# NARRATIVE THERAPY WITH YOUTH AT A JUVENILE BOOT-CAMP FACILITY: A SINGLE CASE RESEARCH DESIGN

A Dissertation

by

JAMES PETER IKONOMOPOULOS

AS, McHenry County College, 2005
BA, Texas A&M University-Corpus Christi, 2008
MS, Texas A&M University-Corpus Christi, 2010

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This dissertation meets the standards for scope and quality of
Texas A&M University-Corpus Christi and is hereby approved.

Robert L. Smith, PhD
Chair

Richard S. Balkin, PhD
Committee Member

Marvarene Oliver, EdD
Committee Member

Ethan Thompson, PhD
Graduate Faculty Representative

JoAnn Canales, PhD
Dean, College of Graduate Studies

May 2014

# ABSTRACT

The purpose of the study was to bring forth the stories from youth cadets in a juvenile justice boot-camp facility, to gain an understanding of the psychological symptoms that youth experience, as well as, to examine the effectiveness of a narrative therapy counseling intervention for reducing clinically relevant psychological symptoms manifested by youth at a juvenile boot-camp facility.

The principal investigator conducted this study with a sample of youth cadets (N = 8) currently enrolled in a juvenile boot-camp facility. Youth chosen to participate in this study were between the ages of 15 to 17. The population for this research was obtained through convenience sampling, and was selected by staff from a South Texas boot-camp facility, based on the level of clinically relevant psychological symptoms in youth cadets.

Analysis of participants' scores on the Brief Symptom Inventory (Derogatis, 1993), using the percentage of data exceeding the median statistical procedure (Ma, 2006) yielded treatment effects indicating that a narrative therapy intervention may be effective for improving youth functioning and reducing mental health symptoms. Treatment effects ranging from moderate to large were noted for scores on Interpersonal-Sensitivity, Depression, Obsessive-Compulsion, and Psychoticism measures of the Brief Symptom Inventory (Derogatis, 1993) for a majority of participating youth cadets.

Using a narrative therapy treatment approach to assist youth on improving clinically relevant psychological symptoms and adjustment problems is a strategy that should be considered by counselors in juvenile justice settings, clinical settings, and by counselors in education programs. Because counselor education programs and mental health treatment settings

are furthering their research activity and counselor supervision, narrative therapy provides a useful and effective means to enhance youth functioning and improvement in coping skills to manage clinically relevant psychological symptoms. It is recommended that this body of research be continued for other educational, work, and health settings. Counselor educators, supervisors, and educational leaders are in a position to promote narrative approaches, which has shown to further youth social and mental health development, however further use and exploration on the effectiveness of narrative therapy is needed.

# DEDICATION

To all of those youth struggling to get through life, and whose stories have never been heard. Please know that you can do anything you set your mind towards.

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# Introduction

Researchers have identified a number of clinically relevant psychological symptoms experienced by youth including somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism, and many others (Jaser et al., 2009; Chew et. al., 2010; Derogatis, 1993). Based on these findings, a number of contributing risk factors were identified. Jaser et al. (2009) examined the relationships between depressive symptoms, clinical risk factors, and health behaviors and attitudes in a sample of urban youth at risk for type 2 diabetes mellitus. In another study, Jaser et al. (2009) obtained data from participants on depressive symptoms and health attitudes and behaviors related to diet and exercise, and clinical data on risk indicators (eg, fasting insulin) from 198 youth from an urban setting (Jaser, Holl, Jefferson, & Grey, 2009). Clinically significant levels of depressive symptoms were reported in roughly 21% of the sample, and higher levels of depressive symptoms were revealed in Hispanic youth than had been reported in black youth. Higher levels of depressive symptoms were related to several health behaviors and attitudes, and especially from less perceived support for physical activity and poorer self-efficacy for diet (Jaser et al., 2009). Depressive symptoms were also associated with some clinical risk indicators, such as higher BMI and levels of fasting insulin (Jaser et al., 2009). These results indicated that depressive symptoms had an impact on the ability for youth to engage in healthy behavior changes.

Chew et al. (2009) examined the relationship between developmental assets, and the likelihood of a young person engaging in health-risk behaviors. Respondents were adjudicated youth who had voluntarily taken the Developmental Assets Profile (DAP) instrument.

Participants reported lacking risk-protective factors in the internal and social context areas (Chew, Osseck, Raygor, Eldridge-Houser, & Cox, 2010). Respondents reported a lack of community involvement in the social context area, and reported an over involvement with negative influences in the internal context areas. Primarily in the internal and external context areas, most respondents reported having more trouble with substance abuse, and not having positive peer influence or parental support (Chew et al., 2010). In the social context area, these youth noted they wanted to do well in activities where they had been encouraged to do well, yet these youth scored low in service to others, and involvement in religious groups (Chew et al., 2010). The results of this study indicated that youth who lack protective qualities, such as not feeling committed to their community, were more likely to develop mental health problems, engage in substance abuse, and exhibit risky behaviors.

Busen et al. (2008) explored a group of homeless youth and adolescents who utilized a mobile unit that delivered medical and mental healthcare services. Busen et al, (2008) also examined the effectiveness of the services provided for reducing the health risk behaviors of youth. Nearly one third of these participants were high school graduates and most were without health insurance (Busen & Engebretson, 2008). Results of their study revealed that living situations were transitory including moving around with friends, moving from shelters, crash pads, or the streets (Busen & Engebretson, 2008). Abuse was identified for the majority of youth leaving home. Psychiatric and substance abuse conditions, as well as medical conditions that were related to transitory living situations, substance abuse, and sexual activity were common for youth (Busen & Engebretson, 2008). Successful completion of the program was attributed to sustained counseling, stabilizing youth on psychotropic medications, reducing substance use,

providing immunizations and birth control, and treatment of medical conditions (Busen & Engebretson, 2008).

Anxiety disorders are some of the most widespread mental health disorders among youth, ranging in occurrence from 12% to 20%. (Gosch, Schroeder, Mauro, & Compton, 2006). Taquechel & Ollendick (2007) described anxiety as a consistent emotional response to an apparent threat to one's emotional or physical wellbeing. Anxiety disorders also tend to have negative long-term effects on emotional and social development when left untreated. The harmful effects of anxiety disorders in youth are associated with poor scholastic achievement, lower levels of social support, low levels of employment, substance use, and high comorbidity with other mental health disorders (Velting, Setzer, & Albano, 2004). Furthermore, Rapee and Barlow (1993) indicted these disorders recur, often leading into adulthood.

Sanders et al. (2010) explored substance use and other risk behaviors among gang youth in Los Angeles, California. A sample of gang youth were recruited into a National Institute on Drug Abuse (NIDA)-funded qualitative pilot study about substance use and other risk behaviors (Sanders, Lankenau, & Jackson-Bloom, 2010). The results of this study exposed some fairly unexplored issues on substance use among gang youth. For instance, many youth were found to abuse a variety of prescription drugs, especially Vicodin and Codeine (Sanders et al., 2010). Many of these youth also discussed mixing substances, mainly marijuana and alcohol. There was also a link between substance use and violence, particularly individual and collective fighting, as well as unsafe sexual practices, particularly group sex (Sanders et al., 2010). Some of these sexual activities explored involved three or more individuals simultaneously or sequentially. Substance use also was associated with the youths' arrest histories. Approximately, 35% of these

youth had been previously arrested for substance use possession, which was often at times linked with more serious arrests (Sanders et al., 2010).

Even with these circumstances, only a small percentage of youth, particularly those involved in the juvenile justice system with clinically relevant psychological symptoms are treated. Because of the hidden nature of these symptoms, there are few treatment providers who are skilled enough to identify these symptoms, and to provide effective treatment programs for these youth. (Gosch, Schroeder, Mauro, & Compton, 2006). The effectiveness of a narrative therapy counseling intervention for adolescents at a juvenile boot-camp facility was evaluated to assess the reduction in clinically relevant psychological symptoms for youth and adolescents at a juvenile boot-camp facility.

## Statement of the Problem

In communities across the United States and across the world, youth increasingly are exhibiting clinically relevant psychological symptoms, and at-risk behaviors (Jaser et al., 2009; Chew et. al., 2010). Some of these psychological symptoms include somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism, and others (Jaser et al., 2009; Chew et. al., 2010; Derogatis, 1993). Clinically relevant psychological symptoms are often minimally recognized, particularly within the juvenile justice system and warranting special attention and concentrated intervention. Few researchers have examined in depth the experiences of youth in a juvenile boot-camp facility, and the ameliorating aspects of counseling and therapy for incarcerated youth. Although some studies have focused on the implementation of counseling techniques to help youth overcome mental health issues such as depression, anxiety, and behavioral problems (Jaser, Holl, Jefferson, & Grey, 2009), there has remained a dearth of literature on the effectiveness of counseling

interventions such as narrative therapy, to help youth overcome clinically relevant psychological symptoms and at-risk behaviors while serving time at a boot-camp facility.

## Purpose of the Study

There is a lack of research on evidenced based counseling interventions aimed at reducing symptoms and increasing functioning of youth and adolescents, particularly those serving time in a juvenile boot-camp facility (Sanborn, 2011). The purpose of this study was to bring forth the stories from youth, age 15-17, in a juvenile justice boot-camp facility. The purpose was to gain an understanding of the psychological symptoms that youth experience, as well as, to examine the effectiveness of a narrative therapy counseling intervention for reducing clinically relevant psychological symptoms manifested by youth at a juvenile boot-camp facility.

## Research Questions

The following research questions were used in the study:

Quantitative Research Questions:

1) What is the effectiveness of a narrative therapy intervention for reducing clinically relevant psychological symptoms on scores of the Brief Symptom Inventory (Derogatis, 1993) in youth at a South Texas juvenile boot-camp facility?
2) What graphical representations will determine whether meaningful change has been noted between the baseline and treatment phases?
3) What effect sizes by non-overlap data analysis procedures are indicative of effective treatment?

Qualitative Research Questions:

4) What stories about being in a juvenile justice boot-camp facility do youth convey?

5) What role do clinically relevant psychological symptoms play within the lives and experiences of youth currently in a juvenile boot-camp facility?

6) What are the perceptions of youth on how the narrative therapy sessions helped them deal with clinically relevant psychological symptoms at a juvenile justice boot-camp facility?

## Significance of the Study

The number of adolescents being jailed and otherwise involved in the criminal justice system in the United States has continued to climb over the past two decades (Granello, & Hanna, 2003; Texas Juvenile Justice Department, 2011). The youth sent to the Texas Juvenile Justice Department (TJJD) are the state's most serious or chronically delinquent offenders. In fiscal year 2011 (9/10 – 8/11), 60% of new admissions had committed violent offenses. The median age of commitment was 16 years old (Texas Juvenile Justice Department, 2011). A juvenile offender is defined as anyone who has broken a criminal law of any state or federal jurisdiction (Flowers, 2002). Additionally, juvenile offenders can range in age from 12 to 25, include both males and females of any ethnic or cultural background, and may be first time, or repeat offenders. Juvenile offenders like other young people, need to become competent, caring individuals who are concerned for those around them as well as themselves. Engaging youth through counseling upon re- entry into society and addressing the developmental needs of these youth, will allow them to explore ways in which they as young people can develop and/or acquire the attitudes as well as the necessary skills to lead productive and law-abiding lives (O'Sullivan, 2001; Chew et al., 2010).

A series of reports indicated the efficacy of narrative therapy (Anderson & Hiersteiner, 2008; Fraenkel, Hameline, & Shannon, 2009). Anderson and Hiersteiner (2008) analyzed

interviews of twenty seven adult survivors of sexual abuse to provide opportunity for the examination of these survivor's shared stories and experiences. The following perspective was provided based on the stories shared from group interviews: "Recreating a life story that goes beyond recovery from childhood, sexual abuse may assist an adult survivor to consider a future full of possibilities, including a story book ending" (Fraenkel et al., 2009). Fraenkel et al. (2009) also explored the effects of narrative therapy with homeless families. By externalizing conversations and identifying unique outcomes, these shared stories and experiences helped families strengthen their family identity, and help to keep a hold on hope for the future (Fraenkel et al., 2009). Narrative therapy also has been helpful in working with parents of lesbian, gay, and bi-sexual adolescents (Saltzburg, 2007), pre-graduate counselors (Whiting, 2007), and students who have learning disabilities (Lambie & Milsom, 2010). Narrative therapists have also been helpful in working with adolescents coping with personal and academic challenges (Butler et al., 2009; Whiting, 2007).

Butler et al. (2009) revealed how puppets have been helpful in working with children to define and externalize problems. In a case illustration with an eight year child named Eric, the following techniques were used: defining the problem, mapping the effects of the problem, evaluating the problem, identifying unique outcomes, and re-authoring conversations (Butler et al., 2009). The therapist first started the session with the preliminary goal of working to identify the problem. The presenting problem was identified as "anger" following a shared discussion with Eric and his mother (Butler et al., 2009). Second, so that the therapist could help in mapping the effects of the problem, the therapist asked Eric to describe what occurs when "anger" shows up. At this moment, Eric revealed the occurrence of consequences and punishment at home and at school. Thirdly, the evaluation on the effects of the problem involved a conversation about

"annoyance" that got in the way of Eric engaging in leisure and recreational activities that he liked (Butler et al., 2009). Fourth, the therapist presented a puppet to help "externalize" the problem of anger from Eric to help him separate himself from the problem afflicting his behavior. Afterward, the therapist asked Eric to identify unique outcomes or times when anger was not present. A week before coming to session, Eric revealed how he had not been upset when a classmate of his had teased him by calling him names. Finally, Eric and his therapist explored ways in re-authoring his preferred life story by exploring positive factors in his life when anger was not present (Butler et al., 2009).

From these aforementioned studies, narrative therapy appears to be helpful by working with people to externalize problems, identify unique outcomes, and in re-authoring their life stories. The researcher addressed gaps in the literature related to understanding clinically relevant psychological symptoms within youth, particularly related to youth involved in the juvenile justice system. The researcher provided further insight on the effectiveness of narrative therapy interventions, and further insight on factors that contribute to positive youth outcomes.

## Fundamental Principles of Narrative Therapy

Narrative therapy is a form of psychotherapy, pioneered in Australia and New Zealand in the 1980s by Michael White and David Epston. Narrative Therapy emphasizes the importance of story and language in the development and expression of interpersonal and intrapersonal problems (White, 2007). The basis of narrative therapy is social constructionism or the idea that the way people experience themselves and their situation is "constructed" through culturally mediated social interactions. (Shapiro & Ross, 2002). Through story and language, cultures send powerful messages to their members about the meaning of important concepts that sustain the culture, including gender, race, class, and health. (Shapiro & Ross, 2002). Narrative therapists

take an approach that explores a client's world, to help them change their life stories (White & Epston, 1990).

Narrative therapy is also a post-modern approach, which uses techniques to facilitate storytelling through defining the problem, mapping the effects of the problem, evaluating and justifying the effects of the problem, and identifying unique outcomes which eventually leads to the re-authoring of client's life stories. A narrative therapist takes an approach to working with clients by objectifying or externalizing the problem, which makes it possible for clients to experience an identity that is separate from the problem.

The use of metaphors is highly significant in the use of narrative practice because metaphors invoke specific understandings of life and identity (White, 2007). Re-authoring conversations is an aspect of narrative therapy that invites people to continue to develop and tell stories about their lives, but also to help people include some of the more neglected but potentially significant events and experiences that are overlooked within their dominant storylines (Shapiro & Ross, 2002). These events and experiences can be considered "unique outcomes" or "exceptions" to when the problem is not present. Given that youth are at-risk for an abundance of issues including juvenile justice involvement, sexual risk behaviors, substance abuse, mental health problems, physical health problems, academic problems, teen pregnancy, and many others, narrative techniques can perhaps help youth not only identify challenges to their lives, but also to recognize coping responses used in overcoming these challenges, so that youth can change these conversations they share about themselves into their preferred life stories.

## Methodology

The principal investigator conducted a single case research design (N = 8) to determine the effectiveness of a narrative therapy intervention for reducing clinically relevant psychological symptoms in youth at a South Texas juvenile boot-camp facility. More specifically, the principal investigator measured improvement of scores measuring clinically relevant psychological symptoms on the Brief Symptom Inventory (Derogatis, 1993). These clinically relevant psychological symptoms include somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism, and many others (Derogatis, 1993). The principal investigator implemented an A-B and for some cadets an A-B-A single case research design (Lundervold et al., 2000; Sharpley, 2007), gathering scores of the Brief Symptom Inventory (Derogatis, 1993), through five measurements to determine a baseline average. Then the principal investigator measured scores of the Brief Symptom Inventory (Derogatis, 1993) throughout up to ten weeks of a narrative therapy intervention. All eight participants received individual therapy only. Field notes were created for each individual in the study. During the treatment phase, the cadets (N=8) were randomly assigned to work with one of two narrative therapists which include the principal investigator, and another counselor. Two narrative therapy practitioners were utilized to help increase the validity of the treatment approach being implemented. This helped increase the validity of the treatment approach by demonstrating the effectiveness of a narrative therapy treatment program performed by more than one therapist. The principal investigator afterwards measured clinically relevant psychological symptoms from scores of the Brief Symptom Inventory (Derogatis, 1993) once the narrative therapy intervention were withdrawn for about three weeks following treatment. Single-case design methodology offers researchers and practitioners numerous benefits. Single-case designs demonstrate causal relations between

different treatment conditions and their effects on a single participant's performance, or for a group's performance over time (Kazdin, 2003; Sharpley, 2007). In general, single-case designs involve collection of data regarding a target of change during a series of phases or period of time during which a specific counselor action is taking place (Lundervold & Belwood, 2000). Continual assessment is vital to single-case design because multiple data points provide the data from which a participant's baseline and intervention phases are analyzed to assess change (Sharpley, 2007). In single-case designs, participants in essence serve as their own control group. Data points from each phase are graphically represented to provide visual representations of change over time. These graphs are perceived as the most effective method for initial examination of data (Sharpley, 1982; Lenz, 2012). Time series statistical analyses help counselors use a relatively easy and reliable method of measuring change in counseling situations.

The principal investigator also infused narratological research methodology as part of the narrative therapy sessions by exploring the stories of youth in a juvenile justice boot-camp facility, exploring the clinically relevant psychological symptoms within the lives and experiences of youth currently in a juvenile boot-camp facility, and examining factors considered important to changes by youth through the measures of clinically relevant psychological symptoms of the Brief Symptom Inventory (Derogatis, 1975). Conversations occurred simultaneously during the individual therapy sessions. Individual therapy sessions occurred once a week for each participant during the time permitted by the boot-camp director. The researcher met with each participant for 10 treatment sessions, and gathered qualitative research data using narrative analysis throughout each individual narrative therapy session.

The goal of using a narratological approach is to understand the human experience through interpreting narrative forms of qualitative research data (Hays et al, 2011). Through a narratological research perspective, the meaning comes from the stories. Hoshmand (2005) proposed that narratology is a method of qualitative inquiry from the premises of narrative theory as opposed to other qualitative methodologies that often explore narrative data but not coming from a narrative standpoint. A narratological mode of qualitative inquiry uses temporal order and/or expresses causal connections in its structural form. Social, political, historical, and cultural contexts of narratives are important because they relate to motives and plots in expressing overall meaning of the data (Hoshmand, 2005). Furthermore, narrative analysis provides a method for examining meaning from within the context of the story as well as in the "how" of the story and the "to whom." (Hayes et al, 2011). “Just as the counseling profession comes to know clients through their stories, so can most areas of counseling research be informed through narrative inquiry” (Hayes et al, 2011).

## Population and Sample

The principal investigator conducted this study with a sample of youth cadets (N = 8) currently enrolled in a juvenile boot-camp facility. Because the cadets are sentenced to serve time in a juvenile boot-camp facility, participants for the current study were derived from a sample of convenience. Youth chosen to participate in this study are estimated to be between the ages of 15 to 17. The population for this research was also obtained through purposeful sampling, and was selected by staff from the South Texas boot-camp facility, based on the level of clinically relevant psychological symptoms in youth cadets. An informed consent statement along with a letter of permission from the director of the juvenile boot-camp facility authorized the researcher to use the facility for the research study. The researcher provided the boot-camp

staff with an information sheet that explained the study conducted. The informed consent statement and the letter of permission from the director of the juvenile boot-camp facility also allowed approval for the researcher to contact the legal guardians of potential participating cadets for consent, as well as requesting assent of the participating youth. The legal guardians of the cadets who filled out the consent form and allowed permission of their children to be participants of the study also were given an information sheet, as well as the youth who gave assent to be participants of the study. There were no monetary incentives, and participants were given the option to opt out from the study at any given time.

## Instrumentation

### Brief Symptom Inventory (BSI) (Derogatis, 1993).

This study assessed the influence of a narrative therapy intervention using the Brief Symptom Inventory (BSI) (Derogatis, 1993). The principal investigator measured improvement of scores on clinically relevant psychological symptoms on the Brief Symptom Inventory (Derogatis, 1993). The purpose of the BSI is to identify self-reported clinically relevant psychological symptoms in adolescents and adults. The Brief Symptom Inventory (BSI) consists of 53 items which cover nine symptom dimensions. These symptom dimensions include: Somatization, Obsession-Compulsion, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic anxiety, Paranoid ideation and Psychoticism; and three global indices of distress: Global Severity Index, Positive Symptom Distress Index, and Positive Symptom Total (Cox, 2011). The global indices measure current or past level of symptomatology, intensity of symptoms, and number of reported symptoms, respectively.

The BSI is the short version of the SCL-R-90 (Derogatis, 1975, 1977), which measures the same dimensions (Cox, 2011). Items for each dimension of the BSI were selected based on a

factor analysis of the SCL-R-90, with the highest loading items on each dimension selected for the BSI (Derogatis, 1993; Derogatis & Cleary, 1977; Derogatis & Spencer, 1982). All materials and copyrighted forms and the BSI manual (Derogatis, 1993) are available from the publisher. The time required to administer the BSI takes an estimated average of 8 to 12 minutes (Cox, 2011). The administration method can be self or interviewer administered, and training on administration of the BSI assessment is said to be minimal (Derogatis, 1993). Regarding the scoring of the BSI, respondents rank each feeling item (e.g., "your feelings being easily hurt") on a 5-point scale ranging from 0 (not at all) to 4 (extremely) (Cox, 2011). Rankings characterize the intensity of distress during the past seven days. The items comprising each of the 9 primary symptom dimensions are as follows:

• Somatization: Items 2, 7, 23, 29, 30, 33, and 37

• Obsession-Compulsion: Items 5, 15, 26, 27, 32, and 36

• Interpersonal Sensitivity: Items 20, 21, 22, and 42

• Depression: Items 9, 16, 17, 18, 35, and 50

• Anxiety: Items 1, 12, 19, 38, 45, and 49

• Hostility: Items 6, 13, 40, 41, and 46

• Phobic Anxiety: Items 8, 28, 31, 43, and 47

• Paranoid Ideation: Items 4, 10, 24, 48, and 51

• Psychoticism: Items 3, 14, 34, 44, and 53.

Several items do not factor into any of the dimensions such as items 11, 25, 39, and 52, but are included because these items are clinically essential (Cox, 2011). For example, the presence of conscious feelings of guilt is useful information to a clinician. These items are included when calculating Grand Total Scores (Derogatis, 1993). Dimension scores are

calculated by summing the values for the items included in that dimension and dividing by the number of items endorsed in that dimension (Derogatis, 1993). Scores are interpreted by comparison to age-appropriate norms. Normative data are available for both clinical and non-clinical samples of adolescents (over 13 years) and adults (Derogatis, 1993; Derogatis & Spencer, 1982). The BSI Administration, Scoring, and Procedures Manual (Derogatis, 1993) provides normative data for four different samples, including non-patient adults, adolescents aged 13-17, adult psychiatric outpatients, and adult psychiatric inpatients.

The authors report good internal consistency of the scores for the nine dimensions, ranging from .71 on Psychoticism to .85 on Depression (Cox, 2011). Internal consistency were strong as supported by several other independent studies (Croog et al., 1986; Aroian & Patsdaughter, 1989 in Derogatis, 1993). Coefficient alpha was not reported for scores on three global indices. Test-retest reliability for the nine symptom dimensions ranges from .68 (Somatization) to .91 (Phobic Anxiety), and for the three Global Indices from .87 (Positive Symptom Distress Index) to .90 (Global Severity Index) (Cox, 2011). Correlations between the BSI and the Wiggins content scales and the Tryon cluster scores from the MMPI ranged from .30 to .72 with the most relevant score correlations averaging above .50 (Conoley & Kramer, 1989; Derogatis, Rickles, & Rock, 1976 in Derogatis, 1993). Confirmatory factor analysis results confirmed the a priori construction of the symptom dimensions. In addition to understanding the validity of the BSI, the authors report correlations between the scores on the BSI and SCL-R-90 were .92 to .99 (Derogatis, 1993). The adolescent norms are based on 2,408 individuals with 1,601males and 807 females. The data were gathered in six separate schools in two states. Approximately 58% of the sample was white, and the mean age was 15.8 (Derogatis, 1993). References to other studies attesting to the validity of the BSI are found in the manual

(Derogatis, 1993). References to other studies attesting to the validity evidence of the BSI are found in the manual (Derogatis, 1993).

## Data Collection and Analysis

The quantitative data on scores of the Brief Symptom Inventory (Derogatis, 1993), were first collected from participating cadets (N = 8) for a total of eighteen consecutive weeks. During the first five consecutive weeks, the principal investigator gathered an average base line measure of clinically relevant psychological symptoms. The Brief Symptom Inventory (BSI) consists of 53 items covering nine symptom dimensions: Somatization, Obsession-Compulsion, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic anxiety, Paranoid ideation and Psychoticism; and three global indices of distress: Global Severity Index, Positive Symptom Distress Index, and Positive Symptom Total. After five weeks of data collection, the baseline phase of data collection was completed. The treatment phase began after the $5^{th}$ baseline measure where the first narrative therapy session occurred, and where data was collected from the sixth week continuing consecutively each week up until the sixteenth week, during which the narrative therapy intervention was implemented. After the fifteenth week of data collection, the treatment phase of data collection was completed. Starting the sixteenth week of data collection the withdrawal phase is where data was collected from the sixteenth week continuing consecutively through the eighteenth week, during which the narrative therapy intervention was withdrawn, therefore throughout week sixteen through week eighteen will be the withdrawal phase of data collection. Questions on the Brief Symptom Inventory (Derogatis, 1993) were randomly distributed for each administration to prevent threats to external validity from the testing effect. Percentage of non-overlapping data procedures was implemented to analyze the quantitative data of the A-B-A single case design. A visual trend analysis was reported as data

points from each phase will be graphically represented to provide visual representations of change over time (Sharpley, 2007). An interpretation of effect sizes was conducted to determine the effectiveness of the narrative therapy treatment intervention when comparing each phase of data collection (Sharpley, 2007).

The qualitative data was gathered through a variety of methods. First, the principal investigator collected field notes each week throughout the seventeen weeks at the time of the quantitative data collection. The principal investigator also gathered qualitative data from participating youth cadets, using a narratological approach exploring the meaning from the stories shared by cadets as related to questions exploring the impact that clinically significant psychological symptoms have had in their lives. Through conversations with participating cadets, the principal investigator also explored the significance and impact of the narrative therapy intervention from each cadet's own perspective throughout each week of treatment implementation, and what constituted changes in their scores of the Brief Symptom Inventory (Derogatis, 1993) throughout each weekly measurement. In reviewing the data and embedded narrative from the field notes and discussions, the principle investigator attended to the relationship between context and story structure.

In data analysis, the principal investigator examined intrapersonal and contextual information, tension within the stories, and the narrative's conclusions (Hays et al, 2011). Other means of qualitative data was gathered by the principal investigator, including field notes taken by the principal investigator on personal experiences shared from sessions, from journal entries written by participants, as well as from conversations with boot-camp staff on their perspective of youth experiences in a boot-camp facility to further develop the narrative of cadets participating in the study. Narrative inquiry is popular in applied sciences, such as social work

and nursing (Lai, 2010). The idea of narrative inquiry is that stories are collected as a means of understanding experience as lived and told, through both research and literature (Lai, 2010).

## Basic Assumptions

One important assumption is that participants being administered the Brief Symptom Inventory (Derogatis, 1993) answered questions on the instrument honestly. It is also assumed that participants were capable of answering questions based on clinically significant psychological symptoms on the BSI, as well as through qualitative inquiry on sharing their story and experiences throughout the study. It is assumed that the principal investigator established rapport enough for participants to engage fully in sessions, and to answer instrument inquiry and qualitative inquiry to their maximum potential. This study is also based on the assumption that all participants were willing participants, and that interviews, focus groups, field notes, journal entries, and observations provided the information necessary to interpret the data through a narratological methodology approach.

## Limitations

### *Delimitations*

In an attempt to narrow the scope of this study, several delimitations were identified. The first delimitation was that the term clinically relevant psychological symptoms was confined to include the operational definitions for each dimension measured by the Brief Symptom Inventory (Derogatis, 1993) which includes somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism, and many others (Derogatis, 1993). Secondly, youth in the general population are not represented in this study. The focus was limited to youth sentenced to serve time at a South Texas juvenile boot-camp facility.

*Limitations*

This was a mixed methods study of purposefully chosen (non-random) participants of the population in focus. The researcher chose to administer the Brief Symptom Inventory (Derogatis, 1993) with these youth after determining that this approach would best measure clinically relevant psychological symptoms, and that using a narratological qualitative approach would best assess their stories. A limitation for this study comes from the small sample size of (N= 8), which limits the ability to generalize findings, however inferences can be made based from these outcomes.

## Definitions

For the purposes of this study, the following terms were used as defined below:

*At Risk*

This term refers to the status of youth who are vulnerable to poor developmental outcomes, learning difficulties, mental health disorders, maladaptive coping styles, exposure to trauma, and substance abuse. A number of studies have found that youth are becoming increasingly more at risk. Many of these risk factors include youth being at-risk for juvenile justice involvement, sexual risk behaviors, substance abuse, mental health problems, physical health problems, academic problems, teen pregnancy, and many others (Jaser et al., 2009; Chew et. al., 2010; Busen et al., 2008, Wilson et al., 2010, Corlis et al., 2011).

*Clinically Relevant Psychological Symptoms*

This term pertains to the variety of symptoms/conditions for which people often seek out mental health treatment. These psychological symptoms include somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism, and many others (Jaser et al., 2009; Chew et. al., 2010; Derogatis, 1975).

*Juvenile Boot-Camp Facility*

This term refers to the facility in which the study is being conducted. Often times, as a result of recidivism and repeated offenses, a Judge may order a juvenile detainee to be sentenced to a term in a boot-camp facility. A juvenile boot-camp facility in a place where youth often times experience a tough military-style type of environment, often aimed at preventing youth from making poor decisions and to stop them from ending up in adult prison. Youth at the South Texas boot-camp facility in which the study will be conducted are generally sentenced to a 9 month term.

*Brief Symptom Inventory (BSI)*

The instrument used in this study to identify self-reported clinically relevant psychological symptoms in participants. The Brief Symptom Inventory (BSI) consists of 53 items which cover nine symptom dimensions. These symptom dimensions include: Somatization, Obsession-Compulsion, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic anxiety, Paranoid ideation and Psychoticism; and three global indices of distress: Global Severity Index, Positive Symptom Distress Index, and Positive Symptom Total (Cox, 2011).

*Single-Case Research Design*

Single-case designs demonstrate causal relations between different treatment conditions and their effects on a single participant's performance over time (Kazdin, 2003; Sharpley, 2007). In general, single-case designs involve collection of data regarding a target of change during a series of phases or period of time during which a specific counselor action is taking place (Lundervold & Belwood, 2000). In single-case designs, participants in essence serve as their own control group. Data points from each phase are graphically represented to provide visual

representations of change over time. These graphs are perceived as the most effective method for initial examination of data (Sharpley, 1982).

*Narrative Therapy*

Narrative therapy is a form of psychotherapy, pioneered in Australia and New Zealand in the 1980s by Michael White and David Epston. Narrative Therapy emphasizes the importance of story and language in the development and expression of interpersonal and intrapersonal problems (White, 2007). Narrative therapy is also a post-modern approach, which uses techniques to facilitate storytelling through defining the problem, mapping the effects of the problem, evaluating and justifying the effects of the problem, and identifying unique outcomes which eventually leads to the re-authoring of client's life stories.

*Narrative Therapy Intervention*

The narrative therapy intervention will follow the guidelines suggested by Michael White in his book *Maps of Narrative Practice* (White, 2007). This book provides the practical and accessible applications of narrative practice as Michael White has developed and taught over the years.

Session 1:

- Defining the problem
- Externalizing the problem

Session 2:

- Mapping the effects of the problem

Session 3:

- Evaluating and justifying the effects of the problem

Session 4:

- Re-authoring conversations
- Landscape of action and landscape of identity

Session 5:

- Re-authoring and re-membering conversations
- Landscape of action and landscape of identity

Session 6:

- Re-authoring and re-membering conversations
- Scaffolding Conversations

Session 7:

- Re-authoring conversations
- Mapping the effects of the re-authored identity

Session 8:

- Re-authoring conversations

Evaluating and justifying the effects of the re-authored identity

Session 9:

- Re-authoring conversations
- Evaluating and justifying the effects of the re-authored identity

Session 10:

- Definitional Ceremony

*At Risk Behavior*

Behavior that youth engage in that puts them at risk for negative consequences. The following consequences are identified: criminal justice involvement, sexually transmitted disease, academic deficiency, poor social relations, poor health, injury, and death.

*Clinically Relevant Psychological Symptoms*

Items identified in literature and measured on the Brief Symptoms Inventory which include: Somatization, Obsession-Compulsion, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic anxiety, Paranoid ideation, and Psychoticism.

*Somatization*

"Reflects distress arising from perceptions of bodily dysfunction. Complaints focus on cardiovascular, gastrointestinal, respiratory, neurological and other systems with strong autonomic mediation. Pain and discomfort of the gross musculature and other somatic equivalents of anxiety are also possible components of Somatization" (Derogatis, 1993, p. 7).

*Obsessive-compulsion*

"This measure focuses on thoughts, impulses and actions that are experienced as irresistible and unremitting and that are of an ego-alien or unwanted nature. Behavior and experiences reflecting a more general cognitive performance deficit also contribute to this measure" (Derogatis, 1993, p. 7).

*Interpersonal Sensitivity*

"The Interpersonal Sensitivity measure focuses on feelings of inadequacy and inferiority, particularly in comparison to other people. Self-deprecation, self-doubt and marked discomfort during interpersonal interactions are characteristic manifestations of this syndrome. Self-consciousness and negative expectations about interpersonal relations are hallmark features of interpersonal sensitivity" (Derogatis, 1993, p. 8).

*Depression*

"The Depression dimension reflects a representative range of the manifestations of clinical depression. It comprises symptoms of dysphoric mood and affect, signs of withdrawal of

life interest, lack of motivation and loss of vital energy. Feelings of hopelessness, thoughts of suicide and other cognitive and somatic correlates of clinical depression are included in this measure" (Derogatis, 1993, p. 8).

*Anxiety*

"General signs of anxiety such as nervousness, tension and trembling are included in the domain definition, as are feelings of apprehension, dread, terror and panic. In addition, some somatic manifestations of anxiety are also reflected in the domain" (Derogatis, 1993, p. 8).

*Hostility*

"The symptoms of the Hostility dimension include thoughts, feelings, and actions that are characteristic of the negative affect state of anger. Items reflect all three modalities of expression, and demonstrate qualities such as resentment, irritability, aggression and rage" (Derogatis, 1993, p. 8).

*Phobic Anxiety*

"The Phobic Anxiety dimension defines the syndrome as a persistent fear response to a specific person, place, object or situation, which is disproportionate to any actual threat, and leads to avoidance or escape behavior. Items overlap highly with DSM-IV Agoraphobia syndrome" (Derogatis, 1993, p. 9).

*Paranoid Ideation*

"The Paranoid Ideation dimension represents paranoid behavior as fundamentally a disordered mode of thinking. The Items comprising P-I reflect the cardinal clinical features of projective thought, hostility, grandiosity, suspiciousness, centrality, and fear of loss of autonomy" (Derogatis, 1993, p. 9).

*Psychoticism*

"Psychoticism was designed to represent the construct as a continuous dimension, from a withdrawn isolated lifestyle at one pole to demonstrable psychotic behavior at the other. The measure attempts to reflect a graduated continuum from mild social alienation to first-rank symptoms of psychosis" (Derogatis, 1993, p. 9).

*Re-authoring conversations*

"Re-authoring conversations take place between a therapist and the person(s) who have come to see them and involve the identification and co-creation of alternative story-lines of identity. The practice of re-authoring is based on the assumption that no one story can possibly encapsulate the totality of a person's experience, there will always be inconsistencies and contradictions. There will always be other story-lines that can be created from the events of our lives. As such, our identities are not single-storied–no one story can sum us up. We are multi-storied. Re-authoring conversations involve the co-authoring of story-lines that will assist in addressing whatever predicaments have brought someone into counseling." (Carey & Russel, 2003).

*Unique Outcomes & Exceptions*

In narrative therapy, unique outcomes are exceptions to the dominant story. These are parts of the story that have been left out but deserve to be explored because they have significant meaning.

*Externalizing the problem*

A technique in narrative practice where the therapist draws out an identified problem and helps the client view the problem as separate from themselves. Rather than viewing the client as depressed, the narrative therapist may explore what it is like for the client when "depression" shows up.

*Metaphors*

"A metaphor is a figure of speech that describes a subject by asserting that it is, on some point of comparison, the same as another otherwise unrelated object" (White, 2007). A metaphor is a type of analogy and is closely related to other rhetorical figures of speech that achieve their effects via association, comparison or resemblance. Metaphors help people make vivid, colorful comparisons or descriptions of their experiences.

*Narratology*

Narratology refers to both the theory and the study of narrative and narrative structure and the ways that these affect our perception. The goal of using narratology is to understand the human experience through interpreting narrative forms of qualitative research data (Hays et al, 2011). Through a narratological research perspective, the meaning comes from the stories. Hoshmand (2005) proposed that narratology is a method of qualitative inquiry from the premises of narrative theory as opposed to other qualitative methodologies that often explore narrative data but not coming from a narrative standpoint. A narratological mode of qualitative inquiry uses temporal order and/or expresses causal connections in its structural form. Furthermore, narrative analysis provides a method for examining meaning from within the context of the story as well as in the "how" of the story and the "to whom." (Hayes et al, 2011).

## Organization of the Remaining Chapters

The purpose of this study was to bring forth the stories from youth, age 15-17, in a juvenile justice boot-camp facility. The purpose is to gain an understanding of the psychological symptoms that youth experience, as well as, to examine the effectiveness of a narrative therapy counseling intervention for reducing clinically relevant psychological symptoms manifested by youth at a juvenile boot-camp facility. Chapter 1 of this study described the need for research

regarding youth, and effective treatment interventions. Information on the population sample, treatment, dependent variables, research design, data analysis procedures, and limitation and delimitations were provided. Chapter 2 contains a review of the related literature and previous research in this area while chapter 3 contains a description of the design of the study, instrumentation, methods, and procedures. Chapter 4 contains the analysis of data and chapter 5 contains the summary, conclusions, implications and recommendations for further research.

