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Counseling toolkit for Youth Workers

DEIS

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Introduction

This booklet is for the use of those who make the first steps in counseling youth. You will learn about psychological disorders first diagnosed in adolescent period, the youth worker's role in the context of other existing professions like clinical psychology, social work and psychiatry. This material does not represent a manual and will not make you a counselor. Instead, it will be a toolbox for using counseling skills in the frame of youth working.

This booklet is a result of the training course “Counseling and Vocational Guidance in Youth Work”, held in Baia Mare city, Romania, from 24 May to 2 June 2013. The training involved 24 participants from 8 countries: Estonia, France, Hungary, Italy, Latvia, Lithuania, Poland and Romania.

It was organized by Asociatia pentru Dezvoltare prin Educatie, Informare si Sustinere – D.E.I.S., together with the partners KAITSELIIT, KODUTÜTRED JA NOORED KOTKAD, TARTU MALEV, EUROCIRCLE, NGO JAUNATNE PAR IESAISTISANOS, JAUNIMO VERSLO BIURAS, SZTUKATER ASSOCIATION, DEBRECENI IFJÚSÁGI SZOLGÁLTATÓ NONPROFIT KFT and L'ALTRA VIA.

The aim of this training was to increase the quality of counseling and vocational guidance services offered by youth workers.

The main objectives of this training course where:

- To improve the participants' competences in the field of vocational guidance and counseling for youth.
- To make participants aware of opportunities provided by Youth in Action concerning personal and professional development of young people.
- To promote vocational guidance and counseling services offered by youth workers in the promoters' communities.
- To develop vocational guidance and counseling instruments and techniques for youth workers.

Content

Chapter 1 – Counseling

Introduction

Definition of Counseling

Encouraging someone to take responsibility for a problem or for improving a situation (often of a personal nature); in other words, to make decisions for themselves and empower the client to act accordingly.

Who to counsel?

In your case, as a youthworker, are teenagers and young people. Before entering counseling it is always helpful to know and remember the general characteristics of the population.

The early years of adolescence can be rocky as children undergo hormonal changes leading to adulthood. They normally move into Piaget's **"formal operations" stage of cognitive development**. This stage involves the ability to reason abstractly and apply logical rules for solving problems in several areas. Normally developing adolescents become more systematic in their approach to academic tasks and social problem solving. They enjoy applying their new reasoning skills to hypothetical situations. You might characterize this as the **"what if" stage of development**, because that is a frequent question adolescents pose to adults and peers. This new and growing ability for hypothetical reasoning can make many **adolescents seem argumentative**.

At the same time, you should not assume that every adolescent is capable of formal operational thought. Adolescents with below-average intelligence or mental retardation, in particular, are unlikely to master abstract logical thinking. Therefore, it behooves counselors to have some knowledge of adolescents' cognitive ability or to screen briefly for ability. Vocabulary and general language skills are often good indicators of intellectual ability, except for individuals with verbal learning disabilities.

In terms of **social–emotional functioning**, many adolescents can take a third-person view of what they and other people are thinking (thinking about thinking). This has been described as **"metacognitive thinking,"** because it allows individuals to simultaneously imagine both sides of a social interaction.

That is, they can understand their own perspective and the perspective of another person, as well as how both perspectives may be viewed by someone else (e.g., "She thinks that I like him and he likes me"). Although metacognitive thinking represents another advance in social reasoning, it can also lead to embarrassing complications, especially in romantic relationships. Some adolescents who are experiencing emotional and behavioral problems may not have the capacity for this type of thinking, which can be a major factor in the poor quality of their social relations with peers and adults.

Adolescence is the time when many individuals reach Kohlberg's (1976) level of **"post conventional moral reasoning,"** though this ability may not develop until ages 17 or 18 in some, or at all in others. At this level, judgments of right or wrong are based on individual principles of conscience or religious or philosophical ideals (e.g., "Violence is wrong because it violates principles of a safe and just society"; "Stealing is wrong because it violates people's personal property rights"; "Lying is wrong because it violates trust"). As adolescents learn to reason according to moral principles, they may also experiment with different ideals and values, which can lead to conflicts with family and peers. Many adolescents struggle with identity issues, which can lead to self-consciousness, and they often experience intense shifts in emotions. As they become more socially aware, adolescents look to peer groups for social acceptance, which is extremely important to them.

Peer interactions among adolescents often involve "hanging out" and communicating with friends. This can take the form of talking in groups, sending notes, making phone calls, and more recently, using e-mail and participating in online chat groups. Managing phone calls and time on the computer can be a challenge with some adolescents. Along with shared activities, intimate self-disclosure often characterizes friendships, especially for girls. Squabbles and arguments at this stage often erupt over relationship issues, characterized by gossiping, betraying of secrets and shifting loyalties. This is also the time for emerging romantic relationships, which now occur as early as ages 11 and 12.

Some adolescents experience distress about their **sexual identity**, which can be especially painful if they are ostracized by peers or family. As in earlier stages, aggressive and antisocial peers are generally disliked, though these adolescents may be accepted into deviant peer groups and gangs. Socially withdrawn individuals and those with odd or atypical behavior may also be rejected and ostracized. Peers who are cooperative, helpful, attractive and competent tend to be liked. In adolescence, peer status is generally defined by group norms, including cliques and clubs.

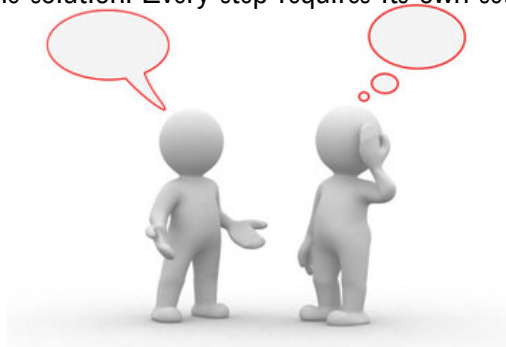
The process

There are numerous counseling theories but for the beginning, an easy way to think of this problem is to have in mind only 3 simple steps: the problem, the objective and the solution. Every step requires its own set of skills as described below:

Step A. What is the problem?

Step B. How do you want things to be different?

