Review of Best Practices in Programs for Youth Offenders at St. Lawrence Youth Association

by

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DEDICATION

This thesis is dedicated first and foremost to my grandmother. Without her support, both financial and personal I would not have been able to attend college or make it through these past four years. To the rest of my family, for their constant support through all of life’s little difficulties. To Jeff for listening to my constant complaints and for being there for me when I am stressed to the max. Last but not least, to all of my friends who have helped me get where I am today.
ABSTRACT

The criminogenic need areas (factors relating directly to recidivism) of youth offenders have been well documented (Sherman et al., 1998). It has also been found that when these need factors are targeted through counseling programs, the risk of recidivism is reduced (Grisso, Vincent & Seagrave, 2005). Group counseling programs that were implemented at a custody facility for youth offenders were created to target these needs; however they were in need of a review to determine if the programming needed to be updated. Six need areas of programming were chosen for further research, based on a review of the literature on the key criminogenic needs of youth offenders, as well as the administration of the Youth Offenders Needs Questionnaire (YONQ). The current group counseling programs for sexual abuse, conduct problems, substance abuse and dependence, anger management, and cognitive distortions were reviewed, and recommendations were made based on the American Psychological Association criteria for a “well-established” program. The only need area in which a recommendation for a change or addition to a group counseling program was not made was for conduct problems. Programming for the other five need areas were found to be in need of revision, in order to ensure that well-established and effective programming was being applied.
ACKNOWLEDGEMENTS

There are a number of people without whom this thesis might not have been written and to whom I am greatly indebted.

To Dr. Gary Bernfeld, to whom I am indebted beyond all belief. For starters, without him there would be no BPSYC program and this thesis would not even be a dot of ink on a piece of paper. For his constant supervision and support, grammatical corrections and rewording suggestions, and of course constant positive reinforcement, I am forever grateful. Also, Gary always pushed me that little bit further to help me realize my own potential. Finally for barely using the phrase “it depends”, when helping me write this thesis.

To Dr. Rob “Robbie” Rowe at the St. Lawrence Youth Association, who taught me everything I know about young offenders, SPSS, intake assessments, criminogenic needs, and diet coke. Without his help, guidance and understanding on my placement’s with the agency I never would have completed my thesis.

I am also very grateful to the directors and staff at the St. Lawrence Youth Association’s custody facilities, including (but not limited to) Mary Lynn, Deb, Deborah, Andrea, Fiona, Rosemary, Norm and Mike. All of the staff supported my research and greeted my colleague and I with wide smiles and open arms, whenever we came to visit. Without their support and constant unlocking of doors (both figuratively and literally) this thesis would never have been completed.

To my fellow BPSYCers for pretty much helping me survive the past nine semesters. Tiffany, thanks for all of the venting sessions, taking me on adventures to CalABA and for all of your help, especially when trying to figure out why the chicken crossed the road, and who will be the next American Idol. Andrew for always explaining things to me, making them more complicated then they are, and then figuring out how to explain it in “Martha” terms. Jess, Rachel, Carolyn for always smiling no matter how stressful things are, for always listening and for always being there, outside of the classroom as well! Thank you to ALL of my classmates for being sources of support, guidance and friendship.

Finally, again to my family and better half, who have supported me in all of my decisions, no matter how “off the wall” they may be. Without my mom, dad, sister, Grandma Dooze, uncle Sid and Jeff I don’t think I would have pursued and stuck with such a demanding program, and I’m so glad that I did.
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Chapter I: Introduction

The current group counseling programs that are being run at the St. Lawrence Youth Association custody facilities are in need of a review in order to determine if programming is "well-established" and effective, and merit the continued use with youth offenders. According to Gullotta & Adams (2005) “the search for effective [youth] programs is being driven by two factors: the realization that the problems experienced by adolescents are very serious and the inability of traditional prevention and treatment programs to have a significant impact on reducing the negative consequences and impact of these problems...”(p.102). Well-established practices are necessary to ensure valid programs are being run for the clients needs. The interventions being run at the agency may be outdated, and less effective for the need areas that they are trying to address.

Needs assessments have been found to be a well-received approach to evaluation (Owen, 2006; Rouda & Kusy, 1995). A needs assessment is a procedure that is carried out for the purpose of making judgments on whether changes or improvements are to be made to a program (Witkin and Altschud, 1995; as cited in Owen, 2006). As indicated by Owen (2006) a need refers to “the difference between the desired and the present situation or condition” (p.171). The needs that are targeted through programming at the agency that will be reviewed in the thesis are: sexual abuse, anger management, cognitive distortions, eating disorders, substance abuse and conduct problems.

The criteria for judging whether a program is ‘well-established’ or evidence-based is defined by The American Psychological Association as “those that have either (a) two or more well-conducted group design studies completed by several different researchers or (b) several well-conducted single-case study designs completed by independent investigators showing at least as good as if not superior to placebo” (Lonigan, Elbert & Johnson, 1998; as cited in Gullotta & Adams, 2005, p.87). Ineffective programming is a problem not only because it does not lead to any changes in an individual, but also because it may cause more harm to that client (Gullotta & Adams, 2005).

The purpose of the thesis will be to review and evaluate the group counseling programs utilized at the agency, compare these to best practices in the field and will eventually serve to suggest changes to programming in the agency. The aim of the review is to provide the agency with the opportunity to have uniform and effective counseling programs run at both custody facilities, which is important because it will help in ensuring that all clients receive the same quality of treatment.

The thesis will consist of the following sections: method, literature review and results, discussion, and recommendations. The literature review will provide background information on each subject and its relevance to the youth offender population. It will also provide an overview of the literature supporting the effectiveness of the program currently delivered, and the literature on other programs that may be more effective than those currently implemented. The literature review will also outline the six different need areas that should be addressed through group counseling programs at the agency. The results and recommendations for program alterations will then be discussed in subsequent sections of the thesis. Although the focus of the thesis will be on the custody facilities, the recommendations made will also benefit the community service and intensive supervision and support workers at the agency, as it will serve as a guide to effective program selection for each need area.
Chapter II: Method

Participants

St. Lawrence Youth Association staff and the young offenders were the participants in this project. Frontline staff and managers at the agency responded to a questionnaire that gathered information about important need areas that programming should address. The young offenders targeted for treatment consisted of females and males in the age range of 11-18 that were in detention awaiting sentencing, or were in custody after being found guilty of a crime. Of 92 client files reviewed at the agency, 42% were female youth offenders and 58% were males. Although a large body of literature focuses on female offenders, some research on youth offenders suggests similar need areas for both males and females (Delligatti, Akin-Little & Little, 2003; Leenars, 2005). The background and criminal history varied from person to person. Most youth were at Sundance and Achievement St. Lawrence (ASL) for a short duration (usually around 10 days), but can be sentenced to the Intensive Support and Supervision Program (ISSP) or Community Service Support team (CSS) for longer periods of time (6 months to a number of years).

Procedures

The first step in the process was to examine current programming in both custody facilities at the agency (see Appendices A and B). A further literature review on the mental health, welfare issues, educational issues and other needs of both male and female youth offenders was performed, in order to uncover need areas for this population. After this, a list of issues and disorders addressed by the current programming at the agency was compiled. Another literature review was then conducted, focusing on clinical need areas of non-criminal adolescent females. This specified need areas that were not addressed currently at the agency, but may indirectly influence criminal activity, and therefore be an area, which would benefit from treatment. The Youth Offender Needs Questionnaire (YONQ) found in Appendix C, asking frontline staff and managers to rank the list of disorders and issues in order of importance was generated and distributed. Based on the literature review and questionnaire results, 12 need areas were chosen for further review. The current report focused on six need areas, while a colleague reviewed the other six. The need areas selected were presented to the managers of treatment at the agency to ensure that the need areas chosen were suitable for further review. After reading through the documentation for group counseling programs offered at the agency, a definition as to what “best practices” refers to and criteria for judging a particular program to be “effective” was generated. The literature was then analyzed, in order to provide recommendations regarding modifications to the current programming at the agency, as well as suggestions for additional programming for youth offenders. A draft of the program recommendations was presented to the manager, to ensure that the recommendations were feasible and input was gained about any needed changes. The final project was then submitted to the agency. Table 1 provides an overview of the methodology for this project.
Table 1

Methodology

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
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<tbody>
<tr>
<td>1.</td>
<td>Review current programming in both St. Lawrence Youth Association Facilities</td>
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<td>2.</td>
<td>Create a list of issues and disorders addressed by current programming at the agency (ex. substance use and abuse)</td>
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<tr>
<td>3.</td>
<td>Develop questionnaire containing the list of issues and disorders created in step 2, to be answered by frontline staff and managers at the facilities to determine key need areas</td>
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<tr>
<td>4.</td>
<td>Operationally define “best practices” to create criteria for judging efficiency of a program</td>
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<td>5.</td>
<td>Review literature on subjects relevant to the needs of youth offenders to be examined further</td>
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<td>6.</td>
<td>Review literature on clinical needs of adolescent female (non-criminogenic need, those not pertaining to criminal activity)</td>
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<td>7.</td>
<td>Based on the preliminary literature review and results of the questionnaire, need areas are chosen for further examination</td>
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<td>8.</td>
<td>Brief the manager and director of treatment services on need areas chosen, to ensure that they agree with these as important areas to be reviewed</td>
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<td>9.</td>
<td>Conduct a literature search on current programming to find if programs have demonstrated validity</td>
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<tr>
<td>10.</td>
<td>Perform another literature search on additional programs that may be more effective for the issues and disorders identified as important</td>
</tr>
<tr>
<td>11.</td>
<td>Analyze and assess data gathered in order to provide recommendations for improvements to existing programs and additional programming for each need identified by the literature review and questionnaires</td>
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<td>12.</td>
<td>Submit draft recommendations to manager for review and modify these based on feedback</td>
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<tr>
<td>13.</td>
<td>Submit final project to the manager</td>
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Materials

Youth offenders needs questionnaire. The Youth Offenders Needs Questionnaire (YONQ) was developed as a tool to identify which need areas were viewed as important by staff at the agency (Appendix C). The YONQ was created based on the need areas that are being addressed by programs found at both custody facilities. The questionnaire consists of 30 different need areas (i.e. anger management, conduct problems etc.) and one “other” area, in which a respondent can provide an area of need that was not previously identified. The participants completed the following steps in the questionnaire: (1) they chose 12 of the 31 options based on their experience with the youth offender population; and (2) the 12 need areas chosen were ranked in order of importance. A score of “1” would indicate the most important need area in the respondents opinion, and a rank
of “12” would indicate the least. The YONQ was distributed to 18 staff members at the agency, ranging from frontline workers to managerial staff.

**Preliminary Results**

Nine of the 18 distributed YONQ questionnaires were returned (for a 50% response rate). The results of the survey (Appendix D) were calculated by counting the number of times the need area was selected, adding the scores and dividing the total by the number of times chosen, thus finding the mean rank for each area. The overall importance was determined based on the average ranking of the need area and the number of times selected. Those areas chosen more often, with the lowest mean rank, would be more important than those chosen only once or twice. The results of the questionnaire show that cognitive distortions, with a mean ranking of 3.4, are thought to be the most important need area according to the staff at the agency. The results of the survey were consistent with the manager’s view of need areas that should be targeted through programming at the agency, though he stressed that anger problems were the most significant objective for treatment. The rationale for this was that nearly all of the youth entering the facilities exhibited problems dealing with their anger in a socially acceptable manner. The YONQ results suggest that overall, anger management is the fourth highest ranked need area, with an average rank of 4.3. Leschied et al. (2001) state that although female and male risk factors are similar, one of the main differences between male and female offenders is the way in which they express their anger. In a study by Owen and McMullin (1995; as cited in Leschied et al., 2001) it was found that females usually utilize verbal attacks, and any physical aggression is usually directed toward other females or people with whom they have close relationships. Where female aggression is usually more covert, males’ aggression is more likely to be expressed overtly through physical means and threats. Supporting both the manager’s view of the need to treat anger and the results of the YONQ, studies have shown that without proper treatment of anger, a high risk of recidivism exists for both genders (Leenaars, 2005).