Chapter 2

## Literature Review

There is substantial evidence to suggest that a great number of young people are in need of mental health services (Angold et al., 1999; Reynolds, 2001, p. 3; Kim et al, 2003; Costello et al, 2003). Due to the growing population of youth and adolescents, it is important to look at what mental health issues a majority of youth experience. A vast number of youth with mental health needs go unrecognized and underserved by mental health and school professionals (Reynolds, 2001; Burke et al, 2005). Adjustment difficulties represent potentially significant mental health problems that may have serious outcomes among adolescents. Previous ideas of "this is just a phase of adolescent turmoil" or "they're just going through a stage" are no longer suitable conclusions (Reynolds, 2001; Nock et al, 2007). This becomes very apparent when one examines the large number of adolescents who engage in antisocial behaviors, or who are depressed and suicidal. A significant number of these youth do not survive into adulthood, or do so with limited psychosocial competency or functioning (Reynolds, 2001, p. 38; Burke et al, 2005; Nock et al, 2007). Incidents of youth violence and anger related problems in schools and community settings have heightened the awareness of mental health and adjustment problems as an important issue among youth and the general population (Reynolds, 2001).

The mental health field has focused to a large degree on mental health disorders defined by classification schemes such as in the *DSM-IV* (American Psychiatric Association, DSM-IV-TR, 2000). A notable *DSM-IV* diagnostic category related to this research study is that of Adjustment Disorders. Although Adjustment Disorders are viewed as related to an identifiable stressor, the *DSM-IV* notes specific subtypes depending on the primary symptom presentation (Reynolds, 2001). These subtypes include: With Depressed Mood, With Anxiety, With Mixed Anxiety and Depressed Mood, With Disturbance of Conduct, and with Mixed Disturbance of

Emotions and Conduct, along with an unspecified type (American Psychiatric Association, DSM-IV-TR, 2000). Many youth who get arrested and are to be served time at a juvenile detention facility or go through further transitions such as to a juvenile boot-camp facility often experience these subtypes of an Adjustment Disorder and more.

There has been a useful phenomenological distinction made between disorders that are internalizing and that which are externalizing in their primary symptom presentation (Reynolds, 2001). This distinction provides a useful overview of youth psychopathology and adjustment. Externalizing disorders of childhood and adolescence are characterized by explicit behavioral problems or disturbances (Reynolds, 2001, p. 3; Kim et al, 2003). Disorders such as Oppositional Defiant Disorder and Conduct Disorder are externalizing disorders. Externalizing problems also include psychological and behavioral disturbances that do not constitute formal *DSM-IV* diagnoses, but none the less represent problem behaviors or sufficient severity or frequency to cause significant problems in school and community settings. Behavior problems like this can include excessive anger, aggression, and delinquency to name a few. Externalizing problems can cause distress and problems for others such as parents, teachers, and peers (Reynolds, 2001, p. 2; Kim-Cohen et al., 2003; Nock, Kazdin, Hiripi, & Kessler, 2007). As a result of adjustment problems, we see antisocial behaviors, anger control difficulties, and oppositional behaviors characterize problem areas related to youth and adolescents.

Antisocial behaviors such as opposition to rules, disregard for authority, damaging property, or use of drugs and alcohol represent significant indicators or adjustment difficulties, but may still be unknown to parents or other adults. Likewise, excessive anger, difficulty to control one's temper, argumentativeness, oppositional behavior, and thoughts of retribution against others signals significant potential for explosive behavior and possible violence

(Reynolds, 2001). Unfortunately in some cases, it is only after tragic outcomes that these externalizing behaviors are recognized as significant aspects of behavioral pathology. For some youth, minor yet persistent problems with behavior and emotions may develop in adulthood leading to more recurring and serious violations of rules. Therefore, it is critical to identify these problems early and begin prevention and intervention efforts.

## Behavior Problems in Youth

There is a high occurrence of oppositional defiant disorder (ODD) in youth, which has strong associations to a wide range of adult mental health conditions (Kim-Cohen et al., 2003; Nock, Kazdin, Hiripi, & Kessler, 2007). These conditions include conduct disorder and antisocial personality disorder (Burke, Loeber, Lahey, & Rathouz, 2005; Costello, Mustillo, Erkanli, Keeler, & Angold, 2003; Ford, Goodman, & Meltzer, 2003). There are also strong associations with attention-deficit/hyperactivity disorder (ADHD) (Angold et al., 1999) and with emotional disorders such as major depression and anxiety disorders (Burke et al., 2005; Maughan, Rowe, Messer, Goodman, & Meltzer, 2004). Disruptive child behavior problems including aggression, oppositional behaviors, and noncompliance are the most common problems for which parents seek professional intervention (Kazdin, Bass, Ayers, & Rodgers, 1990; Reynolds, 2001, p. 4).

Throughout the history of delivery of child mental health services, child-only approaches (e.g., play therapy, individual therapy) have been the primary interventions to reduce these types of behavioral problems (Bourke & Nielsen, 1995; Graziano & Diament, 1992). During the last few decades there has been a strong movement toward treating these types of disruptive child behavior problems through interventions that incorporate parents or are focused on enhancing parenting skills (Bourke & Nielsen, 1995; Graziano & Diament, 1992). This movement toward

using parenting interventions to address disruptive child behavior problems has gained widespread acceptance (Kazdin, 2003). A recent meta-analysis of parenting interventions found that interventions with the largest effects focused on increasing positive parent-child interactions and emotional communication skills, teaching parents to use time-out and the importance of parenting consistency, and requiring parents to practice new skills with their children during parent training session (Kaminski, Valle, Filene, & Boyle, 2008).

As previously mentioned, stress and trauma have a drastic negative impact on youth. In complex ways yet to be understood, the numerous stresses and trauma youth actually do experience are linked to the alarming rise in at-risk behavioral difficulties many youth display (Gottlieb et al, 2010; Kim, Conger, Elder, & Lorenz, 2003; Raghavan & Kingston, 2006; Wilburn & Smith, 2005).

Since the 1980's, there has been a growing interest in the study and understanding of internalizing disorders among children and adolescents (Reynolds, 2001, p. 4). Internalizing problems such as in depressive and anxiety disorders are indeed major symptoms in which the distress is experienced subjectively. These symptoms may include feelings of misery, loneliness, and intense worry which are experienced as inner feelings and sources of distress for the youth or adolescent. In general, externalizing problems also tend to cause distress to others, such as parents, teachers, and peers, whereas internalizing symptoms are experienced internally and cause distress for the adolescent (Angold et al., 1999; Kim et al, 2003; Costello et al, 2003).

Unlike externalizing disorders and problems that are characterized by obvious behavioral expression, internalizing disorders are for the most part covert, and present a major challenge in their evaluation and identification. Internalizing adjustment problems and disorders typically are distressful to the adolescent and are less likely to come to the attention of significant others. The

severity of internalizing disorders is in large part a function of the adolescent's perceived subjective experience. For example, depression and anxiety in adolescents are to a large degree the subjective misery experienced by the individual, with many symptoms such as excessive worry, difficulty concentrating, insomnia, dysphoric mood, tension, feelings of fatigue, and other characteristics that are internal to the adolescent (Reynolds, 2001, p. 37; Chew et al, 2003). Internalizing disorders and problems, because of their less than observable symptoms, are often difficult for parents and teachers to accurately identify in adolescents. This is made even more difficult with limited contact between parents and their children.

The dimensions of internalizing and externalizing mental health disorders is a useful framework for understanding mental health symptoms, but adolescent psychopathology and adjustment do not fit precisely into this dichotomous perspective (Merikangas et al., 2010; Kee Jeong, K., 2012). In some cases, there is a blend of symptoms that may be viewed as externalizing which are included within diagnostic criteria for internalizing disorders such as Major Depressive Disorder. For example the symptom of depressed mood is expressed internally, but for some adolescents, this symptom may be replaced by irritability, and behavioral problems. For these reasons, it is good to consider the poles of internalizing and externalizing as broad domains of adjustment problems and youth psychopathology.

## Anxiety Disorders in Youth

Anxiety disorders tend to have negative long-term effects on emotional and social development if left untreated. The harmful effects of anxiety disorders in youth is associated with poor scholastic achievement, lower levels of social supports, low levels of employment, substance use, and high comorbidity with other mental health disorders (Velting, Setzer, & Albano, 2004). Furthermore, evidence indicates that these disorders reveal a continual

recurrence, often leading into adulthood (Rapee & Barlow, 1993). Even with these circumstances, only a small percentage of children with anxiety disorders are treated. Because of the hidden nature of these symptoms, there are few treatment providers who are skilled enough to make out these symptoms, and present effective treatment for these children. (Gosch, Schroeder, Mauro, & Compton, 2006).

Unfortunately, some of the most frequent psychological difficulties experienced by children and adolescents are anxiety disorders, with these disorders often persisting into late adolescence and adulthood if effective treatment is not received (Taquechel & Ollendick, 2007). Anxiety disorders can frequently have negative effects on a child or adolescent's home or school functioning with consequences on the child's development. (Reinblatt & Riddle, 2007). Anxiety during childhood also is likely to raise the risk for other mental health disorders such as depression and anxiety in early adulthood, as well as the risk of self-harm and psychiatric hospitalizations (Reinblatt & Riddle, 2007).

There is a range of risk factors believed to play a role in the etiology and development of anxiety disorders in children. These risk factors can be a result of internal factors, physiological imbalances, and childhood circumstances. (Bourne, 2005, p. 19; Davis et al., 2000). Internal factors that influence anxiety in children include heredity and biological factors (Bourne, 2005). Children who are brought up with at least one agoraphobic parent is likely to develop symptoms of agoraphobia themselves through an estimation of about 15 to 25 percent, whereas is it estimated that 5 percent of the general population has agoraphobia. (Bourne, 2005, p. 22). Because of this, it can be argued that children learn to have agoraphobic symptoms from their caregivers, although this information in itself doesn't prove that agoraphobia is inherited. (Bourne, 2005, p. 23). More convincing information comes from studies of identical twins, as

their genetic make-up is exactly the same. If one identical twin has an anxiety disorder, the likelihood of the other twin having an anxiety disorder varies from 31 to 88 percent, depending on which study you are investigating. (Bourne, 2005, p. 24).

Many external factors can influence the development of anxiety in children as well. Studies have revealed that separation anxiety disorder in childhood commonly precede panic attacks and agoraphobia in adulthood (Bourne, 2005; Davis et al., 2000). Separation anxiety disorder is a condition that occurs often when children are separated from their parents, such as when they leave for school or even before going to bed, children many times experience panic attacks and other somatic symptoms of anxiety. These children later on as adults often experience anxiety when separated from a "safe" person or place. (Bourne, 2005, p. 28).

Children brought up in a family where substance abuse is present, is also a common contributing factor to anxiety. As explained by Bourne (2005), adult children of alcoholics grow up with characteristics such as being obsessed with control, avoiding their feelings, trouble trusting others, over-responsibility, all or nothing ideas, and excessive eagerness to please at the cost of their own needs (Bourne, 2005, p. 23-25). Many people who exhibit anxiety disorders have a deep-seated sense of insecurity, which is a major theme seen in the background of adult children of alcoholics, and other types of abuse. What will determine whether children later develop a specific type of anxiety disorder, or an addictive personality type, or some other behavioral disorder, is the level of insecurity and the way children respond and adapt to it. A common setting for agoraphobia to develop is when children act in response to insecurity with excessive dependency. This sets the stage for overreliance on a safe person or safe place later in life. (Bourne, 2005, p. 28).

A child's reactions to anxiety has a strong influence in their sense of self-efficacy and belief that they can cope effectively with a feared object or event, which is highlighted by Albert Bandura's social learning theory (Bandura, 1977). A child's sense of self-efficacy concerning a situation can come from other's verbal persuasion, personal encounters with the situation, explicit encounters with the situation, and bodily arousal experiences in the situation (Bandura, 1977).

According to social learning theory, people learn by direct experience and observation. By observing reactions to anxiety being modeled by significant others, children can learn to react to their anxiety in those ways. There is a buildup in evidence that suggests children tend to learn fear responses by observing the responses in others. Children may doubt their own abilities or overestimate the possibility of a threat by seeing caregivers or role models including parents, siblings, peers, and those in the media, responding to threats in similar ways. (Bandura, 1977; Rachman, 1977; Gosch, Schroeder, Mauro, & Compton, 2006)

Bourne (2005) also suggests that parents who suppress the expressions of feelings and self-assertiveness in children may lead to the development of anxiety disorders. Parents may suppress children's innate ability to communicate their feelings and express themselves. For instance, a child speaking up, acting on impulse, or getting angry may have been constantly reprimanded or punished (Bourne, 2005). As a result of this, children grow up exhibiting a restrictive attitude toward their own expression of behaviors and emotions. Sudden recurrences of anxiety and panic may be produced if these behaviors and emotions are suppressed over a long period of time.

As children learn to suppress their feelings, they are more likely to be anxious and unable to express themselves as adults. Children who often suppress their feelings can lead themselves

to develop depressive symptoms later on. Children who express their feelings learn to become more assertive which leads them to very beneficial results. (Bourne, 2005, p. 30).Trauma is a major trigger leading to the development of an anxiety disorder such as Post Traumatic Stress Disorder. Trauma can occur through a variety of factors. These factors can include physical, emotional, and sexual abuse, relationship loss, neglect, abandonment, witnessing domestic and/or community violence, illness, separation, incarceration, and more (Bourne, 2005; Tapert et al. 2001; Kee Jeong, K., 2012).

Treatment approaches for children with anxiety disorders have been greatly influenced by the development of respondent conditioning theories and other behavioral perspectives (Watson & Rayner, 1920; Wolpe & Lazarus, 1966). Watson and Rayner (1920) explain classical conditioning on humans in the little Albert experiment (Watson & Rayner, 1920). An unconditioned stimulus (UCS, e.g., loud noise) leads to an unconditioned response (UCR, e.g., crying). The unconditioned stimulus (UCS) becomes associated with a conditioned stimulus (CS, e.g., rat). When the conditioned stimulus (CS) is presented to little Albert, a conditioned response (CR, e.g., crying) is elicited through this association. (Watson & Rayner, 1920).

Somatic sensations such as rapid heartbeat and other internal cues have also come to be identified as potential conditioned stimuli. This model on somatic sensations and internal cues is currently seen as being insufficient to fully explain the etiology of anxiety disorders, partly because many fears are not easily explained through classical conditioning reactions (Menzies & Clarke, 1995), but also because of questions on whether conditioning depends more on the UCS or the UCR. (Gosch, Schroeder, Mauro, & Compton, 2006). This is to mean that if the UCS occurs alone and without a UCR, then no fear conditioning will take place. Although, as seen in panic attacks, if the unconditioned response (e.g., somatic sensations) is of sufficient intensity

and occurs alone, then fear conditioning can be provoked in the absence of an identified UCS (Forsyth & Eifert, 1998). Because the influences of conditioning stimuli and other causes of anxiety disorders are debatable, many theories stimulated the development of exposure techniques that are an essential for treating children with anxiety disorders (Barrios & O'Dell, 1998; Gosch, Schroeder, Mauro, & Compton, 2006).

## Mood Disorders in Youth

Throughout history, teen depression has been seen as a symptom of other problems such as anxiety, irritability, mood swings, somatic complaints, substance use, and poor school performance (Kee Jeong, K., 2012). As previously mentioned, these symptoms were often considered as part of "adolescent turmoil" being a normal, understandable, and even expected phenomenon (Kee Jeong, K., 2012). For an extensive period of time, this viewpoint concealed depression and other internalizing problems among youth and made it extremely difficult to identify and diagnose youth depression. More recently, however, Mood Disorders have been reported as one of the more common psychiatric disorders among children and adolescents (Merikangas et al., 2010; Kee Jeong, K., 2012). Seeing the growing concern for youth depression and its likely harmful impact on various scopes of adolescent functioning, it is very important for youth, parents, educators, mental health and human service professionals, and other youth workers to better understand and recognize these issues early for the progression of treatment, and prognosis of youth depression (Kee Jeong, K., 2012).

Over the past several decades, Mood Disorders have become more commonly recognized as mental disorders in America within the field of psychiatric epidemiology (Kee Jeong, K., 2012). Approximately 20.9 million American adults ages 18 and older have a mood disorder in a given year (Kessler et al., 2005). Mood Disorders are the third most common mental disorders,

affecting 14.3% of U.S. adolescents between the ages of 13 and 18, following anxiety disorders and behavior disorders (Kessler et al., 2005; Merikangas et al., 2010). Depression is currently classified as one of the diagnostic categories of Mood Disorders. Mood Disorders are a set of diagnoses that involve a disabling disturbance in mood as a predominant feature (American Psychiatric Association, DSM-IV-TR, 2000). As a result, Mood Disorders are often called Affective Disorders because they refer to emotions, moods, and feelings. There are two broad categories of Mood Disorders: Unipolar Disorders and Bipolar Disorders (DSM-IV-TR, 2000). People with Unipolar Disorders feel only one end of the emotion spectrum (e.g., a state of intense sadness). In contrast, individuals having Bipolar Disorders experience alternating cycles between both ends of the emotion spectrum (e.g., a state of extreme sadness and a state of abnormally elevated mood) (Kee Jeong, K., 2012).

There are other specific types of mood disorders that are neither Unipolar nor Bipolar Disorders. An example would be a Substance-Induced Mood Disorder that is either a unipolar or bipolar depressive illness and is generally present during intoxication from a substance and/or withdrawal from it (DSM-IV-TR, 2000). Another example is Mood Disorder due to a General Medical Condition where medical challenges such as cancer, chronic infections, and other physical illnesses can lead to depressive symptoms. Although their depressive symptoms might appear to be similar to those of MDD, their mood disorder is distinguished from MDD if the mood disorder originates from physiological responses to the medical condition and not just by emotional or psychological responses (DSM-IV-TR, 2000; Kee Jeong, K., 2012).

A far reaching question is “why do some youth have depression while others do not?” There are a number of predictors of depression, such as genetic factors, the family environment, and psychosocial characteristics have all been identified (Merikangas et al., 2010; Kee Jeong, K.,

2012). Twin studies, as well as adoption studies, have examined the degree to which genetic and environmental factors lead to variations in depressive symptoms within families. A twin study by Glowinski et al., (2003) of adolescent MDD and several twin studies of adolescent depressive symptoms reported a consistent evidence for heritability (Glowinski et al., 2003; Rice, 2010). However, the heritability estimate for adolescent depressive symptoms was smaller than the one for adolescent MDD (Rice, 2010). This suggests that genetic factors have a greater influence on diagnosable depression; whereas shared environmental circumstances have a stronger impact on depressed moods and feelings (Glowinski et al., 2003; Rice, 2010). In contrast, adoption studies have not found robust evidence for genetic influences on the transmission of depression from parents to their adolescent offspring (Rice, 2010; Kee Jeong, K., 2012). Parental depression was a risk factor for adolescent MDD in both adopted and biological children, which suggests that parental depression can have both genetic and environmental influences in youth depression (Tully, Iacono, & McGue, 2008; Kee Jeong, K., 2012).

From a genetic influence perspective, one could suggest that children of a depressed parent could become depressed because of the inheritance of genes involved in depression (e.g., 5-HTT) (Kee Jeong, K., 2012). From a family environmental influence perspective, others may suggest that children of depressed parents miss out on opportunities to develop competent psychosocial skills and instead, become prone to emotional and behavioral problems. Goodman & Gotlib, (2002) state that by youth observing their depressed parent(s), youth begin adopting dominant features of depression such as social withdrawal and the expression of negative emotions, even though the children themselves are not depressed (Goodman & Gotlib, 2002). Depression in parents can interfere with competent parenting practices in several ways. Some depressed mothers withdraw from interacting with their children while others become overly

harsh and intrusive (Merikangas et al., 2010; Kee Jeong, K., 2012). Researchers suggests that the disturbance in the relationship between a depressed mother and her child may not predict mental health problems in youth, but that the relationship may lead to a vulnerability of depression in children with depressed mothers (Goodman & Gotlib, 2002).

Furthermore, researchers have revealed associations between an increase in the number of stressful life events that youth experience to that of increases in depressive symptoms even after controlling for prior symptoms (Kim, Conger, Elder, & Lorenz, 2003). In addition, a marital relationship under financial hardship is likely to have conflict, and marital discord is one of the clearly identified predictors of offspring's depression (Merikangas et al., 2010; Kee Jeong, K., 2012). Marital tension and harsh marital dynamics are frequently correlated with domestic violence, which in turn, increases the level of anxiety and depression among youth who directly observe the conflict within the family (Merikangas et al., 2010; Kee Jeong, K., 2012).

Cognitive theorists of depression suggest that an organized pattern of thoughts and behaviors shared by depressed individuals includes themes of failure, worthlessness, hopelessness, and loss (Gotlib & Joormann, 2010). As a result, youth with depression develop a systematic and lasting bias in their interpretation of stressful and negative life events and view these events as uncontrollable, fatalistic, and unpredictable. Cognitive theorists imply that this bias makes depression a highly recurring disorder (Gotlib & Joormann, 2010).

These theorists suggests that current symptoms of depression can be improved by treatment, however a lasting bias within the individual can lead to a dysfunctional interpretation of events upon having another life stressor in the future. The sense of being unable to control life circumstances leads to recurring depressive symptoms (Gotlib & Joormann, 2010). These cognitive interpretations further reinforce depressive symptoms within individuals and their

negative beliefs about who they are. The distorted cognitive attribution also hinders the development of coping strategies.

### Other Risk Behaviors and Clinically Relevant Psychological Symptoms in Youth

The number of children and adolescents who engage in behaviors (e.g., unprotected sex, substance use and abuse, abnormal eating patterns, suicide attempts) and are exposed to environmental factors (e.g., abuse, violence, homelessness) that place them at risk for adverse mental and physical health consequences is increasing at alarming rates (Hovell, Blumberg, Liles, Powell, & Morrison, 2001). Researchers have noted a high correlation between various types of delinquent or problem behaviors. Sexual risk factors are also common among youth who are at-risk for other factors such as poor health, homelessness, and mental health conditions. This means that adolescents who engage in one type of problem behavior are likely to engage in others as well (Ellis & Sowers, 2001).

A number of studies have examined high-risk sexual behavior and substance use or abuse among youth. A study by Wilson et al. (2010) found that a majority of youth engages in risky sexual behavior. The results of their study also indicated that transgender female youths were less likely to use condoms during receptive anal intercourse with their main partner and were less likely to use condoms with a main partner while under the influence of substances. These results suggest that youth are increasingly becoming at-risk for multiple factors that include sexual risk behaviors and substance abuse.

In a study conducted by Tapert, Aarons, Sedler, and Brown (2001), assessments of sexual behaviors and substance involvement (78% white, 51% female) were collected at 2, 4, and 6 years after initial assessments, as participants transitioned from middle adolescence to young adulthood (from age 15.5 to age. 21.5 years, on average). The conclusion of their study indicated

that youth identified with substance problems are more likely to engage in risky sexual behaviors during adolescence and to continue risky sexual behaviors to the extent that substance problems persist (Tapert et al.. 2001). Sexual risk factors are also common among youth who are at-risk for other factors such as poor health, homelessness, and mental health conditions.

Furthermore, a study done by Winters, Botzet, Fahnhorst, Baumel and Lee (2009) examined a mediational model of the inter-relationship of drug use, sexual risk and impulsivity in a sample of young adults (N = 89), of which almost half displayed disruptive behaviors as children. According to Winters et al. (2009) primary factors that increase the risk for risky sexual behaviors include early sexual involvement and unsafe sex (i.e. multiple partners, unprotected intercourse, and sex with high risk partners). The researchers also reported that when faced with risk-taking opportunities, such as sexual activity and drug use, which likely provided a type of emotional and behavioral reinforcement, individuals with dysregulated systems are more likely to surrender to the urge to engage in the risky behavior.

In the following studies researchers continue to highlight the use and abuse of substances in connection with homelessness, abuse, and violence. A similar study done by Corlis et al. (2011) focused on comparing the prevalence of current homelessness among adolescents reporting a minority sexual orientation (lesbian/gay, bisexual, unsure, or heterosexual with same-sex sexual partners) with exclusively heterosexual adolescents. Researchers found that sexual-minority males and females were 4 and 13 times more likely to report current homelessness than their exclusively heterosexual peers. Sexual-minority youths' greater likelihood of being homeless was driven by their increased risk of living separately from their parents or guardians (Corlis et al, 2011).

According to the National Network of runaway and Youth Services, six percent of homeless youth are gay, lesbian, bisexual, or transgender (Molino, 2007). Many homeless youth leave home after years of physical and sexual abuse, strained relationships, addiction of a family member, and parental neglect (National Coalition for the Homeless, 2007). In another study, 46% of runaway and homeless youth had been physically abused and 17% were forced into unwanted sexual activity by a family or household member (U.S. Department of Health and Human Services (1997). Homeless adolescents often suffer from severe anxiety and depression, poor health and nutrition, and low self-esteem. In one study, the rates of major depression, conduct disorder, and post-traumatic stress syndrome were found to be 3 times as high among runaway youth as among youth who have not run away (Robertson, 1996).

Throughout our communities, there is a great number of youth who exhibit clinically relevant psychological symptoms, and at-risk behaviors. Some of these psychological symptoms include somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism, and many others (Jaser et al., 2009; Chew et. al., 2010; Derogatis, 1975).

Vazsonyi et al. (2010) examined to what extent entry risk into juvenile justice varies across ethnic/racial groups, and to what extent childhood aggressive behaviors predicted later deviance and entry risk into the juvenile justice system. Aggressive behaviors were rated by teachers during elementary school, and entry risk into juvenile justice was measured by official data, while SES was based on census data. The researchers implemented a survival analysis on a representative sample of youth followed from age 8 to 18 years. Vazsonyi et al's. (2010) sample included N=2,754 lower to lower-middle SES youth from five different ethnic/racial groups (African American, American Indian, Asian American, European American, and Hispanic

youth). “Developmental entry risk into the juvenile justice system peaked at age 14 and subsequently declined. No differences were found across the four racial groups; however, Hispanic youth were at elevated risk (by 73%)” (Vazsonyi & Chen, 2010). “Only childhood physical aggressive behavior increased entry risk (by 87%); this was above and beyond a "simple" maturational liability found and noet any effects by sex, race/ethnicity, and SES.” (Vazsonyi & Chen, 2010).

Accordingly, a study looking at the relationship between developmental assets and the likelihood of a young person engaging in health-risk behaviors was done by Chew et al (2009). Participants in this study were adjudicated youth who had voluntarily taken the Developmental Assets Profile (DAP) instrument. These participants reported lacking risk-protective factors in the internal and social context areas (Chew, Osseck, Raygor, Eldridge-Houser, & Cox, 2010).

The results from this study reflected a lack of community involvement in the social context area, and participants reported an over involvement with negative influences in the internal context areas. Primarily in the internal and external context areas, most respondents reported having more trouble with substance abuse, and not having positive peer influence or parental support (Chew et al., 2010). In the social context area, these youth noted that they wanted to do well in activities where they had been encouraged to do well, yet these youth scored low for service to others and involvement in religious groups (Chew et al., 2010). The results of this study suggest that youth who lack protective qualities, such as those youth who do not feel committed to their community, are more likely to engage in substance abuse and risky behaviors. Youth who are more active in the community can move in a direction away from at-risk factors such as negative peer influence and juvenile justice involvement.

In addition, a study focusing on exploring the relationship between youth assets and sexual risk behavior, Oman et al. (2005) conducted in-home interviews to collect data from 1,253 inner-city teenagers and their parents. Multivariate logistic regressions were conducted separately for youth from one- and two-parent households to assess relationships between youth assets and four behaviors related to sexual risk: "never having had sexual intercourse, not being currently sexually active, having delayed intercourse until age 17 and having used birth control at last intercourse" (Oman et al., 2005). The researchers found that among youth living in one-parent households, those with the aspirations for the future, good health practices (exercise/nutrition), peer role models and family communication assets had significantly elevated odds of reporting one or more of the behaviors examined to overcome sexual risk factors (Oman et al., 2005). Further research regarding mental health practitioners' perceptions of how youth assets assist in overcoming sexual and other at-risk behaviors may provide additional awareness.

Another study done by Jaser et al. (2009) examined the relationships between depressive symptoms, clinical risk factors, and health behaviors and attitudes in a sample of urban youth at risk for type 2 diabetes mellitus. A self-report questionnaire obtained data from participants on depressive symptoms and health attitudes and behaviors related to diet and exercise, and clinical data on risk indicators (eg, fasting insulin) from 198 youth from an urban setting (Jaser, Holl, Jefferson, & Grey, 2009). Clinically significant levels of depressive symptoms were reported in roughly 21% of the sample, and higher levels of depressive symptoms were revealed in Hispanic youth than had been reported in black youth. Higher levels of depressive symptoms were related to several health behaviors and attitudes, and especially from less perceived support for physical activity and poorer self-efficacy for diet (Jaser et al., 2009). Depressive symptoms also had been associated with some clinical risk indicators, such as higher BMI and levels of fasting insulin

(Jaser et al., 2009). These results suggest that depressive symptoms have an impact on the ability for youth to engage in healthy behavior changes.

Furthermore, a study done by Busen et al. (2008) explored a group of homeless youth and adolescents who utilized a mobile unit that delivered medical and mental healthcare services and also used to assess the effectiveness of the services being provided for reducing the health risk behaviors of youth. Nearly one third of these participants were high school graduates and most had been without health insurance (Busen & Engebretson, 2008).

The results of their study revealed that living situations were transitory including moving around with friends, moving from shelters, crash pads, or the streets (Busen & Engebretson, 2008). Abuse was identified for the majority of youth leaving home. It was common for youth to have psychiatric and substance abuse conditions, as well as medical conditions that were related to transitory living situations, substance abuse, and sexual activity (Busen & Engebretson, 2008). Successful completion of the program was attributed to sustained counseling, stabilizing youth on psychotropic medications, reducing substance use, providing immunizations and birth control, and treatment of medical conditions (Busen & Engebretson, 2008).

Particularly within the juvenile justice system, clinically relevant psychological symptoms are often minimally recognized as a discrete issue warranting special attention and concentrated intervention. Very few studies have looked at the ameliorating aspects of stress management for incarcerated youth. Although previous research has focused on the implementation of counseling techniques to help youth overcome mental health issues such as depression, anxiety, and behavioral problems (Jaser, Holl, Jefferson, & Grey, 2009), there has remained a scarceness of literature on the effectiveness of counseling interventions, particularly

the use of narrative therapy, to help youth overcome clinically relevant psychological symptoms and at-risk factors while serving time at a juvenile boot-camp facility.

## Protective Factors

Although several risk factors predicting youth having psychological symptoms have been identified, relatively few research studies have determined which specific factors help youth become resilient to the adverse family and social circumstances which lead to mental health problems. Although scarce, there is promising research findings that show resilient adolescents having demonstrated the ability to think and act independently from their parents, to make deep commitments to relationships, and to attribute life events to internal causes rather than external causes such as luck and fate (Goodman & Gotlib, 2002). In addition, resilient youth have developed cognitive and social skills leading them to have an optimistic thinking style, and a positive outlook on life. Parental support has a shielding effect on the relationship between a pessimistic attribution style and depressive symptoms of youth. Despite the high level of stress that youth experience, a high level of parental support can protect youth from increasing depressive symptoms (Kim et al., 2003). If parents do not provide youth with a nurturing and supportive family environment, other adults such as grandparents, godparents, mentors, teachers, and youth workers could provide the support necessary to buffer adolescents from the harmful effects of unhealthy home environments (Reynolds, 2001; Kim et al., 2003).

## Treatment for Youth and Adolescents

The primary treatment approach used by mental health counselors in community agencies across the state of Texas to treat numerous mental health issues among youth is Cognitive Behavioral Therapy (Clark et al., 2002; Sanborn, 2011). These clients work with their counselor often times using a structured cognitive behavioral therapy curriculum. For example, in the

treatment of depression for adolescents using the STEADY curriculum (Clark et al., 2002), youth are first introduced to concepts regarding a downward spiral educating them on how events and beliefs about their situations can lead them to spiral downward towards further depressive symptoms. Youth will then have the choice of starting with one of two skills approaches to change the downward spiral of their depressive symptoms to an upward one. Youth can work on changing actions or behaviors by increasing pleasant activities; doing more fun things. This involves making a plan, and choosing fun things to do that are realistic that they can do often, and can afford. Examples of these approaches will be provided to clients in a workbook. The youth could also choose to work on changing thoughts by learning skills to uncover and stop negative or unrealistic thinking, and to increase realistic and positive thinking. Examples of these concepts are usually provided in a workbook for them. Doing either one of these two approaches will help them change their mood or feelings. The youth will keep track of their mood using the mood and activity diary, tracking the relationship between their level of mood, and the number of fun social and success activities they engage in daily. These youth will identify changes in their mood related to their activity level.

Clients using the STEADY CBT curriculum will later progress through the thoughts modules being introduced to the personality triangle emphasizing the relationship between our thoughts, feelings, and behaviors, and how each of these characteristics impacts the other. Clients will then be introduced to concepts of the A-B-C model identifying situations in which they develops negative beliefs, and will learn to challenge these negative beliefs by exploring evidence against these beliefs, and exploring alternatives to more reasonable beliefs for these situations. Other techniques in the thoughts module that clients will practice will include thought stopping techniques, and rapid fire techniques practicing in arguing against negative thoughts.

Clients using the CBT STEADY curriculum will also keep track of their mood during their course through the thoughts module by filling out a weekly thought log keeping track of their mood and affect (Clark et al., 2002).

Other clinical interventions are used for treating different symptoms and needs. An intervention aimed in treating substance abuse was studied by Slesnick & Prestopnik (2009), who explored 119 adolescents and their primary caregivers with drug and alcohol problems from two runaway shelters. The researchers assigned the families to either an office-based functional family therapy (FFT) treatment, a home-based ecologically based family therapy (EBFT), or service as usual (SAU) through the shelter (Slesnick & Prestopnik 2009). This study revealed how youths living in the streets avoid going to shelters and having contact with any treatment system, while also dissolving ties with their families. Most youth return home after staying in a shelter, go back to less severe family and individual problems than do youths who are staying out in the streets. Limited treatments are available to practitioners who work with homeless and runaway youth. The article revealed more on the range of problems these youths face, due to the lack of treatment approaches available to help them and their families.

According to Slesnick & Prestopnik (2009) hypotheses, they expected that home-based EBFT and office-based FFT would show significantly greater adolescent improvement in substance use and psychological and family functioning compared with SAU (Slesnick & Prestopnik 2009). They derived these hypotheses through existing research suggesting that active and direct involvement within the patterns impacting family members may be particularly important for youths with multiple problems (Slesnick & Prestopnik 2009). All members of the project were brought into the study through one of two runaway shelters in Albuquerque, New Mexico. The adolescent had to have a primary alcohol problem such as alcohol dependence and

marijuana abuse but alcohol being the primary problem, and be between the ages of 12 and 17 to be eligible for the program.

The goal of the office-based therapy FFT is to alter dysfunctional family patterns that contribute to alcohol abuse, running away, and related problem behaviors (Slesnick & Prestopnik 2009). Ecologically based family therapy EBFT started in several states in the 1980s, and is based upon the Homebuilders Family Preservation model (Slesnick & Prestopnik 2009). Treatment is provided in the family's home or wherever the youth might be located such as a foster home or a shelter. Service as usual SAU consisted mostly of services arranged and provided by shelter staff. Shelter staff mainly provided crisis intervention and assisted youths with placement. A counselor was also available to meet with youths who asked for assistance. Average age of youth was 15.1 years, and the sample included 65 (55%) females and 54 (45%) males (Slesnick & Prestopnik 2009).

From the comparisons among FFT, EBFT, and SAU treatment, differences in results were only found for delinquency from several assessments, with the SAU group reporting higher scores than either FFT or EBFT (Slesnick & Prestopnik, 2009). No differences were found for any of the other main variables measured. The findings along with other research, suggest that family therapy has a strong effect on reducing drug and alcohol use, compared with services provided through the community. All three conditions showed improvements across areas of family functioning, which includes verbal aggression, family cohesion, conflict, and psychological functioning through psychiatric diagnoses, externalizing problems, delinquent behaviors, days living at home, and substance use through the number of substance use diagnoses, and number of problem consequences (Slesnick & Prestopnik, 2009).

Results showed that both home-based EBFT and office-based FFT significantly reduced alcohol and drug use compared with SAU at 15-month post-baseline (Slesnick & Prestopnik, 2009). Measures of family and adolescent functioning improved over time in all groups. All treatment groups showed improved adolescent and family functioning. There were significant differences among the home and office-based interventions found for treatment engagement and moderators of outcome, with the home-based EBFT treatment showing greater efficacy (Slesnick & Prestopnik, 2009).

A meta-analysis done by Erford et al. (2011) examined clinical trials exploring the effectiveness of counseling and psychotherapy in treatment of depression in school-age youth. The definition of counseling or psychotherapy for depression used in this meta-analysis was any treatment or intervention aimed of the alleviation of depressive symptoms or disorders provided by a mental health professional or professional-in-training (Erford et al., 2011). The results were synthesized using a random effects model for mean difference and mean gain effect size estimates. No effects of moderating variables were evident (Erford et al., 2011).

The findings of this meta-analysis of 42 clinical trials suggest that counseling and psychotherapy are effective in the treatment depression in school-age children and adolescents at the termination of treatment (Erford et al, 2011) The effect sizes, derived using a random effects model on studies published between 1990 and 2008, were small to medium-sized. The results of this meta-analysis were consistent with the results of Weisz, McCarty, and Valed's (2006) meta-analysis of 35 studies of psychotherapy for depression treatment in youth, which reported a d+ of .34 using the random effects model, also a small to moderate effect (Erford et al., 2011).

A study by Weisz, Jensen-Doss, & Hawley (2007) assessed the efficacy of evidenced-based treatments for youth compared to usual care treatments. This study was a quantitative

review of published studies and unpublished dissertations in which youths aged 3-18 years were randomly assigned to evidenced-based treatments (EBTs) or usual care (UC) treatment condition to address psychological problems or maladaptive behavior (Weisz et al, 2007). The search period ranged from 1965 to 2004. The target problems were delinquency and/or substance abuse, conduct problems, depression, and anxiety. Results indicated that EBT outcomes were superior to UC outcomes, with an overall average medium effect size (ES) (Weisz et al, 2007). Subsequent analyses explored potential moderators of the effect size, including treatment, therapist, sample, and study design characteristics; none were significant moderators. These results do not support the claim that EBTs are less effective than UC for youths with severe pathology or for minority youths (Weisz et al, 2007). In fact, results showed that to provide best practice, practitioners should move toward the implementation of EBTs with their patients (Weisz et al, 2007). Individual ESs favored multisystemic therapy for the treatment of delinquency and training in problem-solving skills, parent management, and cognitive self-instruction for conduct problems. A combination of motivational interviewing and UC treatment for substance abuse showed better results than UC alone (Weisz et al, 2007).

## Youth in the Texas Juvenile Justice System

For too many young people in the state of Texas, their childhood intersects with the juvenile justice system. Because of the many social challenges that our youth experience, further evaluation and improvement of the juvenile justice system is necessary. Texas leads the nation in uninsured children, and we have one of the largest population of youth living in poverty (Sanborn, 2011). This has only grown by the various challenges with our economy. Additional factors to ongoing poverty and inadequate health and mental health care that impacts our

children include gaps in early development, reduced educational opportunities, neglect, and chronic physical, sexual, and emotional abuse (Sanborn, 2011).

Preventing mental, emotional, and behavioral disorders is very important. In general, one in five young people deal with mental health disorder at any given time, and multiple reports indicate that more than fifty to seventy percent of young people in the Texas juvenile justice system have at least one mental health disorder (Sanborn, 2011). What is even more difficult is that the juvenile justice system is often the first place in which a youth is evaluated and diagnosed with a mental, emotional, or behavioral disorder. As of 2011, Texas has an overall population of more than twenty-five million people, and just fewer than seven million children. (Sanborn, 2011). Texas has also become a "majority minority" state as the Anglo population only accounts for 45.3% of the total population, and two-thirds of Texas youth are non-Anglo minorities (Sanborn, 2011).

