An Integration of Theory and Practice:
A Practicum Experience at Child and Youth Services

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Abstract

This practicum report is an integration of self-reflection and literature based on my MSW field practicum placement at Child and Youth Services (CYS). CYS is a sector of Mental Health and Addictions Services within the Regina Qu’Appelle Health Region. CYS’s mandate is to provide mental health assessment and counselling services to children, youth and their caregivers. This report integrates current literature, research, theory and knowledge, with my clinical experiences at Child and Youth Services over the course of my eight month practicum. It will provide a summary of how I achieved my four central learning objectives which included: intake assessment, theory and skills within cognitive behavioural therapy, participation in individual and group treatment with adolescent sex offenders, and facilitation of the anxiety and depression pathway group for adolescents. Within this paper, topics such as values, ethics, relationships, and skills will also be discussed.
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Introduction

After completing my Bachelor of Arts and Science degree in 2007, I began working for Ranch Ehrlo Society in the position of a youth care worker. I soon realized working with at-risk children and families was my passion. I knew I wanted a career that would allow me to help foster change within at-risk populations; therefore in 2009, I enrolled in the Bachelor of Social Work program at the University of Regina. After graduation with my BSW in 2010, I began working part-time as a Correctional Officer with The Regina Provincial Correctional Center (RPCC), and part-time as a Guidance Counsellor with Lumsden High School. Although I enjoyed my work at RPCC, I excelled at and loved my work with children and youth in the school, and knew that this was what I wanted to do full time. A few months later, I was offered a full time position as a Child and Family Support Worker with Prairie Valley School Division. I accepted this new role and began working in three elementary schools as well as in the Lumsden High School. My role consists of work with children and youth who have a variety of mental health issues, including but not limited to: attention deficit/hyperactivity disorder, major depressive disorder, autism spectrum disorder, generalized anxiety disorder, pervasive developmental disorder, fetal alcohol spectrum disorders and oppositional defiant disorders. In addition, I help students who self-harm and disclose suicidal thoughts, and support children who are experiencing peer relationship problems and behavioural issues in the classroom. In addition, I also provide individual counselling to children and youth and assist their parents in accessing outside agency support, and work extensively with different community organisations and social service agencies.
Working as a social worker in a rural school division provides many rewarding experiences, yet there are many challenges, not just because each situation is different, but because of limited time and limited access to resources. At times, I am the only avenue of support for the youth and children I work with because many families do not have the means for transportation or the funds to travel and access outside agency support located in city centers. The increased demand for individual counseling for clients and my hunger for more knowledge in the area of direct practice led me to the graduate program in Social Work at the University of Regina. This program offered an opportunity to build upon my existing knowledge, and to enhance my counselling skills that are vital to helping children and their families. I felt that the practicum option in my graduate program was the best option as it allowed me to gain valuable supervised counselling experience with an experienced clinical social worker.

**Practicum Setting**

My practicum was located with Child and Youth Services (CYS) in Regina, Saskatchewan. CYS is a sector of Mental Health and Addictions Services within the Regina Qu’Appelle Health Region. CYS’s mandate is to provide counselling and assessment services to children, youth and their caregivers. The agency can be broken down into seven “sectors” that provide services to specific populations. These sectors are: Child, Youth, Young Offender, Cognitive Disability and the Early Psychosis Intervention team, and in conjunction with these teams, are the Autism Center, the Randall Kinship Center and the Kids First program that provides outreach work.

My practicum began in September of 2013 and ended in April of 2014. I chose to do a part-time practicum that involved 16 hours a week and a few additional days and
evenings over the course of seven months. My professional associate works as a clinical social worker with the Early Psychosis Intervention (EPI) team. Although I found the EPI program interesting, it was not an area that I wanted to specifically focus on. To provide the experience I was looking to gain, my professional associate graciously took on several new clients from the Youth Team to help me gain clinical counseling experience with youth and their families. In addition to the Youth Team, I was able to work with the Young Offender Team, the Autism Center, as well as observe and co-facilitate several psycho-educational evening groups in the area of adolescent sex offender treatment, anxiety and depression pathway, and the superflex social thinking group with the Autism Center.

This paper will provide an overview of my four primary learning objectives. The first section speaks about intake assessments and the medical model within CYS. The second will provide a discussion on theory and practice; more specifically it will focus on CBT and how I applied CBT skills during my direct practice work at CYS. Third, I will speak about my observations of the adolescent sex offender treatment group, and my experiences while providing individual treatment to a high risk adolescent sex offender. Last, I will give an overview of the adolescent anxiety and depression pathway group at CYS, and discuss my involvement in co-facilitating the program. Throughout this paper, I will include discussions pertaining to relationships, skills, values and ethics, as well as concluding paragraphs that encompass my thoughts and feelings about my practicum experience as a whole and my vision as I move forward on my social work journey.
Practicum Objectives

Before I started my practicum at CYS, I identified several practicum objectives and learning goals to guide my journey. Once I began, I learnt that there was a slight difference between my learning interests and the opportunities available to me at CYS. Although I achieved all of my objectives in some form or another, in this paper, I chose to focus on four main areas. Below, are my four main learning areas, followed by a description of how each goal was achieved.

1) *Learn about specific mental health disorders that commonly affect children and youth by becoming familiar with the intake process, therapy methods, and case work procedures used at Child and Youth Services.*

My involvement in four intake assessments was essential to my growth in gaining confidence in the area of assessment. I was fortunate to be able to take the lead during the intake interview process, and learnt valuable skills in the areas of counselling, treatment planning and documentation procedures. I also learnt how the referral process for Child and Youth Services is conducted, and how inter-disciplinary referrals within the agency occur.

2) *To increase knowledge of social work counselling theories and methods.*

Going into this practicum, I was very clear that I wanted to expand my skills and strengthen my ability to practice the use of cognitive behavioural therapy (CBT). Thankfully, my professional associate was very experienced and skilled in using this therapy method. She spent a great deal of time educating me about CBT, and provided individualized supervision, while I practiced my skills during counselling sessions.
Because of this experience, I feel that my CBT counselling skills have greatly improved, and I am much more confident when working on a one on one basis with clients.

3) To observe and facilitate treatment programming for youth who have committed a sexual offense(s).

My professional associate and the program manager provided me with ample opportunities to achieve this goal. I was able to observe court ordered psycho-education groups for youth who have been charged with committing a sexual offence(s) and groups for their parents. Secondly, I co-managed counselling sessions with the program manager of the Young Offender team for a high needs youth requiring individual treatment for sexually inappropriate behaviour.

4) To facilitate treatment groups and gain a better understanding of group counselling.

To achieve this goal I was fortunate to have the opportunity to co-facilitate the “Anxiety and Depression Pathway” group on two separate occasions. First, I co-facilitated the pilot trial of this structured group with another social worker, who developed and currently manages the program, and second, I co-facilitated the group again three months later. I found it beneficial to facilitate this group twice, because it gave me the opportunity to witness different dynamics and challenges that occurred with each set of participants. This experience greatly increased my comfort and skill set as a group facilitator.
Intake assessment

