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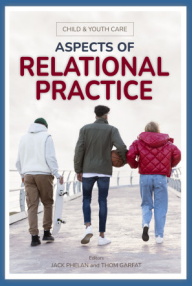

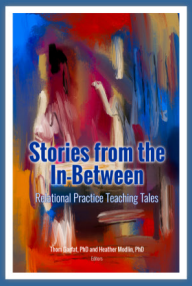

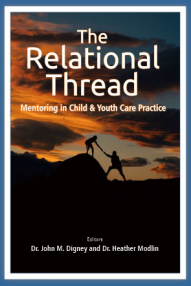

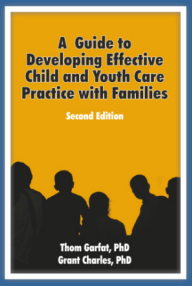

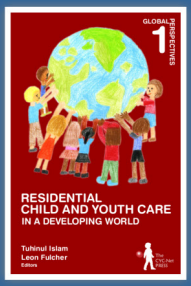

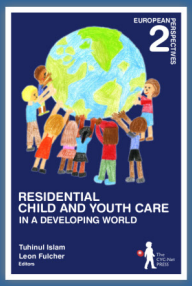

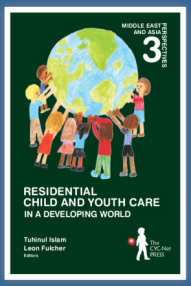

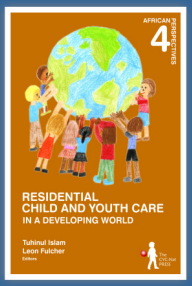

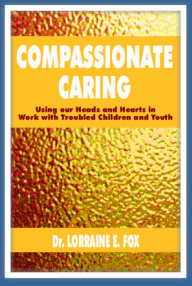

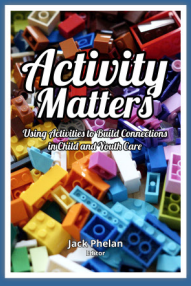

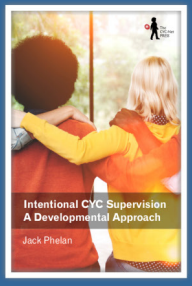

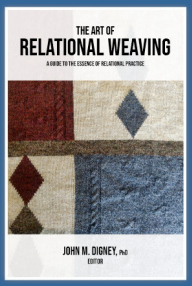

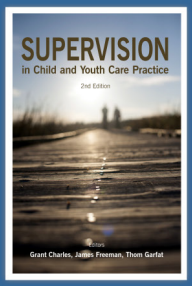

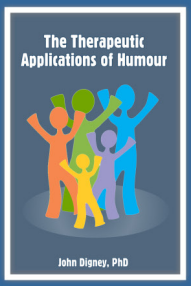

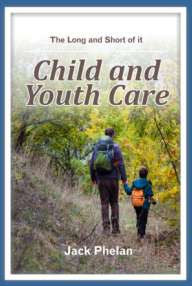

Editorial Comment

Farewell, My Friend

Kiaras Gharabaghi

In July 2016, my *CYC-Online* column was a tribute to Jack Phelan (https://cyc-net.org/cyc-online/jul2016.pdf#page=7). He was alive and well at the time, and I wanted to write it to make sure that he knows how much he is appreciated, loved, and adored by others in our field. Over the past few days, tributes to Jack have been everywhere as CYC people all over the world mourn his passing. I don't know what else to say. Jack gave everything to this field, to the people in the field, and early in his career, to the young people he encountered. He lived this field. He lived the mantra I learned from Thom Garfat: 'child and youth care is a way of being in the world', and the way Jack was in this world is the reason I continue to support our field, write about it, and find my own ways of being in the world that reflect this field.

Life is precious because it doesn't last forever. Jack challenged this simple truth for a very long time. One of the last things he did was to attend a child and youth care conference. I think he knew the end was near. And he wanted to exit on a foundation of love. And that he did as only Jack could do.

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Farewell, my friend. May you dream of dancing in Cape Town, drinking in Winnipeg, and setting the record straight in Taos, New Mexico. I will raise a glass to you at the next child and youth care conference I attend.

In sadness, but with love …

Kiaras

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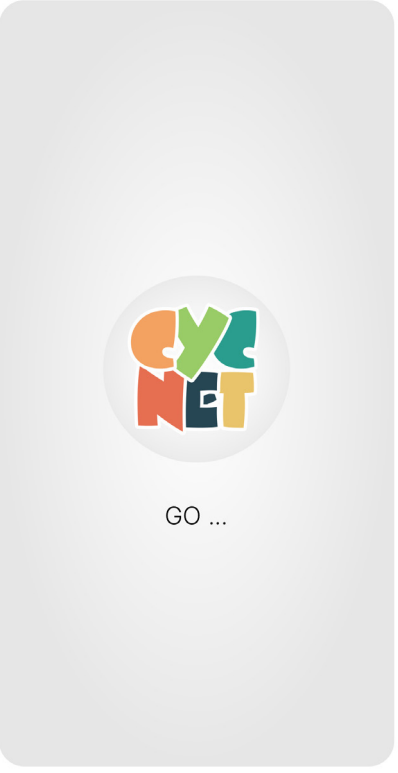

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The Experience Arranger

Jack Phelan

Child and Youth Care practice is not a verbal counselling activity. In fact, we already know through recent brain research that most abused and neglected youths have neural brain patterns that block verbal input about trusting others or being too hopeful. We are most effective when we avoid trying to influence youths through their brains, and instead focus on communicating physically, through the heart or emotions. This is one reason why I do not use the label Child Care Counsellor and prefer to see our professional task as being an experience arranger.

Mark Krueger has described the focus of our work as "creating moments of connection, discovery and empowerment" for youth, and I heartily agree with him. Many CYC writers and thinkers of the past decade define the practice as relational and developmental, not behavioural. The life space work that we do is ideally suited to communicating physically, a process that I have called analogue, not dialogue communication. The goal is to create moments where a youth is staying close to you even though his brain is warning him to move away, because his body/heart is feeling safe and comfortable with the closeness.

The process of becoming a capable, strategic experience arranger is not simple. Inexperienced Stage 1 workers cannot be expected to do this. More mature practitioners, the Stage 2 workers who are able to fully focus on the

youth and are not self-consciously preoccupied with doubts about safety or personal competence, can become better and better at using the multitude of daily events to create experiences that promote connection, discovery and empowerment.

The needs of the youth we work with are quite simple, the ability to provide the help they need is quite complex. Fritz Redl said this over 60 years ago, describing the mundane medicine which is needed, and the superhuman skill needed to get it out of the doctor's bag and into the youth's body. We can readily describe the experiences we hope to provide to our charges; a message of being cared for un-conditionally, a hopeful attitude about the future, a desire to learn and become competent. In sum, Connection, Discovery and Empowerment. An example may be helpful.

A CYC practitioner (Level 2) is observing a youth who is supposed to do the dishes after lunch on a Friday. The youth is getting very agitated because he is going for a home visit in an hour, but he sees the van which will take him leaving the parking space and he believes that he will be left behind. Even though he is told that the van is only going to the gas station and will be back soon, he cannot control his anxiety. The other CYC worker is a Level 1 practitioner, and he begins to insist that the boy finish doing the dishes before he can leave. Unfortunately, the predictable result of this demand is that the boy will lose control, possibly break several dishes or worse, and probably not get through the afternoon smoothly. Level 1 workers are preoccupied with keeping things safe by insisting on the rules and routines. In-stead, the Level 2 worker moves closer to the boy, puts his hand on his shoulder and says that he will finish the dishes and tells the boy to go and get ready. The Level 2 worker knows that the only problem with this interaction is explaining it to his colleague, who will be challenged to see the value here. If we believe that chaos will not result by having this boy abandon his chore so that he can manage his anxiety (a belief which is not

so easy for a Level 1 worker), then the experience arranged by the Level 2 practitioner is that the boy will be relieved and empowered by being able to focus on his trip home and puzzled by the caring gesture of taking over his chore. He may begin to connect more easily with the Level 2 worker and will certainly have a better start to his home visit.

Once we have established a safe environment there is little need for insisting on behavioural expectations when they are counter-indicated by the situation. In fact, our treatment efforts should build experiences of connection, discovery, and empowerment, not adherence to a predetermined schedule. Level 1 workers are not free to think this way and are more focussed on their own experience than the youths', which is a developmental journey that cannot be rushed. The Level 2 practitioner, the Treatment Planner and Change Agent, often has the difficult task of keeping the Level 1 worker safe while arranging this type of experience for the youth.

The physical experiences arranged by skilled workers look simple after-the-fact, but the level of thinking is quite complex. In fact, truly skilled practitioners know that they are continuously improving in this complex ability and never reach a final level of skill. The interesting parallel result of this interaction is that it also enhances the connection, discovery and empowerment experience for the practitioner.