**Preliminary literature review.** The first literature review conducted indicated that there are an increasing number of youth entering the justice system who have mental health issues (and other needs) that may or may not have been previously identified (Grisso, Vincent & Seagrave, 2005). Counselling programs within juvenile justice facilities attempt to preclude further criminal actions by altering dynamic and criminogenic behaviours. Sherman et al. (1998) found that dynamic criminogenic factors include “attitudes, cognitions, behavior regarding employment, education, peers, authority, substance abuse, and interpersonal relationships that are directly related to an individual's criminal behavior” (p.3). In addition, female juvenile offenders are likely to use or abuse substances (drugs and alcohol) and have a poor academic record, including dropouts and failed grades (Barnow, Schuckit, Lucht, Ulrigh & Freyberger, 2002). The YONQ results were similar to those of Sherman et. al. (1998) and Barnow et. al. (2002), in that the criminogenic factors that the authors found to be significant were ranked as important by staff at the agency. In particular, substance abuse was rated as the second most crucial need (with a mean of 5.7), while relationships were ranked as eleventh place (out of 31). Mullis, Cornille, Mullis and Huber (2004) stated that research on female youth offenders has shown that most females have been victims of physical or sexual
abuse, are at high-risk for suicidal behaviours due to low self-esteem. Agency staff rated sexual abuse as the sixth most important need area and physical abuse as tenth on the YONQ.

**Need Areas Chosen.** Based on the results of the YONQ, the preliminary literature review, and the direction of the manager at the agency, the following need areas were chosen as the focus for treatment review: cognitive distortions, substance abuse, emotion regulation, anger management, self-harm, sexual abuse, stress management, conduct problems, eating disorders, physical abuse, relationships and anxiety. This author chose to examine 6 of the 12 need areas, while a colleague focused on the remaining 6 (see Table 2). Research indicated that when these risk and need factors were made the focus of programming, the risk of recidivism was greatly reduced (Sherman et. al., 1998). Even more important, are programs that target these needs, but have also been proven to work through clinical trials, or are considered empirically valid. These findings demonstrated the necessity of effective programming for youth offenders, as research has also repeatedly shown that both males and females who exhibit problem behaviours during their youth continue this pattern of adverse behaviour, causing problems in adulthood (Hipwell & Loeber, 2006).

Table 2

*Chosen Need Areas*

<table>
<thead>
<tr>
<th>Current Author</th>
<th>Rank of Need Area</th>
<th>Colleague</th>
<th>Rank of Need Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Distortions</td>
<td>1</td>
<td>Emotion Regulation</td>
<td>3</td>
</tr>
<tr>
<td>Substance abuse and Dependence</td>
<td>2</td>
<td>Self-Harm</td>
<td>5</td>
</tr>
<tr>
<td>Anger Management</td>
<td>4</td>
<td>Stress Management</td>
<td>7</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>6</td>
<td>Physical Abuse</td>
<td>10</td>
</tr>
<tr>
<td>Conduct Problems</td>
<td>8</td>
<td>Relationships</td>
<td>11</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>9</td>
<td>Sexuality</td>
<td>12</td>
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</table>
**Chapter III: Literature Review and Results**

**Sexual Abuse**

**Definition.** According to the American Psychological Association (APA) sexual abuse refers to the act of placing a child under duress for sexual activity. It may include genital touching; masturbation; vaginal, anal and other forms of penetration, but it is not limited to physical contact. Examples of nonphysical sexual abuse include, child pornography, voyeurism and exposure (2001, ¶ 1). The University of Michigan claims that 38% of girls who have been raped were 14-17 year olds at the time of the assault (as cited in Hossfeld & Taormina, 1997).

**Sexual abuse and juvenile delinquency.** Sexual abuse has been related to disorderly conduct among juvenile females (Gil, 1996; as cited in Hipwell and Loeber, 2006). As indicated by Calhoun, Jurgens and Chen (1993) a history of sexual abuse can be found in 70% of cases involving female offenders. This suggests a correlation between a record of sexual abuse and offending by females. Artz (1998; as cited in Hipwell and Loeber, 2006) states “abuse was particularly linked with subsequent violent behaviours, reporting that one in four violent girls had been sexually abused…” (p. 226). This finding is further supported by the APA (2001, ¶ 3), which found that in addition to increased risk of exhibiting of violent behaviours, children who are sexually abused experience high levels of anxiety, alcoholism, drug abuse and insomnia in adulthood and may have problems sustaining relationships.

**Current agency programming.** Current programming for survivors of sexual abuse at the agency consists of several sessions in various different group counseling programs and individual workbooks. In Girls Circle, the “Pathways to the future” unit covers sexual abuse (Hossfeld & Taormina, 1997), as well as the Teen Relationship Workbook, “Understanding Abuse” (Moles, n.d.). Girls Circle is designed to create a setting in which girls can connect with peers, build self-esteem and express themselves verbally.

**Empirical basis of programming.** The Girls Circle program is based on the premise that it is human nature to want to belong to a group, and by providing support in a group format meets this need. Several studies have been conducted on the Girls Circle program (Dollette et al., 2004; Dollette, Steese, Phillips, Hossfield & Taormina, 2005; Irvine, 2005; Irvine, Roa & Cervantez, 2007; Rough & Matthews, 2005). All of these studies found one common theme “initial results revealed significant increases in perceived social support, perceived body image, and self-efficacy” (Dollette et al., 2004, p.2). A study in 2007, conducted by Irvine et al. found that there were six main benefits of using Girls Circle: “(1) Finding things they have in common with a new person, (2) Trying to see beyond girls' reputations, (3) Telling adults what they need, (4) Feeling good about their body, (5) Picking friends that treat them the way they want to be treated, and (6) Telling people how much they mean to them” (p.9). The same study also reported statistically significant gains in four main areas: “(1) A decrease in self-harming behavior, (2) A decrease in rates of alcohol use, (3) An increase in attachment to school,
An increase in self-efficacy” (p.10). Despite these positive findings, Irvine et al. (2007) also discovered that girls who had previously been or were currently incarcerated in a short-term secure facility were not reporting the same short-term gains in the programming as girls who were not being held in custody facilities. The study also suggests that more research needs to be done to conclude if the program is effective. However, it has been called a “promising approach” in the Model Programs Guide of the Office of Juvenile Justice and Delinquency Prevention (Irvine, 2005).

The Teen Relationship Workbook is designed to teach youth to identify the signs of abuse in relationships and to help the youth develop skills to create healthy relationships. It includes handouts that are used to help the youth examine aspects of their relationships without feeling threatened. This is not used as a treatment for sexual abuse, but rather as an educational tool for healthy relationship building. The literature suggests that sexual abuse is an important target for treatment, as it is linked with a number of adverse outcomes if left unchecked (King et al., 2000).

**Review of best practices.** There are a limited number of studies that have been conducted on group counseling as a treatment for those who have been sexually abused. Due to the lack of literature available on best practices with sexual abuse victims, Nelson-Gardell (2001) conducted a focus group with youth who had been sexually abused in order to discover what victims thought to be important components of treatment. The results indicated four themes that treatment should focus on: believing defines help and support; taking about what happened; talking about feelings; and group counseling. May and Housley (1996) also suggest that group therapy is the most effective therapeutic approach for those who have been abused sexually. The results of the Nelson-Gardell (2001) study illustrated several implications for treatment; there should be an emphasis on making those who have been abused feel as though they are believed; and supported without questioning the events that happen. As well, by creating a strong therapeutic alliance and making what happened to the victim the emphasis of treatment, the group counseling program should be at least minimally effective (May & Housley, 1996).

Recently, several studies have been conducted (Feather & Ronan, 2006; King et al., 2003) on a form of cognitive behavioural therapy (CBT), trauma-focused CBT. This form of CBT has been found effective by the authors of these studies. It also incorporates the key themes that were identified by Nelson-Gardell (2001). Trauma-focused CBT is based on the theory that the typical psychological problems of those who are abused, such as anxiety, social withdrawal, nightmares, shame and guilt, school problems, depression and inappropriate sexual behaviours (Alter-Reid, Gibbs, Lachenmyer, Sigal & Massoth, 1986), are characteristics of post-traumatic stress disorder (PTSD). Further studies have suggested that a large percentage of sexual abuse victims meet the diagnostic criteria for this disorder (Feather & Ronan, 2006). This form of CBT is built on the premise that “cognitive-behavioural treatments, incorporating exposure and cognitive therapy, have found to be effective in treatment of adult trauma sufferers, particularly rape victims and Vietnam combat Veterans” (Keane et al., 1989; as cited in King et al., 2003, p.6). Trauma-focused CBT utilizes coping skills training, social skills training, graduated exposure, education and prevention training and parent training.
The coping skills training component emphasizes skills needed to deal with the negative emotions that come from being abused. This portion of the program also involves relaxation training as a means to cope with anxiety and illustrative materials to help the victim learn what thoughts are provoking decreasing anxiety (King et al., 2003). Owing to the fact that social withdrawal is one of the traits displayed by those that have been sexually abused, the social skills training aspect of the trauma-focused CBT program attempts to develop assertiveness in the form of initiation skills, learning how to say “no” and responding to social invitations. This is done through behavioural rehearsal, modeling and corrective feedback (King et al., 2003). The third constituent of the program, graduated exposure, is thought of as the “cornerstone to effective cognitive behavioural treatment for sexually abused children…” (King et al., 2003, p.7). The graded exposure hierarchy (Deblinger & Heflin, 1996) utilizes \textit{in vivo} exposure, as well as drawing and discussion to move through the steps in the hierarchy. The steps begin with discussing general information about the child’s sexual abuse, eventually leading to discussions about specific events of traumatic abusive episodes. The fourth portion of CBT involves education and prevention training, which is teaching safety skills, body ownership, and the difference between inappropriate and appropriate touching. The final component of the program involves parent training. This helps teach the parent how to redevelop a relationship with their child, how to communicate about the abuse and how to control their adolescent’s disruptive behaviours through behavioural management skills. King et al. (2003) state that it is important to involve the parents (as long as they have not committed the offence) in the intervention program. This may not be possible at the agency, as the parents are rarely involved with the child’s life.

King and others (2003) utilized the trauma-focused CBT program with children aged 5-17 who had been sexually abused and who met the criteria for PTSD. The trial included three conditions, to which the participants were randomly assigned: child alone cognitive behavioural treatment condition; a family cognitive behavioural treatment condition; and a waiting-list control condition. They concluded that the family CBT condition was not more effective than the child alone CBT condition. They also found that, in accordance with a study conducted by Deblinger, Lipmann and Steer (1996), “cognitive-behavioural strategies may be useful in the treatment of sexually abused children with PTSD” (King et al., 2003, p. 9).

Another study conducted by Feather and Ronan (2006) utilized the trauma-focused CBT method in order to test the effectiveness with multiply abused children with PTSD. The author hypothesized that there would be a diminution in their PTSD symptoms and that positive coping skills would be strengthened. They utilized children aged 9-13 who had been referred for psychological assessments. The results of their study indicated that “the level of posttraumatic stress symptoms decreased with treatment and decreased further after a 12 month follow-up period” (p.136). Compared to baseline, which indicated that the average level of PTSD symptoms were in the severe range, during the follow-up stage, there were no reported PTSD symptoms that met severe range criteria.