Step C. Creative ways to obtain solutions



Step A. What is the problem?

First, you have to understand that **problems and difficulties** are not general. They always **happen in a context**, in an environment like a room, on the street, in bed, with a lover, in the absence of the mother, with friends that drink etc. When you consider this area of the problem you can think at the youngster's surroundings: the people and places that they are interacting with, and responding to, when they are engaged in a particular activity.

In this environment the youngsters **act** (or fail to act) in a certain way. At this level of the problem you have to consider their external behaviours. This could include, for example, what an observer would see or hear or feel when they are engaged in a particular activity.

This behaviour expresses the presence or absence of certain **capabilities or skills**. At this level of the problem you can check whether or not they have innate capabilities and/or learned skills for dealing appropriately with an issue.

Looking at **beliefs and values** is a really juicy area. When a young person starts to make changes in this area it will impact other areas automatically. Beliefs can either be positive or negative. If negative they will need to be addressed. If you want your counselee to live a valuable life you have to help him/her find valuable solutions. To help him/her find valuable solutions you must know what does your counselee values in the context of the problem.

As a counsellor it's important to listen out to the youngster's language around **identity** statements. Simply speaking an identity statement is a statement of who you are. When Jack starts to say 'I am a writer' his beliefs, behaviours and actions will start to reflect this. If however he says, "I'd like to be a writer," or "I write in my spare time," then he's not dedicated to his core. When someone says 'I am' they are using an identity statement.

So, when someone asks for counseling you always have to deal with this “sandwich” called

Neurological Levels of Change

LOGICAL LEVELS OF CHANGE

OVERVIEW

'Logical levels' is an NLP term that identifies specific categories of information used during communication and which affect rapport. Developed by Robert Dilts based on a model of change originated by Gregory Bateson, it is also called 'neurological levels' – denoting that it relates to thoughts occurring in the mind. The levels or categories relate to how you think about situations. Each level provides different information to help understand what may be going on or where you may be experiencing difficulty in moving forward.

There are five main levels with an optional sixth depending on the context. They are like a hierarchy with each level connected to the next and influencing each element. You can consider each level personally, or involve a group of people you are working with. Each level provides different information to clarify your understanding.

HOW THEY CAN HELP

Logical levels can help to:

- Clarify how you perceive a situation, eg your thoughts and ideas, what the real issues are
- Highlight at what level work needs to be done to achieve change or how you may need to intervene or interact
- Identify where a problem may come from, eg within an organisation or relationship, to help find a solution to move forward

While learning and change can occur at different levels, change is usually easier in the context of the first level 'environment', eg by moving furniture. Change at a higher logical level usually impacts the lower levels. However, change at a lower level will not always affect change at a higher level. Therefore, to solve a problem at one level, a change may be required at a different level first, eg. you may want to change your behaviour, but are struggling because the change may be linked to another logical level, which you need to address first.

IDENTIFYING THE DIFFERENT LEVELS

I can't do that here Emphasis at IDENTITY level
Eg: who could do the task, or what could you do?

I **can't** do that here Emphasis on BELIEF level
Eg: why, what factors are important to help you continue?

I can't **do** that here Emphasis on CAPABILITY level
Eg: how, do you need additional skills or knowledge to proceed?

I can't do **that** here Emphasis on BEHAVIOUR level
Eg: what actions can the person do? Does the task have a positive intention and link with your personal development?

I can't do that **here** Emphasis on ENVIRONMENT
Eg: where, when or with whom could you take action? Where do you need to work? What time of the day will be best? Where do you need to be to do the task?

All those levels can be discovered by asking directly or during a more formal interview like this one:

COUNSELING INTERVIEW SHEET (General)

Name:	Tel. no:	Religion:
Address:	Ethnicity:	Gender: F/M

FAMILY BACKGROUND: e.g. type of family, family size, family health, brothers, sisters, etc.

FAMILY RELATIONSHIPS: e.g. relationships with parents/careers, relationships with brothers and sisters, etc.

CHILDHOOD AND SCHOOL HISTORY: e.g. anxieties, fears, depression, bereavement or loss, separation, medical problems, specific learning difficulties, school refusal, truancy, substance abuse, physical, emotional or sexual abuse, referral to external agencies, etc.

COLLEGE HISTORY:

General:	Grades:
Course(s):	Tutor and subject reports:

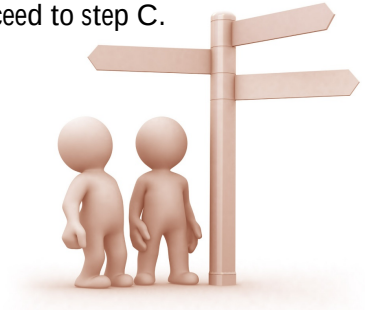
YOUNGSTER'S SELF-ASSESSMENT: Presenting problems (from his/her point of view): e.g. anxieties, fears, depression, medical problems, substance abuse, physical, emotional or sexual abuse, eating problems, sexual problems, academic under-achievement, absenteeism, personal relationships.

COUNSELLOR'S ASSESSMENT, FORMULATION AND RECOMMENDATIONS:

Step B. How do you want things to be different?

If the problem's level and description is clear is now time to go to step B – How do you want things to be different?

If you don't have an accurate and detailed description of what the youngster wants it is impossible to offer help in a proper manner. It is like you start walking on the road without knowing the destination. It is useful to formulate this objective in SMART terms (Specific, Measurable, Attainable, Realistic, and Time-bound) or SMARTER (gives two additional criteria, Evaluate and Reevaluate, intended to ensure that targets are not forgotten). If you have enough information about the counselee's purpose and also about the values that he/she has in the specific environment it is time to offer some guidance and proceed to step C.



Step C. Creative ways to obtain solutions

There are many ways in which you can help your client find valuable solutions in a specific environment. This can include brainstorming, small lectures, different meaningful experiences, behavioral prescriptions, environmental change etc. In chapter 3 you will find some useful suggestions to create your Counseling Toolbox.