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Why Canada Needs a ‘Duty to Assess’ Young Caregivers, Not Just a ‘Duty to Report’

Yana Berardini

Ask almost any teacher, psychologist, social worker, counsellor, healthcare provider, or child and youth worker in Canada about their professional responsibilities, and one obligation immediately comes to mind: **The duty to report.**

Across Canada, professionals are legally required to report to child protection authorities when they have reasonable grounds to suspect that a child is in need of protection due to abuse, neglect, or another situation that places the child's safety at risk (Government of Ontario, 2017). While child protection legislation varies by province and territory, the principle is the same: Protecting children from harm is a legal and ethical responsibility (Government of Canada, 2019; Government of Ontario, 2017). This duty is essential and important. It saves lives. This can’t be debated. What happens though if our first instinct to report causes us to overlook an equally important responsibility: **The duty to assess?**

Millions of children and youth across Canada quietly help care for a parent, grandparent, or sibling living with a disability, chronic illness, mental

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illness, substance use, or age-related needs. These young caregivers, often called young carers, help prepare meals, administer medications, provide emotional support, translate, supervise siblings, and manage household responsibilities or contribute financially to the household's income (Charles et al., 2008; Joseph et al., 2020).

My research, alongside others, consistently reveals that young caregivers experience greater risks for mental health difficulties, interrupted education, financial strain, and poorer health than their peers (Joseph et al., 2020; Stamatopolous, 2018; Lakman et al., 2017; Lakman & Chalmers, 2019). Yet the story is more complicated than simply viewing caregiving as a problem. Many young caregivers describe their role as meaningful, noting they feel proud to support their loved ones (Kavanaugh et al., 2025) and not feeling that it is more overwhelming than the responsibilities of non-carers (Remtulla et al., 2012). In fact, my current research team is examining young caregivers' needs and supports, revealing just how meaningful caregiving is for them. Our focus groups showed that young people wanted more services to ease their role as caregivers, such as more recognition, better understanding, flexibility at school, and access to supports that reduce the negative outcomes they sometimes feel, while allowing them to continue caring safely.

Unfortunately, many families remain invisible. *Why?* Because they fear for a potential child welfare investigation to ensue, rather than an opening for an avenue of support.

In our own research, young caregivers told us they often kept their caregiving responsibilities secret, particularly from adults they did not know or trust. The pressures to keep their role hidden from unwanted intervention was rooted in real fear. In a previous study with my colleagues, we even heard a few teachers and principals expressing uncertainty in supporting young carers, with one indicating that they have a duty to report, if they felt

that something was wrong (Mansell et al., 2021). Therefore, this fear is valid, and young carers did not hesitate to tell us about it; it even exists in families that are not abusive or neglectful.

The duty to assessment should come before Intervention

No one is suggesting that Canada weakens its duty to report. When a child is unsafe, immediate action is necessary and intervention is the best outcome for the children. But not every young caregiver is living in an unsafe home. Sometimes a family is doing the best it can under extraordinarily difficult circumstances such as long waiting lists and dreadful referral times, lack of services or experts in the area, or even worse, inadequate, poor-quality services. These are just some of the things we heard from our caregivers, during our focus groups. In these gaps, families rely on their loved ones to keep the household afloat! In my current research, we heard young caregivers who told us they need more, and better services such as respite services, school accommodations, mental health supports, or community programs that meet their needs as a caregiver. Often what they need is not an investigation but rather careful assessment.

Imagine if professionals were expected to ask:

- Who is receiving care?
- What responsibilities does this young person have?
- Are these responsibilities affecting school, health, or well-being?
- What supports could reduce unnecessary burden while keeping the family together?

Imagine if schools were expected to help identify young caregivers by:

- Mandating school staff to recognize and support young caregivers in class.
- Teaching about caregiving and highlighting children's role in it.
- Offering awareness raising initiatives: Training sessions, school assemblies.
- Equipping schools with social workers, educational assistants, school nurses.

Assessment is a prevention; reporting is an intervention. Both have an important place, but prevention should come first when child safety is not immediately at risk.

The United Kingdom Has It Covered

Canada would not be starting from scratch. The United Kingdom passed legislation that recognizes young carers, namely the Children and Families Act 2014 and the Care Act 2014, for local authorities to legally identify and assess young carers' needs before caregiving becomes inappropriate or harmful (Gowen et al., 2021). This Young Carer's Assessment examines how caregiving affects children, without painting a picture of penalties and hardships that further pushes young caregivers to hide behind closed doors. Rather, the purpose is to provide practical supports that allow families to function while protecting children's development. This shift toward assessment has helped move young carers from being hidden to being recognized, validated, and supported within schools, healthcare, and social services (Becker, 2007; Leu & Becker, 2017).

What About This Duty for Canada?

Canada has made protecting children from harm a priority although protecting children should also mean preventing avoidable harm before

crises develop. Perhaps it is time to ask whether Canada's professional response should begin with a simple but powerful question: **Before we report, have we fully assessed?**

A national conversation about a 'duty to assess' would not replace the 'duty to report'. Rather, it would complement it by ensuring that children who are caring, not because of abuse, but because of family illness, disability, or other challenges, receive the recognition and supports they deserve. Because even though we know that interventions are often necessary, prevention should never be an afterthought, rather something that comes before it is too late!

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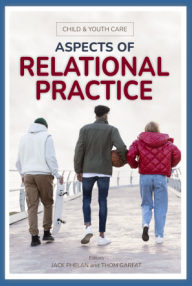

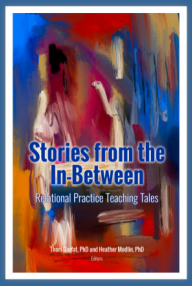

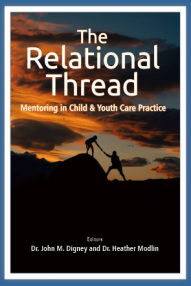

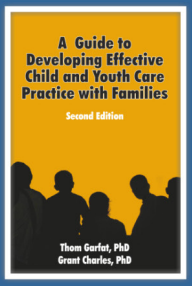

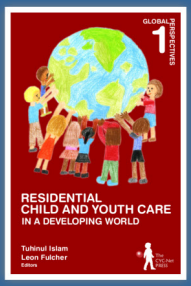

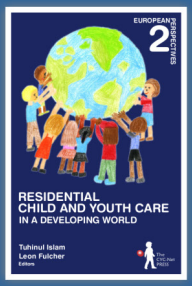

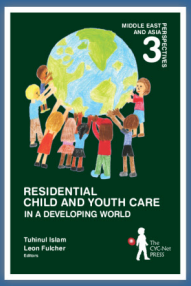

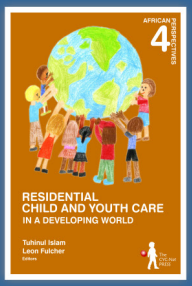

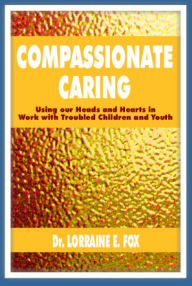

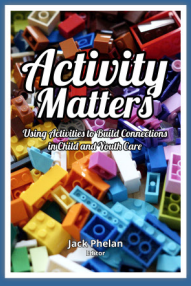

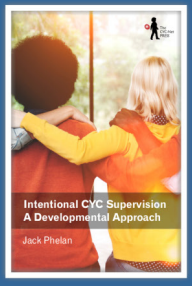

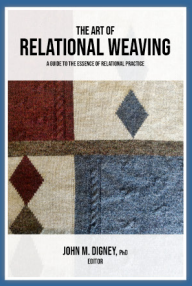

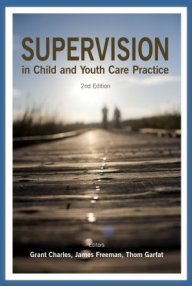

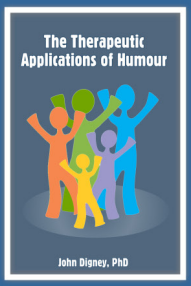

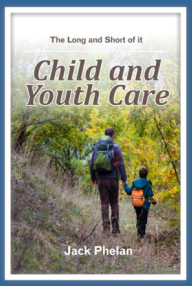

Common Sense, Caricaturization, and Recognition in Residential Services for Young People

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Abstract

In residential care settings for young people, the absence of a rigorous professional framework does not produce a neutral void. It is filled by common sense, which consists of historically produced, culturally available assumptions about who young people are and what they are capable of. The argument advanced here is that when common sense becomes the primary guide for practice, it produces what is here called the caricaturization of youth. Caricaturization is a systematic reduction of the young person that simultaneously infantilizes them, denying their capacity for agency, reflection, and accountability, and absolves them of responsibility for harmful behavior in the name of compassion. These two operations, infantilization and the exemption from accountability, are not contradictory. They are two faces of the same unexamined conception of the young person. Drawing on Gramsci's concept of common sense as ideology, the sociology of childhood's distinction between the child as 'human being' and 'human becoming,' and

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Honneth's theory of recognition, three analytical frameworks are proposed and four operational mechanisms are identified through which caricaturization is produced in practice. Those mechanisms are the infantilizing register of address, interpretive substitution, the systematic absence of consequence, and the structural dissociation between the provision of rights and therapeutic work on conduct. The last of these runs across the entire system of care, from Temporary Care Custody (TCC) to Permanent Care Custody (PCC) settings and implicates residential programs and the child and youth care practitioners within them, as well as case-managing social workers and judicial processes. A single composite hypothetical scenario, constructed solely for analytical purposes and not corresponding to any real identifiable case (any resemblance to actual situations is coincidental), traces how these dynamics accumulate over time.