A randomized trial of CBT, Present-Centered Therapy (PCT) and a wait-list, was conducted by McDonagh et al. (2005), on women who had been diagnosed with PTSD after suffering through childhood sexual abuse. PCT in this study differs from CBT in that it focuses on teaching the client how the history of sexual abuse has impacted her
current coping, and by teaching problem-solving skills that will help to remedy dysfunctional coping styles. The CBT component of this study consisted of 14 sessions involving prolonged imaginal exposure, in vivo exposure and cognitive restructuring. This form of CBT is extremely similar to the trauma-focused CBT for those who have been sexually abused described by Ronan and Feather, (2006) and King et al. (2003). The hypothesis for the study was that CBT would be more efficient than present-centered therapy and the wait-list condition at “a) reducing interviewer-rated PTSD symptoms; (b) reducing self-reported depressive, anxiety, dissociative, and anger symptoms, as well as cognitive distortions; and (c) improving quality of life” (p.516). The results of the study indicated that:

“CBT participants were significantly more likely than present-centered therapy (PCT) participants to no longer meet criteria for a PTSD diagnosis at follow-up assessments. CBT and PCT were superior to wait list in decreasing PTSD symptoms and secondary measures.” (McDonagh et al., 2005, p.515).

The authors also found evidence that supported persistent reduction in PTSD symptoms after treatment had been terminated.

**Recommendations.** Although there are a limited number of empirical studies conducted on treatment methods for those who have been sexually abused, cognitive behavioural therapy, specifically trauma-focused CBT can be judged to be a well-established practice, according to the definition by the APA (1998). It has been shown to be effective in the three group design studies reviewed in this thesis (Feather & Ronan, 2006; King et al., 2003; McDonagh et al., 2005), in which it was compared with PCT, wait-list condition, child alone condition and familial therapy, and was found to have superior and longer lasting effects. The combination of a CBT program along with the use of the six Girls Circle sessions, and the work sheets from the Teen Relationship Workbook, could be used as an effective measure of treatment for those who have been sexually abused.
**Conduct Problems**

**Definition.** The diagnostic criteria for conduct disorder (CD) consists of:

“A pattern of behavior in which the rights of others or age-appropriate societal norms are violated. These behaviors are assessed in four groups: (1) aggression that causes or threatens harm to people or animals, (2) acts that cause property harm or damage, (3) deceit or theft and (4) serious violations of rules. The criteria specify levels of these behaviors during the past year and past six months” (Munson, 2001, p.120).

In the juvenile justice system, boys meet the diagnostic criteria of CD two to three times more often than girls (Hipwell & Loeber, 2006). Although girls are not diagnosed with CD as frequently, they tend to demonstrate behavior problems that are more severe than those exhibited by males. This is known as the “gender paradox”, a phenomenon produced by the fact that the description of CD was created for males and therefore girls may not meet the diagnostic criteria, despite these severe behaviours (Hipwell & Loeber, 2006). Delligatti, Akin-Little and Little (2003) suggest that, despite the “gender paradox” CD is still the second highest diagnosed psychiatric disorder among female adolescents.

**Conduct problems and juvenile delinquency.** A number of negative outcomes are associated with those who are diagnosed with CD, including; “early and violent death, arrest, substance abuse and dependence, antisocial personality disorder, failure to finish high school, pregnancy, sexual promiscuity, and contraction of sexually transmitted disease” (Zoccolillo, Tremblay & Vitaro, 1996; as cited in Delligatti, Akin-Little & Little, 2003, p.183). CD is also found to be co-morbid with a number of other disorders, including anxiety disorder, depression, attention deficit hyperactivity disorder, oppositional defiant disorder and learning disabilities, which presents a unique challenge for treatment options (Short & Shapiro, 1993). Another symptom of CD, as described by Chalmers and Townsend (1990) is that those afflicted with the disorder are unable to take the perspective of others. Research has also shown that “children with greater perspective taking ability are more successful in interactive situations requiring persuasion” (Jones, 1987; as cited in Chalmers and Townsend, 1990, p.178). It has also been found that adolescents with CD attend to few positive social cues in their environment, and selectively focus on hostile social cues (Gouze, 1987; as cited in Van De Wiel, Matthys, Cohen-Kettenis & Van Engeland, 2002). Adolescents whom have been diagnosed with CD also tend to believe that violence and aggression will reduce bullying by others and result in tangible rewards (Van De Wiel et al., 2002).

**Current agency programming.** The current programming for CD at the agency, consists of a cognitive behavioural group-therapy intervention designed to alter dispositions and thinking about offenses. It focuses on taking the perspective of the victim, empathy, legal consequences of crimes and why the youth committed the crime in the first place. The agency also utilizes two workbooks by Berg (1990b, 1990d); the Self-Control Workbook: Exercises to control inattention, impulsivity and hyperactivity and the Conduct Management Workbook.
Empirical basis of current programming. The Self-Control Workbook is mainly utilized as a tool to help those with attention problems find ways to control their inattention; however there are four sections that can be utilized with CD as well: ignoring and observing rules; disturbing others and not disturbing others; being destructive and being careful with others property; calming down and not calming down. The workbook contains handouts that can be utilized to help youth learn about the inappropriateness of their behaviour and how to control it. The Conduct Management Workbook is comprised of five sections: “(1) deciding whether others are acting with hostility; (2) taking the point of view of authority figures; (3) using self-talk to control behavior; (4) praising yourself for appropriate behaviour; and (5) using problem-solving skills” (Berg, 1990b, p.ii). No literature could be found supporting or refuting the use of the Berg (1990b, 1990d) workbooks as a treatment for CD. However, the Conduct Management Workbook utilizes several of the same components as cognitive-behavioural interventions that have been found to be effective with young offenders (e.g. using self-talk, taking the point of view of authority figures, using problem-solving skills). There are several studies that support the continued use of CBT as a treatment for altering key symptoms associated with CD.

Review of best practices. There are several studies that have indicated that group cognitive behavioural therapies have been successful in reducing defiance and destructive behaviours, and increasing perspective taking abilities, as well as empathy (Delligatti, Akin-Little & Little, 2003; Kelsberg & St.Anna, 2006; Mpofu & Crystal, 2001; Van De Wiel et al., 2002). CBT theorizes that CD is a problem in self-regulation, and is thought to be successful in altering social problem-solving abilities in youth (Mpofu & Crystal, 2001). Through CBT in small groups, adolescents can learn how to identify problems, and successfully solve them through recognizing and controlling their feelings (Van de Wiel et. al., 2002). Kazdin (1993), states that CBT therapies are more likely to treat CD than more “traditional” therapies like play therapy, client-centered therapy and others. The literature suggests two specific types of CBT that have been found to be successful with CD: problem-solving skills training and anger-coping intervention (Mpofu & Crystal, 2001).

A wide range of literature (Elias & Weissberg, 1989; Spivack, Platt & Shure, 1976) supports the effectiveness of problem-solving skills training in “improving children and adolescents problem-solving, social relations with peers, school adjustment and reducing the incidence of minor delinquent acts” (Mpofu & Crystal, 2001, p.25). The focus of problem-solving skills training in CBT is teaching self-regulation and impulse control, thus targeting cognitive distortions as well as cognitive deficiencies. There are five procedures used according to Mpofu and Crystal (2001): “(a) stop, calm down and think before you act; (b) say the problem and how you feel; (c) set positive goals; (d) think ahead of consequences and (e) go ahead and try the best plan”(p. 25). Through these steps, the youth are taught to question their motives, take the perspective of an authority figure, and select a solution that is pro-social. Problem-solving skills training is similar to the anger-coping intervention program, though problem-solving can be applied to a more diverse range of behaviours (Mpofu & Crystal, 2001).

Through the use of modeling, role-plays, and biological feedback, anger-coping interventions educate youth in four main domains related to CD: “perspective-taking,
awareness of physiological arousal as a precursor to antisocial action, use of self-instruction or self-talk procedures and problem solving strategies” (Mpofu & Crystal, 2001, p.24). These four learning outcomes all aid the participants in understanding appropriate information processes when making a decision, and recognizing physiological signs that lead to aggressive behaviour and inappropriate problem resolution. Research shows that adolescents who participate in anger-coping interventions have higher levels of self-esteem and less aggressive and disruptive behaviour compared to controls (Kendall, Reber, McLeer, Epps & Ronan, 1990).

Farley et al. (2005) conducted a meta-analysis summarizing 8 reviews of treatment for CD adolescents and found that “behavioral therapy (cognitive-behavioural therapy, social problem-solving skills training, parent management training), comprising 12-25 sessions…decreased disruptive or aggressive behaviours by 20% to 30%” (as cited in Kelsberg & St. Anna, 2006, p.912). Another meta-analysis performed by Woolfenden, Williams, and Peat (2002) of 8 randomized controlled trials of behavioural treatment methods among youth in the age range of 10 to 17, found that CBT significantly reduced recidivism rates and time spent incarcerated. Research suggests that the outcomes of these studies have been maintained at a one-year follow up (Van De Wiel et al., 2001). However, both meta-analyses also reported that when CD is comorbid with other disorders, such as ADHD, the success rate of CBT is reduced.

**Recommendations.** The current CBT program at the agency can be defined as a well-established practice for those with CD, coming into the agency and therefore should continue to be used. Sixteen studies reviewed in two meta-analyses have proven that recidivism rates and disruptive behaviours were decreased when CBT was used (Farley et al., 2005; Woolfenden et al., 2002). However, if CD is comorbid with other disorders, CBT may need to be used in conjunction with other treatments being utilized that target the coexisting disorders (e.g. counseling for anxiety).
**Substance Abuse and Dependence**

**Definition.** The results from the National Survey on Drug Use and Health (Substance Abuse and Mental Health Administration, 2003) indicate that 11% of the youth population was regularly using drugs and of these 9% met the DSM-IV criteria for substance use disorder. The DSM-IV-TR (American Psychiatric Association, 2000) defines substance abuse as:

“A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household)
2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)” (p.199).

This diagnoses differs from substance dependence in that in order to be diagnosed with substance dependence tolerance and withdrawal symptoms must be present. The youth would feel that he or she needs to use more and more of a substance to get the same results and efforts to cut back on the drug will be fruitless. The user will continue substance use despite the suffering of social and other important lifestyle aspects. They will also continue to use despite any known psychological problems caused by the drug (American Psychiatric Association, 2000).

**Substance abuse and dependence and juvenile delinquency.** Adolescents who are high risk sensation seekers and who act without thinking (disinhibition) are thought to be especially at risk for aggression, violence, risky behaviours (i.e. unprotected sex), motor-vehicle accidents, assaults, self-inflicted injuries, and perform more lethal suicide attempts when under the influence of drugs and alcohol (Gullotta & Adams, 2005). Many studies have shown a correlation between substance use in adolescence and subsequent criminal behaviour (Bauman & Phongsavan, 1999). A study by Stice, Myers and Brown (1998) found that “marijuana use before age 16 has been associated not just with later substance abuse but also with juvenile offending and other problematic outcomes” (p.144). This study also found that the more drugs the youth used, the more likely they would be involved in higher levels of law-breaking behaviour (Stice et al., 1998). Bauman and Phongsavan (1999) had similar findings, reporting that youth who had been incarcerated abused substances at a higher rate than non-offending youth of the same age.
in the community. A study conducted by Prinz and Kerns (2003) utilized questionnaires distributed to 189 (93 male, 96 female) incarcerated youth offenders to determine the age of onset of substance use in childhood and other variables surrounding drug use. The study found that “approximately 15–18% of the sample reported drinking alcohol by age 10… In this sample, early substance initiation clearly was a major risk factor that was associated with higher frequencies of substance use at later ages” (p.276).

