SOCIAL WORK PRACTICE WITH

FEMALE JUVENILE DELINQUENTS

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A PROJECT SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SOCIAL WORK

In the College of
Arts, Social and Health Sciences
University of Northern British Columbia

The University of Northern British Columbia

November 1999

ABSTRACT

Recently, in Canada there has been an increase in the number of female juvenile offenders involved in the criminal justice system. This increase has significant implications for clinical and forensic social work practice. The literature available to guide clinical practice with forensic clients is limited and in particular a research gap exists on female adolescent offenders.

The purpose of this project is to examine clinical social work practice with female juvenile delinquents at a forensic clinic in Prince George, British Columbia. This is an analysis of my clinical social work practice through the application of Ferrara's (1991) characteristics of effective group counsellors. The evaluation of my clinical social work practice relied on the observations and assessment of the co-therapist. Feminist and cognitive behavioral treatment approaches have been utilized with adolescent female offenders in this case study. Both treatment approaches have developed from different philosophical paradigms but in clinical social work practice they can be synthesized and applied jointly in a therapeutic setting.

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ACKNOWLEDGEMENTS

This project is dedicated to the young women that attended group therapy at Youth Court Service between January 16, 1996 and July 29, 1997. I would like to thank Peter Clugston and the late Fred Bannon for giving me access to Youth Court Services clinical records for academic purposes. I would like to especially thank Donna Holliday, the co-therapist of the young women's group for believing in me as a clinician and supporting this project by giving her time and expertise.

I appreciate the patience and understanding of my project supervisor, Glen Schmidt. He encouraged me when I needed it and helped me build an idea into a project. I would like to thank Kwong Tang for providing ongoing support to me throughout my years at UNBC in the social work program. Tang has the unique ability to help me focus my thoughts. I would like to thank both members of my committee for their dedication and support while working with me on this project.

I would like to express my gratitude to my deceased grandparents Wilhelmine Posehn and Johannes Wendler who have given me gentle guidance throughout my life. My parents Rita and Dennis McKay who have encouraged and supported me while I worked on my MSW. My children Lawrence, Carla and Ebony who have patiently waited for me to be done my studies. I would like to thank my husband George because he has understood why I should study and has given me the freedom and support to pursue my academic interests.

INTRODUCTION

The phenomenon of female juvenile offenders has caught the attention of politicians, the media, researchers and social workers. The incidence of violent offences committed by female adolescent offenders in on the rise throughout North America. This increase is reflected in the number of arrests of female juveniles who committed violent crimes between 1995 and 1996 in the United States (Yamagata, 1997). In this time period the largest statistical increase is among female juvenile offenders charged for offences against a person such as assaults (Yamagata, 1997). Studies in Canada indicated that female juvenile delinquency has increased in the last decade and the offenders are committing more violent offences (Artz, 1994; Shaw, 1995; Artz, 1998). In British Columbia between 1986 and 1993 statistics from the Attorney General indicate that the number of female juvenile offenders in-custody who have committed assaults has risen (cited in Artz, 1998). I have also recognised in my forensic social work practice between 1993 to 1997, an increase in the number of juvenile female offenders involved in the criminal justice system. More frequently, female juvenile offenders are being referred for counselling to Youth Court Services, a forensic outpatient clinic in Prince George, British Columbia. The increase in the number of female juvenile offenders involved in the criminal justice system has significant implications for clinical and forensic social work practice. The social work

profession has limited literature to guide clinical practice with forensic clients and in particular a research gap exists on female adolescent offenders. This project will contribute to the literature on clinical social work practice with forensic clients.

The purpose of this project is to analyse my clinical social work practice in a group that used a cognitive behavioural intervention approach. In particular, I will examine my clinical social work practice in a case study with respect to female juvenile delinquents at a forensic clinic. The case study discussed in this project is a cognitive behavioural therapy group held at the Prince George Youth Court Services Clinic from January 16, 1996 to July 29, 1997. I have analysed my clinical social work practice through the application of Ferrara's (1991) characteristics of effective group counsellors. A face to face unstructured interview was conducted with the co-therapist of the cognitive behavioral therapy group. The co-therapist was asked to evaluate my clinical social work practice skills in cognitive behavioral therapy. Secondly, I collected archival data from the group therapy notes and discussed participant profiles with the co-therapist. In this project the group participants' profiles were described and related to the limited literature on this population group. I reviewed the literature that relates to the history of social work with groups and treatment modalities with adolescent females in conflict with the law. In this project I will discuss the pertinent literature on the theories of feminism and cognitive behavioural therapy. I will also describe

ways in which I tried to incorporate both a feminist and cognitive behavioural approach.

In Chapter one the relevance to clinical social work practice is examined. Chapter two is a review of the literature that pertains to the history of social work practice with groups, cognitive behavioural therapy, feminist therapy and treatment modalities with female juvenile delinquents. Chapter three describes the profiles of the participants in this case study of a therapy group held at the Prince George Youth Court Services Clinic. Chapter four is an analysis of my clinical social work practice with respect to female juvenile delinquents at a forensic clinic. Chapter five discusses future research implications and the conclusion related to forensic social work practice with female juvenile delinquents.

CHAPTER ONE:
RELEVANCE TO CLINICAL SOCIAL WORK PRACTICE

Clinical social work has a history dating back to the settlement movements in the 1850s and social work with groups has been practised since the 1930s. Clinical social work intervention can occur with clients individually or with groups. Clinical social workers engage clients at mental health and forensic clinics (Hughes, 1983; Whitmer, 1983; Brennan et. al., 1986). In the 1960s members of the social work profession criticised clinical social workers for their application of the medical model in mental health and forensic practice settings (Levine, 1989; Neill, 1993; Pepi, 1997). Social workers at this time did not support individual therapy modalities because they disregarded the social, cultural and political factors. Nevertheless, professionals critical of clinical practice have supported group work with clients (Hayes, 1998).

In the 1970s there were increasing numbers of "forfeited clients"; those persons who did not fit in either the mental health or criminal justice system. The mental health and criminal justice systems are intertwined because the mentally ill are over-represented in the prison populations (Brennan, 1987; Blanchette & Motuik, 1996). Other professions such as nursing have encouraged the development of specialisation in mental health; subsequently there is a growing number of community nurses who practice forensic nursing (Mason & Mercer, 1996). The roles of mental health and criminal justice professionals are similar because in a

forensic specialisation they have common clinical language and practice approaches. Today forensic social workers practising at mental health and forensic settings effectively intervene with "forfeited clients ".

Gorden (1969) defines social work as a profession that improves the fit between the client and their environment (cited in Swenson, 1998). Clinical social work functions include: " case management, advocacy, teamwork, mediation, and prevention roles, as well as therapeutic and counselling roles" (Swenson, 1998, p. 527). The functions of forensic social work overlap with clinical social work because they both involve diagnosis and treatment of clients, mediation, and advocacy. (Brennan et. al, 1986; Soloman & Draine, 1995; National Organisation of Forensic Social Work, 1999). The forensic social worker emphasises the environmental effects on the client, which is complementary to psychiatry, which focuses on individual pathology. "Forensic social work is the application of social work to questions and issues relating to the law and legal systems" (National Organisation of Forensic Social Work, 1999 homepage). Forensic social workers practice in prevention programs, provide consultation, education or training to the courts, develop policies and programs, and facilitate or arbitrate between the client and the environment (Brennan et. al, 1986; Goldmeier, Wise, & Wright, 1986; Soloman & Draine, 1995; O'Hare, 1996).

This project will contribute to the literature in clinical and forensic social work practice. Clinical social workers that specialise in forensic social work are dependent on the literature from other disciplines such as psychiatry, psychology and nursing. The social work profession has limited literature to guide clinical practice with forensic clients and in particular a research gap exists on female adolescent offenders. Additionally, this project will analyse social work practice with respect to female juvenile delinquents in northern and rural settings.