NECESSARY 

in counseling

As a counselor you need to be able to:

- Demonstrate excellent interpersonal skills in the areas of:
- building rapport
- asking questions/gaining information
- giving and receiving feedback
- listening
- persuading, influencing and encouraging others
- Observe and correctly interpret what's happening; before, during and after
- Help others learn, and continue to learn yourself
- Think on your feet and tackle situations creatively
- Help others paint a picture of a higher level of performance

OTHER NECESSARY QUALITIES in counseling

Counseling is not only about having skills, but also about having:

- confidence in your own abilities and a knowledge of what you can't do
- a genuine affinity for people
- a belief in others and a real wish to see them succeed
- an ability to take second place and not seek any glory
- empathy, to see things from others' points of view
- sensitivity, especially knowing when to step in and when to be quiet
- patience and a willingness to make time for people
- a sense of humour

Skill: RAPPORT

Counseling is built on the basis of creating and maintaining friendly relationships (you don't necessarily have to like people, but it certainly helps). The success of this will depend on the amount of rapport that exists between those involved. Without it there is likely to be suspicion; with it there's the basis for trust and co-operation. Rapport means getting your behaviour in harmony with others. It assumes that people like people who are like themselves (it's very rare that you'll buy something from a person that you dislike). It is not simply about getting people to like you, but having the flexibility to behave in the same way as others. People in rapport typically 'match' one another.

☞**What to do ---->**When counseling, try:

- o adopting the same posture and movements
- o talking in the same tone and speed of voice
- o mirroring the person's breathing rate
- o using the same type of language

Don't make it too obvious, as rapport that works is an unconscious process. You may be doing it anyway without being aware of it, as it happens quite naturally.

Skill: **Acknowledging -** you shake your head and say „YES", „UH, HUH", „PLEASE GO ON"

Skill: **Paraphrasing -** repeat back what the speaker has said. „WHAT YOU'RE SAYING IS THAT... (put his/her exact word in here)"

Skill : **Reflecting** – „HOW DID THAT MAKE YOU FEEL", „HOW DID YOU FEEL ABOUT WHAT HAPPENED?" after the counselee offers the feeling repeat back the feeling „I HEAR THAT YOU FELT ... (put the feeling in here)"

Skill: **Questioning** – a.open-ended questions „WHO?", „WHAT?", „WHEN?", „WHERE?", „WHY?", „HOW?"

b.close-ended questions - thise are questions that can be answered with YES or NO

Skill *:* **Crediting** – *„IS THERE ANYTHING ELSE YOU WANT TO ADD?"*

Skill: OBSERVATION

Observation is a key counseling skill. Many of us watch, but how many actually see what's happening? Observation is very powerful, especially when it brings to people's notice behaviour that is not normally commented upon. For example, if you were helping people improve their presentation skills you might notice and give feedback on their mannerisms. As a counseler you need to be able to:

- spot what's happening and what's not
- work out specifically what people are doing and how/why they do it
- feed it back in a way that is constructive and helpful

☞**What to do** when observing:

- take in the overall picture; standing back may help, as will seeing it from different viewpoints; literally move around
- look out for sequences in which people do things, or for patterns of behaviour
- pay attention to any non-verbal signs/clues whilst you're talking to people or watching them carry out a job
- look to see if any patterns of behaviours emerge

Skill: LISTENING

If as a counseler you want to come across as credible, gain people's respect, encourage them to have confidence in themselves, then you must **listen** and understand them. Most people aren't trained to listen. We are all guilty

of daily displaying our lack of skills when we:

- Hear only what we want to hear
- Fail to put ourselves in other people's shoes
- Think we know what people are talking about
- Listen to the words but miss the 'music', the emotions behind them
- 'Already listen', which means that we have made up our minds and only hear what we want to hear

All are disastrous mistakes if you want to succeed as a counselor.

When counseling, you need to listen carefully to what people are telling you about what they have tried and discovered.

☞**What to do**

You can show that you're doing this by:

✓ paying attention and showing an interest

(don't only listen to the words but try to pick up the emotions behind them)

✓ reflecting back what you think they are saying

✓ matching the behaviour of the speaker (rapport)

✓ avoiding distractions; don't look bored

✓ recognising that it's hard work

✓ keeping your mouth shut and not talking!

"It is as though he listened and such listening as his enfolds us in a silence in which at last we begin to hear what we are meant to be"

Lao Tse

Skill: HELPING PEOPLE CHANGE

As a counselor we often see potential or abilities in others that they don't see in themselves. Whilst a lot of our efforts are directed towards encouraging people to have a go, they might say **'I can't do that'**. This can prove to be a stumbling block to progress; where do you go from here? Break down what they are saying and think of the implications.

➢**'I'** is an **identity** or a label that they put on themselves. Typical comments could be:

- *'I've never been any good at that'*
- *'I always make mistakes'*

☞**What to do**

Don't be afraid to challenge words like 'never' and 'always'

➢ **'can't'** is a **belief** that limits their ability to perform (beliefs strengthen and uphold values or what's important to people). What we value and what we believe determines why we do something.

Henry Ford said *"If you believe you can or can't do something, you're right."*

☞**What to do**

Ask questions, eg: ***'how do you know that?'***

➢ **'do'** refers to **capabilities**, in other words how able are they to apply what they know and can do? Often this is influenced by how people see themselves (their identity) as well as what they value and believe.

☞**What to do**

If people say ***'that will never work here'*** try replying ***'but what would happen if it could?'***

➢**'that'** is about **behaviour,** in other words what people say and do. Ideally, to encourage people to change, good role models are needed from whom to learn and grow in confidence. Sadly, all too often these are missing.

☞**What to do**

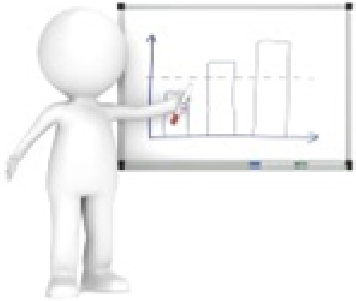
The role of the counselor is to encourage people to take on new behaviours. When faced with an objection try saying ***'why not?'***

When counseling bear in mind that:

- All the levels influence each other; a shift in one affects what happens below it
- If you are trying to encourage people to change the way they think about themselves, this will often mean tackling the corresponding values, beliefs and behaviours.