**Current agency programming.** The current programming at the agency for substance abuse and dependence consists of: The Recovery Workbook: Exercises to Deal with Drugs and Alcohol (Berg, 1990c); Girls Circle curriculum “Paths to the future” focuses on teen drug use and abuse (Hossfeld & Taormina, 1997); Mind/Body Spirit sessions 2-4 discuss using alcohol and drugs and the mind/body balance (Girls circle, Hossfeld & Taormina, 1997) and Substance use and abuse discussion groups.

**Empirical basis of current programming.** The Recovery Workbook (Berg, 1990c) uses the idea that a youth who is addicted has “two selves”; a rational self and an addictive voice. The goal of the workbook is to listen to the rational self and counter the arguments of the addictive voice. The book is divided into four sections: the emotional voice, situational voice, control voice and the relapse voice. Each section contains exercises that challenge reasoning behind continued substance use, in order to educate the individual on how to recognize and avoid emotions and situations that lead to drug use. Literature on the workbook could not be found. As described previously, several studies (Dollette et al., 2004; Dollette et al., 2005; Irvine, 2005; Roa, Irvine & Cervantez, 2007; Rough & Matthews, 2005) have shown that Girls Circle is thought to be a promising option in increasing self-efficacy and perceived social support.

**Review of best practices.** Two forms of treatment have been observed as well established for the cessation of substance abuse in adolescent offenders; Motivational Enhancement Therapy (MET) and Cognitive Behavioural Therapy (CBT). Several studies have also suggested that the combination of CBT and MET have been found to be effective in helping youth quit and maintain abstinence from drugs and alcohol (Copeland, Swift, Roffman & Stephens, 2001; Litt, Kadden & Stephens, 2005; Nowinski, 1990; Polcin, Galloway, Palmer & Mains, 2004; Stephens, Roffman & Curtin, 2000).

MET is a form of psychotherapy for substance abuse and dependence. It is derived from the work of Carl Rogers (Client-Centered Therapy) and Motivational Interviewing (Miller & Rollnick, 1991), and is usually delivered in two to four sessions. It utilizes rolling with resistance, empathy, reflective listening, open questions and summary statements, as well as directive interventions to increase the clients self-efficacy and help them move through Prochaska, Diclemente and Norcross (1992) stages of change model (precontemplation, contemplation, preparation for change, action, change maintenance) (Polcin et al., 2004). Webb, Seudder, Kraminer and Kadden (2002) define MET as: “an approach to treatment that focuses and builds a client’s intrinsic motivation to abstain from or reduce unwanted behavior” (p.109). It does this through assessing the client’s goals and contrasting these with their current situation in order to illustrate the steps needed to reach his or her objectives. MET was traditionally used as a form of
preparation for more intensive treatment, as well as to increase treatment compliance among drug abusers (Polcin et al., 2004).

Recently, the effects of MET as a stand-alone intervention have been studied. Project MATCH (Project MATCH Research Group, 1997) utilized four sessions of MET, 12 sessions of 12-step facilitation (TSF) and 12 sessions of cognitive behavioural therapy on 1726 randomly assigned clients who were addicted to alcohol. The results indicated that even though MET had 8 less sessions than the other two groups, all three conditions resulted in substantial reductions in drinking at a 3-year follow up. Another factor noted about MET in this study, was that it was “somewhat more effective for clients rated high on anger measures” (as cited in Polcin et al., 2004, p.333). Sellman, Sullivan, Dore, Adamson and MacEwen (2001) also conducted a study on MET as a stand-alone intervention, using 122 alcohol dependent subjects. They found that compared to four sessions of nondirective reflective listening (NDRL) and a control condition, four session MET was comparable to NDRL and showed even greater improvement at follow-up.

It has been theorized that MET would be beneficial as a longer treatment (Polcin et al., 2004). The rationale behind this idea, as outlined by Polcin et al. (2004) is threefold. First, as MET progresses based on the stages of change model, four sessions may not be enough time to allow a client to evolve through stages at their own pace (Shaffer & Robbins, 1995). Second, MET is derived from client-centered therapy, which usually consists of 12-16 sessions. Thirdly, those who abuse substances experience severe symptoms compared to alcohol dependent clients; therefore more sessions may be warranted based on the degree of severity of the client’s symptoms.

However, the combined treatment of MET and CBT for substance abuse and dependence has been found to be effective in many studies. The program can consist of 5, or 12 sessions. The first two sessions are individual MET sessions that allow the staff to assess the clients’ substance use history, their stage in the stages of change model and outline their goals, comparing goals to the clients current state (Diamond et al., 2002). The CBT sessions are conducted in a group and cover areas like relapse prevention, anger coping, effective communication skills, skills for refusing drugs and coping with drug cravings (Webb et al., 2002). Research suggests, “cognitive behavioral trials with this population [adolescents with delinquency] have yielded improvements in problem solving, self-control, prosocial behaviors and positive communication that have been sustained for at least a year” (Kendell et al., 1990; as cited in Webb et al., 2002, p.15). It has also been found that CBT is useful at educating the youth about anticipating relapse and how to cope with relapse if it occurs (Webb et al., 2002). Monti et al. (1997) and Rohsenhow et al. (2000) conducted a study on relapse coping CBT, compared with mediation and relaxation training on cocaine dependent patients. They found that the coping skills patients had “fewer days of cocaine use in the first 3 months and reported less severe relapses than the mediation-relaxation patient” (as cited in Litt, Kadden & Stephens, 2005, p.1015).

While these studies support the CBT component of the MET/CBT program, there are several other studies that support the combined use of the two therapies. Stephens, Roffman and Curtin (2000) conducted a study utilizing 291 daily marijuana smokers in two different forms of treatment: a 14 session CB group combined with 2 sessions of MET; and a delayed treatment control condition (DTC). The MET/CB treatment was found to be superior to the DTC treatment at all points throughout the follow up.
(conducted for 16 months). Copeland et al. (2001) reported comparable results in a study utilizing two forms of MET/CBT (either one visit or six visits) and a DTC group. The authors also suggest that there were no differences between the two MET/CBT groups. The Marijuana Treatment Research Group (2004), used 450 subjects in either 9 sessions of multicomponent therapy (MET, CBT and case management), DTC, or 2 sessions of MET and found that the MET-CBT treatment was more successful at reducing marijuana smoking than the other two conditions.

**Recommendations.** MET/CBT programming has been proven to be “well-established” through several studies on large groups. It is also adaptable to individual needs and can be provided in 5 sessions or 12, which is vital to the agency as the youth are usually detained for only short periods of time. However, creating treatment around the client’s individual needs may require individual therapy, rather than group counseling, which may not be viable at the agency’s facilities. This may require the agency to alter the curriculum of this program by excluding or minimizing the number of individual sessions at the beginning of therapy. MET has also been proven to be effective on its own, which may be useful to intensive supervision and support workers who continue to provide treatment to some of the adolescents after they have left the facilities.
Anger Management

**Definition.** Anger is defined by Novaco (1994) as “a subjective emotional state entailing the presence of physiological arousal and cognitions of antagonism and is a causal determinant of aggression” (p.32). Novaco also states that the role of anger in initiating aggression can be modified or offset by social learning factor like role modeling.

**Anger and juvenile delinquency.** Many researchers have acknowledged the link between high levels of anger and increased risk of aggressive behaviour (Dodge, 1991; Dollard, Doob, Miller, Mowrer & Sears, 1939; Novaco, 1994; Spielberger, 1988). An increased number of youth have been incarcerated for violent crimes (Cornell, Peterson & Richards, 1999). The peak age for violent crime has dropped from adulthood to age 17 (Federal Bureau of Investigation, 1997). The increase in violent youth has resulted in a higher prevalence rate of assaults within youth justice facilities (Snyder & Sickmund, 1995). Flores (2003) reported that 82-88% of high-risk youth participated in some form of aggression or violence before age 13, indicating that when aggressive behaviours begin in childhood, they persist through adolescents. Parker, Morton, Lingefelt and Johnson (2005) found that “adolescents who went on to commit nonviolent serious offenses had significantly more prior nonviolent serious and nonserious offenses” (p.407). They also found that MMPI-A scales such as anger, deficient inhibition and brooding were predictive of violent offenses occurring in the future. Leenaars (2005) reports three differences between male and female aggression: (1) females are involved in low-risk aggression (e.g. verbal aggression); (2) female aggression is directed toward people with whom they have a close relationship; and (3) if a female is involved in physical aggression it is usually against another female. Despite these differences in aggression, risk factors for aggressive behaviour appear to be the same for both genders (disturbed family interactions, proviolent attitudes, selective attention to aggressive cues).

**Current agency programming.** The current agency programming for anger management consists of: Berg’s (1990a) Anger Control Workbook: Exercises to Develop Anger Control Skills; Anger Awareness and Interpersonal Problem Solving (Baker, 1998); Cognitive Behavioural Group: Anger Management; and Student Workshop: Handling Your Anger (Sunburst Communications, 1997).

**Empirical basis for programming.** The Anger Control Workbook (Berg,1990a) is designed to help youth alter their negative self-talk and increase their use of positive self-talk. The workbook has exercises surrounding six skills related to anger: knowing when others are being aggressive; knowing feelings related to anger; knowing how victims feel; knowing how others view aggression; talking to yourself to control anger; and looking for alternatives to aggression. The workbook also contains an anger log that is used to record incidents of anger, and who caused the angry feelings as well as the antecedents, behaviour and consequences of the act. Like other Berg (1990a, 1990b, 1990c, 1990d) workbooks, the Anger Control Workbook is based on cognitive behavioural therapy, which has been found to be effective with anger management (Hains, 1989; Landenberger & Lipsey, 2005).
The Anger Awareness and Interpersonal Problem Solving group manual and video by Baker (1998) is also based on cognitive behavioural therapies. It specifically focuses on the strategies of modelling, roleplaying, cognitive restructuring, interpersonal problem solving and homework assignments. The program utilizes these strategies in order to reach the overall goal of “replacing hostile aggressive behaviours with constructive anger expressions” (p.10). The video and program are based on research of what is effective with youth offenders including studies by: Andrews et al., 1990; Baker and Leschied, 1996; Hoge et al., 1995; Lipsey, 1990; Lipsey and Wilson, 1997; and Whitehead and Lab, 1989 (as cited in Baker, 1998) proving that this is an empirically valid treatment method for anger management.

The Sunburst Comunications program, Handling Your Anger (1997), consists of a video and handouts that are divided into four parts: anger triggers and anger cues, anger styles and consequences, dealing with anger, and wrap-up. Each part consists of handouts that correspond with the sections of the video in order to teach youth how to effectively plan for, respond to and apologize for acts of anger or aggression. The overall objective of the workshop is to “enable students to learn and practice the skills of conflict resolution” (p.12). No research could be found on the Sunburst program. However, the manual for the program does explain that it is to be used as an educational tool only and may not be suitable as a sole method of treatment.

**Review of best practices.** Aggression causing harm to others or animals is one of the diagnostic criteria for CD, therefore anger management and aggression problems have similar cognitive-behavioural deficiencies as those that are seen in youth with CD. Such as deficits in problem-solving, self-control, attributional judgements and perspective-taking abilities. Owing to the fact that CBT has been found to be an effective treatment for conduct disordered clients, it has also been found to be suitable for those with anger and aggression problems (Elias & Weissberg, 1989; Farley et al., 2005; Hains, 1989; Landenberger & Lipsey, 2005; Mpofu & Crystal, 2001; Spivack, Platt & Shure, 1976).

