New Beginnings: A relational and educational

approach to group work with female

adolescents with substance use issues

by

Jana E. Estabrooks

A Thesis
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
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New Beginnings: A relational and educational approach to group work with female
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Abstract

Through her work with FAS/E the author became aware of a gap in services for pregnant adolescents with substance use issues. This practicum was developed to address some of those issues. It involved the development and implementation of a time-limited group for pregnant adolescents between the ages of 15 and 18 who had substance use issues. The purpose of this group intervention was to provide some concrete skills to deal with the combination of pregnancy, substance use and adolescence, as well as providing skills to deal with physical and psychological addictions and helping these young women grow in the areas of self-esteem, coping skills, parenting and social support. These goals were accomplished through a combination of educational and relational methods. Results were measured both qualitatively and quantitatively. The girls all scored higher at post-test than pre-test on levels of self-esteem and ability to cope although many scores dropped to pre-test levels at follow-up. Responses from the girls and observations by the facilitator suggest that the group was beneficial in terms of building relationships and helping the girls to 'normalize' their experience and therefore feel more in control and less isolated. An interactive group appeared to work well with this population but it is important to design the group specifically for the population and take into account the unique needs of female adolescents. Developing relationships is important to building self-esteem and group support helped the girls feel more able to cope. This led to less reliance on alcohol and other drugs as a way to cope or feel better.

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This practicum would not have been possible without the help and support of many people.

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Thank-you to family and friends for your support. Thanks for listening to my complaints and frustrations, for being so encouraging and believing in me.

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In order to keep their true selves and grow into healthy
adults, girls need love from family and friends, meaning-
ful work, respect, challenges and physical and psychological
safety. They need identities based on talents or interests
rather than appearance, popularity or sexuality. They need
good habits of coping with stress, self-nurturing skills and
a sense of purpose and perspective. They need quiet places
and times. They need to feel that they are part of something
larger than their own lives and that they are emotionally
connected to the whole (Pipher, 1994, p. 284).

1. Introduction

In Winnipeg, in 1999, there were only a few substance abuse treatment programs that would accept a woman past her sixth month of pregnancy. Of those that would accept pregnant women who were struggling with substance use, only one made accommodation for the children the women were parenting at the time of admission. Out of thirteen treatment centres for addiction in Manitoba, there were four which had youth components. Half of the fourteen pregnancy support organizations had a component for youth (Foucault & Dinney, 1984). None of these organizations overlapped. There were no services which catered specifically to pregnant teens with substance use issues. This practicum evolved out of this lack of specialized services. Through this practicum, the writer intended to develop a time-limited group for pregnant adolescents between the ages of 15 and 18 who were struggling with substance use issues. This is a population which is at high risk. The girls are likely to be engaging in risk-taking activities, because of their substance use, and this could have negative consequences on the health of them and their children. The babies are at higher risk of being born with alcohol-related birth defects or other complications. Both mothers and babies can benefit from intervention at this critical point. The group evolved (for reasons to be described in depth later in this report) into a group for female adolescents with substance use issues. Girls who were pregnant or parenting were welcome but this was not a requirement.

1.1 Goals

1.1.1 Intervention

The purpose of this group intervention was to provide some concrete skills to pregnant adolescents dealing with addiction issues. It provided them with a

group of peers facing similar issues with whom they could talk. They were also offered individual counselling sessions after the group. Adolescence and pregnancy can both be very confusing times of life. If they are also struggling with substance use, young women will need support to move through these life stages.

The goals of this intervention were:

a) To provide concrete skills to deal with the combination of pregnancy, substance use issues and adolescence as well as skills to deal with physical and psychological addictions.

b) To help these young women grow in the areas of self esteem, coping skills, parenting and social support as well as to encourage abstinence.

c) To provide a support group of peers with whom to discuss pertinent issues.

d) To provide information about available resources and referrals to other services.

Through attendance and participation in the group it was expected that the social skills of these young women would increase. Developing these skills would, in turn, help them to maintain a drug free lifestyle after the group.

1.1.2 Educational

The educational benefits to this student were many:

a) To gain experience in running a group for pregnant, substance abusing adolescents and to understand this population better.

b) To learn how to implement various types of group interventions.

c) To establish a structure which would address the needs of this population.

d) To observe the patterns that develop out of the group experience.

e) To evaluate the efficacy of the intervention through the use of rapid assessment instruments.

1.2 Design

This practicum proposed an educational and support group which focused on increasing or developing coping skills and support networks for pregnant adolescents with substance use issues. At the time of writing there were no services being offered specifically to this population. There were services for pregnant youth, for youth with substance use issues and for women who were pregnant and abusing substances, but no services specifically designed for pregnant adolescents with substance use issues. This meant that recruitment for the group needed to come from many different sources. Flyers and letters of explanation were sent to the various agencies involved (see Appendix A). In the original plan, the participants would have been voluntary and either self-referred or referred by the agencies. Appointments would have been arranged to meet with each young woman individually in order to explain the purpose of the group and screen the women for suitability, as well as to administer standardized assessment measures and describe the Addictions Foundation of Manitoba [AFM] intake process. After the initial screening they would have been placed in the New Beginnings group which was developed for the purposes of this practicum.

As the practicum progressed it became obvious that the original plan for the group would need to be modified as the numbers of clients necessary for a group were not being obtained. This new group did not vary significantly from the one originally proposed. It was a group for female adolescents with substance use issues. It was open to all girls ages 15-18, not just those who were pregnant or parenting. The group was still designed specifically with the needs of female adolescents in mind. This change did not affect the theoretical orientations or the measures used. It changed the intervention only marginally. The method of recruitment stayed the same but involved more internal referrals from AFM. The focus of the group was still on building self-esteem, developing coping skills and

becoming aware of support networks. The session on specific child care techniques was not used. Even with these changes the group was still able to address the needs of a very specific population.

The New Beginnings group was a closed group and was run over twelve sessions, twice a week for six weeks between 4:00 p.m. and 5:30 p.m.. The group was facilitated by the writer with the assistance of an AFM youth services counsellor. The group began with eight participants. Two dropped out at the beginning and another in the fourth session. The girls ranged in age from 14-17, with most being 15. None of the group members were pregnant although one was parenting. Each session included a check-in to see how everyone had been doing since the last meeting and an introduction of the day's activities. Each session also incorporated an icebreaker or 'fun' activity as well as some type of active, hands-on project and a discussion. This reflected different learning styles as well as the fact that the participants were teenagers who wanted to play and have fun. It also recognized that those who are pregnant find it difficult to sit for a long period of time. Each session ended with a check-out where the participants had a chance to say how the session was for them and what they had learned.

The group took a psychoeducational approach. The objectives for each session were designed to increase awareness of substance abuse issues and provide skills with which to address life's.difficulties through education and the support of staff and other group members. Keeping in mind that the group members were teenagers, education was accomplished using several different communication styles such as: experiential learning, 'lecturettes', videos, brainstorming, discussion, etc. as opposed to a model where the facilitator does all the talking. The girls were able to teach each other as well as learn from the facilitators.

The following is an outline of the purpose of each group session. (For a more detailed description of each session see Appendix B).

Session One: To engage the girls in the group process and with one another.

Session Two: To encourage the girls to begin to examine their own substance use.

Session Three: To help the girls examine how they cope in difficult situations.

Session Four: To challenge the girls to look beyond themselves to the role substance use plays in their lives.

Session Five: To assist the girls in identifying the types of feelings they are experiencing.

Session Six: To support the girls in examining what forces in their lives push then to abuse substances.

Session Seven: This session was cancelled due to a gas leak in the next building.

Session Eight: To draw attention to the issues surrounding body image, self-esteem and societal views of women.

Session Nine: To reinforce the importance of social support in the girls' lives.

Session Ten: To promote self-care for each participant.

Session Eleven: To encourage mutual aid, and self-care.

Session Twelve: To process the concept of 'ending' and do evaluations.

During the last session questionnaires were administered. These were the same standardized assessment measures which were administered during the original screening interview. They were administered to determine whether there were any changes in the girl's levels of coping skills and self-esteem over the course of the group. Upon completion of the group the girls were told of a group follow-up meeting three weeks later. This meeting would allow the facilitator an opportunity to follow-up with the girls, hand out rapid assessment instruments and allow for the facilitator and the girls to be updated on how everyone was doing.

1.3 Setting

The youth services unit of the Addictions Foundation of Manitoba (AFM) was the setting for the New Beginnings group. It is centrally located at Broadway Ave. and Osborne St. just a few blocks from Winnipeg's main thoroughfare and is on several bus routes. AFM provides for the treatment needs of those addicted to harmful substances or gambling. The youth unit serves those 12 -18 years of age and their families. The building is one of a series of unobtrusive structures along the street and has easy, curbside access. The office is set up to accommodate a large number of adolescents and several groups are often being run simultaneously. This meant that there would have been space to set up child care in another room had it been necessary. The waiting area is large and comfortable. There is reading material and a water cooler available to the youth, and counsellors are generous with access to their phones as well as providing the youth with bus tickets when necessary.

The group rooms have comfortable seating and are carpeted. They are in the basement, so the blinds are usually shut to avoid outside interference but this adds to the coziness of the rooms. The rooms are large enough to accommodate a group and also provide space for active learning. There are a few inspirational posters on the walls but much of the wall space is blank. This is because within a few sessions the walls are covered with the sheets of paper on which the group members have displayed their work. Each room is also equipped with a whiteboard, flipchart, T.V. and VCR, as well as pens, markers and clipboards.

The AFM youth services was chosen for this practicum for several reasons. The location and accommodations are suited to doing group work with adolescents. They also have a large client base from which to receive referrals and are part of a larger network of agencies. They also provide youth services with a strengths-based approach and run groups in a manner which is consistent with the psychoeducational approach. For the purposes of this practicum,

agencies which cater specifically to pregnant and parenting adolescents were also examined but they were less well-equipped to deal with a group and are often reluctant to make substance use the primary focus.

1.4 Terms used in the addictions field

There are many different terms used in the addictions field. Many of these terms are used interchangeably and it can be very confusing to know what is meant by them. Part of this confusion is a result of some agencies moving away from a disease model of addiction and therefore looking for non-medical terms to describe an individual's involvement with alcohol and other drugs. Throughout this practicum the term 'substances' will be used to include alcohol and other drugs. The term 'other drugs' is used to indicate that alcohol is also considered a drug. 'Drugs' include, but are not limited to, alcohol, marijuana, cocaine, magic mushrooms, LSD and solvents. For the purposes of this practicum 'drugs' do not include nicotine.

Drug and alcohol consumption is often measured along a continuum of use. Many organizations have developed their own terminology and definitions for each level of use. The Addictions Foundation of Manitoba uses the terms 'irregular involvement', 'regular involvement', 'harmful involvement', and 'dependent involvement' (see Appendix C).

'Substance abuse', 'substance use issues', 'addiction', and 'harmfully involved' will be used interchangeably throughout this practicum. While there are slight differences, they all imply a level of involvement with alcohol or drugs where at minimum the individual's substance use is starting to interfere with other areas of their lives, but they are not willing to stop their substance use (Gonet, 1994; ARF, 1991). If taken to the extreme, this level of involvement is characterized by a compulsion to use the drug, loss of control over the drug and

continued use of the drug despite adverse consequences (Gonet, 1994). It appears to have taken over the individual's life.

The focus of this practicum project was 15-18 year old girls. The term adolescent refers to people in the stage of life between childhood and adulthood which covers the years from approximately age 12-20. At times, specific age parameters will be defined.

1.5 Relevance to Social Work

Addiction has not traditionally been a social work jurisdiction and yet more and more social workers are finding themselves working with clients who have substance abuse issues. There is a need for more information around social work practice in addictions. This practicum will address practice issues with a specific population of drug abusers. Social workers often work with young, poor, single mothers. "[Drug] dependent women represent 2 to 5 percent of all mothers, and are the group where intervention can produce the most dramatic results" (Geller, 1991, p. 102). Effective programs for working with pregnant adolescents who have substance abuse issues will benefit the social work profession through additional knowledge in the field of addiction and by providing some alternatives to placing large numbers of children in foster care while their mothers try to overcome their addictions. This practicum will help to bring together the areas of addiction counselling, social work with single mothers and work with adolescents.

The social work profession is a humanitarian entity. As such it has an obligation to look out for those who are marginalized in our society. Young, pregnant substance users are part of this marginalized population. There are many adverse consequences of teenage pregnancy. Young women are more at risk for sexually transmitted diseases and their related side effects (HIV, infertility, cervical cancer, ectopic pregnancies, and infections passed on to newborns)

(Dryfoos, 1990). Long term consequences can include poverty, health and social issues and interruption in schooling which can lead to occupational difficulties. Most of these consequences do not have to do specifically with maternal age but more with the circumstances in which young mothers find themselves. "If teenage mothers are allowed to be relatively poor and unsupported then, like mothers of any age in comparable circumstances, they and their children will suffer the consequences" (Gillham, 1997, p. 26). These consequences include psychosocial risks such as low family support and disruptive life events (Oakley, 1990). It is not that young mothers do not want to seek proper treatment for themselves and their babies but often they are constrained by a lack of resources and/or lack of information about available resources (Moss, 1991). As social workers we need to provide the services these young women need.

There are few addiction treatment programs which will accept pregnant women. They are concerned about liability or do not have necessary services such as child care or obstetrical care (Moss, 1991). Lack of child care is a major barrier to women's participation in drug treatment and yet few programs make provisions for children. Of those that do, none make specific provision for teenagers whose needs are different from the adult women in treatment.

This practicum may promote more programs for this population and expand the resources available to them. It provides a service which is not currently available and brings the addiction field together with that of social work. This practicum will also add to social work knowledge by providing information about this population. Group work is taught in social work programs and this practicum could add knowledge to the area of group work with adolescents and specifically those who are pregnant and abusing substances.

Adolescence is a difficult time of life and pregnancy and substance abuse make it even more difficult. Adolescents need somewhere where they can learn

about the effects of their substance use, learn parenting skills, learn how to cope with substance cravings and crying children and receive the support they need. Pregnancy is often a turning point for the adolescent and it is important to provide support at that time and not make her wait until the needs of a new baby overwhelm her resolve to become drug free. This practicum will add to the body of knowledge in the area and offer some concrete solutions to working with this unique and high risk population.

2. Literature Review

Adolescents who are pregnant and abusing substances are a segment of the population which has not been given much attention. They are marginalized in our society on many levels. Many people admire youth as a quality and go to great lengths to stay looking and feeling young but are prejudiced against youth as people. Society tends to stereotype all youth into one group and views them as impulsive troublemakers with little motivation. Women are also marginalized in our society. Despite many advances, it is still difficult for women to break into the more prestigious jobs. Women are criticized by some when they do not make homemaking their primary occupation. Professions which are female-dominated tend to be 'caring professions' and are under-valued and the workers are under-paid. Female youth are therefore doubly marginalized. Along with being female comes the joy (or curse) of reproduction. While being pregnant under certain circumstances is seen as positive, society often views pregnancy during adolescence as a sign of deviant behaviour. "Young mothers may not be valued as much as older mothers" (Wright, 1995, p. 13). A pregnant or parenting teenager is often viewed negatively by 'Western' society. If she also has an alcohol or drug abuse problem there may be few who will feel sympathy for her. Lack of information and support around contraception and pregnancy, and substance abuse are two of the many ongoing struggles for our teens.

This literature review will summarize relevant literature related to adolescence, addiction, adolescent pregnancy, coping and self-esteem as well as the consequences of adolescent addiction and pregnancy. This is not an exhaustive review of all of the literature available on these topics but it is a sampling of the discussion surrounding these topics.

2.1 Adolescence

Adolescence as a concept is a relatively recent phenomenon. Teenagers did not become a recognized segment of the population until the early twentieth century (Luker, 1996). Before this the transition from child to adult happened quickly with people in their early teens taking on adult roles. Now the period of adolescence has been extended. Girls reach menarche four years earlier than a century ago and both girls and boys begin to experiment with drinking, drugs, and sex at an earlier age (Dryfoos, 1990). Despite these changes, adolescence is a unique time of life. It is the time when young people establish what they believe, how they will act, etc. Major changes take place in all areas of life...biological development, cognitive development, and psychosocial development (Addictions Research Foundation, 1991; Dryfoos, 1990; Seiffge-Krenke, 1995; Gordon & Grant, 1997). Adolescents have a culture all their own. This 'peer culture' appears to dominate in terms of clothing, music, films, fast foods, professed ideals, drug preferences and other risk activities (Dryfoos, 1990; Lightfoot, 1997). During the transition from childhood to adulthood, adolescents no longer communicate in the ways of a child but begin to form a new self which they express through this 'peer culture'.

Adolescence is often viewed as a difficult and negative time by the adults who study it. Research is focused on how adolescents are different from adults instead of on the unique aspects of adolescence itself (Lightfoot, 1997). "It is through the wide and seemingly rampant swings from one pole to another that adolescents discover who they are. Yet, for the better part of the twentieth century, professionals have taken these fluctuations as evidence that adolescence is a time of 'storm and stress'" (Magen, 1998, p. 47). "Adolescents are seen as more 'troublesome', 'promiscuous', 'idealistic', or whatever, than the perfectly 'normal' adults" (Lightfoot, 1997, p. xi).

Several writers suggest that 'storm and stress' is not the norm in adolescent development (Frydenberg, 1997; Gibson-Cline & Dikaiou, 1996; Dryfoos, 1990). Most adolescents (80 percent of middle-class teens) go through these years without any major crises and with little difficulty (Frydenberg, 1997; Magen, 1998; Dryfoos, 1990). Adolescence is seen less as a period of crisis and upheaval and more as a series of changes that children go through on their way to becoming adults. But "because of all the changes they are experiencing they may be more vulnerable than at other ages to negative coping mechanisms if they don't have strong, supportive family and friends" (Frydenberg, 1997). It is a confusing time. "Their needs for independence and for the freedom to make their own decisions seem to conflict with their strong need for guidance, relationship, and, not infrequently dependence" (Magen, 1998, p. 47). Those adolescents who ease through their teen years have strong egos, are able to cope well with internal and external stimuli, and have excellent genetic and environmental backgrounds. They are a part of the mainstream and feel comfortable within the general cultural and societal norms (Dryfoos, 1990).

Even when there are problems, the disruptive events that adolescents experience are not pathological but are steps in learning how to cope. With proper support, this can be a very rich time. Lightfoot (1997) suggests that risk-taking in adolescence can be viewed as a form of play and that it plays an important role in adolescent development. Risk-taking often conveys a 'don't have to' or 'just for the hell of it' attitude. By observing the type of risk-taking behaviours adolescents engage in, one can gain insight into how they understand and interpret each other and the world around them. Risk-taking can express a defiance of authority, a commitment to one's peers, or the history of their relationship with a specific person. It is a way of framing the world (Lightfoot, 1997). Risk-taking can also be considered in terms of its dramatic structure and as a narrative or

story. "Risks are understood to chart a course for personal growth and social relationships" (Lightfoot, 1997, p. 111).