Keywords

common sense, child and youth care, caricaturization, residential care, recognition, accountability.

The Confidence of Not Knowing

Ask a practitioner in a residential care setting to describe the principles that guide their work. They will mention values: respect, warmth, consistency, safety. Ask where those values come from, what conceptual foundations sustain them, what theoretical framework gives them concrete content when the situation becomes complicated, and the conversation begins to lose precision. In many residential care contexts, the values that guide practice do not emerge from systematic theoretical reflection. They

are transmitted through organizational culture, consolidated through repetition, and legitimized because they represent the way things have 'always been done.' This is not a description of deficient practice. It is a description of how common sense operates.

The analysis developed here concerns residential out-of-home care settings for young people with complex histories of trauma, neglect, or family disruption. It includes both Temporary Care Custody (TCC) programs, where young people are placed while a longer-term plan is determined, and Permanent Care Custody (PCC) settings, where placement is intended to extend through to adulthood. These settings are characterized by the presence of Youth Care Workers (YCWs) as front-line relational staff, and by the involvement of case-managing social workers and, in many jurisdictions, judicial oversight. The discussion draws primarily on the Canadian residential care context but aspires to applicability wherever analogous structures exist. It does not claim to describe every residential program or every practitioner within them. It describes structural tendencies that are recognizable across systems and that become probable when specific institutional conditions are present.

The term caricaturization, as used here, names a specific form of distortion. It is the systematic reduction of a complex young person to a simplified representation that is easier to manage than the person themselves. The concept is akin to but distinct from adjacent notions in the literature. Caricaturization differs from objectification, in Nussbaum's (1995) sense, because caricaturization does not require treating the person as an instrument for external ends. Its operative logic is protective, not exploitative. Caricaturization also differs from infantilization as discussed in the adultism literature (Flasher, 1978), because caricaturization is not primarily about age-based prejudice but about a conception of incapacity produced and maintained through institutional routines, regardless of the

explicit intentions of the actors involved. What the term names, specifically, is the process by which a structurally generated simplification of the young person becomes the operative framework for every interaction, without anyone having chosen that framework or being aware of its effects.

In residential services for young people, this reduction collapses the young person into a single register of incapacity. The reduction does not come from hostility. It comes from kindness, from the small gestures of protection and accommodation that common sense presents to the practitioner as the obvious way to care. What makes caricaturization particularly resistant to examination is that it resembles its opposite. It resembles sensitivity, genuine care, meeting the young person where they are. The practitioner who speaks to a fourteen-year-old in the tone they would use with an eight-year-old believes they are being compassionate. The institution that avoids meaningful consequence in the face of repeated harmful behaviors believes it is acting in the young person's best interest. Neither is consciously diminishing the young person. Both are acting from a framework that no longer feels like a framework. It feels like common sense.

The concern here is not with trauma-informed approaches per se. Attending to the neurological and relational effects of adverse experience is not only appropriate but necessary in residential care, and the developmental evidence supporting that attention is well established (Perry, 2018). The argument advanced here is more specific. When trauma-informed language is used as a comprehensive explanation that forecloses rather than informs engagement with the young person, it stops functioning as a clinical framework and becomes a form of common sense. The distinction between understanding behavior in context and exempting a young person from any expectation of agency is not merely semantic. It is, as the analysis will show, the line between genuine care and caricaturization.

This article is theoretical-conceptual. It does not report empirical data. Its purpose is to name and examine a phenomenon that many practitioners recognize immediately but that the field has not theorized with sufficient rigor. Three analytical frameworks are proposed to understand why caricaturization occurs and what harm it produces, and four operational mechanisms are identified through which it is produced in everyday practice. That asymmetry between three frameworks and four mechanisms is deliberate. The frameworks are analytical tools from distinct theoretical traditions, whereas the mechanisms are practical patterns that the analysis produces but that do not correspond one-to-one with each framework. The scenario described later in this article is constructed solely for analytical purposes and does not correspond to any real identifiable case; any resemblance to actual situations is coincidental. Its function is to show, through a composite case sustained over time, how the four mechanisms accumulate until they become the dominant operational framework in the relationship between a system and a specific young person. Readers from different countries and systems are invited to assess how far these patterns are recognizable in their own contexts.

Three Frameworks for What Practice Cannot See About Itself

Common Sense as Ideology: Gramsci

Antonio Gramsci (1971) wrote his notebooks from prison in the 1930s, under conditions that required coded and careful writing. From that work emerges, among other things, a theory of common sense that remains one of the most incisive tools for understanding how certain ideas sustain themselves without ever having to justify themselves. The distinction he establishes between common sense and good sense is the point of entry.

Common sense is the sedimented residue of historical processes, made up of layers of belief, value, and assumption that a society inherits from its past and reproduces through its institutions and its language. It is not systematic. It is contradictory, fragmentary, frequently inconsistent. But it is experienced as obvious, as the way things are, not as one possible interpretation among others.

What Gramsci (1971) sees clearly, and what is not always captured when his work is cited, is that common sense is not politically neutral. Common sense reproduces the perspectives that have historically held power. In the field of child and youth care, the common sense that practitioners bring to their work carries centuries of accumulated cultural and institutional belief about children and young people, including beliefs about their rationality, their capacity, their need for protection, and their relationship to responsibility. Those beliefs were shaped by domestic child-rearing, by the church, by the school, and by the juvenile court, for purposes that do not always have to do with the young people who enter residential care today. But common sense is the only thing practitioners have available when more adequate frameworks are absent.

Good sense, in Gramsci's (1971) perspective, is what emerges when common sense is subjected to critical examination, when its assumptions become visible and are tested against reality. Professional formation, at its best, is the process of critical examination. Formation makes visible the assumptions one brings to practice, examines their origins and their effects, and constructs more adequate frameworks. The question the field needs to ask is not whether that kind of formation is desirable. It is whether what formation actually provides does that work, or whether it produces something that looks like formation from the outside and leaves the practitioner's common sense fundamentally intact.

A clarification about the level of analysis is warranted here. Gramsci (1971) developed his concept of common sense as part of a theory of cultural hegemony operating at the level of society and political formations. Transposing it to the micro-institutional context of residential care requires acknowledging a scalar shift. The mechanism being invoked is not hegemony in the political sense but the analogous process by which unexamined assumptions become naturalized within a specific professional field and its institutional structures. What justifies the transposition is precisely his insistence that common sense operates through the reproduction of assumptions in everyday practice, through institutions, and through the practical activity of professional roles. The residential care setting is exactly such a site, a field of professional practice with its own culture, its own institutional logic, and its own sedimented assumptions about who the young person is and what they need. The Gramscian concept illuminates why those assumptions are invisible to those who hold them and why good sense, in this context, requires deliberate structural intervention rather than individual reflection alone.

There is an irony worth naming. The practitioner who has had some training often has more confidence in their assumptions than the one who has had none, because training without critical reflexivity does not alter common sense (Gharabaghi, 2010). Training dresses common sense in professional language. The practitioner who has been introduced to trauma-informed practice without rigorous conceptual grounding now has a new vocabulary for assumptions they already held. Trauma becomes the explanation for everything, a framework so expansive it stops functioning as a framework. The young person is not treated as a complex individual. They are managed as a symptom. Freeman (2014) documented exactly this phenomenon, showing that the proliferation of therapeutic terms in the

everyday language of residential care frequently functions as a layer of legitimacy over practices that have not actually changed.

The Young Person as Social Actor: The Sociology of Childhood

Caricaturization has a specific conceptual architecture. To understand it, one must examine what conception of the young person it rests on. James and Prout (1997) identified two competing models that structure, frequently without anyone making them explicit, the practices of institutions working with children and young people. The first, which they called the 'human becoming' model, understands the child as an incomplete human being, defined by what they lack in relation to the adult endpoint toward which they are developing. Not yet rational, not yet responsible, not yet an adequate social actor. A project. The second model proposes something different. It understands the child as a 'human being,' a full social actor in the present, with perspectives, competencies, and modes of participation that deserve to be taken seriously now, not when they reach adulthood.

The practical consequences of this distinction are direct. The practitioner who operates from the 'human becoming' model, whether they know it or not, tends to speak for the young person rather than with them. They interpret behavior rather than engage the young person about it. They protect the young person from consequences rather than accompany them through the process of navigating those consequences. The young person's account of their own experience carries less authority than the professional interpretation. Their reasoning is not taken seriously even when their emotions are acknowledged. Vis et al. (2011) reviewed studies on young people's participation in care decisions and documented that even when systems have legal obligations to consult the young person, actual participation is mostly symbolic. Young people are informed, not heard.