Texas continues to become increasingly diverse, but unfortunately a disproportionate number of the population in the juvenile justice system is made up by the young future majority (Sanborn, 2011). A juvenile usually first encounters the juvenile justice system when they are arrested by an officer. Juvenile justice differs from the adult system in that a juvenile can be arrested for crimes that are considered "status offenses" such as truancy or curfew violations. These are crimes only because a juvenile has not reached the age of majority and the underlying act would not be criminal if the juvenile were an adult (Sanborn, 2011). Outside of status offenses, juveniles may face "referrals" (the juvenile justice term for charges) for nearly the entire array of adult offenses. Once referred for an offense, a juvenile is sent to juvenile court. These courts differ from the adult system in that they are considered civil, rather than criminal courts (Sanborn, 2011).

Before, during, and after adjudication, juveniles may encounter a variety of facilities in the juvenile justice system. Juvenile probation facilities in various counties house youth at a number of steps in the justice system, including some who have been recently arrested and are awaiting a visit to court. Secure state facilities house some of the juveniles who have been adjudicated delinquent of an offense. For most juveniles certified and referred to the adult system, many programs in various counties such as the Youthful Offender Program at the Clemins unit in Harris County will house them until they reach the age to be allowed into the general prison population.

Often times, as a result of recidivism and repeated offenses, a Judge may order a juvenile detainee to be sentenced to a term in a juvenile boot-camp facility. A juvenile boot-camp facility in a place where youth often times experience a tough military-style type of environment, often aimed at preventing youth from making poor decisions and to stop them from ending up in adult prison. Youth at the South Texas boot-camp facility in which the study was conducted are generally sentenced to a 9 month time span. The juvenile justice center's boot-camp facility has been designed to serve a maximum population of forty at-risk males and females between the ages of thirteen to seventeen years old. Each at-risk youth, adjudicated by a state district judge in the county, is offered a military structured program that addresses self-discipline, mental health issues, and educational needs. The boot-camp facility aims to empower every individual with values such as Honor, Courage, Integrity, and Commitment. In doing so, the boot-camp facility works to provide a disciplined structure, along with an educational setting in a secure environment (Sanborn, 2011). This is just a small sample of the total number of offerings comprising the juvenile justice system. A wide variety of programs exist to serve juveniles in different ways.

A study by Balkin (2011) assessed factors in adolescent adjustment as pre-cursors to recidivism in court referred youth. Participants in this study consisted of 178 adolescent youth who were court-referred to a community-based intervention program to participate in a group-based counseling program consisting of conflict resolution skills, group processing, anger management, and academic and career counseling (Balkin, 2011). At the beginning of the program, youth were administered the Reynolds Adolescent Adjustment Screening Inventory (RAASI) (Reynolds, 2001). The program lasted 7 weeks and included group counseling and modules related to academic and career guidance, anger management, and conflict resolution, as well as a family counseling component with additional individual and family counseling provided as determined by program staff (Balkin, 2011). During and after completion of the program, youth were tracked for re-offenses using court documentation for a period of 2 years. A MANOVA was conducted using an alpha level of .05 on RAASI subscales across two groups: adolescents who did not reoffend after court referral and adolescents who reoffended after court referral. A statistically significant difference between reoffending status was evident, Wilks's $\Lambda = .93$, $F(4, 173) = 3.18$, $p = .015$, indicative of a moderate effect size. Given the significance of the model, a discriminant analysis was conducted as a post hoc analysis for the MANOVA. The discriminant function was significant, Wilks's $\Lambda = .93$, $\chi^2(4) = 12.36$, $p = .015$ (Balkin, 2011).

Both antisocial behavior and anger control loaded strongly on the latent variable and indicated a moderate to high positive relationship with the discriminant function. Although positive self and emotional distress had weak loadings on the discriminant function, emotional distress did have a strong negative relationship with the discriminant function as noted by the standardized discriminant function correlation coefficients (-.61). Thus, emotional distress is likely a function of antisocial behavior and anger control and therefore provides redundant

information to the model (Balkin, 2011). Centroid means for the discriminant functions indicated that higher scores in antisocial behaviors and anger control and lower scores in emotional distress were notable among adolescents who reoffended (.36) than those who did not reoffend (-.20). As a result of this finding, the discriminant function was identified as conduct disorder proneness (Balkin, 2011).

## Assessment in the Juvenile Justice System

There are a variety of instruments and exams used by intake facilities in the juvenile justice system to determine whether or not a juvenile may require treatment for mental health issues. The Massachusetts Youth Screening Instrument Second-Version (MAYSI-2) is used by all juvenile detention centers under the Texas Juvenile Justice Department (TJJD) to screen youth for mental health disorders. The MAYSI was developed by Thomas Grisso, Ph.D., and Richard Barnum, M.D. A revised version the MAYSI-2 was released in early 2000.

In the Fall of 1997, the Florida Juvenile Justice Association received a federal grant from the US Department of Justice to develop improved assessment instruments. “A workgroup of DJJ staff, Department of Children and Families/ADM staff and provider staff was established. During their attempts to revise the instrument that had been used for years (SAMH-1), the workgroup became aware of the MAYSI.” (Florida Department of Juvenile Justice, 2002). In 2000, the Florida Department of Juvenile Justice (DJJ) began using the Massachusetts Youth Screening Instrument-2 (MAYSI-2) as a mental health and substance abuse screening tool for all youth entering the juvenile justice system. “It is a means of identifying signs of mental/emotional disturbance or distress, including suicide risk. The scores obtained on the MAYSI are used to assist in the decision of whether to refer a youth for an assessment or crisis intervention.” (Florida Department of Juvenile Justice, 2002).

The MAYSI-2 is a paper-and-pencil self-report inventory of 52 questions designed to assist juvenile justice facilities in identifying youths 12 to 17 years old who may have special mental health needs. “The Department of Juvenile Justice (DJJ) policy requires that the MAYSI be conducted during the detention screening and intake process for each youth.” (Florida Department of Juvenile Justice, 2002). The MAYSI-2 assessment takes about 10 minutes to administer, and about three minutes to score. The MAYSI-2 assessment is easy to administer and easy to score. The instructions are explained to the youth and the youth is left alone to circle his/her answers to the 52 items. You do not need to have a professional degree to administer the MAYSI-2. In some places, it is a person with a high-school diploma who is administering the MAYSI-2. It does not require that you be a clinician, but you should read the MAYSI-2 manual and if possible have a long-term MAYSI-2 user train you.

Scores on each scale are compared to cut-off scores; there is no “total score”. For each of the six main scales, the developers identified two types of cut-off scores were identified by the developers: “Caution cut-offs” and “Warning cut-offs”. (National Youth Screening Assistance Project (NYSAP), 2011). Youth who score above the Caution cut-off (called the assessment zone) are likely to have "clinically significant" needs and should be referred for a more in-depth assessment. A score within the assessment zone on any one of the scales triggers such a referral. (National Youth Screening Assistance Project (NYSAP), 2011). “The original cut-offs were determined by comparing each MAYSI-2 scale to scales on more comprehensive measures of child psychopathology that were administered to youths in the original MAYSI-2 study. Warning cut-offs are based on the highest 10% of scores of youths in the original study. These cut-offs identify a more serious level of need.” (Florida Department of Juvenile Justice, 2002). There are seven scales on the MAYSI-2 that assess for mental health and behavioral problems. The

Alcohol and Drug scale is an 8-item scale that is used to identify youths who are at risk of substance misuse or dependence with a cut-off score of four positive responses (Stathis et al., Aug2008). The 9-item Angry–Irritable scale with a cut-off of five positive responses identifies feelings of anger and vengefulness, as well as tension, frustration and irritability (Stathis et al., 2008). The 9-item Depressed–Anxious scale with a cut-off of three positive responses identifies symptoms of depression and anxiety, and a 6-item Somatic Complaints scale with a cut-off of three positive responses screens for somatic-related complaints (Stathis et al., 2008). The 5-item Suicide Ideation scale with a cut-off of two positive responses assesses thoughts and intentions about self-harm, as well as depressive symptoms that may present an increased risk for suicide (Stathis et al., 2008). A 5-item Thought Disturbance scale screens for perceptual distortions that are often associated with psychotic disorders (Stathis et al., 2008). The 4-item Thought Disturbance scale with a cut-off of one positive response is calculated for males only because of its psychometric properties and factor structure (Stathis et al., 2008). Finally, a 5-item gender-specific Traumatic Experience scale identifies young people who have been exposed to significant traumatic events (Stathis et al., 2008).

While it is hard seeing past the problematic behavior and offences committed by youth in detention, the MAYSI-2 assessment reveals the mental health needs of youth and adolescent populations. The MAYSI-2 assessment also assists mental health professionals in identifying areas of need when working with a youth population, and factors that may contribute to youth being high risk. This can allow for better approaches to implementing community outreach programs, and in educating mental health professionals for working with juvenile offenders.

## Treatment in the Juvenile Justice System

One treatment curriculum used with both adolescent and adult clients in assertive rehabilitative treatment programs as part of the Texas Department of Criminal Justice (TDCJ) and Texas Department of Criminal Justice (TJJD) program is the Thinking for a Change curriculum (T4C) (Thigpen et al, 2011). In 1998, the National Institute of Corrections produced the first version of Thinking for a Change (T4C). This program combined cognitive restructuring theory with cognitive skills theory to create an innovative and integrated curriculum designed to help individuals in the juvenile and adult justice systems take control of their lives by taking control of their thinking (Thigpen et al, 2011). Since its beginning, Thinking for a Change has gone through a number of revisions and has become the most requested document from the National Institute of Corrections Information Center. (Thigpen et al, 2011). Thinking for a Change has been studied for its efficacy numerous times, and has routinely proven to be effective in reducing recidivism and improving pro-social behavior. Each component is presented in a systematic, logical fashion using the standard procedures for cognitive behavioral interventions (Golden et al, 2006).

The three components of Thinking for a Change are: cognitive self-change, social skills, and problem solving skills. Cognitive self-change teaches individuals a concrete process for self-reflection aimed at uncovering antisocial thoughts, feelings, attitudes, and beliefs (Thigpen et al, 2011). Social skills instruction prepares group members to engage in pro-social interactions based on self-understanding and consideration of the impact of their actions on others (Thigpen et al, 2011). Problem solving skills integrates the two previous interventions to provide group members with an explicit step-by-step process for addressing challenging and stressful real life situations (Thigpen et al, 2011).

A study done by Lancaster, Balkin, Garcia, and Valarezo, (2010) examined an evidence-based approach to reducing recidivism in court-referred youth. The authors obtained recidivism data on a predominantly Latino/a sample of juvenile offenders within a 24-monfh period following their participation in a community-based psychoeducational counseling program emphasizing life skills development (Lancaster et al, 2010). The treatment group was compared with a sample of youth derived from the same database who had participated in community probationary programs. Youth in the treatment group had statistically significant less recidivism in a 24-monfh period subsequent to completing the program than did youth in the control group (Lancaster et al, 2010). Court-referred youth, primarily of Latino/a ethnicity, were significantly less likely to reoffend if provided counseling services (Lancaster et al, 2010). Three out of five court-referred youth did not reoffend when they received a community-based intervention, and the likelihood of maintaining progress after participating in a life skills group for 7 weeks increased if clients passed the 3-month threshold of not reoffending (Lancaster et al, 2010).

## Fundamental Principles of Narrative Therapy

Narrative therapy is a form of psychotherapy, pioneered in Australia and New Zealand in the 1980s by Michael White and David Epston. Narrative Therapy emphasizes the importance of story and language in the development and expression of interpersonal and intrapersonal problems (White, 2007). The basis of narrative therapy is social constructivism or the idea that the way people experience themselves and their situation is “constructed” through culturally mediated social interactions. (Shapiro & Ross, 2002). Through story and language, cultures send powerful messages to their members about the meaning of important concepts that sustain the culture, including gender, race, class, and health. (Shapiro & Ross, 2002). Narrative therapists

take an approach that explores a client's world, to help them change their life stories (White & Epston, 1990).

Narrative therapy is also a post-modern approach, which uses techniques to facilitate storytelling through defining the problem, mapping the effects of the problem, evaluating and justifying the effects of the problem, and identifying unique outcomes which eventually leads to the re-authoring of client's life stories. A narrative therapist takes an approach to working with clients by objectifying or externalizing the problem, which makes it possible for clients to experience an identity that is separate from the problem. The use of metaphors is also highly significant in the use of narrative practice because metaphors invoke specific understandings of life and identity (White, 2007). Re-authoring conversations is an aspect of narrative therapy that invites people to continue to develop and tell stories about their lives, but also to help people include some of the more neglected put potentially significant events and experiences that are out of phase with their dominant storylines (Shapiro & Ross, 2002). These events and experiences can be considered "unique outcomes" or "exceptions" to when the problem is not present. Given that youth are at-risk for an abundance of issues including juvenile justice involvement, sexual risk behaviors, substance abuse, mental health problems, physical health problems, academic problems, teen pregnancy, and many others, narrative techniques can be utilized to help youth not only identify challenges to their lives, but also to recognize times when they have overcome challenges and the coping strategies used in overcoming these obstacles so that youth can change these conversations they share about themselves into their preferred life stories.

## Research on the Use of Narrative Therapy

A series of reports have recognized the efficacy of narrative therapy (Anderson & Hiersteiner, 2008; Fraenkel, Hameline, & Shannon, 2009). A study done by Anderson and

Hiersteiner (2008), looked at interviews of twenty seven adult survivors of sexual abuse to provide opportunity for the facilitation of these survivor's shared stories and experiences. The following perspective was provided based on the stories shared from group interviews: "Recreating a life story that goes beyond recovery from childhood sexual abuse may assist an adult survivor to consider a future full of possibilities, including a story book ending" (Fraenkel et al., 2009). Fraenkel et al. (2009) also explored the effects of narrative therapy with homeless families. By externalizing conversations and identifying unique outcomes, these shared stories and experiences helped families strengthen their family identity, and help to keep a hold on hope for the future (Fraenkel et al., 2009). Narrative therapy also has been helpful in working with parents of lesbian, gay, and bi-sexual adolescents (Saltzburg, 2007), pre-graduate counselors (Whiting, 2007), and students who have learning disabilities (Lambie & Milsom, 2010). Narrative therapists have also been helpful in working with adolescents coping with personal and academic challenges.

A study done by Butler et al. (2009) revealed how puppets have been helpful in working with children to define and externalize problems. Using an example of a case illustration with an eight year child named Eric, the following techniques were used: defining the problem, mapping the effects of the problem, evaluating the problem, identifying unique outcomes, and re-authoring conversations (Butler et al., 2009). The therapist first started the session with the preliminary goal of working to identify the problem. The presenting problem was identified as "anger" following a shared discussion with Eric and his mother (Butler et al., 2009). Second, so that the therapist could help in mapping the effects of the problem, the therapist asked Eric to describe what occurs when "anger" shows up. At this moment, Eric revealed the occurrence of consequences and punishment at home and at school. Thirdly, the evaluation on the effects of the

problem involved a conversation about “annoyance” that got in the way of Eric engaging in leisure and recreational activities that he liked (Butler et al., 2009). Fourth, the therapist presented a puppet to help “externalize” the problem of anger from Eric to help him separate himself from the problem afflicting his behavior. Then afterward, the therapist asked Eric to identify unique outcomes or times when anger was not present.

A week before coming to session, Eric revealed how he had not been upset when a classmate of his had teased him by calling him names. Finally, Eric and his therapist explored ways in re-authoring his preferred life story by exploring positive factors in his life when anger was not present (Butler et al., 2009). From these aforementioned studies, narrative therapy appears to be helpful by working with people to externalize problems, identify unique outcomes, and in re-authoring their life stories.

**Externalizing, Identifying Unique Outcomes, and Re-authoring Conversations**

Narrative therapy involves working with people who are stuck in problem-saturated stories that they tell themselves, and that society has told them, about whom they are and what their lives signify. These stories have become “disabling” in the sense that the individuals feel they have lost control of their stories and are unable to change their meaning. A strategy a narrative therapist may first employ is deconstruction. Deconstruction involves taking stories apart so that the meaning behind the problem and the influence on the beliefs of the problematic aspects of the story emerge. By deconstructing the story, we can see what effects these hidden assumptions about the problem have in the client’s life. (Young, M.E. & Long, L.L. 2007). Narrative therapists encourage the use of client, rather than medical descriptions of the problem. When the client creates a personalized “working label” for his or her situation, they gain power and control.

Allowing the client to rename their own definition of a problem or situation during session can be empowering, and serves as the first stage of externalizing the problem. Many clients in session believe that the problems in their lives are a reflection of their own identity, a reflection of the identity of others, and a reflection of the identity of their relationships. This understanding can lead to efforts by inexperienced counselors to resolve client's problems, which may invariably exacerbate more problems. Clients can come to believe that their problems are internal to their self or the selves of others, or that they or others are in fact the problem. A major premise of narrative therapy is that the person is not the problem but the problem is the problem. "A narrative approach advocates externalizing the patient's problem by locating it outside the individual and within the culture. Through a series of questions, a client can begin to think of "not caring" not as some kind of personality flaw at the core of their being but as a problem that existed outside themselves and was created in part by societal expectations and pressures about gender roles" (Shapiro & Ross, 2002).

Externalizing conversations makes it possible for people to redefine their relationships with the problems of their lives. Externalizing conversations also redefines client's relationships with others in ways that acknowledge other people's voices in the development of their own sense of identity. Through externalizing these conversations, narrative therapists help find ways forward in situations that clients once believed were hopeless (White, 2007). Externalizing conversations has opened new possibilities for people to redefine their identities, and to experience their lives as new, so that they may pursue what is precious to them (White, 2007).

## Using Narrative Therapy with Youth

By utilizing a narrative therapy treatment approach, clinicians are able to pay attention in identifying unique outcomes to the problem saturated story of a client, and noting when the

externalized problem doesn't come around. Exploring times when there is an exception to the problem, and exploring in detail the significance of these moments works towards the client identifying a new preferred outcome (White, 2007). A narrative therapist uses curious questioning to help youth recognize and reflect on the discrepant but positive elements of their current problem saturated stories and to empower them to reformulate a more-preferred life direction. (Weingarten, 1998; White, 2007).

By exploring themes when externalized problems such as anxiety or other problems don't show up in the youth's life story, therapists can assist youth in becoming aware of alternatives to their problem saturated story. The narrative therapist can explore these hidden details in a youth's life that they may have not been previously aware of before. The building blocks for these youth's new story are found in the discovery of hopeful moments, thoughts, or events that do not fit with their problem story, which ultimately assists youth in re-authoring their preferred life narrative (White, 2007).

Although previous research has focused on the implementation of counseling techniques to help youth overcome mental health issues such as depression, anxiety, and behavioral problems (Jaser, Holl, Jefferson, & Grey, 2009), there has remained a dearth of literature on the effectiveness of counseling interventions, particularly the use of narrative therapy, to help youth overcome clinically relevant psychological symptoms and at-risk behaviors while serving time at a boot-camp facility. The purpose of this study was to bring forth the stories from youth, age 15-17, in a juvenile justice boot-camp facility. This study also hoped to gain an understanding on the psychological symptoms that youth experience, as well as, to examine the effectiveness of a narrative therapy counseling intervention for reducing clinically relevant psychological symptoms manifested by youth at a juvenile boot-camp facility.

# Chapter 3

## Method of Experimental Study

### Purpose of Experimental Study

This study brought forth the stories from youth, age 15-17, in a juvenile justice boot-camp facility. The purpose was to gain an understanding of the psychological symptoms that youth experience, as well as, to examine the effectiveness of a narrative therapy counseling intervention for reducing clinically relevant psychological symptoms manifested by youth at a juvenile boot-camp facility. This research study addressed 1) how participation in narrative therapy sessions impacted youth cadet's clinically relevant psychological symptoms and adjustment problems, and 2) provided insight on the experiences of these youth cadets within a juvenile justice boot-camp facility.

### Research Questions

The following research questions were used in the study:

Quantitative Research Questions:

1) What is the effectiveness of a narrative therapy intervention for reducing clinically relevant psychological symptoms on scores of the Brief Symptom Inventory (Derogatis, 1993) in youth at a South Texas juvenile boot-camp facility?
2) What graphical representations will determine whether meaningful change has been noted between the baseline and treatment phases?
3) What effect sizes by non-overlap data analysis procedures are indicative of effective treatment?

Qualitative Research Questions:

4) What stories about being in a juvenile justice boot-camp facility do youth convey?

5) What role do clinically relevant psychological symptoms play within the lives and experiences of youth currently in a juvenile boot-camp facility?

6) What are the perceptions of youth on how the narrative therapy sessions helped them deal with clinically relevant psychological symptoms at a juvenile justice boot-camp facility?

## Participants

The principal investigator conducted this study with a sample of youth cadets (N = 8) enrolled in a South Texas juvenile boot-camp facility. Because the cadets were sentenced to serve time in a juvenile boot-camp facility, participants for the study were derived from a sample of convenience. Youth chosen to participate in this study were estimated to be between the ages of 15 to 17.

The population for this research was obtained from purposeful sampling, and selected by staff from the South Texas boot-camp facility, based on the level of clinically relevant psychological symptoms and adjustment problems present by youth cadets from previous mental health screenings. An informed consent statement form along with a letter of permission from the director of the juvenile boot-camp facility authorized the researcher to use the facility for the research study. The researcher provided the boot-camp staff with an information sheet that explained the study.

The informed consent statement and the letter of permission from the director of the juvenile boot-camp facility also allowed approval for the researcher to contact the legal guardians of participating cadets for consent, as well as requesting assent of the participating youth. The legal guardians of the cadets filled out a consent form and allowed permission for their children to be participants of the study. Parents were also given an information sheet, as

well as the youth, giving assent to be participants of the study. There were no monetary incentives, and participants were given the option to opt out from the study at any given time. All eight of the participants selected were randomly assigned to one of two counselors providing the narrative therapy sessions. Participants were two female adolescents and six male adolescents with a mean age of 16 (*SD* = 0.75), all serving their own respective sentencing time at a juvenile boot-camp facility. Participants were all of heterosexual affectional orientation, and all of Hispanic ethnic identities. Participant's names are not provided; rather participants were assigned pseudonyms to protect their identity.

**Participant 1.**

Michelle was a 16-year-old Hispanic female in the 9th grade. She has one child. She has a diagnosis of Bipolar Disorder NOS, Anxiety Disorder NOS, and Attention-Deficit Hyperactivity Disorder combined assessed by a psychiatrist contracted with the juvenile boot-camp facility. She has a past history of receiving mental health services at an inpatient mental health hospital, and she received individual outpatient counseling services before serving time at the juvenile boot-camp facility. Other mental health services received by Michelle while at the juvenile boot-camp include psychotropic medication management, and chemical dependency group counseling.

**Participant 2.**

Isaac was a 17-year-old Hispanic male in the 10th grade. He had no children. He has a diagnosis of Bipolar Disorder NOS, Conduct Disorder, Cannabis Abuse, and Inhalant Abuse as assessed by a psychiatrist contracted with the juvenile boot-camp facility. Isaac has a past history of mental health services that includes skills training, and inpatient substance abuse treatment.

Other mental health services he received while at the juvenile boot-camp facility include psychotropic medication management, and chemical dependency group counseling services.

**Participant 3.**

Christopher was a 15-year-old Hispanic male in the 10th grade. He had no children. He has a diagnosis of Bipolar Disorder NOS, Post Traumatic Stress Disorder, and Anxiety Disorder NOS assessed by a psychiatrist contracted with the juvenile boot-camp facility. No past history of mental health services before juvenile boot-camp was reported. Other mental health services he had received while at juvenile boot-camp include psychotropic medication management, and chemical dependency group counseling services.

**Participant 4**.

Roman was a 16-year-old Hispanic male in the 10th grade. He had no children. He has a diagnosis of Bipolar Disorder NOS, Attention-Deficit Hyperactivity Disorder combined, and Conduct Disorder assessed by a psychiatrist contracted with the juvenile boot-camp facility. He has a past history of mental health services before serving time at the juvenile boot-camp where he had received psychiatric services, and social skills training services. While at the juvenile boot-camp, he received psychotropic medication management, and chemical dependency group counseling services.

**Participant 5.**

Omar was a 17-year-old Hispanic male in the 10th grade. He has one child. He has a diagnosis of Bipolar Disorder NOS assessed by a psychiatrist contracted with the juvenile boot-camp facility. He has a past history of mental health services before services at the juvenile boot-camp where he received individual counseling and group counseling at a placement facility.

Other mental health services he had received while at the juvenile boot-camp facility include psychotropic medication management, and chemical dependency group counseling services.

**Participant 6.**

Baylea was a 15-year-old Hispanic female in the 8th grade. She has no children. She has a diagnosis of Bipolar Disorder NOS, and Attention-Deficit Hyperactivity Disorder combined assessed by a psychiatrist contracted with the juvenile boot-camp facility. Other past mental health services received by Baylea includes psychotropic medication management, and chemical dependency group counseling.

**Participant 7.**

Randy was a 17-year-old Hispanic male in the 11th grade. He has one child. He has a diagnosis of Mood Disorder NOS and Anxiety Disorder NOS assessed by a psychiatrist contracted with the juvenile boot-camp facility. He has no past history of mental health services other than for substance abuse treatment while at a placement facility. Other mental health services recived by Randy while at the juvenile boot-camp facility include psychotropic medication management, and chemical dependency group counseling services.

**Participant 8**.

Jesse was a 15-year-old Hispanic male in the 8th grade. He has one child. He has a diagnosis of Bipolar I Disorder, most recent episode depressed, Attention-Deficit Hyperactivity Disorder combined, Cannabis Abuse, and Alcohol Abuse assessed by a psychiatrist contracted with the juvenile boot-camp facility. He has a past history of mental health services along with substance abuse treatment which included psychiatric hospitalizations, psychiatric outpatient services, and individual counseling services. Other mental health services he had received while

at the juvenile boot-camp facility included psychotropic medication management, and chemical dependency group counseling services.

## Single-Case Research Design

The American Psychological Association (APA) determined that well-established treatments are those that demonstrate efficacy through at least two between-groups design experiments with approximately 30 participants per group, or through a series of at least nine single-case design experiments. Researchers using either experimental design must compare the intervention to another treatment, use treatment manuals, clearly outline client characteristics, and incorporate research from at least two different investigators. (Society of Clinical Child and Adolescent Psychology [SCCAP], n.d.). Lundervold and Belwood (2000) suggested that a continued emphasis on between-groups experimental designs and statistical analyses within counselor education research courses is overly narrow and will continue to result in counselors who are unable or unwilling to produce research to support counseling practice. As such, Lundervold and Belwood (2000) urged counselor educators to pursue more practice relevant research methods and designated single case design the "best kept secret" in counseling research, citing its relevance to practice settings, evaluation capacity for processes and outcomes, and experimental control. (Lundervold & Belwood, 2000; Ray et al., 2010).

Although the APA recognizes well conducted single-case research designs as meeting criteria for rigorous research methodology, Sharpley (2007) reported that only 1.02% of articles published in the *Journal of Counseling & Development* from 1982 to 2002 used single case design methodology. These results suggest that single-case design methods are an important part of the counseling literature that deserves to be utilized more in practice. CACREP (2009) also

recognizes the importance of single-case designs, as evidenced by inclusion of master's-level curricular requirements for coverage of single-case design methodology (Standard ll.G.8.b.).

Single-case designs demonstrate causal relations between different treatment conditions and their effects on a single participant's performance over time (Kazdin, 2003; Sharpley, 2007). Single-case designs involve collection of data regarding a target of change during a series of phases or period of time during which a specific counselor action is taking place (Lundervold & Belwood, 2000). Continual assessment is vital to single-case design because multiple data points provide the data from which a participant's baseline and intervention phases are analyzed to assess change (Sharpley, 2007): in essence, participants serve as their own control group. Single-case design methodology offers researchers and practitioners numerous benefits.

The principal investigator implemented an A-B and an A-B-A single case research design for participating youth, gathering scores from the Brief Symptom Inventory (Derogatis, 1993), through five measurements providing a baseline average. The principle investigator then measured scores from the Brief Symptom Inventory (Derogatis, 1993) throughout ten weeks or less of a narrative therapy intervention. During the treatment phase, the cadets (N=8) were randomly assigned to work with one of two narrative therapists which included the principal investigator, and another counselor. Two narrative therapy practitioners were utilized to help increase the validity of the treatment approach being implemented. After treatment, the principal investigator measured clinically relevant psychological symptoms from scores of the Brief Symptom Inventory (Derogatis, 1993) once the narrative therapy intervention had been withdrawn for about three weeks following treatment. Scores were obtained throughout each week of treatment and throughout each week of withdrawal. The principal investigator did not obtain withdrawal measures for some participants due to changes in their status and location.

## Narrative Therapy Intervention

A narrative therapy intervention was conducted as part of the counseling activities organized at the juvenile boot-camp facility. Information about the narrative therapy intervention program was sent to parents, cadets, and boot-camp staff and was described as an activity that was being conducted as part of a research study to evaluate whether narrative therapy sessions would help youth cadets in their functioning by decreasing clinically relevant psychological symptoms and adjustment problems. Participants receiving narrative therapy would do so consistently for up to ten weeks from one of two counselors assigned to them after baseline measures were completed. The youth cadets who participated met with their counselor for a 50-60 minute session once per week during the treatment phase.

The narrative therapy sessions integrated the description and progression of sessions outlined in *Maps of Narrative Practice* written by narrative therapy pioneer Michael White (2007), along with other Narrative therapy references. Using a narrative approach to counseling, mental health professionals and school counselors can use techniques described in this current study to help juvenile cadets and other youth overcome factors that contribute to them being at risk.

A fabricated case illustration was constructed for this section based on stories and experiences of at-risk youth from previous research samples, to demonstrate a likely progression of sessions for the course of this study. The following story represents the voice of an at-risk youth who was involved in the juvenile justice system, (Chew, Osseck, Raygor, Eldridge-Houser, & Cox, 2010), was at-risk for substance abuse, (Sanders, Lankenau, & Jackson-Bloom, 2010), and was struggling with mental health issues such as depression and suicidal ideation, (Jaser, Holl, Jefferson, & Grey, 2009).

## Case Example of Jimmy

"I have been arrested many times. Some of my offenses include assault, burglary of habitation, possession of a controlled substance, truancy, and violations of probation. Although I get angry having to be taken to the detention center, I have also gotten used to it. My probation officer keeps giving me chances. Most of my family has a history of getting arrested. My father and most of my uncles are in prison. I haven't had too many male figures in my life because the police have taken them all away from me. I hate the police. I could also care less about going to school. I'm always in trouble there anyway, and I'm a few grades behind. I would rather drop out. My teachers always yell at me, and I get into fights. Some days at school rival gangs talk mess to me, and I don't want to look like a punk in front of my homeboys, so I end up having to fight. Then I end up getting in trouble so I spend most of my days in ISS (In School Suspension). They don't bother to teach me anything in that classroom, so my grades are no good. I'd rather be at home anyway smoking weed with my friends. That seems to be the only thing that makes me happy. Some days I get real depressed, and I'll even have thoughts about dying. I just smoke weed every day and forget about everything. My grandma keeps telling me that I'm going to end up just like my dad. She keeps saying I need to prepare for my future, but I say I have no future."

Using a narrative approach to counseling, mental health professionals and school counselors can implement techniques described in this current study to help Jimmy and other youth overcome factors that contribute to them being at risk. There are a number of important factors illustrated in the aforementioned case example. First, some at-risk youth are responsive to dominant cultural narratives that become internalized as part of their identity. In narrative therapy, the therapist will listen carefully and respectfully to the story while noting what is left out or incongruent, which parts are positive and empowering, and which parts are negative or

disempowering (Shapiro & Ross, 2002). Cultures have dominant theories or dominant cultural narratives about what is good and bad, sick and well, healthy and unhealthy, that become integrated into our identity. There are other stories however that one says to himself or herself that is equally valid to the ones that society tells them. In the current case example, Jimmy was at-risk for several factors. These at-risk factors included juvenile justice involvement, depression, suicidal ideation, substance abuse, and risk for dropping out of school. Jimmy believed that he would be "a punk" should he not fight with rival gang members because of the dominant cultural narratives he internalized from his peers.

**Deconstructing the Problem Saturated Story and Defining the Problem**

Deconstructing the problem saturated story would help uncover the source of Jimmy's beliefs about his position of fighting. Through externalizing conversations, a narrative therapist may work in negotiating Jimmy's experience of a problem. Should Jimmy identify defiance as a dominant problem in his life, a narrative therapist may ask what sort of defiance are we dealing with? What is the nature of the defiance?

A narrative therapist would then ask Jimmy to define or name this problem; what would you name these patterns of defiance that show up? Jimmy may name the problem whatever he likes, which aids in helping Jimmy not only in externalizing the problem, but taking control over the problem. Should Jimmy name the problem as "catching fire", or "fire catching", a narrative therapist may work towards mapping the effects of "catching fire", and exploring the impact that "catching fire" has in various domains of Jimmy's life. A narrative therapist may ask what situations are present when "fire is caught?" What are you noticing when "catching fire" occurs? Who is the first to notice "fire catching"? Who is the last to notice "fire catching"?

**Externalizing Conversations**

The next step to externalizing conversations involves evaluating how the problem impacts Jimmy's life. Is "catching fire" good or bad? It may be possible that Jimmy does not feel the problem being explored is always a problem, so it may be helpful to explore times when the problem is helpful or an ally.

**Evaluating and Justifying the Effects of the Problem**

The next step is justifying the effects of the problem and exploring the client's evaluation through stories that confirm this position. Why is "catching fire" helpful or not helpful? Jimmy may come to a realization that he doesn't want "fire" showing up anymore as it is like "an unwanted guest that follows me around at home and in school". The use of these metaphors can be quite powerful in giving meaning to these life circumstances. Throughout the session, a narrative therapist also works in identifying unique outcomes to when the problem is not present, or when there was an exception to the problem.

**Identifying Unique Outcomes**

Throughout the session, a narrative therapist will pay attention in identifying unique outcomes to the problem saturated story, and noting when "fire" doesn't come around. Exploring times when there is an exception to the problem, and exploring in detail the significance of these moments the therapist works towards helping the client identify a new preferred outcome (White, 2007). A narrative therapist uses curious questioning to help youth recognize and reflect the discrepant but positive elements of their current problem saturated stories and to empower them to reformulate a more-preferred life direction. (Weingarten, 1998; White, 2007).

By exploring themes when "catching fire" or other problems do not show up in Jimmy's life story, therapists can assist Jimmy in becoming aware of alternatives to his problem saturated story. The narrative therapist can explore these hidden details in Jimmy's life that he may have

not been previously aware of. The building blocks for Jimmy's new story are found in the discovery of hopeful moments, thoughts, or events that do not fit with his problem story, which ultimately assists Jimmy in re-authoring his preferred life narrative (White, 2007).

**Re-Authoring Conversations**

The renegotiation of stories in people's lives is also a renegotiation of people's identity (White, 2007). In re-authoring conversations, the concepts of landscape of action and landscape of identity is used to assist the therapist in building a context in which it becomes possible for people to give meaning to, and draw together into a storyline, the many overlooked but significant events in their lives (White, 2007). Throughout exploring Jimmy's problem saturated story, a small theme emerged from Jimmy's story. Jimmy had stated that he had been given chances by his probation officer. This was an opportunity to ask the question; "Jimmy, you mentioned a story about your probation officer giving you chance… what do you suppose your probation officer giving you chances suggests about you?" This is a landscape of identity question. Jimmy could possibly respond by saying "I suppose it suggests that I'm worth keeping out of jail." A narrative therapist can they reply by exploring other themes related to Jimmy being worth keeping out of jail and come to a theme that relates to having value in the community. The narrative therapist can then explore with Jimmy by asking him to share a story about being valued, or doing something of value in the community.

Asking Jimmy a short story that would reflect his action in being valued in the community is a landscape of action question. By Jimmy sharing a story of a time he contributed to the community can further assist Jimmy in coming to the realization that he is someone to be valued. This idea that he is someone who is valued can become part of his identity is his new preferred life story, where can always draw strength from in this new realization when faced with

aversive situations. This can also be associated to the development of new coping skills. Exploring more stories in the context of “landscape of action” and “landscape of identity” from Jimmy’s present, recent history, distant history, remote history, and future may continue to build upon helpful themes previously identified and more.

## Narrative Therapy Intervention

The narrative therapy intervention followed the guidelines suggested by Michael White in his book Maps of Narrative Practice (White, 2007). This book provides the practical and accessible applications of narrative practice as Michael White has developed and taught over the years.

Session 1:

- Defining the problem
- Externalizing the problem

Session 2:

- Mapping the effects of the problem

Session 3:

- Evaluating and justifying the effects of the problem

Session 4:

- Re-authoring conversations
- Landscape of action and landscape of identity

Session 5:

- Re-authoring and re-membering conversations
- Landscape of action and landscape of identity

Session 6:

- Re-authoring and re-membering conversations
- Scaffolding Conversations

Session 7:

- Re-authoring conversations
- Mapping the effects of the re-authored identity

Session 8:

- Re-authoring conversations
- Evaluating and justifying the effects of the re-authored identity

Session 9:

- Re-authoring conversations
- Evaluating and justifying the effects of the re-authored identity

Session 10:

- Definitional Ceremony

## Instrumentation

### Brief Symptom Inventory (BSI) (Derogatis, 1993).

This study assessed the influence of a narrative therapy intervention using the Brief Symptom Inventory (BSI) (Derogatis, 1993). The principal investigator intended to examine improvement of scores measuring clinically relevant psychological symptoms on the Brief Symptom Inventory (Derogatis, 1993). The purpose of the BSI is to identify self-reported clinically relevant psychological symptoms in adolescents and adults. The Brief Symptom Inventory (BSI) consists of 53 items which cover nine symptom dimensions. These symptom dimensions include: Somatization, Obsession-Compulsion, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic anxiety, Paranoid ideation and Psychoticism; and three global indices

of distress: Global Severity Index, Positive Symptom Distress Index, and Positive Symptom Total (Cox, 2011). The global indices measure current or past level of symptomatology, intensity of symptoms, and number of reported symptoms, respectively.

The BSI is the short version of the SCL-R-90 (Derogatis, 1975, 1977), which measures the same dimensions (Cox, 2011). Items for each dimension of the BSI were selected based on a factor analysis of the SCL-R-90, with the highest loading items on each dimension selected for the BSI (Derogatis, 1993; Derogatis & Cleary, 1977; Derogatis & Spencer, 1982). All materials and copyrighted forms and the BSI manual (Derogatis, 1993) are available from the publisher. The time required to administer the BSI takes an estimated average of 8 to 12 minutes (Cox, 2011). The administration method can be self or interviewer administered, and training on administration of the BSI assessment is said to be minimal (Derogatis, 1993). Regarding the scoring of the BSI, respondents rank each feeling item (e.g., "your feelings being easily hurt") on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*) (Cox, 2011). Rankings characterize the intensity of distress during the past seven days. The items comprising each of the 9 primary symptom dimensions are as follows:

• Somatization: Items 2, 7, 23, 29, 30, 33, and 37

• Obsession-Compulsion: Items 5, 15, 26, 27, 32, and 36

• Interpersonal Sensitivity: Items 20, 21, 22, and 42

• Depression: Items 9, 16, 17, 18, 35, and 50

• Anxiety: Items 1, 12, 19, 38, 45, and 49

• Hostility: Items 6, 13, 40, 41, and 46

• Phobic Anxiety: Items 8, 28, 31, 43, and 47

• Paranoid Ideation: Items 4, 10, 24, 48, and 51

• Psychoticism: Items 3, 14, 34, 44, and 53.

