” Research suggests that caregivers who display atypical behaviors often have a history of unresolved mourning or unresolved emotional, physical, or sexual trauma, or are otherwise traumatized. So, for example, a mother who was traumatized as a child may inadvertently display unusual or unhealthy parenting behaviors that create a disorganized attachment in her children.
Infants who have a disorganized attachment react to their caregivers in inconsistent ways, like shifting from distress to anger to avoidance within a single interaction. For example, such toddlers might shift from hitting to kissing their mothers, from staring blankly to crying hysterically, or from pinching themselves to freezing in place.

Disorganization prevents them from developing a strategy for social interaction (even an avoidant or resistant one). Sometimes they become hostile and aggressive, and difficult for anyone to relate to.
This attachment style is recognized as a significant predictor for serious psychopathology – or psychological and behavioral dysfunction -- and maladjustment in children.

They are more vulnerable to stress, have problems regulating and controlling their emotions, and display oppositional, hostile, and aggressive behaviors, and coercive styles of interaction.

This type of attachment style is over-represented in groups of children with clinical problems, and those who are victims of maltreatment. So, for example, in the general population, about 5-10% of infants are this type, but nearly 80% of maltreated infants have a disorganized attachment.
Attachment

As we have shown, the quality of the infant-parent attachment is a powerful predictor of a child's later social and emotional outcome.
One thing to note, however, is that attachment status may shift with family circumstances. For example, abuse or the stress of poverty can make secure attachment less likely. While it may seem strange, children develop attachment relationships with even the most abusive and neglectful caregivers. The question is never, ‘is there an attachment between this parent and child?’ but rather, ‘what is the quality of the attachment relationship between this parent and child?’ Attachment as it relates to abuse and neglect will be discussed in more detail later.
Congratulations! You have completed Part 2 of the RCYCP Module 2 Training. Please use the navigation below to open the next section of the training.
Welcome to Module 2, Part 3 of the Residential Child and Youth Care Practitioner Training.
Also known as the “preschool years” and sometimes the “play years”, early childhood is a period of extraordinary growth in every domain. Children this age spend most of their waking hours discovering, creating, laughing, chasing, and attempting new challenges with their developing bodies. They play with sounds, words, and ideas, and engage in creative and dramatic play, both by themselves and with others.
Early Childhood: Physical (2-6 years)

In terms of physical development at this stage, children continue to gain weight, grow taller, and slim down. Their lower body lengthens and their fat is replaced by muscle.
Early Childhood: Cognitive (2-6 years)

Most of the brain is functioning by age 2. There is a greater speed of thought – essentially more efficient information processing. These changes allow for children to think before they act and be less impulsive.

The maturation of the brain allows for better physical coordination, such as improved speed and grace. Fine motor skills such as writing significantly improve at this age as well.

Cognition develops rapidly from age 2-6, as does language. Today, many 3- to 6-year-olds are in school. Research suggests that there is rapid development and great learning potential in the early years, which makes preschool a valuable resource.
With regard to social and emotional development, during early childhood children learn to regulate and control emotions. They learn when and how to express emotions in a controlled manner. For example, they learn how to be angry without becoming explosive, how to be scared, but not terrified, and how to be sad, but not inconsolable.

Emotional regulation becomes possible as a result of brain maturation.
Children who have difficulty with emotional regulation may develop internalizing or externalizing problems.

Internalizing problems: Involves turning one’s emotional distress inward, such as by feeling excessively guilty, ashamed, or worthless.

Externalizing problems: Involves expressing powerful feelings through uncontrolled physical or verbal outbursts, such as by lashing out at other people or breaking things.
Children’s beliefs about their worth are connected to parental confirmation. Parents confirm children’s worth through comments such as “you are such a good helper,” and remind them of their positive accomplishments. Throughout this process, children form their self-concept, which is their understanding of themselves with regard to their self-esteem, appearance, personality, and various other traits. Self-esteem tends to be high during early childhood.
During early childhood children develop emotions of empathy and antipathy.

Empathy: the ability to understand the emotions and concerns of another person – especially when they differ from one’s own.

Antipathy: feelings of dislike or even hatred for another person.

Empathy leads to prosocial behaviors, such as helpfulness and kindness, without any benefit to oneself. For example, a child experiencing empathy might express concern or offer to share food or a toy. On the other hand, antipathy can lead to antisocial behavior such as deliberate hurtfulness or destructiveness aimed at another person, including people who have not actually harmed the antisocial person. This can be seen in verbal insults, social exclusion, and physical assaults.

By age 4 and 5 most children can be deliberately prosocial or antisocial.
Congratulations!
You have completed Part 3 of the RCYCP Module 2 Training. Please use the navigation below to open the next section of the training.
Welcome to Module 2, Part 4 of the Residential Child and Youth Care Practitioner Training.
Parenting Styles

There are 3 major styles of parenting that differ on the dimensions of expressions of warmth, strategies for discipline, communication, and expectations for maturity. Let’s talk about each one separately:

1. In “authoritarian” parenting:
   a. The parent’s word is law. It should not to be questioned.
   b. Misconduct brings strict punishment (usually physical, but not so harsh as to be considered abusive).
   c. Parents set down clear rules and hold high standards.
   d. They do not expect children to offer opinions.
   e. Discussion about emotions is especially rare.
   f. Finally, authoritarian parents love their children, but they often appear aloof and rarely showing affection.
2. The second style is called “permissive” parenting (also called “indulgent”). In this style:
a. Parents make few demands, hiding any impatience they feel.
b. Discipline is lax.
c. Parents have low expectations for maturity.
d. Parents are nurturing and accepting, listening to whatever their children say.
e. Parents try to be helpful.
f. And finally, permissive parents do not feel responsible for shaping their children.
3. The third style of parenting is “authoritative” parenting. In this style,
   a. Parents set limits and enforce rules, yet also listen to their children.
   b. Parents encourage maturity, but they usually forgive (not punish) if the child falls short.
   c. Finally, authoritative parents consider themselves guides, not authorities and not friends.
The long-term effects of parenting styles are the following:

- Authoritarian parents raise children who are likely to become conscientious, obedient, and quiet, but not especially happy. Such children tend to feel guilty or depressed, internalizing their frustrations and blaming themselves when things don’t go well. As adolescents, they sometimes rebel, leaving home before age 20.
- Permissive parents raise unhappy children who lack self-control, especially in the give-and-take of peer relationships. Inadequate emotional regulation makes them immature and impedes friendships, which are the main reason for their unhappiness. They tend to continue to live at home, still dependent, in early adulthood. In middle and late adulthood, they fare quite well.
- Authoritative parents raise children who are successful, articulate, happy with themselves, and generous with others. These children are usually liked by teachers and peers, especially in the United States and other societies in which individual initiative is valued.
Moral Development: Early Childhood (2-6 years)

Let’s talk about moral development in children now.

According to Lawrence Kohlberg, the leading theorist in moral development, people progress in their moral reasoning through a series of six identifiable stages, beginning as children. He classified these 6 stages into 3 levels (pre-conventional, conventional, and post-conventional). Kohlberg believed that individuals could only progress through these stages one at a time and in order. That is to say that people cannot jump around the stages, nor can they skip stages. At 2-6 years, children are at Level 1: the pre-conventional level.
Children ages 2-6 are focused on the notions of punishment and obedience. Right and wrong is based solely on the idea that whatever leads to punishment is wrong. They see rules as fixed and absolute, needing to be obeyed to avoid punishment. An answer to an ethical question at this stage illustrates a belief that if you are going to get in trouble by doing something, then it is wrong to do it. Take Kohlberg’s classic ethical dilemma, the Heinz Dilemma.

Heinz’s wife was near death, and her only hope was a drug that had been discovered by a pharmacist who was selling it for a lot more money than it cost to make. Heinz could only raise a small amount of money and insurance wouldn’t cover the rest. Heinz offers to pay what he has and continue paying more money later. The pharmacist refuses. In desperation Heinz considers stealing the drug. Would it be wrong for him to do that?
Children at this developmental stage would say that Heinz should not steal the drug because he might get caught and punished.
Sexual Development: Becoming Boys and Girls (2-6 years)

Biology determines whether a person is male or female, depending on their chromosomal makeup. Male and female bodies produce sex-specific hormones that exert control over the brain, body, and behavior. Sexual identity is more than biology, however, and it is during early childhood that patterns and preferences become apparent.
Children are more conscious of gender with every year of childhood. Even 2-year-olds consistently apply gender labels like lady, man, Mr. and Mrs. By age 4, children are convinced that certain toys are appropriate for one sex but not the other, such as dolls and trucks, and that certain roles -- like nurse, teacher, and police officer -- are best for one sex over another.
Sex versus Gender:
Scientists make a distinction between sex differences and gender differences. Sex differences are biological differences between males and females. Gender differences are culturally prescribed roles and behaviors. At around 5 years of age, many children become rigid in their ideas of sex and gender. Boys might argue against playing with dolls because they believe “dolls are for girls.” Gender stereotypes are the strongest at about age 6.
Congratulations!
You have completed Part 4 of the RCYCP Module 2 Training. Please use the navigation below to open the next section of the training.
Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 2, Part 5 of the Residential Child and Youth Care Practitioner Training.
Middle Childhood: Physical Development (6-11 years)

Middle childhood spans the ages of 6 to 11, and for most children is marked by good health, steady growth, the mastery of new athletic skills, language advancement, and less dependency on families.

In terms of physical development, middle childhood is a time of steady growth and few serious illnesses. School-age children’s growth is slow and steady, and they are able to care for themselves more independently – brushing their teeth, getting dressed, making their own lunch, and walking to school. Muscles become stronger, and athletic skills become more advanced. Because children this age can now play organized games with rules, physical games such as tag become age-appropriate and enjoyable.