CHAPTER TWO:
LITERATURE REVIEW

This examination entails a review of historical developments as well as contemporary approaches to social work practice. This writer examined related literature in four areas: the history of social work practice with groups, cognitive behavioral therapy, feminist therapy, and treatment modalities with female juvenile delinquents.

Social work with groups

The Industrial Revolution in England and the United States influenced the development of social work (Neill, 1993). The history of social work with groups can be traced to the 1850s, when social workers were involved in the settlement movements and youth-serving organizations (Rothman & Papell, 1988; Zastrow, 1993). During this time social workers attempted to, "provide practical humanitarian care to casualties of capitalism" (Mullaly, 1993, p. 119). Social workers today can detect their underlying values of humanitarianism, ethics, and social justice in early social work practice with groups (Brown, 1991; Swenson, 1998). Social workers in the settlement houses were committed to social reform and developed group programs for clients (Rothman & Papell, 1988; Brown, 1991). Most group organisations had a religious affiliation to meet the spiritual and recreational needs of the industrial workers (Brown, 1991). The YMCA is one example of an early group which began as a successful prayer group and today

offers many programs to communities all over the world. The client was the community during the settlement movements. After World War I the settlement movement altered its focus from community change to community service (Dorfman, 1988).

During the 1920s social workers were establishing a professional identity for the social work profession (Haynes, 1998). At that same time social work with groups relied on social theorists and philosophers for theoretical direction and became less focused on the impact of social conditions (Brown, 1991; Neill, 1993). Between 1930 and 1940 social work was influenced by a wave of social reform. Subsequently two social work practice areas developed: social group work and community development (Specht, 1988; Haynes, 1998). By the 1930s there were four distinctive practice approaches in group work: social group work, group therapy, group relations and group research (Brown, 1991).

In the 1960s, the effect of a second wave of social reform resulted in two types of social work emerging, clinical and reform (Dorfman, 1988; Haynes, 1998). Dorfman (1988) asserts that clinical social work includes " assessment, diagnosis, treatment including psychotherapy and counselling, client-centred advocacy, consultation and evaluation" (p. 18). Three models of clinical social work practice have emerged: social goals, reciprocal or interactionist, and remedial (Rothman & Papell, 1988; Brown, 1991). The social goals or mutual aid model evolved with

group work practice focusing on citizenship, social action and reform. The reciprocal or interactionist model encouraged the members to develop their own supportive systems to deal with a variety of issues, including social, educational and clinical goals. Social workers contrived the remedial model to serve clients' clinical needs in a therapeutic group. Clinical social workers, "should address the patient's presented deficits this is often called a 'remedial' or 'compensation' approach" (Lewinsohn & Clarke, 1999 p. 332).

Social workers must understand that group counselling with juvenile delinquents differs from group work with adolescents (Ferrara, 1991; Butterfield & Cobb, 1994). Clinical social workers that work with juvenile delinquents have a challenge because the client is involuntary and resistant to change (Schaefer, Johnson, & Whery, 1992; Ferrara, 1991; Lewinsohn & Clarke, 1999). The therapist leading a group of juvenile delinquents must be prepared to deal with various problems including behaviours, attitudes, values, interpersonal relationships and personality factors (Butterfield & Cobb, 1994). Female adolescent offenders can have a history of juvenile delinquency that includes adjustment and school problems, suicide attempts, absconding from institutions, status offences, substance abuse, and violent behaviours (Meichenbaum, Bowers, & Ross, 1968; Ross, McKay, Palmer, & Kenny, 1978; Cornell, 1987). Adolescent offenders have rigid defences and are unable to tolerate or discuss their feelings; therefore individual behavioural

therapy is not a preferred treatment modality with juvenile delinquents, except in sex offender treatment (Adams, 1959; Jurjevich, 1968; Ross & McKay, 1976; Cornell, 1990; Lipsey, 1990; Hollin, 1990). These clients' symptomatology can trigger counter transference responses from their therapists (Mishne, 1998).

Cognitive behavioral therapy

Clinical and forensic social workers can conduct therapeutic interventions with clients in a variety of situations including mental health centres, correctional institutions and halfway houses (Zastrow, 1993; Pepi, 1997). To effectively lead and co-facilitate group therapy, clinical social workers must demonstrate a repertoire of skills and knowledge. One treatment intervention that develops skills and competencies is cognitive behavioural therapy. Social workers can apply this approach individually or with groups (DeLange, Barton, & Lanham, 1981; Barth, 1988; Anderson-Malico, 1994).

In the 1960s a pioneer in cognitive theory Albert Ellis proposed that irrational thoughts and beliefs lead to self-defeating behaviours (Beck, 1976; Butterfield & Cobb, 1994). Rational-emotive therapy (RET) is an educational-didactic approach which focuses on clients' self-talk and changes their thought processes through cognitive restructuring (Dujovnè, 1995). The philosophical basis for rational-emotive therapy is phenomenological (Corey, 1990). Aaron Beck (1976) a cognitive behavioural therapist described the interaction between typical patterns

of thinking and depression (Beck, 1976; Granvold, 1994). Beck's short-term cognitive therapy focused on patterns of thinking with clients suffering from depression (Beck, 1976; Dujovne, 1995). The cognitive behavioural therapist postulates that there is a relationship between the way people feel, think, and behave and their negative views of the self, world, and future (Reeder, 1991; Anderson-Malico, 1994; Dujovne, 1995). Recent studies have shown that individual and group cognitive behavioural therapy is effective with a variety of psychiatric disorders (Hollin, 1990; Martin, 1993; MindStreet, 1996). As well, cognitive behavioural therapy has been a successful therapeutic intervention with prison inmates (Hollin, 1990; Coulson & Nutbrown, 1992; Valliant, Jensen, & Raven-brook, 1995; Holbrook, 1997). Cognitive therapy is widely used to change dysfunctional thoughts, emotions and behaviours (MindStreet, 1999).

The difference between cognitive and cognitive behavioural therapy is a reflection of the conceptual differences of the clinicians (Hollin, 1990). Social workers that guide their practice with the principles of behaviourism prefer cognitive-behavioural therapy. Cognitive therapy is the preferred approach by social workers who follow theories from cognitive psychology. In clinical practice settings the cognitive and behavioural therapist combine therapeutic techniques and strategies. Both cognitive and cognitive behavioural therapists attend to the same underlying principles and concepts of therapy while working toward similar

treatment goals (Granvold, 1994). In cognitive approaches, clients are taught to recognise and change cognitive errors and develop more rational thinking (Reeder, 1991; Martin, 1993; MindStreet, 1996). Behavioural models place primary importance on learning, environmental consequences, skills acquisition, and identifying deficits (Dujovne, 1995). Cognitive-behavioural therapy models are "directive, structured, goal-oriented, time-limited and learning theory based" (Dujovne, 1995 p. 596).

Clinical social workers have developed cognitive models for social work practice (DeLange, Barton, & Lanham, 1981; Ferrara, 1991; Martin, 1993). Cognitive behavioural therapy is a teaching model that helps the client to develop skills and knowledge that pertain to their identified problem (Corey, 1990; Reeder, 1991; Butterfield & Cobb, 1994; Anderson-Malico, 1994). As a treatment modality, cognitive behavioural therapy is problem centred and focused on the individual as the change agent (Hollin, 1990). Reeder (1991) states that "The goal of therapy is to help clients uncover their dysfunctional and irrational thinking, test the reality of their thinking and behaviour, and build more adaptive and functional techniques for responding both interpersonally and intrapersonally" (p.147). The therapist's role in cognitive behavioural therapy with juvenile delinquents is to limit behaviours and lead the therapy group (Ferrara, 1991).