Several items do not factor into any of the dimensions such as items 11, 25, 39, and 52, but are included because these items are clinically essential (Cox, 2011). For example, the presence of conscious feelings of guilt is useful information to a clinician. These items are included when calculating Grand Total Scores (Derogatis, 1993). Dimension scores are calculated by summing the values for the items included in that dimension and dividing by the number of items endorsed in that dimension (Derogatis, 1993). Scores are interpreted by comparison to age-appropriate norms. Normative data are available for both clinical and non-clinical samples of adolescents (over 13 years) and adults (Derogatis, 1993; Derogatis & Spencer, 1982). The BSI Administration, Scoring, and Procedures Manual (Derogatis, 1993) provides normative data for four different samples, including non-patient adults, adolescents aged 13-17, adult psychiatric outpatients, and adult psychiatric inpatients.

The authors report good internal consistency reliability for scores on the nine dimensions, ranging from .71 on Psychoticism to .85 on Depression (Cox, 2011). Good internal consistency reliability for the scores is supported by several other independent studies (Croog et al., 1986; Aroian & Patsdaughter, 1989 in Derogatis, 1993). No alpha reliability is reported for scores on the three global indices. Test-retest reliability for scores on the nine symptom dimensions ranges from .68 (Somatization) to .91 (Phobic Anxiety), and for the three Global Indices from .87 (Positive Symptom Distress Index) to .90 (Global Severity Index) (Cox, 2011). Correlations between the BSI and the Wiggins content scales and the Tryon cluster scores from the MMPI ranged from .30 to .72 with the most relevant score correlations averaging above .50 (Conoley & Kramer, 1989; Derogatis, Rickles, & Rock, 1976 in Derogatis, 1993). Factor analysis results confirmed the a priori construction of the symptom dimensions. In addition to understanding the

validity evidence of the BSI, the authors report correlations between the BSI and SCL-R-90 were .92 to .99 (Derogatis, 1993). The reliability, validity, and utility of the BSI instrument were tested in more than 400 research studies (Derogatis, 1993). The adolescent norms are based on 2,408 individuals with 1,601males and 807 females. The data were gathered in six separate schools in two states. Approximately 58% of the sample was white, and the mean age was 15.8 (Derogatis, 1993). References to other studies attesting to the validity of the BSI are found in the manual (Derogatis, 1993). Primary symptom scores for each dimension and the global severity index scores were obtained only from participating cadets, and raw scores were converted into T-scores for the purpose of data analysis.

## Data Collection

The quantitative data on scores of the Brief Symptom Inventory (Derogatis, 1993), were collected from participating cadets (N = 8) for a total of eighteen consecutive weeks. During the first five consecutive weeks, the principal investigator gathered an average base line measure of clinically relevant psychological symptoms. The Brief Symptom Inventory (BSI) consists of 53 items covering nine symptom dimensions: Somatization, Obsession-Compulsion, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic anxiety, Paranoid ideation and Psychoticism; and three global indices of distress: Global Severity Index, Positive Symptom Distress Index, and Positive Symptom Total.

After five weeks of data collection, the baseline phase of data collection was completed. During the fifth week where the last baseline measure occurred, the first narrative therapy session began and continued consecutively each week for up to ten weeks. After the treatment phase was completed, participating cadets entered the withdrawal phase where data was collected continuing consecutively for about three weeks following the end of treatment, where

the narrative therapy intervention had been withdrawn. Questions on the Brief Symptom Inventory (Derogatis, 1993) were randomly distributed for each administration to prevent threats to external validity from the testing effect. Percentage of data exceeding the median procedures had been implemented to analyze the quantitative data collected from the A-B or the A-B-A single case designs. A visual trend analysis for each participant is reported as data points from each phase of the study is graphically represented to provide visual representations of change over time (Sharpley, 2007). An interpretation of effect sizes was conducted to determine the effectiveness of the narrative therapy treatment intervention when comparing each phase of data collection (Sharpley, 2007).

The qualitative data were gathered through a variety of methods. First, the principal investigator collected field notes each week throughout the total amount of weeks at the time of the quantitative data collection. The principal investigator gathered qualitative data from participating youth cadets, using narrative inquiry in exploring the meaning from the stories shared by cadets as related to questions exploring the impact that clinically relevant psychological symptoms have had in their lives. Through conversations with participating cadets, the principal investigator also explored the significance and impact of the narrative therapy intervention from each cadet's own perspective throughout each week of treatment implementation, and what constituted changes in their scores of the Brief Symptom Inventory (Derogatis, 1993) throughout each weekly measurement.

In reviewing the data and embedded narrative from the field notes and discussions, the principal investigator attended to the relationship between context and story structure. In narrative data analysis, the principal investigator examined intrapersonal and contextual information, tension within the stories, and the narrative's conclusions (Hays et al, 2011). Other

means of qualitative data were gathered by the principal investigator, including field notes taken by the principal investigator and the second narrative therapist on personal experiences shared from sessions, as well as from conversations done with boot-camp staff on their perspective of youth experiences in a boot-camp facility to further develop the narrative of cadets participating in the study.

## Data Analyses

A visual trend analysis was reported as data points for each phase is graphically represented to provide visual representations of change over time (Sharpley, 2007). Graphical representation of data provides a platform to analyze the strengths and weaknesses of an intervention over time. Visual analysis also provides researchers with an opportunity to consider whether the effect size yielded agrees with the overall trends of data observed during an intervention. An interpretation of effect sizes was also conducted to determine the effectiveness of the narrative therapy treatment intervention when comparing each phase of data collection using Percentage of data exceeding the median procedures (Sharpley, 2007). Parker and Hagan-Burke (2007) suggested that measures of effect size provide a number of advantages over visual analysis alone, including (a) an objective measure of treatment effect, (b) increased precision of measurement, (c) allowance for cross-case comparisons and meta-analyses, (d) improved inter-rater reliability for calculating SCRD results, and (e) enhanced efficiency for documentation purposes (Lenz, 2012).

One of the first major alternatives to visual trend analysis was the Percentage of Nonoverlapping Data (PND) procedure presented by Scruggs et al. (1987). This metric is conceptualized as the percentage of treatment phase data that exceeds a single noteworthy point within the baseline phase. (Lenz, 2012). One of the major strengths of PND is that this procedure

can be easily calculated with a ruler and pencil or straight line if using Excel graphs. Furthermore, the PND procedure can be implemented with smaller data sets (i.e., $n < 20$) and has routinely correlated very well with visual analysis judgments during meta-analysis (Parker, Vannest, & Davis, 2011; Lenz, 2012). One limitation however is that the yielded effect size measure of the PND procedure is based on only one data point in the baseline phase and is therefore vulnerable to an outlier that may promote Type 2 error (Lenz, 2012). Should one of the data points in the baseline phase approach the ceiling or floor of the score range, it may be possible for no treatment effect to be yielded even though there may be clear improvements shown in treatment phase data. In addition, because PND is designed to be used for hand calculations with graphical representations of data, analysis can become difficult with very large data sets or crowded graphs (Lenz, 2012). Several applications of the PND statistic are available for review in the counseling and counselor education literature (Lenz, Oliver, & Nelson, 2011; Lenz, Perepiczka, & Balkin, 2012; Schottelkorb & Ray, 2009; Lenz, 2012).

An alternative procedure to PND was introduced by Ma (2006), who developed the Percentage of Data Exceeding the Median (PEM) procedure to support data sets in which outliers in the baseline condition may negatively impact the evaluation of an intervention. This procedure is conceptualized as the analysis of treatment phase data that is contingent on the overlap with the median data point within the baseline phase (Lenz, 2012). Ma (2006, 2009) suggested that PEM is based on the assumption that if the intervention is effective, data will be predominately on the therapeutic side of the median; if an intervention is ineffective, data points in the treatment phase will vacillate above and below the baseline median (Lenz, 2012). Like PND, PEM can be calculated by hand or using Excel files with relative ease and can be reliability implemented with smaller data sets with success.

Similar to the PND procedure, the PEM procedure has also been demonstrated as a suitable tool for completing meta-analyses of SCRDs (Ma, 2009; Preston & Carter, 2009; Lenz, 2012). Some criticisms were noted that if PEM is not prudently selected for use, inflated effect sizes may promote Type 1 error (Lenz, 2012). For this reason, it is recommended that PEM be used in occurrences when there is some variability over time or a significant outlier exists within the baseline data. Because the PEM procedure is reasonably new, the availability of published articles for reference is not as great as that with PND (Lenz, 2012); however, some examples relevant to counselors and counselor educators are available (Lenz & Aguilar, 2012; Lenz, Speciale, & Aguilar, 2012). Because of possible outliers in the baseline condition that may negatively affect the evaluation of this intervention, this current study will utilize the percentage of data exceeding the median (PEM) procedure to interpret effect sizes for all participants.

Scruggs and Mastropieri (1998) provided a rubric for interpreting effect sizes yielded from non-overlap data analysis procedures such as PND, and PEM. Each of the non-overlap methods stated above yields a proportion of data overlap between a baseline and treatment condition expressed in a decimal format that ranges between zero and one. When applying the rubric, higher scores represent greater treatment effects and lower scores represent less effective treatments. Scruggs and Mastropieri (1998) suggested that effect sizes of .90 and greater are indicative of very effective treatments, those ranging from .70 to .89 represent moderate effectiveness, those between .50 to .69 are debatably effective, and scores less than .50 are regarded as not effective.

The goal of also using a narratological approach for this research study is to understand the human experience through interpreting narrative forms of qualitative research data (Hays et al, 2011). Narrative methods include examining life stories and personal accounts (McAdams

1996). Through a narratological research perspective, the meaning comes from the stories. Narratology is a multidisciplinary study of narrative that negotiates and incorporates the insights of that which is represented in the story (Onega and Landa, 1996; Lai, 2010). The term narratology is used in academia for study of the literature, whereas "narrative inquiry" is the study of the development of phenomena and the transition of stories in the lives of people (Widdershoven, 1993). Narrative inquiry is popular in applied sciences, such as social work and nursing (Lai, 2010). The idea of narrative inquiry is that stories are collected as a means of understanding experience as lived and told, through both research and literature (Lai, 2010).

Savin-Baden, & Van Niekerk, (2007) suggest that when using narrative inquiry it is important that the researcher is not only able to ask questions that elicit stories but also that they are able to position themselves so that stories can be examined effectively. In narrative inquiry, Savin-Baden, & Van Niekerk, (2007) would contend that the focus of narrative analysis is the people who tell us stories about their lives, the stories being the means of understanding our participants better. Therefore, storytelling tends to be closer to actual life events than other methods of research that are just designed to elicit explanations. Stories are created and re-created in the interview and then negotiated, so that both researcher and participant do not assume that the stories necessarily reflect a pre-existing reality (Savin-Baden, & Van Niekerk, 2007). The meaning making through story construction and interpretation first happens between the narrator (person who had the experience) and the listener (researcher) (Savin-Baden, & Van Niekerk, 2007). In the next step, this process is reenacted on a different level (one that might be understood to be less personal in nature); the researcher assumes the role of narrator while the listener will be the consumer/reader of the published research (Savin-Baden, & Van Niekerk, 2007; Lai, 2010)

Researchers describe lives, tell stories about them and write narratives of experience. In telling a story, the narrator takes responsibility for making the relevance of the telling clear so that meaning is created between storyteller and listener. The role of the researcher is to be an effective listener and to see the interviewee as a storyteller rather than as a respondent (Savin-Baden, & Van Niekerk, 2007; Lai, 2010). Therefore in interviews, the agenda is open to development and change depending on the story being told. Authors such as Bauer (1996) take the stance that the object of narrative analysis is the narrative itself, as opposed to the events being narrated or the experiences of the narrator. Some researchers would argue that narratives are structured with a beginning, middle, and an end, held together by some kind of plot and resolution (Sarbin, 1986). However, Savin-Baden, & Van Niekerk, (2007) would argue against this, suggesting instead that narratives do not necessarily have a plot or structured storyline but are interruptions of reflection in a storied life. Further, such storied lives may have unplanned interruptions such as an unexpected illness that may disrupt identities, causing changes in the story and the stories of lives (Savin-Baden, & Van Niekerk, 2007)

In chapter 4, the principal investigator will attempt to tell the various stories of each participant, as related to their life story, through stories from participant's experiences in a juvenile boot-camp facility, stories on the impact that clinically relevant psychological symptoms and adjustment problems have had in their lives, and from the experiences of cadets participating in narrative therapy sessions, as a means for the readers to understand the participants experiences.

## Summary

The research design of the current study was presented including the: purpose, research questions, participants, single-case research design, treatment intervention, instrumentation, data

collection, and data analyses procedures. Specific details regarding data analyses methods concluded this chapter.

Chapter 4

Results

## Introduction

In this chapter, the principal investigator provides a discussion of results based on visual trend analysis and non-overlap data analysis procedures, specifically results from the percentage of data exceeding the median procedures. Percentage of data exceeding the median procedures had been implemented to analyze the quantitative data collected from the A-B and the A-B-A single case designs. A visual trend analysis for each participant is reported as data points from each phase of the study and is graphically represented to provide visual representations of change over time (Sharpley, 2007). An interpretation of effect sizes was conducted to determine the effectiveness of the narrative therapy treatment intervention when comparing each phase of data collection (Sharpley, 2007).

The principal investigator also reports qualitative data from participating youth cadets, using narrative inquiry in exploring the meaning from the stories shared by cadets as related to questions exploring the impact that clinically relevant psychological symptoms have had in their lives. Through conversations with participating cadets, the principal investigator also reports the significance and impact of the narrative therapy intervention from each cadet's own perspective throughout each week of treatment implementation, and what constituted changes in their scores of the Brief Symptom Inventory (Derogatis, 1993) throughout each weekly measurement.

The primary purpose of this study was to bring forth the stories from youth, age 15-17, in a juvenile justice boot-camp facility. The purpose was to gain an understanding of the psychological symptoms that youth experience, as well as, to examine the effectiveness of a

narrative therapy counseling intervention for reducing clinically relevant psychological symptoms manifested by youth at a juvenile boot-camp facility.

This research study addressed 1) how participation in narrative therapy sessions impacted youth cadet's clinically relevant psychological symptoms and adjustment problems, and 2) provided insight on the experiences of these youth cadets within a juvenile justice boot-camp facility. Quantitative data was collected during the fall 2013 and spring 2014 semester at a juvenile boot-camp facility in south Texas. Scores were interpreted based on the number of items participants responded to. This chapter provides demographic information for this study's participants, and later reports this study's findings.

## Profile of All Participants

This sample consisted of eight cadets sentenced to serve time at a juvenile boot-camp facility. Participants were two female adolescents and six male adolescents with a mean age of 16 (SD = 0.75), all serving their own respective sentencing time. Participants were all of Hispanic ethnic identities. Participant's names are not provided; rather participants were assigned pseudonyms to protect their identity.

## Outcomes of Therapy

### Participant 1.

Michelle's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 1, illustrates that the effectiveness of a narrative therapy intervention was debatably effective for decreasing or subsiding her clinically relevant psychological symptoms. Evaluation of the PEM statistic for the Global Severity Index measure (.58) indicated that seven scores were on the therapeutic side below the baseline (T-score of 65). Trend analysis depicts Michelle struggling to reduce clinically relevant psychological symptoms during the first half of treatment

as evidenced by high scores on items such as “Feeling easily annoyed or irritated”, “Feeling blue”, and “Feeling nervous when you are left alone.” This contention became most apparent after the second session when a majority of her symptom dimensions such as depression, anxiety, hostility, and phobic anxiety continuously scored high. Following the end of the fifth individual narrative therapy session, Michelle’s overall BSI scores demonstrated a decrease consistently where she remained below that of her baseline measurement. This decrease began occurring during her landscape of action and landscape of identity phases in treatment. The results of the visual trend analysis for the symptom dimension measures of somatization, interpersonal sensitivity, obsession-compulsion, and the paranoid thinking shows Michelle experiencing a decrease in those psychological symptoms. This was observed toward the latter half of treatment and observed throughout the withdrawal measures, suggesting that Michelle made improvement in managing those symptoms at the end and during the withdrawal of treatment.

Michelle’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 1, illustrates that the effectiveness of a narrative therapy intervention was debatably effective for decreasing or subsiding her somatization symptoms. Evaluation of the PEM statistic for the somatization measure (.58) indicated that seven scores were on the therapeutic side below the baseline (T-score of 65). Trend analysis depicts Michelle’s improvement toward reducing somatization symptoms after the sixth session, as evidenced by reduced scores on items such as “Nausea or upset stomach”, and “Pains in the heart or chest.”

Michelle’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 1, illustrates that the effectiveness of a narrative therapy intervention was moderately effective for decreasing or subsiding her obsessive-compulsive symptoms. Evaluation of the PEM statistic for the obsessive-compulsive measure (.75) indicated that nine scores were on the

therapeutic side below the baseline (T-score of 62.5). Trend analysis depicts Michelle's improvement toward reducing obsessive-compulsive symptoms after the fourth session, as evidenced by reduced scores on items such as "Trouble remembering things", and "Difficulty making decisions."

Michelle's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 1, illustrates that the effectiveness of a narrative therapy intervention was moderately effective for decreasing or subsiding her interpersonal sensitivity symptoms. Michelle's interpersonal sensitivity scores however, are not considered clinically relevant because there is no score for interpersonal sensitivity that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the interpersonal sensitivity measure (.83) indicated that ten scores were on the therapeutic side below the baseline (T-score of 46). Trend analysis depicts Michelle's improvement toward reducing interpersonal sensitivity symptoms after the first and fifth treatment session, as evidenced by reduced scores on items such as "Feeling that people are unfriendly or dislike you", and "Feeling inferior to others."

Michelle's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 1, illustrates that the effectiveness of a narrative therapy intervention was debatably effective for decreasing or subsiding her depression symptoms. Evaluation of the PEM statistic for the depression measure (.50) indicated that six scores were on the therapeutic side below the baseline (T-score of 68.5). Trend analysis depicts Michelle's improvement toward reducing depression symptoms after the fifth session, as evidenced by reduced scores on items such as "Feeling hopeless about the future", and "Feelings of worthlessness."

Michelle's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 1 illustrates that the effectiveness of a narrative therapy intervention was debatably effective for decreasing or subsiding her anxiety symptoms. Evaluation of the PEM statistic for the anxiety measure (.58) indicated that seven scores were on the therapeutic side below the baseline (T-score of 70). Trend analysis depicts Michelle's improvement toward reducing anxiety symptoms after the fifth session, as evidenced by reduced scores on items such as "Feeling fearful", and "Suddenly scared for no reason."

Michelle's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 1, illustrates that the effectiveness of a narrative therapy intervention was not effective for decreasing or subsiding her hostility symptoms. Evaluation of the PEM statistic for the hostility measure (.41) indicated that five scores were on the therapeutic side below the baseline (T-score of 69). Trend analysis depicts Michelle's struggle toward reducing hostility symptoms after the first session, as evidenced by increased scores on items such as "Having urges to beat, injure, or harm someone", and "Having urges to break or smash things."

Michelle's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 1 illustrates that the effectiveness of a narrative therapy intervention was not effective for decreasing or subsiding her phobic anxiety symptoms. Evaluation of the PEM statistic for the phobic anxiety measure (.08) indicated that only one scores was on the therapeutic side below the baseline (T-score of 69). Michelle's symptoms of phobic anxiety increased around the time of her first treatment session. During this time, Michelle obtained information from other cadets that an individual she had been in a very volatile relationship with in her recent past, and had experienced trauma from, was staying next door at the juvenile detention center. Trend analysis depicts Michelle's struggle toward reducing phobic anxiety symptoms after the first session, as

evidenced by increased scores on items such as “Having to avoid certain things, places, or activities because they frighten you”, and “Feeling nervous when you are left alone.”

Michelle’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 1, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding her paranoid ideation symptoms. Michelle’s paranoid ideation scores however, are not considered clinically relevant because there is no score for interpersonal sensitivity that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the paranoid ideation measure (.91) indicated that 11 scores were on the therapeutic side below the baseline (T-score of 55). Trend analysis depicts Michelle’s improvement toward reducing paranoid ideation symptoms after the first and fourth session, as evidenced by reduced scores on items such as “Feeling that you are watched and talked about by others”, and “Feeling others are to blame for most of your troubles.”

Michelle’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 1, illustrates that the effectiveness of a narrative therapy intervention was moderately effective for decreasing or subsiding her psychoticism symptoms. Michelle’s psychoticism scores however, only presented a slight decrease from the baseline. Evaluation of the PEM statistic for the psychoticism measure (.83) indicated that ten scores were on the therapeutic side slightly below the baseline (T-score of 64). Trend analysis depicts Michelle’s improvement toward reducing psychoticism symptoms after the fifth session, as evidenced by reduced scores on items such as “The idea that something is wrong with your mind”, and “The idea that someone else can control your thoughts.”

**Participant 2.**

Isaac's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 2, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his clinically relevant psychological symptoms. Isaac's overall Global Severity Index scores however, are not considered clinically relevant because there are no scores for all the dimensions measured that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for any symptom dimension. Evaluation of the PEM statistic for the Global Severity Index measure (1.00) indicated that seven scores in the treatment phase were on the therapeutic side below the baseline (T-score of 31). Trend analysis depicts Isaac's improvement towards reducing clinically relevant psychological symptoms during the beginning of treatment as evidenced by improved scores on items such as "Feeling easily annoyed or irritated", "Feeling blue", and "Feeling nervous when you are left alone."

Following the end of the first individual narrative therapy session, Isaac's overall BSI scores demonstrated a decrease consistently where he remained below that of his baseline measurement. The results of the visual trend analysis for all the symptom dimension measures of somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, paranoid thinking, phobic anxiety, and psychoticism shows Isaac experiencing a decrease in those psychological symptoms. This was observed toward the end of the baseline and observed throughout the withdrawal measures, suggesting that Isaac made improvement in managing those symptoms at the end of baseline phase and maintaining through treatment and during the withdrawal of treatment.

Isaac's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 2, illustrates that the effectiveness of a narrative therapy intervention was not effective because there was no change for decreasing or subsiding his somatization symptoms as he scored a low

as possible on this dimension for having any somatization symptoms. Evaluation of the PEM statistic for the somatization measure (0.00) indicated that all seven scores in the treatment phase were on the therapeutic side even with the baseline (T-score of 36). Trend analysis depicts Isaac's improvement toward reducing somatization symptoms from the beginning of the baseline phase, as evidenced by continuously low scores of "0" scores on items such as "Nausea or upset stomach", and "Pains in the heart or chest."

Isaac's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 2, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his obsessive-compulsive symptoms. Isaac's obsessive-compulsive scores however, are not considered clinically relevant because there is no score for obsessive-compulsion that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the obsessive-compulsive measure (1.00) indicated that all seven scores in the treatment phase were on the therapeutic side below the baseline (T-score of 37.5). Trend analysis depicts Isaac's improvement toward reducing obsessive-compulsive symptoms after the second baseline measure, as evidenced by reduced scores on items such as "Trouble remembering things", and "Difficulty making decisions."

Isaac's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 2, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his interpersonal sensitivity symptoms. Isaac's interpersonal sensitivity scores however, are not considered clinically relevant because there are no scores for interpersonal sensitivity that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the

PEM statistic for the interpersonal sensitivity measure (1.00) indicated that all seven scores in the treatment phase were on the therapeutic side below the baseline (T-score of 39.5). Trend analysis depicts Isaac's improvement toward reducing interpersonal sensitivity symptoms after the first baseline measure, as evidenced by reduced scores on items such as "Feeling that people are unfriendly or dislike you", and "Feeling inferior to others."

Isaac's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 2, illustrates that the effectiveness of a narrative therapy intervention was not effective because of no change for decreasing or subsiding his depression symptoms as his scores were as low as the BSI dimension rating allowed. Evaluation of the PEM statistic for the depression measure (0.00) indicated that all seven scores in the treatment phase were on the therapeutic side even with the baseline (T-score of 36). Trend analysis depicts Isaac's improvement toward reducing depressive symptoms from the beginning of the baseline phase, as evidenced by continuously low scores of "0" scores on items such as "Feeling hopeless about the future", and "Feelings of worthlessness."

Isaac's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 2, illustrates that the effectiveness of a narrative therapy intervention was not effective because of no change for decreasing or subsiding his anxiety symptoms as he scored as low as possible on this rating dimension. Evaluation of the PEM statistic for the anxiety measure (0.00) indicated that all seven scores were on the therapeutic even with the baseline (T-score of 35). Trend analysis depicts Isaac's improvement toward reducing anxiety symptoms at the beginning of the baseline phase and throughout treatment sessions, as evidenced by reduced scores on items such as "Feeling fearful", and "Suddenly scared for no reason."

Isaac's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 2, illustrates that the effectiveness of a narrative therapy intervention was not effective because of

no change for decreasing or subsiding his hostility symptoms as he scored as low as possible on this rating dimension. Evaluation of the PEM statistic for the hostility measure (0.00) indicated that all seven scores were on the therapeutic even with the baseline (T-score of 34). Trend analysis depicts Isaac's improvement toward reducing hostility symptoms at the beginning of the baseline phase and throughout treatment sessions, as evidenced by reduced scores on items such as "Having urges to beat, injure, or harm someone", and "Having urges to break or smash things."

Isaac's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 2, illustrates that the effectiveness of a narrative therapy intervention was not effective because of no change for decreasing or subsiding his phobic anxiety symptoms as he scored as low as possible on this rating dimension. Evaluation of the PEM statistic for the phobic anxiety measure (0.00) indicated that all seven scores were on the therapeutic even with the baseline (T-score of 40). Trend analysis depicts Isaac's improvement toward reducing phobic anxiety symptoms at the beginning of the baseline phase and throughout treatment sessions, as evidenced by reduced scores on items such as "Having to avoid certain things, places, or activities because they frighten you", and "Feeling nervous when you are left alone."

Isaac's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 2, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his paranoid ideation symptoms. Isaac's paranoid ideation scores however, are not considered clinically relevant because there is no score for interpersonal sensitivity that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the paranoid ideation measure (1.00) indicated that all seven scores were on the therapeutic side

even with the baseline (T-score of 35.5). Trend analysis depicts Isaac's improvement toward reducing paranoid ideation symptoms at the beginning of the baseline phase and throughout treatment sessions, as evidenced by reduced scores on items such as "Feeling that you are watched and talked about by others", and "Feeling others are to blame for most of your troubles."

Isaac's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 2, illustrates that the effectiveness of a narrative therapy intervention was not effective showing no change for decreasing or subsiding his psychoticism symptoms. Isaac's psychoticism scores however, are not considered clinically relevant because there is no score for interpersonal sensitivity that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the psychoticism measure (1.00) indicated that all seven scores were on the therapeutic side even with the baseline (T-score of 37). Trend analysis depicts Isaac's improvement toward reducing psychoticism symptoms after the first baseline measure, as evidenced by reduced scores on items such as "The idea that something is wrong with your mind", and "The idea that someone else can control your thoughts."

**Participant 3.**

Christopher's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 3, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his clinically relevant psychological symptoms. Evaluation of the PEM statistic for the Global Severity Index measure (1.00) indicated that all seven scores were on the therapeutic side below the baseline (T-score of 57). Trend analysis depicts Christopher's improvement towards reducing clinically relevant psychological symptoms throughout treatment

as evidenced by low scores on items such as “Feeling easily annoyed or irritated”, “Feeling blue”, and “Feeling nervous when you are left alone.” Following the end of the first individual narrative therapy session, Christopher’s overall BSI scores demonstrated a decrease consistently where he remained below that of his baseline measurement.

The results of the visual trend analysis for all the symptom dimension measures of somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, paranoid thinking, phobic anxiety, and psychoticism shows Christopher experiencing a decrease in those psychological symptoms. This was observed from the first treatment measure and observed throughout to the withdrawal measures, suggesting that Christopher made improvement in managing those symptoms at the end of baseline phase and maintaining through treatment and during the withdrawal of treatment.

Christopher’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 3, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his somatization symptoms. Evaluation of the PEM statistic for the somatization measure (1.00) indicated that all seven scores were on the therapeutic side below the baseline (T-score of 50). Trend analysis depicts Christopher’s improvement toward reducing somatization symptoms after the first treatment measure, as evidenced by reduced scores on items such as “Nausea or upset stomach”, and “Pains in the heart or chest.”

Christopher’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 3, illustrates that the effectiveness of a narrative therapy intervention was moderately effective for decreasing or subsiding his obsessive-compulsive symptoms. Evaluation of the PEM statistic for the obsessive-compulsive measure (.71) indicated that five scores were on the therapeutic side below the baseline (T-score of 58.5). Trend analysis depicts Christopher’s

improvement toward reducing obsessive-compulsive symptoms at the second treatment measure, as evidenced by reduced scores on items such as “Trouble remembering things”, and “Difficulty making decisions.”

Christopher’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 3, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his interpersonal sensitivity symptoms. Evaluation of the PEM statistic for the interpersonal sensitivity measure (1.00) indicated that all seven scores were on the therapeutic side below the baseline (T-score of 52). Trend analysis depicts Christopher’s improvement toward reducing interpersonal sensitivity symptoms at the first treatment measure, as evidenced by reduced scores on items such as “Feeling that people are unfriendly or dislike you”, and “Feeling inferior to others.”

Christopher’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 3, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his depressive symptoms. Evaluation of the PEM statistic for the depression measure (1.00) indicated that all seven scores were on the therapeutic side below the baseline (T-score of 50.5). Trend analysis depicts Christopher’s improvement toward reducing depression symptoms at the first treatment measure, as evidenced by reduced scores on items such as “Feeling hopeless about the future”, and “Feelings of worthlessness.”

Christopher’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 3, illustrates that the effectiveness of a narrative therapy intervention was moderately effective for decreasing or subsiding his anxiety symptoms. Evaluation of the PEM statistic for the anxiety measure (.71) indicated that five scores were on the therapeutic side below the baseline (T-score of 52.5). Trend analysis depicts Christopher’s improvement toward reducing

anxiety symptoms after the first treatment measure, as evidenced by reduced scores on items such as “Feeling fearful”, and “Suddenly scared for no reason.” Christopher showed an increase in this symptom dimension at the last two measurements, suggesting that his anxiety increased towards the end of treatment. This change in anxiety may have occurred due to Christopher anticipating a transition back to the juvenile detention center and appearing back in court due to violating the terms of his conditions at the juvenile boot-camp facility.

Christopher’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 3, illustrates that the effectiveness of a narrative therapy intervention was moderately effective for decreasing or subsiding his hostility symptoms. Evaluation of the PEM statistic for the hostility measure (.85) indicated that six scores were on the therapeutic side below the baseline (T-score of 65.5). Trend analysis depicts Christopher’s improvement toward reducing hostility symptoms after the second treatment measure, as evidenced by decreased scores on items such as “Having urges to beat, injure, or harm someone”, and “Having urges to break or smash things.”

Christopher’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 3, illustrates that the effectiveness of a narrative therapy intervention was moderately effective for decreasing or subsiding his phobic anxiety symptoms. Christopher’s phobic anxiety scores however, are not considered clinically relevant because there are no scores for phobic anxiety that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the phobic anxiety measure (.85) indicated that six scores were on the therapeutic side below the baseline (T-score of 50.5). Christopher’s symptoms of phobic anxiety decreased around the time of his third baseline measure. Trend analysis depicts Christopher’s improvement toward reducing

phobic anxiety symptoms, as evidenced by decreased scores on items such as “Having to avoid certain things, places, or activities because they frighten you”, and “Feeling nervous when you are left alone.”

Christopher’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 3, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his paranoid ideation symptoms. Christopher’s paranoid ideation scores however, are not considered clinically relevant because there is no score for interpersonal sensitivity that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the paranoid ideation measure (1.00) indicated that seven scores were on the therapeutic side below the baseline (T-score of 46.5). Trend analysis depicts Christopher’s improvement toward reducing paranoid ideation symptoms after the third baseline measure, as evidenced by reduced scores on items such as “Feeling that you are watched and talked about by others”, and “Feeling others are to blame for most of your troubles.”

Christopher’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 3, illustrates that the effectiveness of a narrative therapy intervention was moderately effective for decreasing or subsiding his psychoticism symptoms. Evaluation of the PEM statistic for the psychoticism measure (.85) indicated that six scores were on the therapeutic side below the baseline (T-score of 52.5). Trend analysis depicts Christopher’s improvement toward reducing psychoticism symptoms after the fourth baseline measure and again after the second treatment measure, as evidenced by reduced scores on items such as “The idea that something is wrong with your mind”, and “The idea that someone else can control your thoughts.”

**Participant 4.**

Roman's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 4, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his clinically relevant psychological symptoms. Roman's Global Severity Index (GSI) scores however, are not considered clinically relevant because there is no score for GSI that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case. Evaluation of the PEM statistic for the Global Severity Index measure (1.00) indicated that all ten scores were on the therapeutic side below the baseline (T-score of 38).

Trend analysis depicts Roman's improvement to reduce clinically relevant psychological symptoms during the beginning of treatment as evidenced by reduced scores on items such as "Feeling easily annoyed or irritated", "Feeling blue", and "Feeling nervous when you are left alone." Roman's overall BSI scores demonstrated a decrease consistently where he remained below that of his baseline measurement. The results of the visual trend analysis for all the symptom dimension measures of somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, paranoid thinking, phobic anxiety, and psychoticism shows Roman experiencing a decrease in those psychological symptoms. This was observed from the third baseline measure and again at the first treatment measure and observed throughout treatment, suggesting that Roman made improvement in managing those symptoms.

Roman's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 4, illustrates that the effectiveness of a narrative therapy intervention was debatably effective for decreasing or subsiding his somatization symptoms. Roman's somatization scores however, are not considered clinically relevant because there is no score for somatization that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case

for this symptom dimension. Evaluation of the PEM statistic for the somatization measure (.50) indicated that seven scores were on the therapeutic side below the baseline (T-score of 43.5). Trend analysis depicts Roman's improvement toward reducing somatization symptoms after the fourth treatment measure, as evidenced by reduced scores on items such as "Nausea or upset stomach", and "Pains in the heart or chest."

Roman's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 4, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his obsessive-compulsive symptoms. Roman's obsessive-compulsion scores however, are not considered clinically relevant because there is no score for obsessive-compulsion that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the obsessive-compulsive measure (1.00) indicated that all ten scores were on the therapeutic side below the baseline (T-score of 49.5). Trend analysis depicts Roman's improvement toward reducing obsessive-compulsive symptoms at the third baseline measure and at the beginning of treatment at the first treatment measure, as evidenced by reduced scores on items such as "Trouble remembering things", and "Difficulty making decisions."

Roman's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 4, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his interpersonal sensitivity symptoms. Roman's interpersonal sensitivity scores however, are not considered clinically relevant because there is no score for interpersonal sensitivity that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the interpersonal sensitivity measure (1.00) indicated that ten scores were on the therapeutic side

below the baseline (T-score of 40.5). Trend analysis depicts Roman's improvement toward reducing interpersonal sensitivity symptoms after the third baseline measure and at the first treatment measure, as evidenced by reduced scores on items such as "Feeling that people are unfriendly or dislike you", and "Feeling inferior to others."

Roman's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 4, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his depression symptoms. Roman's depression scores however, are not considered clinically relevant because there is no score for depression that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the depression measure (1.00) indicated that ten scores were on the therapeutic side below the baseline (T-score of 38.5). Trend analysis depicts Roman's improvement toward reducing depression symptoms after the second baseline measure, as evidenced by reduced scores on items such as "Feeling hopeless about the future", and "Feelings of worthlessness."

Roman's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 4, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his anxiety symptoms. Roman's anxiety scores however, are not considered clinically relevant because there is no score for anxiety that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the anxiety measure (1.00) indicated that seven scores were on the therapeutic side below the baseline (T-score of 38). Trend analysis depicts Roman's improvement toward reducing anxiety symptoms after the first treatment

measure, as evidenced by reduced scores on items such as “Feeling fearful”, and “Suddenly scared for no reason.”

Roman’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 4, illustrates that the effectiveness of a narrative therapy intervention was moderately effective for decreasing or subsiding his hostility symptoms. Roman’s hostility scores however, are not considered clinically relevant because there is no score for hostility that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the hostility measure (.70) indicated that six scores were on the therapeutic side below the baseline (T-score of 41). Trend analysis depicts Roman’s improvement toward reducing hostility symptoms after the first and at the sixth treatment measure, as evidenced by decreased scores on items such as “Having urges to beat, injure, or harm someone”, and “Having urges to break or smash things.”

Roman’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 4, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his phobic anxiety symptoms. Roman’s phobic anxiety scores however, are not considered clinically relevant because there is no score for phobic anxiety that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the phobic anxiety measure (1.00) indicated that only one scores was on the therapeutic side below the baseline (T-score of 44). Trend analysis depicts Roman’s improvement toward reducing phobic anxiety symptoms after the fourth baseline measure, as evidenced by decreased scores on items such as “Having to avoid certain things, places, or activities because they frighten you”, and “Feeling nervous when you are left alone.”

Roman's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 4, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his paranoid ideation symptoms. Roman's paranoid ideation scores however, are not considered clinically relevant because there is no score for paranoid ideation that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the paranoid ideation measure (1.00) indicated that ten scores were on the therapeutic side below the baseline (T-score of 37). Trend analysis depicts Roman's improvement toward reducing paranoid ideation symptoms after the fourth baseline measure, and sustained throughout treatment as evidenced by reduced scores on items such as "Feeling that you are watched and talked about by others", and "Feeling others are to blame for most of your troubles."

Roman's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 4, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his psychoticism symptoms. Roman's psychoticism scores however, are not considered clinically relevant because there is no score for psychoticism that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the psychoticism measure (1.00) indicated that ten scores were on the therapeutic side below the baseline (T-score of 43). Trend analysis depicts Roman's improvement toward reducing psychoticism symptoms after the fourth baseline measure, and sustained throughout treatment as evidenced by reduced scores on items such as "The idea that something is wrong with your mind", and "The idea that someone else can control your thoughts."

**Participant 5.**

Omar's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 5, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his clinically relevant psychological symptoms. Evaluation of the PEM statistic for the Global Severity Index measure (1.00) indicated that all four scores were on the therapeutic side below the baseline (T-score of 57). Trend analysis depicts Omar's improvement to reduce clinically relevant psychological symptoms during treatment as evidenced by reduced scores on items such as "Feeling easily annoyed or irritated", "Feeling blue", and "Feeling nervous when you are left alone." Following the end of the first individual narrative therapy session, Omar's overall BSI scores demonstrated a decrease consistently where he remained below that of his baseline measurement.

The results of the visual trend analysis for all the symptom dimension measures of somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, paranoid thinking, phobic anxiety, and psychoticism shows Omar experiencing a decrease in those psychological symptoms. This was observed from the first treatment measure and observed throughout, suggesting that Omar made improvement in managing those symptoms and maintaining through treatment. Omar was only able to complete four treatment measures as he afterwards successfully graduated from boot-camp and no longer attended the facility. Omar was linked to appropriate resources following his transition.

Omar's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 5, illustrates that the effectiveness of a narrative therapy intervention was moderately effective for decreasing or subsiding his somatization symptoms. Evaluation of the PEM statistic for the somatization measure (.75) indicated that four scores were on the therapeutic side below the baseline (T-score of 50). Trend analysis depicts Omar's improvement toward reducing

somatization symptoms after the first treatment measure, as evidenced by reduced scores on items such as “Nausea or upset stomach”, and “Pains in the heart or chest.”