Physical activity is beneficial for this group in many ways: better overall health, less obesity, appreciation for cooperation and fair play, improved problem-solving abilities, and respect for teammates and opponents of many ethnicities and nationalities. At this age, there are hazards as well, like loss of self-esteem as a result of criticism from teammates or coaches, sports-related injuries, and reinforcement of prejudices -- for example, reinforced stereotypes of the opposite sex.
Middle Childhood: Physical Development (6-11 years)

In terms of brain development, the brain works faster now and is better coordinated. Children at this stage of development can quickly process information, as well as pay special attention to the most important elements of their environment. By age 7, they are significantly better able to concentrate on some stimuli while ignoring others, termed “selective attention,” which is helpful in both school and play. So, for example, a child in this stage should be able to pay attention to a teacher while ignoring a disruptive student.

This brain development also allows for important accomplishments such as reading, social decision-making, and mental control processes that enable self-control and planning for the future.

While some children develop without any challenges, others have special learning needs that are the result of problems in the development of their brains. Let’s take a few moments and discuss children with special needs.
Children with Special Needs

In the United States, the term “special needs” is used to describe individuals with a developmental disability -- an impairment that may be medical, mental, or psychological and that requires assistance. For example, children with autism, bipolar disorder, Down syndrome, dyslexia, blindness, or cystic fibrosis may be considered to have special needs.

Developmental disabilities affect all racial, ethnic, and socioeconomic groups. In the U.S., about 1 in 6 children have a developmental disability.
Children With Special Needs

Developmental disabilities begin anytime during the developmental period and usually last throughout a person’s lifetime. Most developmental disabilities begin before a baby is born, but some can happen after birth because of injury, infection, or other factors (CDC). Most developmental disabilities are thought to be caused by a complex mix of factors, including:

- Genetics;
- Parental health and behaviors during pregnancy (e.g., smoking and drinking);
- Complications during birth;
- Infections the mother might have during pregnancy;
- Infections the baby might have early in life;
- Exposure of the mother or child to high levels of environmental toxins such as lead

For some developmental disabilities such as Fetal Alcohol Syndrome, which is caused by drinking during pregnancy, the cause of the disability is known. For most, like autism for example, the cause is unknown.
Children With Special Needs

Developmental disabilities are particularly relevant in middle childhood because children are grouped by age and expected to learn on schedule in school. In the United States, schoolchildren who are below average in achievement are given special intervention. Professionals use a battery of tests to diagnose and develop recommendations. If a child has been identified as having special needs, an Individualized Education Plan, or IEP, is established in a partnership between school and family to specify educational goals for the child. About 13 percent of all school-age children in the United States receive special-education services.

Let’s talk about some of the disorders that you, as an RCYCP, might encounter in children with whom you work.
ADHD

People with attention-deficit hyperactivity disorder, or ADHD, may have trouble paying attention or controlling impulsive behaviors – where they may act without thinking about what the result will be -- or they may be overly active. Although ADHD can’t be cured, it can be successfully managed, and some symptoms may improve as the child ages. In order for these problems to be diagnosed, they must be out of the normal range for a child’s age and development. For example, you can expect that a 2-year-old will have trouble sitting and paying attention for long periods of time. That is considered normal. However, if a 6-year-old cannot sit still and pay attention for five minutes, we would consider that out of the normal range of development.
The diagnosis is based on very specific symptoms and must be seen in more than one setting -- for example, at home and in school.

ADHD is the most commonly diagnosed behavioral disorder of childhood. Nearly 1 in 10 children has an ADHD diagnosis. ADHD is diagnosed much more often in boys than girls.

ADHD may run in families, but there is no known cause. Brain imaging studies suggest that the brains of children with ADHD are different from those of other children.

Most children with ADHD have at least one other developmental, psychiatric, or behavioral problem.

Let’s talk about symptoms now.
Symptoms of ADHD fall into 3 groups:
- Lack of attention, or inattentiveness
- Hyperactivity
- Impulsive behavior, or impulsivity

Some children’s symptoms primarily fall into the first category; these children display attention-deficit disorder, or ADD, and tend to be less disruptive.

A child displaying “inattentive” symptoms:
- Fails to give close attention to details or makes careless mistakes in schoolwork;
- Has difficulty paying attention during tasks or play;
- Does not seem to listen when spoken to directly;
- Does not follow through on instructions and fails to finish school work or chores;
- Has difficulty organizing tasks and activities;
- Avoids or dislikes tasks that require sustained mental effort (such as schoolwork);
- Often loses toys, assignments, pencils, books, or tools needed for tasks or activities;
- Is easily distracted;
- And finally, is often forgetful in daily activities.

A child showing “hyperactivity” symptoms:
- Fidgets with hands or feet, or squirms in their seat;
- Leaves their seat when remaining seated is expected;
• Runs about or climbs in inappropriate situations;
• Has difficulty playing quietly;
• And is often “on the go,” and talks excessively.

Finally, a child with “impulsivity” symptoms:
• Blurts out answers before questions have been completed;
• Has difficulty awaiting their turn;
• Interrupts or intrudes on others.
ADHD Videos

ADHD is a chronic and long-term condition. Without intervention ADHD may lead to drug and alcohol abuse, school failure, difficulty with job stability, and trouble with the law. Treatment includes both medication and behavioral intervention. Although it is not curable, with early intervention and treatment, ADHD can be successfully managed.

Click on the links to see some videos about ADHD

How to Recognize ADHD:
http://www.youtube.com/watch?v=IbEPgoS-zSA

ADHD: What It Is, What It Isn't -- Keeping Kids Healthy:
http://www.youtube.com/watch?v=t9ZKdXDTUww

10/10/2010 14:09 BBC Horizon 2005 Living With ADHD(1):
http://www.youtube.com/watch?v=-a9qliaPhRg
Conduct Disorder

Another common psychiatric disorder of childhood and adolescence, and one you will likely see as an RCYCP, is conduct disorder.

Conduct disorder is a group of behavioral and emotional problems in which children and youth have significant difficulty following rules and behaving in a socially acceptable way. You may say to yourself, “Well, a lot of kids are like this.” What makes conduct disorder different from run-of-the-mill behavior issues is that it is characterized by a variety of chronic antisocial behaviors. With conduct disorder, there is a repetitive and persistent pattern of behavior that violates the basic rights of others, major age-appropriate societal norms, or both.
Conduct disorder may include some of the following behaviors:

1. Aggression to people and animals wherein someone
   • bullies, threatens or intimidates others;
   • often initiates physical fights;
   • has used a weapon that could cause serious physical harm to others (such as a bat, brick, broken bottle, knife, or gun);
   • is physically cruel to people or animals;
   • steals from a victim while confronting them (for example, assault);
   • and/or forces someone into sexual activity.
2. Destruction of property, wherein someone
   • deliberately engages in fire-setting with the intention to cause damage;
   • and/or deliberately destroys others’ property.
Conduct Disorder

Deceitfulness, lying, or stealing

- Has broken into someone else's building, house, or car
- Lies to obtain goods or favors, or to avoid obligations
- Steals items without confronting a victim

3. Deceitfulness, lying, or stealing, wherein someone
   - has broken into someone else's building, house, or car;
   - lies to obtain goods or favors, or to avoid obligations;
   - and/or steals items without confronting a victim (such as shoplifting, but without breaking and entering).
And finally,

4. Serious violations of rules, wherein someone
   • often stays out at night despite parental objections;
   • runs away from home;
   • and/or is often truant from school.
Many children with a conduct disorder have other conditions such as mood disorders, anxiety, PTSD, substance abuse, ADHD, learning problems, or thought disorders.

It is critical for children and youth with conduct disorder to receive treatment. Research shows that youngsters with conduct disorder are likely to have ongoing problems if they, and their families, do not receive early and comprehensive treatment. Without treatment, many youngsters with conduct disorder are unable to adapt to the demands of adulthood and continue to have problems with relationships and holding a job. They often break laws or behave in an antisocial manner.
Treatment for conduct disorder includes:

1. Training for parents on how to handle child or adolescent behavior;
2. Family therapy;
3. Training in problem-solving skills;
4. Community-based services that focus on the young person within the context of the family and community influences, and
5. Possible use of medication for those with: difficulty paying attention, impulse problems, or depression.
Conduct Disorder: Video Example

Click on the link to see a short clip of a family struggling with children with conduct disorder.

Conduct Disorder
http://www.youtube.com/watch?v=THsIP7pM9Oc
Autism Spectrum Disorders (ASDs)

Autism spectrum disorders, or ASDs, are a group of developmental disabilities marked by significant social, communication, and behavioral challenges. Autism spectrum disorders affect each person in different ways and can range from very mild to severe.
Autism spectrum disorders begin before the age of 3, with most children showing signs in early infancy. For some children, however, symptoms might not show up until 24 months or later, so that the children appear to develop typically and then stop gaining new skills or lose the skills they had.

Currently, 1 in 110 children (or about 1%) are diagnosed with an ASD. ASDs occur in all racial, ethnic, and socioeconomic groups, but are five times more common in males than females. Also, there are more European American children with ASDs than Latino, Asian, or African American.
Most scientists agree that there is a genetic link to autism. Children who have a sibling or parent with an ASD are at significantly higher risk of having an ASD themselves; however, it is likely that many different factors make a child more likely to have an ASD, including environmental and biological factors. For example, the prescription drugs valproic acid and thalidomide have been linked to a higher risk of ASDs in cases where they were taken during pregnancy.