Overview of the Intake Assessment

The process of completing an intake assessment can at times produce anxiety for both the clinician and the client. There is pressure on the clinician to form a working relationship with the client, build trust with the client, explain confidentiality protocols, develop an understanding of the client’s concerns, and determine how to provide support and/or treatment, all in a timely manner. The process of understanding an individual and their problems is complicated. At times, the client is not able to give a detailed description of their problem or needs, and may be unwilling or unable to provide information that the clinician requires to complete their assessment. According to Freeman, Pretzer, Fleming and Simon (1990), the intake interview is viewed as an extremely difficult, yet a crucial process of treatment. The intake assessment forms “the foundation for the understanding processes that produce and maintain the client’s difficulties and thus is the basis for the initial treatment strategy” (Freeman et al., 1990, p. 27). Cooper and Lesser (2005) describe an intake interview as the process of collecting information to gain a well-rounded understanding of client problems, and then using this information to form treatment goals to meet client needs. In addition, Miller (2003) states that effective case plans must involve a solid intake interview that encompasses gathering client information while maintaining good interpersonal skills. To add to this, Loney and Frick (2003) explain that despite self-report instruments and questionnaires, well balanced case plans and clinical diagnosis are best formed through “face-to-face verbal dialogue between assessor and client and is the prototypical format for most clinical enterprises” (p. 235).
According to Miller (2003), intake interviews can be broadly divided into two categories: unstructured and structured approaches. Unstructured approaches to interviewing allow clinicians to formulate their own questions based on client problems or need. The clinician is responsible for determining what questions need to be asked in order to formulate a diagnosis or develop a well-rounded case plan (Rogers, 1995). An unstructured approach requires the clinician to “rely on client presentation, clinical intuition, theoretical models, knowledge base, view of psychopathology, and interpersonal style to guide the interview process” (Miller, 2003, p. 24). Miller explains that the primary advantage to using an unstructured approach is the flexibility it allows the clinician. Clinicians are able to move fluidly from one subject to another and are able to decide how much time should be spent on a topic and what subject areas are most important. In addition, Freeman et al., (1990) explain that such flexibility positively impacts the clinician’s ability to establish rapport with the client, as the client is able to tell their story, and discuss their concerns in a manner that is meaningful to them. When experienced clinicians observe and assess clients there are some benefits, but also some limitations. Rogers (1995) states that because unstructured interviews are conducted in an un-organised fashion, clinicians run the risk of important information being overlooked or forgotten. Second, Rogers (2001) argues that unstructured interviews reduce reliability and validity due to information variance. Information variance can be defined as “variations among clinicians in what questions are asked, which observations are made, and how the resulting information in organized” (Rogers, 2001, p.5). Miller (2003) states that variations between interviewers naturally leads to different types of information being collected and analyzed, thus creating different concerns, diagnostic formulations,
and case plans. Miller (2003) and Rogers (2001) both state that if clinicians want to reduce information variance, they should refrain from using an unstructured approach to interviewing, and instead adapt a structured approach that requires all clinicians to ask the same questions to all clients, regardless of client problems.

The intake interview approach used at Child and Youth Services is a structured format that requires clinicians to use a standardized interview form/guideline (Child and Youth Services, 2014). The intake form covers eight specific information sections which are: reason for referral; family history and background; social and history; medical; developmental and psychiatric history, high risk behaviour; current concerns; therapist’s evaluation; and immediate plan. Miller (2003) states that there are several advantages for using structured approaches in intake interviewing, including improvements in the assessment of psychometric properties, coverage of background, demographic and diagnostic categories, and ratings of psychopathology. Rogers (2001) adds to this by explaining that structured interviews are more comprehensive and allow clinicians to pick up on diagnoses that are less prevalent. CYS utilizes structured interviews as part of the client intake process.

CYS is part of the Regina Qu’Appelle Health Region, and all members of the CYS team work within a medical model framework. According to Casstevens (2010) the medical model of mental illness can be described as a model that is an extremely influential dominant discourse where people are frequently identified or defined as problems. CYS clinicians complete a standard form in which client symptoms are categorized based on criteria according to the DSM-V; Social workers at CYS are only
permitted to use certain codes within the DSM-V and at this time, do not diagnose (Child and Youth Services, 2014).

**Intake Assessment in Practice**

During my practicum, one of my learning goals was to expand and increase my knowledge and professional competency in working directly with clients. Therefore, my professional associate invited me to conduct four full intake assessments. Prior to conducting these assessments, I was briefed on the interview process, issues such as confidentiality and informed consent, the CYS interview outline, and suggestions on how to appropriately build positive rapport with my client. All four intake assessments were supervised, however I had the freedom to independently run the interview, case plan and complete all intake assessment reports. Each intake interview with the client was approximately an hour in length. Typically, intake assessments are completed with the client and caregiver/parent present to ensure an accurate depiction of past and current information. Out of the four intake assessments, only one intake interview was completed with only the client present, as her father was unable to attend that session. In instances such as this, a phone call is made to the parent to go over any information the youth was unable to provide.

My first intake was with a 14 year old female who I have named Sarah. Sarah came to CYS for support with anxiety and depression. As a new clinician, I was unsure what to expect, and wanted to make certain that I completed all portions of the intake form to gather enough relevant information to form an educated case plan. When Sarah entered my office, I introduced myself and invited her to sit down. When I began the session, I made certain that I moved my chair away from my desk so I was facing her,
and ensured that I left enough distance between us to allow for appropriate personal space and comfort. I did this because it is important to pay attention to seating arrangements during a session. Sands (2001), states that clinicians should avoid sitting behind a desk when interviewing because it can immediately create a power imbalance. I wanted Sarah to feel safe and comfortable to help build our professional relationship.

Next, I explained that I was a student, and asked permission to conduct the intake while my supervisor was present in the room. In addition, I explained that during this intake, I would be asking many questions to gather as much information as possible to try to form an accurate picture of why she was experiencing difficulty. I discussed that when answering questions, there is never a wrong answer, but it is important to be as honest as possible. I believe it was important for Sarah to know that it was not my job to judge her, but to listen to her concerns and act as an advocate for her wants and needs. Cooper and Lesser (2005) explain that clinicians should always explain to the client the kinds of questions that will be asked and reasons for those questions. They state it is important that the client does not feel like the assessment is an investigation or like they are being interrogated and to avoid this, clinicians should present as empathetic, interested and genuine.

The second task of the intake was to explain confidentiality and to describe the parameters of our clinical relationship. Social worker’s at CYS are expected to follow the Canadian Association of Social Work ethical guidelines regarding confidentiality. The Code of Ethics describes confidentiality as a “professional value that demands that professionally acquired information be kept private and not shared with third parties unless the client provides informed consent or a professional or legal obligation exists to
share such information without client informed consent” (CASW, 2005, p.27). In addition, I explained that there were instances when confidentiality would need to be broken. Such instances include disclosure of harm to self, harm to others, or serious threat of harm to property. The third part of the intake was the interview itself: I followed the intake guide, and asked many questions to gather the information I needed. After completing the interview, I asked if Sarah had any questions about the intake, and then finished up the session by booking another appointment with her. The three other intakes I conducted were very similar; with each intake I completed, I became more comfortable and confident with the process and procedures.

**The Medical Model Approach**

Following the standardized intake guide was a process that felt rigid and uncomfortable. Some professionals argue that the rigidity of the structured interview process is one of its major downfalls. Miller (2003) explains that the rigid structure can interfere with relaxed communication, and cause the client to feel interrogated and stressed. In addition, Day (1984) argues that during a structured interview, clinicians control the conversation by focusing on particular topics or specific questions. He states that issues arise when the social worker focuses too closely on the intake guide, and gives less attention to topics that are not “easily categorized” (Day, 1984, p.22). In addition, Shaffer, Fisher and Lucas (1999) explain that structured interviews require clinicians to use specific questions or ask about certain topics and sometimes use precise wording for the questions. Because of this, there is a risk that clients may misunderstand the question and may respond based on false conceptions of what was asked. Another concern I had with using the structured intake form was the lack of flexibility to discuss client strengths
and resilience. The guideline includes one question that focuses on client strengths therefore the least amount of time was spent discussing areas that were going well for the client. This approach lacked flexibility to allow the client to speak about what they wanted to, and as a result, client problems and faults were the focus, and client strengths and resiliency were lost in the structured process of the interview. It seems that using a medical model approach does not allow for client autonomy and empathy. In fact, Weick (1983) explained that the model is a deeply rooted system that is based around the notion of individual fault and deficiency, and Kane (1982) states that the medical model “on an individual level, connotes an emphasis on diagnoses rather than on people” (p. 315).

When Kane states that the model focuses on diagnoses rather than people, he is referring to the way in which clients are viewed as having something wrong with them. The medical model views individuals as being faulty, rather than looking at the client as a whole, and taking into consideration how environmental and social contexts can have an effect on an individual’s circumstances.