Omar’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 5, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his obsessive-compulsive symptoms. Evaluation of the PEM statistic for the obsessive-compulsive measure (1.00) indicated that all four scores were on the therapeutic side below the baseline (T-score of 60). Trend analysis depicts Omar’s improvement toward reducing obsessive-compulsive symptoms after the first treatment measure, as evidenced by reduced scores on items such as “Trouble remembering things”, and “Difficulty making decisions.”

Omar’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 5, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his interpersonal sensitivity symptoms. Evaluation of the PEM statistic for the interpersonal sensitivity measure (1.00) indicated that all four scores were on the therapeutic side below the baseline (T-score of 60). Trend analysis depicts Omar’s improvement toward reducing interpersonal sensitivity symptoms after the first treatment measure, as evidenced by reduced scores on items such as “Feeling that people are unfriendly or dislike you”, and “Feeling inferior to others.”

Omar’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 5, illustrates that the effectiveness of a narrative therapy intervention was moderately effective for decreasing or subsiding his depression symptoms. Evaluation of the PEM statistic for the depression measure (.75) indicated that three scores were on the therapeutic side below the baseline (T-score of 54.5). Trend analysis depicts Omar’s improvement toward reducing

depression symptoms after the first treatment measure, as evidenced by reduced scores on items such as “Feeling hopeless about the future”, and “Feelings of worthlessness.”

Omar’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 5, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his anxiety symptoms. Omar’s anxiety scores however, are not considered clinically relevant because there is no score for anxiety that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the anxiety measure (1.00) indicated that all four scores were on the therapeutic side below the baseline (T-score of 44). Trend analysis depicts Omar’s improvement toward reducing anxiety symptoms after the first treatment measure, as evidenced by reduced scores on items such as “Feeling fearful”, and “Suddenly scared for no reason.”

Omar’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 5, illustrates that the effectiveness of a narrative therapy intervention was moderately effective for decreasing or subsiding his hostility symptoms. Evaluation of the PEM statistic for the hostility measure (.75) indicated that three scores were on the therapeutic side below the baseline (T-score of 51.5). Trend analysis depicts Omar’s improvement toward reducing hostility symptoms after the first treatment measure, as evidenced by decreased scores on items such as “Having urges to beat, injure, or harm someone”, and “Having urges to break or smash things.”

Omar’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 5, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his phobic anxiety symptoms. Omar’s phobic anxiety scores however, are not considered clinically relevant because there is no score for phobic anxiety that falls below

the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the phobic anxiety measure (1.00) indicated that all four scores were on the therapeutic side below the baseline (T-score of 48). Trend analysis depicts Omar's improvement toward reducing phobic anxiety symptoms after the fourth baseline measure, as evidenced by decreased scores on items such as "Having to avoid certain things, places, or activities because they frighten you", and "Feeling nervous when you are left alone."

Omar's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 5, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his paranoid ideation symptoms. Evaluation of the PEM statistic for the paranoid ideation measure (1.00) indicated that all four scores were on the therapeutic side below the baseline (T-score of 58.5). Trend analysis depicts Omar's improvement toward reducing paranoid ideation symptoms after the first treatment measure, as evidenced by reduced scores on items such as "Feeling that you are watched and talked about by others", and "Feeling others are to blame for most of your troubles."

Omar's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 5, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his psychoticism symptoms. Evaluation of the PEM statistic for the psychoticism measure (1.00) indicated that all four scores were on the therapeutic side slightly below the baseline (T-score of 54). Trend analysis depicts Omar's improvement toward reducing psychoticism symptoms after the fourth baseline measure and sustained after the first treatment measure and throughout, as evidenced by reduced scores on items such as "The idea that

something is wrong with your mind", and "The idea that someone else can control your thoughts."

**Participant 6.**

Baylea's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 6, illustrates that the effectiveness of a narrative therapy intervention was debatably effective for decreasing or subsiding her clinically relevant psychological symptoms. Evaluation of the PEM statistic for the Global Severity Index measure (.61) indicated that seven scores were on the therapeutic side below the baseline (T-score of 79). Trend analysis depicts Baylea's struggle to reduce clinically relevant psychological symptoms during the first half of treatment as evidenced by high scores on items such as "Feeling easily annoyed or irritated", "Feeling blue", and "Feeling nervous when you are left alone." Following the end of the fifth individual narrative therapy session, Baylea's overall BSI scores demonstrated a decrease consistently where she remained below that of her baseline measurement. This decrease began occurring during her landscape of action and landscape of identity phases in treatment.

The results of the visual trend analysis for the symptom dimension measures of psychoticism, paranoid ideation, hostility, depression, somatization, and interpersonal sensitivity shows Baylea experiencing a decrease in those psychological symptoms. This was observed toward the latter half of treatment and observed throughout the withdrawal measures, suggesting that Baylea made improvement in managing those symptoms at the end and partly during the withdrawal of treatment.

Baylea's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 6, illustrates that the effectiveness of a narrative therapy intervention was debatably effective for decreasing or subsiding her somatization symptoms. Evaluation of the PEM statistic for the

somatization measure (.69) indicated that nine scores were on the therapeutic side below the baseline (T-score of 72.5). Trend analysis depicts Baylea's improvement toward reducing somatization symptoms after the first and sixth treatment measure, as evidenced by reduced scores on items such as "Nausea or upset stomach", and "Pains in the heart or chest."

Baylea's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 6, illustrates that the effectiveness of a narrative therapy intervention was not effective for decreasing or subsiding her obsessive-compulsive symptoms. Evaluation of the PEM statistic for the obsessive-compulsive measure (.30) indicated that four scores were on the therapeutic side below the baseline (T-score of 77). Trend analysis depicts Baylea's improvement toward reducing obsessive-compulsive symptoms after the eighth treatment measure, as evidenced by reduced scores on items such as "Trouble remembering things", and "Difficulty making decisions."

Baylea's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 6, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding her interpersonal sensitivity symptoms. Evaluation of the PEM statistic for the interpersonal sensitivity measure (.92) indicated that 12 scores were on the therapeutic side below the baseline (T-score of 71). Trend analysis depicts Baylea's improvement toward reducing interpersonal sensitivity symptoms after the first treatment measure, as evidenced by reduced scores on items such as "Feeling that people are unfriendly or dislike you", and "Feeling inferior to others."

Baylea's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 6, illustrates that the effectiveness of a narrative therapy intervention was moderately effective for decreasing or subsiding her depression symptoms. Evaluation of the PEM statistic for the

depression measure (.76) indicated that ten scores were on the therapeutic side below the baseline (T-score of 65.5). Trend analysis depicts Baylea's improvement toward reducing depression symptoms after the second treatment measure, as evidenced by reduced scores on items such as "Feeling hopeless about the future", and "Feelings of worthlessness." Baylea's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 6, illustrates that the effectiveness of a narrative therapy intervention was not effective for decreasing or subsiding her anxiety symptoms. Evaluation of the PEM statistic for the anxiety measure (.38) indicated that five scores were on the therapeutic side below the baseline (T-score of 79.5). Trend analysis depicts Baylea's improvement toward reducing anxiety symptoms after the sixth treatment measure, as evidenced by reduced scores on items such as "Feeling fearful", and "Suddenly scared for no reason."

Baylea's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 6, illustrates that the effectiveness of a narrative therapy intervention was debatably effective for decreasing or subsiding her hostility symptoms. Evaluation of the PEM statistic for the hostility measure (.53) indicated that seven scores were on the therapeutic side below the baseline (T-score of 70.5). Trend analysis depicts Baylea's improvement toward reducing hostility symptoms after the sixth treatment measure, as evidenced by reduced scores on items such as "Having urges to beat, injure, or harm someone", and "Having urges to break or smash things." Baylea's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 6 illustrates that the effectiveness of a narrative therapy intervention was not effective for decreasing or subsiding her phobic anxiety symptoms. Evaluation of the PEM statistic for the phobic anxiety measure (.46) indicated that only six scores were on the therapeutic side below the baseline (T-score of 76). Trend analysis depicts Baylea's struggle toward reducing phobic

anxiety symptoms during the first five treatment measures. We see a reduction in symptoms however, after the sixth treatment measure, as evidenced by reduced scores on items such as "Having to avoid certain things, places, or activities because they frighten you", and "Feeling nervous when you are left alone."

Baylea's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 6, illustrates that the effectiveness of a narrative therapy intervention was moderately effective for decreasing or subsiding her paranoid ideation symptoms. Evaluation of the PEM statistic for the paranoid ideation measure (.76) indicated that ten scores were on the therapeutic side below the baseline (T-score of 70). Trend analysis depicts Baylea's improvement toward reducing paranoid ideation symptoms after the third treatment measure, as evidenced by reduced scores on items such as "Feeling that you are watched and talked about by others", and "Feeling others are to blame for most of your troubles."

Baylea's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 6, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding her psychoticism symptoms. Evaluation of the PEM statistic for the psychoticism measure (.92) indicated that 12 scores were on the therapeutic side below the baseline (T-score of 71.5). Trend analysis depicts Baylea's improvement toward reducing psychoticism symptoms after the second treatment measure, as evidenced by reduced scores on items such as "The idea that something is wrong with your mind", and "The idea that someone else can control your thoughts."

**Participant 7.**

Randy's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 7, illustrates that the effectiveness of a narrative therapy intervention was very effective for

decreasing or subsiding his clinically relevant psychological symptoms. Randy's Global Severity Index (GSI) scores however, are not considered clinically relevant because there is no score for GSI that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case. Evaluation of the PEM statistic for the Global Severity Index measure (1.00) indicated that all nine scores were on the therapeutic side below the baseline (T-score of 40.5). Trend analysis depicts Rudy's improvement to reduce clinically relevant psychological symptoms during the beginning of treatment as evidenced by reduced scores on items such as "Feeling easily annoyed or irritated", "Feeling blue", and "Feeling nervous when you are left alone." Rudy's overall BSI scores demonstrated a decrease consistently where he remained below that of his baseline measurement.

The results of the visual trend analysis for all the symptom dimension measures of somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, paranoid thinking, phobic anxiety, and psychoticism shows Rudy experiencing a decrease in those psychological symptoms. This was observed from the third baseline measure and again at the first treatment measure and observed throughout treatment, suggesting that Rudy made improvement in managing those symptoms.

Randy's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 7, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his somatization symptoms. Randy's somatization scores however, are not considered clinically relevant because there is no score for interpersonal sensitivity that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the somatization measure (1.00) indicated that all nine scores were on the therapeutic side below the baseline (T-

score of 42.5). Trend analysis depicts Randy's improvement toward reducing somatization symptoms after the second baseline measure, as evidenced by reduced scores on items such as "Nausea or upset stomach", and "Pains in the heart or chest."

Randy's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 7, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his obsessive-compulsive symptoms. Randy's obsessive-compulsion scores however, are not considered clinically relevant because there is no score for obsessive-compulsion that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the obsessive-compulsive measure (1.00) indicated that nine scores were on the therapeutic side below the baseline (T-score of 48). Trend analysis depicts Randy's improvement toward reducing obsessive-compulsive symptoms after the second baseline measure, as evidenced by reduced scores on items such as "Trouble remembering things", and "Difficulty making decisions."

Randy's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 7, illustrates that the effectiveness of a narrative therapy intervention was moderately effective for decreasing or subsiding his interpersonal sensitivity symptoms. Randy's interpersonal sensitivity scores however, are not considered clinically relevant because there is no score for interpersonal sensitivity that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the interpersonal sensitivity measure (.77) indicated that seven scores were on the therapeutic side below the baseline (T-score of 40.5). Trend analysis depicts Randy's improvement toward reducing interpersonal sensitivity symptoms after the second baseline

measure, as evidenced by reduced scores on items such as “Feeling that people are unfriendly or dislike you”, and “Feeling inferior to others.”

Randy’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 7, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his depression symptoms. Randy’s depression scores however, are not considered clinically relevant because there is no score for depression that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the depression measure (1.00) indicated that all nine scores were on the therapeutic side below the baseline (T-score of 38.5). Trend analysis depicts Randy’s improvement toward reducing depression symptoms after the third baseline measure, as evidenced by reduced scores on items such as “Feeling hopeless about the future”, and “Feelings of worthlessness.”

Randy’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 7, illustrates that the effectiveness of a narrative therapy intervention was not effective showing no change for decreasing or subsiding his anxiety symptoms. Randy’s anxiety scores however, are not considered clinically relevant because there is no score for anxiety that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the anxiety measure (0.00) indicated that no scores were on the therapeutic side, as they were all even with the baseline (T-score of 70). Trend analysis depicts Randy’s reduced anxiety symptoms, as evidenced by reduced scores on items such as “Feeling fearful”, and “Suddenly scared for no reason.”

Randy’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 7, illustrates that the effectiveness of a narrative therapy intervention was moderately effective

for decreasing or subsiding his hostility symptoms. Evaluation of the PEM statistic for the hostility measure (.77) indicated that seven scores were on the therapeutic side below the baseline (T-score of 49.5). Trend analysis depicts Randy's improvement toward reducing hostility symptoms after the second treatment measure, as evidenced by reduced scores on items such as "Having urges to beat, injure, or harm someone", and "Having urges to break or smash things."

Randy's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 7, illustrates that the effectiveness of a narrative therapy intervention was not effective showing no change for decreasing or subsiding his phobic anxiety symptoms. Randy's phobic anxiety scores however, are not considered clinically relevant because there is no score for phobic anxiety that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the phobic anxiety measure (0.00) indicated that no scores was on the therapeutic side, and they were all even with the baseline (T-score of 40). Trend analysis depicts Randy maintaining a reduction in phobic anxiety symptoms, as evidenced by reduced scores on items such as "Having to avoid certain things, places, or activities because they frighten you", and "Feeling nervous when you are left alone."

Randy's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 7, illustrates that the effectiveness of a narrative therapy intervention was moderately effective for decreasing or subsiding his paranoid ideation symptoms. Randy's paranoid ideation scores however, are not considered clinically relevant because there is no score for paranoid ideation that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the

paranoid ideation measure (.77) indicated that seven scores were on the therapeutic side below the baseline (T-score of 42). Trend analysis depicts Randy's improvement toward reducing paranoid ideation symptoms at the second treatment measure, as evidenced by reduced scores on items such as "Feeling that you are watched and talked about by others", and "Feeling others are to blame for most of your troubles."

Randy's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 7, illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his psychoticism symptoms. Randy's psychoticism scores however, are not considered clinically relevant because there is no score for psychoticism that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for this symptom dimension. Evaluation of the PEM statistic for the psychoticism measure (1.00) indicated that ten scores were on the therapeutic side slightly below the baseline (T-score of 46.5). Trend analysis depicts Randy's improvement toward reducing psychoticism symptoms after the third baseline measure, as evidenced by reduced scores on items such as "The idea that something is wrong with your mind", and "The idea that someone else can control your thoughts."

**Participant 8.**

Jesse's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 8, illustrates that the effectiveness of a narrative therapy intervention was debatably effective for decreasing or subsiding his clinically relevant psychological symptoms. Evaluation of the PEM statistic for the Global Severity Index measure (.62) indicated that five scores were on the therapeutic side below the baseline (T-score of 52.5).

Trend analysis depicts Jesse struggling to reduce clinically relevant psychological symptoms during the end of treatment as evidenced by high scores on items such as “Feeling easily annoyed or irritated”, “Feeling blue”, and “Feeling nervous when you are left alone.” This contention became most apparent after the sixth treatment measure when a majority of his symptom dimensions such as depression, anxiety, hostility, and phobic anxiety continuously scored high. This was because during this time, Jesse experienced conflict with some of the other cadets at the boot-camp facility, and was jumped by two cadets and because of some behavior problems following the incident, he violated the terms of his conditions at boot-camp and was sent back to the juvenile detention center and later was sent to the Texas Youth Commission. An increase in his clinically relevant psychological symptoms was observed toward the latter half of treatment, suggesting that Jesse struggled managing his symptoms at the end of treatment.

Jesse’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 8, illustrates that the effectiveness of a narrative therapy intervention was debatably effective for decreasing or subsiding his somatization symptoms. Evaluation of the PEM statistic for the somatization measure (.62) indicated that five scores were on the therapeutic side below the baseline (T-score of 53). Trend analysis depicts Jesse’s improvement toward reducing somatization symptoms after the second treatment measure, as evidenced by reduced scores on items such as “Nausea or upset stomach”, and “Pains in the heart or chest.”

Jesse’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 8, illustrates that the effectiveness of a narrative therapy intervention was debatably effective for decreasing or subsiding his obsessive-compulsive symptoms. Evaluation of the PEM statistic for the obsessive-compulsive measure (.62) indicated that five scores were on the therapeutic side below the baseline (T-score of 47). Trend analysis depicts Jesse’s improvement toward reducing

obsessive-compulsive symptoms after the second treatment measure, as evidenced by reduced scores on items such as “Trouble remembering things”, and “Difficulty making decisions.”

Jesse’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 8, illustrates that the effectiveness of a narrative therapy intervention was debatably effective for decreasing or subsiding his interpersonal sensitivity symptoms. Evaluation of the PEM statistic for the interpersonal sensitivity measure (.62) indicated that five scores were on the therapeutic side below the baseline (T-score of 53.5). Trend analysis depicts Jesse’s improvement toward reducing interpersonal sensitivity symptoms after the second treatment measure, as evidenced by reduced scores on items such as “Feeling that people are unfriendly or dislike you”, and “Feeling inferior to others.”

Jesse’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 8, illustrates that the effectiveness of a narrative therapy intervention was debatably effective for decreasing or subsiding his depression symptoms. Evaluation of the PEM statistic for the depression measure (.62) indicated that five scores were on the therapeutic side below the baseline (T-score of 58). Trend analysis depicts Jesse’s improvement toward reducing depression symptoms after the second treatment measure, as evidenced by reduced scores on items such as “Feeling hopeless about the future”, and “Feelings of worthlessness.”

Jesse’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 8, illustrates that the effectiveness of a narrative therapy intervention was moderately effective for decreasing or subsiding his anxiety symptoms. Evaluation of the PEM statistic for the anxiety measure (.75) indicated that six scores were on the therapeutic side below the baseline (T-score of 57.5). Trend analysis depicts Jesse’s improvement toward reducing anxiety symptoms after

the first treatment measure, as evidenced by reduced scores on items such as “Feeling fearful”, and “Suddenly scared for no reason.”

Jesse’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 8, illustrates that the effectiveness of a narrative therapy intervention was debatably effective for decreasing or subsiding his hostility symptoms. Evaluation of the PEM statistic for the hostility measure (.62) indicated that five scores were on the therapeutic side below the baseline (T-score of 57). Trend analysis depicts Jesse’s struggle toward reducing hostility symptoms at the seventh treatment measure, as evidenced by increased scores on items such as “Having urges to beat, injure, or harm someone”, and “Having urges to break or smash things.”

Jesse’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 8, illustrates that the effectiveness of a narrative therapy intervention was debatably effective for decreasing or subsiding his phobic anxiety symptoms. Evaluation of the PEM statistic for the phobic anxiety measure (.62) indicated that five scores were on the therapeutic side below the baseline (T-score of 52). Trend analysis depicts Jesse’s symptoms of phobic anxiety decreasing around the time of his second treatment measure, but increasing at his seventh treatment measure, as evidenced by increased scores on items such as “Having to avoid certain things, places, or activities because they frighten you”, and “Feeling nervous when you are left alone.”

Jesse’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 8, illustrates that the effectiveness of a narrative therapy intervention was debatably effective for decreasing or subsiding his paranoid ideation symptoms. Evaluation of the PEM statistic for the paranoid ideation measure (.62) indicated that five scores were on the therapeutic side below the baseline (T-score of 47.5). Trend analysis depicts Jesse’s improvement toward reducing paranoid ideation symptoms after the second treatment measure, but struggled after the seventh treatment

measure as evidenced by increased scores on items such as “Feeling that you are watched and talked about by others”, and “Feeling others are to blame for most of your troubles.”

Jesse’s ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 8, illustrates that the effectiveness of a narrative therapy intervention was moderately effective for decreasing or subsiding his psychoticism symptoms. Evaluation of the PEM statistic for the psychoticism measure (.75) indicated that six scores were on the therapeutic side slightly below the baseline (T-score of 55). Trend analysis depicts Jesse’s improvement toward reducing psychoticism symptoms after the first treatment measure, but struggled gain at the seventh treatment measure as evidenced by increased scores on items such as “The idea that something is wrong with your mind”, and “The idea that someone else can control your thoughts.

## Participant Narratives and Discussion

In the current study, I focused on the mediating effects of a narrative therapy intervention for reducing clinically relevant psychological symptoms among youth in a juvenile boot-camp facility. The secondary purpose of this study was to bring forth the stories from youth, age 15-17, in a juvenile justice boot-camp facility. The purpose is to gain an understanding of the psychological symptoms that youth experience, as well as, to examine the effectiveness of a narrative therapy counseling intervention for reducing clinically relevant psychological symptoms and psychological adjustment problems manifested by youth at a juvenile boot-camp facility. This research study addressed 1) how participation in narrative therapy sessions impacted youth cadet’s clinically relevant psychological symptoms and adjustment problems, and 2) provided insight on the experiences of these youth cadets within a juvenile justice boot-camp facility.

In this chapter, I present narratives of participant's experiences through receiving narrative therapy, and the results of the research questions as well as interpretation of these results. These narratives intend to provide insight as to what it is like being in a juvenile justice boot-camp facility, as well as exploring the role that clinically relevant psychological symptoms played within the lives and experiences of these youth. Lastly, these narratives hope to bring forth the perceptions of youth on how the narrative therapy sessions helped them deal with clinically relevant psychological symptoms at a juvenile justice boot-camp facility. Following this, I offer implications based on this study's findings. Finally, I present recommendations for practice and research.

**Participant 1.**

One of the greatest impacts from the narrative therapy sessions identified for Michelle is seen from her ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 1, on the effectiveness of a narrative therapy intervention being moderately effective for decreasing or subsiding her obsessive-compulsive symptoms. Michelle made improvements on most domains consistently after about the fifth treatment measure. Michelle was a young Hispanic female sentenced to boot-camp for continued charges for runaway behavior. She was there for her second time and she was very unhappy with her life. Michelle had a child who was being raised by her mother due to her continued absence from her parental duties. Michelle and I first talked about why she was there and how this occurred multiple times. She told a story of a young girl who only knew how to run from dysfunction and abuse. She often referred to her lowest moments as "miserable days." During her miserable days she told stories about sadness, guilt, anger, fear, and revenge.

She explained that she was in boot-camp the first time for running away and being in a hostile, volatile environment. She did not like following rules and often displayed defiant behaviors toward anyone in authority. Due to her lack of commitment to the court and the conditions of probation the judge sentenced her to boot-camp. Her child was born and living with her mother. She was there for nine months which is usually the average stay. Upon her release she was told to follow the rules of probation and to take care of her child. She did not go home, she immediately went back to the violent environment and therefore was sentenced back to boot-camp.

Michelle told me that she wanted to feel loved. Although she had been beaten by this person she loved, she felt he was the only one who loved her and took care of her when she was on the streets. She realized this time he was not someone she needed to be with and the relationship was unhealthy. It was so unhealthy she had homicidal thoughts often. She required numerous safety plans, crisis assessments and evaluations by psychiatrist through the boot-camp facility. She told many stories about her experiences with family members that reinforced her belief that she was not loved by anyone but this person who abused her.

When she became pregnant by her abuser, she said her happy days had begun. She was then nurtured based on her story. She talked about being hungry and needing things and he did whatever it took to get what she would need and the baby. Her family she felt had disowned her because they did not check on her or help her plan for the baby. Michelle just wanted to feel loved. Michelle quickly found out that being pregnant did not stop the abuse or change the way he showed her love. She only knew one love, the one that hurt and caused scars that she could not erase. Her stories were filled with abuse by people she loved and cared about. The men in her life that were supposed to protect her, did not, they hurt her and taught her to fight.

Michelle had anger that followed her and hostility that she used toward anyone that crossed her path. She did not get along with the other females in her unit. She had trouble with the staff and always turned to hostility as a way of coping with any situation that was difficult or challenging to manage. Over the course of two months she spoke about her miserable life and how hard it is and will be for her because she is a young mother. She started sharing stories about her child and what type of mother she hoped she could be. She admitted she lacked role models in her life that she could look up to as good mothers. She began to talk about her child and identify what healthy relationships would look like for her. She began to understand she made some negative choices and how they had impacted her relationship with her child.

As Michelle made new discoveries things were changing. Through exploring unique outcomes she found many of her own stories that gave her examples of herself being a good mother. She was granted supervised visitation with her child while in boot-camp and began identifying moments when her child responded to her positively. She began to feel validated as being a good mother by her own mother. Her feelings of hostility began to diminish as a way of coping with difficulty. Her relationships with family members were beginning to improve. She felt stronger and began to talk about what true unconditional love should look like. She talked about feeling important and wanting to get her life together so she could learn to be the best parent she could be. She realized she did not want miserable days filled with anger and hostility to continue to rob her of her relationship with others.

Then she was delivered a message. She began to have feelings of hostility that she stated she could not control. She began to have doubt in herself and the miserable days were back. She found out that someone who hurt her was in close proximity to her and she wanted to get revenge. Her self-worth plummeted and she had very little desire to follow the daily program.

She later worked through her thoughts and feelings through revisiting some of the stories she had previously shared. We worked on what her happy days would look like if she woke up and it was here today. She began to feel some freedom from the anger that was holding her hostage to her miserable days. Michelle was able to shift her focus to her child and renewed relationship with her mother in order to stay focused on her goals.

As we continued to work through landscape of action and identify new themes Michelle struggled to break the link between her past abusive relationship and the person she wants to be. She began to see herself as a loving mother. She rediscovered stories about her family that showed her they cared and wanted to support her. She identified people who showed her unconditional love and provided her with an example of how a loving relationship between her and a significant other should be. Michelle called this her "new life." Michelle was in the discovery phase but she needed more time. The abuse she experienced and the love she desired was so very strong. Her child provided that link between her past life and the life she desired to have. She often said "I need that man in my life he is the father of my child. He was the only person who really loved me, even though he would hit me. You know sometimes I deserved it because I ran my mouth." Michelle, like so many in boot-camp, have experienced abuse causing feelings of hostility to be extremely high.

Living in a hostile environment, while working on decreasing hostility as a way of coping, is difficult. Michelle also shared stories where she felt she needed her hostility to protect herself in boot-camp. Working on finding new ways to cope did not always seem beneficial to Michelle. Michelle is continuing to work toward her new life through therapy. She is also going to start therapy with her mother to help them improve their relationship. She admits she has a long way to go but she is determined. When I asked Michelle, "what have you learned by being

in boot-camp?" Her response was "to stop taking my son for granted. I have to change my life. He needs to know that I am his mother. "

**Participant 2.**

Isaac's Global Severity Index scores, and all other dimension scores are not considered clinically relevant because there are no scores for all the dimensions measured that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for any symptom dimension. Regardless, Isaac was able to benefit from the narrative therapy sessions as explored in the following narrative:

Working with Isaac using Narrative therapy seemed to be an opportunity for him to view himself different than he had before. Isaac was in boot-camp for various offenses linked to substance abuse and violation of probation. He often talked about how he felt bad about himself and depression would show up often encouraging him to want to continue his drug use to escape his family and the life he had. Throughout our early sessions various themes arose as we explored his struggles with substance abuse. He would tell me how he was always in the darkness and drugs formed a disconnect between him and his family members, and his ability to function in school and life. He stated it led him to boot-camp, which felt like being in Alaska. Isaac stated he did not mind being in Alaska because he was learning structure and he needed that in order to improve his relationship with his family and change his life.

He would talk about how his addiction to drugs was like the sun. The drugs were what he wanted more than anything. He preferred having the sun around because it made him feel better. Isaac stated the sun allowed him to escape and feel free, happy and alive. He was able to recognize the negative impact the sun had on his life but the addiction was so strong that he would often find himself in a searching for it after a few days of not using. He described the

moments of searching like being in a hot tub unable to get out. The hot tub was bearable at times but then it would sting and feel prickly so a change had to be made so he would use. He stated he felt so low in those moments. He would become rude and disrespectful and often isolated.

Isaac was able to find some unique outcomes through our session in his life that allowed him to see hope within himself over time. He was able to recall times when he was able to resist the drugs, ask for help and be someone his family could depend on. Although the times when he identified resisting and seeking help was minimal it became impactful to him as he went through boot-camp. Being in Alaska became important. It was a contributing factor in him feeling better about trying to make a change in his life. He was concerned that Alaska might be a temporary improvement but was willing to explore how in the past he was valued in his family, and he could make concrete changes.

He was able to tell stories about his grandmother and how she has loved him unconditionally even though he stole from her, was rude and extremely disrespectful. He would talk about how she always saw the good in him even when he could not. She would tell him about the things he did that made her proud. He said she saw him as a diamond. He told a story about how in boot-camp he had to dig deep to make real change like a diamond being created under pressure. He stated that he has flaws but realized he is more like a diamond than he knew. Isaac pointed out that “diamonds are flawed but never bad.” He described a diamond as a mixture of virtues in a person and how everyone wants to have the best virtues possible. Isaac said “people die for diamonds, they call them blood diamonds.” Isaac was referring to when his grandmother told him, “I would die for you Isaac” and he never really believed he could be loved like that. He was developing hope even though he was trapped in Alaska.

Although we found exceptions to the thoughts and feelings Isaac had about himself, he did not truly start to believe in himself and his ability to change and improve relationships until we explored landscape of identity. Isaac began to work on using his visitation to be more open and honest with his family. He volunteered more in order to help shape himself and mold himself into the diamond he wanted to be while in boot-camp. Isaac began to hear praise from his family, staff and his peers. His insight provided him clarity about what he would need to do to be more successful and he said "I feel like I am finally walking back to Texas." He no longer felt like he was in Alaska.

He earned his furloughs (extended visits with family outside of the boot-camp facility) and used the visits to practice various skills he would need once released. He was able to plan and problem solve as needed when faced with challenges and peers that were negative influences. He noticed his coping skills worked better than before to help him avoid urges to use. He started talking in session about leaving a legacy behind one day. He hoped that he would be remembered for being a good person, like someone who looks people in the eyes when he shook their hands and helped people no matter what. He later revisited the metaphor of being a diamond. He stated "diamonds are worth dying for if you love them, but no one needs to die. I just hope I end up on the hand of a pretty girl instead of in the mouth of a rapper."

**Participant 3.**

Christopher's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 3 illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his interpersonal sensitivity symptoms and symptoms of depression. Christopher is a young adolescent male who grew up in a single parent home with several encounters with Child Protective Services. He often talked about what it was like not having both

parents in his life and how he felt his charges for his offense were not fair. He was reluctant to talk about his charges and would shut down when he felt pushed to communicate. Over time Christopher would discuss various day to day problems of the boot-camp life. He was able to identify the need to improve his anger. He often referred to his moments of anger as Hurricanes, Tornadoes and Earthquakes.

Christopher would explain how life would take a turn when he was trying to make the right choice or avoid negative interactions. He explained a story about being around an older male who he looked up to and felt he could turn to when he needed to get away from the challenge at home. One day of trying to avoid a volatile situation at home by escaping to his friend's house he found himself in a Hurricane. The Hurricane collided with a Tornado and he was left with a sentence to boot-camp. He had hurt someone but he did not agree with his punishment. He would talk about feeling like he was viewed as an evil person. He felt like he was worthless and did not feel like he could recover from what had happened. He felt anger showing up often and did not know how to cope because he felt like no one ever listened to his side of the story.

While in boot-camp the tornadoes and the hurricanes continued to show up and again he felt like no one would ever listen to him. He frequently lost his level, and would get regressed, which meant his time stopped and he had to earn his status back over time. This caused his sentence to be lengthened. He felt hopeless and defeated, but always denied feeling depressed. Christopher began to revisit times in his life that there was a hurricane or tornado and he realized a major trigger was feeling disrespected. He was also able to explain why respect was so important. His father was a man he respected and showed respect to others. He was also able to identify other individuals like the judge and attorney he worked with who were respectful

people. He was able to define respect as listening to someone and caring about what was going on with them. He told me instances where both his attorney and the judge listened and he valued what they had to say and how they interacted with him.

Christopher was beginning to understand why his anger was taking control of him and how not being respected and refusing to give respect was impacting him. He began to try and make some changes even when he felt like he should not. He was able to identify unique outcomes from his past when he was doing well in school and his relationships with his siblings and family were positive. He earned a furlough to go home for a visit and he felt freedom was possibly in his reach. There was an incident while on furlough and he handled it well and the staff investigated it and he was not at fault so he felt trust building between him and staff. He was able to recall staff telling him they can see him trying to keep to himself and follow the rules. He was earning the respect he wanted and he realized he was learning to control his reaction and behaviors.

Although he was doing better, the challenge of living in a boot-camp facility with other males with extreme hostility, led to some small tornadoes and one big Hurricane. Christopher had several altercations that caused him to pick up more charges while at boot-camp. He began to feel like he was in an Earthquake and his world was changing too fast. He would say he just wanted to be free. He began to feel hopeless again and he withdrew. Due to the new charges he was no longer allowed to be in the boot-camp facility, and was transferred to another wing within the building to the juvenile detention center. He was now pending charges and a longer sentence. I was able to continue seeing Christopher at the other lockdown facility and to my surprise he was ready to tell his story. He explained to me that he told his family and attorney the truth about what happened when he picked up the charge for hurting that older man.

Christopher was smiling although he knew he had pending charges that could change his life. He heard from his family that they were proud of him for telling them the truth about that night. He stated his attorney was willing to share it with the judge in order to help him. He felt empowered but still had a lot of concern and his anxiety was taking control more days than not. Christopher was opening up more than ever. He told me his story. He shared how the tornado began to form and he tried to avoid it but there was no way he was trapped and then the hurricane came and he knew the destruction was too much to repair. He explained how challenging it is for him to share this part of his story because he has very little trust in people.

As we explored his side of the story regarding his initial charges using landscape of action, Christopher was able to see how he was not an evil person. He shared moments were he tried to handle the situation appropriately. He was able to identify that he was defending himself as anyone would if they felt attacked. He was still able to share ways he could have handled it differently but he no longer felt like he was a "bad kid". He realized he needed to work harder to maintain self-control in all situations to prevent the hurricanes and tornadoes from occurring.

Christopher wanted to hang on to his new found hope but he struggled to hang on to the elements of his story that validated he was a good person who lost self-control. The earthquake was moving too fast for him and there was nothing more he could. His story was told and he felt good about no longer holding it inside allowing anger to take control. In his cell he had a Bible the last time we met. He had begun reading it to help himself cope with all he was facing. I encouraged Christopher to use the coping skills that were most helpful and he was depending on God. He said "praying right now is what continues to give me hope. I just give it all to God."

**Participant 4.**

Roman's Global Severity Index scores, and all other dimension scores are not considered clinically relevant because there are no scores for all the dimensions measured that falls below the cut-score guideline on the BSI of a T-score of 63, which considers an individual a clinical case for any symptom dimension. Regardless, Roman was able to benefit from the narrative therapy sessions as explored in the following narrative:

Roman began the narrative therapy sessions sharing stories about his past history of mental health treatment. Roman reported how he had been on medications from a young age to assist him in managing his ADHD and Bipolar Disorder symptoms. Roman also shared stories about the many different times he would get in trouble at home and at school due to displaying disruptive and aggressive behaviors. Roman came to define and name his symptoms of impulsivity and hyperactivity as "going for a ride" or having "the rush". Roman shared stories of when the rush would show up in the mornings and blast him through his day at school often leaving no room for focusing and learning. Roman had a history of disrupting class and would often get sent home or be served suspensions. Most of the stories Roman shared about displaying behavior problems and experiencing the rush, followed with stories exploring of the negative impact that these behavior problems had in different areas of his life. Roman used metaphors in his stories about times in which the rush was like a large wave that would pick him up and he take him for the ride like a surfer.

Roman described the waves of the rush causing him to crash into everything leaving people spun and tired from having to keep up with him. Roman talked about how he would see his grandmother tired from taking care of him, and from having to drive him back and forth to appointment after appointment for treatment, with little to no changes occurring with his symptoms. Roman shared how the rush had a negative impact on his relationships at home with

his grandparents, and with his father. There were many occasions in which he was in trouble at school, times he would be lost in class and unable to follow instructions, and Roman shared stories about times he felt as though he was powerless to stop the rush from taking control of his life despite having received a long history of treatment for his symptoms through psychiatric medications and psychosocial rehab skills training and counseling services. Roman also shared stories on how the rush would pull other negative things into his life such as drug use, and other risky behaviors that would cause him to get into further trouble such as involvement with the juvenile justice system. Roman would find himself swept up by the waves of the rush and this led him to believe he is a bother to others, that he has no self-control, and that there is no hope for his future. Much of our sessions focusing on unique outcomes came from stories in his recent history of serving time at the juvenile boot-camp facility. Roman was forced to be in situations in which the rush would show up and he would face serious consequences should he allow the rush to take over. Roman shared times in which he would be restrained, or end up getting into fights with other cadets due to his impulsivity as a result of the rush taking over.

Throughout the sessions, Roman also shared stories that presented evidence of unique outcomes to times in which he practiced self-control. Counselor further explored stories from times in his recent history of when Roman displayed self-control, and what these actions in displaying self-control suggested about what he is capable of. Other stories that were significant came from the boot-camp staff who acknowledged Roman for having self-control, and shared these stories in the presence of Roman and counselor; times in which Roman displayed self-control over a variety of situations that normally would have the rush present. Many stories in which self-control was present was during times when Roman was confronted by boot-camp staff, when other cadets challenged him, and when he was able to learn about school related

material and stay on task in the classroom. Other stories of self-control that emerged throughout sessions were related to Roman achieving success with his physical training tests, and showing self-discipline in his daily routine. Through Roman exploring stories on the impact that his self-control had in different areas of his life, particularly his life in boot-camp, Roman came to believe that he can control his actions and behaviors, and is capable of making better choices for himself leading him to positive outcomes in the future.

**Participant 5.**

Omar's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 5 illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his obsessive-compulsive symptoms, interpersonal sensitivity symptoms, symptoms of paranoid ideation, and symptoms of psychoticism. Since the beginning of treatment, Omar would report having problems getting along with others. Some of the common themes in our sessions would be about his unpleasant encounters with boot-camp staff and with other cadets. Omar would often share stories about how he was criticized by other cadets and how they would regularly bully and pick on him. One of the major causes of their bullying was related to Omar's primary offense that led him to juvenile boot-camp. Omar had shared his primary offense with the other cadets whom he later regretted sharing with, as the other cadets would constantly criticize him and treat him badly after they knew what he had done. Omar would come to believe that he not only was disliked by peers his age, but also by boot-camp staff and by his teachers. Omar would share stories about times he was neglected by others and would come to believe that others do not find him or what he has to say important. Omar would also be very critical of him-self and would say how he thinks he is a bad person for what he had done. Other stories he shared were about his struggle with drug use, and how certain people who had

been important in his life introduced him to drugs which led him to experience struggles in different areas of his life.

Throughout our sessions, there were several unique outcomes that served as discrepancies within the stories he shared. These unique outcomes suggested more about him than how he had initially viewed himself. Omar would share stories about his recent experiences going on furloughs, and how these furloughs were very eventful in how his family and friends interacted with him when he was able to spend free time with them. Omar would share stories about his family and friends throwing big parties for him when he was granted a furlough, and as more furloughs were granted on days between sessions, Omar would return from his furloughs sharing events that were pleasant. In exploring the significance of these events, Omar would come to later believe these events suggested he was cared for and supported by others. Omar would come to later state how he had identified changes in his beliefs about himself based on exploring his stories from the landscape of actions and landscape of identity sessions. Several landscapes of action themes that emerged as a result of our sessions included Omar taking action in seeking support, thinking through challenges, thinking about people important to him, exercising and waking up early, using appropriate communication, and avoiding confrontation.