Another form of cognitive intervention that has been found to be effective with youth whom have been incarcerated for violent offenses is Aggression Replacement Training (ART). Goldstein and Glick (1987) created ART as a comprehensive intervention for aggressive youth. There are three components of ART: Skillstreaming; Anger Control Training; and Moral Reasoning. Skillstreaming evolved from Bandura’s (1973) Social Learning Theory, which focuses on direct instruction through modeling, role-playing, feedback and transfer. In ART these four principles are used to teach youth desirable social behaviours to replace inappropriate aggression (McGinnis, 2003). An outline of the ART curriculum (Goldstein & Glick, 1987) can be found in Appendix E. Anger Control Training was developed based on the work of Feindler and Ecton (1986), as well as Meichenbaum (1977). This principle of ART teaches youth how to respond to provocation, using knowledge about their internal triggers, cues, reducers and reminders instead of reacting with anger. The third component of ART, Moral Reasoning Training, is based on the stages of moral development (Kohlberg, 1973). Youth are given a situation in which they must morally justify which action they would take. Through this, the adolescents are exposed to differing moral reasoning levels of the others within the group. The ART method has been found to be effective by many researchers.
ART has been recognized by: the U.S. Department of Education’s Panel on Safe, Disciplined & Drug Free Schools, The U.S. Department of Justice, The American Correctional Association, and the United Kingdom’s Home Office as a “model program” (Amendola & Scozzie, 2004). Jones (1990) found support that ART results in skill acquisition, increased moral reasoning and enhanced anger control. The Jones study also found that there was a decrease in aggressive behaviours as well as an increase in self-control, coping and other prosocial behaviours. Also, other studies have found an “overall reduction in acting-out behaviors and an increased level of functioning, even when applied in settings with chronically aggressive adolescents” (Goldstein, Glick & Gibbs, 1998, p.16).

Glick and Goldstein (1987) conducted two separate, yet similar, studies using ART on males age 14-18 who had committed crimes, such as: assault, burglary, autotheft, possession of stolen property, criminal trespassing and drug use. There were 3 conditions, each containing 12 offenders. The first condition was ART, second condition was motivation training and the third was a control group that received no treatment. The first study using these conditions found that those who had been in the ART condition when compared to the other 2 conditions, changed significantly in all 10 skills tested (expressing a complaint, responding to feelings, stressful conversation, responding to anger, keeping out of fights, helping others, accusation, group pressure, expressing affection, responding to failure). Glick and Goldstein (1987) also found that “youngsters completing ART also changed significantly more in their overt, in-facility behaviour. In terms of both number of acting out incidents and the intensity” (p.360). The second study, contained 51 participants who were incarcerated, but the conditions remained the same. The results of the second study indicated that:

“youths receiving ART, as compared to those who did not, increased significantly over their base rate levels in the constructive, social behaviours they used (e.g. offering or accepting criticism appropriately…), and decreased significantly in their rated levels of impulsiveness” (p.361).

The results of both of the Glick and Goldstein (1987) studies indicate that ART is a credible treatment option for aggressive and assaultive youths who are incarcerated in a juvenile justice facility.

**Recommendations.** Overall, the programming that the agency currently offers: The Anger Control Workbook (Berg, 1990a) and The Anger Awareness and Interpersonal Problem Solving group manual and video (Baker, 1998), are both cognitive-behavioural treatments that should continue to be used. However, ART (Goldstein & Glick, 1987) has been proven to be “well-established” through several studies, and should be used in conjunction with the workbook and video, replacing the current CBT group and the Sunburst Communications program.
Cognitive Distortions

**Definition.** Cognitive distortions are defined by Abel, et al. (1989) as:

“An individual’s internal processes, including the justifications, perceptions and judgments used by the offender to rationalize his or her criminal behavior…which appear to allow the offender to justify his or her ongoing criminal behavior without the anxiety, guilt and loss of self-esteem that would usually result from an individual committing behaviours contrary to the norms of society” (as cited in Maruna & Mann, 2006, p.159).

Cognitive distortions related to criminal offending have been called “self-serving” (Barriga, Harold, Stinson, Liau & Gibbs, 1998) because they create false justifications for the reasoning behind the crime that allow the offender to escape feelings of guilt. There are four types of self-serving cognitive distortions (as outlined in Table 3).

Table 3

**Four Types of Self-Serving Cognitive Distortions**

<table>
<thead>
<tr>
<th>Cognitive Distortion</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>Self-Centered</td>
<td>Justifying one’s own needs, views, expectations, rights, immediate feelings to the point that the legitimate views of others are barely or not considered at all.</td>
</tr>
<tr>
<td>Blaming Others</td>
<td>Falsely attributing blame for one’s actions onto others or momentary events.</td>
</tr>
<tr>
<td>Minimizing/Mislabeling</td>
<td>Describing antisocial behavior as harmless commendable or suitable; or dehumanizing and ridiculing others or victims.</td>
</tr>
<tr>
<td>Assuming the Worst</td>
<td>Ascribing hostile intentions to others without proof; considering a worst-case scenario for a social situation as if it were inevitable; or assuming that improvement is impossible in one’s own or others’ behavior.</td>
</tr>
</tbody>
</table>


**Cognitive distortions and juvenile delinquency.** Sharp (2000) describes the relationship between criminal behaviour and cognitive distortions, when he states that
“criminal’s thinking leads to their feelings, their feelings lead to their behavior, and their behavior reaffirms their thinking” (p.2). A large body of research supports this notion (Henning, Jones & Holdford, 2005; Larden, Melin, Holst & Langstrom, 2006; Liau, Barriga & Gibbs, 1998; Palmer, 2005; Shoal & Giancola, 2005). Liau et al. (1998) conducted a study with 52 male delinquents and 51 non-offending high school students, to test if there was a relationship between cognitive distortions and antisocial behaviour. They found that the delinquent group had higher levels of self-reported cognitive distortions and anti-social behaviours. Palmer (2005) also indicated that there is a relationship between moral reasoning, specifically distortions in this reasoning, and aggressive behaviour in adolescent offenders.

Several other studies (Dodge, Price, Bachorowski & Newman, 1990; Lochman & Dodge, 1994) have found that “severely aggressive boys in particular have specific cognitive styles or difficulties that contribute to difficulties with social adaptation” (Larden et al., 2006, p.455). Cognitive distortions like minimization have also been linked to substance use and abuse (Shoal & Giancola, 2005). Constructive thinking (the ability to solve problems with minimal stress or harm to the individual) has been found to correlate negatively with adolescent boys and girls who use and abuse substances, while a positive correlation is found with minimization and mislabeling errors in thinking (Giancola, Shoal & Mezzich, 2001; Shoal & Giancola, 2001).

Self-serving cognitive distortions have also been implicated as reasoning behind adolescent sex-offences. The results of a study conducted by McCrady et al. (2005) indicated an elevation in cognitive distortions in adolescent sex offenders. They also found that cognitive distortions were not only apparent in crimes that were sexual in nature, but they were also associated with other offenses that involved diminished empathy for the victim. Henning et al. (2005), conducted a study of male and female sex offenders and found that males tended to blame the victim, stress, substances or other outside factors for their sexual misconduct. The authors also found that females attributed their behaviour to self-defense; however they also “engaged in significant minimization, denial, and external attributions related to the offense” (p.137). This suggests that both males and females utilize self-serving cognitive distortions to justify their criminal behaviours. Cognitive distortions can be linked to anti-social criminal behaviour, aggression, substance use and abuse and sexual offences, and therefore are an important target for treatment in order to reduce recidivism within the youth offender population.

**Current agency programming.** The current agency programming for cognitive distortions consists of two separate CBT programs; self-talk and distorted thinking. Each program consists of 9 to 11 sessions, in which distorted thinking is discussed using the “A-B-C model” (Ellis & Grieger, 1977). The A-B-C model is based in Rational Emotive Behavior Therapy (REBT) and states that what we experience is part of a process including an activating event situation, a belief about the situation and the consequences of that situation.

**Empirical basis for programming.** No research could be found on the exact CBT program being run at the agency. However, Rosenbaum & Carty (1994) utilized a CBT
group to diminish the cognitive distortions of depressed patients, and found it to be an effective option with low rates of drop out. REBT has been found effective for reducing cognitive distortions in adolescents by a number of studies (Warren, Deffenbacher & Brading, 1976; Zelie, Stone & Lehr, 1980; Raynor, 1992; Morris, 1993; DeAnda, 1998).

**Review of best practices.** Several studies have found that the EQUIP program developed by Gibbs, Potter and Goldstein (1995) is an effective intervention for the reduction of cognitive distortions in adolescent offenders (Moody, Edward & Lupton-Smith 1999; Nas, Brugman & Koops, 2005; Steele, 2002). Through a peer-helping approach, the EQUIP program is designed to encourage youth to act and think responsibly. The program is designed around the Positive Peer Culture (PPC) model (Vorrath & Bendtro, 1985) which is based on the premise that negative peer culture must be transformed into positive peer pressure in order for treatment to be effective. The EQUIP program is designed for groups of 6 to 10 adolescents, consisting of 5 sessions per week for 1 to 1 and a half hours per session. It is recommended that the EQUIP program be run for 10 weeks, but it can be shortened based on the duration of custody for each youth (Gibbs et al., 1995).

There are four phases involved in the EQUIP program: modeling, role-plays, providing feedback to the role-player and practicing the skill (Gibbs, 2003). EQUIP also features a helping skills curriculum consisting of social skills training, anger management training and moral education. This portion of the program is based on Goldstein and Glick’s (1987) Aggression Replacement Training, which utilizes CBT concepts to alter cognitions and has been empirically supported as a treatment for aggression in youth offenders (Amendola & Scozzie, 2004; Goldstein et al., 1998; Jones, 1990). Anger management, social skills training and moral education are all provided in EQUIP meetings, in which the facilitator guides the youth and teaches them specific skills. The program also includes “mutual help meetings” in which youth can talk about their problems and have their thinking patterns discussed by the group in order to correct any distortions. Mutual help meetings are more youth oriented and the facilitators role is to guide the adolescents in using the skills they have been taught. These meetings are held once or twice a week and replace the EQUIP meetings during this time. According to Nas, Burgman and Koops (2005) the EQUIP program is a promising approach for two main reasons,

“First, EQUIP is a multi-component helping skills program, and these helping skills are practiced in a peer group approach. Second, the results of a study using a preliminary version of the EQUIP program have shown the program to have great potential in reducing recidivism” (p.421).

In a quasi-experimental study conducted by Leeman, Gibbs and Fuller (1993) comparing an intervention group (EQUIP group) with a control group, it was found that the EQUIP group displayed fewer behavioural problems than the control group. In the follow up of this study it was found that 6 months after release, 29.7% of the control group had re-offended, while only 15% of the treatment group committed further crimes. At a twelve month follow-up of the two groups, the control group had continued to re-
offend (40.5%) while the EQUIP group remained at the 15% mark. Thus illustrating that the EQUIP program reduces the rate of recidivism in youth offenders.

Nas et al. (2005) conducted another quasi-experimental study on the effects of EQUIP on four main areas: moral judgment; social skills; cognitive distortion; and social information-processing. The study was similar to Leeman et al. (1993) in that it consisted of a control group as well as a treatment group. The participants were 108 male youth offenders between 12 and 21 years old who were incarcerated. The EQUIP groups consisted of six youth that met for 1 hour, three times a week. The results of the study indicated that the experimental group showed a significant reduction of all four types of self-serving cognitive distortions.

**Recommendations.** Overall, the agency’s current CBT intervention for cognitive distortions can be seen as effective, as demonstrated by studies on similar CBT programming for youth offenders. However, EQUIP, a more modern intervention, which features several components of both CBT and ART, has been demonstrated to be a promising approach after two separate quasi-experimental studies. The EQUIP implementation guide and program book (Gibbs et al., 1995) can be purchased online at http://www.researchpress.com for $54.80. Research has shown that the EQUIP program has been successful at reducing recidivism of youth offenders and correcting cognitive distortions, and therefore should be implemented at the agency.
Eating Disorders

**Definition.** Body image is defined by Cash and Pruzinski (1990) as “a complex and multidimensional construct which several components interact: cognitive, affective, evaluative, tactile-kinestesic, and social”(p.12). When adolescents become fixated on perfecting their body image, eating disorders often result. There are three main categories of eating disorders that are found in the DSM-IV-TR (APA, 2000); Anorexia Nervosa, Bulimia Nervosa and Eating Disorder Not Otherwise Specified (EDNOS). The key characteristics of Anorexia are refusing to maintain a normal body weight, an intense fear of becoming fat or gaining weight, an incongruence between the way one perceives their body or body shape and how it actually looks, and amenorrhea (the absence of three consecutive menstrual cycles).