Cognitive behavioural therapy (CBT) has shown to be effective in the treatment of depression among adolescents (Dujovne, 1995; Lewinsohn & Clarke, 1999). Research in the Netherlands has shown that there is a co-morbid relationship between emotional and cognitive problems and suicidal behaviours among female adolescents (Darnefski & Diekstra, 1995). Depressed adolescents have responded favourably to therapy approaches including cognitive, social skills, problem solving, and relaxation components (Dujovne, 1995). Recently, cognitive therapy has been successfully used to prevent relapse among adolescents who suffer from a psychotic disorder (Beeken & Dwivedi, 1996). Additionally, cognitive behavioural approaches are an effective therapeutic intervention with juvenile delinquents in social skills groups (Hollin, 1990; Dujovne, 1995). Social skills training includes modelling by the therapist, role-playing, performance feedback, praise, and self-monitoring of behaviours (Dujovne, 1995). As well, juvenile delinquents have used cognitive behavioural techniques to control their anger (Barth, 1988; Hollin, 1990; Valliant, Jensen, & Raven-brook, 1995).

Cognitive behavioural group work with juvenile delinquents is the most appropriate approach because it allows the client to practice new knowledge and skills in a safe environment (Patterson, 1950). Cognitive therapy is dynamic with adolescents because it is collaborative, non-confrontational, safe and fun (Beeken & Dwivedi, 1996). Cognitive behavioural therapy models communication skills

that juvenile delinquents can apply through active participation in the group. Generally, the goal of therapy with juvenile delinquents is to find motivation and develop interpersonal or social skills (Schaefer, Johnson, & Whery, 1982; Butterfield & Cobb, 1994; Valliant, Jensen, & Raven-Brook, 1995). Despite the potential difficulties, juvenile delinquents in cognitive behavioural groups have learned skills and knowledge to change their offending behaviour (Ferrara, 1992; Vallaint, Jensen, & Raven-brook, 1995). Researchers argue that the use of video playback was effective to improve reality testing and reducing participants' denial among a group of female delinquents (Marvit, Lind, & McLaughlin, 1974). Clinical social workers leading cognitive behavioural groups can use videotaping as a strategy to help clients in identifying their behaviours.

Feminist therapy

The first wave of feminism occurred around the early 1900s when women fought for their right to vote. Betty Frieden proclaimed the second wave of the feminist movement in 1974 with the publication of *The feminist mystique* (Valentich, 1986). Today three types of feminist ideology have emerged: liberal or mainstream, socialist, and radical. Liberal feminists focus on equal rights, individual liberty and equality of opportunity. Socialist feminists strive to eliminate oppression based on class, sexual orientation, race and age (Bishop, 1984; Adamson, Briskin, & McPhail; 1988). Radical feminism strives to eliminate

patriarchy and violence against women (Valentich, 1986). Most feminists are committed to identifying and addressing practices that disempower and oppress individuals and raise consciousness about oppression (Swensen, 1998).

Feminists in the 1960s began to examine the mental health services for women. They identified a medical model of treatment that blamed clients for their illness and treatment was individually focused (Levine, 1989; Pepi, 1997). Gender differences in treatment of male and female patients were apparent (Valentich, 1986). The feminist ideology advocates for egalitarian relationships between the therapist and client (Paquet-Deehy, 1991). In the mid 1970s feminists criticised clinical social work which was based on medical model approaches and Freudian insight oriented therapy. Boettcher (1997) argues that the qualitative and subjective nature of psychiatry has become aligned with feminism because it empowers marginalized groups. Feminists scrutinised psychological theories based on male psychological development, such as Erickson and Maslow (Valentich, 1986; Pepi, 1997). Conarton and Kreger-Silverman (1988) have developed a gender-specific life-span developmental model for women. Sociological and social learning theories were congruent with feminist theory because they viewed the client's experience in the context of their environment. Assertiveness training is, a method of therapy that uses cognitive behavioural techniques, was considered as an effective therapeutic intervention (Valentich, 1994; Shaw; 1995). In the 1970s

there were limited services available for women and as a consequence feminists developed their own support system through consciousness-raising groups. At the same time feminists organised collective women's centres to provide crisis intervention services to victims of sexual and spousal abuse (Valentich, 1986).

During the 1980s theoretical models for feminist counselling were developed by Collier (1982), Levine (1983), and Russel (1984). Levine (1983) defines feminist counselling as, "a way of linking women's personal struggles with the political context of our lives as both providers and consumers of services, and working toward change together" (p. 87). In the 1980s feminist clinicians set up a wide range of intervention strategies, including individual counselling, advocacy, patient support networks, self help, kinship and friendship groups (Valentich, 1986). Later in the 1990s feminist counselling is described as a philosophy rather than a clinical approach to social work practice (Shaw; 1995). From a feminist perspective, the mental health clinician is a change-agent who works with the client systematically toward long term goals (Pepi, 1998). Treatment based on the feminist model helps the client "find her voice".

Researchers and social workers generalised theories of male crime and delinquency to female offenders until after the second wave of feminism in the 1970s (Balthazar, 1994). Feminist researchers continue to make a substantial contribution to the development of female crime and delinquency theory

(Konopka, 1966, 1983; Chesney-Lind 1989, 1992; Campbell, 1986, 1993; Morris 1987; Adelberg & Currie, 1987; LaPrairie, 1992). A feminist researcher strives to gain an understanding of the nature of juvenile delinquency by listening to the young women's stories. Chesney-Lind & Sheldon (1992) state "listening to the girls" stories is essential to understanding female delinquency (p. 166).

A number of studies are examples of the type of listening and understanding espoused by feminist researchers. Among these a study conducted between 1984 and 1985, with female juvenile offenders who lived in a short-term residential program in Hawaii was unique because it gave young women involved in the criminal justice system a voice to tell their story (Chesney-Lind & Sheldon, 1992). Robinson (1994) another feminist researcher, conducted a study on female juvenile delinquents in Massachusetts. She argues that the goal of this research was to understand female juvenile offenders and not to control or reform them. Previously, society saw female offenders as having sexual issues that required change and control (Pepi, 1997). From a feminist perspective the researcher strives to understand the women's actions as contextualized within society. Therefore, feminist researchers pay attention to the issues of gender, race and class (Shaw & Dubois, 1995).

Artz (1994) conducted a study in Victoria, British Columbia, with young women who use violence in high school. These young women attempt to gain status with

their peers by violent means. Paradoxically their use of violence against their peers makes them outcasts. Molidor (1996) another feminist researcher, examined the etiology of female gang members in a residential treatment facility. Her research gave the young women a voice and allowed them to make recommendations to the social workers. The female gang members advocated for school-based programs that would deal with the issues of violence, poverty, and discrimination.

Demographic variables of adult and adolescent female offenders

A longitudinal study completed in the United States suggests that among adolescents there is a relationship between aggression and alcohol usage (White & Kowalski, 1993). White's study assesses the reciprocal relationship between alcohol abuse and aggressive behaviour among adolescents. White concluded that both alcohol and aggression have common percussive influences, including family dysfunction and victimisation. Recent research in the United Stated has found that abused children are twice as likely to be involved in the criminal justice system (Allen-Hagen & Sickmund, 1993). The literature on female adult and juvenile offenders reports that many have been victims of physical, emotional and sexual abuse (Adelberg, 1987; LaPrairie, 1987; Reistma-Street, 1991; Stewart, 1991; Troyer, 1997). Research in the United States and Canada indicates that in 1994 female juvenile violent crimes were on the increase with aggravated assault

accounting for the most frequent offence (Yamagata; 1997). Many therapists have the perception that female juvenile delinquents are not amenable to therapy because they do not trust adults and their present behaviours, values and lifestyles are different from their parents and professionals (Cornell, 1987; Mishne, 1998). Few studies have given consideration to the unique needs and characteristics of female juvenile delinquents. Robinson (1994) describes female juvenile offenders as a unique population with special life issues. Adolescent females have a different way of understanding than their male counterparts and their self-esteem diminishes during this developmental stage (Miller, Trapani, Fejes-Mendoza, Eggleston & Dwiggins, 1995). Female offenders can be withdrawn, depressed, anxious and externalise their feelings (Epstein, Cullinan & Lloyd, 1986). Major depressive disorders are twice as prevalent among adolescent females than males (Lewinsohn & Clarke, 1999). Adolescent female offenders in custodial settings can be severely impacted and their prognosis in treatment is limited (Miller, Trapani, Fejes-Mendoza, Eggleston & Dwiggins, 1995).