Several landscape of identity themes that emerged from our sessions which allowed us to explore more about who Omar was and what he valued were related to Omar being supported and cared for by friends and family, and how Omar is supportive. Other landscape of identity themes that emerged were in Omar believing he is a problem solver, he is polite, he has self-control, his is athletic, and that he is a responsible person. We further explored what impact these actions taken, and the themes present in his identity have on implications for his future. Each theme was identified by Omar through the stories he told about himself in the context of the

landscape of action and landscape of identity sessions. When Omar got news that he was going to be going home, he was very excited and happy to be leaving the juvenile boot-camp. Treatment session 5 was our last session together, as he afterwards continued to go on longer furloughs during the times and days in which I was allowed to conduct my study. He later successfully graduated from juvenile boot-camp.

**Participant 6.**

Baylea's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 6 illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding her interpersonal sensitivity symptoms, and symptoms of psychoticism, and moderately effective for decreasing or subsiding her symptoms of paranoid ideation and depression. Baylea is a young Hispanic female who was eager to begin Narrative Therapy. She had struggled with low self-esteem for a couple of years and depression had recently become a challenge for her. She often talked about how she never felt beautiful, important or loved. She had bounced around between parents but yearned for her father's love and attention. She talked about feeling like the "ugly duckling" but with no hope of a positive future with a family that loved her for who she was.

When adolescents are sentenced to boot-camp the staff shaves the male's heads and the females are given a buzz cut. Baylea was devastated and it made a huge negative impact on her self-esteem. She said she felt like she was invisible. She often referred to invisibility showing up and what it was like to not be seen or feel appreciated or valued. She told a story about being assaulted at a party by multiple people and it being displayed for many to see. She stated since then she has been on a "highway to hell." She felt afraid, degraded and unloved. She often shared stories that continued to validate her feeling invisible.

She shared a story about how she worked hard to form a relationship with her father but he was busy working. She felt like any spare time he had was given to others and she again felt invisible and unloved. Baylea wanted her father's time but he did not give it to her so she said she found it elsewhere. When she became sick and needed medical attention she then had to inform her father about the decisions she had made. Her father was angry with her and delivered harsh punishment that she states, "I will never forget because he then stopped talking to me and never looked at me the same. I became invisible." Baylea continued to work through narrative therapy to help her find unique outcomes that she may have not realized were part of her story.

She began to realize that she had moments she experienced with other that provided some discrepancies to her story. She told a story about her relationship with her father and how he would take her shopping. He would allow her to do things that enhanced her looks like getting her nails done, getting her hair cut and also getting a piercing. She also told stories about being respected by others before coming to boot-camp and how she had friends that valued her time and her as a person. She was able to talk about friendships she had developed in boot-camp with some of the female cadets and males that were not about her looks or what she had or did not have. She began to find value in herself. Her "highway to hell," was coming to a fork in the road. She was about to go back to court for a review hearing to discuss her progress and possible early release.

She was not approved to be released. She was disappointed but state she refused to become invisible again. She did not want to allow her value to be determined by one event. She realized that she was feeling better from the inside out. She took what the judge recommended and decided to get a plan to prepare herself for going home. She began to transfer her work from therapy into her school and daily life. She told her story. Baylea decided to trust herself and her

feelings that being open and talking about tough topics with her peers would be okay. She took a leap of faith and she felt free. She also talked to her father and apologized for behaviors that he disapproved of. She was determined to fight off depression and conquer her struggles with low self-esteem.

As Baylea worked on herself new landscape of identity themes began to emerge. She was able to talk about how she felt like a "Picasso" but was working toward becoming a "Mona Lisa." I asked her to explain more and she stated, I am only a Picasso and some people really love those painting but for some they cannot really make it all out. It is blurry and not really clear. It has value and worth but not the true beauty. Through landscape of action she was able to identify that she was beautiful inside an out. She found stories that spoke to her being a strong and resilient person through traumatic events she faced growing up. She was validated by her peers when she shared her story about what happened to her. She no longer felt like she was only capable of being a "Picasso," but well on her way to feeling like a "Mona Lisa."

**Participant** 7.

Randy's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 7 illustrates that the effectiveness of a narrative therapy intervention was very effective for decreasing or subsiding his obsessive-compulsion symptoms, and moderately effective for decreasing or subsiding his symptoms of hostility which was the focus of treatment. Randy approached the narrative therapy sessions rather comfortably. Randy was open to sharing various stories about different experiences that were significant to him in his life. One of the major themes in the stories that Randy would tell and was a focus of treatment was on anger. Randy would talk about how anger had a negative impact in different areas of his life such as at home, in school, and in his relationships with his girlfriends, and his peers. What was particularly

important to Randy was his relationship to his ex-girlfriend. Randy initially began talking about how he would get angry at various times in this relationship, going into detail about different events that would occur, and how his anger would lead his girlfriend to break up with him. Randy also spoke about times he would get angry at the juvenile boot-camp staff, and times in which his anger would get him in trouble. Randy would have to be restrained or spend hours in isolation as a consequence to his anger related behaviors. Randy spoke about his anger as though he himself was an angry person who could not control his actions and behaviors during anger provoking situations.

When Randy was beginning to define and externalize the problem, anger became the problem of focus. In defining and naming the problem, Randy chose to keep the name anger in describing his problem, and began to speak differently on the role of anger and its impact in different areas of his life. Through externalizing the conversations about anger, Randy no longer began to speak as though anger was part of his identity, but rather it being something separate from him. Randy would share other stories as to when this anger became a problem in his life, and the major characters involved. Randy shared how his mother and his girlfriend were the first to notice when the anger would come around, and he was often times the last to notice.

During the evaluating and justifying the effects of the problem stages, Randy shared stories as to how anger would show up during times that he wish it hadn't, and would come to a point in session to say that anger often goes too far and how anger is no longer welcome in his life. Randy would use a variety of metaphors to describe anger, one being that of fire. Randy described anger as a fire in which it would catch onto situations that were important to him, and how it would burn and destroy important things in his life such as his relationship with his girlfriends, and how anger would get him in trouble with the juvenile justice system. There were

stories about anger playing a positive role in his life as well, which was explored in session in the development of unique outcomes to anger and other roles anger had in his life.

During the latter parts of the narrative therapy sessions, several unique outcomes to anger provoking situations were explored. Randy told stories about being involved in anger provoking situations with peers and with adults, and how he was able to have control over anger during those situations. Counselor explored the actions that Randy took in managing his anger, and what Randy believed those actions he had taken in different stories suggested about who he was and what he valued. Randy came to realize throughout treatment that there had been many times in which he had displayed control over anger, and times he took action in mending friendships and relationships. This suggested to Randy that he could be a good friend, and that he is not an angry person but rather someone who values friendship. Through exploring meaning behind other unique outcomes and stories, he came to believe he has self-control in many other aspects of his life, and also he is someone who is goal oriented and has leadership qualities.

**Participant 8.**

Jesse's ratings on the Brief Symptom Inventory (Derogatis, 1993), presented in Figure 7 illustrates that the effectiveness of a narrative therapy intervention was modertaely effective for decreasing or subsiding his anxiety symptoms, and moderately effective for decreasing or subsiding his symptoms of psychoticism. Jesse's experience at juvenile boot-camp were at times challenging for him. During the baseline phases, Jesse reported having few problems managing his mental health symptoms. However following Jesse's fourth baseline measure, that week he experienced a traumatic situation in which he was assaulted by two cadets. Jesse began experiencing an increase in his mental health symptoms, particularly that of depression, suicidal thoughts, and hallucinations. Jesse would occasionally make outcries to boot-camp staff on

having suicidal ideation, and would have to be assessed by a mobile crisis outreach team for crisis assessment and intervention services. Jesse was also hospitalized for five days as a result of his suicidality in between his fourth baseline measure and first treatment session.

During treatment, Jesse shared stories about conflicts he would have with other cadets, and how they would threaten him regularly. Jesse went on to share stories about his past history receiving mental health services, and stories about his life being raised at home. Many of the details within Jesse's stories of growing up were filled with traumatic events. Jesse mentioned characters in his life that made his living situation unpleasant for him. Jesse reported experiencing much criticism at home, and at school. As a result of the different traumatic events he experienced, Jesse would react to many situations in ways that he would find himself in trouble. Jesse would display disruptive and aggressive behaviors often, and would exhibit much of his behavior problems at home towards family members. Some of the beliefs Jesse shared related to his perception of people were that most people are dangerous, and that people can't be trusted. Jesse also verbalized thoughts that he was "stupid" and that he was "unlikeable". When defining and externalizing the problem, Jesse named the problem "the shakes" for his reactions taken in which he identified being the result of various traumas in his life. The "shakes" were primarily intense feelings of anger and sadness in response to unpleasant situations he was faced with. Counselor and Jesse mapped the role that "the shakes" had in different areas of his life, primarily the shakes' role in the juvenile boot-camp facility. Several unique outcomes were identified as the weeks went on.

Jesse shared a story of a time when he was able to handle the shakes appropriately by managing his urges to act out in anger. Within his story, Jesse shared how he was challenged to a fight by another cadet, the same cadet who had previously attacked him. Jesse reported how they

were both in the dorm giving each other mean looks (mad dogging), and the drill sergeant started counting down to ten for them to stop. Jesse stated that when he looked away, he was hit in the head by the other cadet. As a result of this, his reaction was to act out in anger as he reported that he was “really, really, pissed”. Instead of hitting the other cadet back however, he walked away and told the drill sergeant that he wants to be left alone. The drill sergeants left him alone and allowed him time to work on calming down. Jesse reported that he was able to calm down by stopping and thinking about his son. Jesse shared more stories of times when he would reflect on his relationship with his son, and how much his son means to him. Jesse shared strategies he would use such as looking at pictures he had of his son, as well as journaling. Through taking these actions in calming down during times when “”the shakes” showed up, he was able to put some space between the “shakes” and himself in being able to control his behaviors. Other unique outcomes identified from his problem saturated stories came from changes in his physical fitness. Jesse shared stories about how he was teased often when he was young due to being out of shape and overweight.

As Jesse’s time at the juvenile boot-camp facility progressed, he noticed changes in his appearance, as well as in his strength and conditioning. Counselor explored with Jesse through landscape of action and landscape of identity questions what implications these activities of working out and doing physical training suggest about who he is and what he is capable of doing. Jesse came to recognize that he is capable of overcoming his challenge of losing weight. Jesse also came to value his physical fitness and realized that he holds more value in himself than he previously recognized. Other actions Jesse took were to take time in studying and doing homework suggesting that he is capable of doing well in school as he improved his grades for a period of time. After Jesse’s sixth treatment measure, Jesse was assaulted again by two other

cadets. After this event, Jesse exhibited an increase again in mental health symptoms and would fall back in crisis situations having suicidal ideation and displaying hostile behaviors. Due to the increase in Jesse's behavioral problems, he violated the terms of his conditions at juvenile boot-camp, and was sent back to the juvenile detention center where he was later sent to the Texas Youth Commission facility.

In this chapter, the principal investigator provided results based on percentage of data exceeding the median procedures, and also provided qualitative results by sharing participant narratives. It is important to note that although this study measured the effectiveness of a narrative therapy intervention over ten dimensions of functioning on the brief symptom inventory, only several of the dimensions were the focus of treatment for many participants during the narrative therapy sessions. Table 1 provides an overview of participant's effect sizes calculated from PEM procedures. From the results of the PEM analysis, a number of important findings are presented. First, narrative therapy appears to be helpful for reducing clinically relevant psychological symptoms for participants as seen from scores of the Global Severity Index measure ranging from debatably effective to very effective.

Second, there are several dimensions that appeared to show greater improvement over time. These dimensions include interpersonal sensitivity, obsessive-compulsion, depression, and psychoticism. Third, the dimensions of hostility and phobic anxiety were common with some participants for showing lesser improvement over time. Lastly, the results of the narrative inquiries suggest that narrative therapy provided participants with an opportunity to share significant stories of their lives, and assisted participants in exploring positive elements of their stories, and in discovering what these elements explored throughout sessions suggested about

them. Narrative therapy allowed participants to explore new meanings from their stories, in further developing their identity and in creating a preferred life direction.

## Summary

The purpose of this study was to bring forth the stories from youth, age 15-17, in a juvenile justice boot-camp facility. The purpose was to gain an understanding of the psychological symptoms that youth experience, as well as, to examine the effectiveness of a narrative therapy counseling intervention for reducing clinically relevant psychological symptoms manifested by youth at a juvenile boot-camp facility. This research study addressed 1) how participation in narrative therapy sessions impacted youth cadet's clinically relevant psychological symptoms and adjustment problems, and 2) provided insight on the experiences of these youth cadets within a juvenile justice boot-camp facility.

Table 1

*Percentage of Data Exceeding the Median Procedures*

Participants and their Effect Sizes

| Symptom Dimensions | Michelle (10) | Isaac (7) | Christopher (7) | Roman (7) | Omar (4) | Baylea (10) | Randy (9) | Jesse (8) |
|---|---|---|---|---|---|---|---|---|
| Somatization | 0.61 | 0.00 * | 1.00 | 0.50 * | 0.75 | 0.69 | 1.00 * | 0.62 |
| Obsessive-compulsion | 0.76 | 1.00 * | 0.71 | 1.00 * | 1.00 | 0.30 | 1.00 | 0.62 |
| Interpersonal Sensitivity | 0.84 * | 1.00 * | 1.00 | 1.00 * | 1.00 | 0.92 | 0.77 * | 0.62 |
| Depression | 0.53 | 0.00 * | 1.00 | 1.00 * | 0.75 | 0.76 | 1.00 * | 0.62 |
| Anxiety | 0.61 | 0.00 * | 0.71 | 1.00 * | 1.00 * | 0.38 | 0.00 * | 0.75 |
| Hostility | 0.46 | 0.00 * | 0.85 | 0.70 * | 0.75 | 0.53 | 0.77 | 0.62 |
| Phobic Anxiety | 0.07 | 0.00 * | 0.85 * | 1.00 * | 1.00 * | 0.46 | 0.00 * | 0.62 |
| Paranoid Ideation | 0.92 * | 1.00 * | 1.00 * | 1.00 * | 1.00 | 0.76 | 0.77 * | 0.62 |
| Psychoticism | 0.84 | 0.00 * | 0.85 | 1.00 * | 1.00 | 0.92 | 1.00 * | 0.75 |
| Global Severity Index | 0.69 | 1.00 * | 1.00 | 1.00 * | 1.00 | 0.61 | 1.00 * | 0.62 |

*Note. Effect sizes of .90 and greater are indicative of very effective treatments, effect sizes ranging from .70 to .89 represent moderate effectiveness, effect sizes between .50 to .69 are debatably effective, and effect sizes less than .50 are regarded as not effective.*

*Note. Parentheses next to participant names indicate number of treatment sessions. Note. *scores are not clinically relevant.*

# Chapter 5

## Summary, Discussion, and Implications

### Summary

Due to the growing population of youth and adolescents (U.S. Census Bureau, 2005), the growing need for mental health services among youth (Angold et al., 1999; Reynolds, 2001, p. 3; Kim et al, 2003; Costello et al, 2003) and the growth of youth and adolescents involved in the juvenile justice system (Sanborn, 2011), the current study was prompted to examine the effects of narrative therapy with youth at a juvenile boot-camp facility. In the review of the literature, I focused on how a vast number of youth with mental health needs go unrecognized and underserved by mental health and school professionals (Reynolds, 2001; Burke et al, 2005).

Researchers have identified a number of clinically relevant psychological symptoms experienced by youth including somatization, obsessive-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism, and many others (Jaser et al., 2009; Chew et. al., 2010; Derogatis, 1993). Previous research on various treatment approaches used to assist youth in overcoming a variety of mental health disorders were explored. The primary treatment approach used by mental health counselors in community agencies across the state of Texas to treat numerous mental health issues among youth is Cognitive Behavioral Therapy (Clark et al., 2002; Sanborn, 2011).

Although previous research has focused on the implementation of counseling techniques to help youth overcome mental health issues such as depression, anxiety, and behavioral problems (Jaser, Holl, Jefferson, & Grey, 2009), there has remained a dearth of literature on the effectiveness of counseling interventions, particularly the use of narrative therapy, to help youth overcome clinically relevant psychological symptoms and at-risk behaviors while serving time at

a juvenile boot-camp facility. The purpose of this study was to bring forth the stories from youth, age 15-17, in a juvenile justice boot-camp facility. This study also hoped to gain an understanding on the psychological symptoms that youth experience, as well as, to examine the effectiveness of a narrative therapy counseling intervention for reducing clinically relevant psychological symptoms manifested by youth at a juvenile boot-camp facility.

## Discussion and Implications

From the stories shared throughout the narrative therapy sessions, many common similarities were found within participant's narratives. Common at-risk factors were identified as experienced by cadets before coming to juvenile boot-camp. Participants shared similarities related to having a previous history of juvenile justice involvement, a history of mental health issues, poor academic achievement, sexual risk behaviors, teen pregnancy/parenthood, and substance abuse. These similarities relate to the literature as a number of studies have found that youth are becoming increasingly more at risk. Many of these risk factors found in the literature also include youth being at-risk for juvenile justice involvement, sexual risk behaviors, substance abuse, mental health problems, physical health problems, academic problems, teen pregnancy, and many others (Jaser et al., 2009; Chew et. al., 2010; Busen et al., 2008, Wilson et al., 2010, Corlis et al., 2011).

A study by Wilson et al. (2010) found that a majority of youth engage in risky sexual behavior. The results of their study found that youth were less likely to use condoms during receptive anal intercourse with their main partner and were less likely to use condoms with a main partner while under the influence of substances. These results suggest that youth are increasingly becoming at-risk for multiple factors which include sexual risk behaviors and

substance abuse. Sexual risk factors are also common among youth who are at-risk for other factors such as poor health, homelessness, and mental health conditions.

Participating cadets shared similarities in their involvement with the juvenile justice system. Throughout narrative therapy sessions, cadets shared stories about previous arrests and offenses, along with stories from their history struggling to manage significant mental health issues. Many of the participants shared similar past offenses such as burglary, unauthorized use of a motor vehicle, possession of marijuana or other drugs, assaults, truancy, and violations of probation. These similarities suggest that youth are increasingly becoming more at-risk for converging factors.

In a study by Balkin (2011) assessing factors in adolescent adjustment as precursors to recidivism in court-referred youth, court-referred adolescents who had higher degrees of antisocial behavior and anger mismanagement were more likely to reoffend within 2 years of receiving an intervention program. A MANOVA was conducted using an alpha level of .05 on RAASI subscales across two groups: adolescents who did not reoffend after court referral and adolescents who reoffended after court referral (Balkin, 2011). From the results of the MANOVA, the discriminant function in this study was labeled conduct-disorder proneness as a result of the increased scores in antisocial behavior and anger control. Thus, reoffending adolescents may be more likely to engage in antisocial behaviors and have poorer anger control, which are similar characteristics to adolescents diagnosed with conduct disorder (Balkin, 2011). The results of Balkin's (2011) findings may reveal some insight as to the history of repeated offenses from several individuals in this current study. Participant 8, Randy, shared many stories related to anger mismanagement, and how anger would have a negative impact in different areas of his life leading him to reoffend. Although he had been given a diagnosis of Mood Disorder

NOS and Anxiety Disorder NOS, his stories throughout treatment revealed a history of repeated offenses and oppositional tendencies. For Randy, a further diagnostic evaluation may be warranted.

A history of substance use was one of the most commonly shared similarities by participants. Participants Isaac and Jesse had a substance abuse disorder associated with other mental health conditions. Youth with externalizing symptoms and behavioral problems as seen in Table 1 and in the figures for hostility measures, were commonly seen to also have substance abuse in their history. This is seen with participant Isaac and participant Jesse together having a Mood Disorder and /or Conduct Disorder with a secondary diagnosis of Cannabis Abuse and/or Alcohol-related disorder. Many other participants who shared stories related to hostility and anger mismanagement were also noted to share stories of using a variety of substances. Participants also mentioned to have a history of using medications for recreational purposes without being prescribed these medications by doctors. Some of the youth who were mentioned to have substance abuse issues were also noted to be non-compliant with medications prescribed by their psychiatrists. These similarities with participants also relates to the literature, as seen from a study done Sanders et al. (2010) exploring substance use and other risk behaviors among gang youth in Los Angeles, California.

A sample of gang youth were recruited into a National Institute on Drug Abuse (NIDA)-funded qualitative pilot study about substance use and other risk behaviors (Sanders, Lankenau, & Jackson-Bloom, 2010). The results of this study exposed some fairly unexplored issues on substance use among gang youth. For instance, many youth were found to abuse a variety of prescription drugs, especially Vicodin and Codeine (Sanders et al., 2010). Many of these youth also discussed mixing substances, mainly marijuana and alcohol. There was also a link between

substance use and violence, particularly individual and collective fighting, as well as unsafe sexual practices, particularly group sex (Sanders et al., 2010). These themes suggest that youth are increasingly being perceived to use substances as an alternative to taking their prescribed medications, and that youth with externalizing symptoms such as behavioral problems are increasingly being seen as at-risk for using drugs and alcohol.

Many participating cadets shared their perceptions of drug use, with similarities found with cadets being ambiguous to the dangers of drugs like alcohol, marijuana, cocaine, and ecstasy. Participant Randy shared stories of abusing a variety of drugs and alcohol, and how he would ignore the warnings from adults on the harmful effects of drug use. These similarities relate to the findings from a study done by Demant et al. (2010) which explored the risk perceptions of drug-related risks among Danish youths. This study identified five discourses in the discussions on risk of substance abuse by youth. These discourses position specific drugs as more or less harmful. Focusing on cannabis, ecstasy and cocaine, it appeared that light cannabis use is seen as both harmless and accepted, whereas ecstasy is considered very dangerous among youth. Cocaine has an ambiguous position, being perceived as neither harmless nor very dangerous (Demant et al, 2010).

There were differences identified between participants who struggled managing their mental health symptoms throughout the course of the study compared to those who were coping more effectively with their mental health symptoms at the juvenile boot-camp. Participants who managed their mental health symptoms easier shared stories related to having family involvement; and family values. Most participants reported family support and involvement to be the most significant difference in managing their mental health symptoms before receiving treatment and before coming to the juvenile boot-camp facility. Some participants who struggled

in managing their mental health symptoms mentioned having little family support and involvement from parents, as noted by the lack of visitation from family on the weekends. Some cadets had a history of living in foster homes, and mentioned to have spent much of their time unsupervised. Before coming to juvenile boot-camp, many participants had been living at home with a grandparent, rather than with two parents, or were living with a single mother. Many of the participants also shared stories related to their history of family conflict and CPS involvement. In addition, participants who struggled with their symptoms commonly shared similarities associated with discouragement received from their families, and some participants shared similar stories about abuse from family members.

**Challenges and Benefits from Treatment**

Some participants commonly mentioned problems with engaging in session and difficulties sharing their stories. Much of what participants attributed this to was associated with their fears of the counselors disclosing information to boot-camp staff or family members. Other challenges associated to working with participants were related to youth having negative self-regard. Participants had negative expectations about themselves, and had limited understanding of their strengths and began sessions with more awareness of perceived limitations of themselves. Many participants had low self-esteem related to their sense of identity, and internalized their mental health treatment as a deficit in their identity as well. These similarities with participants suggest that youth who are involved with the juvenile justice system continue to have trust issues with mental health professionals, for fear of releasing disclosed information.

Participants shared common elements as a result of treatment associated with positive changes in their symptoms and functioning. Defining and naming the problem, externalizing the problem, and mapping the effects of the problem, all were elements of the narrative therapy

intervention shared by participants to be helpful in working through problems and establishing goals to relieve their symptoms. By exploring the problem and mapping the effects it has had it different areas of their lives, it allows for the development of further sessions in evaluating and justifying the effects of the problem which motives clients to establish goals and banish the problem in their lives. The benefit of this can be linked to the literature from a study done by Balkin et al, (2011) who evaluated the relationship between therapeutic goal attainment to symptomatology for adolescents in acute care psychiatric hospitalization. Four canonical correlations were conducted utilizing the set of subscales for the Goal Attainment Scale of Stabilization (GASS) with each set of subscales for the (a) Suicide Probability Scale (SPS), (b) Target Symptom Rating (TSR), (c) Minnesota Multiphasic Personality Inventory- Adolescent (MMPI-A), and (d) Millon Adolescent Clinical Inventory (MACI). A statistically significant relationship was found between GASS subscales and the TSR subscales. The first canonical root was significant, $\lambda = 0.89$, $F(4, 232) = 3.55$, $p = 0.008$, accounting for 11% ($r_c$=0.33) of the overlapping variance. The results of this study suggested that psychiatric symptoms appear to contribute to therapeutic goal attainment (Balkin et al., 2011). For counselors working with adolescents in crisis residence, familiarity with client issues that promote or inhibit therapeutic progress may be helpful (Balkin et al., 2011).

Other factors that were commonly attributed to youth overcoming many of their problem saturated stories was the use of the landscape of action and landscape of identity questions which occurred for most cadets throughout the fourth and fifth treatment sessions. Change is likely to occur during this phase in treatment rather than in earlier sessions in narrative practice. This is because in earlier sessions, there is the exploration of problems and the impact that the problems have had in participant's lives. Unique outcomes and exceptions to these problems are identified

and later used to explore alternative meanings within the participant's narratives further in treatment. The practices of identifying unique outcomes, landscape of action, and landscape of identity questions in narrative therapy share similarities to the practices in solution-focused therapy. In solution-focused therapy, the conceptualization of the problem is in terms of both the problem and the exception to the problem (de Shazer, 1988), For example, if a client were to define a problem as ineffective coping skills, then the problem would be conceptualized as entailing both ineffective coping skills and effective coping skills (George, 2008; Guterman & Leite, 2006). The change process, therefore, would be for the client to identify exceptions to the problem and amplify them. An exception refers to a circumstance in which the problem does not occur or occurs less frequently or intensely (George, 2008; Murphy, 1997). The counselor then amplifies the client's awareness of how her or his strengths contributed to the absence of the problem. The goals of therapy would, therefore, be achieved by building on existing strengths and resources. The establishment of goals helps to build the expectation that change is going to happen (George, 2008).

Also noted for making positive changes in cadet's mental health symptoms was the increase in family support, and the use of re-membering conversations, having stories told of what family members and boot-camp staff recognized as significant events and unique outcomes to participant's stories, as well as stories of participant's successful utilization of coping skills in overcoming challenging situations at the juvenile boot-camp facility. Participants who also had an increase in family and community support commonly mentioned to be motivated in making positive changes in their lives and also showed an increase in self-esteem as observed in session and measured by the interpersonal-sensitivity measure on the BSI. This relates to findings in the literature for promoting the use of parents and family support with youth and adolescents

(Bourke & Nielsen, 1995; Graziano & Diament, 1992). A recent meta-analysis of parenting interventions found that interventions with the largest effects focused on increasing positive parent-child interactions and emotional communication skills, teaching parents to use time-out and the importance of parenting consistency, and requiring parents to practice new skills with their children during parent training session (Kaminski, Valle, Filene, & Boyle, 2008). It is recommended that family involvement play a role within the implementation of treatment interventions in a juvenile boot-camp facility, especially if narrative practices are implemented because the stories parents and family members can share may serve as unique outcomes and exceptions to a youth's problem. Family support using narrative practice can be very powerful and can lead a youth to have a renewed identity.

Another significant element in this study that lead to positive outcomes with youth cadets came from the relationship established between the cadets and the narrative therapy practitioners. Both narrative therapy practitioners agreed that the therapeutic relationship played a significant role in the progression of the narrative therapy sessions leading towards the reduction in clinically relevant psychological symptoms. Through the establishment of a therapeutic relationship, youth cadets perceived their therapists as trustworthy, which allowed for the sharing and exploration of stories. The cadets shared how because they felt supported and understood by their therapists, and how they felt more free to express themselves in session. Some participants also shared that because they had minimal rapport established with boot-camp staff, meeting for individual therapy sessions was an enjoyable experience. Because there was good rapport established between the cadets and the narrative therapy practitioners, participants were able to share their stories more comfortably with their counselor, enhancing the progression of treatment. The principles at work that lead to establishing a strong therapeutic relationship with

youth cadets can be attributed to conditions of empathy, genuineness, and unconditional positive regard as Rogers (1957) notes being necessary and sufficient conditions for therapeutic personality change to occur. Narrative therapists also agree that these conditions play an important role in establishing good rapport with clients, as the therapeutic relationship is noted by White (2007), as being a critical element in narrative practice.

The results of this research study on the effects of narrative therapy with youth cadets provided insight on the experiences of youth receiving a narrative therapy treatment intervention. By utilizing a narrative therapy treatment approach, the narrative therapists were able to pay attention in identifying unique outcomes to the problem saturated stories of cadets, and noted when the externalized problem doesn't come around. Exploring times when there is an exception to the problem, and exploring in detail the significance of these events works towards the client identifying a new preferred outcome (White, 2007). The narrative therapists used curious questioning to help youth recognize and reflect on the discrepant but positive elements of their current problem saturated stories, which helped to empower them to reformulate a more-preferred life direction. (Weingarten, 1998; White, 2007).

By exploring themes when externalized problems do not show up in the youth's life story, the narrative therapists were able to assist participants in becoming aware of alternatives to their problem saturated story. The narrative therapists were able to explore the hidden details in each participant's life that they had not been previously aware of before. The building blocks for these youth's new story were found in the discovery of hopeful moments, thoughts, and events that did not fit with their problem story, which ultimately assisted youth in re-authoring their preferred life narrative (White, 2007).

From the results of the PEM analysis, a number of important findings emerged. First, narrative therapy appears to be helpful for reducing clinically relevant psychological symptoms for participants as seen from scores of the Global Severity Index measure ranging from debatably effective to very effective. Second, there are several dimensions that appeared to show greater improvement over time. These dimensions include interpersonal sensitivity, obsessive-compulsion, depression, and psychoticism.

Third, the dimensions of hostility and phobic anxiety were common with some participants for showing lesser improvement over time. Lastly, the results of the narrative inquiries suggest that narrative therapy provided participants with an opportunity to share significant stories of their lives, and assisted participants in exploring positive elements of their stories, and in discovering what these elements explored throughout sessions suggested about them. Narrative therapy allowed participants to explore new meanings from their stories, in further developing their identity and in creating a preferred life direction.

## Considerations for Practice

The results of these findings support the use of implementing narrative therapy treatment approaches in juvenile boot-camp settings assisting youth in gaining an increase and awareness of coping skills that can be used to improve their functioning and in managing clinically relevant psychological symptoms and adjustment problems. This study showed the effectiveness of narrative therapy being especially effective for improving symptoms of interpersonal sensitivity, obsessive-compulsion, depression, and psychoticism as demonstrated by the PEM statistic calculated from scores on the Brief Symptom Inventory (Derogatis, 1993). It is recommended that narrative therapy be implemented within juvenile boot-camp facilities and other centers working with youth and adolescents. Narrative therapy appears to yield positive outcomes for

youth who struggle with low self-esteem and depressive symptoms. Not all clients may be suitable for narrative therapy, as there may be other approaches more efficacious for a particular client. Some participants were expecting themselves to violate the terms of their conditions and be sent to the Texas Youth Commission. These participants shared stories about times they won fights, and spoke about the value of being tough and the importance of being strong. These participants shared more stories such as these to prepare themselves for the expectations they had for what they needed to prepare for should they be sent to a facility like TYC. These types of stories suggested to the participants that they were touch and capable of defending themselves, but it is unclear as to the benefit of these stories as it may lead participants to be more prome to violent and hostile actions and behaviors. These stories were carefully examined by the therapists and were not encouraged during session. It is recommended that narrative therapists explore the function of the stories being shared in session, particularly by this population, and explore what other alternative meanings they stories have and say about who they are and what they are capable of.

Although this study assessed the effectiveness of a ten-session narrative therapy intervention, some participants were able demonstrate a reduction in symptoms in as little as four treatment sessions. This may suggest that narrative therapy may yield positive treatment effects with fewer sessions required. A series of reports also have recognized the efficacy of narrative therapy (Anderson & Hiersteiner, 2008; Fraenkel, Hameline, & Shannon, 2009). A study done by Anderson and Hiersteiner (2008), looked at interviews of twenty seven adult survivors of sexual abuse to provide opportunity for the facilitation of these survivor's shared stories and experiences. The following perspective was provided based on the stories shared from group interviews: "Recreating a life story that goes beyond recovery from childhood sexual abuse may

assist an adult survivor to consider a future full of possibilities, including a story book ending" (Fraenkel et al., 2009). Fraenkel et al. (2009) also explored the effects of narrative therapy with homeless families. By externalizing conversations and identifying unique outcomes, these shared stories and experiences helped families strengthen their family identity, and help to keep a hold on hope for the future (Fraenkel et al., 2009). Narrative therapy also has been helpful in working with parents of lesbian, gay, and bi-sexual adolescents (Saltzburg, 2007), pre-graduate counselors (Whiting, 2007), and students who have learning disabilities (Lambie & Milsom, 2010). Narrative therapists have also been helpful in working with adolescents coping with personal and academic challenges.

Several considerations for practice are suggested for counselor educators teaching courses related to narrative therapy. One recommendation is that counseling students involved in sites for practicum and internship courses be allowed the choice to practice narrative therapy in clinical settings that would not otherwise allow narrative therapy in place of CBT within managed care settings. By having counselors practice narrative therapy in clinical settings, there may be an increase in sensitivity and understanding of the experiences many youth face in challenges related to clinically relevant psychological symptoms and adjustment problems. From the results of these findings, it is recommended that narrative therapy be implemented within juvenile boot-camp settings, as narrative therapy can be helpful in assisting youth cadets overcome mental health issues. By giving youth an opportunity to tell their story, they feel acknowledged and heard. Narrative therapy also allows youth cadets to hear elements of their own story that they may have not realized before. By telling their story, youth come to recognize many positive elements of who they are and what they are capable of becoming.

## Limitations and Directions for Future Research

While this study on the effectiveness of narrative therapy for improving adolescents scores on the Brief Symptom Inventory employed several experimental controls, including five baseline measures before treatment, as well as a withdrawal measure following treatment, a well-organized intervention, and assessments of well-validated instruments to assess the dependent variables, some notable limitations are apparent. Although both treatment providers had similar qualifications, participants were not asked to rate the therapeutic relationship with their counselor, which may have impacted the results of this study. It may be possible that a variable for efficacy was the narrative therapist being able to create a more therapeutic environment in addition to their theoretical orientation; therefore more research on the relational qualities of each counselor's approaches is warranted. Because we have a small participant size in our sample, the results of this study and effectiveness of narrative therapy may not be generalizable to the rest of the population, however inferences may be made on the effectiveness of narrative therapy from these outcomes to spur further research.

Although this study used many of the narrative therapy principles as outlined by Michael White in *Maps of Narrative Practice* (White, 2007), there were some elements of narrative therapy that did not occur for all cadets. There was not an opportunity for many cadets to have sessions consisting of definitional ceremonies as many of these cadets were transitioned out due to graduation or other circumstances. Some cadets were unable to have ten sessions of narrative therapy; therefore further research is needed to examine the effectiveness of this approach. Narrative therapy is not an approach that is meant to be 'manualized', this study only examined the impact of narrative therapy as performed by two counselors using principles of narrative therapy as outlined in Michael White's book *Maps of Narrative Practice* (White, 2007).

Due to the clinical presentation of adjustment disorders, the domains of the Brief Symptom Inventory may not easily identify psychological adjustment problems. Therefore, further research using the Reynolds Adolescent Adjustment Screening Inventory (RAASI) assessment (Reynolds, 2001) is recommended for youth and adolescents with psychological adjustment problems within a juvenile boot-camp setting. Because we did not further examine scores on the BSI and other scales for this study, more instruments may be needed to measure the efficacy of interventions.

Researchers can use single-case A-B and A-B-A designs to investigate the treatment interventions on several measures. With this information, counselor educators can implement models that make best use of course time and available supportive resources. Further studies may help to give to an evidence base for narrative therapy interventions with youth and adolescents in a juvenile justice setting.

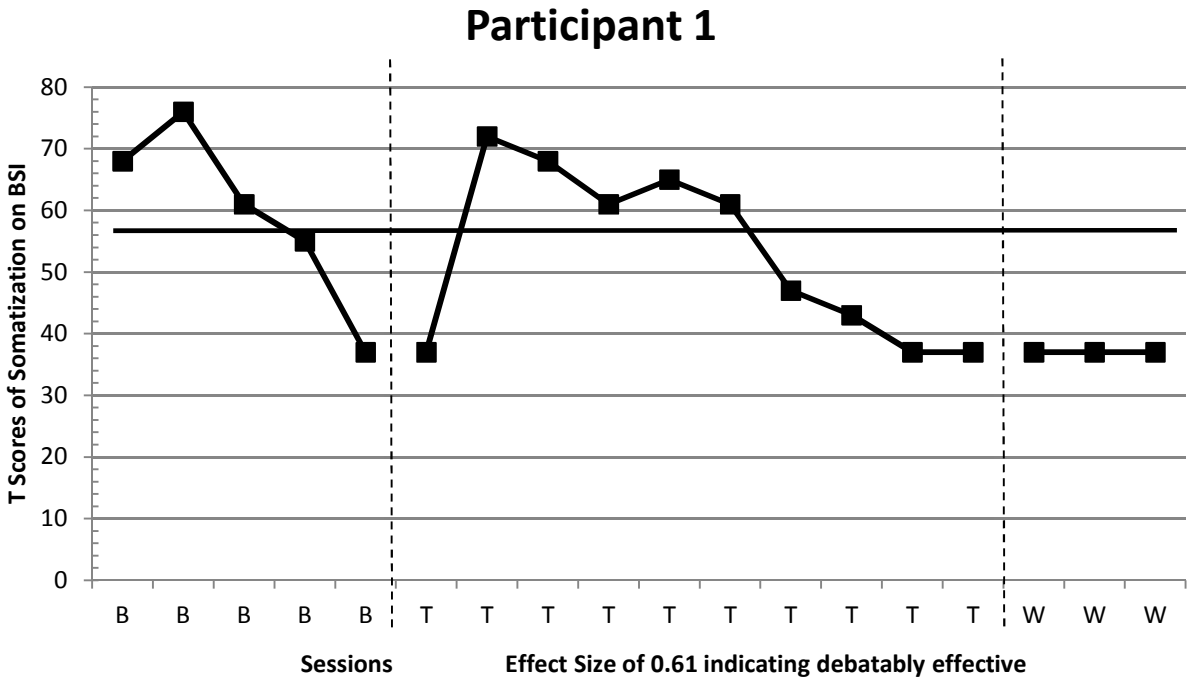
The results of this study allows one to make inferences that narrative therapy treatment approaches are helpful for improving the scores of clinically relevant psychological symptoms in youth using the Brief Symptom Inventory. Further exploration may be warranted on examining the effectiveness of this treatment intervention. Further research would be helpful in validating our quantitative findings as well as a qualitative study in furthering the understanding of what participants identify as important aspects of their experiences of receiving narrative therapy. Further information that may be helpful can include exploring facilitator qualities, opinions of techniques such as externalizing the problems and the use of metaphors, and definitional ceremonies.