Let’s talk about some signs and symptoms of ASDs.
A person with ASD might:

- Not respond to their name by 12 months
- Not point at objects to show interest
- Not play “pretend” games by 18 months
- Avoid eye contact and want to be alone
- Have trouble understanding other people’s feelings or talking about their own feelings
- Have delayed speech and language skills
- Repeat words or phrases over and over, known as echolalia
- Give unrelated answers to questions
- Get upset over minor changes
- Have obsessive interests
- Flap their hands, rock their bodies, or spin in circles
- Have unusual reactions to the way things sound, smell, taste, look, or feel

Some children never speak, rarely smile, and often play for hours with one object (such as a spinning top or a toy train).
Currently, there is no known cure for ASDs; however, research indicates that early intervention services can greatly improve a child’s development. Typical services include therapy to assist with social interaction and communication, and behavioral interventions.
Autism Spectrum Disorders (ASDs): Video

Click on the link to see a short video about the early signs of Autism Spectrum Disorder

Bringing the Early Signs of Autism Spectrum Disorders Into Focus:
http://www.youtube.com/watch?v=YtvP5A5OHpU
Learning Disabilities (LDs)

As an RCYCP, you will likely encounter youth with learning disabilities. So what do we mean by the term “learning disabilities”? 

Learning disabilities, or LDs, are a group of varying disorders that have a negative impact on learning. They may affect one’s ability to speak, listen, think, reason, read, write, spell, or compute. LDs are a group of disorders, not a single disorder. You may be familiar with some LDs; the most common is in the area of reading, known as dyslexia.
Intellectual disability (once referred to as “mental retardation”), autism, deafness, blindness, behavioral disorders, and ADD/ADHD are not learning disabilities, though often these conditions are confused with LD. Additionally, LD is often mistaken as laziness, or associated with disorders of emotion and behavior. In fact, people with LDs are often of average or above-average intelligence but still struggle to acquire that impact their performance in school, at home, in the community, and in the workplace.
According to the National Center for Learning Disabilities, the hallmark sign of a learning disability is “a distinct and unexplained gap between a person’s level of expected achievement and their performance.” That means, for example, that you might see a youth who is clearly smart, but is not earning the grades that you would expect him or her to earn.
Learning disabilities affect every person differently, and they look different at various stages of development. They can range from mild to severe, and it is not uncommon for people to have more than one learning disability. In addition, about one-third of individuals with an LD also have ADHD.

Currently 2.4 million students in the United States are diagnosed with LD and receive special education services in our schools.

There is no known cause of learning disabilities and there is no cure for learning disabilities. They are lifelong. People with LD need services in order to succeed at school and in social situations.
Let’s look at some of the most common learning disabilities.
Learning Disabilities (LDs): Video

Click on the link to hear more about learning disabilities.

Learning Disabilities, What Are the Different Types?:

Emotional Disturbances

As an RCYCP, you might work with children that are labeled as having an “emotional disturbance” or “ED”. Emotional disturbances is a category of disability that is defined as:

A condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child’s educational performance:

• An inability to learn that cannot be explained by intellectual, sensory, or health factors;
• An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
• Inappropriate types of behavior or feelings under normal circumstances;
• A general pervasive mood of unhappiness or depression, and/or
• A tendency to develop physical symptoms or fears associated with personal or school problems.

You can see that emotional disturbances can affect not only an individual’s emotional state, but their physical, social, and cognitive (or thinking) skills as well.
You can think of Emotional Disturbances as an umbrella term for a wide range of conditions. These include, but are not limited to:

- Anxiety Disorders
- Autism Spectrum Disorders
- Bipolar Disorder
- Conduct Disorders
- Eating Disorders
- Obsessive-Compulsive Disorder (OCD) and
- Psychotic Disorders

You will learn about many kinds of Emotional Disturbances in this module.
Some of the characteristics and behaviors that you might see in a child who has an emotional disturbance include:
• Hyperactivity, including short attention span or impulsiveness;
• Aggression or self-injurious behavior, such as acting out or fighting;
• Withdrawal -- not interacting socially with others due to excessive fear or anxiety;
• Immaturity, which can be characterized by inappropriate crying, temper tantrums, and poor coping skills, and
• Learning difficulties, characterized by academically performing below grade level.

Children with the most serious emotional disturbances may have more severe behaviors, such as distorted thinking, excessive anxiety, bizarre physical movements, and abnormal mood swings.

There are many children who do not have an emotional disturbance but still display some of these behaviors at various times during their development. That is normal. What separates children with emotional disturbances is that these behaviors continue over long periods of time.
As with many other developmental issues, there is no known cause for emotional disturbances, although several factors may contribute to the problem, including heredity, brain disorder, diet, stress, and family functioning.
Children with ED often have special education and related services in the school setting that are designed to deal with their emotional needs. Typically these programs include providing emotional and behavioral support (such as therapy and behavior plans), as well as services to help them master academics, develop social skills, and increase self-awareness, self-control, and self-esteem. Treatment outside of the school setting is similar, and may include medication, therapy, and behavioral support.
Congratulations! You have completed Part 5 of the RCYCP Module 2 Training. Please use the navigation below to open the next section of the training.
Welcome to Module 2, Part 6 of the Residential Child and Youth Care Practitioner Training.
Middle Childhood: Cognitive Development (6-11 years)

In terms of cognitive development in middle childhood, school-age children become more systematic, objective, and scientific, which makes them great learners.

They also have better memories. They can recall things faster and more efficiently, especially when they are interested. For example, a child might memorize all facts about football history if he or she likes football, but can’t memorize math facts. Their language improves as well. They are more knowledgeable, and are better able to understand the meaning of new words, as well as understand jokes and metaphors. They also adapt their language to the people they are with, for example, speaking one way with friends and another way with adults.
Middle Childhood: Cognitive Development (6-11 years)

Differences in learning by:
• Inherited characteristics
• Socioeconomic status (SES)
• Learning style

Children differ in their success with learning to speak, read, and write. Some differences may be genetic; however, researchers agree that social context matters. There is a strong link between socioeconomic status, or SES, and language. Children from families with a low SES (that is, more impoverished) tend to have smaller vocabularies, simpler grammar, shorter sentences, and tend to fall behind peers in talking, reading, and other subjects.

There are also differences in learning style. That is to say, not everyone learns effectively in the same way.
Learning Style

There are three types of learners:

- Visual learners have a preference for acquiring knowledge through seeing. They think in pictures or images. They benefit greatly from slides, diagrams, handouts, and the like.
- Auditory learners obtain knowledge best through listening. They learn by reading aloud and remember things by verbalizing lessons to themselves or having discussions with others. They benefit greatly from lectures, discussion, audio recordings, and the like.
- Finally, Kinesthetic learners or tactile learners prefer to learn through experience and active exploration. They are “hands-on” learners. For example, kinesthetic learners enjoy experiments, activities, field trips, and so forth.
Middle Childhood: Moral Development (6-11 years)

Stage 2: Self-interest

He will have to live in jail and be unhappy

He will be happier if he saves his wife

Development

With regard to moral development in middle childhood, as children grow older, they begin to see that there is not just one right view. They begin to think more about themselves and their own self-interest, thus leading them to the next stage of moral development – self-interest. Essentially, they think about “what’s in it for me?” The answer to the Heinz dilemma at stage two, then, is along the lines of, “Heinz should steal the medicine because he will be happier if he saves his wife,” or “Heinz should not steal the medicine since he will have to live in jail, and then he would be unhappy.” It is not the question of whether or not Heinz should steal the medicine that illustrates the morality, but the reasoning that is given for the answer – in this case, driven by self-interest.
Middle Childhood: Social and Emotional (6-11 years)

In middle childhood kids make some significant advances in social and emotional development. In particular, there is an increase in independence and self-determination. Children at this stage are increasingly able to manage themselves, take responsibility, and exercise self-control.

Sexual impulses are quiet at this developmental stage. Children at this stage typically choose to be with others of the same sex.
Most children in middle childhood are happy with themselves and have friends who appreciate them. In terms of self-concept, schoolchildren begin to rely on peers’ opinions of themselves rather than their parents’. They care more about what others think about them and do a lot of comparing of themselves to others – “Is he better at sports than I am?” “Does she have more friends than I do?” This is also the stage when peer pressure can become an issue.

Because there is more of an emphasis in this stage about the opinions of peers, it is not surprising that kids have a drop in self-esteem. They are now vulnerable to the opinion of others – even other children whom they don’t know.

Also, materialism increases and attributes that adults might find superficial become important – which makes self-esteem more fragile (for example, kids may want the latest toys, shoes, clothes, video games, etc.).
After-school activities, especially sports, can be very valuable at this stage because it helps kids with a foundation for friendship and realistic self-esteem. It also helps with building teamwork, cooperation, and commitment.
Congratulations! You have completed Part 6 of the RCYCP Module 2 Training. Please use the navigation below to open the next section of the training.
Residential Child and Youth Care Practitioner (RCYCP) Training

Module 2
Part 7

Welcome to Module 2, Part 7 of the Residential Child and Youth Care Practitioner Training.
Adolescence: Physical Development (12-18 years)

Adolescence begins with puberty. Puberty refers to the years of rapid growth and sexual maturation that complete the transition from child to adult in terms of size, shape, and sexuality. It usually lasts three to five years and is marked by an increase in hormones for both males and females. Girls get their periods and their bodies begin to change, for example with breast maturation, pubic-hair growth, and widening of the hips.

For boys, puberty means that boys will undergo physical changes as well. Boys will develop pubic hair and facial hair. They will have a growth spurt that includes growth of penis and testicles. Their voices will deepen and they will experience spermarche, which is the first ejaculation of sperm – either by a wet dream or physical stimulation.

Picture source: http://mrclay10sci2.wikispaces.com/puberty
The increase in hormones has an effect on mood as well. Adolescent outbursts of sudden anger, sadness, and lust are caused by hormones combined with reactions from other people to the young person’s changing body.
The typical age of puberty for males and females is just under 13 years of age, although it can vary. Many factors affect the onset of puberty, especially among girls. Such factors include genes, body fat, and stress.