Research in Ontario has found that a third of the women in conflict with the law were first arrested in their teens (Troyer, 1992). Previous research on female delinquency has been predominately conducted in urban centers (Webber, 1991). The literature suggests that race, gender and class play a role in the over representation of First Nations women in the criminal justice system (LaPrairie,

1984b, 1987, 1992; Maracle, 1993). In British Columbia twenty percent of women in provincial jails are of Aboriginal descent; while Native people represent five percent of the population (Johnson, 1987; LaPrairie, 1992). Native women represent twenty-one percent of the prison population at the federal penitentiary for women in Kingston, Ontario (Sugar & Fox, 1980; Task Force, 1990). Feminist researchers state that female offenders charged with status offences are over represented in the prison population and on community probation dispositions (Chesney-Lind, 1989, 1992; O'Reilly-Fleming & Clark, 1993; Pepi, 1997). Research conducted at the Pinegrove Correctional Centre, a woman's provincial facility in Saskatchewan found that seventy-one percent of the female inmates had their first child before the age of twenty (Troyer, 1979). Sixty percent of the female inmates at Pinegrove reported being in foster care or adopted (Troyer, 1979).

Treatment modalities with female juvenile delinquents

Social workers have traditionally practised casework, individual and group counselling as intervention strategies with these clients. Present research shows that many social work interventions have been inadequate with female adolescents and juvenile offenders. Female juvenile delinquents are engaged in a lifecycle that involves a separation from figures of authority. Among female juvenile delinquents individual psychotherapy is the least effective treatment modality because it depends on the development of a therapeutic alliance with the therapist

(Adams, 1959; Jurjevich, 1968; Ross & McKay, 1976; Lipsey, 1990; Lewinsohn & Clarke, 1999). Meyer, Borgatta and Jones (1965) completed a study on the effectiveness of casework with females who had potential problems in a school setting. The results of this study suggested that no dramatic changes occurred and they discouraged traditional casework with these young women.

Group counselling has been effective with young women if the focus is on the their specific problems (Lipsey, 1990). Truax (1971) suggests that group counselling with institutionalised female offenders can be effective when the therapist is open, nondefensive, real and genuine. A caring community was developed for female juvenile delinquents that needed emotional support in their daily lives to maintain the changes they made in group therapy (Raubolt, Strauss, and Bratter; 1976). Therapy with female juvenile delinquents in discussion and drama groups has been effective. Patterson (1950) states that both groups improved the girls' interpersonal relationships and social adjustment. A study suggests that small group discussion with female juvenile delinquents in a custodial setting can develop moral reasoning skills (Gibbs, Arnold, Cheesman & Ahlborn, 1984). Short-term client centred treatment in-groups has had a positive influence on female juvenile delinquent's attitudes toward themselves and others (Redfering, 1972). A follow up study by Redfering suggests female clients in treatment were released early from the institution and had a lower recidivism rate than their female

counterparts (Redfering, 1973). Group therapy with a feminist philosophy has encouraging potential with teenage street prostitutes in Seattle, Washington (Davidson, 1992). This program has a strong feminist component and has been offered effectively in an open detention setting. Similarly, the New Directions program in Tucson, Arizona, followed the principles of feminist counselling with the focus being on women helping women in a non-hierarchical, reciprocal and supportive way (Davidson, 1983). Group support sessions focus on assertiveness training, sexuality, life planning and value clarification.

Clinical social workers have discovered that family involvement in therapy with adolescents can be successful (Dujorne, 1995; Mishne, 1996). A study in Minneapolis, Minnesota established that family therapy was effective in reducing recidivism rates among female juvenile offenders (Druckman, 1979). Youth charged with behavioural or status offences have shown some progress with a family-based crisis intervention program in San Fernando, California. The female offenders in this program have spent fewer days in custody and they were arrested less frequently than other offenders that did not attend the program (Stratton, 1975). Therapists that practice family therapy with female offenders must be sensitive to gender issues and familial abuse. Many female offenders have been and continue to be oppressed and abused by family members (Kolko, 1976).

The literature indicates the most effective treatment approaches with female offenders are multimodal programs and cognitive behavioural therapy in-groups. It is well documented by researchers that multimodal programs with female juvenile delinquents have been effective in reducing antisocial behaviours (Gross, Brigham, Hopper, & Bologna, 1980; DeLange, Barton & Lanham, 1981; Lipsey, 1990). Many female offenders are involved in street prostitution; the Children of the Night is a multimodal program in southern California developed to deal with the issues of juvenile prostitution. Through this multimodal program street youth can access a crisis hot line, a walk in centre and professional counselling. This program has outreach volunteers who provide educational information and crisis counselling to street youth (Chesney-Lind, 1992; Shaw, 1995). The emancipation program, in Portland, Oregon was developed as a short-term program to prepare delinquent and troubled females for independent living. This program encompasses counselling in a broader sense through skills development and employment readiness (Chesney-Lind & Sheldon, 1992).

As early as 1935, social workers have used cognitive behavioural interventions with female juvenile delinquents. Neva Boyd a social worker practised recreational therapy to modify behaviours of female delinquents in a training school (Brown, 1991). In the United States almost one-third of all institutions for female juvenile delinquents use behaviour modification programs (Siegel & Senna cited in Pepi,

1997). A Canadian study by Meichenbaum, Bowers, and Ross (1968) concluded that inappropriate classroom behaviour of institutionalised female offenders could be modified by behavioural techniques. Among institutional female offenders peer intervention with behavioural strategies have had a positive outcome and continued when they were released into the community (Ross & McKay, 1976). Furthermore, a Canadian study investigating self-mutilation or " carving" among girls in a training school reveals, positive behaviour modification seemed to reduce carving behaviour, but did not eliminate it (Ross, McKay, Palmer & Kenny, 1978). Self-mutilating behaviours can occur among patients in psychiatric hospitals, adult and youth correctional institutions, units for autistic children and institutions for the mentally challenged. In contrast, Williams and Akamatsu (1978) have concluded that cognitive self-guided procedures with a group of female juvenile delinquents in a medium-security institution had no significant impact on their behaviours. More recent studies indicate that cognitive behavioural therapy (CBT) is an effective treatment approach with depressed adolescents individually or in a group format (Lewinshohn & Clarke, 1999). Victims of childhood violence can benefit from cognitive-behavioural and social learning procedures to help reduce the adverse psychological effects of their experience (Kolko, 1976). In particular, cognitive behavioural approaches are an effective therapeutic intervention with juvenile delinquents in social skills groups (Hollin, 1990). As well, therapists using

cognitive behavioural approaches have developed client skills and competencies in anger management groups (Barth, 1988; Hollin, 1990).