The defining criteria of Bulimia include episodes of binge eating that consist of eating more than a normal person would within a certain time and a sense that the person has no control or is unable to stop eating during a binge. Purging behaviours that include self-induced vomiting, and laxative misuse also characterize Bulimia.

EDNOS are dietary problems that meet some of the criteria for either Anorexia or Bulimia but do not meet enough to be classified as either of these primary eating disorders. An example of an EDNOS is binge-eating disorder, as it includes the binging behaviour of bulimia, but not the purging behaviour, therefore the individual does not meet the criteria for bulimia.

**Eating disorders and juvenile delinquency.** Literature suggests that more females than males experience body-image dissatisfaction across all ages. Males generally desire a muscular physique, while women tend to worry about being heavy or overweight (Viviani, Bortoli & Robazza, 1996; as cited in Fairburn, 1997). Owing to the fact that adolescent offenders often have impulse-control problems, it is expected that they would also have high levels of problems regarding weight-control (Cooper, Wood, Orcott & Albino, 2003). A study conducted by Neumark-Sztainer, Story, Dixon and Murray (1996) with adolescents in the sixth to twelfth grade, discovered a significant relationship between criminal behaviour and harmful weight loss methods. Results of the Youth Risk Behavior Survey (1993; as cited in Ho, Kingree & Thompson, 2006) indicated that youth who used and abused drugs and alcohol showed “relatively high levels of extreme weight-control behaviors, such as vomiting and taking diet pills” (p.477). Cognitive distortions are thought to be the “core psychopathology” of anorexia and bulimia and other eating related problems (Fairburn, 1997). Cognitive distortions have also been linked to aggression, substance abuse and misuse and sexual offences (Dodge et al., 1990; Henning et al., 2005; Lochman & Dodge, 1994).

**Current agency programming.** Current programming at the agency consists of several modules on body image, including a Girl’s Circle (Hossfeld & Taormina, 1997) unit entitled “Body Image” and several Girls Group Modules discussing body image and the media as well as nutrition and eating disorders. The Body Image unit in the Girl’s Circle program consists of 8 sessions: body talk; body messages (two parts); my body; body wisdom; accepting and nurturing our bodies; body expression; and whole body/whole person. Each session has activities and discussions to encourage the
adolescents to participate. The Girl’s Group Modules consist of several handouts including Canada’s Food Guide (Health Canada, 2007).

**Empirical basis of programming.** As previously mentioned, Girl’s Circle (Hossfield & Taormina, 1997) has been proven to be a promising treatment method. In the case of body image, it has shown to significantly improve body-image satisfaction and self-efficacy (Irvine, 2005). There is no information at the agency regarding Girl’s Group Modules, no author or date could be found in any of the binders and no empirical data regarding the modules could be found.

**Review of best practices.** Although Girl’s Circle addresses eating disorders, and allows youth to discuss issues surrounding body image, it is not designed to treat eating disorders. According to Hong and Todd (2004), “the cognitive behavioural account of body image disturbances show that a distorted or negative self-schemata contributes to a distorted body image and affects the body-connected aspects…” (p.176). Cognitive Behavioural Therapy (CBT) in groups, has been found to be effective for Anorexia, Bulimia and EDNOS (Bowers, 2001; Corstorphine, 2006; Glover, Brown, Fairburn & Shafran, 2007; Smith, Marcus & Kaye, 1992; Wifley et al., 2002; Wonderlich et al., 2004). In fact, CBT has been “recommended as a primary approach in the treatment of eating disorders and been called ‘the gold standard’ in the treatment of bulimia nervosa” (American Psychiatric Association, 2002, as cited in Bowers & Andersen, 2007). Bowers and Andersen (2007) indicate that there have been more than 20 controlled trials utilizing CBT as a treatment for bulimia that have illustrated that CBT is effective at significantly reducing binging and purging in patients with bulimia. Bowers (2001) also found that CBT has been found to be a superior treatment to other forms of therapy (behavior therapy, psychodynamic therapy and pharmacotherapy). Several studies have found that CBT is more effective than antidepressants for the treatment of bulimia (Agras, Rossitier, Arnow, Raeburn & Bruce, 1994; Fetcher et al., 1991, Goldbloom et al, 1997; Mitchell et al., 1990). CBT also works well with binge-eating disorder and has shown to reduce binging episodes and overall weight (Bowers & Andersen, 2007). According to Glover et al. (2007), CBT is able to reduce “perfectionism” which has “been implicated in the maintenance of eating disorders” (p.85).

Corstorphine (2006) has proposed Cognitive-Emotional-Behavioural Therapy (CEBT) for eating disorders. CEBT is a combination of dialectical behaviour therapy, cognitive behavioural therapy, mindfulness training and experiential exercises. The outline of the CEBT program can be found in Appendix F. CEBT is thought to be a promising approach, as it combines all of the elements of other treatment methods that have been found to successfully treat eating disorders. Dialectical behaviour therapy, has been found to be effective in treating eating disorders a number of studies (Hinrichsen, 2005; Safer & Hugo, 2006; Telch, Agras, Linehan, 2001). Baer, Fisher and Huss (2005) found that mindfulness training is an effective piece of major intervention programs for eating disorders. Corstorphine (2006) noted that CEBT is not meant to be a new invention for the treatment of eating disorders, but is more of an innovation by combining key components of successful programs into one.
Recommendations. It is recommended that the agency continue to use the Girl’s Circle programming, in addition to incorporating information regarding nutrition (i.e. healthy eating and activities) for educating youth entering the facilities on eating disorders and body image. It is also recommended that CEBT proposed by Corstorphine (2006) be utilized for instances where there are actual cases of eating disorders, as this program is designed to treat the problem, where as Girl’s Circle is an educational tool. The agency was provided with the Corstorphine (2006) article, which outlined how to implement the treatment.
Chapter IV: Discussion

The programming implemented at the St. Lawrence Youth Association custody facilities was in need of a review to discern if the group counseling methods were reflective of the current state of literature, and ‘well-established’ or representing best-practices for the need areas they were addressing. The criteria for well-established practices was defined by the American Psychological Association, as a program that had either two or more group design studies that had been completed by different researchers or, had a number of single-case studies conducted by different researchers that resulted in a significant change in the target area (Lonigan, Elbert & Johnson, 1998; as cited in Gullotta & Adams, 2005). All of the programs that were recommended had components of, or were a form of, cognitive-behavioural therapy, which has shown to be effective with young offenders (Cohen-Kettenis & Van Engeland, 2002; Delligatti, Akin-Little & Little, 2003; Mpofu & Crystal, 2001; Van De Wiel, Matthys, Kelsberg & St.Anna, 2006). A summary of the recommendations that were made for each need area can be found in Appendix G. This summary also lists the key articles for each need area and a copy of the articles was left with the agency.

New programs were suggested for five of the six need areas reviewed in this project: sexual abuse, substance abuse and dependence, anger management, and eating disorders. For conduct problems, the agency was already running a CBT program that was found to be “well-established” and effective at reducing symptoms and problems associated with CD.

For all six need areas, it was recommended that portions of the original programming be kept and used in conjunction with the new group methods, which had key components that the research suggested was effective. Since the original programming consisted of mostly workbooks, it included handouts that could help the youth to remember what they had learned in each session. These handouts could potentially compliment the suggested programming and strengthen the impact of the curriculum being taught.

*Strengths.* The need areas chosen were selected based on staff input and research on youth offenders, which ensured that the areas reviewed were important to the agency. All recommendations that were made were based on peer-reviewed journal articles, which utilized research studies to prove that the treatment method was effective in the adolescent population. Another strength of this program evaluation was that research on treatment programs was reviewed on both youth in general, and the adolescent offender population, in particular. This was crucial to ensure that all suggested programming was relevant to the needs of the agency. Also, due to the fact that the youths remain in detention or custody for varying periods of time (usually short stays), the programming that was recommended is flexible, in that the number of sessions can be altered to suit the agency’s needs. The recommendations made in this thesis are not only useful for the current agency, but could be applied to other juvenile justice facilities. This project has contributed to the field of behavioural psychology by providing an overview of effective and well-established group treatment programming for youth offenders.
**Limitations.** One of the limitations of the review was that there was only a modest return rate of the YONQ survey, by 50% of the staff. Therefore many staff did not give their input on their perceptions of the importance of the need areas. Another limitation of this review, was that the recommended treatment method for eating disorders had not been applied to youth offenders. An additional limitation is that there was no descriptive information regarding the empirical basis for some of the programs currently being run at the agency. Therefore, these programs could not be thoroughly researched. A further limitation is that the agency had suggested that they were going to be eliminating custody services for males and become an all female institution; therefore the YONQ was created with only female youth offenders in mind. If the questionnaire had been made to include both genders, the need areas chosen by staff as important might have been different, potentially influencing the areas focused on in this thesis.

**Future directions.** It is suggested that the agency carefully record all bibliographic information on any future programming that they adopt. In the future, research could be conducted on the effectiveness of the recommended programs once they have been implemented at the agency’s facilities. Although 12 need areas in total were reviewed (6 by this author and 6 by a colleague) there are still many more areas of programming that merit review. It is also recommended that feedback be obtained from the staff and youth at the agency on the new programming, so that changes can be made.

**WORD COUNT: 12,393**
References


problems in teenagers: A path analysis. *Journal of Studies on Alcohol, 63*, 305-316.


Aldine.


Appendix A: Programs Delivered at Achievement St. Lawrence

**Educational**
- Cognitive Behavioural Intervention: Educational Program
- Honouring Our Diversity (Girls Circle)
- Values, Influences and Peers (VIP)
- Goal Setting: Introduction (Girls group modules)
- Goal Setting: Identifying Goals (Girls group modules)
- Goal Setting: Action Plan (Girls Group modules)
- Problem solving/Decision making (Girls group modules)
- Celebrating Diversity (girls group modules)
- Homophobia and discrimination
- Mental health: Education around suicide, depression, self harm and substance use
- Know Your Rights

**Conduct Problems**
- Cognitive Behavioural Intervention: Offenses/Dispositions
- The Self-Control Workbook: Exercises to control inattention, impulsivity and hyperactivity (Berg, 1990)
- Conduct Management Workbook (Berg, 1990)

**Substance Use/Abuse/ Addiction**
- The Recovery Workbook: Exercises to Deal With Drugs and Alcohol (Berg, 1990)
- Mind/Body Spirit (Girls Circle)
- Paths to the future (Girls circle)
- Sex and Alcohol: Date rape drugs (girls group modules)
- Substance use (discussion group)
- Substance abuse (discussion group)
- Gambling (discussion group)

**Anger Management**
- The Anger Control Workbook: Exercises to Develop Anger Control Skills (Berg, 1990)
- Conflict Resolution (girls group modules)
- Anger: What is anger? (girls group modules)
- Expressing Anger: Promoting Assertive ways of managing anger (girls group modules)
- Cognitive Behavioural Intervention: Anger Management
- Sunburst Curriculum Module: Resolving Conflicts
- Sunburst Curriculum Module: Handling Your Anger
- Anger Awareness and Interpersonal Problem Solving (Baker, 1996)