'Don't let what you can't do interfere with what you can do'

Skill: MEASURING THE OUTCOME



How do you go about measuring the success of your counseling efforts?

To do this you have to:

✓ Be clear about what you want the counseling to achieve. This is where setting clear outcomes at the early stage of the counseling process is critical.

✓ Focus on what the counseling has achieved; in other words, look at the outcome or effect rather than the way that the counseling was carried out.

✓ Ask yourself what people have done differently as a result.

VOCATIONAL GUIDANCE

In this particular type of counseling you are still working with the same population, using the same skills (listening, questioning, rapport etc.), engaging in the same process with the same steps: defining the problem, establishing how do you want things to be different and find a valuable solution together with the youngster.

That means that you still have to pay attention to identity statements, the values that the person holds in and about the working context, skills and behaviours that must be adopted or learned.

The only thing that changes is the theme in the counseling session – that is career and vocation, meaning that interest and skills to be practised need to be underlined. You can do this easily by using **HOLLAND TEST**. This test will identify the strongest career interest among six occupational themes: Realistic, Investigative, Artistic, Social, Enterprising, and Conventional. You can find this test online, just Google it.

Chapter 2

Psycho-emotional difficulties in youth

Introduction

When it comes to counseling you never know what you are going to get. The counselee might be ready to make big and rapid changes, can be resistant or can have a serious psychological problem. If this is the case, than is beyond your competences and is better to recommend the client to a clinical psychologist or psychiatrist.

There are 2 simple ways you can decide if it is in your competencies to work with the person or not. One is to be aware of different types of psychological diagnostics, so that you can orient yourself on this land.

Beware!!! It is not for you to make diagnostics!!!

The following descriptions will only help you to be with your lights on, in case the problem is not for a youth worker to handle.

Substance abuse and dependence

The two concepts of substance dependence and substance abuse are differentiated in the following ways.

Substance abuse

This is the stage before total substance dependence. Any one of the following counts as having substance abuse:

- drug-connected difficulties in going to school or keeping a job;
- using drugs in dangerous circumstances;
- drug-connected legal problems;
- persistent use of drugs despite social and personal problems

Substance dependence

Any three out of the seven criteria below count as experiencing substance dependence:

- preoccupation with the drug;
- over-using the drug;
- developing tolerance for the drug;
- experiencing psychological and physical withdrawal symptoms;
- making continual efforts to control the use of the drug along with repeated relapses;
- neglecting social, job and leisure activities in order to use the drug;
- persisting in drug use despite serious health problems.

A significant proportion of adolescents have tried alcoholic and non-alcoholic substances. Some try drug cocktails or are poly-drug users.

The essential aim of most drug use is to attain a sense of elation.

Habitual drug use can lead to deterioration in physical and mental health including suicide, impaired cognitive functioning, criminality, educational and academic failure, financial problems and difficulties in maintaining close personal and family relationships.

Drug abuse can be associated with other disorders such as conduct, ADHD, mood and eating disorders.

Children of drug abusers may suffer from drug-related problems.
With street drugs there is always a danger of impurities or accidental overdosing.

Alcohol abuse and dependence

Excessive consumption of alcohol is connected to a significant proportion of murders, suicides, juvenile delinquencies, school drop-outs, car accidents and health problems as well as the reduction of life expectancy. Excessive alcohol use among adolescents is related to family conflicts, inadequate parenting (poor supervision, low expectations and few rewards) and heavy parental drinking. It is also connected to an adolescent's peer group abuse of alcohol, particularly if they are older adolescents. Adolescents who are easily bored and who want immediate gratification are particularly at risk.

Effects of over-use of alcohol

- acts as a brain depressant – depending on the level of alcohol it can affect motor and emotional control areas of the brain and eventually lead to respiratory and heart disturbances resulting in stupor, coma and finally death;
- can adversely disturb sleep;
- is connected to the development of health problems, e.g. cirrhosis of the liver, heart disease, various cancers and gastrointestinal problems.

Alcohol abuse and dependence are characterized as follows:

- need for regular, daily and large intakes of alcohol;
- periods of being sober interrupted by binge drinking;
- inability to cut down or stop drinking;
- experiencing blackouts when drunk;
- persistent drinking despite having health problems made worse by alcohol;
- social, occupational, legal and family problems, e.g. absence from college, work, arrests for drunkenness, traffic accidents and being verbally and physically aggressive towards family members.

Amphetamine use

Amphetamines are addictive drugs which can have the following effects on people:

Intoxication

- behavioral or psychological changes, e.g. euphoria emotional blunting, anxiety, anger and tension, impaired judgment, adverse social and occupational functioning;
- physical symptoms, e.g. racing or slow heart rate, widened pupils, high or low blood pressure, perspiration or chills, nausea or vomiting and agitation or retardation.

Withdrawal effects

- dysphoria;
- physical symptoms, e.g. fatigue, vivid unpleasant dreams, insomnia or excessive sleep, agitation or retardation.

The most adverse physical effects are on the heart, e.g. heart attacks and high blood pressure and on the nervous system, e.g. seizures, coma and death. The most adverse psychological effects are restlessness, irritability, insomnia, hostility and confusion. Anxiety and panic disorders, hallucinations and paranoid delusions can result from amphetamine use.

Designer drugs

There are also manufactured drugs which are modified versions or analogues of drugs like amphetamines, which are called 'designer drugs'. Ecstasy or MDMA is a well-known 'designer drug'. There is an increasing demand for designer drugs, in other public places besides clubs and the price is falling. The heaviest use is among young people from 18 to 25. The drug affects the neurotransmitters serotonin and dopamine. Use of designer drugs can bring about mood changes particularly in relating to others, as people feel closer to each other and feel they can more easily communicate with one another. It can also produce feelings of euphoria, empathy, self confidence and self-acceptance. Some users have also reported perceptual effects, e.g. after-images, geometrical patterns in the visual field and distortions of objects. Other possible effects are sweating, nausea, headaches, unsteadiness, widened pupils, rapid heart rate, insomnia, tension in the jaw, teeth clenching and grinding. After use it can also result in anxiety and depression. Bad experiences are normally the result of high doses, e.g. visual and auditory hallucinations, panic, insomnia, flashbacks and even psychosis in susceptible people. Fatalities occur due to heat stroke, excessive water retention and heart failure.