There are cultural variations as well. Well-nourished Africans tend to experience puberty a few months earlier than Europeans, and Asians a few months later than Europeans. Urban children tend to experience puberty earlier than rural children, most likely as a result of less physical activity and higher fat levels.
Proper adolescent nutrition is important to the physical changes that occur during this time period, but may be complicated by a desire to eat junk food, as well as by peer culture, and body image issues.
Let’s talk about body image issues for a moment. By “body image issues,” we are referring to the concerns that adolescents have about their changing bodies. Body image issues may arise during this time period. Adolescents tend to focus on, and exaggerate, imperfections in their body, as well as compare themselves to others. Girls may want to be thinner, whereas boys tend to want to look taller and stronger.
Adolescence: Eating Disorders

Body image issues can put adolescents at risk for eating disorders. Eating disorders, while rare in childhood, increase dramatically at puberty. They are more common among females, but occur with males as well. They can take a variety of forms, such as eating erratically, ingesting diet pills, taking steroids to increase muscle mass, or over-exercising. Two eating disorders that are common in adolescence are Anorexia Nervosa and Bulimia Nervosa.
Anorexia Nervosa is a disorder characterized by voluntary starvation – that is, a disorder where someone essentially starves himself or herself.

The 4 symptoms of anorexia are:
1. Refusal to maintain a weight that is at least 85 percent of normal Body Mass Index (BMI).
2. Intense fear of weight gain.
3. Disturbed body perception and denial of the problem; and,
Eating Disorders: Bulimia

The second common eating disorder in adolescence is Bulimia. The 3 symptoms of bulimia include:

1. Bingeing (or overeating) and purging at least once a week for 3 months.
2. Uncontrollable urges to overeat.
3. A distorted perception of body size.

Bulimia is three times as common as anorexia.
Eating Disorders Video Examples

Click on the links to see some videos about the devastation of eating disorders.

The Worst Case of Anorexia and Bulimia You’ll Ever See:  
http://www.youtube.com/watch?v=iY_RPP2elfk

Anorexia:  http://vimeo.com/22689975

Extreme Anorexic Speaks Out About the Eating Disorder:  
http://www.youtube.com/watch?v=sz-nPMTXduo
Adolescence: Sexual Development (12-18 years)

During puberty, sex hormones are responsible for the physical development of males and females, and for other changes as well. In particular, sex hormones trigger thoughts and emotions so that adolescents become more interested in sexual activity.

Romances often begin in adolescence, and about half of all U.S. teens become sexually active.
Typically, children and then adolescents progress through relationships in the following way:
1. First, adolescents have groups of friends that are typically of their own gender.
2. Eventually, there is a loose association of girls and boys, mainly interacting within a crowd.
3. Next, small mixed-sex groups of the advanced members of the crowd begin to form.
4. Finally, adolescents begin to form couples, with relationships becoming more private and less group-focused.
First romances typically begin in high school and rarely last more than a year. Females are more likely than males to have a steady partner. Breakups are common, as are unrequited crushes, and are typically on display to the high school peer group. Adolescents tend to react strongly to rejection, in severe cases even contemplating revenge or suicide. Peer group support is helpful for such romantic ups and downs.
Adolescence: Cognitive Development (12-18 years)

In terms of cognitive development, it is typical for young adolescents to think intensely about themselves and about what others think of them. This is termed “egocentrism.” Egocentrism is common in early adolescence among both males and females and every ethnic group. This leads adolescents to think of themselves as unique, special, and much more socially significant (that is, noticed by everyone) than they actually are. That means that they believe what they observe in others must be directly related to them. For example, a teacher’s frown must surely be about the adolescent doing or looking a certain way rather than about something entirely unrelated to them. This belief that others are always watching and evaluating them can lead to feelings of self-consciousness.

Additionally, they believe that their thoughts, feelings, and experiences are more unique and more wonderful or awful than everyone else’s. Their egocentrism also lends itself to feelings of invincibility – they cannot be harmed by the things that would defeat a normal mortal. For example, “Texting and driving may kill people, but it won’t kill me.”
Adolescence: Moral Development (12-18 years)

By adolescence most youth have moved into stage 3 of Kohlberg’s moral development, which centers on social conformity and good interpersonal relationships. In this stage kids have a sense of what “good boys” and “good girls” do and that they should live up to social expectations of the family and community. There is also a certain need for approval by others at this stage.

With regard to the Heinz dilemma, adolescents may suggest that Heinz should steal the medicine because his wife expects it, or he wants to be a good husband. Or, adolescents might suggest that Heinz should not steal the drug because stealing is bad and he is not a criminal, and that he has tried all that he can do without breaking the law so he should not be blamed.
Eventually, as adolescents near adulthood, they will shift into stage 4 of moral development with a focus on law and order for maintaining the social order. In this stage, there is a focus on respecting authority. In response to the Heinz dilemma, older adolescents might respond that Heinz should not steal the medicine because the law prohibits stealing; it is illegal, and all actions have consequences.
Adolescence is a period marked by a search for identity and a time for self-discovery. Self-expression and self-concept become increasingly important. Adolescents try to answer the question “who am I?” especially with regard to religion, politics, vocation, and sexuality. In their search for identity, adolescents will evaluate the goals and values of their parents and culture, keeping pieces that make sense to them and discarding others.
Relationships with families are important during this stage. Families continue to be influential, although not surprisingly, there is an increase in rebellion and bickering. Adolescents seek independence and freedom, but also rely on parental support. The most successful families have good communication and warmth, while allowing adolescents to develop independence. Too much control can interfere with the developing adolescent, while too much freedom can be problematic as well.
Other relationships are important during this stage as well. Adults who are not parents (for example, grandparents or coaches) can be positive role models and offer support. Friends and peers of both sexes are increasingly important during this stage.
Depression and Suicide

As we talked about, nearly all adolescents become self-conscious and self-critical. A few become chronically sad and depressed. Some adolescents have suicide thoughts; some attempt it. Few adolescents actually kill themselves.
The general emotional trend from late childhood through adolescence is toward less confidence. There is a dip in self-esteem at puberty for children of every ethnicity and gender. Both parents and peers have an effect on an adolescent’s self-esteem. Often, young adolescents with very low self-esteem turn to drug use, early sex, and disordered eating which further reduces self-esteem. Some adolescents sink into clinical depression.
Clinical Depression

What do we mean by clinical depression? Clinical depression refers to feelings of hopelessness, exhaustion, and worthlessness that last two weeks or more.
Depression and Suicide

Depression puts adolescents at risk for suicidal ideation. Suicidal ideation is serious and distressing thoughts about killing oneself. Suicidal ideation is most common at about age 15 and can lead to attempted suicide (a potentially lethal action against the self that does not result in death), or a completed suicide (a lethal action against the self that does result in death).
Depression and attempted suicide are more common among females than males, but completed suicide is higher for males. Males tend to use more lethal methods of suicide than females do.
Depression and Suicide Signs and Symptoms

Many of the signs and symptoms of suicidal feelings are similar to those of depression. Let’s look at them now:
- Change in eating and sleeping habits.
- Withdrawal from friends, family, and regular activities.
- Violent actions, rebellious behavior, or running away.
- Drug and alcohol use.
- Unusual neglect of personal appearance.
- Marked personality change.
- Persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork.
- Frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches, fatigue, etc.
• Loss of interest in pleasurable activities
• Not tolerating praise or rewards
• Complaints of being a bad person or feeling rotten inside
• Giving verbal hints with statements such as: I won’t be a problem for you much longer, nothing matters, It’s no use, and I won’t see you again.
• Putting his or her affairs in order, for example, giving away favorite possessions, cleaning his or her room, throwing away important belongings etc.
• Becoming suddenly cheerful after a period of depression
• Having signs of psychosis (hallucinations or bizarre thoughts)
Depression and suicidal feelings are treatable mental disorders. With the help of mental health professionals who can diagnose and establish treatment plans, young people can be helped. Caregivers who have concerns about the emotional state of a child or adolescent should seek professional help from a physician or a qualified mental health professional. You, as an RCYCP, should share any concerns you might have about a youth with your supervisor.

Let’s discuss now some other mental illnesses that can affect youth.
Bipolar Disorder

Bipolar disorder can begin in childhood and during the teenage years, although it is usually diagnosed in adult life. The cause of bipolar disorder is unknown although there is a genetic link. It occurs more often in relatives of people with bipolar disorder. If one or both parents have bipolar disorder the chances are greater that their children will develop the disorder. Family history of drug or alcohol abuse also may be associated with greater risk for bipolar disorder.
There are 3 different types of bipolar disorder:
1. The first is Bipolar Disorder Type I: people with this type have had at least one manic episode and periods of major depression.
2. The second type is Bipolar Disorder Type II: people with this type have never had full mania. Instead they experience periods of high energy levels and impulsiveness that are not as extreme as mania as described earlier. This form of mania is referred to as hypomania. These periods of hypomania alternate with episodes of depression.
3. The third type is a mild form of bipolar disorder called cyclothymia. Cyclothymia involves less severe mood swings. People with this form of bipolar disorder alternate between hypomania and mild depression. Occasionally people with bipolar disorder type II and Cyclothymia are misdiagnosed with depression.
In the majority of people with bipolar disorder, there is no clear cause for the manic or depressive episodes. The following, however, may trigger a manic episode in people with bipolar disorder:

- Life changes such as childbirth.
- Medications such as antidepressants or steroids.
- Periods of sleeplessness.
- Recreational drug use.
There is a high risk of suicide with bipolar disorder, and behavior that may accompany the disorder, such as alcohol abuse or drug use, can make symptoms worse and increase the suicide risk.
Bipolar disorder is extremely difficult to treat. Treatment includes mood stabilizing medication, and other forms of therapy. Because periods of depression or mania return in most patients, even with treatment, the main goals of treatment are to:

- Avoid moving from one phase to another.
- Avoid the need for a hospital stay.
- Help the patient function as well as possible between episodes.
- Prevent self-injury and suicide.
- Make the episodes less frequent and severe.
Let’s look at some videos on childhood bipolar disorder. Click on the links to watch. (Ellen Leibenluft)

Mania and Depression in Bipolar Disorder:
http://www.youtube.com/watch?v=1U9tD2dquOA&list=PL6DC4C789ACF50063

Childhood Bipolar Disorder:
http://www.youtube.com/watch?v=ri0LTG7gL1k&list=PL6DC4C789ACF50063

Childhood Bipolar Disorder - Tantrums or Mania?:
http://www.youtube.com/watch?v=04FgLeODwbl&list=PL6DC4C789ACF50063

Anxiety Disorders

Let’s now turn to a discussion of anxiety disorders.