In residential care, the 'human becoming' model is especially persistent, and the reasons for that persistence are not arbitrary. The young people in these settings have, by definition, been removed from their families of origin because those environments could not provide adequate care. Their presence in residential care is already a product of a system that has assessed them as requiring intervention, protection, or both. The institutional logic of out-of-home placement is organized around what the young person lacks, whether a stable family, adequate parenting, or a safe environment. That deficit framing is built into the structure of care from the outset, and it shapes every subsequent interaction. The practitioner who observes the effects of trauma, instability, and relational disruption on a young person's behavior finds confirmation, at every turn, of the framework that says the young person is not yet capable. The framework generates the evidence that confirms it. That is what Gramsci (1971) meant by the self-validation of common sense, which structures perception in ways that make alternative interpretations of the same evidence difficult to access.

The critical distinction is between two observations that look similar. The first is that this young person's developmental trajectory was affected by adverse experiences, and that this informs how the practitioner understands and responds to specific behaviors and needs. The second is that this young person is not capable of agency, reflection, or accountability. The first is clinical sensitivity. The second is a caricature. And the caricature, once installed as the operative framework, shapes every interaction in ways that produce the same incapacity it assumes. Garfat and Fulcher (2012) put this in relational terms, arguing that genuine encounter in child and youth care requires engaging with the young person as they actually are, not as the file or the diagnosis suggests they should be. That is not optimism. It is rigor.

Recognition and its Distortions: Honneth

Axel Honneth (1995) argued that the young person's practical relation to themselves, their self-confidence, self-respect, and self-esteem, is not a private achievement. It depends on being recognized by others in three spheres: that of affective care, which grounds self-confidence; that of right, which grounds self-respect; and that of social esteem, which grounds self-worth. Each sphere has its correlative form of disrespect. The thesis that Casas Corrales (2026) applied to the intake process, that placement decisions produce conditions of recognition or disrespect before any intervention begins, has a logical extension here. If intake configures the environment, the everyday practice within that environment populates it with interactions that either recognize the young person as a full participant or systematically reduce them.

What makes the framework of Honneth (1995) especially useful for this analysis is its insistence that disrespect does not require hostility or intention. The most damaging forms are enacted through the routines of care itself. When a practitioner systematically speaks to a young person as though they cannot understand or interpret their own experience, the practitioner denies recognition in the sphere of social esteem. When an institution declines to hold a young person accountable for their conduct, the institution denies recognition in the sphere of right, communicating that the young person is not a legitimate agent whose actions carry weight. Those denials are not experienced as attacks by those who enact them. They are experienced as care. That is exactly the problem.

Marshall et al. (2020) demonstrated that recognition in residential care settings is structured by institutional conditions, not only by individual dispositions. That connects directly to Gramsci (1971). Institutional common

sense produces the conditions under which disrespect becomes systematic rather than accidental.

There is a genuine tension the field cannot sidestep. Voices within child and youth care have argued that even well-grounded expectations and consequences can replicate dynamics of control that have historically harmed young people in institutional settings (Gharabaghi, 2010; Smith, 2009). That concern is legitimate and should not be dismissed. What the empirical record suggests, however, is that the field has not so much resolved this tension as declined to theorize it. Gharabaghi and Phelan (2011), in a qualitative study of residential staff teams in children's mental health and private group care facilities, found that a strong reliance on control-based approaches persists and that very little conceptual or theoretical thinking informs how teams discuss or approach holding young people accountable for their actions. That finding is the hinge of the present argument. Where conceptual thinking about accountability is absent, what fills the space is not a considered position on the risks of control. It is common sense, which oscillates between control and its avoidance without examining either. The distinction between accountability and punishment is exactly what child and youth care practitioners, case-managing social workers, and the systems within which they work need to examine with rigor, rather than collapsing both categories into the comfort of compassionate common sense.

Four Mechanisms of Caricaturization

Caricaturization is not an event. It is accumulation. No single interaction produces it. It is the sediment of many interactions, each unremarkable on its own, until the young person lives within a relational structure that has systematically told them who they are. The four mechanisms described

below are not a typology of independent variables. They have a structural logic. The register of address establishes the relational frame within which the young person is perceived. Interpretive substitution operates within that frame to foreclose the young person's own account. The absence of consequence consolidates what the frame communicates about the young person's moral status. And the dissociation between rights and therapeutic work extends and institutionalizes that same logic across the entire system of care. Each mechanism presupposes and reinforces the others. Together, they produce not a set of separate errors but a coherent, if unintended, institutional practice.

The Register of Address

Language carries more information than its propositional content. The tone, vocabulary, and relational posture with which the practitioner addresses the young person communicate, before anything is said about the content, what kind of young person the practitioner perceives to be in front of them. When that register corresponds to an adult addressing a much younger child, it communicates that the practitioner does not perceive the young person as capable of genuine exchange. It is not a conscious choice. It is the reproduction of a culturally available model that positions the vulnerable young person as someone to be soothed rather than engaged. Gharabaghi (2010) described this posture as therapeutic niceness, a stance that prioritizes the avoidance of discomfort over genuine encounter and that produces a superficial relationship serving neither the young person's development nor the practitioner's professional growth.

Interpretive Substitution

When a young person's behavior is explained through the file or through pre-existing clinical categories, without anyone asking the young person what they think is happening, the interpretation does not illuminate their experience; it replaces it. Fricker (2007) called this testimonial injustice in its most insidious form. The problem is not the outright rejection of testimony but the systematic privileging of one form of knowledge, professional interpretation, over another, the young person's self-report. That privileging rests on reasons that have nothing to do with the quality of the evidence and everything to do with who produces it. The question institutional culture tends to deflect is also the most necessary. What does the young person know about their own behavior that the professionals in the room do not?

The Systematic Absence of Consequence

When an institution declines to hold a young person accountable for repeated harmful behaviors, it communicates something it does not intend to communicate. It communicates that it does not believe they are capable of acting differently. In the framework of Honneth (1995), accountability is not a disciplinary concept. It is a recognitive one. To hold someone accountable is to recognize them as a moral agent whose choices carry weight and who can understand their consequences. Refusing accountability is refusing that recognition. Smith (2009) argued that the relational traditions of residential care have always understood the combination of warmth and expectation as the core of the work, not warmth instead of expectation. The young person who is never held accountable does not feel protected. They feel untouchable in the worst sense, placed beyond the reach of ordinary human expectations.

The Dissociation Between Rights and Therapeutic Work

This fourth mechanism is the most widespread and the most systematically invisible. It does not operate only within care institutions. It runs through the entire system, from case-managing social workers to the judicial processes that determine the young person's legal status, and it traverses both TCC and PCC settings. The role of the case-managing social worker is distinct from that of the YCW, in that the former holds statutory responsibility for the young person's overall plan rather than for daily relational care. The precise name for this mechanism is the structural dissociation between the provision of rights and therapeutic work on conduct.

The argument is not that the system provides resources poorly. On the contrary, the young person has a right to clothing, technology, medical

attention, and dignified living conditions, regardless of their behavior. That provision is correct from a rights perspective and must not be conditioned on conduct. The problem is what happens at the same time. Those needs are met completely disconnected from any process of work on the behavior that harms others and the young person themselves. The result is a young person whose material needs are guaranteed and whose harmful behaviors encounter no framework that challenges them, names them, or places them in relation to their effects on others.

This pattern tends to be especially pronounced in TCC settings. The temporary nature creates an additional incentive to avoid conflict; when a case is theoretically transitional, the urgency of escalating it diminishes. The case-managing social worker may prioritize immediate stability. The residential program may prioritize the young person not generating reportable incidents. The judicial process may focus on determining legal status rather than asking whether the care plan includes a methodological approach to conduct. In many contexts, the logic that predominates across those different levels is the same, which is to manage the distress rather than work the development. In PCC settings the situation does not automatically improve; permanence can generate greater institutional passivity because the sense of urgency dilutes. Anglin (2002), in a comparative study of residential programs in Canada, documented that the absence of an explicit methodological framework for work on conduct is one of the factors that most consistently distinguishes programs with worse outcomes from those with better outcomes. Gharabaghi and Stuart (2013) have noted that the proliferation of de-escalation approaches without a parallel work framework can produce exactly this effect, containing behavior in the short term while addressing no dimension of development.

What the field has not examined with sufficient rigor is the difference between two propositions that are frequently confused. The first is that the

young person's needs must be met unconditionally, because they are rights. The second is that work on harmful conduct must be a constitutive part of the care plan, because it is part of development. These two propositions do not compete. They are complementary. When institutional common sense collapses them, the result is a system that provides rights and omits development, that guarantees comfort and evades the most difficult question. How do we help this young person understand that their actions have effects on others and that there is both an expectation, and a possibility, that they act differently?

From Honneth (1995), what is missing in this dissociation is recognition in the sphere of right in its fullest sense. What is missing is not only the right to receive, but the recognition that the young person is an agent whose actions carry moral weight and who can therefore be held responsible for them. A system that guarantees the young person's rights as a recipient of care but does not recognize them as a responsible moral agent offers an incomplete recognition, one that reproduces the same caricature as the previous mechanisms. The young person becomes a human being in process, not yet fully capable, to be managed rather than engaged.