Social workers who prefer to focus on strengths rather than problems must try to find a balance between medical based practice policies, and client centered practices. Weick (1983) suggests that if social workers working within a medical model wish to move towards a more holistic view of practice they must ensure that they try to promote client self-determination at every opportunity they have. Thus, although I was expected to follow the standardized intake process, I made certain to always try to focus on self-determination whenever possible. I believe that my clients have an innate wisdom about themselves, and they should be an equal part of determining what will help them heal. Therefore during my assessments, I allowed my clients time to speak about what they
believed will help them. I ensured that they had the opportunity to discuss their goals and what they would like to see happen in the following sessions. By doing this, I felt that I was able to balance the demands of the medical model, but also promote self-determination and help build positive rapport with my client.

**Theory**

**Theory in Practice**

During my practicum, I worked with individuals whose lives were affected by a wide variety of mental health conditions yet each one had their own unique story shaped by individual experiences that affected their lives. Clinicians have a variety of therapeutic models to choose from. Social workers should choose a model that allows for an understanding of how social and environmental factors directly contribute to emotional and behavioural problems for individuals. Typically, I work from a strengths perspective model. The strengths based approach is defined by Saleebey (2006) as:

> A dramatic departure from conventional social work practice…everything you do as social worker will be predicated in some way, on helping to discover and embellish, explore and exploit clients’ strengths and resources in the service of assisting them to achieve their goals, realize their dreams, and shed the irons of their own inhibitions and misgivings, and society’s domination (p. 1).

In using this approach, clinicians see clients as having unlimited capacity for growth and utilize a collaborative approach to treatment by showing empathy and sharing power throughout the entire process of change (Shiller, 2003). For my practicum, I wanted to work from a strengths based approach while gaining knowledge and
experience in a new therapeutic model. I set a goal to learn about cognitive behavioural therapy (CBT) as I have always been interested in using CBT in my professional practice, but never felt confident enough to try it. It was my hope that during my practicum, I would have access to direct supervision and constructive criticism based on my counselling sessions using CBT. Therefore, I felt very fortunate to be in an agency that consistently uses CBT as a primary treatment method for several mental health disorders. In addition to this, I was also assigned a supervisor who is trained in using CBT and was willing to offer me the instruction and supervision I was searching for. Thus, this section of my paper will provide an overview of CBT, a description of how CBT can be successfully applied to social work practice, a critique of its strengths and limitations, and a reflection of my experience using CBT during my practicum.

**Cognitive behavioural therapy**

Founded in the 1970’s by Dr. A. Beck, cognitive behavioural therapy (CBT) is known worldwide as one of the leading evidence-based psychological treatment methods for a variety of mental health disorders (Ronen and Freeman, 2007). Beck and Weishaar (1993) describe the goal of CBT as:

> The goals of Cognitive Therapy are to correct faulty information processing and to help patients modify assumptions that maintain maladaptive behaviors and emotions. Cognitive and behavioral methods are used to challenge dysfunctional beliefs and promote more realistic adaptive thinking. Cognitive therapy initially addresses symptom relief, but its ultimate goals are to remove systematic biases in thinking and
modify the core beliefs that predispose the person to future distress (p. 250).

Cognitive behavioural therapy has been proven very effective in treating a variety of conditions including, generalized anxiety disorder (GAD), adult and adolescent unipolar depression, obsessive compulsive disorder, panic disorder, social phobia, and post-traumatic stress disorder (MacKay, 2012). In a meta-analysis review of 16 studies, Butler, Chapman, Forman and Beck (2006) found that CBT was associated with improvement in bulimia nervosa, schizophrenia, childhood somatic disorders, marital distress and aspects of chronic pain.

CBT is a method of therapy that focuses primarily on thoughts and behaviours. It is based on a structured process that works by systematically targeting unhelpful thoughts and behaviours that maintain negative feelings (MacKay, 2012). It is founded on the idea that thoughts and emotions are deeply connected, and when individuals are able to change the way they think, they will be able to change their behaviour, which ultimately allows them to change the way they feel (Beck, 2011).

According to Beck (2011), when using CBT in clinical practice, therapists should focus on several key aspects. First, clinicians must ensure that the client-therapist relationship is collaborative. The clinician and the client must work together to investigate the client’s difficulties and the possible factors that may be contributing to them (Beck, 2012). Although the therapist is the primary expert in CBT, the client is the expert on their life, their experiences and preferences. Thus, the therapist should act as a guide, and the client must offer ideas and feedback to contribute to the case plan. The client and therapist work together to generate and try out new ways for the client to think
During my counselling sessions with my first client Sara, I ensured I applied this skill; I acted as a guide during our sessions, and allowed Sara’s mood to dictate where the session was going to go. Although the use of CBT is structured, I was able to be flexible and change the case plan to meet her needs on any given day that we met. For example, one session I had planned to create a fear ladder with Sara to help her work through her anxiety about performing tasks in front of others. However, when Sara came in that day she was feeling very low due to an argument that occurred with her best friend, and was not in the right mental or emotional state of mind to complete the task that I had planned. Because of our strong relationship, I was able to pick up on her mood and suggest that it may be best to focus on what had occurred that day which was contributing to her depressive state.

The second important skill in CBT is goal setting (Beck, 2011). The therapist and the client should develop appropriate goals that will help the client deal with their specific problems. For example, Beck (2011) suggests that clients should describe their problems and set specific goals in the first session in order to ensure that the therapist and the client have a mutual understanding of what the client is working towards. One of my clients was struggling with perfectionism; the need for perfection was resulting in anxiety that was negatively impacting her functioning. Together, she and I developed achievable treatment goals to reduce her anxious symptoms, and to help her change the way in which she thinks, so she could start to feel better about herself. The process of setting these treatment goals early on was very important, as it helped me determine needs and resources for upcoming sessions.
Third, therapists should ensure that they focus on the present (Beck, 2011). CBT focuses primarily on how clients feel and how they are coping with their problems in the present. Because feelings and behaviours are commonly determined by past experiences, it is acceptable for clients to explain how a past experience may be related to their current problem (Ronen & Freeman, 2007). However, the majority of therapy should be based around present functioning. While working with my clients, I ensured that I focused on their present situation, however, I also felt that it was important to talk about their past. As a clinician who uses a strengths perspective, I always want my client to think about a time when things have been going well for them. I like to explore what was going on during that time, and what abilities they used to help them overcome obstacles and achieve positive outcomes. For example, a twelve year old female whom I will call Amanda came to CYS for support with symptoms of depression and peer relationship problems. Amanda explained that she could not stop feeling sad and alone. However when I asked her to talk to me about a time when she did feel happy, she explained that during her seventh year of school she felt stable and happy. By exploring what was going on during this time, she and I were able to determine that she had several friends; was sociable and enjoying life at the time which contributed to her good mood and overall happiness. Amanda and I talked about her strengths, and focused on the positive qualities she has to offer the people around her and how her negative thoughts were causing her to forget her interpersonal gifts.

Fourth, CBT sessions are structured and time limited. Typical CBT sessions are one hour in length, and follow a specific agenda that is pre-determined at the beginning of the session (Beck, 2011). The sessions are usually broken down into three parts. First,
the therapist and client will set the agenda, do a mood update by asking the client to rate their mood using a numbered scale, then discuss the patient’s diagnosis and go through an education piece (Beck, 2011). The second part consists of identifying problems, setting goals, teaching the cognitive model, and discussing specific client problems. And the last part of CBT treatment includes a summary of the session, a review of homework assignments, and an opportunity for the client to offer feedback (Beck, 2011).

CBT was developed to be a fairly brief form of treatment. In most cases, a therapist will draw up a contract with the client to dictate how many sessions will occur. Barrington (2006) suggests that typical CBT sessions are six to fourteen sessions in length, however some disorders or problems will allow for brief therapy to occur in one to three sessions. Although CBT should be time limited, it is important to understand, that the length of treatment can be fluid and negotiated with the client throughout treatment (Ronen & Freeman, 2007). The ultimate goal of treatment is to decrease symptoms and prevent relapse, thus if a client requires longer treatment, then the therapist will accommodate this. The structured format of CBT helped me feel prepared and ready for my client. I always ensured that I had a plan, handouts and information ready, and that I knew the goal for that session. As previously mentioned, sometimes sessions did not go as planned; however I still enjoyed the idea of being able to prepare an agenda for a session and tried my best to follow it.