Both boys and girls face many challenges growing up. Girls often react differently to stressors than do their male peers due to socialization, personality, and modelling in the home. The adolescent period can be more traumatic for girls especially in areas involving relationship and appearance. They more often experience strong emotions, both highs and lows (Gordon & Grant, 1997). Girls, like boys, are asked to separate themselves from their mothers as they grow. This also means separating from themselves, from women. Girls lose their voices and their ability to relate as they grow into the male world (Gilligan et al, 1990; Brown and Gilligan, 1992; Pipher, 1994). Our society is destructive to the selves of adolescent girls. Society sends very mixed messages about what is valued in women and how they should look and behave. Young women struggle to figure out where they fit. We need to provide opportunity for their voices to be heard. We need to provide a bridge so that they can move gracefully from childhood into womanhood and still know who they are and feel good about themselves.

The specific needs of female adolescents are beginning to be understood but much more work needs to be done to provide areas where they can continue to mature as women and have their competencies focused on and supported. Girls are not just like boys. Adolescents are not simply 'little adults'. This is a unique population.

> My horticulturist friend says that the environment is
> the richest and most diverse at the borders, where
> trees meet fields, desert meets mountains, or rivers
> cross prairies. Adolescence is a border between
> adulthood and childhood, and as such it has a richness
> and diversity unmatched by any other life stage. It's
> impossible to capture the complexity and intensity
> of adolescent girls. (Pipher, 1994, p. 52)

2.2 Addiction

The traditional medical model views addiction as a disease. The person is not responsible for their affliction and can't be expected to recover without the intervention of professionals. "Medical treatment today retains AA's [Alcoholics Anonymous] emphasis on the permanence of alcoholism and the need for the patient to assume a lifelong identity as an alcoholic - which means that alcoholism is never cured and that the person remains a potential patient forever" (Peele, 1989, p. 25). It is something that a person will always have even if they learn to control it. Addiction has become a multi-million dollar industry. There are many therapists, agencies and groups which cater specifically to addictions. Celebrities pay large amounts of money to be housed in private rehabilitation centres away from prying public eyes. Many return several times. It has become somewhat of a trend among the elite.

"Drug and alcohol treatment has a narrow focus and was created by and for white, upper-middle-class men who have been insensitive to the needs of minority people" (Kasl, 1992, p. 11). The field of addiction treatment has been primarily based on research which focused on men (Bepko, 1991). There is little known about the physiological effects of drugs and alcohol on women. There is also little known about different approaches that might be more effective in meeting women's needs. A main feminist critique of the twelve step model of recovery is the fact that it emphasizes that powerlessness is liberating (Bepko, 1991; Kasl, 1992). For female youth this is not the case. Often their drug use is a result of feeling powerless and what they need is a program which focuses on competency and taking control, rather than a deficit model of human personality. They need to be supported and encouraged to take control of their substance use and not let it control them. "[Treatment programs] were designed to break down an inflated ego. People who have been victimized and oppressed need to build a

sense of ego and affirm their power in order to take charge of their lives" (Kasl, 1992, p. 9). Because children and especially adolescents are slow to adjust to adult demands and expectations they are often seen as having behavioural diseases which do not exist in adults. Adolescent drug and alcohol use are also seen as diseases (Peele, 1989).

An alternative view is that drug use is a learned behaviour and can therefore be changed and overcome. For many youth non-abstinence is often easier to comprehend and accomplish. They may set the goal of cutting out only one substance or cutting back on the amount used. This is often a good place to start. "Although, in fact, most would quit drugs or cut back their drinking on their own, they are saddled with a lifetime identity of addict or alcoholic, one that - to the extent that they believe it - they cannot escape" (Peele, 1989, p. 101). For a teenager, the thought of never being able to have a drink for the rest of their life can be pretty overwhelming. It is also important for them to understand the difference between social use and harmful use. For some adolescents abuse of drugs or alcohol becomes a rite of passage. It is seen as fulfilling the functions of adolescence (Wright, 1995). In most cases, no matter how harmfully involved adolescents seem to be, they grow out of their using patterns as they move into a new stage of life (Peele, 1989).

Adolescents are also given mixed messages about the appropriateness of drug use. For example, in Ann Arbor, Michigan, teenagers caught with marijuana face only a $25 fine but are fined $50 if caught riding a skateboard in the downtown area. Some parents argue that abstinence is the only solution while others remember adolescence as a difficult time and believe that drug use will help teenagers to handle the stress. Between these two extremes are many value-laden emotions, opinions and beliefs (Gonet, 1994).

In helping teens with substance abuse issues, it is necessary to take a holistic approach. While there are physical aspects of addiction, they are often triggered by psychological issues. One must look past the drug use to other areas such as problem solving, cognitive skills, social skills, use of leisure time and vocational skills (Addictions Research Foundation, 1991). For most teens drug use is not an addiction but a form of risk-taking. According to Lightfoot (1997), adolescents give many reasons for drinking. They see it as a means of defying authority, and find getting drunk novel and exciting. They are still uncertain about how much alcohol is too much alcohol, and will err inevitably on the side of excess. Adolescents say that they conform to the social expectations that adolescents drink more than adults, or drink for the purpose of becoming intoxicated. Adolescents are also inclined to use alcohol for the purpose of feeling more comfortable in social interactions, or as an 'excuse' for engaging in potentially unacceptable behaviour (Lightfoot, 1997).

Adolescents who present with drug and alcohol issues are usually in crisis. It may be that all other coping techniques have been exhausted or were never modelled and learned, or their substance abuse has progressed to a level where it is affecting other areas of their lives. They may be referred for treatment by doctors, parole officers, schools or other institutions with which they are involved. Although many of the reasons for substance use are the same for adults and children, adolescents do present with some unique issues and characteristics. They tend to be polydrug users, use for a shorter duration and are often involved in other deviant behaviour. An increase in deviant behaviour is often seen as a normal part of adolescent development as it reflects an attempt to master all the developmental tasks which an adolescent faces. At the same time many deviant behaviours or changes in emotional and behavioural states may be the result of alcohol and drug use (Baer, 1993). It is often difficult to determine which came

first. Adolescents also lack adult coping skills, are sexually insecure and have often failed to live up to adults' expectations of success. This means that programs focused on adults, while they will cover the basic issues, will fall short in dealing with issues specific to adolescents.

Women, as well as adolescents, face many unique issues. They are perceived as more deviant than men if they drink. Women are supposed to be the 'responsible' ones and so it is worse for them to slip up. Because of the societal pressures and stigma around heavy drinking they more often deny problems (Thompson & Wilsnack, 1984). "Drinking has not been a part of traditional roles for women and girls. Rather, drinking and drunkenness have often been viewed as a threat to traditional feminine values and role performance..." (Thompson & Wilsnack, 1984, p. 55). Alcohol or drug use and early pregnancy combined is a blatant challenge to this traditional view.

Gender differences in adolescent drinking could also be related to body weight. The same amount of alcohol will cause a higher blood alcohol content in a girl than a boy. What is not clear is whether these differences influence girls to drink less than boys or if it makes girls more likely to have drinking problems when consuming alcohol with their male counterparts. Programs designed for adult men, as mentioned earlier, may not address these issues and may ignore practical issues such as the difficulty of accessing child care while in treatment (Beckman & Amaro, 1984). Other women's service needs include treatment for prescription drug use, counselling for incest victims, counselling for battered women, women's support groups, child treatment or counselling, and medical and nutritional care for pregnant women (Beckman & Amaro, 1984).

Politics play a role in women's substance use. It is important to recognize the need for separate services for women which empower rather than degrade. Social influences play a large role. Women suffer different and more punitive

social consequences than men. "...since women spend more time in the home caring for children and are more likely to identify this as their primary role, it is to be expected that they perceive greater negative consequences of drinking for the parent-child relationship (or for their children) than do men" (Beckman & Amaro, 1984, p. 326). The issues surrounding Fetal Alcohol Syndrome and Effects (as will be discussed in a later section) also complicate the discussion (Collins, 1993; Ettore, 1992; Shiffman & Wills, 1985). "...[W]omen are likely to identify their substance use as resulting from or being linked with some other stressor or event and to seek help for that problem" (Wright, 1995, p. 14). We need to be sensitive to these issues when working with women.

The mainstream view of addiction as a disease with the treatment being abstinence does not fit well for adolescents or women who are facing many issues not addressed by that model. When working with teenage women it is important to identify female sensitive adolescent models. The philosophy in these youth focused programs is that peer power is very important to a young person's recovery; youth have higher energy levels than adults; and social workers or counsellors must be sensitive to treating young women with dignity and respect. It is important to develop services which are sensitive to the needs of female adolescents.

2.3 Adolescent Pregnancy

Pregnancy among adolescents emerged officially as a social problem as recently as 1975 (Luker, 1996). Before this unwed mothers were part of the general population and teens were not seen as having different needs. However, teen pregnancy continues to be a concern. Early sexual intercourse places young women at very high risk of health consequences. The younger a girl is when she first has intercourse, the more likely she is to suffer negative consequences such

as sexually transmitted diseases and their related side effects (infertility, cervical cancer, ectopic pregnancies, and infections passed on to newborns) (Dryfoos, 1990).

Teenage pregnancy has long term consequences. Schooling is often interrupted which leads to occupational difficulties, many young moms live in poverty, and many health and social issues can arise. Babies don't go away. They are there for a long time and adolescent mothers spend the rest of their lives dealing with the consequences of bearing children so young. "Through their actions, teens are trying to come to terms, sometimes ineptly, with the immense social and economic challenges they face in today's world: a shrinking job market, an indifferent community network, and public scepticism about the worth of minorities" (Luker, 1996, p. 135). Many also find it difficult to ask for help either because they don't know where to turn or because they are afraid they will be perceived as failures. Teen pregnancy is not only occurring among the poor or minority groups, it is a growing issue with all segments of the population and is the result of many societal ills (Luker, 1996).

Many young mothers begin parenting in less than ideal circumstances. They are often living on a subsistence income, and that, coupled with the demands of parenting, will expose them to more stress and stretch their coping abilities. By providing support services, both relational and material, it is possible to reduce the stress on parent and child (Wright, 1995).

We need to be aware of the underlying issues facing these youth. We need to understand family and peer dynamics; we need to work at fostering self-esteem and respect; and teach them the coping skills necessary to deal with life's challenges.

2.4 Pregnancy and Substance Use

> Women who continue to use foreign substances
> during pregnancy may be unaware or unconvinced
> of the risks and require education. Or they may
> be addicted. Those who are addicted may be
> aware of the risks to themselves and the fetus, but
> cannot stop using substances (Geller, 1991, p. 101).

Many people cannot understand why anyone would continue to use alcohol and other drugs during a pregnancy. The above quote gives some indication. Substance use during pregnancy does raise concerns. Fetal alcohol syndrome is one of the top three known causes of birth defects with accompanying mental retardation (Kasl, 1992). In Manitoba FAS/E is estimated to occur from 2 to 40 times in 1,000 live births (Addictions Foundation of Manitoba, 1998). Studies have shown that "...[w]omen who drink an average of 2 drinks per day give birth to smaller infants" (Geller, 1991, p. 103).

While this population is of particular concern because of the long term effects that substance use has on the fetus it is important to realize that these women are struggling with the same issues as everyone else. "Women of childbearing age should be advised to abstain from alcohol if they intend to become pregnant or as soon as they learn they are pregnant. Women, however, should also know that an occasional drink during pregnancy or a pattern of having consumed 1-2 drinks a day prior to becoming aware of pregnancy is unlikely to be associated with a severe fetal outcome" (Geller, 1991, p. 103). If women who are pregnant and using substances are singled out it should be because we recognize the need for services to assist them and not to blame them for their condition.

Although the effects of alcohol on the fetus are widely known there are risks with other drugs as well. "...[I]n practice women who use any drugs at all

during pregnancy are frequently using more than one" (Geller, 1991, p.101). Cocaine use during pregnancy is harmful to the fetus and can cause withdrawal symptoms in newborns. "It is estimated that as many as 60% of crack users are women. The majority of these women are mothers of small children and head single parent households" (Bepko, 1991, p.7). Studies show that marijuana and tobacco both have effects on the fetus (Geller, 1991). "Pregnant women should be advised to abstain from the use of all mood-altering drugs and to exercise caution in the use of medications generally - so, perhaps, should we all" (Geller, 1991, p. 104).

"The strong positive association between substance use of any kind and early sexual activity has been well documented in the work of Elliot, Kandel, Jessor and others" (Dryfoos, 1990, p. 101). As we have seen, teens are more susceptible to substance use and therefore to pregnancy. Substance use can also mean poor prenatal care, poverty, poor nutrition, violence, lack of sleep, and no visits to the doctor (Geller, 1991). This leads to long term effects on the child which can provide more stress to the mother. A young mother with limited resources is ill equipped to deal with an infant, let alone one who needs extra care and attention. The harmful effects of substance use do not end with the child's birth. "Most drugs which cross the placenta also appear in breast milk, although usually in lower concentrations than in maternal blood...breastfeeding mothers should be advised to abstain from drug use other than an occasional drink" (Geller, 1991, p. 105).

Women in the pilot study on social support and pregnancy, in their own accounts of what happened, made connections between stress and the risk to their own and their babies' health (Oakley, 1992, p. 114). Helping young mothers with their stress levels and resources can aid them in avoiding substances as a way of coping and in turn help them and their babies.

2.5 Coping, Social Skills and Self-Esteem

Substances may be used as a coping mechanism because they can reduce negative affect or because they can increase positive affect. Teenagers may have limited knowledge of various coping mechanisms. Substances, especially alcohol, are easily available and provide a 'quick fix'. However, substance abuse is a "maladaptive attempt to deal with life stresses" (Shiffman and Wills, 1985, p. xxi). Since teens often respond to stress with an 'all or nothing' reaction substances become the perfect solution. "Substance use among young women often begins as a way to temporarily ease the pain of some of their experiences and provide them with a coping mechanism to deal with pain" (Wright, 1995, p. 15). Substances help everything seem manageable. "...[T]eens who are comparatively low in basic coping skills will be more likely to experiment with substances...or that, once having experimented, they will be more affected by the stress-reducing aspect of substance use" (Shiffman & Wills, 1985, p. 17). Stress is a significant predictor of alcohol use in adolescents. When students are able to deal with those stresses constructively they don't feel the need to turn to substance use. Coping skills and substance use are linked. Pregnancy in itself can also be viewed as a coping mechanism. "Some young women may chose to become mothers and use their pregnancy to attain another goal from which they are blocked, such as achieving autonomy or expressing opposition to adult authority" (Wright, 1995, p. 16).

Coping is a type of problem solving. It is a reaction to life stressors. Teens go through many experiences which require coping. When they need the skills most "[t]eens' coping skills are still in the formative stages" (Wright, 1995, p. 14). They need resources in order to cope. Those who cope best are those who best use the resources accessible to them. When teaching coping skills it is important to understand the different types of coping. Coping can be

problem-focused or emotion-focused. Although there are not male or female

ways of coping females tend to seek help from others, and look for physical

contact, while males tend to act out aggressively and seek attention.

> ...girls consistently seem to be more 'people oriented'
> than boys...girls more often say that their happiness
> depends on their romantic relationships, their families,
> going out, people being nice to them, feeling loved,
> having a laugh, others being happy and receiving
> compliments. There is a sense that girls more than boys
> link their happiness to a world of people (Gordon &
> Grant, 1997, p. 16).

Age 15 seems to be a turning point in adolescent coping. Changes occur

because of both contextual and developmental factors. At this age teens tend to be

more focused on social skills and learn how to incorporate other's feelings and

beliefs into their own realities (Seiffge-Krenke, 1995). Adults also play an

important role in adolescent coping. "When children and young people feel

valued and loved, they also feel more able to deal with the ups and downs of life"

(Gordon & Grant, 1997, p. 133). This is especially true for girls. Women's drug

use is related to lack of social support while men's is not necessarily (Shiffman

and Wills, 1985). "Coping skills are sets of learned, purposeful, individual

responses to stressors that increase positive outcomes in stressful situations and

reduce or eliminate negative stressful states" (Forman, 1993, p.15).

There is recognition that, despite adolescents' unique vulnerability to

stress, they are capable of actively and productively coping with the challenges

they face and of seeking solutions that use the resources available to them

(Magen, 1998, p. 48).

To be helpful, counsellors need to have a good understanding of what

youth are facing. People draw on six major areas in order to cope. These include:

health and energy; positive beliefs; problem-solving skills; social skills; social support; and material resources (Forman, 1993). The more resources they have in these areas the better they'll be able to cope. Youth often have not developed all of these areas and some may even be non-existent (i.e., material resources). If they can't deal with the stressors they may turn to alcohol and drugs to forget, hide or cover the pain. Adolescents face stress and need to cope on a regular basis. They are experimenting and figuring out what works and how their actions affect their ability to cope. These can be augmented by good social skills.

Social skills are difficult to define. Michelson, Sugai, Wood, and Kazdin (1983) took all the current definitions and came up with an integrated definition. Social skills are primarily acquired through learning; contain specific and distinct verbal and nonverbal behaviours; optimize social reinforcement; are interactive by nature and include both effective and appropriate interaction and responses; are influenced by the attributes of the participants and the environments in which they occur; and deficits and excesses in social performance can be designated and marked for intervention (Merrell & Gimpel, 1998). Put simply, social skills are behaviours that produce positive consequences for the user (Forman, 1993). Everyone has social skills to some degree and the ability to use them provides for positive outcomes. Social skills help with the development and maintenance of friendships (which leads to a strong social support network). They also help with the resolution of social problems and general ease in social situations. "Findings show that positive or adequate social skills development during childhood is an important foundation for good social, occupational, and personal adjustment throughout life" (Merrell & Gimpel, 1998, p. 28).

Social skills training appears to work best with small groups of adolescents. It is also most effective with assertive individuals and those undergoing multiple life transitions. When small groups are not possible the

worker must provide training and feedback similar to what would be found in the natural environment. "Wolkind and Kruk (1985) in a UK study of pregnant teenagers and motherhood found that those who had support from their families and friends were less prone to depression than those who lacked social support" (Gillham, 1997, p. 24). The development of social skills allows adolescents to begin to form social ties. Social networks are the result of social ties. Social ties are not isolated but interconnected. One person's family and friends are likely to know each other. The more interconnectedness there is in a social network the more likely there is to be consistent support for that individual (Oakley, 1992, p. 9). "Networks provide shared norms, values and ideologies, whereas individual relationships lack this collective consensual element" (Oakley, 1992, p. 29). "In the absence of a strong support network, women at risk, because of their personal and family histories or addiction, will be predisposed to consume alcohol during pregnancy" (Van Bibbler, 1997, p. 33).