CHAPTER 3:
A PROFILE OF THE CASE STUDY PARTICIPANTS

The case study discussed in this project is a cognitive behavioural group held at the Prince George Youth Court Services Clinic between January 16, 1996 and July 29, 1997. Since 1920 clinical social workers have used the case study in research (Sherman & Reid, 1994). Both quantitative and qualitative research methods have been applied to analyse the data in this case study. The researcher in quantitative study analyses data statistically; in this case study descriptive statistics are used to summarise sample data (Leedy, 1985; Palys, 1997). The qualitative research method is used for in-depth study on a person, a cultural incident or community. "A case study is an empirical inquiry that – investigates a contemporary phenomenon within its real-life context, especially when-the boundaries between the phenomenon and context are not clearly evident" (Yin 1994, p. 13). The single case study is particularly suitable for this project because it focuses on the analysis of individual social work practice within a therapy group.

The aim of this exploratory project is " to gain familiarity with or to achieve new insights into a phenomenon … in order to formulate a more precise research question or develop a hypothesis" (Palys, p. 77). Little research exists on clinical social work practice with female juvenile delinquents. This case study is a purposive sample because the group was "intentionally sought because they meet some criterion for inclusion in the study" (Palys, p. 137). The therapy group

was a convenience sample. Additionally this cognitive behavioral group included involuntary clients who were female juvenile delinquents. Two data collection strategies were used in this project. Firstly, archival data was collected from the group therapy notes. Secondly, a face to face unstructured interview was conducted with the group co-therapist. In this chapter I will describe the profiles of the group participants and identify commonalties among female juvenile delinquents in the group.

The literature review suggests that social work intervention with female adolescents and juvenile offenders has been effective (Patterson, 1950; Meyer, Borgatta and Jones, 1965; Redfering , 1972; Gibbs, Arnold, Cheesman and Ahlborn, 1984). What constitutes effective clinical intervention with female juvenile delinquents? Meyer, Borgatta and Jones (1965) state a social work intervention with female adolescents is effective when the client exhibits prosocial behaviors in a school setting. The improvement of interpersonal relationships, social adjustment and moral reasoning have been used as measurements of clinical effectiveness with female juvenile delinquents (Patterson, 1950; Gibbs, Arnold, Cheesman and Ahlborn, 1984). Redfering (1972) identified improvement in an adolescent's attitude toward themselves and others as indicative of treatment effectiveness. Treatment with adolescent female offenders is considered ineffective because a therapeutic alliance is not developed between the therapist

and client (Adams, 1959; Jurjevich, 1968; Ross & McKay, 1976; Lipsey, 1990; Lewinsohn & Clarke, 1999). In this project clinical social work intervention is effective when a therapeutic alliance is developed between the therapist and client. Specifically, clients that brought friends to the therapy group must trust the therapists. Clients continue to contact the therapists following the completion of group therapy; while some had maintained contact for two years. This definition of effectiveness does not include change internally or externally among the clients. It does suggest that these clients are amenable to treatment if they had engaged with the therapists.

This cognitive behavioural therapy group operated for sixteen months at the Prince George Youth Court Services Clinic. Two female therapists, a nurse and social worker facilitated sixteen cognitive behavioural therapy sessions with female juvenile offenders. The twenty-seven participants collectively attended one hundred and sixty-nine sessions. The mean for the participant attending the group was six sessions while the median was five.

A significant number of the participants, fifty-five percent met the therapists while they were in a youth containment center. The in-custody participants' motivation for attending the group could have been secondary gain such as a temporary absence from the youth containment centre. However, these participants continued therapy upon their release into the community. A related study by

Valliant, Jenson & Raven-Brook (1995) conducted in Sudbury, Ontario found that thirteen percent of the participants in the study were on probation. In contrast, forty-five percent of the participants in this case study were on probation (Appendix 6). The number of group sessions the participants attended varied from one to twenty-eight (Appendix 5). Also, the length of time the participants attended the group, varied between one to fifteen months. But at least fourteen of the participants had attended the group for more than three months; this was not expected considering most of the literature describes a very poor prognosis for female adolescent offenders attending traditional forms of therapy.

As noted in the literature review individual counselling with female juvenile delinquents is not effective. Individual therapy depends on the development of a therapeutic alliance with the therapist, which is difficult to establish with female adolescent offenders. The participants in this case study demonstrated that they had formed a therapeutic alliance with their therapist because they attended individual and group sessions, invited friends to the group and contacted the therapist after the group ended (Appendix 7). The participants that were not regularly attending weekly group sessions contacted their therapists for individual counselling. It would seem that individual therapy in this case study enhanced the group sessions. Four of the participants invited friends to the therapy group. They perceived the group as worthwhile and wanted to share the experience with their

peers. Six of the participants voluntarily contacted their therapists after the group was completed. This implies that a therapeutic alliance had been developed with the participants. In the past social workers did not support clinical intervention with involuntary clients. This writer would argue those adolescent female offenders have gained from individual and group therapy in this case study.

The profiles of the group participants suggest that female delinquency and teenage prostitutes are apparent in rural and northern communities. Eighty-five percent of the participants in this case study were originally from northern British Columbia (Appendix 8). In this case study twenty-six percent of the participants had been charged with a status offence. Status offences are those behaviours that are law violations when committed by a person under the age of eighteen. Forty-four percent of the participants had committed an assault (Appendix: 6). In this study the researcher found that eight percent of the participants who committed violent offences were on probation, while the remaining twenty percent of violent offenders were sentenced to a custody sentence. The majority of the participants, seventy–four percent, had committed a violent offence against a person (Appendix: 6). Most research on female offenders does not support the conjecture that they are violent. But recent examples in the United States suggest violent offences among female juvenile delinquents be on the increase. Fifty-two percent of the participants in this case study were of First Nation's ancestry. The prevalence of

First Nation's female juvenile delinquents in conflict with the law in northern British Columbia is considerable.

This writer serendipitously found that, thirty-seven percent of the young women in this case study were pregnant during or after they were involved in group therapy. The literature on adult female offenders indicates that teenage pregnancy is very common. The frequency of teenage pregnancy could be related to the overall high teenage pregnancy rate in northern British Columbia. The northern regional health authorities have the highest percentage of teenage pregnancies in the province of British Columbia. In this case study fifty-three percent of the participants had disclosed that they were adopted or in foster care. The literature on adult female offenders also implies that a high percentage of the offenders were adopted or in foster care (Shaw, 1995; Blanchette & Motuik, 1996).

In the literature the significance of alcohol and drug dependency has been identified among female juvenile delinquents charged with status offences (White, 1993; Webber, 1991). In this case study all of the participants charged with status offences had a drug addiction and approximately fifty-seven percent had attended alcohol and drug treatment programs. Overall fifty-nine percent of the participants is the case study had an alcohol or drug dependency. Between January 1996 and July 1997 residential programs for alcohol and drug treatment for female juvenile delinquents in northern British Columbia where unavailable. Recently, the British

Columbia government has identified high-risk communities, in the north which include Prince George, Terrace, Fort St. John, Dawson Creek and Fort Nelson. These high-risk communities will be funded for adolescent intensive day treatment, family and youth counselling programs (Prince George Citizen, 1999). In addition, a significant number thirty-three percent of the participants who had committed violent offences had an alcohol or drug dependency. The frequency of alcohol and drug dependency among female juvenile delinquents is similar to female adult offenders in provincial and federal correctional institutions. The literature suggests that many of the adult female inmates have an alcohol or drug dependency (Adelberg, 1987; Troyer, 1997). Only, two of the female juvenile delinquents that participated in the case study have become involved in the adult criminal justice system. It is likely more female juvenile offenders are involved in the adult criminal justice system and that this information is unknown to the therapists. In this case study fifty-two percent of the participants were identified as victims of physical or sexual abuse. Some participants might not have been identified as victims by the therapists because of their limited self-disclosure or lack of participation in the group discussion.