The fifth concept in understanding CBT practice is formulation. The therapist should formulate a model of the client’s problems and what may be contributing to them (Beck, 2011). The therapist will often ask the client to log or keep track of their beliefs, the feelings associated with these beliefs, the evidence for these beliefs and an alternative
view point to their beliefs (Ronen & Freeman, 2007). According to Miller (2012), the logs will help the client chart their thoughts, feelings, behaviours, somatic changes, and events in their daily life. These exercises have been shown to help clients find understanding in how their thoughts are linked to their behaviours and feelings (Beck, 2011). Formulations and exercises can evolve as the client presents new information and experiences throughout treatment (Center for Applied Research in Mental Health and Addiction 2007).

The process of tracking thoughts and recording triggers and feelings was an exercise I used with every client I worked with. To me, this process is an extremely important part of CBT, and I found my clients were able to have break through moments when they were able to make the connection between their thoughts and feelings, and gain a deeper understanding of themselves. One of my clients came to CYS as she was struggling with an eating disorder and perfectionism. In the beginning of therapy, she had difficulty accepting that her thoughts were controlling her feelings; she instead chose to blame her family and friends for her struggles. However, after numerous thought tracking exercises and several sessions, she had her break through moment and was able to make the connection between her thoughts, feelings and behaviours. She realized that her negative thoughts were occurring far too frequently throughout her day, and typically, there was little evidence to support her negative thoughts. By gently confronting her, I was able to show her that there were alternative ways at looking at situations, and when she was cognisant of her thoughts, she could avoid falling victim to negative thinking traps. I found when my clients were able to see their negative thoughts written down on paper, they found it easier to understand the impact these thoughts had on their daily
functioning. I believe that as I move forward in my social work career, I will continue to use this exercise with my clients as I truly find it beneficial.

And last, the therapist will teach clients new skills and assign homework to help clients achieve successful outcomes. Beck (2011) explains that there are numerous cognitive and behavioural techniques that can be applied to therapy sessions. Some of these skills include: problem solving and skills training, decision making, refocusing, mindfulness and relaxation, graded task assignment, exposure, role playing etc. The aim for teaching these skills is to “influence the patient’s thinking, behavior, mood and physiological arousal” (Beck, 2011, p. 256). Homework, is an extremely important part of treatment, and is not optional. Researchers have found that “cognitive behavior therapy patients who carry out homework assignments progress better in therapy than those who do not” (Beck, 2011, p.294). Out of all of the CBT skills and concepts, I found the principal of homework most frustrating. I believe that practicing skills and completing homework has a positive impact on treatment, yet as a clinician it was difficult to plan a session based around the assumption that a client will would complete the assigned homework, and also remember to bring it with them to their session. I had several incidents when my client either forgot to complete the homework, or did not remember to bring it with them. In these instances, my client and I would work together and try to complete the exercise in the office. The majority of the time it worked out and the sessions were successful, however there were a few times when my clients could not remember past events, and I had to change the case plan and chose another activity or topic to focus on.

**Strengths and Limitations of CBT**
As mentioned earlier, CBT is one of the leading evidence-based psychological treatment methods for a variety of mental health disorders, and there are several reasons for its popularity among clinicians and clients. Today’s society is fast paced and individuals want instant gratification. Individuals do not want to spend years in therapy discussing their childhood memories; they want fast and easy results. Although CBT is not necessarily easy, it is an efficient and structured formula that if practiced, will produce results that clients will notice quickly (Burns, 2012). The effectiveness of CBT has been proven beneficial with or without the use of pharmaceutical support. Sudak (2012) found that when CBT is employed either with or without medication, treatment is more durable than with medication alone. Furthermore, it was found that “there was a 50% reduction in relapse rates for depression and anxiety in patients who receive CBT as compared to patients using medication alone” (Sudak, 2012, p. 99).

Although there are many benefits to CBT, literature shows that there may also be limitations. In his article, Holmes (2002) discusses what he feels are some important limitations of CBT. First, Holmes explains that the National Institute of Mental Health study of depression, found cognitive behaviour therapy to be less effective in treating depression than the two other main treatment arms, interpersonal therapy and clinical management plus antidepressants. Secondly, he believes that there is a lack in research on the impact of different psychotherapies, including cognitive behaviour therapy, on the long term course of psychiatric illnesses. Holmes states that without “comparative follow up studies it is surely premature to champion any one therapy” (Holmes, 2002, p. 282). Finally, Holmes argues that CBT seems to be widely used because of its impeccable marketing campaign, as opposed to the actual effectiveness of the model itself. In
addition, Bateman (2000) says that the clinical therapy field is entering a “post-cognitive behaviour therapy world, which goes beyond brand name therapies to considering the active ingredients of therapy, specific competencies and techniques, and the similarities and differences between different approaches at both theoretical and practical levels” (Bateman, 2000, p.155). Because it exclusively focuses on the psychological and emotional issues of the individual, CBT neglects to consider that some issues are embedded in the individual’s physiological and genetic makeup. For example, an individual with a low IQ or developmental deficiencies will have an extremely difficult time applying CBT skills which require abstract thought. In addition, CBT is based on learning and applying new skills to change negative thought patterns. Thus if an individual is not willing to change, CBT will not be effective until that person feels ready to put in the effort and work to create positive growth. By only looking at the psychological makeup of an individual, important environmental and social contexts of the individual are ignored. For example, if an individual is experiencing homelessness as a result of a low income housing shortage, they may experience feelings of hopelessness and depression. However, the reason they are depressed is not only due to their negative thoughts, but more so a direct result of the current environmental problem to which they have no control over.

**Social Work and Cognitive Behavioural Therapy**

Social work as a profession is based around the objective of aiding, protecting and empowering vulnerable populations. Social workers must adhere to rules and guidelines that are outlined in the Code of Ethics that demand social workers to strive to improve the physical and mental well-being of their clients and attempt to break the oppressive factors
that are deeply rooted within our society. Ronen (2007) describes the main goals of social work as the want or the need to aid “individuals and groups to identify and resolve or minimize problems arising out of disequilibrium between themselves and their environment...to prevent the occurrence of harm and...to identify and strengthen the maximum potential in individuals, groups and communities” (p.4). Social workers always strive to better the lives of others; however and in efforts to help, social workers must educate themselves about knowledge, skills and tools to help make these changes a reality. When it comes to clinical social work, professionals working in a clinical practice continuously try to find a treatment model that follows the social work code of ethics, fits with social work values, and allows clinicians to work collaboratively with their clients to promote positive change. There are many practice models and therapeutic approaches that social workers chose to use when helping clients. For someone to say that one approach is better than another seems erroneous as each clinician is different and will use a method(s) that they are comfortable with to address specific client concerns. However for the purpose of my practicum, I chose to focus on CBT and wanted to understand how CBT could be applied in the context of social work practice.

Ronen and Freeman (2007) state that CBT has “almost specifically been crafted for social work practice” (Ronen & Freeman, 2007, p. xxiii). CBT as an effective therapy for social work practice can be best explained by describing key concepts and skills of CBT, and connecting them to social work practice.

First, cognitive behavioural therapy is based on the concept of cognitive schemas (Beck, 2011). Schematic thinking is formed in childhood, and is described as the automatic thoughts that are based on schematic interpretation of the meaning of a
situation. Automatic thoughts are skewed by negative assumptions as opposed to more positive assumptions of a situation, resulting in a negative belief about themselves or the world around them (Miller, 2012). As social workers, we work with vulnerable people who have been through difficult and aversive experiences. It is more than likely these individuals have formed cognitive schemas that produce feelings of anxiety, depression or hopelessness. It is the responsibility of the social worker to not only examine the client’s negative schemas, but also the environmental context in which someone exists, and work to empower them to live a better life. To do this, Miller (2012) suggests that social workers develop an understanding of the core cognitive structures that a client has developed, use empathetic listening skills, and help individuals to express their views of life and their experiences relating to past, present and future.