Teenagers value both being successful as an individual and being part of a winning team, they place importance on educational achievement and find value in doing for others (Gordon & Grant, 1997). As girls reach puberty they face many changes - physically, emotionally, and socially. They are much more vulnerable to being hurt and having their self-esteem damaged. Praise and support from significant adults can go a long way to building girls' self-esteem. "...[W]ith older children and young people we need to recognize efforts and achievements, but we also need to realize that criticism can be very hurtful" (Gordon & Grant, 1997, p. 133). Girls tend to take stressors more seriously and personally than boys. This means that they are more susceptible to serious hurts (Pipher, 1994; Frydenberg, 1997). Many young people identify their general physical appearance as having a negative effect on their self-esteem and girls are also more likely than boys to talk of issues relating to body image (Gordon &

Grant, 1997). "The most pervasive predictor of adjustment was self-esteem, with low hostility playing a significant role in adjustment to school and family, but not to friends, whereas low anxiety had direct impact only on interpersonal adjustment" (Scott & Scott, 1998, p. 133). "Low self-esteem is believed by many to be an important predictor of problem behaviour. The literature, however does not support that hypothesis. Measures of self-esteem and locus of control rarely reach significance levels in multiple variable analyses. Low self-esteem has been related to substance abuse but found not to relate to dropout rates [from school]" (Dryfoos, 1990, p. 96).

"We see that other things that make me 'feel good about myself' include: having money, feelings about the future, having responsibility and drinking alcohol" (Gordon & Grant, 1997, p. 27). All adolescents experience some difficulty and turmoil as they go through the stages of adjusting from being a child to being an adult. How well they cope with stress will have an impact on how easily they move through adolescence. "Stress which is well managed increases self-esteem when it is overcome. Too much stress can prevent action and led [sic] to a loss of self-esteem... Resilience to stress seems, in part, to be bound up with self esteem" (Gordon & Grant, 1997, p. 147-149).

3. Theoretical Orientations

In order to understand the rationale behind this practicum and group work with pregnant adolescents with substance use issues it is important to understand group work in general as well as specific interventions for adolescents and those struggling with substance use. Many different group work approaches will be incorporated within a psychoeducational model. The overall approach focuses on the strength of the individual and the fact that they have the capacity to change. It also recognizes that there are many societal forces influencing individual choice. The general approach used in this practicum is based on the psychoeducational model with a recognition that it is also important to incorporate the emotional and relational pieces as described in self-in-relation theory (Surrey, 1991). Motivational interviewing (Miller, 1989) and stages of change theory (Prochaska and DiClemente, 1982) are also presented as important theoretical orientations underlying this group.

3.1 Groups

Group counselling is the approach which is generally favoured in work with young people and it has been shown to facilitate the recovery process for addicts (Gonet, 1994). Focusing on the here and now issues seems to hold the most promise of succeeding with adolescents. They often find therapy threatening or feel singled out in a one-on-one situation. "Many are relieved to enter a group of peers and discover that others are experiencing similar problems. The support and encouragement that the group members provide each other ensure their continued participation in the therapeutic process and boost their self-esteem" (Felsted, 1986, p. 88). Youth also seem to be able to challenge each other in a more positive way than the practitioner can.

There is value in small group counselling with adolescents in general. It is cost-effective for service providers and adolescents seem more willing to learn from each other than from adults. In addition, group work with people with substance abuse issues is effective for several reasons. Sitting and talking with others who genuinely understand the struggle for abstinence and sobriety can be very affirming. Secondly, the learning process that takes place in small groups is often contagious. It acts as a normalizing force. When everyone shares a similar experience much of the guilt and shame is reduced. As well, the group can be a place of positive peer pressure. It can provide a sense of belonging and build self-esteem and a feeling of security (Gonet, 1994). Youth programs which offer a wide range of professional services as well as opportunities for personal growth, educational and vocational development, recreation, and creative expression seem to be the most successful (Felsted, 1986). Groups allow the practitioner to reach a large number of youth and if the treatment is offered in the context of a youth centre the access to addiction treatment is less stigmatizing.

Therapy, support and self-help groups are the type of groups most commonly associated with treating addiction. They all provide a forum to increase self-awareness, offer a safe environment for self-disclosure, and create a place to receive reinforcement for accomplishments and behavioural changes, as well, some important education and teaching occurs (Gonet, 1994). The group in this practicum incorporates aspects of all these types. It provides education as well as support and reinforces the concept of mutual aid.

3.2 Psychoeducational Model

This model was chosen for several reasons. First, as mentioned above, group therapy is an effective intervention method with adolescent substance abusers. Second, the psychoeducational model combines education and support

which are needed with this population. It allows the group facilitator to educate about issues around substance use when pregnant and parenting. It also provides concrete behavioural and cognitive changes. "Psychoeducation and other kinds of family support programs have had notable success in motivating alcoholics to seek treatment..." (Nichols & Schwartz, 1998, p. 516). This approach was also chosen because it fits with existing programs at the practicum site. In addition, it allows for referral to other sources which is important as this population has more issues than can be adequately dealt with by a single mode of treatment.

Treatment groups can serve five purposes: support, socialization, education, growth and therapy. The focus of a psychoeducational group is on educating members of the group as well as providing emotional support. Much of the material comes from a social learning or behavioural perspective and may include but is not limited to: reinforcement, coaching, modelling, rehearsal, stimulus control, and discrimination. Support occurs throughout the group while specific educational interventions are planned in each session.

This model allows for the integration of a number of theories or approaches. It is similar to the integrative approach. The social worker uses advice, education and guidance and demonstrates techniques. He/she "encourages appropriate role development, communication patterns, decision making, and family responsibility" (Johnson, 1995, p. 417).

The content of the group follows a predictable schedule of events which includes educational material; exercises, role play, and simulations to help members practice the material; discussion of the material and the problems members are experiencing outside of the group; a brief period of going over assignments to be done outside of the group; and an evaluation of the meeting. As well, when developing the structure of the psychoeducational group it is important to consider elaboration of the goal; specification of major program elements;

identification of objectives and selection of appropriate exercises and techniques; provision of the opportunity for reality testing; and determination of size, duration and membership.

3.3 Self-in-Relation Theory

Self-in-relation theory balances the cognitive side of the psychoeducational approach with a focus on emotion and relationship. This theory was developed specifically for women and girls and arose out of the recognition that the developmental stages outlined by Erickson (1968) didn't fit very well for women. Girls develop their sense of self through their relationships rather than through becoming independent and autonomous. This focus on relationship begins with the mother-daughter relationship. In desiring to be connected with her mother a girl begins to develop the ability to connect with the feeling state of others. She begins to understand the difference between other and self. As they develop girls come to recognize that the mutual sharing of experience leads to psychological growth. As the emotional and cognitive connections between mother and daughter develop, a relationship develops where each cares for the well-being and development of the other. As a girl begins to relate to others this sense of mutual empowerment and competence is transferred to those relationships. This pattern of relating becomes an intrinsic part of girls' lives.

Girls' self-esteem develops through a shared sense of understanding and positive regard. They learn that being understood by others goes hand-in-hand with understanding others. They develop their sense of self through their relationships. Without significant relationships girls can withdraw and lose their sense of self. As girls get older and try to fit into a predominantly male world they discard or undervalue relationships in exchange for independence and autonomy.

By combining self-in relation theory with the psychoeducational approach this practicum provided a group which catered specifically to the needs of female adolescents with substance use issues. Motivational interviewing and stages of change were also important in understanding the attitude towards substance use issues at Addictions Foundation of Manitoba.

3.4 Motivational Interviewing and Stages of Change

Motivational interviewing is based on motivational psychology. It is a mechanism for drawing people forward using their own strengths and goals. This intervention was developed by Miller (1989) for alcohol/substance abuse. Often in addictions counselling motivation is defined as "a willingness on the part of the drug user to acknowledge his/her problem, and engage in counsellor-directed efforts to change" (Addiction Research Foundation, 1991, p. 3-26). The result of this is that people who are not seen as 'motivated' are labelled as resistant or in denial. This does not help to engage them in a process of change. Motivation can also be seen as a more interactive process where the counsellor and drug user work together to "bring to awareness the reality that drugs or alcohol are a problem, address the ambivalence and fear many feel about changing and provide choices about how these changes can come about" (Hohman, 1998, p. 279).

Motivational interviewing is based on the conceptual framework of Stages of Change developed by Prochaska and DiClemente (1982). They identify several stages that a person goes through in order to achieve change. The first stage is *pre-contemplation*. At this stage the person is not intending to change and they may even be unaware that their behaviour has negative consequences. *Contemplation* involves thinking about change in the foreseeable future. *Preparation* or *determination* is the beginning of the action stage where the person is now planning for change in the foreseeable future. *Action* is having

recently made a successful change. *Maintenance* is when a successful change continues for a period of six months or longer. Included in this framework is the concept of *relapse* where a person may slide back into any of the previous stages and begin again from there. The goal in treatment using the stages of change model is to move clients forward through the stages.

Motivational interviewing was developed as an intervention for use when clients are at the pre-contemplation and contemplation stages. It is based on five main principles. *Expressing empathy* refers to the practitioner's ability to establish rapport, to show the client that their struggles and feelings are understood. *Developing discrepancy* happens when the practitioner helps the client to struggle with the discrepancy between the positives and negatives of drug use and by aiding them to discuss their ambivalent feelings about change. *Avoiding argumentation* and *rolling with resistance* refer to the practitioner avoiding pushing the client to admit to behaviour or to label themselves in a certain way. The practitioner changes or diffuses the topic rather than confronting an issue. Once a client starts to lean more towards change then towards the status quo the practitioner is there to *support self-efficacy*. He/she affirms and supports the client in their ability to succeed in changing their behaviour. There are many other issues which can arise when working with someone who has difficulties with substance abuse. This model focuses on the process of change needed to deal with the substance abuse which may then lead to the resolution of other issues.

3.5 Summary

Group work with adolescent substance abusers is an accepted and successful way of doing treatment. The mix of the psychoeducational approach with self-in-relation theory gives these girls the support and education they need

around substance use and pregnancy and also reinforces their self-worth as women and encourages them to develop their support networks. Although these are the two main approaches cited, many sources were incorporated in designing the specific content for each session. Motivational interviewing and the process of change give an understanding of the orientation to counselling which was used with this group.

4. Implementation of Practicum Plan

4.1 Intervention

This group was designed for girls aged 15-18 who were pregnant (or new parents) and were regular users of alcohol/ drugs or had recently quit. This is a very specific population and therefore many agencies were contacted in order to access an adequate client base. Several agencies agreed to distribute flyers and some were also willing to make referrals. This approach to recruitment was unsuccessful and the group was adapted in order to acquire internal referrals through AFM. Because of the transiency of this population and in anticipation of some girls dropping out at least twelve young women would be admitted to the group in order to complete the group with at least eight participants.

This group was run at the Addictions Foundation of Manitoba [AFM] Youth Services Unit. The meeting rooms have room for a circle of chairs and space to move around to do different activities. The office is centrally located, and along several major bus routes which made it easier for the clients to attend. The group was led with assistance from a current AFM staff person. Child care was planned for in an adjacent room if this were needed. Staffing and payment for child care, if required, was to be provided by the writer.

The approach used in working with this population was the psychoeducational approach to group work. Self-in-relation theory served as the foundation and a variety of other techniques were employed in the administration of the group. The combination of these approaches worked well for this population.

Evaluation consisted of standardized measures for coping and self-esteem as well as written and verbal feedback from the participants and the co-facilitator. The writer kept notes of the group dynamics and individuals' progress. Client satisfaction surveys were also administered to determine the groups' efficacy.

4.1.1 Recruitment of Participants.

At the time of the practicum there were no services which addressed all the needs of pregnant adolescents who were abusing substance and therefore it was necessary to target many different agencies in order to gather a sufficient number of girls who fit the criteria for this group. Flyers and letters of explanation were sent to over forty agencies involved with segments of this population. These agencies included inner city high schools, health centres, programs for adolescent parents and programs focused on addiction (see Appendix D). Recruitment began in February in order to have a group in place for April and May. Many program directors and school counsellors were spoken to over the phone and a few staff groups were met in person. Positive response was received from almost everyone who was contacted. They thought the group sounded like a good idea and many said that they would most likely have some girls who would fit the profile. A few schools were reluctant to bring up the topic of drug use or pregnancy with their students and so didn't participate in the recruitment process.

As the time for the group approached possible referrals had been received for only two girls. Because of the initial positive response, the group start date was moved forward a few weeks and the agencies were notified that they could still refer. Even with the change of date, sufficient referrals were not received. At this point, a few key agencies who had been particularly supportive and were providing services specific to female adolescents were contacted to determine the course which recruitment should take. The general response was that the group should be put on hold until September. At that point girls would be settling back into school, agencies would be receiving referrals and they would be able to pass on potential clients.

This was a very frustrating experience considering that out of the forty agencies contacted it was expected that at least ten potential clients would be

received. The group was put on hold for the summer. During the spring and summer the writer spent time sitting in on other AFM groups and assisting with intake interviews. This prepared her to do intake on her own with the girls who would be referred to the New Beginnings group and develop a specific plan for the implementation of the group. In mid August, agencies were once again contacted about setting up meeting times to speak to their staff or students about the group and who would be recruited. The writer met personally with approximately one third of the agencies who were again very supportive and excited, said it sounded like a great group and they could think of some girls who would really benefit. Presentations were given to three groups of girls to explain the group to them and to provide an educational piece around pregnancy and substance use.

After this aggressive recruitment campaign a call was received from only one girl who was interested. A screening meeting was set up with her but she did not show up and further contact was unsuccessful. At the same time, through conversation with my advisor, my committee, and AFM I decided to revise the group in order to recruit other girls. The group was adapted to cater to female adolescents with substance use issues. The pregnant or parenting piece became optional. This changed the focus of the group only slightly as the girls were all still at high risk for pregnancy and a large part of the group was focused on things other than pregnancy and parenting. All of the original agencies were made aware of this change and encouraged to refer. No outside referrals were received but after making this change the AFM staff team were able to identify nine clients who fit the profile and could benefit from this type of group.

The writer met each girl with her counsellor, explained the process, screened them for suitability, and administered pre-tests. Most had already been through the AFM intake process but if they hadn't this was reviewed. Assessment

included questions to gather background information about school/work, family, medical, legal, and treatment history, as well as drug use patterns. The most important piece of the assessment was to determine whether they were group ready. Some reasons for not admitting an individual to the group would have been very limited language capabilities, low level of cognitive functioning or extremely disruptive and negative behaviour. Though these clients were the ones who needed the most help, they would benefit more from a one-on-one intervention. If a young woman was not group ready she would have been referred to an appropriate source. During the initial assessment interview the girls were given standardized assessment measures to determine their levels of pre-group self-esteem and their coping strategies. At this time it was also explained that this group was part of degree requirements for the Master of Social Work program and that the results would appear in print but that their identities would be protected by changing names and any identifying details. They were also given consent forms to sign and to be signed by their parent or guardian (see Appendix E).

Nine girls were screened and the group began with eight. The group began in mid-October once all the screening was completed. At the time of the first group meeting each client had had a screening interview, filled out assessment questionnaires and been given a tour of the facility.

4.1.2 Client Profile

Although each girl in the group is a distinct individual and brought with her many specific strengths and her own unique history, the girls also shared many similarities. In the interests of brevity and to protect confidentiality the following is a composite description of all the girls in the group in order to give an understanding of the clients for whom this group was designed. The average age

of the girls in the group was fifteen (one was fourteen and one seventeen). They came from all areas of the city but were all from low to middle income homes. Most travelled by bus although one was routinely dropped off and picked up by one of her parents. Three of the girls were living at home with one parent and the parents' boyfriend/girlfriend. Over the course of the group three of the girls were residents of a hospital psychiatric ward. One of the girls missed two sessions due to being admitted to the Manitoba Youth Centre. All of the girls attended school on at least a semi-regular basis. Those in a supportive setting (hospital, school for adolescent parents) did their schooling more regularly.

All of these girls started smoking and drinking before the age of twelve and using drugs shortly after. For many this use coincided with a trauma in their lives. The traumas included such things as: parents splitting up, a parent dying, getting involved with gangs, hanging out with a substance using crowd, being raped, being sexually assaulted by family members, or moving houses and schools. Their drug of choice was marijuana with alcohol taking a close second but they have used cocaine, acid, and magic mushrooms. One girl has also used heroin.

Most of these girls had a limited number of coping strategies and only a few individuals that they could count on for support. Most had low self-esteem although there were exceptions and it varied greatly depending on what was going on in their lives. Underlying their feelings of hopelessness was a strength of character and an attitude of not taking nonsense from anybody. They all knew what they wanted and didn't want and what was important. Some were simply so caught up in their substance use that they were unable to find their way to the place where they wanted to be. Those who were more successful at changing their lifestyles were those with support around them. This support came in many different forms. It usually involved people in their lives who built them up instead

of tearing them down and encouraged them not only in their fight against substance use but also with their schooling, relationships and other important aspects of their lives. The more consistent and regular the support, the more helpful it was. One girl was able to go to school each day and know that there would be a support network there. Another found the structure of the psychiatric ward and the nurses there to be a good source of support. Others had boyfriends or parents with whom they were able to talk and from whom they received support. Despite the fact that these girls had been through more than their share of difficulties, they were a fun and energetic bunch who looked forward to being able to interact with each other and participate in the activities presented. They were all very likeable and made running the group an enjoyable experience.

Most of the girls involved in the New Beginnings group lived at a low socio-economic level. This is an important factor to be aware of when planning a group for this population. The lack of money or resources meant that the girls often showed up hungry, so providing food was important to an effective group session. Some also had a limited vocabulary, so when providing information it was important to present it in simple and clear manner. For example, during one session the girls were asked whether they thought attendance was important and one of them had to ask what was meant by 'attendance'. Many of the issues these girls are dealing with at home are also a result of the lack of money or resources available to the families. These girls are often considered part of an 'undesirable population' with whom therapists avoid working.

In therapy "clients who are perceived as co-operative, motivated to change, and interesting are often the favourites. Most likely they are bright, not too old, articulate, and attractive" (Gerhart 1990, p. 95). These clients are preferred because they often improve quickly and make the therapist look good and help them to feel like they've made a difference. Clients who are working

through many issues at once and have limited resources to start with are not going to 'get better' quickly and will often have setbacks which do not look favourable for the therapist. This favouritism has been called the YAVIS factor. It is when therapists tend to focus on those who are Young, Attractive, Verbal, Intelligent and Successful (Gerhart, 1990).

While the girls in this group were young and attractive, many were not articulate, were behind in school, and struggling to be successful with friends, at home, or in their studies. This is not an easy population to work with and these girls required a lot of energy on the part of the facilitator to deal with the multitude of issues they were facing. Along with the lack of resources brought on by a lowered standard of living, these girls were faced with chaotic home lives, often moving from parents' home to boyfriend's home to foster home or psychiatric ward and back again. One girl was also helping to care for an ailing mother while another was trying to cope with raising her new son. These girls lacked positive role models for problem solving and coping and learned survival skills from those around them. Often those role models who were present were in need of as much assistance as the girls. When designing and running a group for this population it is important to keep the above issues in mind.

Another factor to consider is how to reach the girls who do fit the YAVIS profile. We know that they are out there and are also in need of assistance but their higher socio-economic status makes it easier to cover up some of their difficulties or attend private therapy sessions.