CHAPTER 4:
AN ANALYSIS OF CLINICAL SOCIAL WORK PRACTICE

Introduction

In this case study the clinical social work intervention adheres to cognitive behavioral and feminist theory. Both theoretical approaches have developed from contrary epistemologies. Sherman and Reid (1994) define an epistemology as " The branch of philosophy concerned with the theory of knowledge, the scope of knowledge and the reliability of claims to knowledge". (p.494). A feminist epistemology is based on how we construct meaning from our life experiences. Some feminists do not consider knowledge as an absolute social construct, this is similar to constructionist theory. The way we view the world is questioned from a phenomenological point of view (Van Manen, 1990). Cognitive behavioral theory follows an epistemology of empiricism where "direct observations of the world are seen as the way to generate and validate truths" (Plays, 1997 p. 414).

Theorists argue that the researcher must adhere to one theoretical approach whilst conducting research. Both cognitive behavioral and feminist approaches hold assumptions about how we know which can lead to very different ways of generating data (Sherman & Reid, 1994). In a research setting the separation of empirical and phenomenological approaches is very distinct; however in clinical social work practice the approaches can be complimentary. A relevant offender population, male batterers are commonly treated by therapists with cognitive

behavioural and feminist approaches. The Duluth model is an educational approach to working with males who commit violence in relationships (Shepard, 1990). The curriculum for this educational program defines violence from a feminist perspective. The violence in relationships is understood in the context of the male's need to have power and control over females. The participants of this group are taught non-controlling behaviors through cognitive behavioral techniques. The men use behavioral checklists to identify the use of threatening behaviors in relationships.

My social work practice is eclectic, which means that many theoretical approaches to counselling are used as an intervention strategy with clients. I have found in my clinical social work practice feminist and cognitive behavioural approaches to therapy do not have to be mutually exclusive. In this case study I have applied the principles of socialist feminist theory to my clinical social work practice. For example a feminist therapist shares all information with the client in group therapy setting. Thus, while sharing information with the client I can teach problem-solving skills, which is a cognitive-behavioural strategy.

Analysis of clinical social work practice

The purpose of this project is to analyse my clinical social work practice in a cognitive behavioural group. In particular, I will examine my clinical social work

practice in a case study with respect to female juvenile delinquents at a forensic clinic. I will analyse and describe my clinical social work practice in a case study through the application of Ferrara's (1992) social work practice model and the feminist counselling principles. I completed a face to face unstructured interview with the group co-therapist. (Appendix 3). The evaluation of my clinical social work practice relied heavily on the observations and assumptions of the co-therapist. Social workers must exhibit a repertoire of clinical skills to effectively lead a cognitive behavioral therapy group. Clinical social work practice is an applied knowledge and skill. Qualitative data is used to analyse the group process and content through the ideas, opinions and impressions of the co-therapist and myself. As well, I will compare my assumptions on group process and content with the co-therapist's.

Counselor characteristics applied in cognitive behavioral therapy

I will describe and analyze my clinical skills through applying the characteristics of an effective counselor to my social work practice (Ferrara, 1991). Ferrara has described characteristics that a counselor must have to effectively lead cognitive behavioral therapy with juvenile delinquents. The following are the five characteristics described by Ferrara:

> "The counselor must be committed to working with juvenile delinquents. The responsible counsellor is a sharp contrast to the role models that the delinquents find on the street. Since observational learning does occur, being a responsible counsellor should be a form of teaching. The intense

> counselor has the strength to penetrate the youth's defenses and the persistence to pursue an issue to closure. Since so much of the delinquent's life is based upon deception, the counsellor must be sceptical of what the delinquent says and does. The counsellor constantly pushes for more information and more honesty. Flexibility is important; however it is more important for the counselor to be aware that juvenile delinquents require a more direct and confrontational style of leadership in a therapy group than other clients" (p. 23-24).

The co-therapist, Donna Holliday and myself had discussed the clinical skills that were implemented in this case study. We both have had professional training in nursing and social work; therefore we did not imply that the required clinical skills were based on a specific profession. Holliday commented that clinical skills can be learned by a professional but "all the training in the world cannot make you a people person".

"The counselor must be committed to working with juvenile delinquents" (Ferrara, 1992, p.23). Female juvenile delinquents are very emotionally intuitive and can tell if the social worker is not committed to work with them. The therapists at the forensic clinic were reluctant to participate in a young woman's group because other agencies had not been able to engage them. The co-therapist and myself did not have clinical experience working with young women. As stated by Holliday, "...I had never worked with a group of young women". The female juvenile offenders were aware that Holliday and myself were committed to working with them. As a forensic social worker I believed that female juvenile offenders would benefit from group therapy. The co-therapist was an experienced

therapist who maintained the effectiveness of group therapy. After I left the forensic clinic, the group process was disrupted because the young women realised that no other therapist was committed to co-lead the group. Holliday commented,

> " ...Right after you left the girls' group, just disintegrated, it just disappeared, I don't know what happened to it...we never tried to set up a meeting with another therapist or to work with it because I didn't think that there was anybody else in the clinic that would be able to work with them ".

"The responsible counsellor is a sharp contrast to the role models that the delinquents find on the street. Since observational learning does occur, being a responsible counsellor should be a form of teaching" (Ferrara, 1992, p. 23). The therapists model their personal qualities, values and life experiences in the therapy group. The juvenile delinquents in therapy take over many of the behaviors and attitudes of the therapist.

I applied the principles of cognitive behavioural therapy in the group which included connecting the clients' thoughts to their behaviours. Holliday explains,

> "I think we went into the feeling states of the girls and I think they were really quite open with us because we gave them respect to do that and their behaviours I think they talked quite openly about their behaviours too in the group".

I modelled being open, respectful and accepting toward the young women in the group. In group therapy the young women demonstrated how to connect their thought and behaviours with their life experiences. They developed the ability to identify options and problem-solve within a group setting.

"The intense counselor has the strength to penetrate the youth's defences and the persistence to pursue an issue to closure "(Ferrara, 1992, p. 23). The social worker is taught communication skills to facilitate the helping process. The practice skills used by the social worker are basic communication skills, including attending, listening, empathy, and probing (Egan, 1986). The goal of cognitive behavioural therapy is to change the thoughts, behaviours and beliefs of the client (Martin, 1999). In order for the social worker to effectively intervene with juvenile delinquents different practice skills are applied in therapy than with other adolescents in a clinical settings. "I think we were quite eclectic really but I think that the reality kind of therapy modality was probably the best we could have used with them, because it was reality based", stated Holliday. As a clinical social worker working with female juvenile offender I learned clinical skills from the group participants and the co-therapist. My personal style of counseling was very non-directive and process oriented. At times during the group I thought that I could have been more directive. To effectively intervene with female juvenile offenders I had to learn to use the advanced communication skill of challenging the client in group therapy. Holliday remarked that, "I think one of the things is that you are a very up front person." Clinical social workers tend to see their role as supportive and empathetic to the client. Juvenile offenders view the therapist as a weak role model if they are not direct in therapy. I had to learn to be direct and lead the

clients to develop problem-solving skills. One of the most important qualities of a therapist is the ability to be direct and tell the client what they might not want to hear (Corey, 1999).

" Since so much of the delinquent's life is based upon deception, the counsellor must be sceptical of what the delinquent says and does. The counsellor constantly pushes for more information and more honesty" (Ferrara, 1992, p. 24). Clinical social workers traditionally help clients set goals and tell their stories. The role of the social worker is to assist the client to gain an understanding of their experience and make changes through their own decisions. The goal of therapy with juvenile offenders is to have them identify the truth and be given options to deal with their situation. This is a paradigm shift for social workers, as they do not see themselves as being an interrogator. From my personal experience, I knew if I was sceptical it would help the teenagers to become more aware of their own issues. The paradigm shift was not that difficult in my practice. Holliday explains,

> "I think that you have recognised game playing and I think maybe because you have daughters but I think that you are pretty alert to the issues that were sort of suggested but weren't put forth. You were pretty good at picking up the underlying issues that would come up and identifying them and dealing with them. I think too that the girls had a lot of trust in you and this probably had to do with you would see this stuff and move in on it, in a general manner of course".