A Composite Scenario for Reflection

The scenario that follows is hypothetical, constructed solely for analytical purposes. It does not correspond to any real identifiable case or to any specific organization; any resemblance to actual situations is coincidental. It is not here to illustrate what others do wrong. It is here to show, through the same young person at different moments, how the four mechanisms accumulate until they become the dominant framework in the relationship between a system and a specific young person. The question

that follows each moment is not rhetorical. Is this pattern recognizable in the context where I work?

The First Encounter: What the Tone Already Decided

A fifteen-year-old enters a Temporary Care Custody (TCC) residential program. Their history includes family neglect, multiple placement changes, and a conduct disorder diagnosis. In their first week they have a heated argument with another resident. The Youth Care Worker on shift approaches with a soft voice, simple vocabulary, and a deliberate calm one would associate with managing a much younger child. The young person calms down. The worker steps back, satisfied that the immediate situation has been contained.

Regulating before reasoning is neurologically sound. Perry (2006) has argued that a young person in a state of acute distress operates primarily from lower brain regions associated with survival responses, and that meaningful reflection becomes possible only once the nervous system has settled. The worker's instinct to approach calmly and de-escalate first is not the problem. What happens next is. Once the young person is regulated, no one returns to ask what happened from their perspective, what triggered the conflict with the other resident, or what they think they might have done differently. The regulated state, which was the starting condition for genuine encounter, becomes the endpoint of the interaction. The situation was managed. The encounter never took place.

From Gramsci (1971), the gap between regulation and engagement is not accidental. It reflects a cultural repertoire of what caring for a young person in crisis looks like, a repertoire that stops at containment and does not include the expectation that the young person will account for their experience. The worker has no awareness of having communicated

anything about their conception of the young person. They believe they did their job well. What the young person learned in that first encounter was not only how to be regulated but also what kind of young person the institution believes they are, and what it expects, or does not expect, of them once the crisis passes. That learning is not in any file. But it orients every interaction that follows.

The Weeks That Follow: The Explanation That Closes the Door

Three weeks after admission, the young person has spent ten days refusing to attend school. The team meets. The young person is not present and was not invited. The meeting produces a consensus explanation, namely avoidance behavior related to documented trauma history with school. The support plan is updated. After the meeting, the supervisor informs the young person of the decisions. The young person responds that the problem is not school in general but a specific conflict with a classmate that no one had asked about. Their response is recorded in the file as 'resistance to intervention.'

There is a circularity in this sequence worth examining. The young person was excluded from the process that produced the explanation of their behavior. When they dispute that explanation with information that would have changed the analysis, their dispute is reabsorbed by the same framework that excluded them. If they had insight, the reasoning goes, they would agree. The framework becomes unfalsifiable. From Fricker (2007), the young person's testimony is not rejected because it is implausible. It is subordinated because of who they are. Vis et al. (2011) documented that this dynamic is structural. When professionals perceive the young person through the 'human becoming' model, they tend to filter their participation

through prior interpretations rather than update those interpretations with what the young person says.

Two Months Later: The Kindness That Does Not Hold

The young person presents recurring episodes of verbal aggression toward staff and on two occasions damages property in the home. Each incident is processed through debriefings, behavior support reviews, and notes in the file. What does not occur is any response that communicates, clearly and consistently, that these actions have real consequences for those who share the space with them. The team's justification, articulated sincerely, is that imposing consequences would risk re-activating trauma responses in the young person given their history. How long can that argument hold when other residents begin to feel unsafe, when staff carry week after week the weight of incidents that find no response, when the young person themselves receives no signal that anything needs to change?

The critique that the framework of Honneth (1995) makes of this situation is not that the team is cruel. It is that they confused compassion with the absence of expectation. To hold someone accountable for their actions is to recognize them as a moral agent whose choices carry weight. The institution, by protecting the young person from meaningful consequence, communicates that it does not believe they are capable of being otherwise. Smith (2009) has noted that the relational traditions of residential care have always understood structure and expectation as constitutive parts of care, not as its negation. The question the institution needs to ask is not whether accountability is punitive. It is what the absence of accountability communicates, and whether that is the message it would choose to send if it were aware it was sending it.

At Three Months: The Dissociation the System Normalized

The case-managing social worker conducts a review visit. The young person has had more incidents; on one occasion they physically assaulted a staff member. The social worker listens to the report, records the incidents in the file, and proceeds to manage the young person's material needs, including seasonal clothing, replacement of damaged personal items, and an update to their technological device. All of this is correct. The young person has a right to those things. What does not occur in that visit, or in the next, or in the judicial review that determines the continuation of TCC status, is any question about what specific work the program is doing regarding the harmful behaviors. It is not asked because no plan exists. And no plan exists because the system, from the social worker to the judge, has operated with the same implicit logic. Guaranteeing the young person's immediate wellbeing is the objective, and addressing the conduct of their actions is a secondary problem managed case by case.

This logic is not anyone's error. It is the product of a system that has not formulated the most basic question. Anglin (2002) documented that the absence of a methodological framework for work on conduct is one of the factors that most consistently distinguishes programs with worse outcomes, and it is not a marginal deficiency but a structural gap that runs through the complete logic of intervention. Gharabaghi and Stuart (2013) add something more precise, showing that the prioritization of de-escalation over foundational work produces young people whose behavior is momentarily contained but not transformed. What the social worker did in that visit, and what the judge did not ask in the review, is not negligence. It is the natural expression of a system that has implicitly resolved that those questions belong to no one.

Is this pattern recognizable? The visit that closes without conflict, the judicial review that approves the continuation without asking about work on conduct, the file that grows with incidents but not with response plans. And the young person, who has spent three months in a system that guarantees their rights and asks nothing of them regarding their relationship with others, has received a very clear message about who the system believes they are.

From Honneth (1995), the dissociation between the provision of rights and therapeutic work produces an incomplete recognition that damages as much as its absence. The young person is recognized as a recipient of care but not as a moral agent. They have rights but no responsibilities. They are inside the system but excluded from the expectation that their choices matter. This is not trauma-informed care. It is the caricaturization of the traumatized young person, reduced to their needs, exempted from their agency, managed rather than engaged.

At Four Months: The Framework is Fixed

A placement review is convened. The meeting, again without the young person, reviews progress against the objectives set at intake and makes decisions about the coming months. Afterward, the supervisor informs the young person of what has been decided. The young person responds with anger. They say they need to maintain contact with their family and that the only positive bond they have is with a specific teacher that the proposed school change would eliminate. The team listens. At the next meeting, the team concludes that the young person is struggling with the changes, consistent with their pattern.

The circularity is complete. The young person's substantive objections, which contain clinically relevant information about what sustains them, are

processed as evidence of their difficulty with transitions rather than as evidence about what conditions matter for them. At four months, the framework is fixed. The young person is difficult, their behavior is symptomatic, their responses are predictable. No one in the system decided this explicitly. It happened one interaction at a time, from the first encounter where regulation ended without genuine engagement, to the last visit without a plan for working on conduct.

What would have needed to be different for this young person to reach the fourth month with a different framework? A formation that had given the YCW the tools and the expectation to return to the young person after regulation, to open rather than close the encounter? A supervision structure that had made visible the circularity of the unfalsifiable file? A case-managing social worker who in every visit had asked not only what the young person needs materially but what the program is doing about their conduct? A judicial process that had made that question a condition of the continuation of TCC status? These are not rhetorical questions. They are the ones the field should be asking, at every level, before the young person crosses the door.

What Makes Caricaturization Probable

Attributing what happens in this scenario to the failures of individual practitioners would be comfortable. It is more accurate to understand it as the product of four institutional conditions that, when they coexist, make caricaturization structurally probable.

The first is the gap between what the work requires and what formation provides. In many jurisdictions, front-line staff receive primarily procedural training in risk assessment, documentation, and intervention protocols. The conceptual foundations that would allow them to examine their own assumptions about who young people are and what genuine care requires

are absent or present in a decorative way. Gharabaghi (2010) has argued that this gap reflects an implicit decision by the field about what kind of practitioner it wants to produce, whether technicians who implement procedures or relational professionals who exercise judgment grounded in theory and reflection. When the field settles for the first model, common sense fills the conceptual space that model leaves empty.

The second is the absence, or the inadequacy of critical supervision. Fewster (2002) described reflective supervision as the space in which practitioners learn to ask questions about their own internal processes and their effects on the young people they serve. When supervision is reduced to administrative monitoring, that space disappears. The Gramscian sedimentation process operates unchecked. Each unreflective interaction reinforces the framework that produced it, until what began as an assumption has become a habit so deep it feels like professional identity.

The third is the absence of effective mechanisms for the young person's participation in decisions that affect them. Thomas (2000) argued that genuine participation of young people in care is not only a question of rights; it is a source of knowledge that care systems systematically underuse. When case reviews and support plans are produced without the young person's real participation, the institution structurally reproduces the 'human becoming' model, treating the young person as an object of planning rather than a participant in it.