4.2 Group Process

Although theories about groups vary, they all describe a series of stages through which a group moves. The group as a whole changes as it progresses and so does each group member and the facilitators. Co-facilitation is an important

dynamic in the development of a group. While theories of group are meant to describe the stages through which the group as a whole progresses, the facilitator also faces different leadership issues at each stage. Group stages as described by Toseland and Rivas (1998) fit most closely with the process through which the facilitator went. Tuckman and Jensen (1977) describe another set of stages which more closely mirror the changes which happened among group members. Overall both the facilitator and group members moved quickly through the initial stages and got to a point where some important work could be accomplished.

4.2.1 Facilitation Issues - Stage by Stage

In order to obtain maximum learning benefits from this practicum it was decided to run the group with a co-facilitator. Another facilitator was provided for this practicum through the AFM. There were many benefits to having a co-facilitator. In this case, the co-facilitator was an addictions counsellor with AFM youth services and as such had conducted many intervention groups for adolescents. She was an invaluable resource in planning the group content and was able to suggest which types of activities would be most appropriate. She also had a good understanding of the policies of AFM and so was able to help with fielding questions around confidentiality and agency rules. She also understood both the youth and drug cultures, so was able to relate more intimately with the girls in these areas.

Having a competent co-facilitator allowed the writer to relax and enjoy the group as she knew that the co-facilitator would be able help if the group became too difficult to handle. The co-facilitator was able to act as a sounding board and reflect back what happened during group sessions. At times it was necessary to deal with one of the group members individually or leave the room for some reason and with a co-facilitator this was possible without causing undue

interruption to the group. Having two facilitators also meant that had it been necessary for one to be absent the group would still have been able to progress.

Because of the fact that the group was designed and facilitated as a degree requirement, the writer took on the primary role in the running of the group. The co-facilitator was there as a support and a backup although she did take an active role in the interactions in the group. It was important to have two people who were compatible and had the task of running the group been more evenly divided it would have been even more necessary to be able to work as a team. Co-facilitation is a definite advantage over leading a group alone but it does require open and honest dialogue between the two facilitators to make it an enjoyable experience both for them and for the group members.

Toseland and Rivas (1998) describe the phases that all groups go through as the planning, beginning, middle and ending stages. The issues faced by the facilitator are most easily described through these group stages. The role of the facilitator also changed with the transitions from one stage to another. Much planning went into developing all the areas necessary to running an effective group. The planning phase is outlined in detail in the section on intervention. It was a stage of much frustration but also learning and because attention was paid to the planning stage the rest of the group ran fairly smoothly. The beginning stage of the group incorporated the first two sessions. "The beginning of a group is often characterized by caution and tentativeness" (Toseland & Rivas, 1998, p. 175). This was true of the girls but also for the facilitator. It was difficult to know how the girls would react to the schedule of activities and discussions which in turn made it difficult to know how to react to their behaviour.

There are certain objectives that should be achieved during the beginning stage of group in order for the group to proceed comfortably to the middle stage. These include: introducing members of the group; clarifying the purpose and

function of the group; clarifying confidentiality issues; helping members feel a part of the group; balancing task and socioemotional aspects of the group process; setting goals; contracting for work; facilitating members' motivation and ability to work in the group; and anticipating obstacles (Toseland & Rivas, 1998). Despite the original discomfort which the facilitator felt in the group, it was possible to achieve the above mentioned objectives and establish patterns of relating and a comfort level which allowed the group to move into the middle stage.

"The middle stage of treatment groups is often characterized by an initial period of testing, conflict, and adjustment as members work out their relationships with one another and the larger group" (Toseland & Rivas, 1998, p. 235). This was certainly true in the New Beginnings group. The girls questioned much of what the facilitator had to say, at times refused to participate in activities, and challenged the facilitator on her drug use and lack of disclosure. This behaviour was alternately frustrating and threatening but at the same time it was recognized as a group stage and indicated that the group was moving towards a more intimate dynamic. This testing was evident in sessions three and four after which point the group settled down and was able to focus on the tasks at hand. Sessions five through ten comprised the majority of the middle stage. As the girls settled down the facilitator was better able to deal with the ongoing group dynamics and feel confident in her ability to lead the group through this stage.

Toseland and Rivas (1998) outline six activities which are important to the leadership of a group at this stage. The facilitator spent time *preparing for group meetings* trying to focus not only on content but also on group dynamics and creating an atmosphere where the girls felt that they could share and grow. This involved having an outline ready but also being able to adjust it based on who turned up for the group and what the girls brought with them to the group. Part of this involved structuring the group work so that there was a balance of different

types of activities as well as times for check-in and check-out. There were times when it felt awkward attempting to transition from one activity to another or when trying to get the group back on task but this became easier as the group progressed. Another important piece was *involving and empowering group members*. This was achieved through a series of activities and discussions as well as by asking the girls to provide solutions for each other and to be involved in the process of the group. The girls all arrived with many strengths and by drawing on those it was possible to help members achieve their goals through discussion, challenges and accountability.

     Working with reluctant and resistant group members was one of the more challenging activities required at this stage. One young woman in particular often refused to participate or simply chose to refute everything which was said. By continuing to engage with and support her it was possible to eventually build some trust with her which allowed her to open up and begin to participate as an active group member. The other girls also helped with this behaviour by challenging her with the fact that this was a voluntary group and that she had choices and could always leave. Throughout the duration of the group the facilitator *monitored and evaluated the group's progress* in order to better plan for the next session and determine whether the group was achieving the goals set forth. This was done through video taping as well as the writer's notes and on-going feedback from the co-facilitator.

     The ending stage of the group began later than planned because of poor attendance in the last couple of weeks and the need to incorporate middle stage work before we moved on. The idea of ending was brought up during the eleventh session but the real 'ending' work didn't occur until the twelfth and final session. Before continuing with a description of this ending process it is important to note that there were a couple of unplanned terminations before the

end of the group. One girl came to the building but did not even attend the first meeting. Another came to the first meeting and decided that the group was not advanced enough for her. These two occurred very early in the group process and so there was not any formal termination involved. Another girl stayed until the fourth session and decided halfway through the session that she would prefer individual counselling. This was somewhat difficult as it disrupted the session and caused anxiety among some of the other girls. She was supported, reminded that it was her choice as the group was voluntary and then allowed the freedom to leave. At the next session, the names of the group members who had left were erased from the board. The girls had questions and concerns but after these were addressed they accepted that the group had two less members. There were also times when it was unclear whether someone had decided not to return without the benefit of an actual 'ending' but everyone eventually returned to the group.

The ending stage of the group went well. All of the tasks associated with group endings were covered. These include: maintaining and generalizing change efforts; reducing group attraction and promoting the independent functioning of group members; helping members deal with their feelings about ending; planning for the future; making referrals; and evaluating the work of the group (Toseland & Rivas, 1998). The group had already been working on things that they could take away with them at the end of the group. The facilitator initiated discussion on how the information gained during the group would carry over into their lives. Because this was a community-based group and met for only six weeks it was not necessary to reduce group attraction but rather to discuss how they could continue to support each other while outside of the group. We did a termination exercise which allowed the girls to discuss their feelings around leaving and they wrote down their three-month goals for future reference. Because the girls were all connected with AFM they continued to meet with their

counsellors rather than being referred elsewhere. The final session concluded with the presentation of a flower to each girl as a symbol of the steps they had taken towards a 'new beginning' and as a reminder of how unique and special they each are.

Although the ending of the group was positive the facilitator could have ended the group more strongly. A party was planned for the last day and each girl was presented with a flower but each was not specifically told how important they were or encouraged in their goals. There wasn't much talk about how they felt about leaving and the girls drifted out of the room at the end. At the time it was assumed that the girls weren't ready for something more structured or emotional but it could have provided a better ending for the group.

4.2.2 Members

Another way of classifying the stages of a group are: forming, storming, norming and performing (Tuckman & Jensen, 1977). The girls moved through these phases with almost textbook precision. Each session began with a check-in where each girl had a chance to share about her week, any issues that had arisen since the last meeting, and her struggles with substance use. After the check-in, an interactive activity was presented to help the girls engage in the group process and prepare them for the session. After the activity, the topic for the session was presented and the girls explored the topic either through worksheets, discussion, or some other form of learning. A hands-on activity was also provided where they could physically draw, write or create around the topic presented. Each session ended with a check-out which gave the girls an opportunity to reflect on what they had gained from the session as well as preparing for what the days ahead might bring.

The first two sessions represented the forming stage. The girls were tentative entering the group room. They were assessing each other to pick up cues as to how to behave and asked many questions in order to understand the purpose of the group and what the guidelines of the group were. This process was aided by doing icebreaker games and allowing them to help establish group guidelines. The first session was also a time to work on 'drug charts' where the girls were given a chance to show their knowledge of different drugs. The second session focused on reasons for using and not using drugs. This was particularly revealing when one young woman shared that the worst thing about not using was being unable to see her family as they all had substance use issues. This session also included some discussion of Fetal Alcohol Syndrome and Effects. By the end of the second group most of the participants seemed fairly comfortable and were able to relate to the facilitators and each other. They were also moving into the second or storming stage.

At the end of the second session the girls began to challenge the facilitator. They wanted to know if she used drugs or not and said she was in denial when told that what was going on with the facilitator wasn't relevant. One of the girls put up her own challenge by stating that she had admitted she was an alcoholic and hadn't denied it. They all went home in a good space but came to the third session fully into the storming stage. This seemed to be augmented by the fact that there was a lot of 'storming' happening in their own lives. It is hard to know whether this was coincidental or a result of being in the group. One girl who had been sober for four months had used marijuana several times over the weekend and even earlier that same day. The younger sister of another girl ran away over the weekend and blamed it on her big sister. 'If she can do it why can't I?'. The same girl also found out that her boyfriend was in jail.

A third girl shared after some initial hesitation that she was feeling very depressed after experiencing much teasing and bullying over the weekend. She hadn't used alcohol since the group started over a week before but felt that she would probably go home and 'do something'. The facilitators made a suicide assessment at that time and determined she was at high risk. Her determination to remain abstinent for the length of group was putting her at risk as she had now lost her primary coping mechanism. Two other girls shared that they had used drugs over the weekend despite a commitment to try and abstain. At the end of group the last group member approached me to say that she thought she was pregnant. We talked about her getting tested and whether there was somewhere she felt safe doing that. Some of this storming may have been a result of the group. Some may have already been happening but was now revealed as the girls began to feel comfortable sharing. It is possible that it was just a bad week. Whatever the reason, going through all these crises allowed the girls to bond on a deeper level and to develop more trust with each other.

All this 'storming, was occurring while the facilitator continued to lead a group session. Time was given to support the girls in the many issues they brought forth but the topic of defenses was also introduced as originally planned. Discussion focused on defenses used when confronted about drug use. During this session they again challenged the facilitator about drug use. They also stated that they wanted to have more in depth discussion of problems. The girls quickly moved themselves out of the storming phase and into the norming phase.

Although there was still some questioning and conflict during the fourth and fifth sessions the girls settled down to the tasks and work presented to them and began to interact as a group. As they said they were ready for more problem solving, the facilitator changed the order of the sessions in order to accommodate that desire. They worked on genograms which gave a picture of their families and

showed patterns of use. They also prepared life maps. Some of the girls came up with only negative life events but when pushed were able to include positive events in their lives as well. The fifth session also involved drawing how they were feeling inside. They began interacting with each other about their lives and giving each other advice. These sessions were difficult for the girls because of the focus on their families but most participated fully. One of the girls took much longer to get through the storming stage and when the group moved on to more intense activities such as drawing feelings her negativity and refusal to participate in the group increased. The other girls and the facilitators were able to continue to be supportive and, while recognizing where she was at, still push her ahead with the rest of the group. During session five she was able to begin sharing about herself through the lifemaps and the real breakthrough came in session six when she was able to share her feelings with the group and feel supported. After that she moved quickly into the norming stage.

By the time the girls had completed half of the group sessions they were moving into the performing stage of group. They began to recognize the gains that they were making and were able to encourage and support each other. Session eight focused on body image and sex role stereotyping. The girls talked about this but it did not seem to be a big issue for them. Most were already quite clear on what they thought. A video of girls discussing these issues was shown as a way to initiate discussion but it was not helpful. While structured discussion didn't result in meaningful content, unstructured discussion about this topic during check-out resulted in more significant sharing.

A majority of the girls were absent for sessions nine and ten which affected the development of the performing stage. This was unfortunate as these sessions focused on social support and mutual aid and those who were present appreciated the exercises which reinforced who their important sources of support

were. One of the girls commented that in filling out the graphs she realized that even though she depended mostly on her friends at present, her family would always be there to support her. They were a much more dependable source than friends.

The girls all returned to the eleventh session ready to 'perform'. They had really connected as a group. They were aware that the group was ending and although they were reluctant to give up the good experiences they'd had and the friends that they'd made, they also recognized the gains they had made and were looking forward to a new stage in their lives. Session eleven continued on the theme of mutual aid and also introduced self care techniques. They continued making 'happy boxes' which were started the week before and enjoyed the time to interact while creating. The 'happy boxes' involved colouring, cutting and pasting. While focusing on those activities conversation flowed much more naturally and the topics of mutual aid and self-care were covered in a much more relaxed manner than some of the topics in previous sessions. The final session focused on ending and is detailed in the section of facilitator stages.

Overall, the group experience was a positive one. Although it was challenging at times, the girls were able to move through various tasks much more easily than if we had attempted to do the same counselling individually. The literature on groups supports the fact that groups are the favoured way of working with adolescents and those with substance use issues (Gonet 1994). This was reinforced in my experience with this group. The group was also more effective as a girls group than it would have been were it a co-ed group. The girls felt that they were able to open up and share in more areas than they would have had there been males present.

4.2.3 Follow-up

A group follow-up occurred three weeks after the intervention ended. Of the five girls who ended the group three showed up for this meeting. They had all received reminder phone calls but said they remembered. They were looking forward to seeing each other again. One girl didn't show because she was out of town, the other had said she was coming but didn't show. It was determined later that she had been admitted to the Manitoba Youth Centre. During this session the standardized assessment scales were re-administered and each girl was asked to report on how she was incorporating what was learned in group and how her life was going. Some girls were doing better and some were not. They all have ongoing crisis in their lives and are better able to deal with them on some days than others. The encouraging piece was that they all looked forward to coming back to the group. Relationships were formed in the group which were significant. They have made changes in their lives since starting the group. One girl has completely stopped drinking alcohol and is starting to deal with her negative feelings towards her family and others. Another girl admitted that substance use was an issue for her and was able to begin receiving help. Another began to recognize that she was not responsible for the crisis in her family and begin to let go of some of that responsibility. Some felt that this was a direct result of being in the group while others did not.

The group had a good time visiting and when they left they each received a certificate of completion which they appreciated. One of the girls did not show up for the last session or the follow-up as she was in the Manitoba Youth Centre. Follow-up did not occur. The other girl who missed follow-up met with her AFM counsellor later and completed the follow-up material. The purpose of this follow-up was to determine whether gains made during the group had been maintained after the group. Originally, the participants were to be offered three to

five individual counselling sessions after the group. This was to ensure that any issues which were not addressed during group could be dealt with. The change in recruitment meant that all of the girls were already AFM clients. Therefore they continued to meet individually with their AFM counsellors. As these were counsellors with whom they already had relationship it provided a better continuity of care than if they had received individual sessions with the group facilitator.

5.0 Evaluation

The New Beginnings group was developed to specifically address the needs of pregnant adolescents with substance use issues. The goals of the group were:

a) To provide concrete skills to deal with the combination of pregnancy, substance use issues and adolescence as well as skills to deal with physical and psychological addictions.

b) To help these young women grow in the areas of self esteem, coping skills, parenting and social support as well as encouraging abstinence.

c) To provide a support group of peers with whom to discuss pertinent issues.

d) To provide information about available resources and referrals to other services.

Once the group was amended to focus on any females 15-18 years of age the pieces on pregnancy were no longer specific goals but all other objectives remained.

5.1 Evaluation of Group Members

Evaluation took place throughout this practicum. The initial screening process used the AFM youth intake form [Module Four: Part One] as well as some questions about pregnancy and willingness to be in group. Once it was determined that a client was a suitable candidate for group she was given consent forms as well as standardized scales to assess her level of self-esteem [Hare Self-esteem scale] (Hare, 1985), and her ability to cope [Adolescent Coping Orientation for Problem Experiences] (McCubbin & Thompson, 1991) (see Appendix F). These assessments were repeated at the end of the group and at

follow-up in order to determine whether any change had occurred. These results are discussed in detail in the section on quantitative evaluation.

Some of the data gathered for this evaluation was by way of self report in order for the practitioner to observe daily how the clients perceived their ability to cope and their level of self-esteem. This was supplemented with the standardized measures to determine whether the clients had improved in these areas from beginning to end as well as simply determining their current status in these areas and whether that corresponded with what they were reporting about themselves. Client satisfaction surveys and a group evaluation were completed by each group member at the end of the group to determine the overall success of the group. Each of these measures and the results obtained from them are outlined below.

5.1.1 Quantitative

Two standardized measures were used in this practicum. The Hare Self-esteem Scale and the A-Cope were both designed specifically for adolescents and measured the necessary information.

The Hare Self-Esteem Scale [HSS] (Hare, 1985) was chosen because it measures self-esteem in school age children of which this population is a part. It also consists of three subscales which are area specific (peer, home and school) and gives some insight into external forces impacting on the girls' self-esteem. It is intended to illicit a response of general self-feeling in each area and because these three areas are the major areas where children develop their sense of self-worth this should give an good overall indication of self-esteem. It is also relatively short - 30 questions - which is important as the girls filled out several scales at once. "The HSS can be administered individually or in groups, orally or in writing" (Fischer & Corcoran, 1994, p. 472). This makes it very user friendly

and allows the group facilitator to adapt the data gathering process to the needs of the group.

The HSS has been tested on fifth and eighth graders which represent the lower end of this therapeutic group. It has also been tested on boys and girls as well as cross-culturally with subscale scores available for each. This makes it a good measure for this population as we know it works specifically for 15 year old girls of different racial backgrounds.

Scoring for this scale is relatively simple. Negatively worded questions are reverse scored and then each letter is assigned a score with a=1, b=2, c=3, and d=4. Each subscale is totalled and the total of the subscales gives an overall score with a higher score indicating higher self-esteem. The mean score ranges from 90.4 to 95.0 with a group mean of 91.1 for all subsamples (Fischer & Corcoran, 1994).

Many of the advantages of this scale have already been outlined above. A disadvantage would be whether using the scale as a pre- and post-test would give an accurate indication of a change in self-esteem or whether the change could be accounted for by normal fluctuations. Also, the subscales assume that home, peer and school are the main influences in a child's life. It is possible that a child could be living in a group home, not be in school and have a limited social network in which case the questions and therefore the scale may not be relevant.