Anxiety in children is both expected and normal at specific times in development. For example, young children experience distress and anxiety in response to separation from a parent or caregiver. Some children’s distress may be intense. As mentioned earlier in this module, this is referred to as “separation anxiety”.

Young children also experience developmentally typical (that is to say, normal) fears, for example, fear of the dark, storms, animals, or strangers. At some point, however, anxiety is developmentally atypical (that is to say, not normal), and begins to get in the way of daily life. When this happens, there is a need for some type of therapeutic intervention.

There are different types of anxiety. Let’s talk about these.
Anxiety Disorders: Separation Anxiety

Separation anxiety: is intense distress and anxiety at times of separation from parents or other persons with whom they are close. Symptoms of separation anxiety include the following:

- Constant thoughts and intense fears about the safety of parents and caretakers.
- Refusing to go to school.
- Frequent stomachaches and other physical complaints.
- Extreme worries about sleeping away from home.
- Being overly clingy.
- Panic or tantrums at times of separation from parents.
- Trouble sleeping or nightmares.
Anxiety Disorders: Phobia

Another type of anxiety is Phobia. Phobia is excessive anxiety evoked by specific objects or situations. Symptoms of phobia include the following:

- Extreme fear about a specific thing or situation (e.g., spiders, dogs, needles).
- The fears cause significant distress and interfere with usual activities.

So for example, you have probably heard of “arachnophobia”, which is the fear of spiders.
Anxiety Disorders: Social Anxiety

A third type of anxiety is Social anxiety which is fear of social situations and interaction with other people. People who have social anxiety worry, in part, that others are scrutinizing or judging them. Symptoms of social anxiety include the following:

- Fears of meeting or talking to people.
- Avoidance of social situations.
- Few friends outside the family.
Anxiety Disorders

Other symptoms of anxiety include:

- Many worries about things before they happen.
- Constant worries or concerns about family, school, friends, or activities.
- Repetitive, unwanted thoughts or behaviors and,
- Fears of embarrassment or making mistakes.
Anxiety Disorders: OCD

One of the most recognized anxiety-based disorders is Obsessive Compulsive Disorder (known as OCD).

OCD typically begins in young adolescence or early adulthood and is seen in as many as 1 in 200 children and adolescents. OCD is an anxiety-based disorder that is characterized by recurrent intense obsessions and/or compulsions that cause severe discomfort and interfere with daily functioning.
So what are obsessions? Obsessions are: recurrent and persistent thoughts, impulses, or images that are unwanted and cause marked anxiety or distress. Oftentimes, these obsessions are unrealistic or irrational rather than simply excessive worries about real-life problems or preoccupations. So for example, adolescents might worry about being gay, even when they are sure they are not. Such obsessions consume these persons’ thoughts (they can’t stop thinking about it or get it out of their heads). Obsessions are NOT occasional thoughts about getting sick or about the safety of loved ones. Obsessions may then lead to compulsive behavior.
So what are compulsions? Compulsions are repetitive behaviors, rituals, or mental acts that a person engages in to neutralize, counteract, or make their obsessions go away. So for example, a youth might have an obsessive thought that harm will come to a loved one if they don’t go up the stairs correctly (remember, the obsession is not rational); so to protect their loved ones they may go up the stairs several times to make sure they have done it right, and may even walk down the stairs backwards in an effort to “undo” any “damage” they believe they have done by not going up the stairs correctly. Sometimes the compulsions are linked to the obsessions. For example, a person might have a strong fear of germs and contamination that will cause harm (an obsession) and the response might be a compulsion to wash their hands such that they are constantly washing their hands. Sometimes, however, the obsession and compulsion are unrelated. For example, a youth might worry that they will lose control of themselves and hurt others and deals with that obsession compulsively by repeating activities in multiples, for example, in 3’s because 3 is a “good” or “safe” number.
Anxiety Videos

Click on the links to view some videos about anxiety disorders.

Separation Anxiety - Boys Town Center for Behavioral Health:
https://www.youtube.com/watch?v=7CflE0vZeDo

Child Specific Phobia Disorder:
http://www.youtube.com/watch?v=ht3Hy4RZzLs&list=PLehGvMkd5jMakBQcMMrA2l2z02xeThVv1

Social Anxiety: Max - Part 1:
http://www.youtube.com/watch?v=HKORi449_4E

A personal story of OCD:
http://www.youtube.com/watch?v=x4sadYeLHKU

Howie Mandel Talks About Living With OCD:
http://www.youtube.com/watch?v=dSZNnz9SM4g
Anxiety Disorders

Anxiety disorders such as those just described are thought to involve atypical activity in the brain. There is also a genetic component to anxiety disorders such that parents with anxiety disorders are more likely to have children with anxiety disorders as well, although children may also develop anxiety with no previous family history. OCD in particular, may also develop or worsen after a streptococcal bacterial infection.
Anxiety Disorders: Treatment

Anxiety disorders in children and adolescents are highly treatable. That is to say, with treatment many children and adolescents can improve significantly. Treatment typically involves therapy, medication, behavioral treatments, and consultation with the school.
Congratulations!
You have completed Part 7 of the RCYCP Module 2 Training. Please use the navigation below to open the next section of the training.
Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 2, Part 8 of the Residential Child and Youth Care Practitioner Training.
Sexually Acting Out

In addition to being able to identify and understand some of the mental health challenges faced by children and adolescents it is important to also look at some behaviors that could indicate non-normative (that is to say not normal) developmental issues. In particular, let us talk about sexual acting out.

It is important to know that some sexual behavior or exploration is normal for children. Children who show normal sexual behavior or exploration associated with expected development are not considered to be acting out. Rather, sexually acting out refers to children who engage in sexual behaviors that are not ordinary for their age, or that are hurtful to others, or that concern adults. Sexually acting out also refers to sexual behaviors that result from trauma, anxiety, or abuse of the child. So what do we mean by sexually acting out?
Sexually acting out may include:

- Sexual language (e.g., direct and inadvertent statements).
- Increased sexual exploration.
- Exhibitionism.
- Excessive masturbation, and often in public.
- Inappropriate physical boundaries.
- Intense preoccupation with sexual matters.
- Sexual aggression toward other children, adults, or animals.
Why does sexually acting out happen?

Children sexually act out for many different reasons. It can be:
1. As an attempt to deal with difficult emotions (sadness, anxiety, fear, abandonment)
2. Or to decrease tension
3. Or to satisfy impulsive sexual needs,
4. Or to cope with intrusive, trauma-related memories
5. Or as a result of sexual abuse

A majority of kids (though not all) who act out sexually have been sexually abused. Also, not all children who have been sexually abused show sexual behaviors, but many do. Some children do not engage in sexually acting out behaviors until years after their initial abuse.
Sexual aggressiveness is a form of sexually acting out that includes coercive, forceful, and/or manipulative sexual behavior towards others. Every act of sexualized behavior has the potential for increasing the probability of future acts.
Group I: Normal Sexual Exploration

To help you get a better understanding of sexually acting out, let’s first look at normal sexual exploration. Then we will look at some other categories on the continuum of sexual behavior. As we progress through each category you will see that the behaviors are considered out of the range of normal and become more disturbed.

So let’s start begin now with Group 1: Normal Sexual Exploration.
Normal Sexual Exploration

- Is voluntarily and exploratory in nature.
- Is sexual behavior based on the discovery and development of their physical and sexual selves.
- Is characterized by spontaneity and lightheartedness (fun and silly).
- It includes an interest in sex that is intermittent and balanced with curiosity about all things.
- In normal sexual exploration, sexual behavior may leave the child feeling embarrassed but not fearful or anxious.
- It is done solitarily or with friends of similar age and size; less often with siblings.
- It usually does not include feelings of deep shame, fear or anxiety.
- For teens this often involves intense feelings for someone they are attracted to and involves sexual exploration in relationships.
- These behaviors may need limits, guidance or education, but are not considered abnormal or pathological.
Let’s look at what is normal sexual exploration by age. Click on each developmental level to hear what is considered normal.

Infancy:
- Children begin to explore their bodies, including their genitals.
- Skin touch is the primary method infants have available for learning about their bodies, other's bodies, and their sexuality.
- Other people's response to that body exploration is one of the earliest forms of social learning.

Childhood:
- Half of all adults report having participated in sex play as children.
- Children express interest in feelings aroused by touching their genitalia in the same way they express interest in the light of the moon, or a flower blooming. Children express general interest in others' bodies and may touch. Adult reactions teach shame or that privacy is important for certain behaviors.
- Masturbation occurs naturally in boys and girls, and begins in infancy. By the age of two or three years, most children have learned that masturbation in front of others is likely to get them in trouble.

Pre-Adolescence:
- A strong interest in viewing other people's bodies via photographs, films, videos, etc.
• Very few children become sexually active in pre-adolescence. When they do, adults usually initiate it.
• Sexual activity or play during this age usually represents the use of sex for non-sexual goals and purposes.