"Flexibility is important; however it is more important for the counsellor to be aware that juvenile delinquents require a more direct and confrontational style of

leadership in a therapy group than other clients" (Ferrara, p. 24). Social workers working with juvenile delinquents must be willing to take on a more directive and confrontational leadership style. As stated earlier this approach to therapy would require a paradigm shift for social workers.

Client confidentiality is paramount in clinical social work. The therapists in the group must work together and share information about the clients. For clients to develop a therapeutic alliance they must trust the therapist and be reassured that the information will not be given to others. To effectively direct and confront juvenile delinquents the therapist must be aware of all the information available about the client. All of the clients had individual-counseling sessions with their therapist in this case study. The clients were informed that the two therapists would share information and they could attend sessions with either therapist. This model of leadership requires both therapists to work very closely and to eliminate territorial boundaries between the professions. Holliday explains, "…we shared the information about the people that were in the group so we both had a real awareness. We weren't territorial".

Clinical social work practice and feminist counseling principles

The clinical social worker counseling adolescent female offenders must have personal characteristics that compliment the needs of these clients. The fit between my personal beliefs and social work skills gave me the characteristics

needed to work with this challenging group of clients. When I analyzed my clinical practice it became apparent that I preferred a process orientated approach to counseling. The social work practice principles underlying the clinical intervention in a therapy group must not be overlooked. I have chosen to analyze my clinical social work practice based on the principles of feminist counseling. Levine (1989) states, " Feminist counseling is a helping process that means working with women, individually or in groups, around, their situation as related to the society that shaped them. The focus is on women helping women in a non-hierarchical, reciprocal and supportive way" (p. 257).

Initially, the therapy group was modeled after a cognitive behavioral anger management group for male offenders. Shortly after working in the group with female offenders we modified our approach to be a process rather than content group to reflect their unique treatment needs. "Feminist counseling helps women to validate their behavior and experience in their own way" (Levine, 1989, p. 260). This group was based on cognitive behavioral therapy and identified client competencies which are congruent with feminist principles of counseling. According to Pepi (1997), a feminist therapist,"Competency-based counselling assists the female adolescent in reclaiming her voice and recognition of the privilege and responsibilities of self-identity and membership in the greater society" (p. 96).

Some female adolescent offenders have been oppressed and powerless in their relationships with adults and males. Among this group some have been victims of physical or sexual abuse by male perpetrators. In order to retake power in their life the client must be given experiences that are empowering. Feminist principles in counseling suggest that the client feels like she has no control over her life and the counselor acknowledges their experiences of powerlessness. Holliday's insightful comment states, "... I think most of the young women that we worked with were in an oppressed role ...[and they would] take back their own power". The client and therapist negotiated decisions and the client had decision-making power in the young women's therapy group. Holliday comments, "Well I think if you're dealing with power issues and a lot of these young women are really powerless. It's a good thing to give some of the power to them. It's their group, it's not our group". The differences of power are implied within a social work relationship. The client and social worker have a shared understanding of why, when and how they are going to work together, there are no hidden agendas (Bourgon & Buberman, 1993). The counselor shares all the information with the client so she knows where she stands. Levine (1989) describes it as, "a peer kind of relationship, with the focus necessarily concentrated on the consumer. It is understood that without conscious reciprocal learning between counselor and consumer, there can be no authentic respect and trust in the counseling

relationship" (p.261). In this therapy group neither therapist saw themselves as an expert and I understood that I could learn from the young women in the group. Holliday stated that "...we are going to learn from our groups and I think the more groups you run, the more we're going to learn".

In this case study the treatment approach with adolescent female offenders has been built on the principles of feminist counseling and cognitive behavioral therapy. While both therapeutic approaches have developed from different philosophical paradigms, in practice they can be applied in a therapeutic setting. As a social worker in clinical practice I have integrated both approaches and this intervention is effective when working with adolescent female offenders. The strict adherence to a specific therapy approach would not be effective with adolescent female offenders. These clients have issues related to oppression, powerlessness and have not been able to raise their voice. At the same time they have limited skills and competencies in problem solving, coping and dealing with relationships. In the literature both cognitive behavioral and feminist therapies have been effective with these clients. In this case study the joint approach has shown to meet the treatment needs of the adolescent female offenders.

CHAPTER 5:
FUTURE RESEARCH IMPLICATIONS/ CONCLUSIONS

This project has two major limitations: generalization to other populations and the data collection method. Firstly, the conclusions from this case study are based upon the female juvenile delinquent population that attended therapy at the Prince George Youth forensic clinic between January 16, 1996 and July 29, 1997. This case study is a purposive sample where the unit of analysis was not randomly selected from the entire population. Therefore the conclusions from this case study cannot be generalized to all female juvenile delinquents and only apply to the participants in the case study. Secondly, the participants were not interviewed in this case study. The participants in this case study are a transient population and are not presently involved in the criminal justice system. The information for this project was entirely based on secondary sources that included group notes and an interview with the co-therapist. The interview with the co-therapist is not considered objective information. The co-therapist had a vested interest in the therapy group and could present information in an overly positive light. Strength of this project is the co-therapist had more than six years of clinical experience working with adolescent offenders in a forensic setting. Additionally, the qualitative data collected in this project can be used in further to develop effective clinical interventions with female adolescent offenders.

The social work profession has limited research to guide clinical social work practice with forensic clients. In particular a research gap exists on female juvenile delinquents in Canada. In the past treatment options were modelled after programs developed for male adolescents and often did not address the gender-specific needs of female juvenile delinquents. The limitations of the existing research in this topic area have implications for forensic social work. More specifically forensic social workers must develop a body of research on female juvenile delinquents to explore the linkages between research, practice and policy. At the conclusion of this project I have identified a number of areas that future researchers could explore.

Recent literature has shown that more female juvenile delinquents are in conflict with the law because of violent offences. The present studies do not address how or why female juvenile delinquents enter the criminal justice system. A theoretical framework is required to examine the unique situation of female juvenile delinquents in the criminal justice system. Exploratory research has been conducted on risk prediction of adult female offenders (Kirkpatrick, 1999). Little information is available on female juvenile delinquents crimogenic behaviour and the commonality of risk factors. In order for forensic social workers to effectively develop clinical interventions with female juvenile delinquents they need a better understanding of their social, economic, psychological and family history. Clinical

social workers should develop prevention, intervention and treatment programs that are specifically designed for female juvenile delinquents.

The prevalence of First Nation's female juvenile delinquents in conflict with the law in northern British Columbia is considerable. Fifty-two percent of the participants in this case study were of First Nation's ancestry. Race and socio-economic status also influence the treatment needs of female juvenile offenders. In general, research has been completed on First Nation's offenders and their involvement in the criminal justice system. This writer did not find Canadian literature available specifically on First Nations female juvenile delinquents. In the future social work researchers must focus on this unique population to ensure that policies and practice approaches are culturally relevant.

Social workers have understood female juvenile delinquency and teenagers at risk as an urban social issue. Subsequently, there is no research conducted on the area of female juvenile delinquents in northern and rural settings. The adolescents in rural and northern regions have different developmental needs than their counterparts in urban settings. The northern region of British Columbia has the highest teenage pregnancy rate in the province. Social work research overall has neglected to study the issue of addictions among women and in particular female juvenile delinquents. In this case study fifty-nine percent of the participants had an alcohol or drug dependency. Clinical social workers should develop prevention,

intervention and treatment programs that are specifically designed to include these unique treatment needs for northern and rural female juvenile delinquents.