The other standardized measure used for this evaluation was the Adolescent Coping Orientation For Problem Experiences [A-COPE] (McCubbin & Thompson, 1991). This measure was designed specifically for adolescents through literature reviews and interviews with adolescents regarding life changes. "A-COPE is designed to record the behaviours adolescents find helpful in managing problems or difficult situations which happen to them or other members of their families. Coping is defined as individual or group behaviour used to
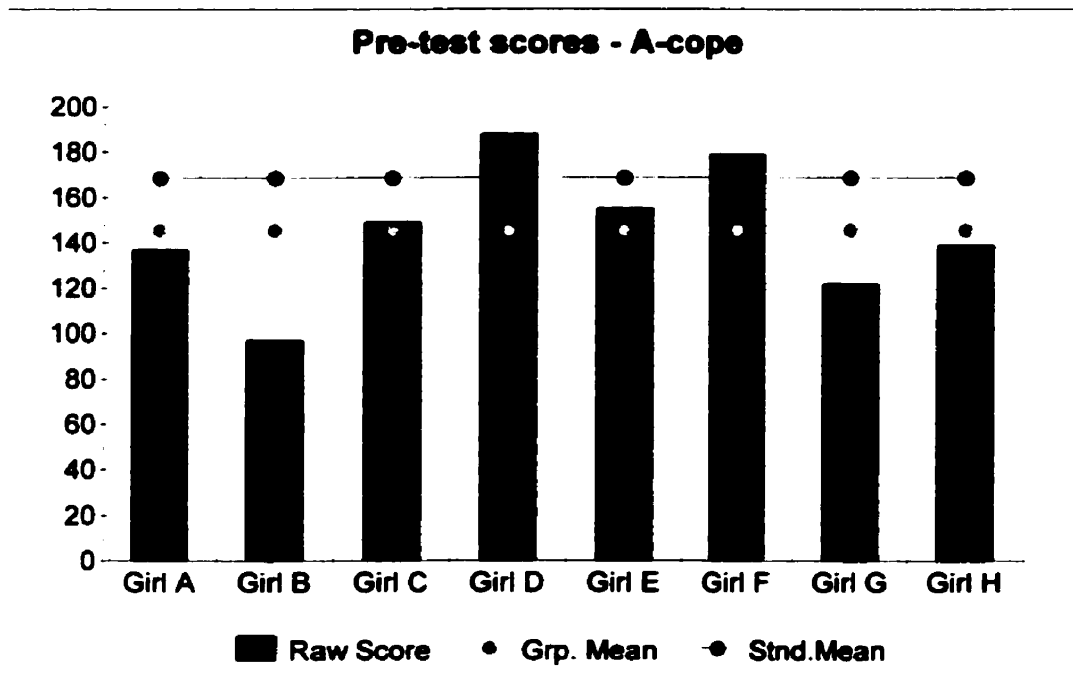
manage the hardships and relieve the discomfort associated with life changes or difficult life events" (Fischer & Corcoran, 1994, p. 403). This was the type of coping focused on with this intervention. Scoring for this scale is also just a simple summing of item scores for a total score. A few of the questions are reverse scored. The mean score for adolescents in residential treatment is 168.7 with a standard deviation of 26.3 (Fischer & Corcoran, 1994).

The primary advantage of this measure is the fact that it is specifically designed for adolescents. It also shows no difference in scores between races and therefore is applicable to different populations. The questions are simple and straightforward and the scale makes allowances for family to be defined as step parents and siblings as well as natural family groupings. It was tested on both males and females but scores are not given for each separately. It was also tested in several different settings which is positive. It was tested in junior and senior high schools as well as in a health maintenance agency and with adolescents who were in residential treatment.

These two scales were administered during the screening interview (pre-test), during the last group session (post-test) and then again at follow-up three weeks later. Because of this being a very small sample it is difficult to draw any general conclusions from the results. It is however interesting to note individual fluctuations. Charts 1 and 2 display the scores for all of the girls at pre-test. Even with individual fluctuations, the mean for this group was below the standardized mean. Three of the girls who had high beginning scores (C, D, and E) ended up self-selecting out of the group near the beginning of the group sessions as they were at a level beyond that of the rest of the group members. They decided that they would not receive the benefits they needed from the group. All of the remaining girls (A,B,F, and G) scored higher on the post-test than on the pre-test for both coping and self-esteem. Girl H was not at the final group

session or at the follow-up meeting and so comparison scores are not available for
her.

Chart 1

Pre-test scores - A-cope

Raw Score   • Grp. Mean   → Stnd.Mean

Chart 2

Pre-test scores - Self-esteem

Raw Scores   • Grp. Mean   → Stnd.Mean

Chart 3

A-Cope - All sessions complete
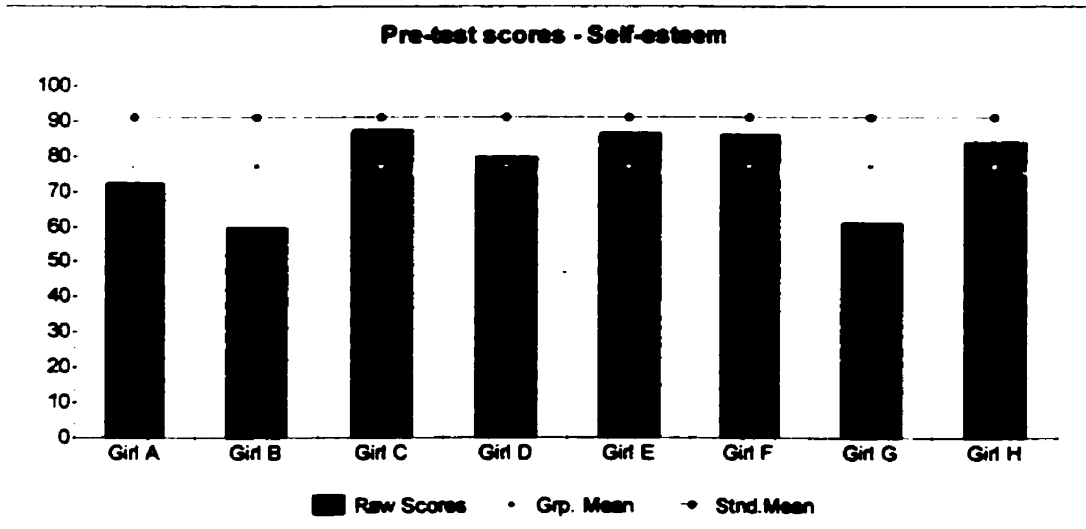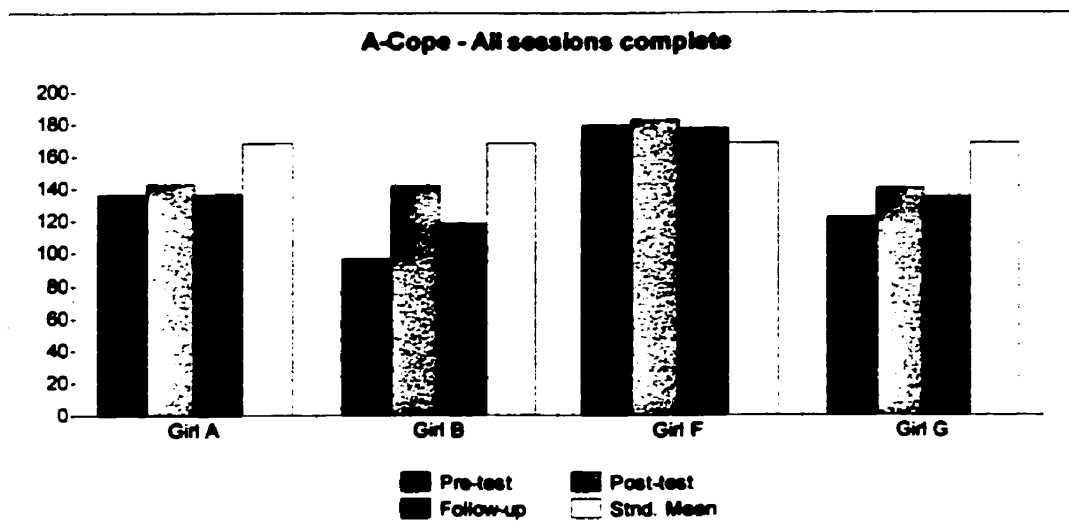

Four girls completed the group and all the testing material. All of them scored higher on coping skills at post-test then pre-test. Two of these girls (A and F) had their coping scores drop back to pre-test levels again at follow-up. Girl A was experiencing additional stress at home during this time and recognized the difficulties she had with coping effectively. Girl F's self reports indicated that she felt good about herself and was able to cope with life on a daily basis. This is reflected in her scores which started out high and dropped only slightly at follow-up. Interesting to note, Girl G's coping score was almost as high at follow-up as her post-test level and yet by her reports she was not doing well and feeling unable to cope. Girl B's coping scores fell at follow-up but remained well above pre-test levels which is consistent with her self-reports. It would appear that gains were made during the group and were partially maintained three weeks later at follow-up. Confounding factors include the fact that many of these girls were in different living situations at follow-up than they were during the group and were needing to learn new ways to cope as they continued to work at cutting down on or abstaining from alcohol and other drugs.

<u>Chart 4</u>

Self-esteem - All sessions complete
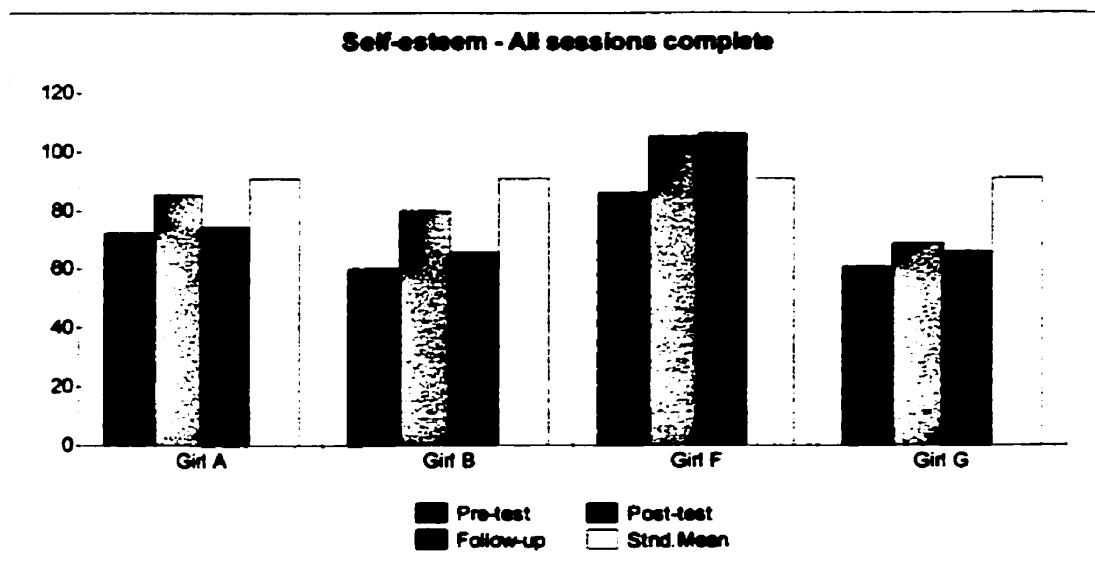
The fluctuations in self-esteem scores are similar to those seen in the coping scores. The post-test scores for all of the girls were higher than their pre-test scores. Girl F's follow-up self-esteem score remained at her high post-test level at follow-up. In referring back to chart two it can also be seen that Girl F's scores were consistently higher than the standardized mean for the scale. Girls A, B and G all had self-esteem scores which dropped at follow-up but remained above pre-test levels. Girl B improved dramatically from pre-test to post-test and maintained those gains at follow-up. A dramatic change was also observed in her demeanour and bearing during group sessions as she became more confident and sure of herself.

The self-esteem assessment instrument was broken down into subscales of peer, home, and school. It is interesting to note fluctuations in each of these areas as well. For most of the girls each area moved up and down similar to their overall scores but they always scored the same area lower or higher relative to the others. The exception to this is Girl B who scored home lower on both pre- and post-tests but then scored it as her highest area of self-esteem at follow-up. This

may be partly a result of the fact that at follow-up she was no longer living with her family but was in the psychiatric ward of a hospital. Despite this change her scores overall were still low but improving.

Chart 5

Self-esteem Subscales
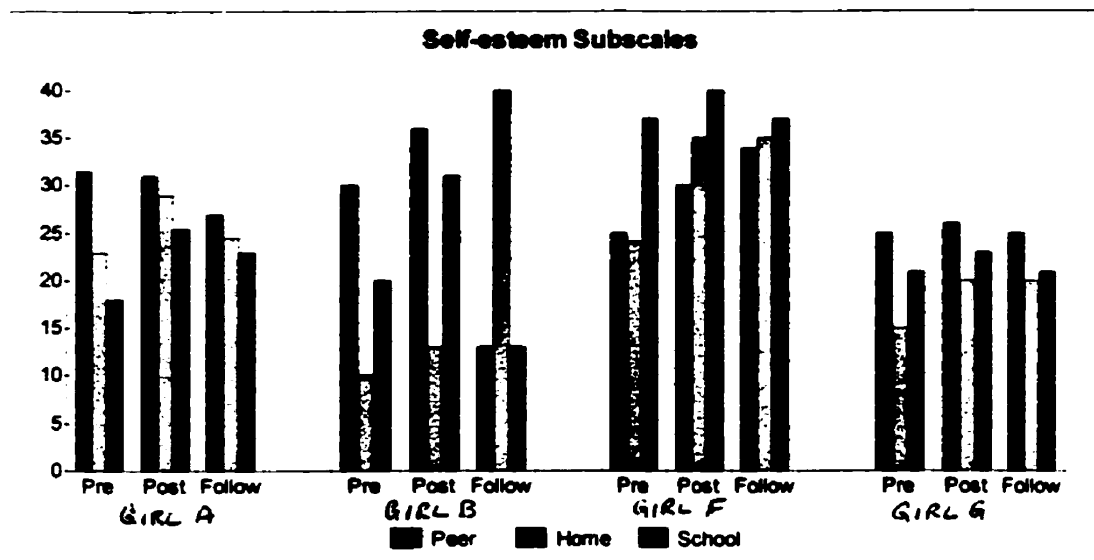
The scoring helped to give a general idea of gains made by the group but on their own they were inconclusive. With the addition of self report data and observations by the facilitator it was easier to get a full picture of the gains made by the girls. The group acted as a strong normalizing force which allowed the girls to feel better about themselves and focus on how they could begin to deal with the many issues in their lives. They were most excited and positive at the last group session. At follow-up some of life's realities had hit them and they were struggling to cope but they all still had a positive outlook and could plan ahead for bigger and better things.

5.1.2 Qualitative

Qualitative measures were used to supplement the information gained through the rapid assessment instruments. These measures took the form of

verbal questions asked of the girls, observations by the facilitators and long answers on the exit questionnaire. Quantitative measures give an indication of how a person responds to a specific set of questions. While this gives some hint of their self-esteem or coping there are many other factors to be considered. Qualitative and oral evaluation provide an opportunity for the practitioner to understand the factors underlying the answers to certain standardized measures. The girls were asked halfway through the group and then again at the end of group how they felt they were benefiting from the group. The facilitator also observed the interactions and dynamics in the group and kept notes. Through the qualitative measures of the girls own reports and the facilitators' observations it was possible to expand on the results obtained through the standardized measures.

Group sessions were video taped to record the interactions in the group as well as for supervision purposes. This provided a source to evaluate the group dynamics and for the facilitator to receive feedback on performance. Written notes were also kept for each girl as well as notes to evaluate the group dynamics. In addition, each client was encouraged to keep a journal to help them process what was going on for them in group. If this was done it became something they did themselves and was not incorporated into the group. Check-in and check-outs provided the opportunity to evaluate each girl's status in terms of the group and what needed to be addressed in group as well as what was going on in their lives.

After six sessions, most girls said they were simply going through the motions. They said the group was okay but they were just doing it to satisfy Child and Family Services or their parents or their parole officer. The fact that they voluntarily continued to show up for the group gave some indication that it was perhaps somewhat helpful to them personally. By the end of the group they were all able to indicate how the group had helped them. They felt better about

themselves and their ability to control their drug use. They also appreciated learning new things (like 'happy boxes') which they hadn't known before.

Facilitator observations of the girls indicated that there was significant growth with each of them. They all still had a long way to go in becoming drug free or getting their substance use under control but they had made significant gains. Some of the girls had and will continue to have very difficult times; others have yet to face their biggest difficulties. The decision to quit using a substance meant that things got worse for a time before they started to get better but the girls persevered. As the group progressed they began to look forward to attending each session. They built relationships with each other and the facilitators and were able to come to the group and talk about what was going on in their lives. They all looked more alert and less depressed as the group progressed. Some still indicated feeling depressed but their outward appearance indicated some change in their feelings about themselves. One girl began wearing her hair pulled back instead of hanging in her face, another sat up in her chair and looked interested rather than slouching and looking bored. They began to be able to problem solve and help each other look for solutions. They were learning the concrete skills necessary to deal with the many life changing events in which they were caught up. For instance, there was discussion around specific ways to cope with stressful events, a pooling of known resources to turn to when in crisis, discussion of how to deal with conflict with parents and peers at school, as well as problem solving around safety plans. They were able to give each other advice and offer community resources which were available to each other. They also smiled and laughed together as the group progressed. Laughing is often used as a coping mechanism at this age but is also an indication of the resiliency of these girls. Despite the many issues they were dealing with, they could still laugh and enjoy the activities and each others company. Some of these reactions may simply have

been a result of the members becoming more comfortable as a group. It may also be that they were starting to deal with some of the issues they were facing in their lives, recognized that they were able to take control and make changes, and were not alone in their struggles.

Three of the five group members attended the follow-up session. One had made significant improvements. She had used marijuana only once and was gearing up for Christmas in a very positive manner. She was saving her money and had already spent some on gifts for her son. She was planning family events and had changed her focus away from substance use. The other two girls were dealing with a lot of crisis in their lives. It was difficult to know whether this was regression or just a reflection of their chaotic lives. One of the girls said she was doing worse at follow-up than she was before. She was on a psychiatric unit at that point so life was very different than what it was at home. She seemed to be very aware of her issues around substance use but was unable to overcome them. The other girl was taking on a lot of responsibility at home and feeling stressed as a result. She recognized the connection between the stress at home and the urge to smoke marijuana but had not yet figured out how to start changing that coping behaviour.

All of the girls were moving on to other groups at AFM. They were all excellent group members and were motivated to make changes although many could not see how. This was a positive group experience for them and they were expressing readiness to continue working at improving themselves.

5.1.3 Self-report

In order to continue to evaluate the girls' level of self-esteem, coping skills and social support during the group the young women were asked to rate themselves on a scale of one to five in response to the following questions: I feel

good about myself today; I feel able to cope with stress in a positive way today; I feel supported by friends or family today (see Appendix F). These scales were administered twice during the group but because of fluctuating attendance it was difficult to get a response from all the girls at a similar period of time. If this were to be repeated it would be important to administer this self-evaluation scale at least every other session if not every session in order for it to be useful.