Adolescence:
• Adolescence itself is generally marked by the societal acknowledgment of sexual capacity. The way other people react to a teen's physical sexual characteristics (body hair, formation of breasts, deepening of the voice, beginning of menses) have a profound effect on both the young person's sense of self-esteem and the development of his/her social skills.
• The adolescent develops a growing awareness of being a sexual person, and of the place and value of sex in one's life, including such options as celibacy.
• The adolescent may work toward significant resolution of confusion and conflict about sexual orientation.
It is during this time that individuals are able to join together the physical and social aspects of sex and sexuality.
• Most adolescents practice some types of interactive sexual behaviors with others, such as fondling, open-mouth kissing, and simulated intercourse.
Now that you know about normal sexual exploration, let’s look at some other categories on the continuum of sexual behavior. We will begin a discussion of the non-normative behaviors with Group II: Sexually Reactive.
Group II: Sexually Reactive

**Preoccupation with sexuality**

- Self-stimulating behaviors toward or in view of adults
- May coerce other children, but no threats or attempt to hurt
- Partial form of reenactment of sexual abuse as a way to understand
- Confusion ends up increasing their sexual behavior
- Shame, guilt, anxiety, and fear
- Many have been abused or exposed to pornography and sexual stimulation
- Respond well to therapy and education
- When anxiety is reduced, sexual behavior tends to decrease

For children and adolescents who fall into the sexually reactive category:

- **Sexual behaviors may be frequent, with their sexuality being out of balance compared to their peer group.** These youth exhibit more sexual behaviors than Group I and have a preoccupation with sexuality.
- **Many of the behaviors for youth in this group are self-stimulating (done to physically stimulate themselves) but may be directed toward and/or done in view of adults.**
- **Youth in this group may coerce other children, though the other children may dislike or be bothered by the behavior; there are no threats and no attempt to hurt.** The difference in age is usually not great and force is not usually involved.
- **Sexual behavior in this group often represents a partial form of reenactment of sexual abuse the child has experienced and may be the child's way of trying to understand.**
- **Youth in this group have trouble making sense of such stimulation and so their confusion ends up increasing their sexual behavior.**
- **Sexually reactive youth often feel shame, guilt, anxiety, and fear related to the having or doing the sexual behaviors.**
- **Many of these youth have been abused or exposed to pornography and sexual stimulation.**
- **Youth in this group respond well to therapy and education.**
- **For these youth, when the anxiety is reduced or more age appropriate and less sexually stimulating environments are encouraged, the level of sexual behavior tends to decrease.**
Group III: Extensive Mutual Sexual Behaviors

So as we move along the continuum we get to Group III – the Extensive Mutual Sexual Behaviors group.
• For youth in this group, sexual behaviors are often habitual and extensive, with the child participating in the full spectrum of adult sexual behaviors.
• Generally this happens with other children in the same age range, and the youth conspire to keep the behaviors secret.
• These youth are often distrustful; they are chronically hurt and abandoned by adults; and they relate best to other children. Sexual behaviors are a way of coping with their feelings of abandonment, loss, and fear.
• Youth in this category may or may not experience sexual pleasure.
• They often approach sexuality as just the way they “play”.
• These youth are usually more resistant to treatment than Group Two.
• They use persuasion, but don’t usually force or coerce other children into participating in sexual acts.
• Characteristically they are without emotional feelings around sexuality – they don’t have the lighthearted spontaneity of normal children, nor the shame and guilt of the sexually reactive children.
• Often they have a history of severe physical and emotional abuse and abandonment.
• Some are siblings who mutually engage in extensive sexual behaviors as a way of coping in a highly dysfunctional family life.
• Sex is a way for them to relate to their peers and a way to make a “friend”.
• These children need an intensive and rigorous relearning of social skills and peer relationships.
• They need intensive supervision in the home setting and around other children.
• Some kids move between groups III and IV, forcing or coercing another child into sexual behaviors of their choices.
Group IV: Children Who Molest

Now we are on the end of the continuum of sexual behavior with the fourth group: Children who molest.

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Group IV: Children Who Molest

Now we are on the end of the continuum of sexual behavior with the fourth group: Children who molest.
Group IV: Children Who Molest

Behaviors are frequent and persistent with intense sexual confusion
Sexual behaviors are frequent and persistent with intense sexual confusion.

Sexuality and aggression are closely linked
Sexuality and aggression are closely linked so that when they act out sexually it often is with feelings of anger, rage, loneliness, or fear.

Use of coercion such as bribery or trickery
Use of coercion such as bribery or trickery.

Impulsive, compulsive, and aggressive quality
Impulsive, compulsive, and aggressive quality in many behaviors - not just sexual behaviors.

Obsession over sexual thoughts
They obsess over sexual thoughts and participate in a full range of sexual behavior which becomes a pattern, rather than isolated incidents.

Participation in a full range of sexual behavior as a pattern
They lose control over their sexual behavior and have a very difficult time not repeating actions, even when punished or when trying to stop.

Lack of compassion and empathy
These youth seek out children who are easy to fool and bribe, or force them into sexual activity.

Boys who molest a sibling pick the “favorite child”
They frequently use social and emotional threats to keep their victims quiet.

Loss of control over their sexual behavior and have a difficult time stopping
They lack compassion and empathy with their victims and feel regret in getting caught, their regret is not with hurting another child.

Seeking out of children who are easy to fool and bribe, or force
When boys in this group molest a sibling, the victim is typically the favorite child of the parents.

Parents typically have history of sexual, physical, and substance abuse in their family
Most parents also have sexual, physical and substance abuse in their family history.

Homes environments are marked by sexual stimulation and lack of boundaries
The home environments of these children are marked by sexual stimulation and lack of boundaries. For example, parents might watch pornography at home in front of their children.

Children in this group have the most severe problems with sexually acting out. They are children who become offenders themselves. For these youth:

• Sexual behaviors are frequent and persistent with intense sexual confusion.
• Sexuality and aggression are closely linked so that when they act out sexually it often is with feelings of anger, rage, loneliness, or fear.
• They use some kind of coercion to gain participation such as bribery or trickery.
• There is an impulsive, compulsive, and aggressive quality in many of their behaviors - not just sexual behaviors.
• They obsess over sexual thoughts and participate in a full range of sexual behavior which becomes a pattern, rather than isolated incidents.
• They lose control over their sexual behavior and have a very difficult time not repeating actions, even when punished or when trying to stop.
• These youth seek out children who are easy to fool and bribe, or force them into sexual activity.
• They frequently use social and emotional threats to keep their victims quiet.
• They lack compassion and empathy with their victims and feel regret in getting caught, their regret is not with hurting another child.
• When boys in this group molest a sibling, the victim is typically the favorite child of the parents.
• Most parents also have sexual, physical and substance abuse in their family history.
• The home environments of these children are marked by sexual stimulation and lack of boundaries. For example, parents might watch pornography at home in front of their children.
• These youth have severe behavior problems at home and school and typically have few friends.
• They do not, and cannot stop without intensive and specialized treatment.
• Often this includes therapy, strong intervention, and medication to control their impulses.
Treatment for Sexually Abusive Youth

The majority of sexually abusive youth are responsive to, and can benefit from, treatment. Sexually acting out children, despite their acts, need to be viewed compassionately and with a hopeful attitude toward recovery. These children are often victims of maltreatment themselves and deserve a chance to heal and live a healthy life.
Sexually Acting Out

While you as an RCYCP will follow the guidelines set up at your work site, in general, the immediate goals for working with sexually acting out children include the following:

1. Be sure the child is not being sexually abused or abusing others.
2. Report any/all incidents of sexual abuse to all parties involved.
3. Provide “sight and sound supervision” at all times (that means being able to both see and hear what is going on).
4. Follow a written safety plan at all times.
5. Refer children for psychiatric and/or medical evaluations when needed.
6. Collaborate with school, daycare, or after school personnel.
Congratulations! You have completed Part 8 of the RCYCP Module 2 Training. Please use the navigation below to open the next section of the training.
Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 2, Part 9 of the Residential Child and Youth Care Practitioner Training.
LGBTQ Youth

During the past decade, lesbian, gay, bisexual, and transgender adolescents have become increasingly visible in our families, communities, and systems of care. A significant number of these youth are in residential care and require understanding and care that is specific to their unique needs and development. We are going to discuss those issues now. Let’s start with an overview of terminology.

Sexual orientation: is an enduring emotional, romantic, sexual, and affectional attraction to others that is shaped at an early age. Although there are many theories about the origin of sexual orientation, most scientists agree that it is probably the result of a complex interaction of environmental, cognitive, and biological factors. Sexual orientation exists on a continuum from exclusively homosexual (attraction to same-sex people) to exclusively heterosexual (attraction to opposite-sex people), and includes varied expressions of bisexuality (attraction to same-sex and opposite-sex people).

Many youth realize that they are lesbian, gay, or bisexual long before they become sexually active, some by age 5.
Gender Identity

As mentioned previously in this module, gender identity is distinct from sexual orientation and refers to a person's internal identification or self-image as male or female. Every person has a gender identity. Most people’s gender identity (their understanding of themselves as male or female) is consistent with their anatomical sex. For a transgender person, however, there is a conflict between the two; the individual’s internal identification as male or female differs from his or her anatomical sex.

Gender identity is also established at an early age, generally by age 3. Increasingly, young people who identify as transgender do so during adolescence. Many youth who later identify as transgender report feeling that they were in the wrong body as a young child.
LGBTQ Terminology

Click on the links to hear the different definitions of other terms you need to know.

Gay: Which refers to homosexual men who partner with men (although it is also used as an overarching term).
Lesbian: Refers to homosexual women who partner with women.
Bisexual: Refers to individuals who partner with both genders.
Transgender: Refers to gender identity that is different than birth assigned gender.
Questioning: You might also hear the term “Questioning” which refers to not yet being certain of one’s sexual orientation.
“Coming Out” as LGBTQ

Finally, you will hear the phrase “coming out.” So what does that mean?