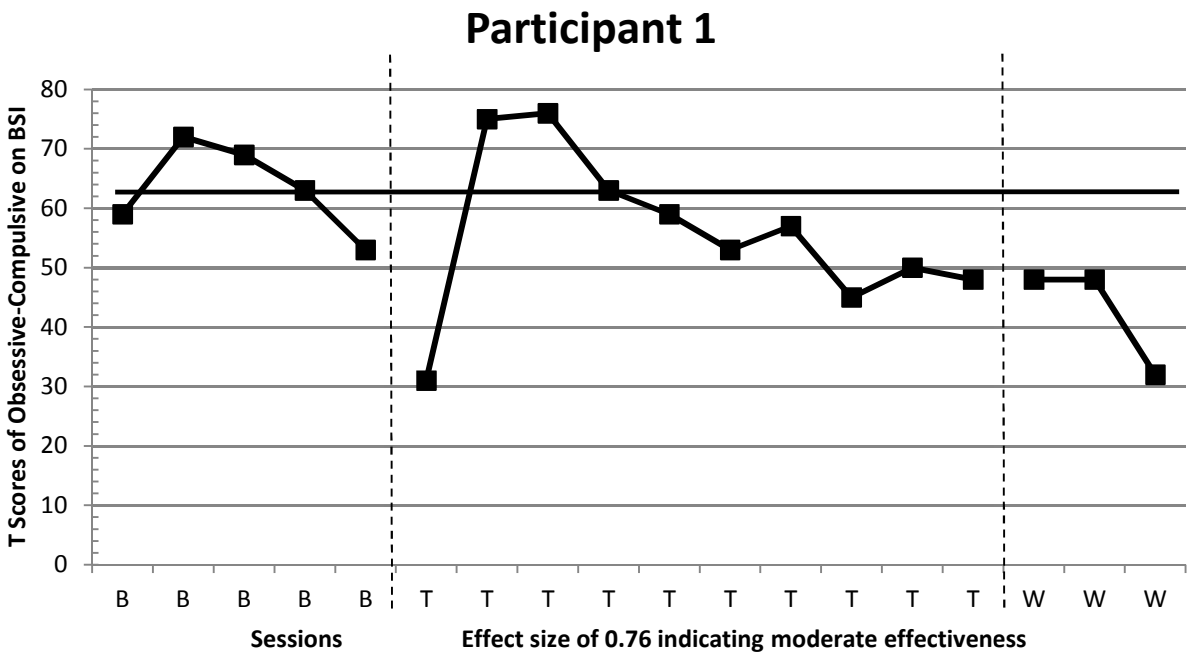
## Conclusion

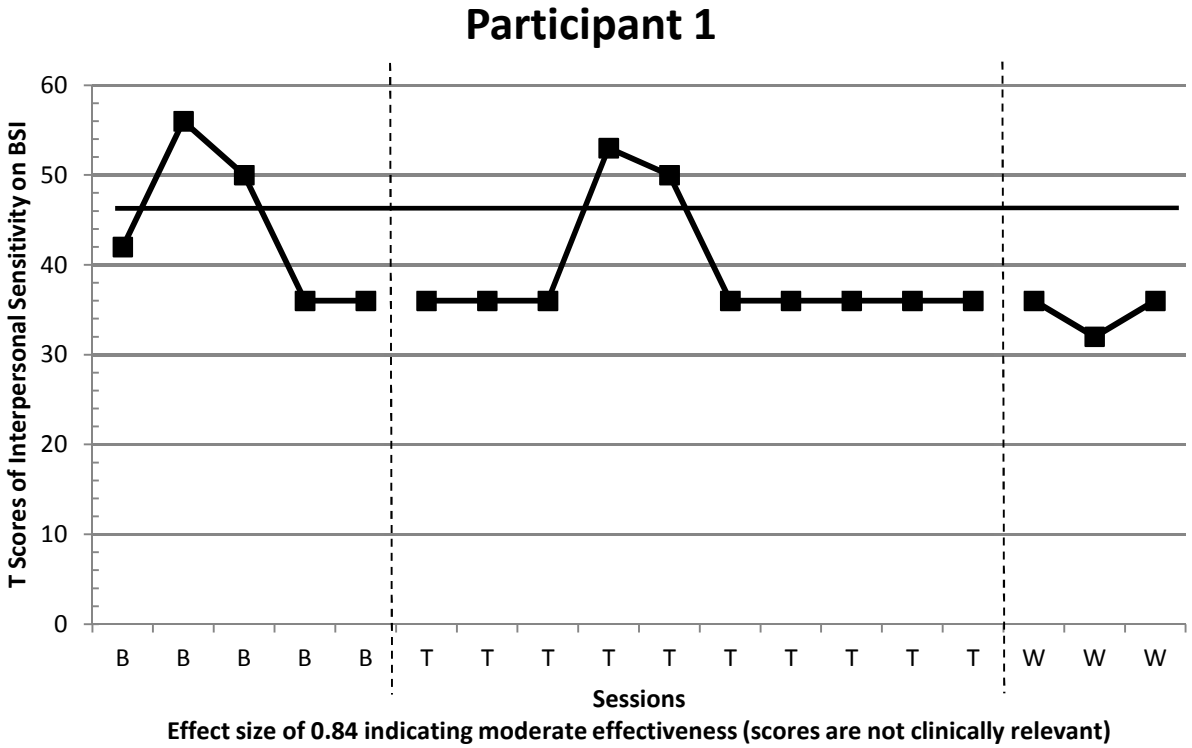
Using a narrative therapy treatment approach to assist youth on improving clinically relevant psychological symptoms and adjustment problems is a strategy that should be considered by counselors in juvenile justice settings, clinical settings, and by counselors in education programs. The results of this single-case research found that implementing a narrative therapy treatment program was associated with generally improved scores for interpersonal sensitivity and an overall improvement in scores for participants with depression, anxiety, obsessive-compulsion, and psychoticism as evidenced by scores on the Brief Symptom Inventory. Because counselor education programs and mental health treatment settings are furthering their research activity and counselor supervision, narrative therapy provides a useful and effective means to enhance youth functioning and improvement in coping skills to manage clinically relevant psychological symptoms. Provided are some guidelines for counselor educators and practitioners to consider when implementing treatment approaches for youth with clinically relevant psychological symptoms and adjustment problems, and it is recommend that this body of research be continued for other educational, work, and health settings. Counselor educators, supervisors, and educational leaders are in a position to promote narrative approaches, which has shown to further youth social and mental health development, however further use and exploration on the effectiveness of narrative therapy is needed.

Figure 1.

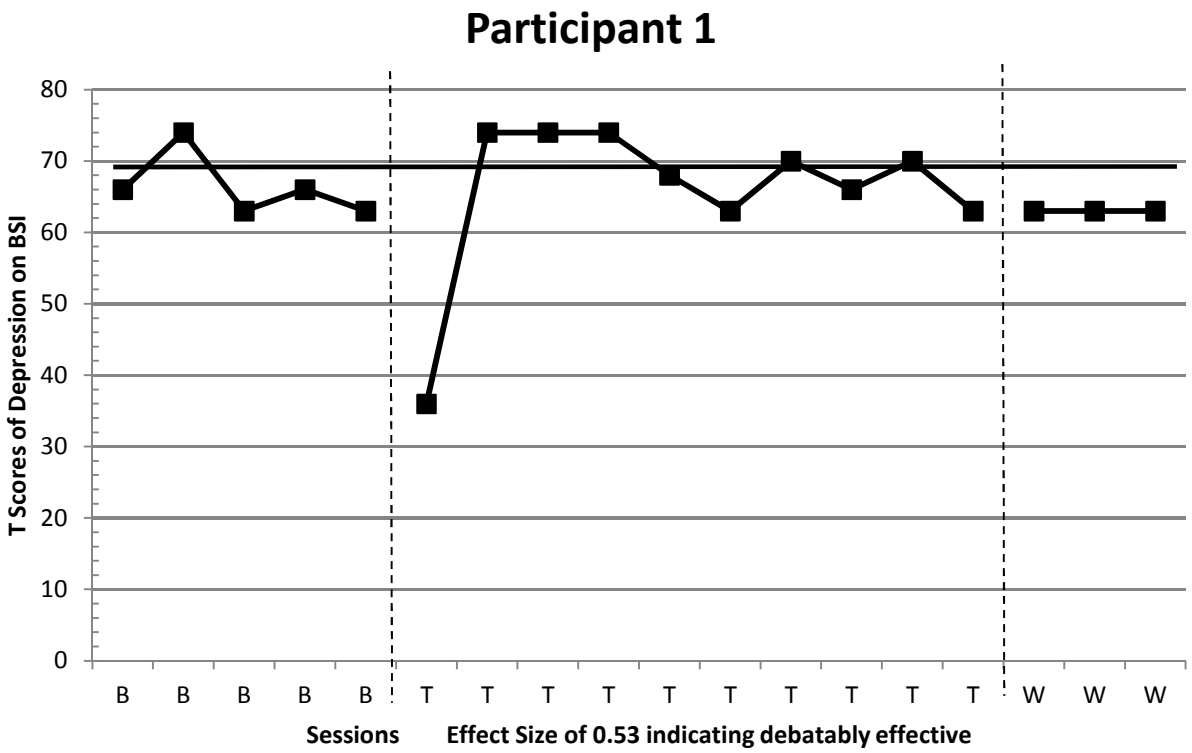
*Graphical Representation of Percentage of Data Exceeding the Median for Ratings of Clinically Relevant Psychological Symptoms by Participant Michelle Engaging in Narrative Therapy Sessions.*



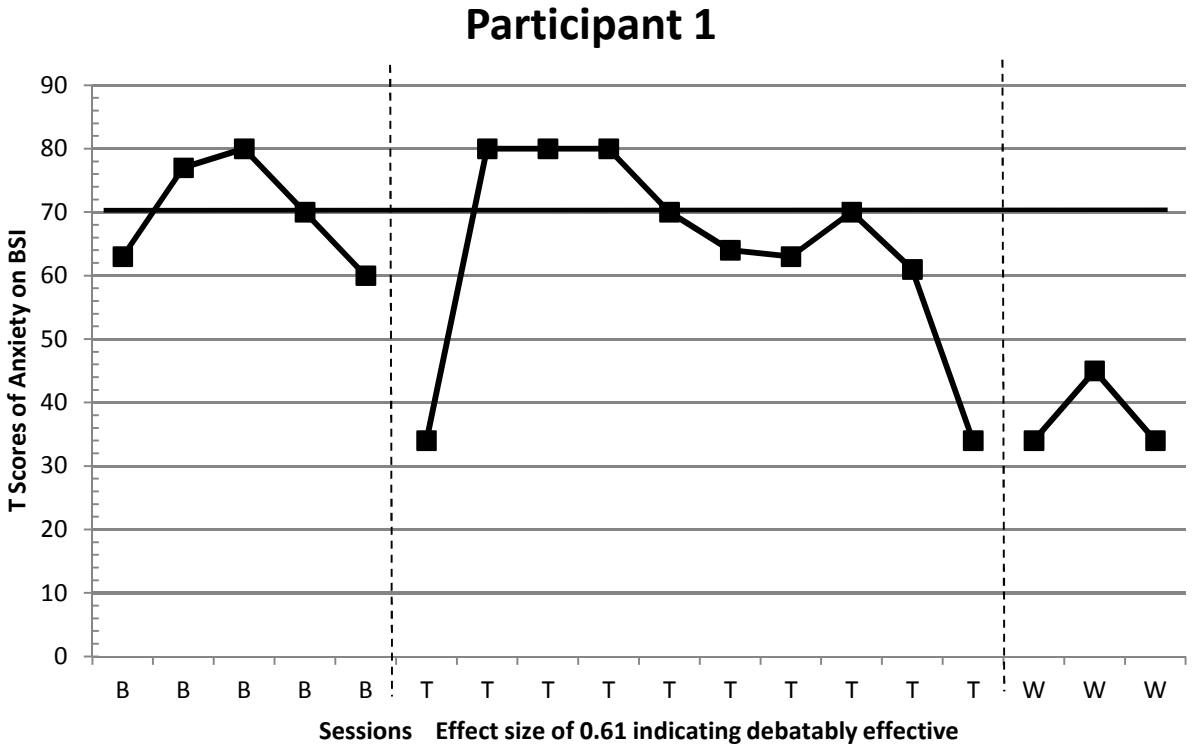



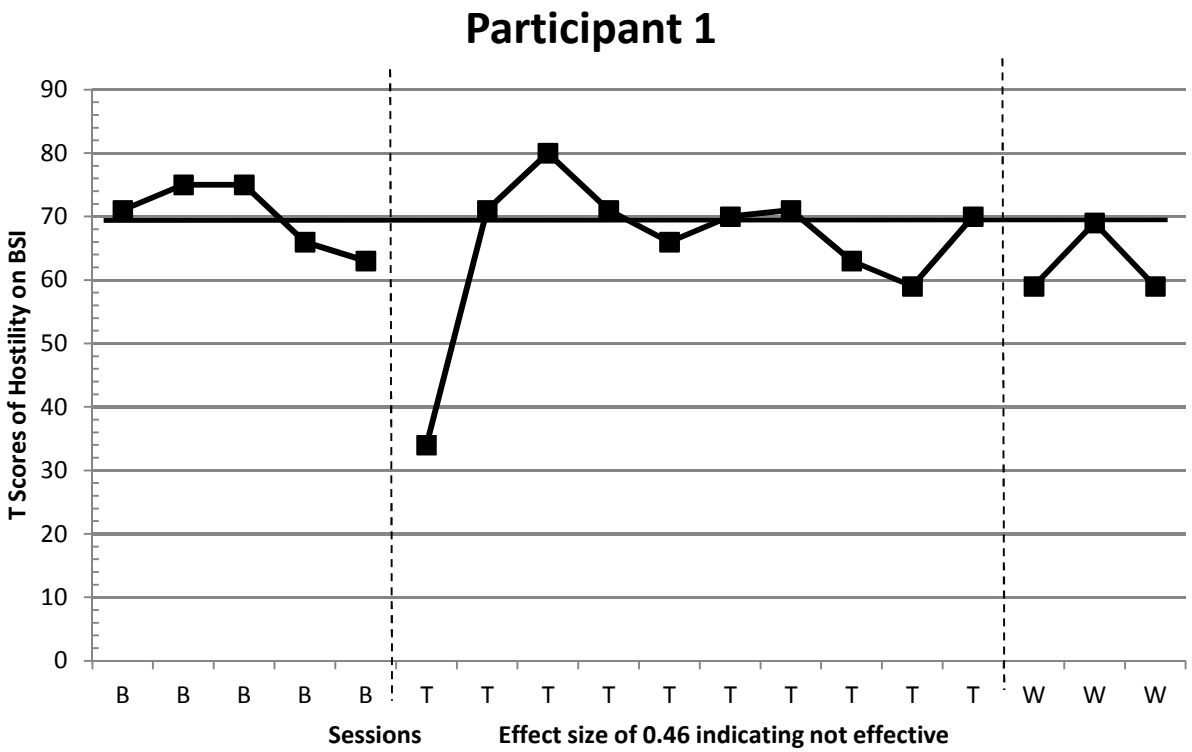


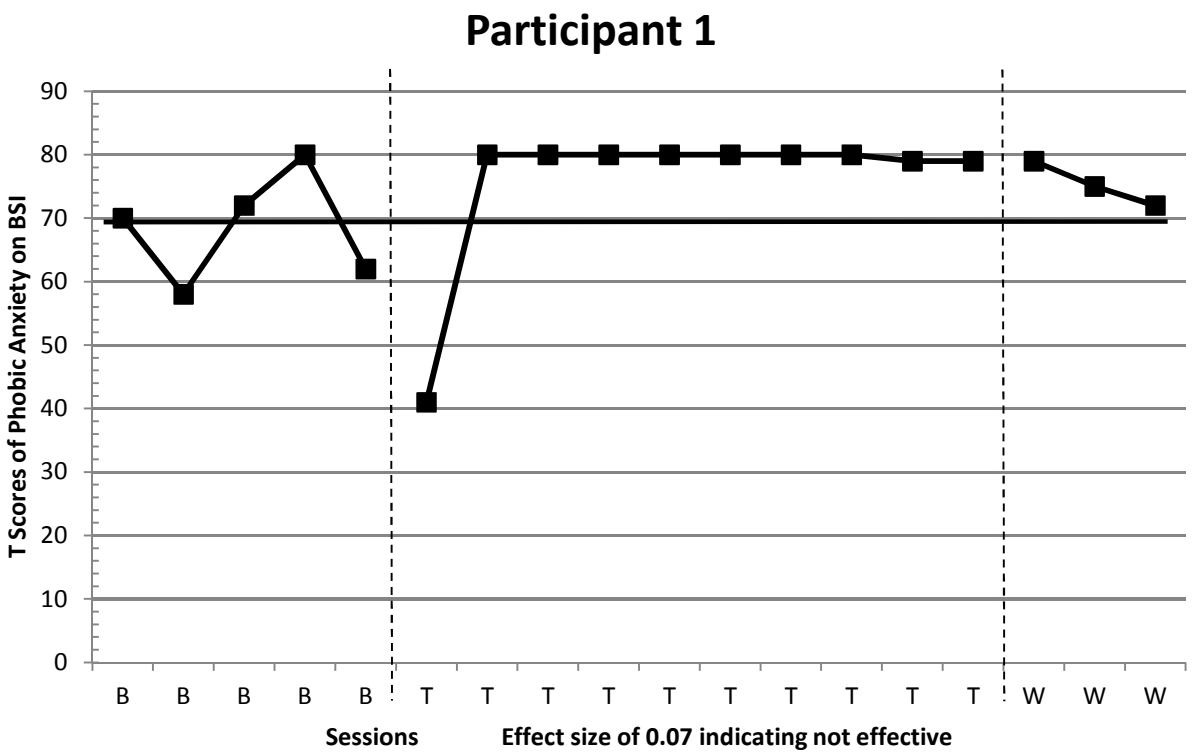

Effect size of 0.84 indicating moderate effectiveness (scores are not clinically relevant)

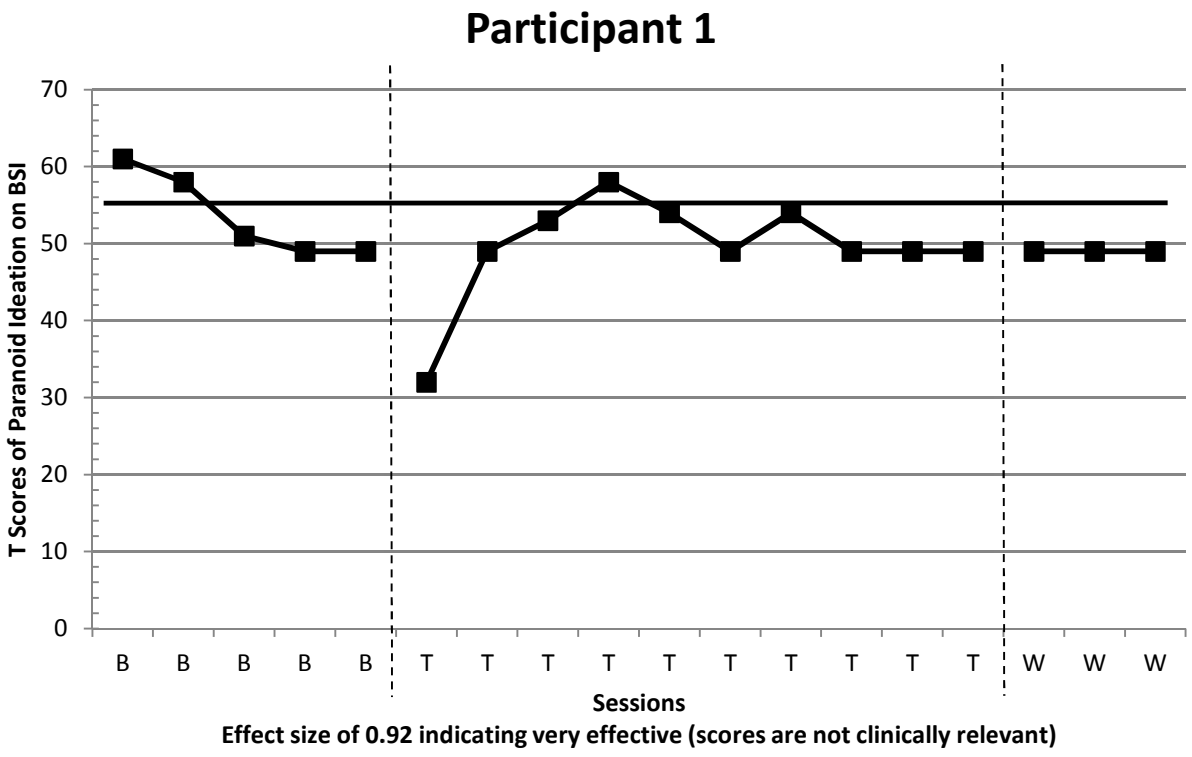


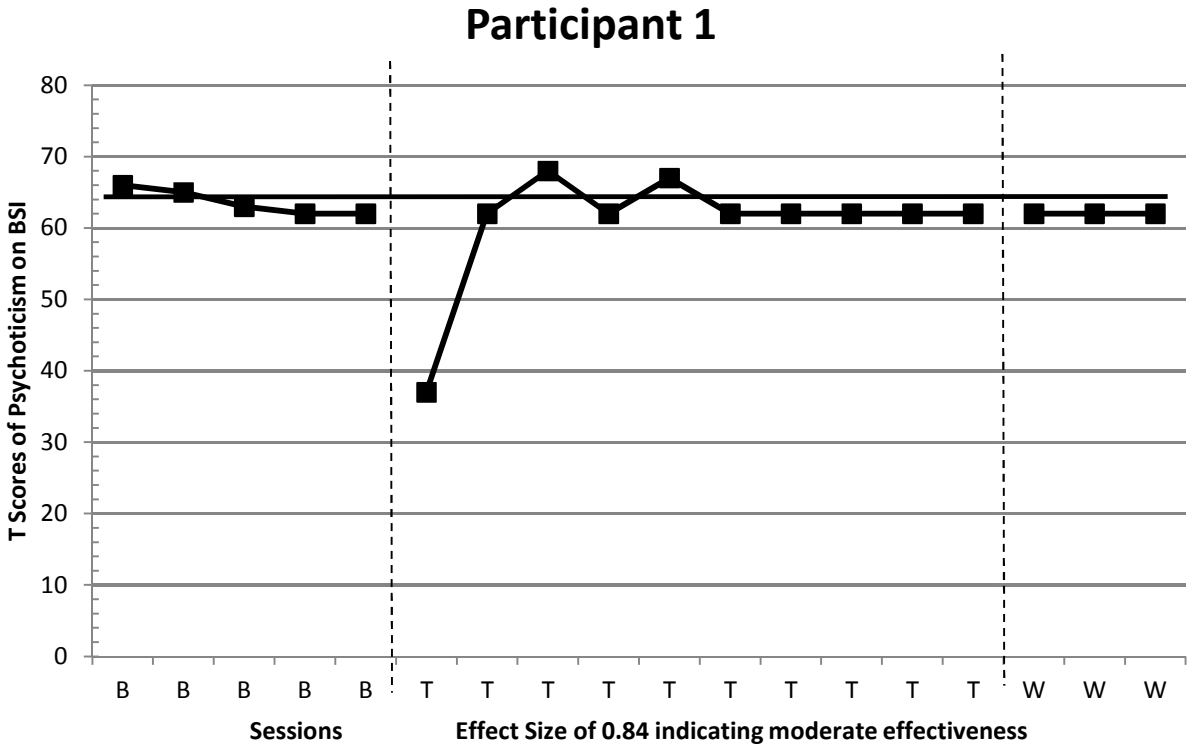

Effect Size of 0.53 indicating debatably effective


Participant 1
T Scores of Anxiety on BSI
90
80
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T W W W
Sessions
Effect size of 0.61 indicating debatably effective


Participant 1
T Scores of Hostility on BSI
90
80
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T W W W
Sessions
Effect size of 0.46 indicating not effective


Participant 1
T Scores of Phobic Anxiety on BSI
90
80
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T W W W
Sessions
Effect size of 0.07 indicating not effective


Participant 1
T Scores of Paranoid Ideation on BSI
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T W W W
Sessions
Effect size of 0.92 indicating very effective (scores are not clinically relevant)


Participant 1
T Scores of Psychoticism on BSI
80
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T W W W
Sessions
Effect Size of 0.84 indicating moderate effectiveness

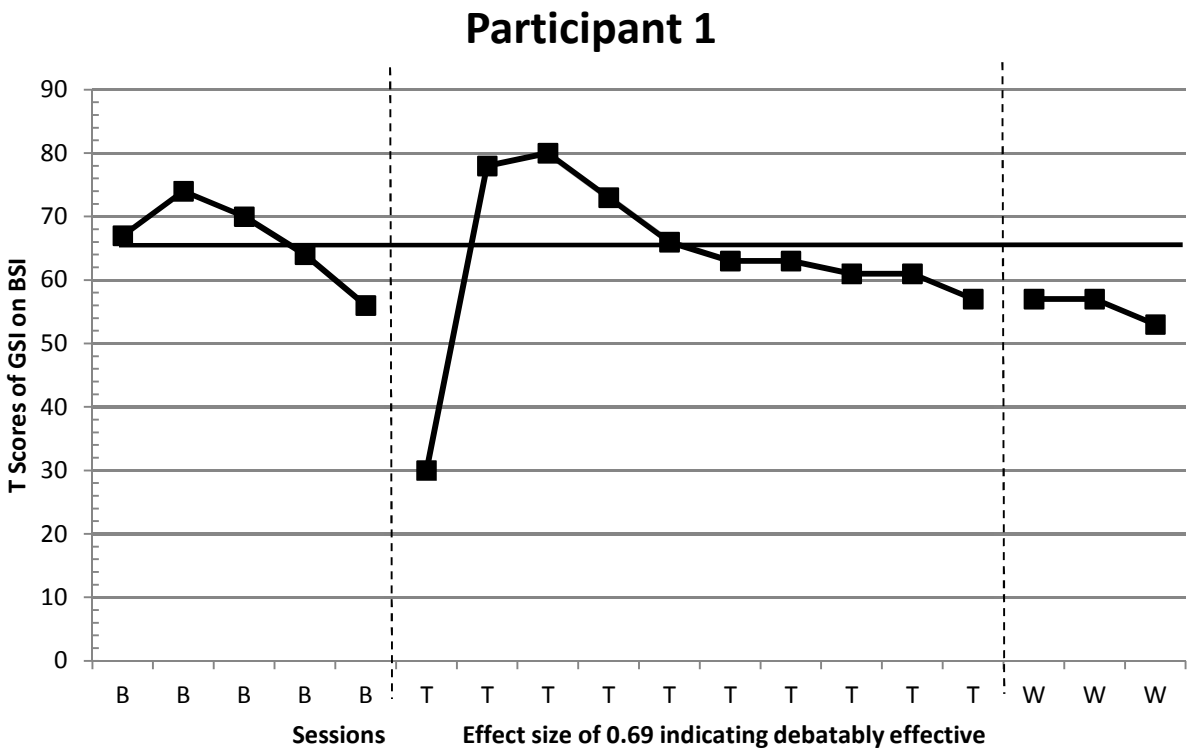
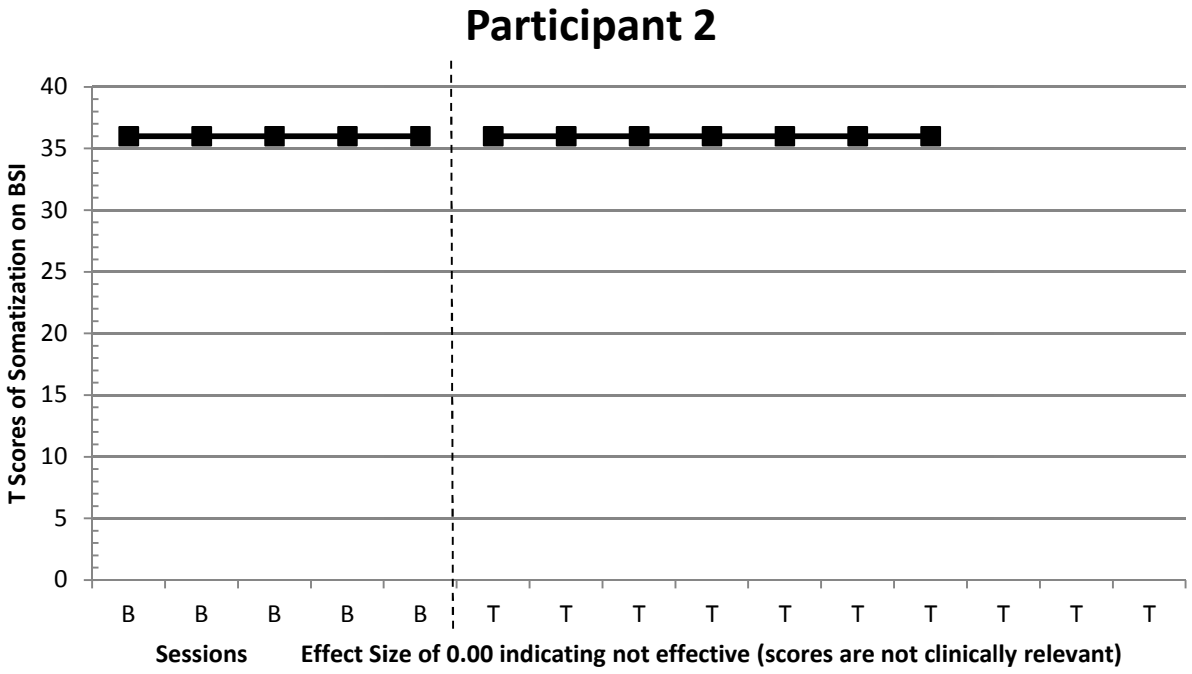
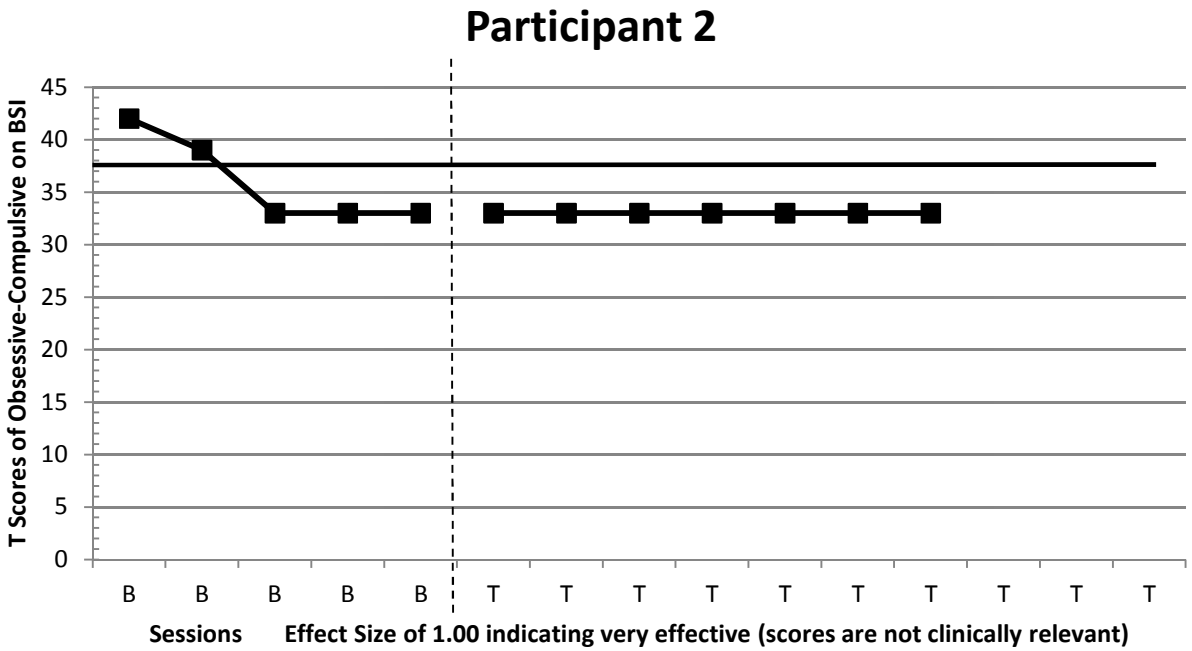
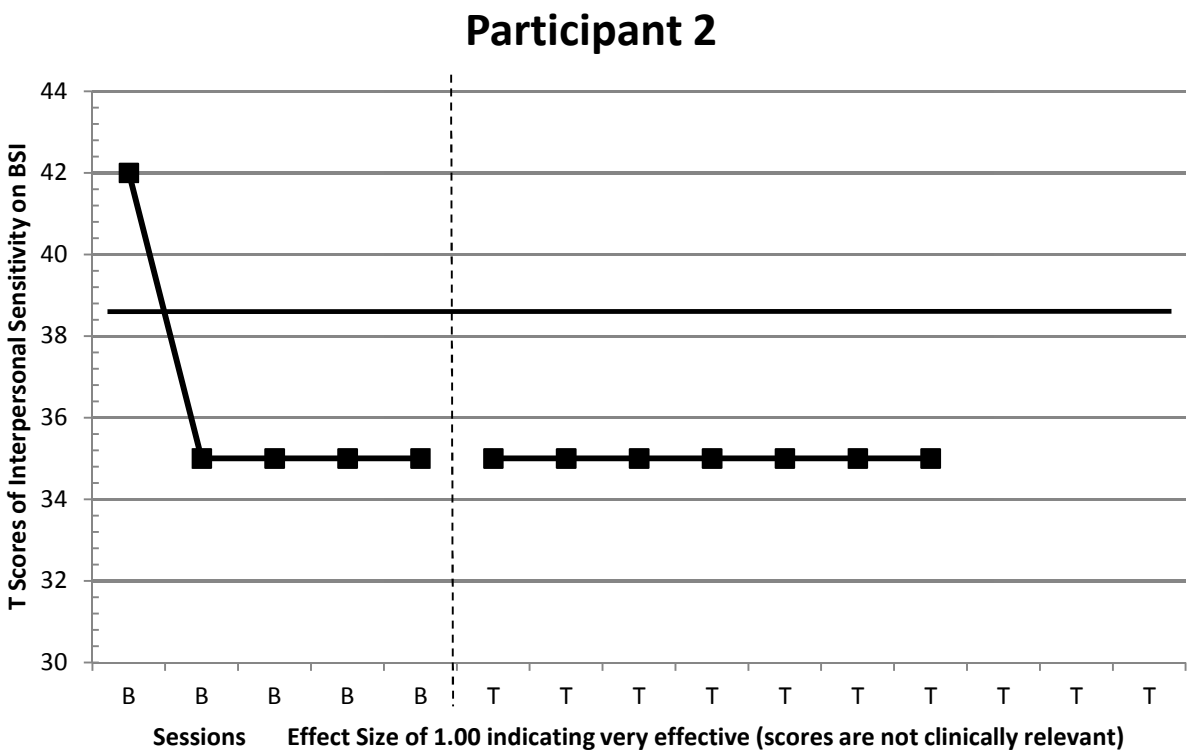

Participant 1
T Scores of GSI on BSI
90
80
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T W W W
Sessions
Effect size of 0.69 indicating debatably effective

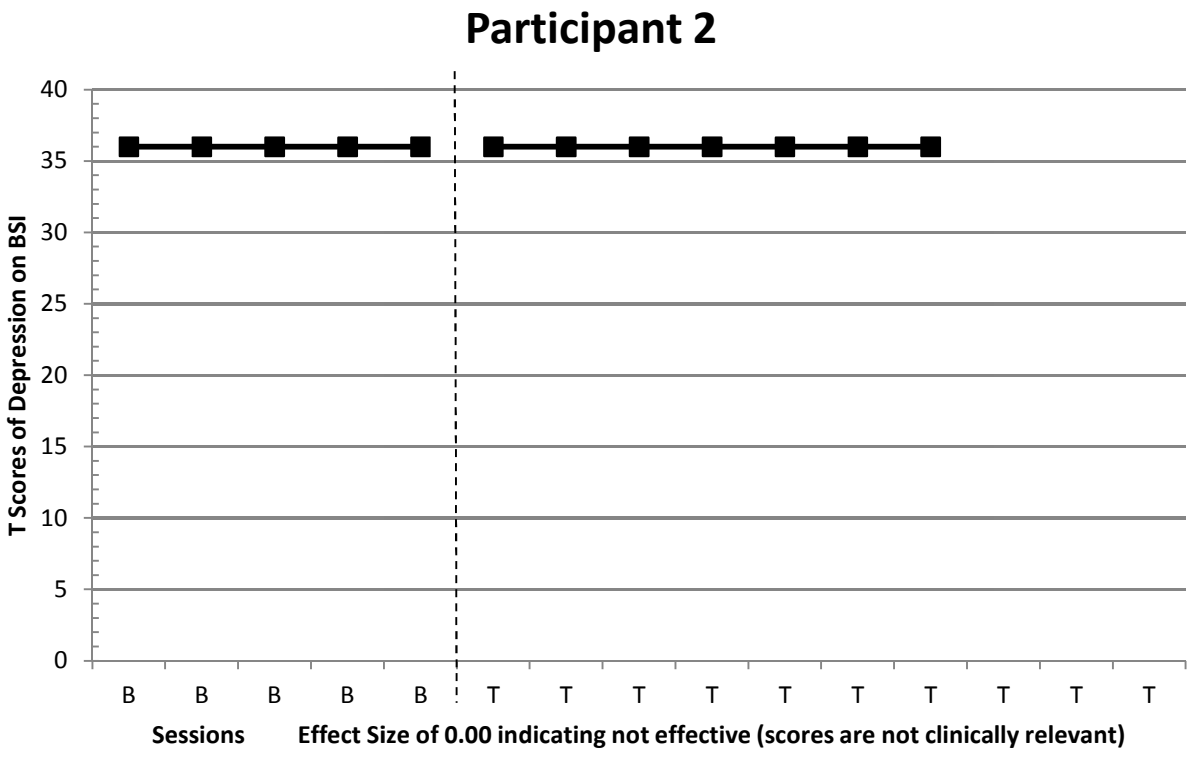
Figure 2.