By examining the two scales, collecting written self-reports from the girls, and through qualitative measures such as oral reporting and answers to the exit interview, it was possible to examine whether the group had a positive effect in the areas of self-esteem and coping. The exit questionnaire at the end of the group helped to determine what they thought of the group in general and to evaluate the facilitator.

Running a group for female adolescent substance abusers presented many challenges. The fact that it was multi-faceted made it difficult to evaluate. For this reason, many different measures were used in order to assess as many different facets of the intervention as possible.

5.2 Evaluation of Learning Benefits

Educational benefits were evaluated through self-report, verbal and written evaluation from the co-facilitator and verbal direction from her advisor. Self-evaluation reflected whether the educational goals set out by the writer were met. The co-facilitator provided ongoing feedback as well as supervision and coaching over the course of the group, and provided a written evaluation at the end of the group. The writer's advisor viewed the videotapes and provided evaluation through them.

There were many learning benefits gained through this practicum. The educational goals which were set out were met and much was learned in the

process of achieving these goals. The writer gained experience in designing and running a group specifically for this population as well as observing group dynamics and how each person in the group affects others. The balance of process and content presented an unexpected area of learning. The girls' response to a female only group was also an area of learning.

Several educational goals were established at the beginning of the practicum:

a) Gaining experience in running a group for female, substance abusing adolescents and understanding this population better.

b) Learning how to implement various types of group interventions.

c) Establishing a structure which will address the needs of this population.

d) Observing the patterns that develop out of the group experience.

e) Evaluating the efficacy of the intervention through the use of rapid assessment instruments.

All of these goals were realized by the writer. By the end of the group the writer felt much more confident in her abilities to run this type of group and deal with issues which might arise. She was also able to use many different types of interventions in the course of the group and learn which types worked well and which didn't. This eclectic combination of interventions also allowed for the development of a group which specifically met at least some of the needs of this population. It also required a clear understanding of many different approaches and how they could be implemented in practice.

Many aspects of running a group and group dynamics were learned before the New Beginnings group even started. The recruitment process for this practicum provided for much learning. Although the agencies approached were excited and supportive few provided clients for the group. There were many

reasons for this which can be explained using the systems approach. Barriers were encountered at the community, family and individual levels.

Barriers were encountered at the community level in several ways. There were no organizations which specifically addressed the needs of this population. It was therefore necessary to recruit from many different organizations each of whom had only a few girls who fit the profile. Some organizations, especially schools, were reluctant to broach the subject of drugs with their pregnant students. Also, in Winnipeg, everything tends to slow down over the summer and so potential clients are not as accessible. At a more global community level, society attaches a stigma to drinking and using drugs while pregnant and so girls were reluctant to come forward because of being singled out or looked down upon.

The unpredictability of the family life of these girls also made recruitment difficult. They may move from living with parents, to boyfriend, to a group home or institution. This lack of consistency makes it difficult for the girls to follow through on commitments. The family unit is often unsupportive or lacks the resources to give the individual the support she needs. Individually, these girls lead very transient lives which makes it difficult to follow-up even after an initial contact has been made. It is difficult for them to be consistent in attending appointments or following through on tasks. By recruiting through agencies it was only possible to connect with those individuals who are already engaged with an organization. Those who were not connected to resources were very difficult to find. Also, many girls will not admit to using substances or will not see their use as a problem and therefore do not seek help.

At each level, there are many other issues occurring simultaneously. Addressing alcohol/drug use may not always be the first priority. There are many life aspects which need to be dealt with throughout the systems in order for these girls to even be open to drug/alcohol treatment.

Much was also learned about group dynamics by observing the girls moving through the group stages and also what effect each girl has on the rest of the group. The mood with which each person, including the facilitator, entered the group affected everyone else either positively or negatively. When someone didn't show up for a group session this also affected everyone else. It changed the group dynamics and made them start questioning their motivation for being there.

The facilitator's reactions and body language also affected the group. Through watching the videos it was possible to observe areas of discomfort which was reflected in the group's reactions. As the facilitator became more comfortable with the group, the group members relaxed and opened up. A habit of standing with arms crossed comes across as being a defiant or uninterested stance. By the middle of the group, this habit was recognized and the facilitator was able to take her seat when a girl wanted to talk instead of standing and appearing anxious for her to finish. Lukewarm reactions were often given to important information shared by the girls. This may have been a result of a level of discomfort or an attempt to stay 'professional'. Through self-observation in the group it was possible to see how reactions could be given with more emotion and as such be more supportive and encouraging.

The writer tended to take a very relaxed and casual approach to leading the group and tried to be as genuine as possible. This approach worked well with these girls as they felt like they were able to connect and be comfortable in the group. At the same time, it was important to not get too casual and friendly but remain in a facilitator/client relationship. This tension was manageable in the group as the girls didn't push the facilitator in the sharing of personal information with them after the first few sessions.

The use of rapid assessment instruments to evaluate the group's efficacy was a positive exercise. The girls did not mind completing the instruments and it

did not appear to take much away from the rest of the group time. While the instruments do indicate a rise in the girls' perceived ability to cope and their levels of self-esteem, because they were administered as pre- and post-tests, it is unclear whether or not this is a significant change or reflective of the day on which they filled out the forms. One of the forms required them to simply circle the correct response. The other required that they write in a letter from a code at the top of the page. This was more difficult and the process would have been faster and clearer if the letters had been next to each question where they could simply circle the correct one. If this type of measurement were to be administered again it would be important to ensure that all of the instruments were as simple as possible.

Another important learning benefit which occurred during this group was the realization that the group process was much more important than the actual content. Many important and interesting topics were introduced and the girls did learn from these. However, the bigger benefits of the group were gained through the development of relationship and the girls being able to talk with each other. Moving the girls to the stage of group where they felt comfortable doing this was an important part of the group process. The activities could have been focused around different topics or no topic at all and the girls would still have moved though the group stages. While there are certain things which need to be covered in this type of group and certain subjects which helped to develop trust and openness such as the work around families, the stages that the girls worked through were most important. The hands-on activities were catalysts for discussion and helped to break down barriers. Were a group like this to be run in the future it would be important to provide more activities which would allow the girls to focus on their creativity and provide a casual environment for them to talk

rather than trying to structure a discussion by providing worksheets directly on the topic.

5.3 Evaluation of practicum

The development and implementation of this group was a positive experience. There was opportunity to educate the girls on the many different issues which needed to be covered. The combination of games and activities provided an environment where the girls felt comfortable and able to discuss important issues in their lives. Through the support in the group and raising their awareness the girls' levels of self-esteem and coping appeared to increase according to their scores and this was backed up by the qualitative data. The 'female only' format was an important piece of the success of the group. Many of the girls indicated that they felt more able to share and to share on more subjects because there were only females in the room. The group also progressed through a series of stages which allowed the girls to begin to develop strategies to deal with their substance use and other areas of conflict in their lives. The excitement around getting together again for follow-up indicated that the group served the purpose of beginning to develop relationships between the girls and creating an environment where they felt comfortable and could share what was happening in their lives.

Another unexpected result of this group was the strong support for gender specific groups. The girls who participated in this group appreciated the fact that it was all female. There were many things that they would not have felt comfortable sharing had it been a mixed group. They also felt that they bonded more quickly as a group because they were all girls. It gave them one more thing in common. As a result of girls being redirected from other groups at AFM to New Beginnings, the clients left for the regular AFM group were mostly boys and

so a male only group was run simultaneously with the New Beginnings group. This was also a positive experience for the boys and there is interest in implementing gender specific groups in the future.

Co-facilitation was an area where unexpected learning benefits were acquired. The writer had not indicated that this would be an area of learning and yet the whole area of co-facilitation was a new one and there were many benefits gained through leading the group with another person. It was necessary to learn how to work together as a team and to decide who was taking leadership when. The co-facilitator also had knowledge in many areas (e.g. drugs and addiction, AFM policies and procedures) which were invaluable to the writer and which would not had surfaced had the group been facilitated by one person. Co-facilitating brought about an awareness of the importance of communication and being clear on roles and expectations before beginning the group. In the future this writer will be sure to incorporate co-facilitation issues into any group which she is helping to facilitate.

Though the writer has had much exposure to youth at risk, it was still amazing to observe how much these girls were able to cope with on a daily basis. They came to the group because they needed help with their substance use and yet what repeatedly was exemplified was how many stressors and challenges these girls face on a daily basis with which they are able to cope. Many of these girls had responsibilities beyond their years and had found ways to live up to them. They needed to be supported in dealing with these tasks in a positive way. They also needed to be encouraged to be children. They had so many issues in their lives that they had little time to relax and have fun. The activity they liked best in group was making 'happy boxes' which involved cutting, pasting and colouring. Many had not done this for years and it was very therapeutic. They shied away

from the games at the beginning but as they became more comfortable with each other they began to play and smiled and laughed, at times in spite of themselves.

All of this simply reinforces the fact that resources need to be established which take into account all the needs of this population and offer services which touch the many areas of these girls' lives and will allow them to enjoy their childhood instead of being saddled with adult responsibilities and difficulties. It is hoped that the learning benefits gained through this practicum experience will extend not only to practitioners working with this population but may also make others more aware of the issues facing young women.

6.0 Discussion

6.1 Theoretical Applications

This practicum incorporated several different theories in order to design a program specifically suited to the needs of female adolescents with substance use issues. Some of the theories were upheld through the observations made within the groups, others need to be adjusted. Recommendations will also be made on how this type of group could be run in the future.

6.1.1 Group Theory

The group approach to counselling appeared to work well with this population. The girls had an opportunity to interact with each other and were able to avoid the intensity of an individual session as the attention of the facilitators and members shifted from one to another. This is consistent with adolescent development and the need to interact and be accepted, not singled out. Two girls left the group near the beginning as they felt that they needed more intensive one-on-one counselling which couldn't be provided by the group. This indicated a higher level of maturity and commitment on the part of these two girls to specifically deal with their drug use.

The girls all brought many skills and strengths to the group and were able to share them and learn from each other. They also acted as a strong normalizing force for each other. One girl commented that before she started the group she thought she was bad and the only one with these problems. After being a part of the group she recognized her value as a person and also understood that many other girls were struggling with issues similar to hers. Positive peer pressure was also a benefit of the group structure. One of the girls in the group was very negative and resistant at the beginning of the group, other girls were able to

confront her on the behaviour and to support her in making positive changes. Positive peer pressure was more effective in altering her behaviour than was practitioner intervention. The group provided a sense of belonging and built self-esteem and a feeling of security as suggested by Gonet (1994). Gonet also suggests that addiction treatment groups provide a forum to increase self-awareness, offer a safe environment for self-disclosure, and create a place to receive reinforcement for accomplishments and behavioural changes as well as some important education and teaching. All of these things happened in the New Beginnings group using a combination of the psychoeducational approach and self-in-relation theory.

6.1.2 Psychoeducational Approach

This approach appeared to work for this population. The group setting was beneficial as mentioned above and the combination of education and support was the right balance for this group. The group was able to examine issues around substance use as well as coping, self-esteem and social support. It provided the structure for concrete and solution focused behavioural and cognitive changes. The girls began to recognize the consequences of their actions and to make specific plans to modify their behaviour such as recognizing a specific trigger and developing a way to avoid it. Although the girls were educated about these areas in group sessions, it was the support that they were able to give each other and the support that they received from the facilitators which allowed them to follow through on what they had learned.

The psychoeducational approach also follows a predictable schedule of events which allowed the girls to quickly become comfortable with the group because they always knew what was going to happen next. One session ended without provision for check-out and the girls had a difficult time understanding

that the session was over. It was necessary to repeat several times that the session was finished and they could leave. Usually during check-out they are all on the edge of their seats ready to go.

Some other factors which are important in a psychoeducational group are: determination of size, duration and membership; elaboration of the goal; provision of the opportunity for reality testing; specification of major program elements and identification of objectives; and selection of appropriate exercises and techniques. The size of the group was important. The group began with eight members, which was an adequate number. It allowed the girls a chance to go around the circle and all be heard. Had there been more members some may have slipped into the background. The group ended with five members. In order to do many of the activities it was necessary to have no fewer than five. There were two sessions when only two or three girls attended the group which made it difficult to stay with the original plan of activities. This leads to the issue of membership. It is important in developing the group that those who are selected are committed to the group and are able to attend. Guidelines should be set at the beginning of group in order to ensure that the girls attend consistently. Attendance was allowed to be somewhat loose in order to have enough participants complete the group but it did cause disruption in the group and took away from the group cohesion.

The duration of the group is also important to take into consideration. These girls were beginning to bond as a group by the eleventh session. Had there been more sessions we would have been able to move to more intimate and challenging levels. At the same time a six week commitment is a long time for this population because of their transiency and the rapidity with which they move through life stages. Having a closed and time-limited group was very important to the development of the group. Another group could have been developed to build

on the gains made during this group but it would be better to have it start as a separate group rather than a continuation of this one.

The group structure also provided the opportunity for reality testing. Within the group the girls were able to test things with each other, understand other's stressful or crisis experiences and observe how it applied to their own lives. Because the group met only twice a week the girls were able to apply what they learned in group outside of the group. They were not in an intense environment which changed the way they acted on a daily basis. This meant they had more setbacks but also better prepared them for the ending of group and applying what they had learned to their lives outside of group. Elaboration of the goal and specification of major program elements occurred before the group started. It was important to have these in place in order to have a focus and structure for the group. This also allowed for the planning of specific objectives and exercises.

The objectives for each session were generally planned before the group started but it was important to be flexible and adjust each session according to the needs of the girls and the attendance at each session. For example, during the fourth session the plan was to do some more work on general substance use issues, but the girls were ready for something more intense so we moved into looking at their families and lifemaps. Another day an all group activity was planned which had to be dropped because there were not enough girls to make it work. The specific exercises developed for each group were important but not so much because of their content but because of how they helped with the group process. Exercises were planned to help the girls feel more comfortable with each other or to give them ideas as to what to share. The discussions of a specific treatment area, although it may have offered some specific educational information, further served to make the girls feel supported and helped to

normalize the issues they were experiencing in their lives. My observations of the gains made by the girls during group have caused me to realize that the process of developing relationships in the group was much more important than the actual group content. We could have had discussion on many different topics and played games that were not relevant to the topic but still developed the relationships that appeared to be so important to the girls as the group progressed. This emphasizes the importance of incorporating self-in-relation theory which balances the cognitive side of the psychoeducational approach with a focus on emotion and relationship.

6.1.3 Self-in-relation Theory

This theory of development (Surrey, 1991) was developed specifically about women and girls and focuses on observations that girls develop their sense of self through their relationships rather than through becoming independent and autonomous. This was certainly true of the girls in the New Beginnings group. They quickly formed relationships with each other and this helped them to feel better about themselves and their situations. Many of these girls have had unstable home lives and have not had the opportunity to form positive relationships with their mothers. This means that they do not easily move into relationships with others. But with a safe environment and some structured interaction they were able to begin connecting with peers. The mutual sharing of experience allowed them to grow and develop. By relating to each other, recognizing the similarities in their lives, and being able to be of assistance to each other they began to realize that theirs was not an isolated problem and they were not 'bad'. This helped to raise their self-esteem.

Although this group was just the first step to developing relationships with peers it was an important step. It was the first time that these girls had

participated in an all female group and they recognized that they shared more and at a deeper level than they would have had there been males present. As girls grow up and try to fit into a male dominated world they often undervalue relationships in exchange for independence and autonomy. In the group they were reinforced as to the importance of relationship. They recognized that although they have generally positive images of themselves as women that society as a whole does not share those images and that they will have to work hard to continue to care for themselves and others despite pressure from the world at large. The most important gains from this group were the girls' reliance on each other, their ability to begin to engage in mutual aid, and the development of better self-regard.

6.1.4 Motivational Interviewing and Stages of Change

Motivational interviewing (Miller, 1989) was developed to work with people with substance use issues using their own strengths and goals. It is most often used with people who are in the first two stages of change set forth by Prochaska and DiClemente (1982). The first stage is *pre-contemplation* where the individual is not intending to change and may be unaware of the consequences of their behaviour. In the *contemplative* stage the person is beginning to think about change. The girls in the New Beginnings group were at one of these two stages. Those who were beyond these stages self-selected out of the group when they realized that they were not going to get the support they needed in the group. The goal of the New Beginnings group was to move these girls on to the next stage of change - from pre-contemplation to contemplation and then to action. This was accomplished using the interventions in motivational interviewing.

By employing the five main principles of motivational interviewing it was possible to focus on the girls' strengths and assist them to recognize the

consequences of their substance use and to develop abstinence goals and plans. One even chose to quit smoking marijuana halfway through the group. The first principle of motivational interviewing is *expressing empathy*. This was accomplished by establishing rapport with the girls, helping them to feel comfortable and validating their feelings. This is the primary intervention used at the precontemplative stage. They needed to know that this was a safe place to start examining their substance use.

Activities which looked at the positive and negative consequences of using substances as well alternatives to substance use helped the girls *develop discrepancy* and make more concrete decisions about their use. This helped the girls move into the contemplative stage where they recognized a problem with their use and began to think about making changes. During this stage there is often questioning and arguing as to whether substance use is really an important issue or not for the individual. For the most part the facilitator was successful in *avoiding argumentation* and *rolling with resistance* by validating what was being said, allowing the girls some autonomy in setting up the group and re-focusing the girls to the task at hand after giving them a chance to express their ambivalence or discomfort.

As the group progressed and the girls began to feel better about themselves and their abilities some moved into the action stage of change. At that point they were ready to make decisions regarding cutting down or abstaining from substances. The facilitator was able to aid this process by *supporting self-efficacy* and encouraging the positives seen in each group member and affirming each small step they took in changing their behaviour.

6.2 Alternative Theories

During the planning and implementation of this group many different approaches and theories were drawn from in order to provide the environment and activities the facilitator desired in running this group. The facilitator took a strengths based approach to the group process and focused on the skills and abilities which each girl brought with her. In addition to the theories detailed above, the facilitator also drew from the existential approach (May, 1961), the person centred approach (Rodgers, 1951), behavioural therapy (Kazdin, 1978) and reality therapy (Glasser, 1965).

6.2.1 Existential and Person Centred Approaches

These approaches focus on the climate of the group and personal awareness and growth rather than specific techniques. The existential approach (May, 1961) stresses the importance of the facilitator being 'with' the client in order to understand the subjective world in which each person lives. It focuses on the individuals' desire to change and grow. The person centred approach (Rodgers, 1951) attempts to establish an environment where group members feel safe and able to disclose. This is seen as important in their ability to move towards change. Both of these approaches were important in the development of the New Beginnings group.

They are also congruent with self-in-relation theory which focuses on the relationships being developed in the group as opposed to specific content. The facilitator wanted to create an environment where the girls felt comfortable and trusted enough to share and begin to work on some of their issues. The person centred approach details several elements which are important for the facilitator of such a group. The first element is *genuineness*. "The greater the extent to which facilitators become involved in the group as persons, putting up no professional

front, the greater is the likelihood that the members will change and grow" (Corey, 1995, p. 267). The other elements are *unconditional positive regard*, which refers to accepting clients as they are and *empathic understanding*, which means accurately sensing what a client is thinking and feeling. These approaches focus on an individuals' strengths and their ability to become more self aware and to move towards change. This was one of the goals of the New Beginning group.