The second important CBT concept is automatic thoughts (Miller, 2012). Automatic thoughts are one of the most important concepts in CBT. These thoughts occur in every individual and are based on unique cognitive schemata. When people hold negative automatic thoughts about themselves or the environment around them, the more likely it becomes that they will experience emotional and behavioural problems. Miller (2012) explains that social work professionals must develop an understanding of how automatic thoughts are generated, and how they impact client choices, behaviour, and life. Social workers should investigate what is standing in the way of client change, and through conversation and skill teaching, try to remove some of these thoughts to foster change. In addition, social workers must look beyond the psychological makeup of the individual and look and environmental and social factors that impact their clients. As previously mentioned, there are many situations when clients do not have control over
their situation, and simple changing their thoughts will not create resolution for all the problems they are experiencing.

The third concept is the cognitive model (Miller, 2012). As described earlier, the cognitive model describes the way in which thoughts are produced and established, and how they are connected to our feelings and behaviours. As social workers, we need to educate our clients on the cognitive model, and empathetically explain how this model, if recognised and used, can positively impact their lives. Miller (2012) explains that social workers must be careful when applying this model to practice, as it can sometimes lead to focusing too much on negative aspects. Although it is important to focus on the negative thoughts, therapists should try to use a strengths based approach when identifying negative thoughts. Miller (2012) suggests that social workers can selectively use language that is inclusive and empowering rather than categorising individuals as having intrinsic problems. Social workers should always try to become familiar with the thought patterns that their clients hold, however, they should also use language that defines the “nature of the problem, rather than labelling an individual in general and stigmatising terms” (Miller, 2012, p. 60).

The fourth CBT concept that directly applies to social work practice is the therapeutic relationship between the client and the therapist. Social workers place a large emphasis on the importance of fostering a strong therapeutic alliance with the people in which they work (Ronen & Freeman, 2007). Creating a positive and strong relationship, allows the client to feel comfortable with their worker, and helps them let down their guard and begin to trust that their worker has their best interest in mind. The therapeutic relationship is even more important when working with mandated clients. Clients who
are forced to work with social workers will often come in angry and defensive. However, by slowly and patiently working with the client, an alliance will form, and the client will begin to trust and work with their worker to reach the goals that were collaboratively created. Historically, the therapeutic relationship was not always an important aspect of CBT practice. Yet, in recent years, more emphasis has been put on fostering a relationship with the client in order for effective collaboration to occur. Miller (2012) explains that when social workers apply the CBT concept of relationship or engagement, it creates a truly collaborative relationship. This relationship should maintain clear boundaries, and as these boundaries become accepted, the relationship will provide “a secure enough temporary base within which difficult experiences and feelings can be explored” (Miller, 2012, p.62).

The final component of CBT is assessment (Ronen & Freeman, 2007). A CBT assessment looks at factors present when an individual comes for therapy with a specific problem that is negatively impacting their functioning in day to day life. However, from a social work perspective, assessment lacks a broader exploration of the environmental factors that may be contributing to problems the client is experiencing. The assumption of the CBT assessment model is that there is a problem or a distortion in thinking that exists within the individual which is affecting them emotionally and impacting their behaviour (Sands, 2001). However, social workers must ensure that they are mindful that poverty, oppression and extrinsic systemic factors can also generate problems for clients that cannot be overcome by changing their thinking. Therefore, it is extremely important that social workers working with a CBT model ensure that they are always aware of social and environmental factors that contribute to individual problems.
My Reflection of Cognitive Behavioural Therapy in Direct Practice

Applying CBT skills during client sessions was definitely a unique experience. During my practicum, I provided treatment for the clients that I completed the intake assessments on. I continued working with them until the completion of my practicum. I have great passion for direct client work and have a strength and talent for building strong professional relationships with my clients, which enables trust and therefore the opportunity to create change within my client. While working with my clients at CYS, I was less confident in my abilities and became anxious before individual sessions. Although I was always prepared and knew that I had a solid plan going into the session, I still found myself doubting my abilities. I worried that I would not have the right answers, or would not be able to “fix” my client’s troubles. When I spoke to my supervisor about my feelings, she explained to me that it is not our job to fix problems we are guides that offer our clients skills so they can make changes in their own lives. Once I sat down and thought about that statement, I realized that she was correct. As a social worker I am not going to be able to solve every problem for my client; however I am able to offer them tangible skills that they can use to foster change within themselves. Once I realized this, I felt much more comfortable during my sessions, and began to see an improvement in my skills and growth from my clients.
Adolescent Sex Offender Treatment

Adolescent Sex Offender Psycho-Education Group

Identifying the Population

According to Sermabeikian and Martinez (1994), the legal definition of a juvenile sex offender is a person under the age of 18 who has committed a sexual offense against a person of any age that was against the victim’s will, and without the victim’s consent. It is an act described as an “array of sexual behaviour that is abusive, exploitative, and/or aggressive in nature” (p. 970). In addition, Ryan (1991) states that these acts can include intercourse, fondling, fellatio, rape, frottage and exhibitionism. According to research, there is no concrete evidence as to why certain youth commit illegal sexual acts. In their article, Davis and Leitenberg (1987) reviewed literature on sexual offences committed by adolescents and explored topics such as incidence statistics, offender and victim characteristics, recidivism and treatment. Their findings concluded that at that time research showed that adolescents accounted for a large share of sexual offences committed in North America. Secondly, they found that in nearly two thirds of the offences, younger children were the victims, and the majority were acquaintances or relatives of the offender. Third, there are typically more female victims than males and 95% of adolescent sex offenders are male. Fourth, adolescent male sex offenders had a higher frequency rate of being abused than other groups of male adolescents. And last, this study found that adolescent sex offenders claim to have had more experience in consensual sexual acts compared to other groups of adolescent males, which appears to contradict the belief that sexual offences occur because offenders are curious and lack sexual experience. In a more recent study, Vizard (2007) found similar conclusions. Her
research shows that characteristics of adolescent sexual offenders are becoming increasingly categorizable. Typically, offenders who exhibit sexually abusive behaviour show a wide range of dysfunctional features including sexually abusive or over sexualized behaviour, family breakdown, lack of stability, comorbidity for other psychiatric disorders notably conduct disorder, past history of victimisation, cruelty or sexual behaviour towards animals and learning disabilities (Vizard, 2007).

**Recidivism**

In a review conducted by the Ministry of the Solicitor General of Canada, Hanson and Bussiere (1994) provided quantitative summaries of over 61 data sets that reported on recidivism rates and characteristics of adolescent sexual offenders. The results of this review suggest that recidivism for adolescent sexual offenders was related to sexual deviance. The authors suggest that the strongest predictors were “phallocentric assessments of sexual preferences for children, general deviant sexual preferences, a history of prior sex offenses… general criminality, such as prior nonsexual offenses and antisocial personality disorder” (p. 17). The term phallocentric refers to assessment centered on men or on a male viewpoint, especially one held to entail the domination of women by men (Hanson and Bussiere, 1994). Sermabeikian and Martinez (1994) found similar findings, however emphasized that predictive factors are not nearly as important as intervention, and suggested that judicial systems should focus on early intervention to treat, disrupt and prevent sexually offending behaviour before it has the opportunity to become a chronic and compulsive problem.

**Treatment**
Worling and Curwen (2000) conducted a study to examine best practice treatment methods for adolescent sex offenders. The results of their study indicate that specialized treatment reduces the risk of subsequent sexual and nonsexual offending for adolescents and it appears that “comprehensive treatment that combines a strong family-relationship component along with certain offense specific interventions may be most successful for adolescent sexual offenders” (p. 979). Similarly, Bonner (2009) suggests that the four most effective treatment methods are: multi-systemic therapy, cognitive behavioural therapy, group therapy, individual therapy, and family therapy.