The fourth condition is more difficult to name precisely because it has no single responsible party. It is the absence of articulation among the actors of the system. The case-managing social worker, the residential program, and the judicial process each operate from their own logic, with their own objectives and their own timelines. What none of them requires is that the care plan include a methodological approach to harmful conduct. The social worker verifies immediate wellbeing. The program manages incidents. The

judge reviews legal status. And the question of what the system is doing to help this young person understand the relationship between their actions and their effects on others, that question, is formulated by no one. Not because it is unknown. Because the common sense of the system has resolved, without saying it, that it falls within no specific mandate. The harm produced by that omission does not appear in any report. It appears in the young person.

Conclusions

Caricaturization is not a marginal phenomenon. It is a structural possibility that arises with predictable regularity when formation is insufficient, supervision is inadequate, the young person's participation is symbolic, and the system has not articulated who is responsible for the work on conduct. Understanding it as structural is not a way of excusing it. It is the prior condition for addressing it.

Gramsci (1971) gives us the most uncomfortable instrument, which is that of self-visibility. Common sense does not announce itself as assumption. It feels like the obvious, like the natural response to the situation. That means the antidote is not good intentions. It is structures that oblige the practitioner to ask what they would otherwise not ask. The sociology of childhood identifies what is at stake in each of those unformulated questions, which is the conception of the young person. Every time the system treats the young person as a project rather than a person, as a problem rather than an actor, as a recipient rather than an agent, it is taking a position on who that young person is and taking it without knowing it. That is exactly the condition under which the harm becomes most difficult to interrupt. Honneth (1995) names that harm. It is disrespect, not as an act but as the accumulated result of a system that has decided, without deciding, what the young person is worth.

The question left open here is not what the practitioners in the analyzed scenario did wrong. It is what conditions made probable what they did. And that question cannot be answered by individuals alone. When you adjust your tone of voice to speak with a young person and then step away once they are calm, what does that sequence communicate about what you expect from them? When your team explains their behavior without asking them, what does that communicate about whose knowledge holds authority? When the system guarantees their rights but includes no plan for working on what harms others, what is it telling them about who it believes they are? And where did the answers to those questions come from? Were they ever examined, in any meeting, in any supervision, in any instance of the system where someone had both the authority and the disposition to ask them? Or did they simply feel like the obvious thing to do?

The field has the theoretical resources to answer these questions rigorously. What it does not yet have, in many contexts, is the institutional architecture that makes them obligatory rather than optional. And that difference is not minor. As long as those questions depend on the individual initiative of someone at some point in the chain, their occurrence will be as variable as the people who occupy those roles. It is worth asking whether a system that places the possibility of good care in the hands of personal initiative rather than structural conditions is really organized to care, or for something else.

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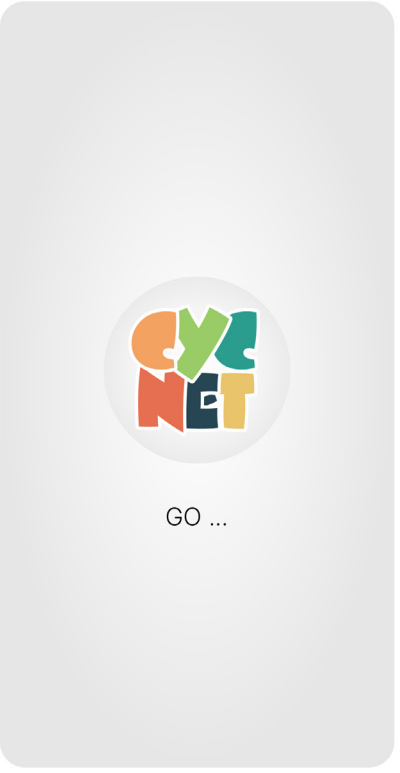

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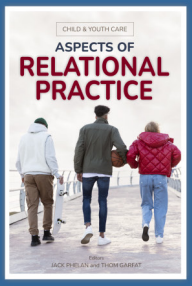

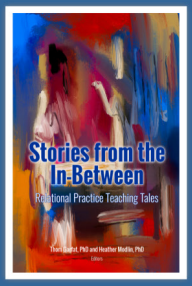

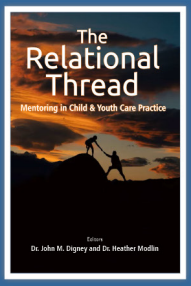

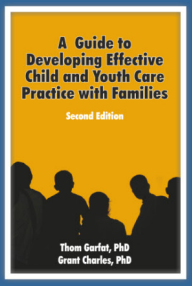

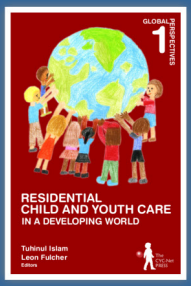

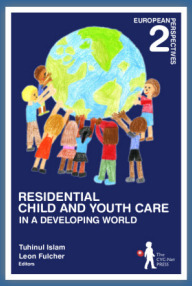

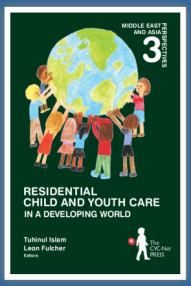

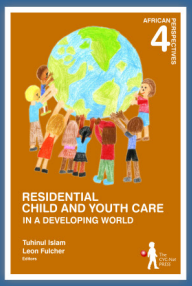

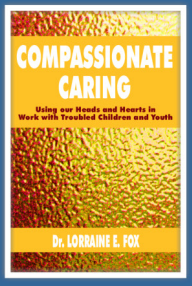

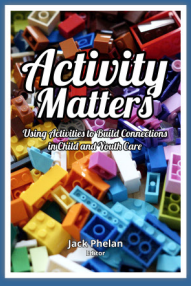

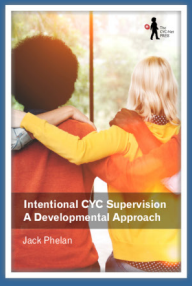

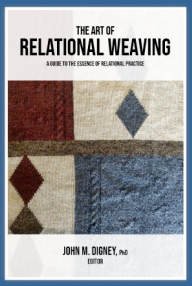

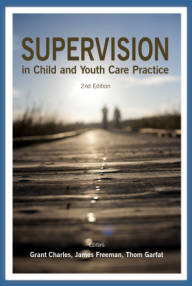

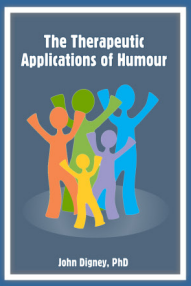

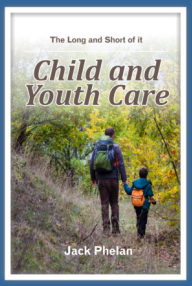

Move More, Worry Less?

What 38,000 young people can teach us about mental health

Gary Goldfield

For years, conversations about youth mental health have focused on therapy, medication, screen time, and social media. Yet one of the most accessible interventions may be hiding in plain sight: exercise.

A major 2026 umbrella review published in the *Journal of the American Academy of Child & Adolescent Psychiatry* analyzed the findings of 21 systematic reviews, incorporating 375 randomized controlled trials and more than 38,000 children and adolescents. The question was simple: Can exercise meaningfully improve symptoms of depression and anxiety in young people? The answer was a resounding yes.

Mental health challenges are rising

Depression and anxiety have become some of the most common health concerns facing young people. The authors note that approximately one in four children and adolescents experience elevated symptoms of depression, while about one in five experience elevated anxiety symptoms. These challenges can affect academic performance, relationships, self-esteem, and long-term well-being, often persisting into adulthood if left untreated.

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Although psychotherapy and medication remain important evidence-based treatments, many young people never receive them, and others experience limited benefits. Cost, accessibility, stigma, and treatment adherence continue to pose significant barriers. This has prompted increasing interest in interventions that are effective, affordable, and easier to implement in everyday life.

The exercise effect is real

After pooling evidence from hundreds of studies, the researchers found that exercise produced clinically meaningful reductions in symptoms of both depression and anxiety among children and adolescents. The effects were remarkably consistent across diverse populations, including healthy youth, those with diagnosed depression, ADHD, obesity, cancer, and other clinical conditions.

Notably, the magnitude of benefit observed for exercise was similar to, and in some cases larger than, the effect sizes reported in previous meta-analyses of traditional treatments such as antidepressants and psychotherapy. The authors note that exercise generated improvements similar in magnitude to those previously observed in adult mental health research, suggesting that physical activity should be viewed as a legitimate therapeutic tool rather than merely a wellness recommendation.

It is not just about running

Not all movement appears to have the same impact.

For depression, the strongest effects were observed with mixed-mode exercise, which combines aerobic and resistance activities, and with moderate-intensity exercise. For anxiety, resistance training emerged as the most effective approach. Interestingly, extremely intense workouts

were not necessary. In some cases, lower or moderate intensities appeared more beneficial than vigorous exercise. Importantly, exercise benefits for depression in youth were nearly identical to those previously reported in adults, suggesting that the mental-health benefits of physical activity extend across the lifespan.