Cannabis

Cannabis is a psychoactive drug which can produce euphoria and the most common physical effects are red eyes, increased appetite, dry mouth and a mildly racing heart rate.

Intoxication

- maladaptive behavioral or psychological changes, e.g. Impaired co-ordination, anxiety, feeling time has slowed down, impaired judgment and withdrawal;
- the psychoactive part of cannabis can precipitate paranoia and hallucinations leading eventually to a cannabis-induced schizophrenia. People prone to psychotic symptoms include those who smoke in their early teens and those who have a genetic predisposition to mental illness. There is tolerance to the effects of the drug but there is no clear evidence of physical dependence and no psychological dependence.

Heroin

Heroin is an opiate derived from morphine. Various chemicals and refining processes are used to produce heroin. The degree of purity depends on the manufacturing process.

Most heroin users are poly drug users, e.g. tranquillizers, amphetamines and cocaine. Heroin can be injected (most popular method), snorted, smoked or taken as pills. Injecting heroin can lead to HIV, and hepatitis B and C. Heroin imitates the effect of endorphins which kill pain through decreasing nerve impulses that communicate pain. It can have a serious effect on breathing, cause flushing, sweating and itching and also cause vomiting and constipation. Conspicuous effects include the constriction of the pupils to pinpoints along with slurred speech. The sought-after effect is euphoria and the removal of tension and anxiety. Heroin abusers may neglect their appearance and fail to eat and sleep sufficiently creating health problems. Excessive spending on the drug may also lead to poor living conditions. Long-term health problems include skin and pulmonary abscesses, septicaemia, collapsing veins, infections of blood vessels and heart, liver and respiratory disease. Overdosing is a serious risk due to drug impurities and adulteration of the drug. Overdosing may lead to coma and

death. Mental health problems include depression and mood swings. Women may be at risk of irregular periods and, if pregnant, of miscarriage, of low weight babies and premature birth. Heroin produces a high degree of tolerance and physical dependence. Withdrawal conditions occur if the drug is stopped or reduced. These conditions include aches, spasms, goose bumps, tremors, chills and kicking movements. Psychological dependence takes the form of feeling unable to cope with life without the drug.

Cocaine and crack use

Cocaine is a drug derived from the coca plant and tends to be used by older adolescents. It is very addictive and can be highly dangerous. Injecting cocaine can lead to hepatitis C. It works by concentrating the neurotransmitter dopamine in the synapses between neurons. This high can last 40 to 60 minutes after which another intake is necessary to maintain the high. Crack is a very powerful form of cocaine and is highly addictive. Crack addicts need large sums of cash to feed the habit and this can induce them to resort to street robberies. Crack is used by some along with heroin. Addicts can become suspicious, secretive and aggressive.

Effects of cocaine

- It has an effect almost immediately and lasts briefly (30 to 60 minutes).
- Psychological dependence can occur.
- Tolerance and sensitivity to its effects can occur after repeated use. Physical dependence does happen, but withdrawal is relatively mild compared to that of opiates.

Intoxication

- psychological effects: elation, euphoria, raised self-esteem, perceived improvement in performance. High intake can lead to agitation, irritability, impaired judgment and aggression. Paranoid delusions and auditory hallucinations can also occur.
- physical effects: increased blood pressure and heart rate, headaches, nausea, nasal problems, damage to lungs, breathing difficulties, intravenous use carries possibility of HIV infection/hepatitis C, heart problems (irregular heartbeat, heart valve disease), stroke, seizures and death.

Withdrawal effects

- dysphoria, anxiety, irritability, fatigue and being awake a great deal;
- craving for the drug can be extremely powerful.

Hallucinogen use

Hallucinogenic drugs are sometimes called psychedelics. They produce hallucinations but also they lead to loss of contact with reality and feelings of an expanded consciousness. LSD is one of the main forms of hallucinogenic drug. There is no physical dependence and no withdrawal symptoms but a psychological dependence can develop. Tolerance occurs and reverses quickly. Intense and brilliant colors are seen and the other senses are heightened. There are also changes in body image and one's perception of space and time. Visual hallucinations occur. Feelings become more intense. There are feelings of religious, mystical and philosophical insight.

Intoxication

- psychological changes: anxiety, depression, ideas of reference, fear of going mad, paranoia, impaired social and job performance;
- perceptual changes: heightened perception, feelings of unreality, feelings of losing one's sense of self, illusions, hallucinations and flashbacks;
- physical symptoms: widened pupils, rapid heartbeat, sweating, palpitations, blurring of sight, tremors and lack of co-ordination.

Inhalant use

There is a relatively high use of inhalants, e.g. solvents, glues, aerosols, paint thinners and lighter fuels among adolescents and high use is also connected with an increased probability of juvenile delinquency. Inhalants are depressants and rapidly affect the brain. Tolerance can develop. In small amounts the effects can be euphoria, excitement and pleasant feelings.

Intoxication

Can lead to apathy, nausea, dizziness, lack of co-ordination, slurred speech, unsteadiness, tremor, impaired social and job functioning and impulsive or aggressive behavior. High intake levels can also result in anxiety, illusions, auditory and visual hallucinations, distortions of body image, stupor and unconsciousness.

Withdrawal effects

Withdrawal effects are not common but when they do occur they can take the form of sleep problems, irritability, sweating, nausea, vomiting, rapid heart rate and on occasion delusions and hallucinations.

Smoking

Many smokers start the addiction in early adolescence and smoking is on the increase among adolescents. Adolescent smokers are more likely to be involved in delinquent activities than non-smokers.

Effects

Users report that smoking improves attention, learning and problem-solving and also reduces anxious and depressive feelings. Premature death can eventually result, e.g. through emphysema, lung cancer and heart problems.

Withdrawal effects

Can be nausea, vomiting, stomach pain, diarrhoea, dizziness, tremor, headache, raised blood pressure and heart rate.

Self-harm

Self-harm is a way of expressing very deep distress, when people intentionally and habitually inflict damage to their bodies. It is a behaviour that usually has its onset during adolescence and mainly affects young females and those women in their twenties or thirties. Certain groups self-harm more than others, e.g. gay men and women and those with learning disabilities.