Social workers working with female juvenile delinquents must be comfortable with the fit between their therapeutic approach and counseling philosophy. Clinical social workers specialising in forensic social work must make peace with medicine and its disciplines. Professional territorial boundaries must be eliminated between clinical practitioners. Social work must learn to develop clinical practice approaches with other professions to meet the clinical needs of their clients. The forensic social worker is a member of a multidisciplinary team that assesses the client's potential for utilizing treatment and provides clinical intervention. Clinical social workers prefer to provide service to voluntary clients because they believe involuntary clients do not benefit from therapeutic interventions. In this case study the female adolescent offenders demonstrated that they had formed a therapeutic alliance with their therapist because they attended individual and group sessions, invited friends to the group and contacted the therapist after the group ended. In conclusion this project has substantiated that clinical social work practice with female juvenile delinquents can be productive for both the client and social worker.

Social work practitioners have the ability to learn skills and techniques for clinical practice with female juvenile delinquents. Social work practice highlights

that the therapist must have specific characteristics that make their interventions more effective with these clients. In particular, the counsellor must be committed to the client; be a responsible professional who is persistent and sceptical while showing leadership qualities. Clinical social workers are taught to be supportive and empathetic toward their clients. Female juvenile offenders see therapists who are non-directive as weak. The goal of therapy with juvenile offenders is to have them identify the truth and be given options to deal with their situation. Social workers must learn to be more confrontational with female juvenile delinquents in therapy. This is a paradigm shift for social workers, as they do not see their helping role as influencing clients in therapy.

Social workers should research the effectiveness of treatment modalities with female juvenile delinquents. Cognitive behavioural therapy is a therapeutic approach that teaches clients to develop skills and competencies. The principles of feminist therapy are very liberating and effective with female juvenile offenders. Cognitive restructuring, assertiveness skills and problem-solving techniques allow these clients to set future goals. The forensic social worker must integrate the techniques of cognitive behavioural therapy with feminist principles to effectively meet the treatment needs of female juvenile delinquents. The strict adherence to a specific therapy approach would not be effective with adolescent female offenders. Forensic social workers have to learn from these clients, few social workers have

the life experiences that the adolescent female offenders bring to the therapy group. Therapy is a reciprocal process where both therapist and client learn from each other. It is my hope that other forensic social workers will learn from this project that working with female juvenile delinquents can be a rewarding opportunity.

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APPENDICES

APPENDIX 1

Letter of approval from UNBC ethics review committee

APPENDIX 1

Letter of approval from UNBC ethics review committee

UNIVERSITY OF NORTHERN BRITISH COLUMBIA
3333 University Way, Prince George, BC, Canada V2N 4Z9

Dr. Alex Michalos
Chair, UNBC Ethics Review Committee
Tel: (250) 960-6697 or 960-5820
Fax: (250) 960-5746
E-mail: michalos@unbc.ca

UNBC Ethics Committee

July 19, 1999

Ms. Connie Kaweesi
646 Pilot St.
Prince George, BC V2M 5J1

Proposal: 19990510.49

Dear Ms. Kaweesi:

The UNBC Ethics Committee met on July 16, 1999 to review the re-submission of your proposal entitled, "Clinical Social Work Practice With Female Juvenile Delinquents".

The Committee has approved your proposal and you may proceed with your research.

If you have any questions, please feel free to contact me.

Sincerely,

Alex Michalos
Chair, UNBC Ethics Review Committee

APPENDIX 2
Letter of informed consent

Project title: Clinical social work practice with female juvenile delinquents
Researcher: Connie Kaweesi, Graduate Student, University of Northern British Columbia. Telephone number: 250-562-3912.

I understand that I am being asked to participate in an interview to evaluate the interviewer's clinical social work practice. In particular I will discuss the process and content of a cognitive behavioral therapy group.

1. The interviewer has informed me that I can stop the interview at anytime. The interviewer has my consent to audiotape and take handwritten notes during the interview.
2. Connie Kaweesi may use the information for preparation of her project report. The only persons who will have access to the audiotape and handwritten notes are interviewer and her academic committee at UNBC.
3. The interviewee understands that she can waive her right to maintain anonymity. The interviewee should be given recognition for her expertise in the area of clinical practice with juvenile delinquents. I _____ give Connie Kaweesi permission to disclosure my identity in this project.
4. I can contact interviewer by telephone at 250-562-3912 in case I have questions about the interview or the project. The interviewee will be given a copy of the complete project.
5. The videotape and hand written notes will be stored in a locked drawer in Connie Kaweesi's home office. Following the completion of the project the videotape and hand written notes will be destroyed.

Both the researcher and the participant have discussed and agreed to the above conditions.

_____

Signature of participant Date

_____

Signature of researcher Date

APPENDIX 3

Sample interview questions

1. Do you believe cognitive behavioral therapy is an effective treatment modality for female juvenile delinquents?

2. In your opinion did the young women's group held at the Youth Court Services clinic between January 1996 to August 5, 1997 follow the principles of cognitive behavioral therapy?

3. Did the therapist use other treatment approaches in the group?

4. Would you describe the other treatment modalities the therapist used in the group setting.

5. Describe the skill and competencies the therapist demonstrated in this therapy group.

APPENDIX 4

Letter of authorization for records review from Youth Court Services

APPENDIX 4

Letter of authorization for records review from Youth Court Services

BRITISH COLUMBIA

March 26, 1999

Connie Kaweesi, BSW, Clinic Coordinator
Forensic Psychiatric Services, Prince George
BY FAX

RE Access to Youth Forensic clinical records for academic purposes

I am writing to confirm that you are authorized to review treatment records prepared by you when you were a team member in this Clinic. This will be for the purpose of completing work toward an MSW at the UNBC School of Social Work.

Cordially

Peter Clugston, MSW
Regional Manager

Ministry for Children and Families
Youth Forensic Psychiatric Services
Prince George Clinic
1594 - 7th Avenue
Prince George, B.C. V2L 3P4
Phone: 565-7115
FAX: 565-7119

APPENDIX 5

Participants attendance at group sessions

Participant	Number of sessions
1	28
2	6
3	9
4	5
5	5
6	1
7	6
8	1
9	17
10	4
11	3
12	2
13	11
14	2
15	5
16	17
17	1
18	2
19	4
20	1
21	2
22	9
23	11
24	6
25	8
26	2
27	1

Mode: 1 and 5 session (bimodal)
Median: 5
Mean: 6
* (If participants that attend 1 session are excluded the mean = 7.4)
*Data collected: July 16, 1996 to July 29, 1997

APPENDIX 6

Female adolescent offenders offences and sentencing
(N=27)

Sentence:	
Custody	15 participants
Community sentence	12 participants
Offenders offences:	
Assault	12
Offence Unknown	2
Status Offence	7
Other Offences	6
Violent Offence	15
Non-violent Offence	10

*Data collected: July 16, 1996 to July 29, 1997

APPENDIX 7

Group participants' indicators of effectiveness
(N=27)

Participants invited a friend to the therapy group	4
Participants voluntary contact with therapist after group	6

*Data collected: July 16, 1996 to July 29, 1997

APPENDIX 8

Profile of female adolescent offenders
(N=27)

Participants from the north	23
Participants from other areas	4
Ethnicity First Nations	14
Ethnicity Caucasian	13
Participants in foster care or adopted	14
Previous alcohol/drug treatment	15
Identified substance abuse *	16
Victims of physical/sexual abuse	14
Teenage pregnancy	10

*All status offenders identified a substance abuse problem.
*Data collected: July 16, 1996 to July 29, 1997

APPENDIX 9

Teenage pregnancy rates in north health regions

Provincial Average	4.9%
Caribou	11.3%
North West	11.1%
Peace Laird	8.9%
Northern Interior	7.6%

Adapted from Vital Statistics Agency British Columbia March 1999.