This is an important message for families. Improving mental health does not require children to become elite athletes or spend hours in the gym. Walking, recreational sports, circuit training, strength exercises, dance, and other enjoyable activities may all contribute to better psychological well-being.

Short-term efforts can yield meaningful results

Another surprising finding was that programs lasting less than 12 weeks produced larger improvements in depression symptoms than longer interventions. Researchers speculate that motivation and engagement may be highest during the early phase of participation, when activities feel novel and rewarding. However, in those who stuck with their exercise routine, the benefits in anxiety were maintained.

The good news is that benefits did not depend heavily on how often children exercised each week or how long individual sessions lasted. This flexibility may make exercise one of the most practical mental health tools available to schools, clinicians, and families.

Why might exercise work?

The answer appears to involve both the brain and behavior. Exercise can increase levels of brain-derived neurotrophic factor (BDNF), which supports brain plasticity and healthy neural functioning. Physical activity also influences neurotransmitters such as serotonin and dopamine,

regulates stress-response systems, and can improve sleep quality. Psychologically, exercise can enhance confidence, create opportunities for social connection, provide distraction from negative thoughts, and foster a sense of accomplishment.

In other words, exercise is not simply burning calories. It is a biologically and psychologically active intervention.

A shift in how we think about treatment

The most important takeaway from this study is not that exercise should replace therapy or medication, but rather, it suggests that movement deserves a much more prominent place in conversations about youth mental health and throughout the lifespan.

For clinicians, educators, and parents, the message is clear: Physical activity is no longer just a recommendation for physical health. It is an evidence-based strategy that can help alleviate symptoms of depression and anxiety across a wide range of young people.

As rates of youth mental health concerns continue to climb, some solutions may require new technologies, policies, or treatments. Others may be surprisingly simple. A structured exercise program, a sports team, a strength-training class, a yoga class, or even regular opportunities to move may be among the most powerful mental health interventions we have been overlooking.

Key points

- Exercise significantly reduces depression and anxiety symptoms in youth, based on 38,000+ participants.
- Moderate and resistance exercise are especially effective; vigorous activity isn't required.

- Physical activity should be a core part of youth mental health prevention and treatment.

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Echoes of Courage and Hope

Paul W. Baker

Courage and hope are powerful forces that can reshape a young person's life, especially in the face of adversity and uncertainty. For youth who have experienced trauma, these qualities are not always instinctive – they are learned, nurtured, and strengthened through supportive relationships. This story explores how courage can emerge through connection and how hope can grow when someone believes in your potential.

In the heart of a small urban Texas therapeutic day program, 14-year-old Alex, a young person with a significant trauma history, paced the worn linoleum floors, his fists clenched and his face twisted in frustration. Alex had always been the kid who lashed out – knocking over chairs during group activities, storming out of conversations, or isolating himself when things got tough. His teachers called it 'behavioral issues,' stemming from a chaotic home life where his single mom worked double shifts and his absent father was just a faded memory. Deep down, Alex yearned for control, but every setback felt like a personal defeat, wiring his brain to react with anger rather than resilience. He watched other kids at the center effortlessly glide on skateboards in the outdoor park, laughing and high-fiving, but the

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thought of trying it himself terrified him. “What if I fall? What if they laugh?” he’d mutter to himself; his mind trapped in a cycle of self-doubt.

Enter Ms. Jordan, a seasoned Child and Youth Care worker with the local CYC program. She wasn’t the type to lecture or punish; instead, she believed in meeting kids where they were – in their life-space, in the raw moments of everyday struggles. From their first encounter, Ms. Jordan focused on building a genuine connection. She sat with Alex during lunch, not probing his past traumas but sharing light stories from her own youth about overcoming fears.

“You know, Alex,” she said one day, “our brains are sort of like muscles. When we connect with others and try new things, it actually rewires those pathways – makes us stronger, more adaptable.” This was her awareness of interpersonal neurobiology, explaining how positive relationships could calm the storm in his amygdala, the brain’s fear center, and foster emotional regulation through shared experiences.

Alex eyed her skeptically at first, but Ms. Jordan persisted with a relational approach, consistently showing up with empathy and authenticity. She didn’t see Alex as ‘problematic’; instead, she highlighted his strengths.

“I’ve noticed how observant you are,” she’d say. “You spot things others miss – like how that kid balanced on the board by shifting his weight just right. That’s a real talent for detail.”

This strength-based perspective shifted the narrative from Alex’s deficits to his potential, boosting his self-efficacy. Drawing from positive psychology, she encouraged him to practice gratitude for small wins: “What went well today? Even if it’s just showing up.”

Over weeks, their bond grew – through shared games, walks in the park, and honest talks about feelings. Ms. Jordan modeled vulnerability, sharing how she once feared public speaking but built courage through tiny steps,

reinforcing that optimism and perseverance could transform challenges into growth.

One afternoon, the therapeutic turning point arrived.

The skate park buzzed with energy, and Alex hovered at the edge, board in hand, his heart pounding. “I can’t do this,” he whispered, his old behaviors bubbling up – ready to throw the board and run.

Ms. Jordan knelt beside him, her presence a steady anchor. “Remember, Alex, we’re in this together. Your brain’s already wired for bravery; you’ve shown it in how you’ve opened up to me. Let’s focus on what you can do – start with one push.”

Her words echoed relational trust, reminding him that he wasn't alone. With a deep breath, Alex stepped on the board. He wobbled, fell once, but got up laughing – not out of embarrassment, but genuine joy.

By the end, he managed a short glide, his face beaming with pride. "I did it!" he exclaimed, high-fiving Ms. Jordan. In that moment, he felt the shift: courage wasn't about perfection; it was about trying, supported by someone who believed in him.

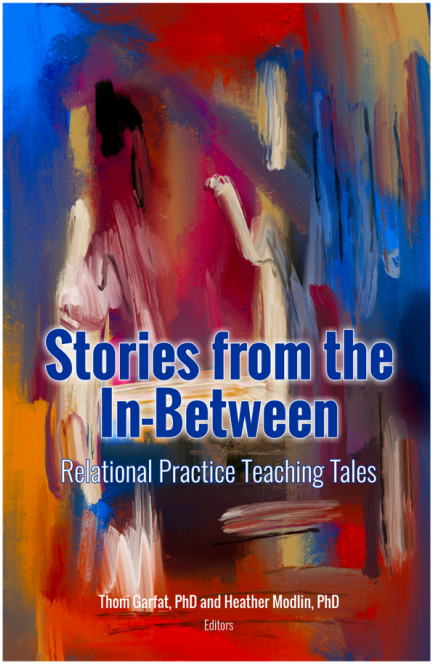
As Alex's confidence grew, so did his ability to manage his behavior, turning outbursts into conversations and isolation into connection. The day program became his safe space, where relationships healed and strengths flourished. Through his journey, Alex learned that courage is not the absence of fear, but the willingness to try despite it, especially when supported by someone who believes in you. Hope emerged as he began to see his own strengths and possibilities, transforming setbacks into opportunities for growth. Ultimately, Alex discovered that with relational support, self-awareness, and small steps forward, both courage and hope can become lasting tools for resilience and change.

Reflective Questions

- How can CYC workers effectively use everyday interactions and real-time experiences to support developmental growth, emotional regulation, and meaningful change?
- In what ways can practitioners identify and amplify a young person's strengths to promote self-efficacy, resilience, and a more positive self-narrative?
- How can CYC practitioners intentionally build authentic, trust-based relationships within the life-space to foster safety, connection, and emotional growth?

DR PAUL W. BAKER is a neuropsychologist with professional experience as a special education teacher, school principal, Director of Clinical Services, Chief Operating Officer, Chief Executive Officer, and is the developer of The PersonBrain Model, a NeuroTransactional approach to help transform challenging behaviors through hope, neuroscience, and relational practice. Dr. Baker is the co-author of *The Hopeful Brain, The Minded Brain, and Better Behaviour … Positively*, a frequent speaker at professional conferences and consults with organizations internationally across a wide range of human service areas. He is a former foster carer for 29 young people and the adoptive parent of four amazing humans.

This is the fifth of six chapters being published in CYC-Online from the new book Stories from the In-Between: Relational Practice Teaching Tales. (Garfat and Modlin, eds. CYC-Net Press)



Becoming the Diagnosis

Hans Skott-Myhre

It is Foucault who warns us that often times the most repressive functions of modern society are carried out by institutions whose mission appears to be benign, if not actually helpful. In his work, he points out the ways in which modern society has removed the most obviously brutal forms of repression in the name of social progress. For example, the contemporary narrative about institutions of incarceration and punishment argues that we have moved beyond brutal forms of punishment in favor of more humane approaches to social deviants such as delinquents, criminals, and mad people. However, Foucault argues that what we have really done is to become more sophisticated and less obvious in the ways in which we discipline and control minoritized populations.

For example, our "enlightened" account of madness describes how we now have mental health and trauma informed care rather than brutal asylums. We are told that we are working towards destigmatizing mental illness and only use institutional incarceration and forced treatment under extreme circumstances. Instead of ridiculing the mentally ill, a contemporary mantra, in today's society, is to treat each other with kindness. Models of relational care permeate the helping professions with the admonition that we all need psychiatry and psychology to heal our trauma and toxic relationships. The common discourse is that mental health services provide enlightened and humanistic evidenced based care for those suffering emotionally and psychologically.