**Treatment Approach at CYS for Youth Sexual Offenders**

Treatment for adolescent sex offenders at CYS begins with an adolescent sexual offender risk assessment. This assessment is conducted under Section 34 of the Youth Criminal Justice Act and provides information to the courts on the level of risk the youth presents, recommendations on sentencing, intensity and type of treatment necessary, and if the youth requires any other sort of immediate intervention (Child and Youth Services, 2014). After assessment, treatment occurs and consists of the psycho-educational group for youth and their caregiver(s). This group is an eight week program that aims to educate youth on common terminology and statistics that is necessary for youth offenders to understand in order to be successful in treatment. The youth and their caregivers/parents are given mandatory weekly homework assignments that are graded to ensure the youth understands the material given to them. If a youth is not putting in the required effort to complete the homework, or does not seem to understand the material, a caseworker will contact the youth and arrange supplementary sessions, or ask the youth to come back at a later time when they are ready to take treatment seriously. Delaying treatment has serious
implications of the youth’s sentencing, and may result in additional probation time or conditions; therefore there is coercion to comply with processes of the treatment group. The psycho-educational group includes material on the following topics: statistics and information on sexual abuse, psychology of the offender, impact on the victim, sexuality and basic sexual education, dating, the offending cycle, relapse prevention and safety planning (Child and Youth Services, 2014).

The last component of treatment is the process group. Youth can only attend this portion of treatment once they have successfully completed that psych-educational group. The theoretical treatment model used is group cognitive behavioural therapy. Youth are challenged to examine their situation, and to develop an understanding of why they committed their offense. This group challenges youth to identify their own cycle of offending and to determine what issues in their lives contributed to their offense, and what their triggers are. An important component of this group is helping youth understand how to change their thinking which has historically allowed them to justify their wrong doings. In addition to the CBT model, youth are also required to develop safety plans, relapse prevention plans, and goals on how they will incorporate positive relationships into their lives. Like the psycho-educational group, youth are required to complete homework and must also keep a journal of their thoughts and feelings during the treatment process. Sermabeikian and Martinez (1994) state that treatment groups for adolescent sex offenders present social circumstances that greatly “influence moral judgement and thinking so that it will govern conduct” (p.974). Thus, the group environment itself creates a culture and moral standard against sexual offending. When a
youth is faced with the thought or opportunity to re-offend, he will most likely stop himself because of the peer influence the group members hold amongst each other.

**My Involvement in the Psycho-Educational Group**

As part of my learning objectives, I was given the opportunity to observe the adolescent psycho-educational group from start to finish. Research in the area of sex offender treatment strongly suggests that all treatment should be conducted only by trained and experienced facilitators (Bonner, 2009). Child and Youth Services has strict policies that ensure the court ordered treatment groups are always facilitated by trained members of the young offender team. The psycho education group consists of a total of eight sessions composed of seven educational sessions for the youth and their caregiver(s), and one final session for the caregiver(s). The group I observed was made up of ten youth and their caregivers. The ages ranged from 11-17 years and the types of offences varied among group members. The following section will give a brief description of eight group sessions based on my observations.

The first session is intended as an introduction to treatment and group expectations. Terminology specific to adolescent sexual offenders was introduced, group rules, expectations and confidentiality were explained, and the definition of a sexual offence and sexual act were taught. Time was spent discussing what typical sexual behaviour during adolescent consists of and what would constitute sexually inappropriate behaviour (Child and Youth Services, 2014).

The second and third session involves teaching detailed terminology of sexual offensive behaviour such as, exhibitionism, fetishism, voyeurism, frottage, fondling and molestation. Definitions of terms are discussed, and work sheet activities that included
true and false and matching questions were assigned as homework. Furthermore, these sessions included information about the impact a sexual offense has on a victim. An emotional video is shown where real life sexual abuse victims spoke about how the offence had negatively impacted their lives. In my opinion, this video was very powerful and seemed to impact many of the parents in the group, however, I was surprised by the lack of emotional reaction displayed by the youth. Following the third session, I discussed my observation with my supervisor, and she explained that it is common for the youth to react this way, as many are still in denial during the primary phase of treatment.

The fourth session is based on how sex is portrayed in today’s media. Gender roles are discussed and the youth were asked to go through magazine advertisements and discuss how sex was used to promote the product. I really enjoyed this session, and felt that the youth were very engaged and did an excellent job pointing out the blatant marketing tool of using a woman’s body to sell products. The youth were respectful, and mature considering some of the ads were border line inappropriate and extremely sexual and offensive to women.

The fifth session is basic sexual education. Videos were shown to discuss the reproductive organs of a female and male body. This session also included a discussion around common derogatory and inappropriate language used to describe parts of the male and female body, safe sex and sexually transmitted infections.

The sixth session is based on triggers and the offending cycle. This session was extremely important because many parents seemed to be engaged and curious as to what may have triggered their child. I felt that it was very interesting to look around the room
while the youth were thinking about their triggers; many of the youth had a difficult time identifying their triggers.

The seventh session is about creating safety plans. The facilitators stressed to the youth and to parents how crucial it is to always have a solid safety plan in place. They explained to the youth that identifying their triggers will make it easier to create sound safety plans. If an individual is aware that certain feelings or environmental stimuli create an urge to offend, then they are more likely able to create a plan that lays out positive alternative actions instead of negative and illegal choices. One youth in the group shared that when he feels lonely and depressed he has negative thoughts that have led to offending. For his safety plan, he identified that when he is feeling lonely and depressed, he will ensure that he communicates these feelings to his parents, he will plan to do something with a friend, and he will make sure that he does not put himself in an environment where he would be near or alone any vulnerable individuals, such as children. I thought teaching youth and their parents how to create safety plans was extremely important because it is a proactive step to avoid future offenses.

The last session is for parents only. This session was much more intimate and was set up as a talking circle. Facilitators were not in front of the group; instead they facilitated the discussion while being part of the talking circle. Parents were asked to share their thoughts and concerns about what they had learnt over the last seven sessions, and how this information has affected them and/or their families. This session was very emotional for many parents. Some parents were visibly angry with their child and had clenched fists, and some were in tears and needed to step out of the room to compose themselves. I also noticed that a few parents were disengaged and seemed to be in denial.
that their child had done anything wrong. My supervisor explained that this is typical and it sometimes takes a while for some parents to accept the reason their child was charged and are in denial of the offense, which only enables their child’s sexual offending behavior. It is difficult to hear parents speak of the negative implications the sexual offence has had on their lives. Some families had to move out of their communities, lost friends and family, and some worry about how the offense has affected their other children in the family. As an observer, I caught myself thinking about how truly empathetic I was for the families and for their suffering.

**Individual treatment**

The second piece to achieving my learning objective of gaining clinical experience in the area of adolescent sex offender treatment was to be involved in individual treatment with adolescent sexual offenders. I was asked to co-facilitate individual treatment sessions with a clinical psychologist and program manager of the young offender team. She was working with a high needs client who had been involved in several incidents of sexually inappropriate behaviour, however he had never been charged. According to the youth’s file, he had a history of aggressive behaviour, inappropriate comments, and very limited self-control. I was asked if I wanted to take the lead on sessions with this youth with her guidance and supervision. As mentioned previously, all court ordered treatment must be conducted by an experienced and trained professional, however because this youth was not charged, I was able to facilitate treatment with the program manager’s assistance. Prior to the first session, we went through his file together and developed a case plan and goals. This case was different from the other clients whom I was assigned, because this client did not have the
opportunity to participate in goal development. The program manager had specific
treatment pieces that she wanted to focus on. I led three sessions with this youth. The
first session was extremely difficult as the youth struggled with attention deficit
hyperactive disorder (ADHD), autism spectrum disorder and oppositional defiance
disorder that strongly impacted his level of functioning and self-control. He was unable to
stay on task for more than five minutes at a time, he continuously muttered inappropriate
comments, and at one point took a picture of me on his phone and refused to delete it.
After the session, I spoke with his grandmother and was informed that he had not taken
his medication to control his ADHD which most likely resulted in his negative behaviour.
We spoke to his grandmother about the importance of treatment and we were assured
prior to the next session, he would take his medication.