The existential and person centred approaches are both very subjective and don't have clear techniques. There is recognition that technique and technical skills are important but that they should come out of the therapeutic process rather than structuring it. The ice breakers and transition exercises as well as many of the check-in questions were techniques which were used to attempt to establish a supportive and nurturing environment where the girls felt comfortable and felt that they could begin to explore some of the events occurring in their lives.

6.2.2 Behavioural and Reality Therapy

Behavioural and reality therapy were the basis for many of the specific activities and discussions topics used in the New Beginnings group. These theories fit in well with the psychoeducational approach which focuses on the structure of the group. The most obvious example of behavioural therapy (Kazdin, 1978) in this group was through the use of the educational process. The assumption that most behaviours, cognitions and emotions are learned means that group members can learn new ways of acting, thinking and feeling which can help them move towards their goals. Reality therapy (Glasser, 1965) balances out some of the more intangible aspects of the existential and person centred approaches by focusing on problem solving and how to cope with the demands of reality. The focus is on group members' strengths and potential and how they can use them to cope with what they are experiencing.

Facilitator presentations of topics, brainstorming and group problem solving are some of the ways that these therapies were used in the New Beginnings group. The girls were often asked to reflect on how what they were learning in group related to their lives and were challenged with incongruities between their words and their feelings or actions.

The combination of approaches which focus on developing a positive climate and theories which focus on problem solving and application to the 'real' world provided for a rich group experience. Any of these approaches on their own would not have allowed for the flexibility to establish a group which worked well for adolescent girls.

6.3 Recommendations for Future

Overall this group was a positive experience and worked well. The recruitment process needs to be handled differently in order to maximize the number of clients reached. Running the group in a venue which already has an existing population may be the better route. It is also important to take into consideration the timing of the group. Many girls are in school and so want to meet after school hours. Also running it in the fall meant that by the time group was ending it was getting dark outside and the girls had to find their way home in the dark. Conversely, in terms of recruitment, fall is the time when agencies are seeing new clients and are more willing to refer. In May and June things are winding up for the summer and so no one is ready to start anything new.

It is important that a group like this be flexible in terms of agenda and attendance as this population is very transient and attending a group regularly is difficult. At the same time regular attendance is important in order for the girls to receive the most benefit from the group. Because of sporadic attendance the self-evaluation tools were administered only twice. If a similar group were to be

repeated it would be important to administer this self-evaluation scale at least every other session if not every session in order for it to be useful.

These girls are still young even though they are dealing with many 'grown-up' issues. Food was a drawing card for this group. Many of the girls came hungry and even those who didn't enjoyed a snack just as all teenagers do. It was important for them to have time to have fun and to play. Ice breaker and transition activities served this purpose as did allowing them to draw, colour and use their hands to create. They interacted and opened up best when focused around a hands on activity. Were a group like this to be run in the future it would be important to provide more activities which would allow the girls to focus on their creativity and provide a casual environment for them to talk rather than trying to structure a discussion by providing worksheets directly on the topic. This group covered a lot of information on many different topics and while this was important for the girls less time could have been spent on the content and more on the process. This is discussed in the section on learning benefits.

The social work profession has done a good job working with adolescents, young mothers and families but addiction treatment has been an issue which has been left mostly to the health care profession. It is important that social work move into this field. In working with this group of girls it became obvious that their substance use was just one small part of the issues with which they were coping. In order for them to work through the difficulties they were dealing with they needed to be able to work on many different areas of their lives simultaneously.

Many of the girls in this group also spent time on adolescent psychiatric wards while they were in the group because of depression or threats of suicide. While this may help some and is at least a short term solution it does not address the complex issues faced by this population. It is imperative that the profession

start looking at ways in which they can holistically cater to the many and diverse

needs of adolescents in general and girls in particular so that they can move on to

be healthy and productive members of our adult population.

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Appendix A

Introduction to study: New Beginnings: an educational and support group for female adolescents with substance use issues.

You are invited to participate in an educational and support group for young women aged 15-18 and are experiencing difficulties with substance use. The purpose of the group is to provide information which may be useful to you in coping with your life, as well as providing an opportunity to meet others who are in similar circumstances.

This group has been designed for adolescent girls and encourages the attendance of pregnant and parenting adolescents. By participating in this group you will help to provide the knowledge necessary to run similar groups in the future.

Your participation in this group is voluntary and you will be free to leave at any time. This group is a part of my practicum thesis so I will be distributing forms and taking notes in order to demonstrate whether there is some benefit in this type of group. Your name will not be used in the final report and confidentiality within the group will be encouraged. Your participation in this study would mean meeting with me prior to the group to fill out some forms and to make sure that we are both clear on each others expectations. If after this meeting you wish to participate in the group you will be expected to attend three times a week for four weeks. Four weeks after the end of group I will contact you once more by phone to follow-up on any gains made during the group experience. You will also be offered 3-5 sessions of individual counselling after completing the group.

This group is being run through the Addictions Foundation of Manitoba and so you will be required to go through their intake process as part of the initial interview.

Thank-you for considering being a part of this study.

Jana Estabrooks
M.S.W. Student, University of Manitoba.

New Beginnings
An educational and support group for pregnant teens with substance abuse issues.

Purpose
To develop a group for and bring attention to a population that has received very little recognition and where there is enormous potential for change and growth.

Setting
This group will take place at the Addictions Foundation of Manitoba (AFM)
Youth program.
200 Osborne St. N.

Group time and duration
Sept. 20 - Oct. 27 1999.
The group will run from 4:00 to 5:30 Mondays and Wednesdays for six weeks.

Appropriate Referrals
Girls 15-18 who are pregnant and using alcohol/drugs or have recently quit. I am open to having girls join who may deliver their babies before the program ends. My hope is that they would feel free to continue after the birth of their baby. I am also open to the possibility of accepting new moms and would be willing to discuss this with you. My only criteria for accepting girls into this group is that they are willing to look at their substance use and are able to participate as a group member.

To refer:
Call Jana at AFM -944-6235 and leave a message or have the girls call.
They will go through the AFM intake process and then be directed to 'New Beginnings'.

Philosophy
Each person has strengths and the ability to deal the issues they face in life given adequate support and resources. Addiction is a multi-faceted issue without a simple solution. Relapse is not seen as a failure but as a step in a long process. Pregnancy is something to be valued and young mothers need to be supported in order to support their children.
AFM values openness, interdependence, integrity and inclusiveness.

Objectives
To help these young women to grow in the areas of self esteem, coping skills, parenting and social support as well as encouraging abstinence.
To better equip these young women to deal with life's difficulties without having to turn back to substance abuse.
To provide a support group of peers with whom to discuss pertinent issues.
To provide information and referrals to other available services.

NEW BEGINNINGS

Are you pregnant and using drugs or alcohol?

Are you between the ages
of 15 and 18 years old?

Do you have questions or concerns?
Want to talk to others in similar circumstances?

This may be the group for you!

New Beginnings is a group for adolescents who are pregnant and using alcohol/drugs or have recently quit. This group will address drug use as well as looking at alternate ways to cope, examine issues around self-esteem and provide information about social support.
It is also a group where you can meet others in similar circumstances, share ideas and be supported.

Does this sound like the group for you?

If you are interested in finding out more or signing up for the group call Jana at the Addictions Foundation of Manitoba (AFM) 944-6235.

Appendix B

DAY ONE

Plan ahead: Muffins and juice
                   Flip chart paper and markers
                   AFM rules, group rules

Purpose: To engage the girls in the group process and with each other.

Intro.: - leaders, program,
             - go over confidentiality and breaches, other AFM rules (not coming drunk or high, etc.)

Fun Stuff: (ice breaker) Fruit Basket

(Set up chairs in a circle - one less than the number of people. The group sits in the chairs with one person standing in the middle. The person in the middle then calls out something about people in the room. Anyone who fits the description moves to another chair and the person in the middle tries to get a seat. The last person up becomes the one in the middle.)

Check-in: - get to know each person a bit (name, why they're here, what drugs the use, amounts, last use, goals around substance use)
-encourage abstinence.

Discussion: 1) Group rules - so that everyone feels safe and able to participate fully. (Respect, confidentiality, coming and going, attendance, promptness, etc.)
2) Make drug charts. (Alcohol, marijuana, mushrooms, cocaine, heroin, LSD.) What are the street names, what does it look like/taste like, what's the high like, how accessible is it/where can you get it, how much does it cost, short term and long term effects, is it legal/illegal, how is it used.

Check-out: How are they feeling? (use feelings sheet). Encourage journaling.

Next session: Effects of drugs and alcohol on them and during pregnancy.

Handouts: Feelings Chart

DAY TWO

Plan ahead: Juice
                FAS/E Questionnaire, information sheets

Purpose: To have the girls examine their own use and learn the dangers of
        substance use during pregnancy.

Fun Stuff: (ice breaker) Human Knot
(Have everyone face one another in a tight circle. Each person hold out their right hand and
grasps the right hand of someone else, as if they were shaking hands. Then each person extends
their left hand and grasps the hand of someone else, so that each person is holding two different
hands. Now, have them try to untangle themselves without letting go of each others hands. There
will probably be lots of laughing and confusion, they will take on different roles and will usually
end up in a circle again. If the group has been struggling with a knot' for longer than your session
has time, offer an honourable out called Knot First Aid. Allow the group to decide which grip
should separate and re-grip. This is only allowed if they're really stuck!)

Check-in: How is everyone doing? Do we need to update 'last uses'. Have those
        who didn't do intro yesterday do it now.

Discussion/Activity: - agreement of abstinence during group.
        1) Brainstorm Best and Worst reasons for using/not using.
        2) Do FAS/E questionnaire and discuss.

Check-out: Talk about weekend. How are they going to try and uphold contract
        of abstinence, what will make it difficult?
        (Remind them that they can talk to me or their counsellor if they feel they
        need to.)

Next Session: look at defenses and coping skills

Handouts: FAS/E Questionnaire
           Fetal Development Chart

DAY THREE

Plan Ahead: Juice and cookies
Get consent forms from those who haven't returned them
Handouts, flipchart paper, markers.

Purpose: For girls to begin to look at how they cope.

Fun Stuff: (ice breaker-same as pervious session, not done because of small numbers)

Check-in: How was the weekend, update last uses.

Discussion/Activity:
1) Defenses -fill out worksheet and discuss what their main forms of defense are.
2) Brainstorm a list of coping skills that they presently use. (point out how many ways they already know to cope)

Check-out: How are they feeling about group?

Next Session: Genograms and lifemaps.

Handouts: Defenses worksheet.

DAY FOUR

Plan Ahead: Juice
                  Flipchart paper and markers, pens and paper, tape

Purpose: To begin to look beyond themselves to role drug use plays in their lives.

Check-in: How was their week, tell something about their families.

Discussion/Activity:
        1) Genograms -draw on poster paper a representation of their families, put in as much of the family as the know, circle those with drug and alcohol problems, problems with the law, discuss.
        2) Begin work on lifemaps. Write down all the significant events in their lives. Try to put in significant future events too.

Check-out: What's going to happen over the weekend (it's Halloween), how was group?

Next Session: more work on life maps, begin to look at feelings.

Handouts: none.

DAY FIVE

Plan Ahead: Hot drinks and cake
                 Paper and pens

Purpose: For the girls to begin to look at the feelings they are experiencing.

Check-in: Find out how weekend went. (Allow extra time.)

Discussion/Activity: -talk about doing life maps, what kinds of feelings/
       difficulties might come up?
       1) Continue work on life maps.

Fun Stuff: (transition game) Funny Faces
(Give everyone a piece of paper and a pen. Have them draw hair a t the top of the page. Have them fold the paper over and pass it to their left. Have them draw eyebrows, fold it down and pass it to the left. Continue this with eyes, cheeks, nose, mouth, chin. When you're done have everyone unfold their paper and show their funny face.)

      2) Draw their feelings. Have the girls use a piece of poster paper and
      draw with colour, shapes or images what kinds of feelings they have
      inside.

Check-out: How is everyone feeling?

Next Session: Finish lifemaps and look at triggers.

Handouts: none.

DAY SIX

Plan Ahead: Drinks
                  Self evaluations
                  Triggers worksheet

Purpose: To examine what are the forces in their lives which push them to abuse substances.

Check-in: -have them fill out self evaluations.
           -how have the last few days been, when do you most feel like using?

Discussion/Activity
      1) Finish up life maps. Put them on flip chart paper and present them to each other. This allows them to share a bit about their lives and dialogue with each other.
      -discuss how their families have affected their lives/how will their future be affected

Fun Stuff: (transition game) Pulse (not done because of numbers)
(Divide the group in half. Have them sit in two lines facing each other. Place an object that can be grabbed (a shoe, stuffed animal, pen) at one end between the two lines. Have each person holt hands with the person beside them. The object of the game is for the people at one end to receive a signal and then pass it on by squeezing the person's hand next to them. When the pulse gets to the last person (A) they try to grab the object before the other team does. You start the pulse by flipping a coin. The two end people (B) need to watch for heads. As soon as heads comes up they start sending the pulse. Once an attempt has been made A's go to the other end of the line and take B's job. Everyone else moves down and the next in line takes A's job, and so on.)

      2) Fill in triggers worksheet. Discuss what is the biggest trigger for them and how can they avoid it or neutralize it this weekend.

Check-out: We're halfway through - what have you learned? What else do you want to get out of group?

Next Session: Body image and self esteem.

Handouts: Triggers worksheet.

DAY EIGHT

Plan Ahead: Chips and drink
                Sheets of paper with names on for game
                Copies of questionnaire
                Video and T.V./ VCR

Purpose: To look at body image, self esteem and societal views of women.

Check-in: How was the weekend? Were they able to avoid triggers? What part of themselves do they like best?

Fun Stuff: Who am I?
(This game can be played using a variety of topics. In this case choose the names of actresses or supermodels. Write these names on sheets of paper. Tape a piece of paper onto each person's back. Now everyone else can see who they are but they can't. People must circulate around the room and ask each other yes' and no' questions until they figure out who they are. Don't give them the subject right away. They'll probably figure it out by reading the names around them. If your group is ready. You might want to put in one name that doesn't fit with the rest to make it more difficult.)

Discussion/Activity: - discuss the names the girls had on their backs and why those people are role models. (Roseanne, Kate Moss, Sailor Moon, Jennifer Aniston, Drew Barrymore, Oprah)
1)Video Thin Dreams - watch and then discuss.
2)Gender Roles questionnaire. How do our roles affect body image, self esteem, substance use?

Check-out: Say something they like about the person to their left. Think about how they are going to avoid triggers over the weekend.

Next Session: social support.

Handouts: Sex Roles Questionnaire.

DAY NINE

Plan Ahead: Cookies and juice
                 Social support networks grid and instructions
                 Index cards and pens

Purpose: To look at where their social support comes from and what kind of support they get from who.

Check-in: How was the weekend? Why is it difficult to stop using? Who in their lives gives them the most support?

Discussion/Activity:
       1) Fill out social support network grids and talk about where they put each person and why. Why is support important.

Check-out: Did they learn anything new? Did it help to look at support?

Next Session: self-care and 'happy boxes'

Handouts: Social support network grids.

DAY TEN

Plan Ahead: 'Happy boxes', things to decorate with (magazines, pretty paper, material, markers, stickers), things to put inside (stickers, candles, bath beads, balloons, chocolate hugs)

Check-in: -have them do self evaluations.
How's it been going. What do they like best about group?

Discussion/Activity:
1) Look at previous list of coping techniques. Which are not appropriate, which are most effective?
2) Work on 'Happy Boxes' - decorate them and fill them with 'happy thoughts'. Discuss how we take care of ourselves when we are feeling down.

Check-out: none.

Next Session: 'happy boxes' and mutual aid.

Handouts: none.

DAY ELEVEN

Plan Ahead: Chocolate milk
                Bring all the supplies for happy boxes
                Fancy paper and tape for Affirmations
                Copy of self care techniques

Purpose: To understand mutual aid and self care.

Check-in: Some have been missing for awhile - What's up?

Discussion/Activity
        1) Mutual Aid - discuss how they can support each other. Brainstorm a list of resources.
        2) Self-care - explain 'Happy Boxes' and discuss self-care techniques.
        3) Affirmations -these can be added to boxes or kept for themselves.
        (Have each girl write her name on a piece of paper and then tape it on her back. Everyone should then write a statement of affirmation on each others backs. This is a good way for the girls to begin to support each other and also provides for some physical contact in a fairly safe way.)

Check-out: Group is almost over. How do they feel about that? Can they see any application to the rest of their lives?

Next Session: Endings

Handouts: Self-care techniques.

DAY TWELVE

Plan Ahead: Pita pizzas and pop
                 Rapid assessment instruments, client satisfaction survey
                 Paper and envelopes, balloons and string
                 Termination exercise

Start with filling out rapid assessment instruments.

Check-in: How has being in the group affected their lives?

Discussion/Activity
        1)Termination exercise -have them discuss how they would spend the last
        few hours with a friend who had been visiting and was leaving in the
        morning. Relate this to ending the group.
        2)Write letters to self -these will be returned to them in three months and
        will allow them to put down goals, words of encouragement or whatever
        they want to remind themselves of.

Fun Stuff: (transition activity) Balloon Stomp
(Bring enough balloons for everyone in the group. Tie a balloon to each person's right ankle. The object of the game is to stomp on and pop as many balloons as you can while keeping yours intact. You may want to have more balloons in reserve so that if it ends too quickly you can try it again!)

        3) Food and visiting time.

        -have them fill out client satisfaction surveys.

Check-out: What has changed for them?
        -Give each girl a flower to represent her 'new beginning'.

Next Session: Follow-up in three weeks.

Handouts: none.

Appendix C

The Addictions Foundation of Manitoba
Levels of Involvement for Alcohol, Other Drugs and Gambling

Non-involvement

Where a person:

- has never gambled, used alcohol or other mood/mind altering drugs; or,
- has chosen a non-involved lifestyle following some involvement.

Irregular Involvement

- Random or infrequent involvement, usually confined to specific occasions or situations,
- Little or no evidence of harmful or adverse consequences,
- Includes experimental involvement, defined as trying a substance or gambling activity once or several times.

Regular Involvement

- Regularly recurring involvement (patterns evident).
- Some evidence of adverse, related consequences (typically minor or isolated) may be apparent.
- Often characterized by individuals who actively seek involvement, or where involvement has become a regular feature of their lifestyle.

Harmful Involvement

- Evidence of recurring adverse consequences is apparent. For example:

> - involvement resulting in recurring failure to fulfil major role obligations at home, school, or work;
> - involvement resulting in recurring financial or legal problems;
> - continuing involvement despite repeated or

persistent problems, in one or more life areas, which are caused by or made worse as a result of the involvement.