Types of self-harm include cutting, making incisions and scratching the skin and hitting and inflicting burns on the body. Many who self-harm are attempting to cope with unbearable emotions and hope to achieve emotional self-healing or to feel relief. It can also be an attempt to gain a sense of self-control. For some it can be a mean of expressing grief, despair, anger, frustration and protest. Self-harm can also serve as self punishment or punishment of others and as a way of communicating with others. The reaction of others can be shock and alarm, some blaming themselves. A common factor in self-harm is childhood sexual abuse.

Schizophrenia

Schizophrenia is a persistent and diverse disorder of thought and perception. It can be characterized by delusions of thought insertion, withdrawal and broadcasting and also by culturally inappropriate delusions such as claiming to be a great religious or political figure or having superhuman abilities.

There are also auditory hallucinations (hearing voices) along with incoherent thought or speech. The sufferer often becomes socially isolated as well as socially awkward, apathetic, emotionally flat, lacking in will and displays a paucity and poverty of speech. There is evidence that schizophrenics also suffer downward social drift, dropping down to a lower social level. There is cognitive impairment in the form of memory, attention, concept formation and executive functions.

Schizophrenia is rare in childhood but increases significantly during adolescence. The average age of onset is 18 to 25 for males and 26 to 45 for females. There are no biological markers for schizophrenia and the mode of inheritance is unknown, which makes it difficult for genetic studies of the disorder. Currently the cause of schizophrenia is unknown.

Obsessive Compulsive Disorders (OCD)

These disorders are characterized by persistent, intrusive, recurrent obsessive thoughts and covert (cognitive) or overt (behavioral) compulsions that the sufferer finds distressing. These may take the form of washing/cleaning compulsions (mainly female), checking compulsions (males and females), list-making (males and females), hoarding and ruminations, persistent and unproductive thinking about personal matters or religious and philosophical themes. Obsessive thoughts include those about contamination, disasters, illness, death, order and forbidden sexual thoughts. Obsessions and compulsions can occur separately. It is a relatively rare disorder.

The onset is usually in adolescence before the age of 25 and occurs earlier in males than females. Many people have obsessions and compulsion but do not find them distressing and do not experience them as interfering with their social, familial and working lives. Children and adolescents who suffer from OCD are as likely to be compulsive cleaners and checkers as adults. The sufferer has insight and recognizes that these thoughts and actions are voluntary but unnecessary. However, he or she finds it

impossible to resist them permanently without becoming extremely anxious.

These disorders often occur with anxiety, depression, sleeping problems, tics and occasionally aggressiveness. Symptoms similar to OCD can result from brain damage. Although there are people with obsessive personalities, most of these do not develop the disorder. The family can be adversely affected through the sufferer dominating family life and demanding that other family members observe certain prohibitions or perform certain actions such as cleaning and washing rituals. Many family members at first resist then comply for the sake of peace and quiet.

The result of OCD can be social isolation and restriction of social activities. It can also lead to separation and divorce. Factors linked to the onset of the disorder include depression, shyness, illness, death or illness of a relative.

Depression

Depression has a range of symptoms including persistent sadness and despair, diminished interest or pleasure in social, leisure and sexual activities, weight loss or gain, sleep disturbances, restlessness, fatigue, feelings of worthlessness and hopelessness, lack of concentration, indecision, recurring thoughts of death or suicide ideation and negative views of other people, the world and the future. As well as these symptoms, there is often a deterioration in family and peer relationships and in school or college achievement.

Depression is not rare but is more common among adolescents than children and often occurs along with other disorders such as those of anxiety and conduct. It is more common among adolescent girls than boys.

Symptoms

The symptoms for major depression are:

- depressed or irritable mood most of the day;
- loss of interest or pleasure;
- failure to gain expected weight;
- insomnia or excessive sleep;
- agitation or loss of energy;
- feelings of worthlessness or guilt;
- a sense of hopelessness;
- poor concentration;
- persistent thoughts of suicide;
- delusions and hallucinations may also occur – delusions focusing on guilt, illness, death, punishment, personal inadequacy and persecution, and hallucinatory thoughts having an abusive or suicidal content.

To be diagnosed as having a major depression, an adolescent must experience five or more of the above symptoms for the same two-week period. There is some overlap with other problems, e.g. separation anxiety, school refusal, antisocial behavior, substance abuse, anorexia and physical complaints.

With adolescents there may be additional symptoms, e.g. delinquency, use of drugs, moodiness, restlessness, reluctance to participate in family and social occasions and difficulties at school or college.

There is an increase in depressive feelings with age, particularly comparing adolescence with pre-adolescence. There is evidence that the prevalence of depression is increasing among adolescents. Most adolescents recover from depression within a year but are likely to develop depression later in adulthood. Parents and teachers may be unaware of an adolescent's suicidal ideas and feelings; this is because adolescents may not 'act out' their feelings and so are overlooked.

Suicide and attempted suicide

Suicide is the taking of one's life and its criminal status as self-murder did not end until 1961. Suicide is closely connected to having a psychiatric illness such as a major depression, alcoholism, schizophrenia or a personality disorder, in particular, a borderline or an anti-social personality disorder. It is a leading cause of death among adolescents and has risen sharply since the 1960s, particularly among young working-class males, those 15 to 24 since 1982, and there is a higher rate of suicide among young males as against females, a current ratio of 6:1. Adolescents who commit suicide tend to display a combination of depression along with a conduct disorder. The risk increases rapidly through adolescence and into the early adult years.

Attempted suicide is far commoner among females than males, increasing among girls from 12 years upwards and peaking at 16 years of age. The general rate has been increasing since 1990 and in particular there has been a rise in the male rate. In fact, having suicidal thoughts is not that rare.

Suicidal thinking – some particular thoughts and motives that may occur in an adolescent's suicidal thought processes:

- that one will be reunited with a loved one or will be reborn;
- that one will escape despair and attain a state of tranquility;
- self-punishment and punishment of others or revenge;
- an appeal for help by expressing intentions beforehand;
- a sense of control over an intolerable situation;
- frequent hints or talk of suicide indicate that the suicidal process is accelerating;
- poor problem-solving thought processes;
- feeling trapped by circumstances or by thoughts and feelings.