However, Foucault would argue that all of this is an elaborate architecture designed to create subjects amenable to psychiatric and psychological control on behalf of the logic of the existing system. I could say the "ruling class" here, but even the top echelons of global virtual capitalism are subject to internalized discourses of psychological and psychiatric pathology. If we accept Foucault's assertion that the industry of mental health services is a facade for discipline and control, then those subject to its assistance are at risk for misunderstanding the conditions of their own oppression.

The horror of all of this is that there actually is quite a lot of dystopic lived experience across our society today. The social field of civil society is increasingly vacuous. The social structures that were designed to provide social comfort and a sense of belonging are less and less functional all the time. As a result, an increasing number of us feel psychologically or emotionally broken or inadequate. Regrettably, this very real sense of disconnection is precisely what the mental health industry is designed to exploit but not necessarily remedy.

I don't mean to say that the practitioners of this array of mental health services are in any way pernicious or less than sincere in their efforts to be helpful. They see suffering and they do their best to alleviate that pain. It is the social architecture in which they work that is suspect, not the practitioners themselves. Of course, that is not to say that there are not less than ethical practitioners, but they are not the majority. Not are they emblematic of those whose good intentions inform their work every day.

But there is a reason for burnout that is not to be found in the toxicity of those seeking service. The frustration that underlies burnout, at the most basic level, is that workers believe that what they are doing should work. And there is enough short-term success to keep that belief in the mental health system operational. There are enough patient blaming discourses,

such as the as the belief in resistance to treatment, denial of symptoms, transference, and so on to give succor to the worker when what should work doesn't yield the desired results. However, I would argue that, at the core of burnout is the gradual realization that there is an intolerable degree of futility in all the good intentioned practices of psychiatric and psychological care.

Of course, there is research that gives an ongoing discourse of evidence-based practice that tells us that what is done is effective. And for a while, perhaps for a whole career, this belief that what we do should work can allow for a level of comfort and a blurring of our vision such that we highlight our successes and excuse our failures. However, buried in statistics and integral to the ability to find evidence-based methodologies is the ability of the system to set the parameters for success.

The question of how we measure the effectiveness of psychological and psychiatric intervention is saturated with the logic of the dominant system of virtual global capitalism. The anti-psychiatrist Franco Basaglia said that he believed psychiatry should be a practice of freedom that liberates patients. Notably he suggested that such liberation should eliminate institutional control and social exclusion. In his work on dismantling the asylums he envisioned a practice of psychiatry that focused in enhancing lived experience, sociality, and human dignity. He maintained that true healing necessitated open human connections.

Certainly, in a field such as CYC the question of true care is also reliant on lived experience, sociality, human dignity, and open human connection. But when we look at the evidenced based outcomes that indicate success in current psychological and psychiatric practice, we are largely looking at symptom reduction and behavioral compliance with social norms.

Even when fields such as social psychiatry take sociality into account, it is in the service of symptom reduction and behavioral stabilization. The

question of open human connection and a richness of lived experience is often reduced to mood stabilization, emotional regulation, or a reduction in what is perceived to be psychosis. In other words, to be successful, psychiatry and psychology have narrowed the focus in such a way as to define success through observable behavioral measures. Those measures dovetail with the societal expectations of compliance and acceptance of what is considered normal under contemporary social conditions.

Of course, I could be seen as being overly critical here. Surely the helping professionals have some degree of intrinsic worth. And I would reply that the possibility is there, as indicated at the edges of mainstream psychiatry/psychology/social work. There are those practitioners whose work is centered on liberating those they encounter from the strictures of virtual global capitalism. However, too often their work is co-opted and turned to the needs of an ever more voracious marketplace of mental health remedies. The truly radical nature of work such as humanistic, critical, feminist, and transpersonal psychology is subjected to a substantive revision and turned into something as benign and socially palatable as technologies of self-help. Similarly, the liberating potentials of psychedelics are quickly being turned to creating more creative workers for corporate capital or increasing the capacity for tolerating an intolerable set of life circumstances.

It is within this context that we find the emotional and psychological world of young women. To think about young women's suffering and our response to it, it is important to acknowledge that the relationship between women and psychiatry has always been fraught. To say that psychiatry has a history of misogyny is to state the obvious. Women have historically been over diagnosed and incarcerated for a range of behaviors that in men were seldom questioned. Women's suffering and women's drive towards physical,

emotional, and psychological emancipation from patriarchal society have often been pathologized.

The use of diagnosis to obscure domestic abuse, sexual assault, and incest has a troubling history dating back to the foundations of psychiatry as a medical discipline. Well into the 20th century women' sexuality was considered a source of psychological and psychiatric dysfunction, with women being incarcerated and subjected to brutal regimes of treatment as nymphomaniacs or hysterics. Husband or fathers could legally commit women for being perceived as having too much sexual desire or being disobedient. Such commitments occurred without trial or appeal. Unmarried women who had children out of wedlock, disobedient young women or wives, sex workers, lesbians, and sexual assault survivors often faced such diagnosis and incarceration. Women who were incarcerated were subject to physical restraints, ice baths, aversive shock therapy, lobotomies, and surgical mutilation. In more recent times, most of the most draconian elements of psychiatry's relationship with women have been significantly moderated. However, there are still significant anomalies in the diagnosis of women vs. men.

So, when young women encounter the mental health system, they enter a system that has a dubious history of being helpful to them. This is crucially important in the 21st century where there are significant indicators of stress and distress among women in general. For young women trying to make sese of the world they are inheriting, their pain and suffering makes them particularly subject to the seductions of mental health/psychiatry as a way of explaining their pain and sense of dislocation.

In a recent article in the *New York Times*, psychiatrist Suzanne Garfinkle-Crowell expressed her concerns about the way that young women have incorporated the language of psychiatry into the ways they describe themselves and their place in the world. She notes that previous

generations avoided being diagnosed by psychiatric workers, or when diagnosed tended to hide it. The prevailing belief was that to have an identified mental illness meant there was something wrong with you.

Dr. Garfinkle-Crowell notes a significant shift in the way that young women are viewing their relationship with diagnosis. In a twist on destigmatization of mental illness, young women appear to be seeking a diagnosis as a key element in their description of who they are. She states that the young women who are coming to see her in her practice

> were announcing their diagnoses — attention deficit hyperactivity disorder, obsessive-compulsive disorder, anxiety, depression — almost before telling me their names … The patients of this new wave were talking in therapy-speak, and their therapy hadn't even started.

This internalization of diagnostic categories as self-descriptors used to be something CYC workers found in young people who had been in the system for many years. Such young people as veterans of social services had seen a lot of social workers, psychologists and psychiatrist and been in various forms of therapy for most of their childhood. Those of us working with these children and youth would often describe how fluent they were in "therapy speak."

But there was always a cynical and ironic edge to the way in which these young people used the language of therapy. The most therapeutically experienced would often use their own diagnoses (and there were often many) to signal a passive aggressive anger at the futility of their encounter with mental health. Or they might use it as a method of avoidance, hoping they if they spoke the code clearly enough and seem to have psychiatric self-awareness, the worker would leave them alone.

The phenomenon that Dr. Garfinkle-Crowell is describing appears to be something else. She suggests that there is a deep acceptance of the language of diagnosis and that these young women may be using such psychiatric descriptors in a different way. Certainly, they are not using them in the way the community of helping professionals do. That is, as a scientifically-based assessment of pathology that can be linked to evidence-based treatment. Nor are these young women using their diagnosis to indict or parody the professionals trying to be of assistance. Instead, they are producing a self-narrative by finding information about diagnosis on social media and AI and then self-diagnosing. In short, they are using frameworks of psychiatric pathology as coping mechanisms to make sense of the level of suffering they are experiencing in their lives.

The use of social media as a forum for discussing young women's experiences and feelings is often inclusive of a search for labels that can make sense of their suffering. In a society saturated with mental health discourses, it might well seem quite sensible to use the common discourse of therapy speak and diagnosis. That said, I would argue, along with Dr. Garfinkle-Crowell, that the use of this kind of cultural shorthand obscures the capacity for talking in real terms about the life struggles young women are facing. The use of psychiatric nomenclature as a significant set of descriptors inducts young women into the world of psychiatry and psychology that has seldom been kind to women. It also interferes with the

world of young women talking about themselves and with each other in their own language and on their own terms.

For those of us in CYC, we know the value of young people's unique vernaculars as a way to describe their world away from the world of domination and control that is too often the world of adults. Therapy speak and diagnostic descriptions are a massive colonial incursion into the world of young women. It is crucial to our work in CYC that we find way to undo this loss of local language. Otherwise, the capacity for the kind of relational work we aspire to will be at serious risk. If young women can't find their own voice, then we will have lost a very important part of our socio-cultural ecology. That loss is significant and we should see it as the foreshadowing of more losses to come. And in the world today we don't need any more losses.

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