Dependent Involvement

- In addition to the characteristics of *Harmful Involvement*, at this level, involvement tends to be patterned, and is characterised by particular features. Most notably:

> - the individual experiences a physiological and/or psychological need for continued involvement; and,
> - the individual experiences some loss of control over his/her involvement.

- Evidence of dependent involvement may include:

Impaired control

> - levels of involvement frequently exceed original intentions
> - several unsuccessful efforts have been made to cut down or otherwise control involvement.
> - the individual experiences a compelling need to continue involvement.

Preoccupation
- increasing amounts of time, money and energy are devoted to activities related to maintaining involvement or recovering from it.
- the individual has given up or significantly reduced involvement in other previously valued activities.

Adverse consequences
- involvement is continued despite the individual's knowledge that the persistent physical, mental, social or financial problems they experience, likely have been caused or made worse as result of the involvement.
- the individual attempt to cope with losses through continued involvement.

Withdrawal Distress
- the individual experiences physical or mental distress as a result of abstaining from involvement and may continue involvement in order to avoid experiencing that distress.

Progression
- increased levels of involvement (frequency, quantity, or duration) are required over time to achieve or maintain the desired effects.

Transitional Abstinence

- Where an individual with past involvement at harmful or dependent levels has chosen to abstain from alcohol, other drugs or gambling but has yet to achieve a sense of comfort with, or confidence in, that decision.

Stabilized Abstinence
Or
Recovery

- Where an individual with past experience at harmful or dependent levels has chosen to abstain from alcohol, other drugs, or gambling, and has achieved a sense of comfort with the decision, or a measure of confidence in the ability to maintain an abstinent lifestyle.

Appendix D

Referral Agencies

The following are the organizations which I contacted and who were willing to distribute flyers or give direct referrals.

Addictions Foundation of Manitoba
APIN
Crisis Stabilization Unit
Child and Family Services
- Central
- East
- NortWest
Facts of Life Line
Health Action Centre
Health Sciences Centre
- Women's Pavilion
Health Sciences Centre
- Children's Gynecology
Healthy Start for Mom n Me
Hope Centre
Klinic
Laurel Centre
MacDonald Youth Services
Mamawi - Broadway
Mamawi - Anderson
Marymound
Medical Arts Building - Drs. Donke
Mount Carmel Clinic
New Directions - TERF
New Directions - RAP
Nor'West Mentors Program
Pregnancy Distress Service
Rossbrook House
St. Norbert Foundation
Teen Touch
Villa Rosa
Winnipeg Clinic - Gynecology
Wolsely Family Place
Women's Health Clinic
Youville Clinic - Family Health
Young Parents Community Centre

Adolescent Parent Centre
Argyle Alternative H.S.
Children of the Earth H.S.
Churchill H.S.
Daniel McIntyre H.S.
Elmwood H.S.
Gordon Bell H.S.
Grant Park H.S.
Kelvin H.S.
R.B. Russell H.S.
St. John's H.S.
Sisler H.S.
Tec. Voc.

Appendix E

Practicum Participation Consent Form
New Beginnings: An educational and support group
for female adolescents with substance abuse issues.

You have agreed to participate in a social skills group for female adolescents with substance use issues. The facilitator, Jana Estabrooks, is in the master of Social Work program at the University of Manitoba. This project will examine the usefulness of an educational support group for the reduction of substance use with young women in your circumstances.

This group is being run through the Addictions Foundation of Manitoba and so you will be required to go through their intake process as part of the initial interview. Your participation in this project is voluntary and will not affect any other programs you may be involved in. Any information you provide to the facilitator will be kept confidential and confidentiality will be encouraged within the group. This group is being run as a part of my Masters practicum and therefore the observations and final results will be published. Any identifying information will be removed. Videotapes of sessions will be stored in a locked cabinet at AFM and will be erased following supervisory sessions.

As a participant in this group you will be asked to fill out several questionnaires at the beginning and again at the end of the group in order for me to determine whether any changes have occurred during the group process. In addition you will be expected to attend two weekly sessions of one and a half hours in length over the course of six weeks. Four weeks after the end of the group you will be contacted by phone to find out whether gains achieved during the group have been maintained. You will also be offered 3-5 sessions of individual counselling after completing the group.

If you have any questions, you can contact Jana Estabrooks or my supervisor, Laura Gossen, at AFM - 944-6235. You will be offered a copy of this form to keep. Your signature indicates that you have read the information provided and have agreed to participate in this group. You can withdraw from the group at any time if you change your mind about participating. A summary of the conclusions will be made available to you through myself or Brenda Bacon (474-9798), if requested.

Signature of Participant   Date

_____   _____

Signature of Parent/Guardian (if applicable)   Date

_____   _____

Signature of Witness   Date

_____   _____

Signature of Practitioner   Date

_____   _____

Appendix F

Name:

Session #:

Self-evaluation

Please circle the number which most honestly answers the following questions.
1 = not at all, 10 = yes, totally.

1. I feel good about myself today.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

2. I feel able to cope with stress in a positive way today.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

3. I feel supported by friends or family today.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Exit Questionnaire - New Beginnings Group

Please take a few minutes to answer the following questions as honestly as possible. It will be of great help for any future groups which may be run.

What did you like best about the New Beginnings group. What did you like least?

What was your favorite topic/least favorite topic?

What did you like best about the group facilitator (specifically Jana). What did you like least about her?

Do you feel that your current ability to cope with life's stressors is a direct result of the New Beginnings group? Yes _____ No _____

Do you feel that your current level of self-esteem is a direct result of the New Beginnings group? Yes _____ No _____

Did the age range (15-17 years) seem appropriate for this group? Why or why not?

Did you enjoy the all girls group or would you have preferred a mixed group? Why or why not?

Other comments about the group in general or the facilitator?

Hare Self-Esteem Scale (HSS)

a = strongly disagree,   b = disagree,   c = agree,   d = strongly agree

Peer Self-Esteem Scale - In the blank provided, please write the letter of the answer that best describes how you feel about that sentence. These sentences are designed to find out how you generally feel when you are with other people your age. There are no right or wrong answers.

___ 1. I have at least as many friends as other people my age.
___ 2. I am not as popular as other people my age.
___ 3. In the kinds of things that people my age like to do, I am at least as good as most other people.
___ 4. People my age often pick on me.
___ 5. Other people think I am a lot of fun to be with.
___ 6. I usually keep to myself because I am not like other people my age.
___ 7. Other people wish they were like me.
___ 8. I wish I were a different kind of person because I'd have more friends.
___ 9. If my group of friends decided to vote for leaders of their group I'd be elected to a high position.
___ 10. When things get tough, I am not a person that other people my age would turn to for help.

Home Self-Esteem Scale - In the blank provided, please write the letter of the answer that best describes how you feel about the sentence. These sentences are designed to find out how you generally feel when you are with your family. There are no right or wrong answers.

___ 1. My parent are proud of the kind of person I am.
___ 2. No one pays much attention to me at home.
___ 3. My parents feel that I can be depended on.
___ 4. I often feel that if they could, my parents would trade me in for another child.
___ 5. My parents try to understand me.
___ 6. My parents expect too much of me.
___ 7. I am an important person to my family.
___ 8. I often feel unwanted at home.
___ 9. My parents believe that I will be a success in the future.
___ 10. I often wish that I had been born into another family.

School Self-Esteem Scale - In the blank provided, please write the letter of the answer that best describes how you feel about the sentence. These sentences are designed to find out how you generally feel when you are in school. There are no right or wrong answers.

___ 1. My teachers expect too much of me.
___ 2. In the kinds of things we do at school, I am at least as good as other people in my class.
___ 3. I often feel worthless at school.
___ 4. I am usually proud of my report card.
___ 5. School is harder for me than most other people.
___ 6. My teachers are usually happy with the kind of work I do.
___ 7. Most of my teachers do not understand me.
___ 8. I am an important person in my classes.
___ 9. It seems that no matter how hard I try, I never get the grades I deserve.
___ 10. All and all, I feel I've been very fortunate to have had the kinds of teachers I've had since I started school.

Adolescent Coping Orientation For Problem Experiences (A-COPE)

Read each of the statements below which describes a behaviour for coping with problems. Describe how often you do each of the described behaviours when you face difficulties or feel tense. Even though you may do some of these things just for fun, please indicate ONLY how often you do each behaviour as a way to cope with problems. Circle one of the following responses for each statement:

1 = Never   2 = Hardly ever 3 = Sometimes 4 = Often   5 = Most of the time

(Anytime the words parent, mother, father, brother, or sister are used, they also mean stepparent, stepmother, etc.)

When you face difficulties or feel tense, how often do you:

1.	Go along with parents' requests and rules	1	2	3	4	5
2.	Read	1	2	3	4	5
3.	Try to be funny and make light of it all	1	2	3	4	5
4.	Apologize to people	1	2	3	4	5
5.	Listen to music - stereo, radio, etc.	1	2	3	4	5
6.	Talk to a teacher or counsellor at school about what bothers you	1	2	3	4	5
7.	Eat food	1	2	3	4	5
8.	Try to stay away from home as much as possible	1	2	3	4	5
9.	Use drugs prescribed by a doctor	1	2	3	4	5
10.	Get more involved in activities at school	1	2	3	4	5
11.	Go shopping; buy things you like	1	2	3	4	5
12.	Try to reason with parents and talk things out; compromise	1	2	3	4	5
13.	Try to improve yourself (get body in shape, get better grades, etc.)	1	2	3	4	5
14.	Cry	1	2	3	4	5
15.	Try to think of the good things in your life	1	2	3	4	5
16.	Be with a boyfriend or girlfriend	1	2	3	4	5

1 = Never   2 = Hardly ever   3 = Sometimes   4 = Often   5 = Most of the time

When you face difficulties or feel tense, how often do you:

17.	Ride around in the car	1	2	3	4	5
18.	Say nice things to others	1	2	3	4	5
19.	Get angry and yell at people	1	2	3	4	5
20.	Joke and keep a sense of humour	1	2	3	4	5
21.	Talk to a minister/priest/rabbi	1	2	3	4	5
22.	Let off steam by complaining to family members	1	2	3	4	5
23.	Go to church	1	2	3	4	5
24.	Use drugs (not prescribed by a doctor)	1	2	3	4	5
25.	Organize you life and what you have to do	1	2	3	4	5
26.	Swear	1	2	3	4	5
27.	Work hard on schoolwork or other school projects	1	2	3	4	5
28.	Blame others for what's going wrong	1	2	3	4	5
29.	Be close with someone you care about	1	2	3	4	5
30.	Try to help other people solve their problems	1	2	3	4	5
31.	Talk to your mother about what bothers you	1	2	3	4	5
32.	Try, on your own, to figure out how to deal with your problems or tension	1	2	3	4	5
33.	Work on a hobby you have(sewing,model building,)	1	2	3	4	5
34.	Get professional counselling (not from a school teacher or school counsellor)	1	2	3	4	5
35.	Try to keep up friendships or make new friends	1	2	3	4	5
36.	Tell yourself the problem is not important	1	2	3	4	5
37.	Go to a movie	1	2	3	4	5
38.	Daydream about how you would like things to be	1	2	3	4	5

1 = Never   2 = Hardly ever   3 = Sometimes   4 = Often   5 = Most of the time

When you face difficulties or feel tense, how often do you:

39.	Talk to a brother or sister about how you feel	1	2	3	4	5
40.	Get a job or work harder at one	1	2	3	4	5
41.	Do things with your family	1	2	3	4	5
42.	Smoke	1	2	3	4	5
43.	Watch TV	1	2	3	4	5
44.	Pray	1	2	3	4	5
45.	Try to see the good things in a difficult situation	1	2	3	4	5
46.	Drink beer, wine or liquor	1	2	3	4	5
47.	Try to make your own decisions	1	2	3	4	5
48.	Sleep	1	2	3	4	5
49.	Say mean things to people; be sarcastic	1	2	3	4	5
50.	Talk to your father about what bothers you	1	2	3	4	5
51.	Let off steam by complaining to your friends	1	2	3	4	5
52.	Talk to a friend about how you feel	1	2	3	4	5
53.	Play video games , pool, pinball, etc.	1	2	3	4	5
54.	Do a strenuous physical activity (jogging, biking)	1	2	3	4	5

Appendix G

MY DEFENSES

Everybody tries to protect themselves from uncomfortable thoughts, feelings or situations. Ways we keep ourselves from facing these things is through our "defenses". As a person becomes more involved with drugs, they form a strong wall around their feelings and behaviours. Even though the consequences of their drug use become more serious, it is difficult to get through this wall of defenses. As a result the individual may not see the need to make changes in their use.

There are many different defenses people use when they are involved with alcohol and other drugs. Take some time to discuss these defenses with your counsellor and give an example of a time you have used these defenses. Put a star beside the ones you use the most!

DEFENSES

A TIME I HAVE USED THIS....

Denial:
Inability to see the truth. Insisting that AOD is not causing any problems when they really are.
["I drink but I don't have a problem."]

Minimizing:
Admitting you have some degree of involvement with AOD but in a way that it appears less serious.
["I only had a couple of drinks."]

Rationalizing:
Use is not denied, but you give reasons, excuses and explanations for using.
["We were celebrating my friend's birthday!"]

Projecting/Blaming:
Blaming other people or things for your use.
["If you lived in my house you'd drink too."]

Maximizing:
Admitting you use AOD but saying you use more than you actually do.
["I drank a 40 all to myself."]

Self Blame:
Putting yourself down and using it as an excuse to stay down.
["I'm a loser, anyway!"]

DEFENSES   **A TIME I HAVE USED THIS....**

Intellectualizing:
Using theories, statistics, studies
to support decisions about use.
["There are a lot of medical uses for
marijuana, if only they'd legalize it..."]

Hostility:
Becoming angry, aggressive,
annoyed when someone mentions
your use or using behaviour.
["Why don't you mind your own
$%&# business!"]

Fantasy:
Replacing unsatisfactory aspects
of reality with more pleasant
thoughts and daydreams.
["If only I didn't live in this boring town,
I wouldn't use drugs."]

Avoidance:
Behaviours used to resist facing
consequences of use.
[Walking out in the middle of a
conversation, not going home, not
showing up for counselling.]

Diversion:
Changing the subject to avoid a
topic that is threatening to AOD
behaviour.
["Did you do drugs?" " Did you see
that movie?"]

Procrastination:
Putting off into the future things
you need to do now.
["I'll quit after Spring Break"
"I'll quit when I'm 20"]

Isolation/Withdrawal:
Being alone or using silence to
distance yourself from others
who threaten your choice to use.
[the silent treatment, "I prefer
to use alone" (so no-one knows
how much I'm using)]

TRIGGERS

Emotions

- Feeling sad or depressed
- Feeling lonely
- Feeling anxious or tense
- Feeling frustrated or disappointed
- Feeling emotionally aroused
- Feeling helpless
- Feeling afraid
- Feeling upset by injustices and how rotten the world is
- Feeling angry
- Feeling good/happy etc.
- Feeling bored
- Other:_____

Social/Interpersonal

- When alone
- When asked to use drugs or drink by someone else
- Peer pressure
- When shy or inhibited
- When you're not able to express affection towards another
- When you're not able to express anger towards another
- A nagging spouse or friend
- When with an aggressive person
- Experiencing conflict or stress with someone else
- In a social situation/at a party
- Being with certain people
- Communication problems
- When wanting to increase your sexual urge or improve sexual function
- When wanting to decrease or control sexual urge, sexual arousal/frustration
- When unable to stay abstinent
- Other_____

Physical

- Unable to sleep
- Experiencing withdrawal symptoms
- Wanting to feel mellow
- Wanting to feel high
- Wanting to experience a rush
- Feeling pain or physical discomfort (other than withdrawal)
- When hungry
- When thirsty
- When having a lack of energy
- When having a headache

-
- Wanting to lose weight

Other_____

Thoughts

- Unpleasant thoughts
- Fear of withdrawal
- "I'm no good" thoughts
- "Why did I act so stupidly" thoughts
- "I'll show him or her" thoughts
- "He(or she or they) can't tell me what to do" thoughts
- Guilt related thoughts
- Saying things to yourself to justify your drug /alcohol use
- Thinking about hang-ups
- Thinking about social problems

Other _____

Situation

- When not wanting to do anything
- Failing to accomplish a task or goal
- When faced with a difficult problem(s)
- Seeing or hearing alcohol/drug advertisements/videos
- Walking by a bar/lounge
- Hearing references to drug taking or drinking
- Facing large responsibilities
- Having money
- Having alcohol or drugs
- Being in debt
- Being in a place where you often drink or take drugs
- Being in a bar or restaurant
- Being in a friend's home
- While driving
- Being out of doors
- When your curiosity is aroused
- When engaging in pleasant events
- After using drugs once or taking one drink
- Pressured from school or work
- Special occasion
- Having a meal
- Other_____

<u>Termination Tuning In Exercise</u>

<u>Purpose:</u> To assist class members/ group members in developing awareness regarding the many ways individuals respond to termination.

The following case scenario can be provided to the class/group and then a brainstorming session can occur. To help orient the class/group into thinking about the ways people respond to termination, first read the case scenario, and then ask the question "How have you or would you prepare for or respond in this situation?"

The worker and each group member are predisposed to handle termination in his or her own unique manner. To grasp the various ways that human beings deal with issues of termination, the following scenario may be useful.

A very close friend or relative comes to visit for a weekend. Their scheduled time of departure is Monday morning by the 7:30 train. Each person will handle the departure of their loved one in his or her own unique manner. The options are many. A few of these are:

❖ On Sunday evening discuss the visit, its importance, and arrangements for getting to the train the next morning;

❖ not to even mention the visit but make plans for getting to the train;

❖ at bedtime on Sunday evening to indicate that you will not be able to go to the train station but have made arrangements for the loved one to get there;

❖ to discuss the visit, the arrangements for departure and future contacts;

❖ not to mention the visit or any arrangements to leave;

❖ to make elaborate plans for breakfast on Monday morning and specific times and arrangements for getting to the station;

❖ to find activity and discussion to fill in the time prior to the loved one's departure;

❖ to reminisce about earlier shared experiences; or

to deny that the visit will be over shortly.

If we chose to take our visitor to the train station, some of us will leave our visitor outside the station with his or her bags and hurry off.

Others will enter the station and chat for awhile. Yet others will go on to the platform and wave goodbye long after the train is out of sight, even though unable to see where the visitor is sitting. All of the above will be accompanied by a variety of emotional states such as happiness, sadness, relief, mild forms of depression and possibly excitement about future visits.

Congratulations!

You accepted a NEW challenge, and started a NEW group, with NEW people, NEW facilitators and a NEW focus. You learned NEW things, met NEW people and set some NEW goals for yourself. You successfully completed the

NEW BEGINNINGS GROUP

You are ready to move on to NEW things. This may mean NEW friends, NEW relationships, a NEW home, or a NEW school. The NEWness is exciting and scary. You have a chance to focus on your goals for a NEW you and have a fresh start. Enjoy all the all the NEW challenges which await you.

Jana Estabrooks