- Coming out means revealing that a person is LGBTQ to others. The average age that youth come out is now 16. It is incredibly difficult and a huge personal risk. Many youth are rejected by loved ones for coming out. There is also a danger in “ outing.”
  - Over 30% of LGBTQ youth reported suffering physical violence at the hands of a family member after coming out
  - Creating a support system of people can help many to feel a sense of pride and understanding of who they are.
LGBTQ Youth

So what do we know about LGBTQ youth?

- There are an estimated 2.7 million school age LGBTQ youth in the United States, and they are a vulnerable population.
- LGBTQ youth are more likely than their heterosexual peers to:
  - Experience depression.
  - Attempt suicide.
  - Be harassed at school and in the community.
  - Experience verbal and physical violence.
  - Abuse substances.
  - Drop out of school.
  - Become homeless.
Click on the links to hear some startling statistics about LGBTQ youth.

With regard to education:
- 31% of LGBTQ youth reported skipping school each month because of fear for their own safety (4.5 times more than heterosexual peers).
- 28% of LGBTQ youth dropped out of school due to peer harassment (3 times the national average).
- 97% of all students report hearing anti-gay remarks in school.
- 18.8% have heard anti-gay remarks from faculty.
- 82.9% reported that staff never or only sometimes intervened.
- In one study of LGBTQ adolescents, half said homosexuality was discussed in their classes. 50% of the females and 37% of the males said it was handled negatively.

With regard to Violence/Bullying:
- 84% had been verbally harassed at school.
- 65.3% had been sexually harassed.
- 55% of transgender youth reported physical attacks.
- 100% of LGBTQ youth in New York City group homes reported verbal harassment while at their group home and 70% reported physical violence due to their sexual orientation or gender identity.
- Over 39% of all gay, lesbian, and bisexual youth reported being punched, kicked, or injured with a weapon at school because of their sexual orientation.
• 77.9% of LGBTQ youth reported sometimes or frequently hearing anti-gay remarks. They reported hearing slurs such as “homo,” “faggot,” and “sissy” about 26 times a day or once every 14 minutes.

With regard to Substance Abuse:
• Youth who are harassed because of their real or perceived sexual orientation are more likely than non-harassed youth to use crack cocaine, cocaine, anabolic steroids, and inhalants.
• 68% of teen gay males and 83% of teen lesbians use alcohol.
• 46% of teen gay males and 56% of teen lesbians use other drugs.

With regard to Homelessness:
• Between 20-40% of homeless youth are LGBTQ.
• Homelessness increases the likelihood of engaging in prostitution and alcohol and drug abuse, violence, suicide, and HIV and other STDs.
• 26% of LGBTQ youth who “come out” to their families are thrown out of their homes because of conflicts with moral and religious values.
• 78% of the LGBTQ youth were removed or ran away from their foster placements as a result of hostility toward their sexual orientation or gender identity.

With regard to Suicide:
• 33% of LGBTQ high school students reported attempting suicide in the previous year, compared to 8% of their heterosexual peers.
• LGBTQ youth are 4 times more likely to attempt suicide.
• 16% required medical attention as a result of an attempt compared to 3% of heterosexual peers.

With regard to LGBTQ Youth of Color:
• Stigma creates even greater risk for substance use, violence, and risky sexual behaviors.
• Youth of color often don’t identify as “gay” which may mean they will not seek services or hear messages designed for the White LGBTQ community.
• LGBTQ youth of color may not receive their community’s support regarding sexual orientation or transgender identity
• LGBTQ Native American youth have increased risk for substance abuse, mental illness, and HIV infection due to racial/ethnic discrimination and to homophobia within native cultures.
Myths and Misconceptions about LGBTQ Youth

Do you know what are myths and facts about LGBTQ youth? Let’s look at some.

Answer the question by clicking on the True or False

Myth: You can tell which people are gay just by looking at them.
Fact: Society and the media have perpetuated stereotypes of gay and lesbians for so long that people believe that the only way to identify a gay or lesbian is to look for the stereotype. There is a great deal of diversity in the gay and lesbian community.

Myth: I don’t know any gay, lesbian, or bisexual people.
Fact: Statistics show that one in ten people are gay or lesbian. Given this figure, you probably do know someone who is gay, lesbian or bisexual; they probably are just not “out” to you.

Myth: Gay men really want to be women or just haven’t found the “right woman.”
Fact: Most gay men do not want to be women. Their sexual, affectional, and emotional orientation is towards men. A significant number of gay men have been married.

Myth: Gay women really want to be men or just haven’t found the “right man.”
Fact: Most gay women have no desire to be men. Their sexual, affectional, and emotional orientation is towards women. A significant number of lesbians have been married.
Myth: Lesbians and gay men could change if they really wanted to.
Fact: Most studies indicate that those who are highly motivated to change their sexual orientation may change their behavior, but not their underlying desires. In fact, it is often societal homophobia that forces people to attempt to change. Therefore, energy should be focused on dismantling homophobia so that people will feel comfortable with their orientation, whatever that may be. Another fact is that most gay or lesbian people would not want to change, even if there was a way.

Myth: Loving people of the same sex is abnormal and sick.
Fact: According to the American Psychological Association as of 1972, “It is no more abnormal or sick to be homosexual than to be left-handed.” Isolation, fear from hiding, and alienation as a result of homophobia is what causes mental illness, not the orientation itself. Therefore, homophobia is what should be cured.
Myths and Misconceptions about LGBTQ Youth

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<td>Gay men and women usually make poor parents</td>
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Myth: Loving people of the same sex is sinful and immoral.
Fact: While some religious denominations believe this, many do not. What is universally preached is that intolerance and hatred is wrong.

Myth: Gay men and women are more creative than other people.
Fact: While many gay men and lesbians are creative people who have challenged the roles which society has tried to pigeon-hole them into, they are no more creative than their heterosexual counterparts.

Myth: Gay school teachers can persuade young people to be gay.
Fact: Gay and lesbian people do not have a desire or a need to recruit. No one can be persuaded to be gay or lesbian. Gay and lesbians may encourage those in the closet to “Come Out,” but there is no desire to change heterosexuals into homosexuals.

Myth: Gay men are usually hairdressers, interior decorators, or artists.
Fact: Some gay men are hairdressers, interior decorators, and artists, but so are some straight men. This is a stereotype perpetuated by the media.

Myth: Gay men and women usually make poor parents.
Fact: One out of four families has a lesbian or gay man in its immediate family; heterosexual parents are not found to be consistently more loving or caring than their lesbian, gay or bisexual counterparts.
Myths and Misconceptions about LGBTQ Youth

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<tr>
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Myth: A person can become gay by associating with gay people.
Fact: A person cannot be made to be gay by association any more than a Caucasian could be made African-American by association.

Myth: Homosexuality is caused by weak parents.
Fact: There is no evidence that homosexuality is caused by weak or strong parents. There is no real consensus on what causes homosexuality. Most gay or lesbian teenagers sense that they are “different” during their early adolescent years.

Myth: Homosexuality can be cured.
Fact: Homosexuality is not a disease or an illness or an affliction and therefore, there is no need to cure.
So how many youth in residential care are LGBTQ? That is difficult to answer because many of these youth hide their sexual orientation and gender identity from anyone whom they perceive as rejecting or unsupportive. Also, LGBTQ youth who come into care are often in various stages of awareness and comfort with their sexual orientation and gender identity, and they may not have resolved these issues for themselves. Even if the youth internally identifies as lesbian, gay, bisexual, or transgender, he or she may still choose not to reveal this information to agency personnel. Although there are no reliable statistics, providers and other individuals who work in child welfare and juvenile justice systems consistently report that LGBTQ youth are disproportionately represented among youth in out-of-home care. That is to say that there is a higher percentage of LGBTQ people in out-of-home care than one would expect based on the percentage of LGBTQ in the entire population.
How LGBTQ Youth Enter the System

So how do LGBTQ youth typically enter the system? For some, they enter the same way that other non-LGBTQ youth enter the system, for example, from families with abuse or neglect, or because they have been charged with illegal conduct.

A large proportion of LGBTQ youth enter these systems, however, for reasons either directly or indirectly related to their sexual orientation or gender identity. This includes youth who, because of their sexual orientation or gender identity, have been rejected, neglected, or abused by their birth families; youth who have stopped attending school because of anti-LGBTQ abuse or harassment, runaway, “throwaway,” and homeless youth, some of whom engage in survival crimes, and youth who have been mislabeled as sex offenders simply because of their sexual orientation or gender identity.
Click on the boxes to hear more statistics related to LGBTQ youth.

Family Acceptance and Rejection: Nearly half (42%) of LGBTQ youth in out-of-home settings who participated in a study on family acceptance and rejection of LGBTQ adolescents were either removed or ejected from their homes because of conflict related to their LGBTQ identity.

School Harassment: A national survey of LGBTQ youth in high schools and middle schools in 48 states found that one in three reported being harassed as a result of his or her sexual orientation, and an equal proportion said they had been harassed because of their gender expression. Most youth (85%) reported hearing homophobic remarks from other students, whereas nearly one-fourth (24%) heard such remarks from faculty or school staff, and few faculty intervened to help.

School Violence: Lesbian, gay, and bisexual students are more likely to be in a physical fight, to be threatened or injured with a weapon at school, and to skip school because they felt unsafe, compared with their heterosexual peers.

Suicide Attempts: Compared with their heterosexual peers, lesbian, gay, and bisexual youth were more than three times as likely to have attempted suicide during the past twelve months.