The second session I facilitated went much smoother. The youth appeared more
focused and willing to participate. He and I went over terminology that is commonly used
in sex offender treatment, and began discussing his triggers and feelings towards his
inappropriate sexual behaviour.

The third and final session I facilitated was based on the offending cycle and
creating safety plans. The youth did very well for the first part of the session, however
during the second half of the session, his inappropriate comments were becoming
excessive and he would not respect my boundaries. The program manager stepped in and
ended the session early. She explained the sessions were occurring for his benefit and
confronted him to put in the effort and take treatment seriously before his negative sexual
behaviour became habitual and resulted in charges. She expressed that although she was
empathetic to his mental health struggles, he needed to accept responsibility for his
actions and respect the boundaries of those around him. I appreciated how the program manager spoke to him and the language she used. Although we were frustrated, she maintained professionalism and respected the dignity and worth of our client. I felt very fortunate to have had this opportunity and learnt not only about best practice approaches for individual treatment with adolescent sex offenders, but also numerous skills on how to build and maintain a strong rapport with clients.

**Values and Ethics**

Observing the psycho-educational group was a great learning experience, however I also found it ethically difficult. As a social worker, I am guided by a set of rules and core values which are outlined in the Canadian Association of Social Workers Code of Ethics. These principles aid in ensuring that all social work professionals uphold ethical practice in all areas of their practice. At CYS, all clinical team members follow a specific set of ethical guidelines that integrate the highest standards of professional practice (Child and Youth Services, 2014). All clinicians at CYS are registered with a professional association, such as the Saskatchewan Association of Social Workers and the Saskatchewan College of Psychologists, to ensure professionalism and distinct ethical service to all clients, outside agencies, and community members.

During the eight weeks I spent observing the sex offender psycho-education group, I ran into two instances where I felt an internal struggle with two of the CASW values.

Value 1 states that as a social worker I must always respect the inherent dignity and worth of all people (CASW, 2005). My struggle with upholding this value was an internal battle. As a mother of a young child, I found it extremely difficult to remain free
of judgment and maintain a high level of respect for the members of the group who I knew had offended on young children. I understand that I must treat all individuals with dignity and respect, and that it is my job to help clients grow and change despite their behaviour. Yet, I still found myself upset because sexual offences were committed against young victims. I also felt frustrated when parents made excuses for their child and the offense they committed. I understand that treatment is a fluid process, and each person will learn and accept responsibility at different times; and as a social worker I must respect their journey and support the process. However, as an observer of this group, I did at times experience some negative emotions when hearing some of the details of the offences that these youth committed. Yet, as a professional I understood that these young men were there for treatment, and were trying their best to move forward. Therefore, through this process I learnt the importance of personal integrity and the value in being self-aware of one’s feelings so that in the future when working with populations that I personally find difficult, I am able to maintain objectivity and neutrality and identify if I am able to work with specific populations.

The second value I had difficulty maintaining was Value 4 which demands integrity in our professional practice (CASW, 2005). This value ensures that social workers maintain professional and honest practice and that social workers do not push their own morals, values and beliefs on clients. This value means that social workers separate their own values to help clients to the best of their ability. When I experienced the strong feelings I had during the eight session observation, I was forced to re-evaluate some of my own values and beliefs. I realized that as a professional I have my own limits and boundaries as to what type of cliental I am able to work with. I take great
pride in knowing that I am not easily stressed, and can excel in many difficult professional environments. However, after being involved in the sexual offender group, I am certain that my current personal circumstances would impact my ability to professionally work with sexually offending youth and I would not want to put myself or any client in that position. I reflected on this for a long while, and questioned if these limits weakened me as a social worker. I came to the conclusion that by admitting my limitations is not a weakness, if anything it has made me stronger as I am now able to avoid potentially detrimental situations and focus my work in areas where I can offer the greatest level of support to clients. I highly value and respect all the work that is being done to support and treat individuals who have committed sexual offences, and believe that because of these CYS professionals' commitment and hard work, many of the youth were able to change and learn from their wrong doings and go on to live functional and positive lives.

Adolescent Anxiety and Depression Pathway Group

Overview of the Anxiety and Depression Pathway for Adolescents

Group Cognitive Behavioural Therapy

Group cognitive behavioural therapy (GCBT) for anxiety and depression is a research based treatment that has shown to be effective. Petrocelli (2002) conducted a meta-analysis of research on GCBT and found that GCBT was an effective method of treatment for many common mental health problems, but it appeared to be more effective for children and adolescents than adults. In addition, Whitfield (2010) states that GCBT is not only an effective method of treatment for depression and anxiety, but also a cost-effective program for mental health agencies. With this in mind, CYS created an
education group designed specifically for adolescents suffering from low to moderate levels of depression and anxiety (Child and Youth Services, 2014). This group was developed as a first level of intervention. Clients are screened in through intake, and administered a questionnaire called the RCADS (Revised Children’s Anxiety and Depression Scale) to determine their level of symptoms (Child and Youth Services, 2014). Clients experiencing high level of symptoms are placed on the wait list for individual one-to-one counseling, and those experiencing low to moderate symptoms are encouraged to participate in the pathway group. After completion of the group, the RACDS is administered again, and any client who had a significant increase in symptoms would then be referred for individual intervention.

**Pathway Group in Practice**

The anxiety and depression pathway group is a cognitive behavioural therapy (CBT) based group involving youth and their parents. The overall goal of the group is to teach CBT skills to help reduce anxiety and depression. The group was designed to have adolescents participate with their parents in hope that the caregivers would learn to use the skills to increase positive functioning within their family. Over five sessions, youth and their parents are taught basic CBT skills including mindfulness/relaxation strategies and positive communication skills (Child and Youth Services, 2014). The group is facilitated in a fun and interactive manner, and all group members including parents are asked to participate in activities and discussion. Group members are assigned weekly homework, and asked to keep track of their progress in a journal assigned to them at the beginning on the group.

**Group Composition**
Group composition plays an important role in group therapy. Not every client is appropriate for a particular group, and it is important to determine in advance whether a potential member’s needs could be met by the group, and if the potential member fits the group criteria (Reid, 1991). For example, as previously mentioned, the program supervisor must ensure that all youth who have been referred to the group have low to moderate levels of anxiety. If anxiety symptoms are in the moderate to high range, youth are referred on for individual counselling because the pathway group is not designed for the level of support they require (Child and Youth Services, 2014).

One factor that needs to be considered for group formulation is sex composition. The gender of group members can have great implication for the group’s overall functioning (Reid, 1991). In a study conducted by Martin and Shananhan (1983) found that males and females disclose different aspects of themselves depending on the gender makeup of the group. In both groups I co-facilitated, the gender makeup was unequal, in that there were primarily more females than male youth. In the first group, there was one male group out of six youth, and one male parent out of six parents. In the second group, there was one male youth out of seven youth, and two male parents out of nine. However, despite the imbalance of male to female group members, group functioning seemed very positive and member feedback did not note any dissatisfaction with group composition.

Another factor that is important in group composition is group size. According to Reid (1991), group size is dependent on group goals. If facilitators are expecting everyone in the group to participate and there is an emphasis on close relationships, then Reid suggests that a smaller group of five to twelve members is desirable. The first pathway group I co-facilitated had six youth and six parents, and the second group had
seven youth and nine parents. As a facilitator I noticed that the first group was fairly small and at times thought that this hindered participation. On a couple of evenings the group ended early because we covered topics too quickly due to a lack of participants; only three youth attended on two sessions. However, the second group I co-facilitated was more productive as group discussions had more depth due to more members and an increase in participation. Also, sessions went for the entire time allotment as members asked questions, which allowed my co-facilitator and me to expand on information topics.