Anxiety

Fear and anxiety are adaptive responses to threatening situations or perceived threats. Adaptive responses are based on an accurate assessment of potential risk or danger whereas maladaptive response is based on an inaccurate assessment. Anxiety has physiological (physical arousal), affective (tense feelings), cognitive (perceived as threatening) and behavioral (avoidance) components.

Factors contributing to anxiety include low self-esteem, anxious attachment, exposure to carer anxiety, loss or separation from carers or peers, changing school, bullying and moving away from the neighbourhood.

Types of anxiety include simple phobias, separation anxiety, test anxiety and post-traumatic-stress disorder. Types of anxiety tending to appear first in adolescence include generalized anxiety, social anxiety, panic attacks and agoraphobia. Many experience more than one type of anxiety. Some adolescents experience a generalized anxiety, a persistent, excessive and uncontrollable worry about problems; others experience a panic reaction.

Panic attacks

These generally begin to occur in late adolescence. Adolescents experience thoughts and feelings of panic which occur along with physiological reactions, e.g. Sweating, giddiness, hyperventilation and palpitations. There is also a fear of public embarrassment and, as a result, an overwhelming desire to get away from the public place in which the attack occurs. Some attacks occur unpredictably, others occur in response to specific situations. They can be associated with agoraphobia – a fear of leaving home and experiencing an attack in a public place.

Phobias

Some adolescents experience an intense, persistent and unrealistic fear of an object or situation, resulting in avoidance. These phobias often first appear between the ages of 11 and 17. There are specific phobias, e.g. of animals. There is also social phobia: a general fear of public embarrassment, a fear of making mistakes and avoidance of participation in public events. This phobia can arise in some adolescents due to acute self consciousness.

Eating disorders

Eating disorders include anorexia and bulimia. The peak age for onset is around the middle of adolescence. In adolescence eating disorders are characterized by an excessive preoccupation with body weight and shape. There is a refusal to maintain weight, an intense fear of gaining weight or being obese and excessive concern over size and shape, particularly the stomach, buttocks and thighs.

Physical complications may occur when adolescents develop eating disorders, such as amenorrhoea, delayed puberty, anaemia and electrolyte abnormalities. Anorexia and bulimia are most frequently seen among female adolescents. Other aspects include easy access to food, loss of personal and social interests, perfectionist attitudes, academic challenges and failure, depression and family conflict. There has been an increase in both disorders in Western countries and it is also increasing in non-Western countries. Eating disorders have a relatively high mortality rate, the highest for any psychological disorder.

The main eating disorders are anorexia nervosa, bulimia and obesity.

Anorexia nervosa

The onset of this disorder is often in adolescence, increasing rapidly after 13 years of age, and at a maximum between the ages of 17 to 18 years. It is much more common in females than males, and it is on the increase. This eating disorder is where an adolescent, usually a teenage girl, although boys suffer from it too, has severe problems with body image and who, as a result, pursues thinness to the point of starvation.

The criteria for anorexia are:

- restricting food consumption to the point of refusing to eat hardly anything at all;
- refusal to maintain body weight less than 85 per cent of normal for age;
- intense fear of gaining weight and becoming fat;
- distortion of image of body weight and shape;
- cessation of periods over three consecutive cycles.

Bulimia

Bulimia often occurs later in adolescence than anorexia; it is much more common than anorexia and is predominantly a female disorder. This disorder is characterized by a fear of weight gain which leads to repeated bouts of binge eating, frequently followed by self-induced vomiting and purging, or the abuse of laxatives and diuretics. The bulimic's weight is just below normal, normal or even above normal.

The criteria for bulimia are:

- repeated sessions of binge eating;
- repeated sessions of purging through use of laxatives, diuretics and enemas in order to avoid weight gain;
- binge eating occurs at least twice a week over a period of three months;
- self-esteem is disproportionately influenced by concerns over body shape and weight.

Aggressive behavior

Aggressive behavior may take the form of physical and verbal aggression, bullying and cruelty towards peers. Adolescents may be hostile, defiant and rude towards adults. Lying, theft, violence, truancy, vandalism, substance abuse and fire-setting may occur. There may be difficulties with developing and maintaining peer relationships, or friendships may develop with younger or older peers.

There is often egocentric and egoistic behaviour – manipulating others and being unconcerned about another's feelings or wishes.

Characteristics of adolescents with persistent aggressive behavior or conduct disorders:

- noticeable tendency to externalize guilt and tension, to blame others and to see others as hostile;
- poor frustration tolerance, irritability, oppositional, provocative and unpredictable behavior;
- evidence of involvement in bullying, theft, vandalism and cruelty;
- peer rejection, difficulties with peer relationships and low self-esteem, but there can also be friendships with younger or older children, with individual delinquents and with gangs;
- overlap with ADHD, substance abuse, learning difficulties and school under-achievement.

Attention-deficit hyperactivity disorder (ADHD)

The main symptoms are: inattention, hyperactivity and impulsivity and these symptoms should have persisted for at least six months, be manifested in two settings and have had an onset before the age of 7 years and not be the result of some other mental disorder, brain injury or physical condition.

There are various categories within ADHD – namely children who are mainly **inattentive** or **hyperactive-impulsive**, or both. Conduct disorders and learning difficulties overlap with ADHD.

Peer rejection also occurs. Some children do outgrow the disorder.

In adolescence, children with ADHD have an increased risk of delinquency, truancy, substance abuse and difficulties with relationships.

Chapter 3 - Counselor's toolbox

Youth worker's role in counseling context

Although specific studies are needed in order to make a diagnosis and you are allowed this only as a clinical psychologist or psychiatrist, there is still another way to orient yourself to respect the framework of occupations.

Using a scientifically validated test to give you a broad idea about the seriousness of the situation can be life saver. Such a tool is **Hospital Anxiety and Depression Scale** (known as HAD), originally developed by Zigmond and Snaith and commonly used by doctors to determine the levels of anxiety and depression that a patient is experiencing. The HADS is a fourteen item scale. Seven of the items relate to anxiety and seven relate to depression. Each item on the questionnaire is scored from 0-3 and this means that a person can score between 0 and 21 for either anxiety or depression.