Anti-gay Victimization: LGBTQ young adults who had experienced high levels of anti-gay victimization in middle or high school were more than twice as likely to report symptoms of
depression and substance abuse problems, three times as likely to report suicide attempts, and more than twice as likely to have put themselves at risk for HIV infection during the past six months, compared with their LGBTQ peers who reported low levels of anti-gay victimization during adolescence.

Self-Esteem: Young adults who reported high levels of anti-gay victimization in school had significantly lower levels of self-esteem, social support, and life satisfaction than their LGBTQ peers who reported low levels of victimization.

Homeless: A study of lesbian and gay youth in New York city’s child welfare system found that more than half (56%) of the youth interviewed said they stayed on the streets at times because they felt safer there than living in group or foster homes (Mallon, 1998 as cited in CWLA, 2006).

Throwaway: Among LGBTQ homeless youth in San Diego, 39% said they were ejected from their home or placements because of their sexual orientation.
Click on the link to see a short video about homeless LGBT youth.

A Day in Our Shoes – Homeless Youth: Video:
http://www.youtube.com/watch?v=PRGXERBKVt8
As you can see, LGBTQ youth face a number of significant challenges. Unfortunately, those challenges do not end when they enter out-of-home care. LGBTQ youth commonly experience rejection, harassment, and discrimination from peers and staff - some of it intentional, and some unintentional. Even when staff members are well-meaning, they often lack the knowledge or training to provide appropriate services to LGBTQ youth. For example, staff members frequently respond to the harassment or assault of an LGBTQ youth by isolating or moving the youth – often to a more restrictive facility - rather than addressing the underlying prejudice. Although this response may make it easier to protect the young person, it punishes the victim and often results in drastically reduced services and psychological distress for LGBT youth.

Click on the link at the bottom of the slide to watch a short video about some of the challenges facing LGBTQ youth in the system.
Video: LGBT youth in foster care http://www.youtube.com/watch?v=nuSikwpqazA
LGBTQ Youth: Developmental Tasks

LGBTQ youth have the same developmental tasks as their heterosexual and non-transgender peers, but they also face additional challenges in learning to manage a stigmatized (that is to say a shamed) identity and to cope with social, educational, and community environments in which victimization and harassment are the norm. Just like their heterosexual peers, they need to be able to explore, express, and develop an identity.
LGBTQ Youth: Needs in Residential Care

So what do they need most in residential care? They need supportive, caring, and respectful relationships. They also need to be in an environment in which every person is respected and every person is treated fairly and equally. This type of environment makes it safe for young people to explore their own emerging identities and to accept and value differences in others.
LGBTQ Youth: What RCYCPs Should Not Do

Once again, you should realize that your job as an RCYCP is critical to the success of the youth with whom you work. Regardless of how a youth self-identifies or how others perceive him or her, RCYCPs should treat all youth equally, respectfully, and with sensitivity to the developmental issues faced by all adolescents. RCYCPs should affirm all young people’s intrinsic worth, regardless of their sexual orientation or gender identity.

- So in the interest of providing a safe and nurturing atmosphere for the youth in care, RCYCPs should not condemn, criticize, or pathologize youth who explore their attractions for same-sex youth in an age-appropriate, consensual manner.
- By pathologize we mean treating someone like they are psychologically abnormal or unhealthy.
- RCYCPs should not subject LGBTQ youth to lectures, sermons, or other materials that condemn or pathologize homosexuality or gender nonconformity. For example, an RCYCP should absolutely not be telling LGBTQ youth that they are “sinful” or “going to hell.”
- Permitting or condoning any of these practices sends a message to LGBTQ youth that they are deviant, immoral, or mentally ill.
LGBTQ Youth: What RCYCPs Can Do

Also, RCYCPs:

• Should avoid making assumptions about a young person based on his or her physical appearance or behavior. Instead professionals working with youth should adopt an approach that helps youth feel safe to disclose information about themselves – at their own pace and on their own terms.

• Should take care to use inclusive language that avoids implicit assumptions about a young person’s sexual orientation (for example, using neutral language such as “do you have a boyfriend or girlfriend?”)

• Should not disclose a youth’s sexual orientation or gender identity without the youth’s permission. It could subject the youth to rejection, ridicule, and even violence. It can also derail an LGBTQ youth’s development and adjustment, resulting in negative health effects and loss of trust. In certain circumstances, limited disclosure may be legally required to protect a young person’s safety (for example, within the context of abuse/neglect). When disclosure is legally required, you should consult with a supervisor for guidance.

• As an RCYCP you should be familiar with your agency’s policies and procedures, as well as the applicable confidentiality laws.

Finally, all RCYCPs should model and communicate the message that every person is entitled to respect and dignity and that disrespect or intolerance of any kind is not permitted. Staff should
promptly intervene whenever a young person uses homophobic or transphobic language or engages in behavior that is discriminatory or demeaning toward LGBTQ individuals or groups. This situation can be an opportunity for staff to discuss the issue of homophobia or transphobia or in general the facility’s policy on treating everyone with respect.
All agencies are different, and have different policies and procedures. While you should be familiar with your agencies policies and procedures, it is good to have general knowledge about some of the ways that organizations can promote positive adolescent development for LGBTQ youth. In particular, agencies benefit from policies and practices that:

1. Prohibit all forms of harassment and discrimination, including jokes, slurs, and name calling.
2. Permit youth to disclose their sexual orientation to other youth, caregivers, and agency personnel.
3. Permit youth to discuss their feelings of attraction to youth of the same sex, consistent with discussion of romantic attachments among heterosexual youth, without being penalized or shamed.
4. Permit youth to participate in social activities that are geared toward or inclusive of lesbian, gay, and bisexual youth.
5. Permit youth to express their sexual orientation through their choice of clothing, jewelry, or hairstyle.
6. Permit youth to have access to LGBTQ-inclusive, supportive books and materials, and . . .
7. Permit youth to post LGBTQ-friendly posters or stickers in their rooms.
8. Do not penalize youth who become romantically involved with a youth of the same sex when the same involvement with a person of a different sex would not result in punishment.
9. Prohibit the use of isolation or segregation as a means to protect LGBTQ youth when others subject them to discrimination, harassment, or violence.
In addition to having policies and procedures in place to protect LGBTQ youth, agencies and RCYCPs can help by ensuring that LGBTQ youth in their care have access to appropriate social, spiritual, and recreational opportunities that encourage and support these youth in developing into self-assured, healthy adults. Some of the ways that this can be accomplished include:

• Introducing youth to others who share their experiences (this can be positive because these settings embrace LGBTQ youth for who they are – these activities and social relationships are also important in fostering the development of necessary life skills, such as forming and maintaining friendships, increasing communication skills, and handling interpersonal relationships and dating).

• Ensuring that LGBTQ youth are aware of, and have access to, social and recreational services and events consistent with their interests and geared toward the community with which they identify.

• Agencies and RCYCPs should not force youth to participate in activities or groups that denigrate or discriminate against LGBTQ youth or that simply decline to acknowledge their existence (e.g., religious services in which a youth is condemned because of his/her sexual orientation).

Agencies should also ensure that their own services and programs are LGBTQ inclusive. For examples, if facilities or programs provide books, magazines, and movies to youth, they should include materials with positive LGBTQ images and role models. When youth are given
information about sexuality and development, this information should be inclusive of LGBTQ individuals and should not present same-sex relationships or behavior, or gender-nonconforming behavior, as inappropriate or immoral. LGBTQ youth should be permitted to receive and possess LGBTQ-supportive books and magazines to the same extent that books and magazines are generally available to youth in the facility.
Transgender Youth

Let’s talk now about transgender youth specifically. Transgender youth may present health concerns distinct from those common to lesbian, gay, or bisexual youth. Transgender youth experience very high levels of stigmatization, which may increase their feelings of depression and hopelessness. They may also experience significant distress because their body does not correspond to their gender identity.

The incongruity between a transgender youth’s gender identity and anatomical sex can cause intense feelings of conflict and emotional pain.
Transgender Youth Videos

Click on the links to watch some videos about transgender youth.

Transgender Tween Enters Dating World, Faces New Host of Problems - Barbara Walters:
http://www.youtube.com/watch?v=QxhyFA8iV9o

Transgender at 11: Listening to Jazz:
http://www.youtube.com/watch?v=bJw3s8EcxM
Transgender Youth

The most appropriate treatment for transgender youth involves providing access to medical and mental health professionals who can help assess whether hormone treatment is appropriate for care for these youth.
As we finish up this module on development, let’s briefly discuss the importance of developmentally appropriate programming for at-risk youth with whom you, as an RCYCP, will be working.

At-risk children and adolescents vary tremendously from one another based on their different family circumstances and histories. They are also different based on their developmental needs and abilities, which change as they age. In order to work effectively with youth in residential care, you will need to understand the individual youth as a whole with all of his/her unique needs, strengths, and challenges, as well as the family, and community in which s/he lives. You will need to bear this in mind in everything that you do as an RCYCP. That means, that whatever programming you do with kids needs to be appropriate to their individual developmental needs. For example, if you are working with a youth with ADHD you might not choose activities that require long periods of sitting quietly. That type of activity is not going to work with someone with ADHD.

Similarly, if you are taking the kids you work with to the movies, and they are 10 and 11 years old, taking them to a PG-13 movie would not be an appropriate choice. In fact, you might work with 16 year olds who are not socially and or emotionally mature enough for a PG-13 movie. Chronological age does not necessarily equate with social and emotional age or developmental level.
The underlying point is that you need to understand the youth with whom you work. Play to their strengths and developmental level and you will be most successful.
References

- American Academy of Child & Adolescent Psychiatry (2011). Obsessive-Compulsive Disorder in Children and Adolescents. No. 60.4
- Attention deficit hyperactivity disorder.


Congratulations!
You have completed Part 9 of the RCYCP Module 2 Training. Please use the navigation below to complete the Post-test.