**Group Process**

White and Freeman (2000) state that group cohesiveness and task focus are two elements that must be present for an effective CBT group. All CBT groups should be task-focused with defined goals for group members to achieve. The pathway group is broken down into five sessions. Each session is goal oriented and teaches a specific set of skills that are built on material from the previous sessions. White and Freeman (2000) explain that group cohesiveness is achieved by clear rules and boundaries that are created at the beginning of the group and agreed upon by all group members.

The first session begins with an overview of group rules and confidentiality. Members introduce themselves and give a short synopsis of why they are there and what they hope to get out of the group. Members are given an explanation of mindfulness/relaxation, and a short mindfulness exercise is completed. Next, CBT is introduced through a PowerPoint presentation. The concept of how our thoughts affect our feelings is explained and tied in using video clips and personal examples. Group members are asked to keep a thought log throughout the week, and track their feelings
and reflections in their journal. The group members appeared anxious; therefore my co-facilitator and I conducted a mindfulness exercise to allow members to relax; once this occurred, members appeared relaxed and open to learning.

The second session focused on negative thought traps. According to Burns (1989), thought traps are common thought distortions that are commonly experienced by most individuals several times a day. One example of a negative thought trap is catastrophizing; imagining the worst-case scenario, no matter how unlikely it would be to occur (Beck, 2011). To help participants understand these concepts, a handout describing the ten most common thought traps was given, and a discussion was held about which traps were most meaningful to them. One participant shared that he displays catastrophic thinking at school. He explained that when he got one bad grade and he believed that he was going to fail his class and never graduate from high school. In both groups, this discussion was well received, and youth and parents appeared surprised by how many of them fell subject to negative thought distortions on a daily basis. I found this exercise to be an eye opening moment for most group members, as many of them did not realize how consistently negative their thoughts were.

The third session was developed to teach group members positive coping. Schure, Christopher, and Christopher (2011) discuss the use of positive coping skills and self-care and explain that these skills can be implemented with a wide variety of clients to address several areas of concern. To teach these skills during the group we had a discussion on coping strategies was had and clients were asked to discuss what they do to relax when they are feeling anxious or down. Group members were then asked to create coping cards. These cards are used as reminders to help client’s cope when they are in a situation
where they are feeling anxious or depressed. This activity went over extremely well, as
the youth were very engaged and seemed to enjoy making the cards. Most of the
members shared their cards with the group once they were completed.

The fourth session was based around positive communication skills. Beck (2011)
explains that positive communication skills are key to developing positive relationships
and building a strong support network. In addition, Ronen and Freeman (2007) explain
that healthy communication skills will help individuals express their own needs, while
being respectful of the needs of others. Learning positive communication does not always
come naturally; like most skills, it is learned through trial and error and repeated practice
(Beck). Youth and parents were taught how to appropriately communicate using “I
statements” versus “you statements”. Role playing activities were used to allow members
to practice using the skills. Most youth were uncomfortable with role playing, however
most parents seemed to enjoy this activity. Parent feedback indicated they felt this session
was the most beneficial as it helped them communicate with their youth in a more
effective manner.

The final session was an overview of all the skills that were taught, feedback of
the group experience through confidential surveys were administered, re-administration
of the RCADS were completed, and evaluation forms evaluating myself and my co-
facilitator were completed.

Challenges

Despite running two successful groups, there were some challenges. Bieling and
McCabe (2006), state that although GCBT is an effective method of treatment for many
mental health disorders, challenges throughout the group process may occur and can

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Unfortunately interfere with group goals, process and efficacy of the group intervention. Problems that may arise are as follows:

- Problems with group process (subgroups and group culture).
- Problems with group leadership (facilitator style and/or skills).
- Problems with individual group members’ personality styles or expectations (lack of participation, hopelessness or negative attitude) (Bieling & McCabe).

During the first group, I experienced a challenge that fell within the category of problems with individual group member’s personality style. As previously mentioned, the first group consisted of six youth/parent teams. One male parent from this group displayed a negative attitude and engaged in inappropriate comments and discussion. My co-facilitator and I noticed this challenge during the first session. We discussed our thoughts about this issue afterwards, and made a plan to see how the next session went, and if his inappropriate behaviour continued we would discuss our concerns with him in private. We did not want to react immediately to our concerns because we wanted to ensure we were putting the best interest of his child first, however we also needed to protect the integrity of the group. The following session was much the same and the parent continued to make inappropriate comments and exhibit improper behaviour. During the break we spoke with the parent in confidence and asked that he refrain from using vulgar and disrespectful language. He did not seem to realize that his actions were negatively impacting others and was surprised by the discussion. During the following two sessions he and his child were absent due to self-reported illness, and therefore did not return until the final session. However, based on group feedback, it was apparent that other group
members were uncomfortable by his language, and thought he brought the group morale down. Upon reflection, I believe that we should have spoken to him the first evening during the break, and perhaps we may have avoided the negative impact his behaviour had on the overall group experience. Although we wanted to ensure that his child continued to be part of the group, we could have offered his child one-to one intervention as opposed to the group setting.

**Conclusion**

Going into this practicum I was unsure what to expect. I knew it was going to be difficult to juggle fulltime work, motherhood and a part time practicum placement. However, I promised myself that I would start my placement with an open mind and remind myself that no matter how overwhelmed I may become, the knowledge and direct supervision I would gain through this experience would be priceless. When I took the time to sit down and create my practicum objectives, I questioned what it was that I truly wanted to get out this experience. In the end I decided that the most important factors to me were to learn new methods and skills sets for direct practice work, obtain direct supervision experience on using cognitive behavioural therapy, facilitate treatment groups and learn about best practice treatment for adolescent sex offenders. I chose these objectives because to me they were the perfect mixture to create a practicum experience that would improve my existing counselling abilities, but also challenge me to work outside of my comfort zone and become a well-rounded social worker.

I believe that all of my learning objectives were met and I feel that the experience I gained in my four core areas exceeded my expectations. First, learning how to conduct effective and accurate intake assessments was an experience that I do not take lightly.
Learning to work within a medical model of practice was difficult, yet I learnt to navigate through while also maintaining a focus on client strengths and resiliencies. As Day (1984) explained, excellent intake assessments require as much or more skill and experience as other social work tasks. Therefore, having the opportunity to learn this skill will most definitely have a positive impact as I move forward in my social work journey.

Secondly, I am grateful for the knowledge I gained in the area of CBT and the direct supervision I received by my practicum associate. As a professional I have always been comfortable working from a strengths based model, while applying theoretical skills from solution focused brief therapy. However, after some self-reflection, I came to realize that it is important to expand my knowledge and become skilled in other theories. I enjoyed learning about the theoretical footings of CBT and more specifically how these skills are applied to direct social work practice. Miller’s (2012) suggestion that social workers should use CBT skills to develop an understanding of the core cognitive structures that a client has developed, using empathetic listening skills, and helping individuals to learn to communicate and express themselves provided me with a guideline of how to carry out my direct work with clients.

Third, I believe that observing the adolescent sexual offender treatment group was an extremely important part of my practicum. I believe that it was during this time that a large portion of my self-reflection occurred. As mentioned earlier, I struggled with my own personal feelings towards the offences that were committed and the impact on the young victims, however as a professional, I was able to acknowledge my feelings and remain ethically competent during the groups and individual treatment. I walked away from this experience with an enlightened view of my own boundaries and limitations, and
feel stronger for it. And last, I enjoyed learning about and facilitating the anxiety and depression pathway group. Group facilitation is a passion of mine, and having the opportunity to facilitate a new and much needed youth group was a joy. I felt grateful that I was able to share this opportunity with two wonderful co-facilitators, and am proud that I was able to be part of what I hope to be a lasting and permanent program at CYS.

Because of the wonderful staff within the agency who willingly shared their knowledge and skills, my practicum experience at CYS was beneficial and one that I will never forget. I have increased my competency in clinical social work skills, and have grown as a clinician. Moving forward, I am now more confident in the therapeutic process, and will continue to work with youth and try to help them make positive changes in their lives.
References