**Cognitive Distortions**
- Cognitive Behavioural Intervention: Distorted Thinking
- Cognitive Behavioural Intervention: Self-Talk
Eating Disorders
Body Image (Girls circle)
Body Image (Girls group modules)
Body Image and the Media (Girls Group Modules)
Nutrition (Girls Group Modules)
Eating Disorders (Girls Group Modules)
Accept the good and the bad
Celebrate yourself

Self-Awareness
Young Women’s Lives (Myhand & Kivel)
Mind/Body Spirit (Girls Circle)
Being a girl (Girls Circle)
Expressing my individuality (Girls circle)
Who I am (girls circle)
Inner vs. Outer Self (Girls’ Group Modules)
Who am I on the Inside? (Girls Group Modules)
Self-Concepts: Personal Values (Girls Group Modules)
Self-Esteem (Girls Group Modules)
Spirituality: Mind, Body, Spirit Connection
Sunburst Curriculum Module: Self-Esteem
Get to Know Yourself
Stay True To Yourself
Realize You are Responsible For Your Own Happiness
Don’t Worry About What Others think
Give Yourself a Break
Learn from your pain
Go Beyond your comfort zone

Relationships
Friendship (Girls Circle)
Cognitive Behavioural Intervention: Family Factors
Paths to the future (Girls circle)
Healthy Relationships: Healthy vs. Unhealthy (Girls group modules)
Sexual Assault (Girls Group Modules)
Safe Dating (Girls group modules)
Healthy Sexuality: Attitudes, Exploring Abstinence (Girls group modules)
Healthy Sexuality: Birth Control, Pregnancy and STI’s (girls group modules)
Healthy Sexuality: Decision making (girls group modules)
STI’s (girls group modules)
Partner abuse and dating violence (discussion group)
The Teen Relationship Workbook (Moles)
Let Others Love You
Building positive relationships
Social Skills
Social Skills Lessons and Activities for Grades 7-12 (Begun)
Communication: Verbal/Non-verbal, one and two way communication (Girls group modules)
Communication: Assertiveness training (girls group modules)

Stress Management
Stress Management: what is stress? Coping strategies (girls group modules)
Stress management: Identifying individual stressors and strategies

Life Skills
Grief and Loss
Employment Readiness
Appendix B: Programs Delivered at Sundance

**Educational**
- Cognitive Behavioural Intervention: Educational Program
- Honouring Our Diversity (Girls Circle)
- Values, Influences and Peers (VIP)
- Goal Setting: Introduction (Girls group modules)
- Goal Setting: Identifying Goals (Girls group modules)
- Goal Setting: Action Plan (Girls Group modules)
- Problem solving/Decision making (Girls group modules)
- Celebrating Diversity (girls group modules)
- Homophobia and discrimination
- Mental health: Education around suicide, depression, self harm and substance use
- Know Your Rights

**Conduct Problems**
- Cognitive Behavioural Intervention: Offenses/Dispositions
- The Self-Control Workbook: Exercises to control inattention, impulsivity and hyperactivity (Berg, 1990)
- Conduct Management Workbook (Berg, 1990)

**Substance Use/Abuse/Addiction**
- The Recovery Workbook: Exercises to Deal With Drugs and Alcohol (Berg, 1990)
- Mind/Body Spirit (Girls Circle)
- Paths to the future (Girls circle)
- Sex and Alcohol: Date rape drugs (girls group modules)
- Substance use (discussion group)
- Substance abuse (discussion group)
- Gambling (discussion group)

**Anger Management**
- The Anger Control Workbook: Exercises to Develop Anger Control Skills (Berg, 1990)
- Conflict Resolution (girls group modules)
- Anger: What is anger? (girls group modules)
- Expressing Anger: Promoting Assertive ways of managing anger (girls group modules)
- Cognitive Behavioural Intervention: Anger Management
- Anger Awareness and Interpersonal Problem Solving: (Baker, 1996)

**Cognitive Distortions**
- Cognitive Behavioural Intervention: Distorted Thinking
- Cognitive Behavioural Intervention: Self-Talk

**Eating Disorders**
- Body Image (Girls circle)
- Body Image (Girls group modules)
- Body Image and the Media (Girls Group Modules)
- Nutrition (Girls Group Modules)
Eating Disorders (Girls Group Modules)

**Self-Awareness**
- Young Women’s Lives (Myhand & Kivel)
- Mind/Body Spirit (Girls Circle)
- Being a girl (Girls Circle)
- Expressing my individuality (Girls circle)
- Who I am (girls circle)
- Inner vs. Outer Self (Girls’ Group Modules)
- Who am I on the Inside? (Girls Group Modules)
- Self-Concepts: Personal Values (Girls Group Modules)
- Self-Esteem (Girls Group Modules)
- Spirituality: Mind, Body, Spirit Connection

**Relationships**
- Friendship (Girls Circle)
- Cognitive Behavioural Intervention: Family Factors
- Paths to the future (Girls circle)
- Healthy Relationships: Healthy vs. Unhealthy (Girls group modules)
- Sexual Assault (Girls Group Modules)
- Safe Dating (Girls group modules)
- Healthy Sexuality: Attitudes, Exploring Abstinence (Girls group modules)
- Healthy Sexuality: Birth Control, Pregnancy and STI’s (girls group modules)
- Healthy Sexuality: Decision making (girls group modules)
- STI’s (girls group modules)
- Partner abuse and dating violence (discussion group)

**Social Skills**
- Social Skills Lessons and Activities for Grades 7-12 (Begun)
- Communication: Verbal/Non-verbal, one and two way communication (Girls group modules)
- Communication: Assertiveness training (girls group modules)

**Stress Management**
- Stress Management: what is stress? Coping strategies (girls group modules)
- Stress management: Identifying individual stressors and strategies

**Life Skills**
- Grief and Loss
- Employment Readiness
Appendix C: Youth Offender Needs Questionnaire

Students Caroline Fleming and Martha McCann from the new Behavioural Psychology Degree Program at St. Lawrence College are conducting a review of counseling programs run at the St. Lawrence Youth Association. In order to do this, we would appreciate your input on the needs relevant to young offenders.

Instructions:
1. From the list below, please circle 12 areas you feel are the most important to female youth offenders, based on your experience.
2. Rank these in order of importance (“1” being the most important need area, “12” being the least)

1. Anger Management
2. Social Skills
3. Eating Disorders/Body Image
4. Communication Skills
5. Cognitive Distortions
6. Life Skills
7. Coping with Abuse (physical)
8. Sexual Abuse
9. Relationships
10. Spirituality/religion
11. Self-harm
12. Depression and Suicide
13. ADD/ADHD
14. Sexually Transmitted Infections
15. Sexuality
16. Substance Use and Abuse
17. Conduct Problems
18. Borderline Personality Disorder
19. Anti-Social Personality Disorder
20. Stress Management
21. Family Problems
22. Grief and Loss
23. Relaxation
24. Emotion Regulation
25. Education
26. Self-esteem
27. Trust Building
28. Personal Hygiene
29. Bullying
30. Anxiety
31. Other (please explain):

___________________________
___________________________
___________________________
___________________________
___________________________

Thank you for your time!
## Appendix D: Results of the Youth Offender Needs Questionnaire

<table>
<thead>
<tr>
<th>Need Area</th>
<th>Number of times Chosen (out of 6)</th>
<th>Ranks</th>
<th>Mean</th>
<th>Overall Importance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Distortions</td>
<td>7</td>
<td>1,1,1,3,2,5,11</td>
<td>3.4</td>
<td>1</td>
</tr>
<tr>
<td>Substance Use and Abuse</td>
<td>7</td>
<td>1,3,4,4,6,10,12</td>
<td>5.7</td>
<td>2</td>
</tr>
<tr>
<td>Emotion Regulation</td>
<td>6</td>
<td>1,2,3,9,9</td>
<td>4.2</td>
<td>3</td>
</tr>
<tr>
<td>Anger management</td>
<td>6</td>
<td>1,6,6,4,8</td>
<td>4.3</td>
<td>4</td>
</tr>
<tr>
<td>Self-harm</td>
<td>6</td>
<td>4,6,7,7,10</td>
<td>5.4</td>
<td>5</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>6</td>
<td>3,6,9,10,11</td>
<td>7.0</td>
<td>6</td>
</tr>
<tr>
<td>Stress Management</td>
<td>6</td>
<td>4,7,7,8,10</td>
<td>7.2</td>
<td>7</td>
</tr>
<tr>
<td>Conduct Problems</td>
<td>5</td>
<td>2,5,6,11</td>
<td>5.8</td>
<td>8</td>
</tr>
<tr>
<td>Eating Disorders/Body Image</td>
<td>5</td>
<td>2,6,6,9,9</td>
<td>6.4</td>
<td>9</td>
</tr>
<tr>
<td>Coping with Abuse (Physical)</td>
<td>5</td>
<td>2,2,5,11,12</td>
<td>6.4</td>
<td>10</td>
</tr>
<tr>
<td>Relationships</td>
<td>5</td>
<td>4,6,7,7,9</td>
<td>6.6</td>
<td>11</td>
</tr>
<tr>
<td>Sexuality</td>
<td>5</td>
<td>3,11,11,12,8</td>
<td>9.0</td>
<td>12</td>
</tr>
<tr>
<td>Self-Esteem</td>
<td>4</td>
<td>1,2,10,10</td>
<td>5.8</td>
<td>13</td>
</tr>
<tr>
<td>Depression and Suicide</td>
<td>4</td>
<td>2,5,8,9</td>
<td>6.0</td>
<td>14</td>
</tr>
<tr>
<td>Family Problems</td>
<td>4</td>
<td>8,8,11,12</td>
<td>9.8</td>
<td>15</td>
</tr>
<tr>
<td>Anxiety</td>
<td>4</td>
<td>10,11,12,12</td>
<td>11.3</td>
<td>16</td>
</tr>
<tr>
<td>Communication Skills</td>
<td>3</td>
<td>2,4,8</td>
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<tr>
<td>Trust Building</td>
<td>3</td>
<td>5,9,11</td>
<td>8.3</td>
<td>18</td>
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<tr>
<td>Bullying</td>
<td>3</td>
<td>7,8,12</td>
<td>9.0</td>
<td>19</td>
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<tr>
<td>Borderline Personality Disorder</td>
<td>2</td>
<td>3,4</td>
<td>3.5</td>
<td>20</td>
</tr>
<tr>
<td>Education</td>
<td>2</td>
<td>1,8</td>
<td>4.5</td>
<td>21</td>
</tr>
<tr>
<td>Social Skills</td>
<td>2</td>
<td>5,7</td>
<td>6.0</td>
<td>22</td>
</tr>
<tr>
<td>Sexually Transmitted Diseases</td>
<td>2</td>
<td>5,10</td>
<td>7.5</td>
<td>23</td>
</tr>
<tr>
<td>ADD/ADHD</td>
<td>1</td>
<td>3</td>
<td>3.0</td>
<td>24</td>
</tr>
<tr>
<td>Anti-social Personality Disorder</td>
<td>1</td>
<td>5</td>
<td>5.0</td>
<td>25</td>
</tr>
<tr>
<td>Category</td>
<td>Count</td>
<td>Rating</td>
<td>Subtotal</td>
<td>Position</td>
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<td>------------------------</td>
<td>-------</td>
<td>--------</td>
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<td>----------</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>9</td>
<td>9.0</td>
<td>26</td>
</tr>
<tr>
<td>Relaxation</td>
<td>1</td>
<td>10</td>
<td>10.0</td>
<td>27</td>
</tr>
<tr>
<td>Spirituality/Religion</td>
<td>1</td>
<td>12</td>
<td>12.0</td>
<td>28</td>
</tr>
<tr>
<td>Life Skills</td>
<td>1</td>
<td>12</td>
<td>12.0</td>
<td>29</td>
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<tr>
<td>Personal Hygiene</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>30</td>
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<tr>
<td>Grief and Loss</td>
<td>0</td>
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<td>0</td>
<td>31</td>
</tr>
</tbody>
</table>
## Appendix E: Aggression Replacement Training Curriculum