Another very useful test in your toolbox is called **Holland** and is going to help you a lot in the practice of vocational counseling.

The tests can be easily found on the Internet. Just Google them!

Beyond tests you have to create your own collection of activities and exercises to help you in the counseling process. Here are some ideas:

Lifeline

Published in Assessment & Treatment Activities for Children, Adolescents, and Families Vol 1 Edited by Lowenstein, 2008

Goals

- Learn more about the youngster's life from his perspective
- Increase the youngster's ability to organize her/his sense of self
- Develop the youngster's ability to express feelings about her/his self, life events, and significant people
- Develop the youngster's awareness of her/his choices in creating the future

Materials: Large piece of paper, Markers, Scissors, Glue, Magazines, Scrap items that can be used for art

Description

The Youth Worker invites the youngster to take part in an activity about her/his life. The activity involves outlining the counselee's life onto a piece of paper. The first step is to give her/him a large piece of paper and ask her/him to draw a horizontal line across the middle of the paper. At one end of the line, the YW writes down the youngster's date of birth. At the other end, place the projected year which the coounselee imagines would represent the length of her/his life. For instance, a birth date might be 1998, making her/him 15 years old at the time of creating the lifeline and she/he might imagine living to be 85 years old. So, the year at the other end of her/his life would be 2083. The YW then divides the line into four segments and then into eight segments and then into sixteen segments. Each segment represents approximately 5 years of his/her life. The YW then draws a second line the same length as the lifeline that represents the age of the youngster. So it begins with the birth date and ends with age 15. This allows more space for the details of the counselee's life. Then he/she illustrates significant life events on the lifeline by writing words, drawing pictures, creating a collage, pasting on personal photographs, and so on. The YW can facilitate this process by asking questions about

important events, milestones, and significant people in her/his life. As the youngster begins to slowly recall the easy events such as birthdays, preschool, or births of siblings, other more difficult events will be remembered. The YW processes this activity by asking questions about events, feelings experienced, and significant people identified in the lifeline.

The YW encourages the counselee to recall as much details as she/he is comfortable sharing. It is important to explore his/her perceptions and feelings about the past and integrate them into the present. For instance, "How did you feel when this happened? How do you feel now? Is there any difference?"

Another helpful question to ask is, "If you had a way of changing anything that has occurred in the past to make your life better today, what would you do?"

Another facet of this activity is to look at how much of the lifeline remains. If the person is 15, for example, and the lifeline is projected at 85 years, then 70 years lie ahead. These years can be filled in with the youngster's fantasies,expectations and hopes — for example, going to college, writting a first novel by 30, learning to drive a car, travelling the world, getting married, taking early retirement. If the counselee is having difficulty envisioning her/his future, the counselor can ask prompt questions such

as, "What do you hope to be you grow up and what kind of schooling would you need in order to do that? Do you see yourself remaining single, or getting married? Would you like to have children? Where in the world would you like to visit? When you are not working, what do you think you will want to do for fun? What one thing do you want to have in your future that money cannot buy? What do you hope will be your biggest life achievement?

Discussion

This activity helps a youngster to understand that her/his life is unique and that every person has a different life story. It allows a young person to reflect on the processes of change and growth. It can also stimulate to begin creating a cohesive narrative that can provide her/him with support in coping with past trauma as well as present challenges and accomplishments. Furthermore, through thinking about the events of her/his life while in contact with another person, she/he can be supported in actively imagining the possibilities for the future.

The Way I Want It To Be

Hobday, A., & K. Ollier. (1998). Creative therapy with children and adolescents.Atascadero: Impact Publishers.

The youngster draws two pictures. The first on the sheet of paper is titled: **The Way My Life Is**. The second on the sheet of paper is titled **The Way I Want It To Be**.

Then she/he discusses the two pictures. The Youth Worker can ask the following process questions: How did you feel during the drawing activity? How are you going to get from the way it is to the way you want it to be? What do you need to do differently in order to get to the way you want it to be? How might counseling help you get to where you want to be? How will you feel when you get to where you want to be?

A person's artwork can be used in counseling sessions as tools for assessment and creative expression. This drawing exercise enables a youngster to examine presenting issues and define counseling goals for future intervention.

Paparazzi

Assessment & Treatment Activities for Children, Adolescents, and Families Vol 1 Edited by Lowenstein, 2008

Goals

- Identify personal strengths and challenges
- Identify personal values
- Create a personal story using pictures
- Explore the significance of people and objects in the client's life

Materials : Disposable camera, Scrapbook, Pens, Markers, Sticker

Description

Note: This activity will require two sessions to complete. Introduce the concept of "phototherapy" (using cameras to tell a story). Ask the youngster to take pictures of meaningful people, places, and other points of interest in her/his life. Like the celebrities in Hollywood where the paparazzi take pictures of them, their homes, families, where they shop, eat and so forth, the youngster will act as her/his own paparazzi by taking pictures of the many different aspects that make up her/his life.

Encourage her/him to include the following themes: strengths, support people, hobbies, home, school, etc. Remind the youngster that as the "paparazzi", she/he is to capture all elements of her/his life. Print the photos before the next session. At the next session, give the counselee a scrapbook to put the photos in, along with stickers, stencils, rubber stamps and other decorative supplies to enhance the scrapbook. The youngster will create a "tabloid magazine" using the scrapbook to hold the photos. The photos should have short descriptions. Encourage the youngster to leave the first page blank as this will serve as the cover page. After all the pictures have been pasted in and the descriptions created, encourage her/him to look through the pages and then create a cover and a title for the scrapbook that captures the essence of her/his life.

Encourage the youngster to reflect upon the themes that are represented in the photographs. Ask how his/her strengths and challenges are revealed in the photos, or what values are represented. What does the counselee notice is missing (if anything)? What seems to influence a large part of his/her life?

Reading List

http://nlpuniversitypress.com/html2/N32.html

http://en.wikipedia.org/wiki/Rapport

http://nlpuniversitypress.com/html3/R.html

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"Understanding career counseling", Kidd M. Jennifer, Sage Publications, London, 2006

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