<table>
<thead>
<tr>
<th>Week</th>
<th>Structured Learning</th>
<th>Moral Reasoning</th>
<th>Anger Control</th>
</tr>
</thead>
</table>
| 1    | *Expressing a complaint* | 1. The used car  
            2. The dope pusher  
            3. Riots in public places | Introduction to anger control |
|      | 1. Define the problem  
            2. Decide how the problem might be solved  
            3. Tell the person what the problem is and how it might be solved  
            4. Ask for a response  
            5. Show that you understand his or her feelings  
            6. Come to agreement on the steps to be taken by each of you | 1. The passenger ship  
            2. The case of Charles Manson  
            3. LSD | |
| 2    | *Responding to the feelings of others (Empathy)* | 1. The passenger ship  
            2. The case of Charles Manson  
            3. LSD | Assessment |
|      | 1. Observe the other persons words and actions  
            2. Decide what the other person might be feeling  
            3. Decide whether it would be helpful to tell the other person that you understand how they are feeling  
            4. Tell the other person in a warm, sincere manner how you think he/she is feeling | 1. The passenger ship  
            2. The case of Charles Manson  
            3. LSD | |
| 3    | *Preparing for a stressful conversation* | 1. Shoplifting  
            2. Booby trap  
            3. Plagiarism | Triggers |
|      | 1. Imagine yourself in a stressful situation  
            2. Think about how and why you will feel that way  
            3. Imagine that other person in the stressful situation and how they would think and feel | 1. Shoplifting  
            2. Booby trap  
            3. Plagiarism | |

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<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>4</td>
<td><strong>Responding to anger</strong></td>
<td></td>
</tr>
</tbody>
</table>
|   | 1. Listen openly to what the other person has to say | 1. Toy revolver  
2. Robin Hood case  
3. Drugs |
|   | 2. Show that you understand the other person’s feelings | Reminders |
|   | 3. Ask the other person to explain anything you don’t understand |   |
|   | 4. Show that you understand why the other person feels angry |   |
|   | 5. If it is appropriate, express your thoughts and feelings about the situation |   |
| 5 | **Keeping out of fights** |   |
|   | 1. Stop and think about why you want to fight | 1. Private country road  
2. New York Vs. Gerald Young  
3. Saving a life |
|   | 2. Decide what you want to happen in the long run |   |
|   | 3. Think about other ways to handle the situation besides fighting |   |
|   | 4. Decide on the best way to handle the situation and do it |   |
| 6 | **Helping others** |   |
|   | 1. Decide if the other | 1. The kidney transplant  
2. Bomb Shelter |
<p>|   |   | Thinking ahead |</p>
<table>
<thead>
<tr>
<th>7</th>
<th>Dealing with an accusation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Think about what the other person has accused you of</td>
</tr>
<tr>
<td>2.</td>
<td>Think about why the person might have accused you</td>
</tr>
<tr>
<td>3.</td>
<td>Think about ways to answer the person’s accusations</td>
</tr>
<tr>
<td>4.</td>
<td>Choose the best way and do it</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8</th>
<th>Dealing with group pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Think about what the other people want to do and why</td>
</tr>
<tr>
<td>2.</td>
<td>Decide what you want to do</td>
</tr>
<tr>
<td>3.</td>
<td>Decide how to tell the group what you want to do</td>
</tr>
<tr>
<td>4.</td>
<td>Tell the group what you have decided</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9</th>
<th>Expressing affection</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Decide if you have good feelings about the other person</td>
</tr>
<tr>
<td>2.</td>
<td>Decide whether the other person would like to know about your feelings</td>
</tr>
<tr>
<td>3.</td>
<td>Decide how you might express your feelings</td>
</tr>
<tr>
<td>4.</td>
<td>Choose the right time</td>
</tr>
</tbody>
</table>

1. Lt. Berg
2. Perjury
3. Doctors Responsibility

The angry behaviour cycle

1. Noisy Child
2. The stolen car
3. Discrimination

Full sequence rehearsal

1. Defense of other persons
2. Lying in order to help someone
3. Rockefeller’s Suggestion

Full sequence rehearsal
<table>
<thead>
<tr>
<th>and place to express your feeling</th>
<th>5. Express affection in a warm and caring manner</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>10</strong> Responding to failure</td>
<td><strong>1. Decide if you have failed</strong></td>
<td><strong>1. The desert</strong></td>
<td>Full sequence rehearsal</td>
</tr>
<tr>
<td></td>
<td><strong>2. Think about the personal reasons and circumstances that have caused you to fail</strong></td>
<td><strong>2. The threat</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>3. Decide how you might do things differently if you tried again</strong></td>
<td><strong>3. Drunken Driving</strong></td>
<td></td>
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<tr>
<td></td>
<td><strong>4. Decide if you want to try again</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>5. If it is appropriate, try again, using your revised approach</strong></td>
<td></td>
<td></td>
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</tbody>
</table>

### Appendix F: Components of Cognitive-Emotional Behavioural Therapy

**Goal Of Therapy.**
“To enable patients to challenge the basis of their emotional distress, thus reducing the need for the function of the associated eating behaviours” (Corstorphine, 2006, p.448).

<table>
<thead>
<tr>
<th>Key Component</th>
<th>How it is realized</th>
</tr>
</thead>
</table>
| Psychoeducation                                           | -0 Assessment of patients current knowledge of their emotions and functions of these emotions  
-1 Presentation of a model of emotions and functions  
-2 Discuss: (1) what is an emotion?  
(2) Why do we have them?  
(3) Primary and secondary emotions  
(4) Expressing emotions |
| Techniques to enhance emotion and motivation to change     | -3 Enhance patients awareness of their emotions and their functions  
-4 Use: (1) Diary monitoring  
(2) Experiential exercises  
-0 Enhance motivation to change through exploration of advantages and disadvantages of emotion suppression |
| Experiential exercises                                     | -1 Enable the patient to bypass his/her beliefs about emotions  
-2 Help to begin to identify and organize feelings through writing and drawing exercises |
| Strategies to restructure beliefs about the experience and expression of emotion | -3 At this point the patient should begin to develop his/her own rationale for challenging beliefs  
-4 This component deals with identifying and restructuring beliefs about emotions  
-5 Use: (1) Cognitive challenging  
(2) Behavioral experiments  
(3) Teach skills clients might need to begin to respond to their emotions |
<p>| Identifying and responding to primary                     | -Behavioral experiments and cognitive |</p>
<table>
<thead>
<tr>
<th>emotions adaptively</th>
<th>challenges should help diminish maladaptive beliefs in clients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>At this point it is important to add training to help develop new skills (e.g. assertiveness training to help clients express emotions appropriately) in order to help the client put new thinking patterns and beliefs to use</td>
</tr>
</tbody>
</table>

*Note.* Adapted from “Cognitive-emotional behavioural therapy for the eating disorders: Working with the beliefs about emotions” by E. Corstorphine, 2006.
Appendix G: Summary of Recommendations

Sexual Abuse

• Trauma-focused cognitive behavioural therapy as outlined by Feather and Ronan, 2006, combined with the Girls’ Circle sessions that are already being run.

• See articles:


Conduct Problems

• The current CBT program should continue to be used.

Substance Abuse and Dependence

• The agency should utilize the MET/CBT program as outlined by Webb, Seudder, Kraminer and Kadden, which is available online for free (a copy will be provided to the agency). It is also adaptable to individual needs and can be provided in 5 sessions or 12, which is vital to the agency as the youth are usually detained for only short periods of time.

• See article:


Anger Management

• The Anger Control Workbook (Berg, 1990a) and The Anger Awareness and Interpersonal Problem Solving group manual and video (Baker, 1998), are both cognitive-behavioural treatments that should continue to be used.

• Aggression Replacement Training (ART) (Goldstein & Glick, 1987) should be used in conjunction with the workbook and video.
See:


**Cognitive Distortions**

- The EQUIP program (Gibbs, Potter & Goldstein, 1995) has been successful at reducing the rate of recidivism within youth offenders and correcting cognitive distortions, and therefore should be implemented at the agency.

- The EQUIP implementation guide and program book can be purchased online at http://www.researchpress.com for $54.80.

- See article:


**Eating Disorders**

- It is recommended that the agency continue to use the Girl’s Circle programming, in addition to incorporating information regarding nutrition (i.e. healthy eating and activities) for educating youth entering the facilities on eating disorders and body image.

- It is also recommended that CEBT proposed by Corstorphine (2006) be utilized for instances where there are actual cases of eating disorders, as this program is designed to treat the problem, where as Girl’s Circle is an educational tool.

- See article:

Consent For Use of Agency Name

Date: Dec 2007

I, Robert Lee, consent to the use of the St. Lawrence Youth Association's agency name in Martha McCann's applied thesis for the Bachelor of Applied Arts in Behavioural Psychology program at St. Lawrence College.

Agency Staff Signature

Student Signature
From: MMccann06@Student.SL.On.Ca  
Sent: Tuesday, November 13, 2007 7:47 PM  
To: gibbs.1@osu.edu  
Subject: Self-Serving Cognitive Distortions

Dear Dr. Gibbs,

My name is Martha McCann and I am a student at St. Lawrence College in Kingston Ont. Canada, enrolled in the Bachelor of Applied Arts in Behavioural Psychology program. I am currently writing a thesis regarding youth offenders and "need areas" that should be focused on for programming at an agency in the Kingston area. I have been reading dozens of articles of cognitive distortions and was wondering if I could have your permission to reproduce a table defining the four types of self-serving cognitive distortions that I have found on page 334 in the article Measuring Cognitive Distortion In Antisocial Youth: Development and Preliminary Validation of the "How I Think Questionnaire" published in 1996 in the Aggressive Behavior journal. Of course you will be given full credit for the table. I find your work fascinating and this piece would fit nicely into my thesis as part of the definition for cognitive distortions.

Thank you for your time.

Martha McCann

"John Gibbs" <gibbs.1@osu.edu>
To: <MMccann06@Student.SL.On.Ca>
Date: Tuesday, November 13, 2007 07:57PM
Subject: RE: Self-Serving Cognitive Distortions

From: MMccann06@Student.SL.On.Ca [mailto:MMccann06@Student.SL.On.Ca]
Sent: Wednesday, January 23, 2008 7:02 PM
To: bglick01@nycap.rr.com
Subject: Aggression Replacement Training

Dear Dr. Glick,

My name is Martha McCann and I am a student at St. Lawrence College in Kingston Ont. Canada, enrolled in the Bachelor of Applied Arts in Behavioural Psychology program. I am currently writing a thesis regarding youth offenders and "need areas" that should be focused on for programming at an agency in the Kingston area. I have been reading; Glick, B., & Goldstein, A.P. (1987). Aggression replacement training. Journal of Counseling and Development, 65, 356-362.

and have recommended that this program be implemented. As such, I was wondering if I could have your permission to reproduce the table outlining the Aggression Replacement Training Curriculum as one of my appendices in my thesis. Of course Dr.Goldstein and yourself will be given full credit for the table. I find your work fascinating and this piece would fit nicely into my thesis as an overview of the wonderful program that you and your colleague have developed.

Thank you for your time.

Martha McCann

-62-
Hi Ms. McCann:
All materials are copyright protected by the authors and Research Press. As long as you properly site what you use (using APA writing style or some similar publications standard) you may use whatever you wish. Good luck in your project.

Barry Glick, Ph.D., NCC, ACS, LMHC
Chief Operations Officer