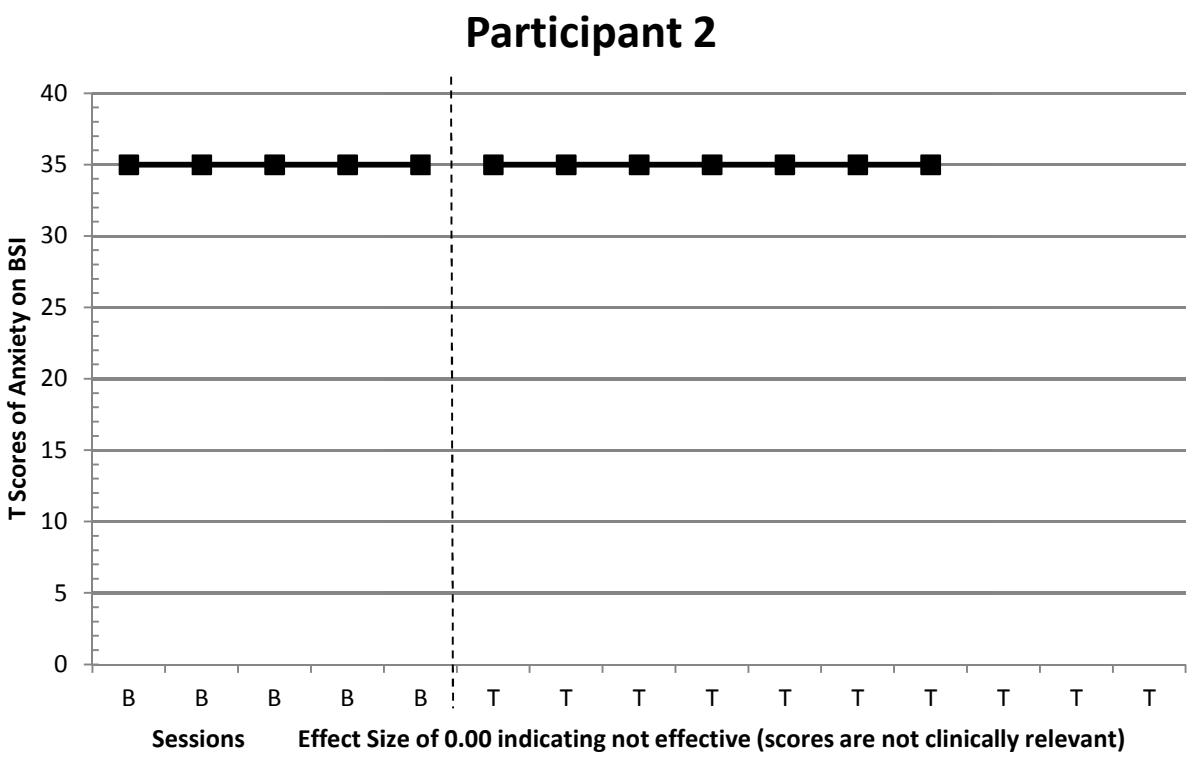
*Graphical Representation of Percentage of Data Exceeding the Median for Ratings of Clinically Relevant Psychological Symptoms by Participant Isaac Engaging in Narrative Therapy Sessions.*

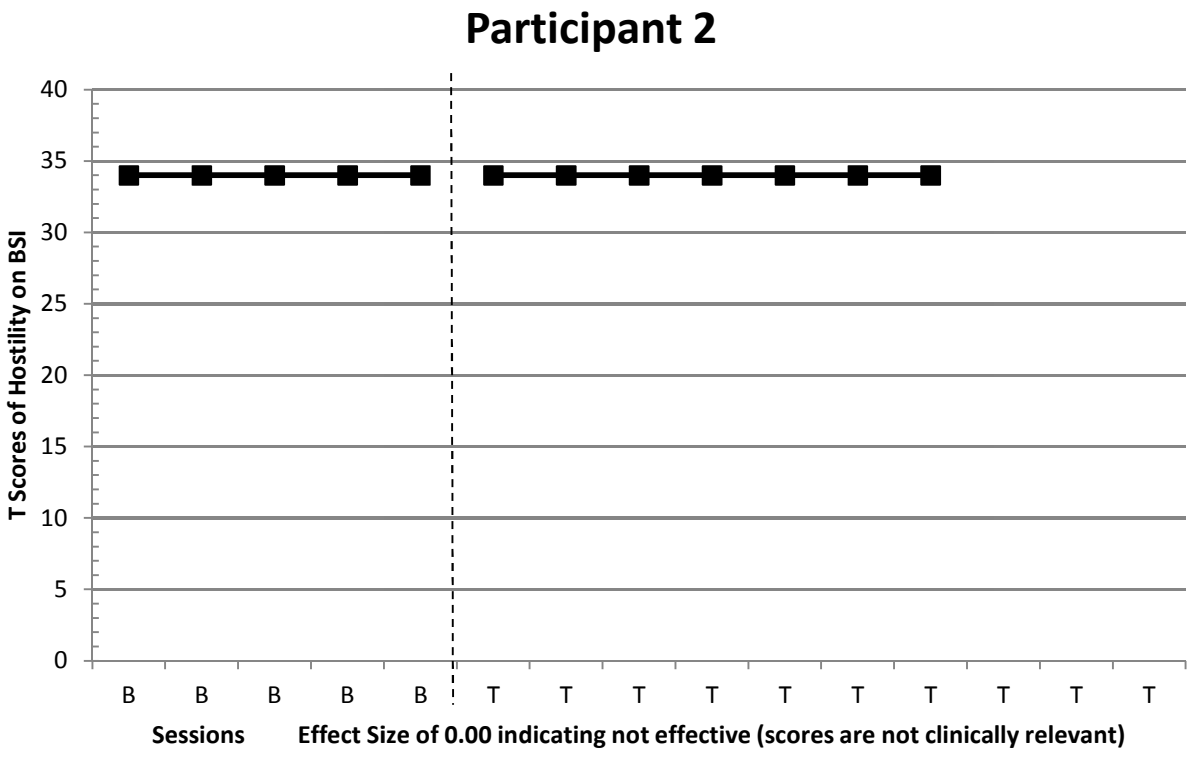


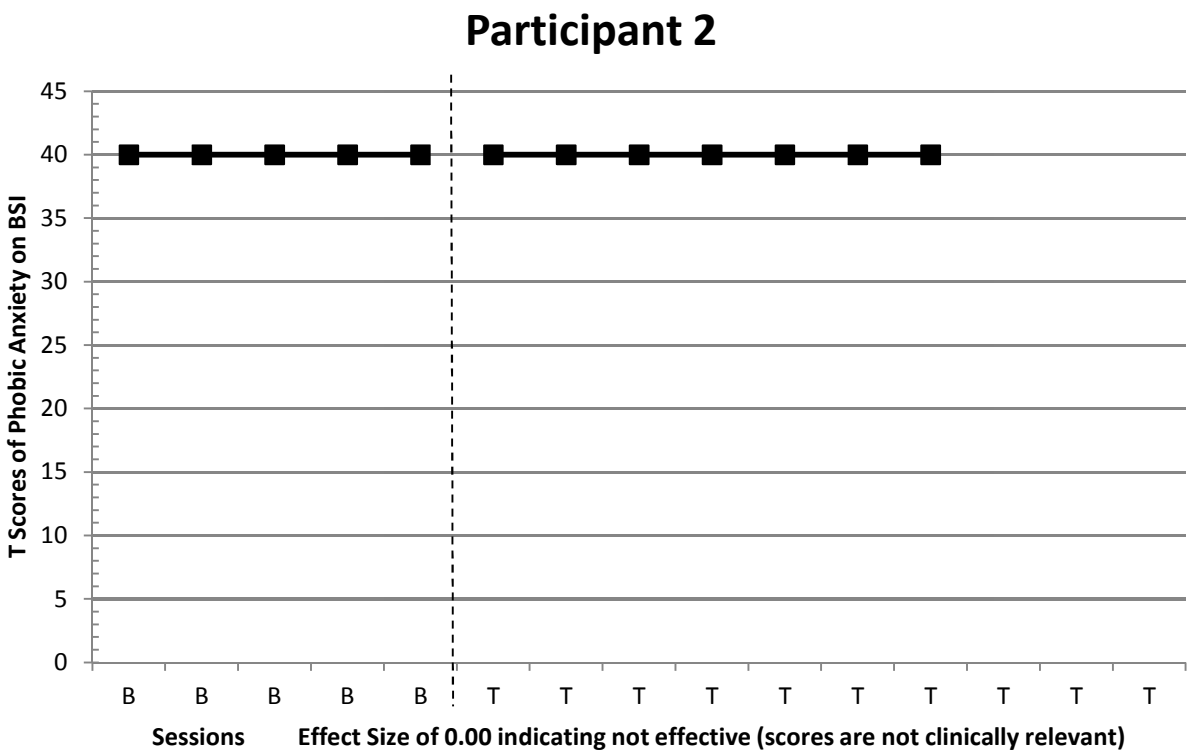



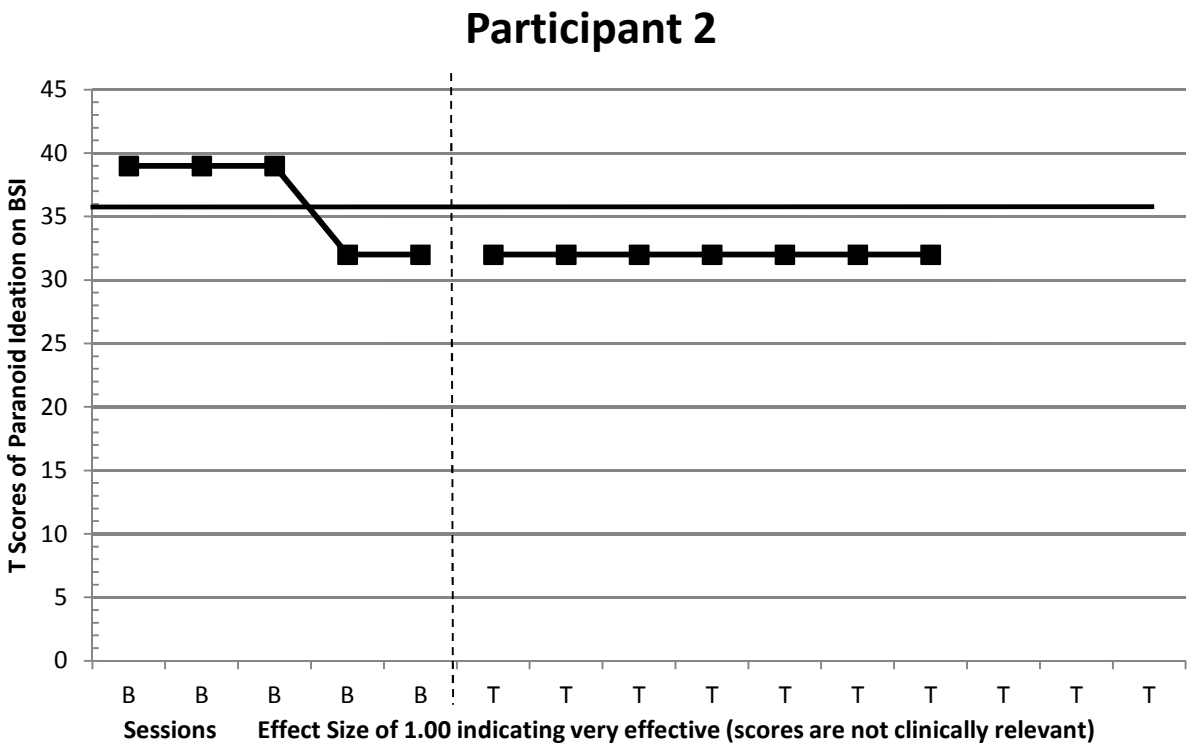

Participant 2
T Scores of Interpersonal Sensitivity on BSI
44
42
40
38
36
34
32
30
B B B B B T T T T T T T T T T
Sessions
Effect Size of 1.00 indicating very effective (scores are not clinically relevant)

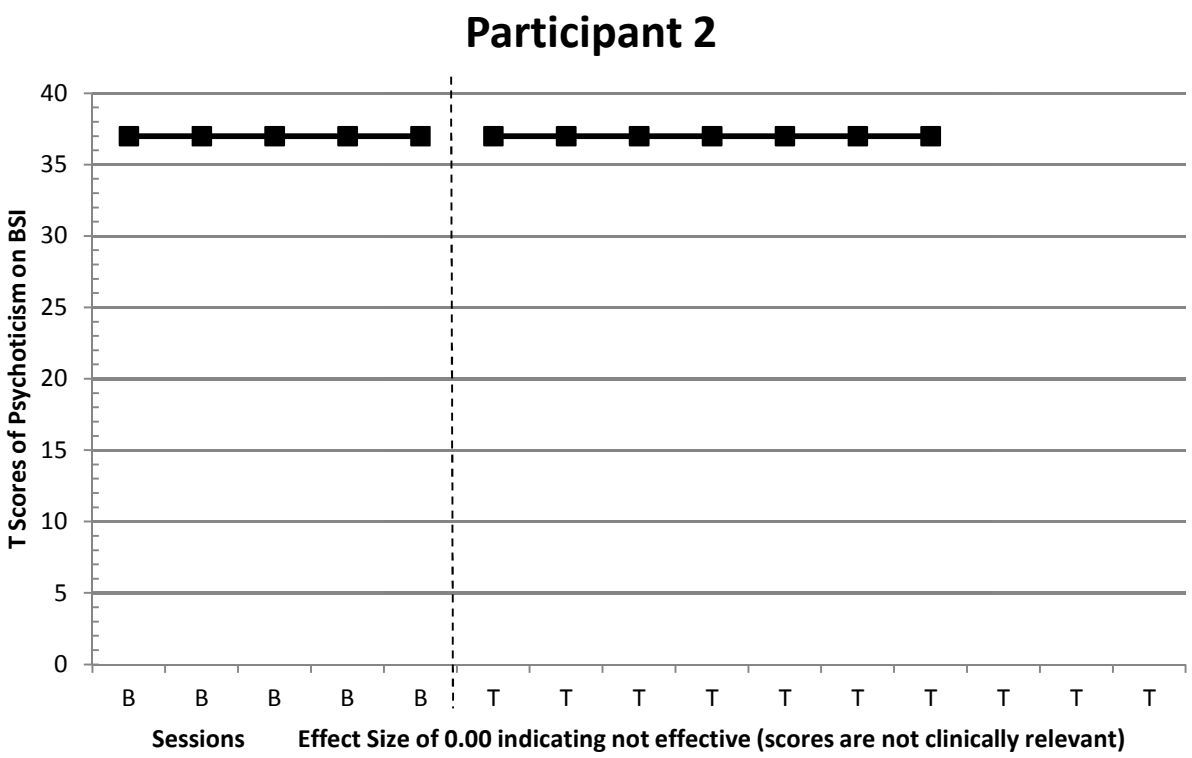

Participant 2
T Scores of Depression on BSI
40
35
30
25
20
15
10
5
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 0.00 indicating not effective (scores are not clinically relevant)


Participant 2
T Scores of Anxiety on BSI
40
35
30
25
20
15
10
5
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 0.00 indicating not effective (scores are not clinically relevant)


Participant 2
T Scores of Hostility on BSI
40
35
30
25
20
15
10
5
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 0.00 indicating not effective (scores are not clinically relevant)


Participant 2
T Scores of Phobic Anxiety on BSI
45
40
35
30
25
20
15
10
5
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 0.00 indicating not effective (scores are not clinically relevant)


Participant 2
T Scores of Paranoid Ideation on BSI
45
40
35
30
25
20
15
10
5
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 1.00 indicating very effective (scores are not clinically relevant)


Participant 2
T Scores of Psychoticism on BSI
40
35
30
25
20
15
10
5
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 0.00 indicating not effective (scores are not clinically relevant)

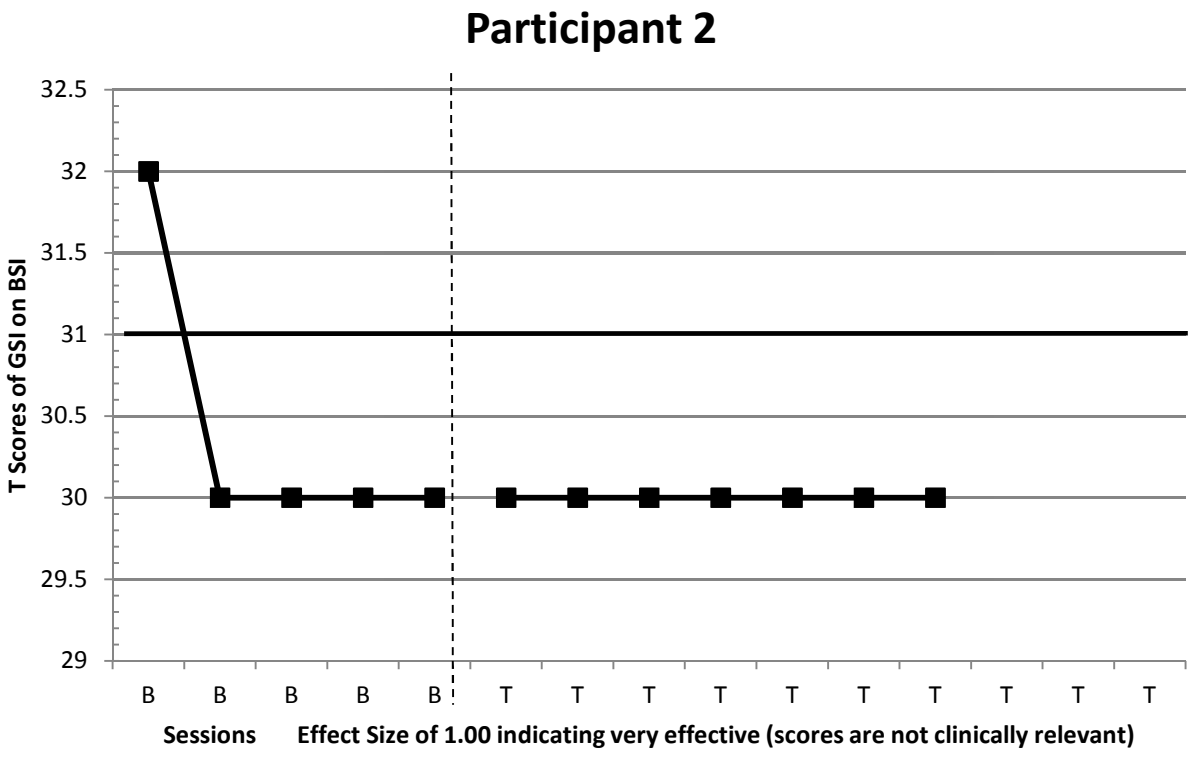
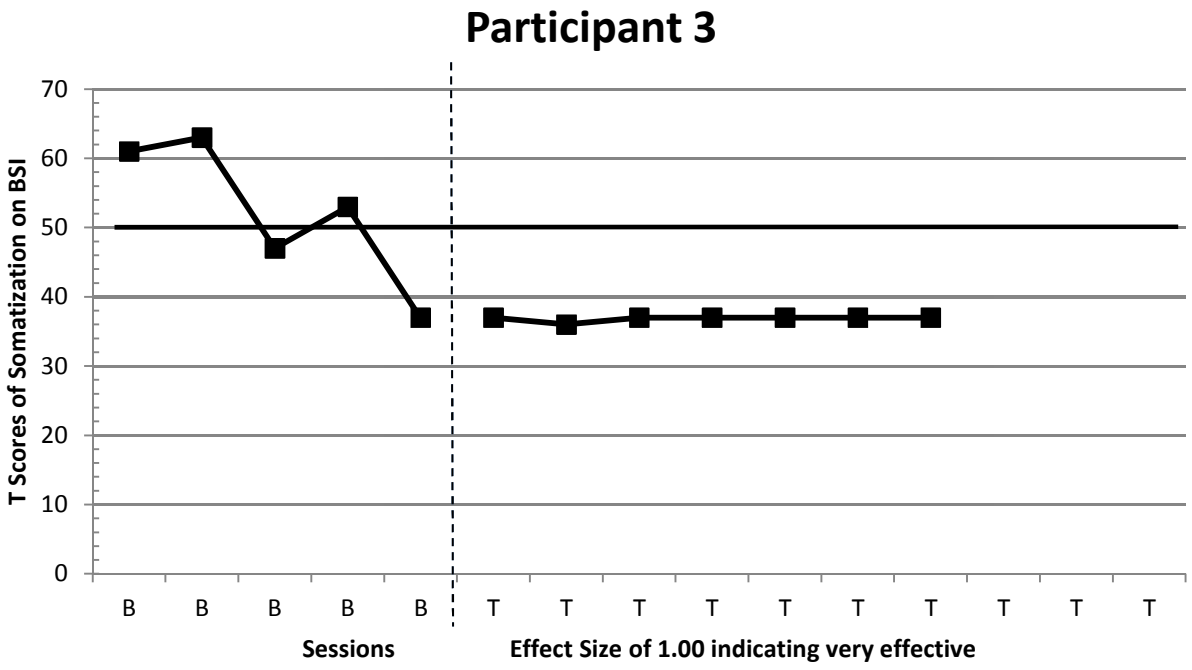
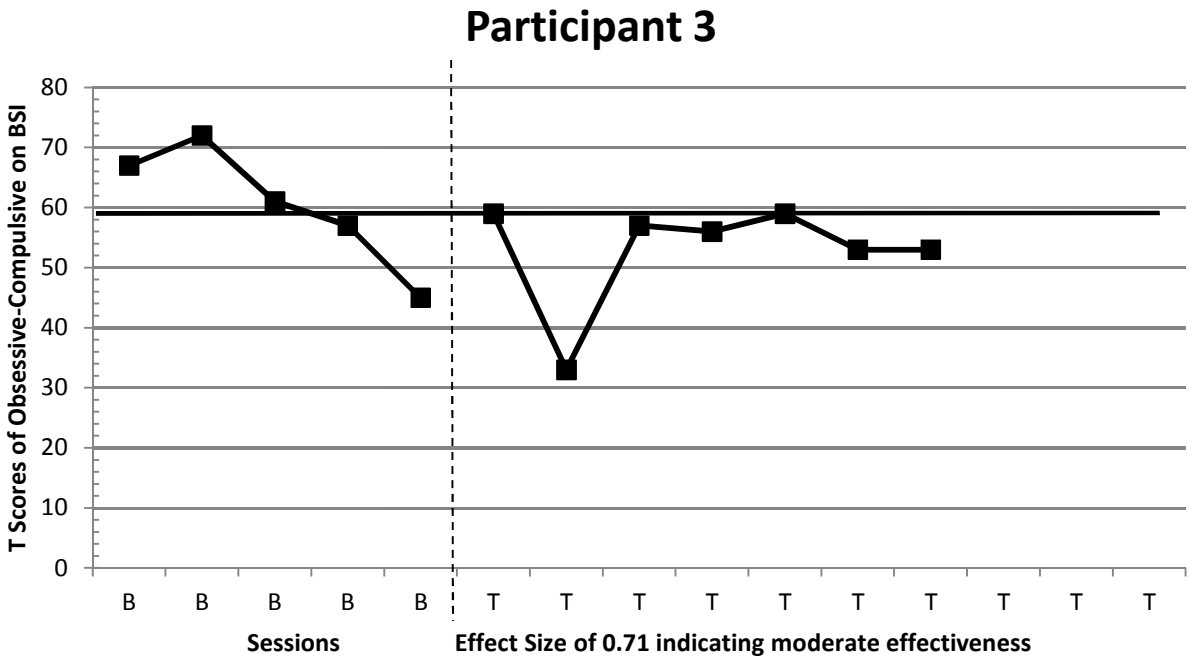
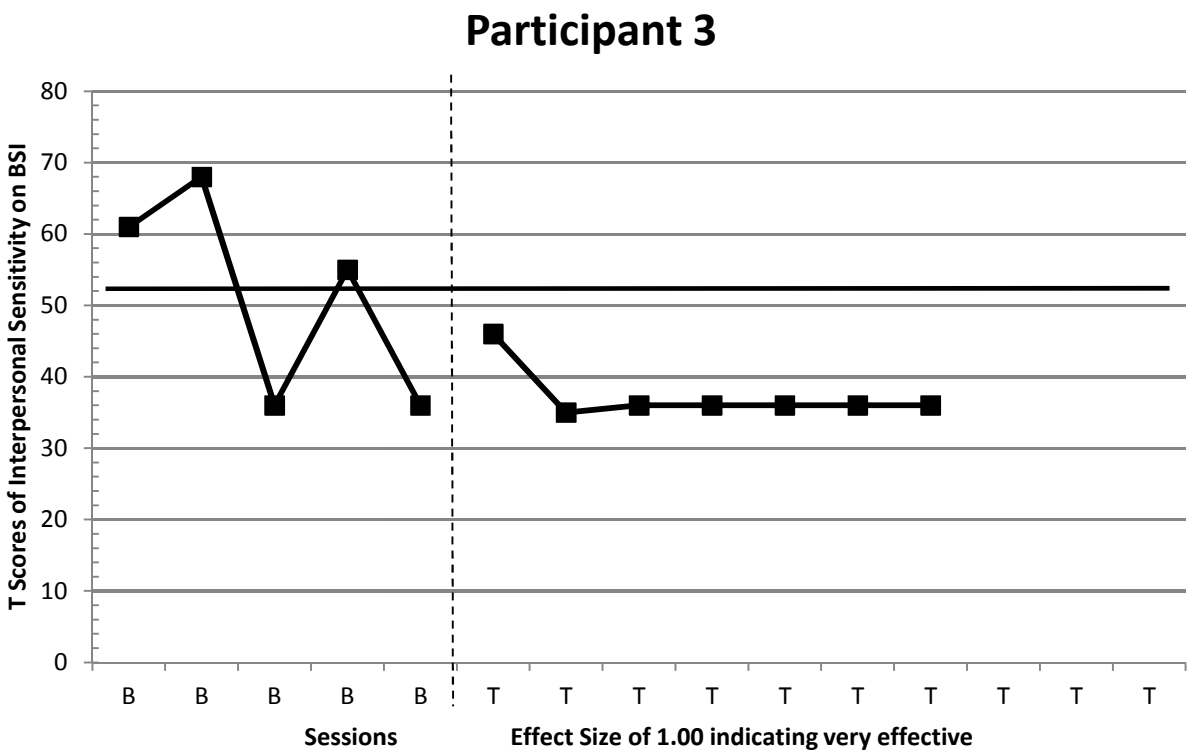

Participant 2
T Scores of GSI on BSI
32.5
32
31.5
31
30.5
30
29.5
29
B B B B B T T T T T T T T T T
Sessions
Effect Size of 1.00 indicating very effective (scores are not clinically relevant)

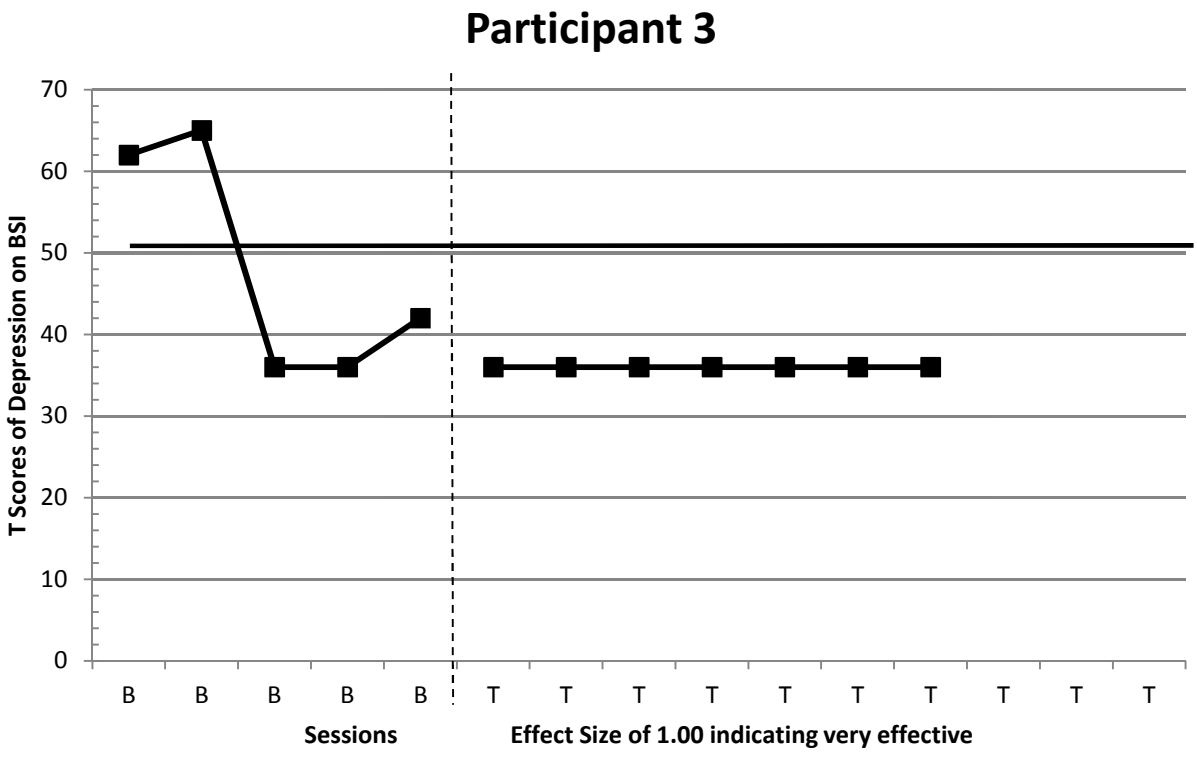
Figure 3.

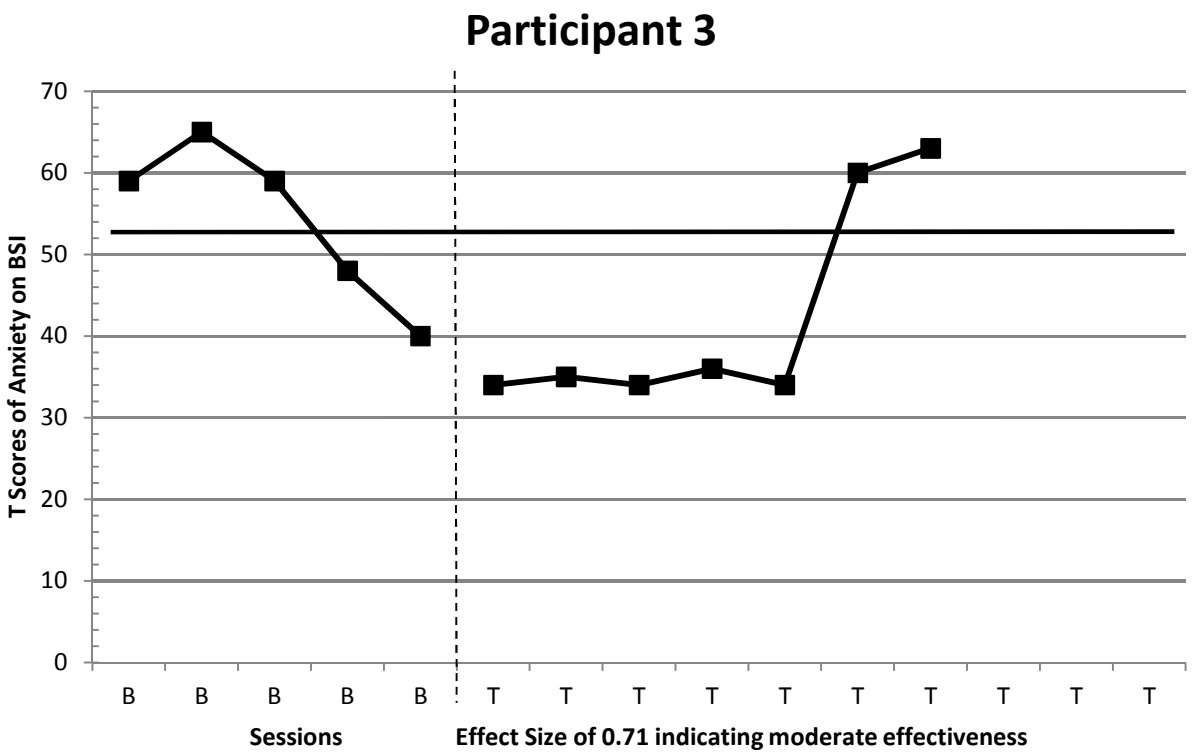
*Graphical Representation of Percentage of Data Exceeding the Median for Ratings of Clinically Relevant Psychological Symptoms by Participant Christopher Engaging in Narrative Therapy Sessions.*

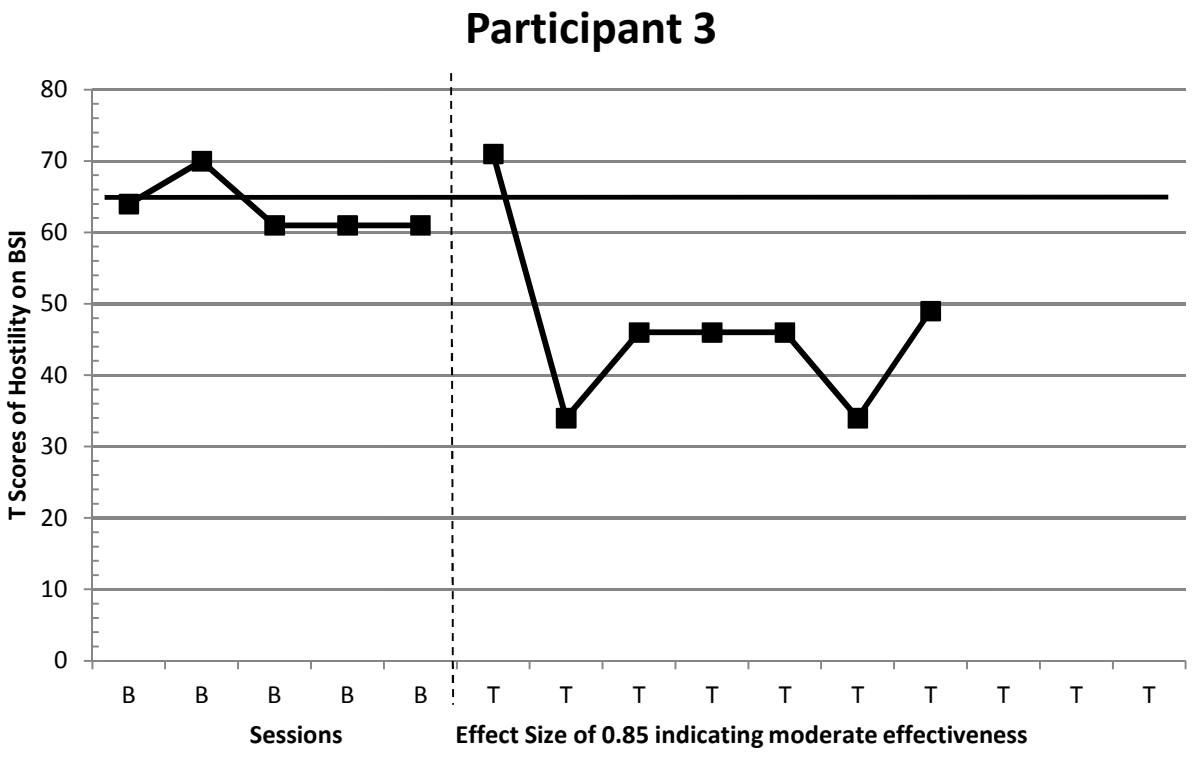


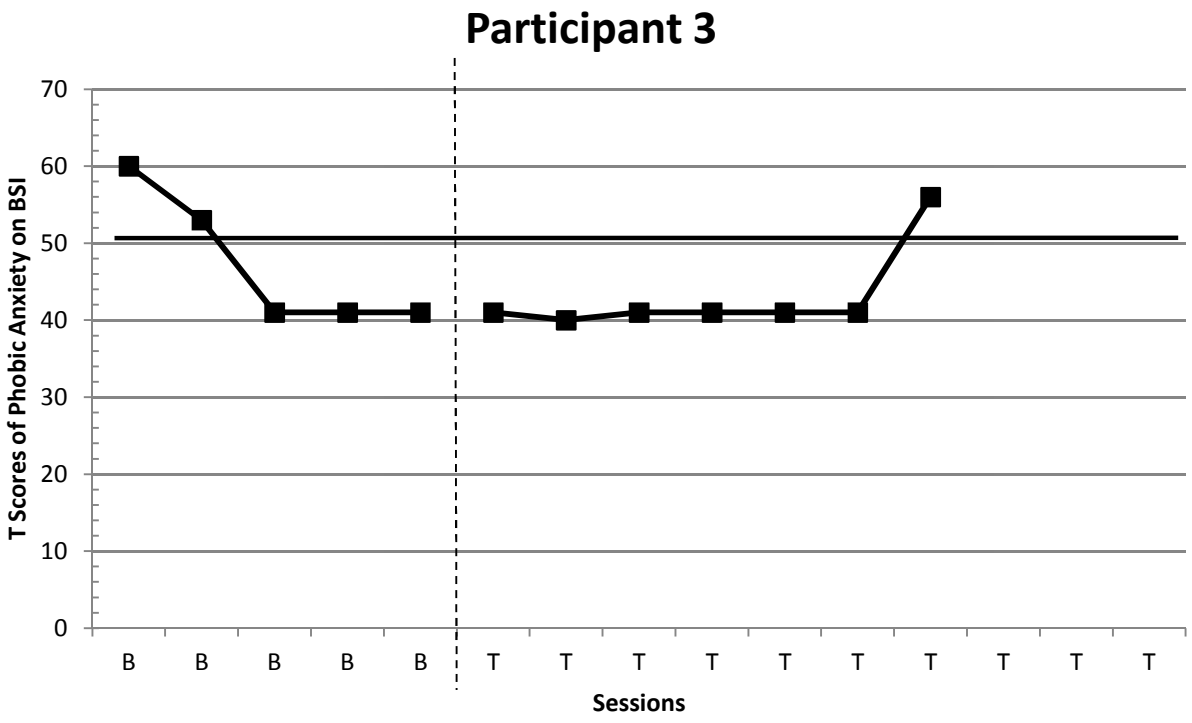




Participant 3
T Scores of Interpersonal Sensitivity on BSI
80
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 1.00 indicating very effective

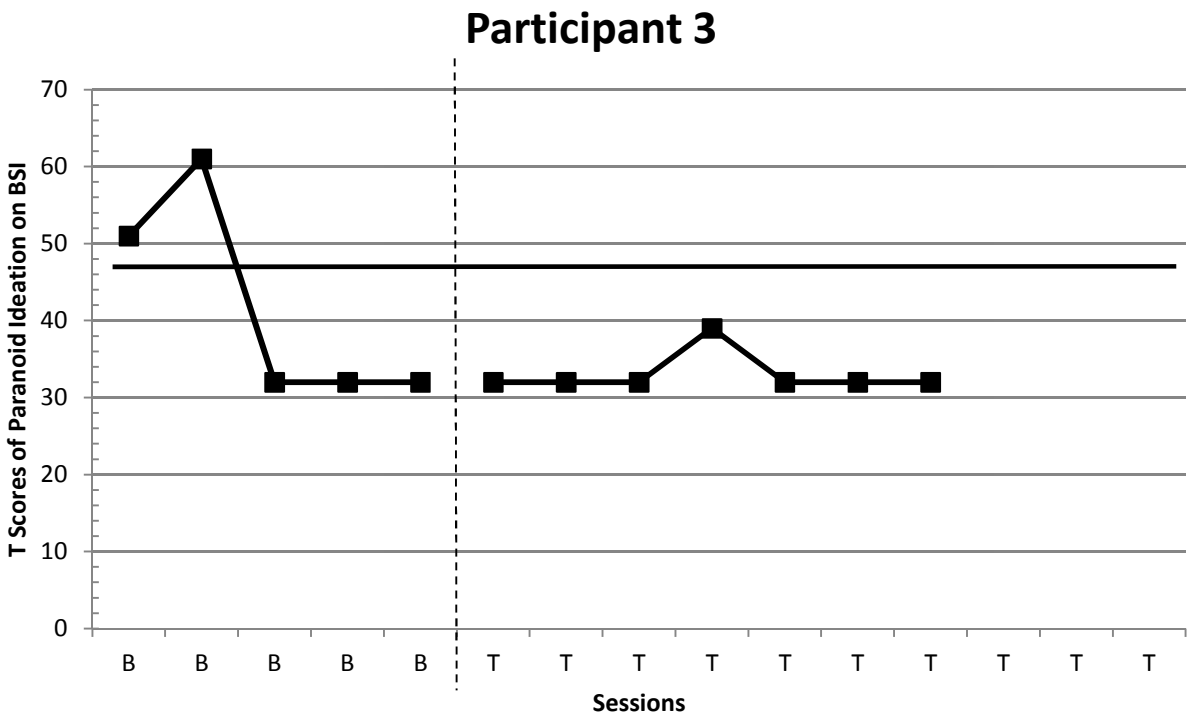

Participant 3
T Scores of Depression on BSI
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 1.00 indicating very effective


Participant 3
T Scores of Anxiety on BSI
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 0.71 indicating moderate effectiveness

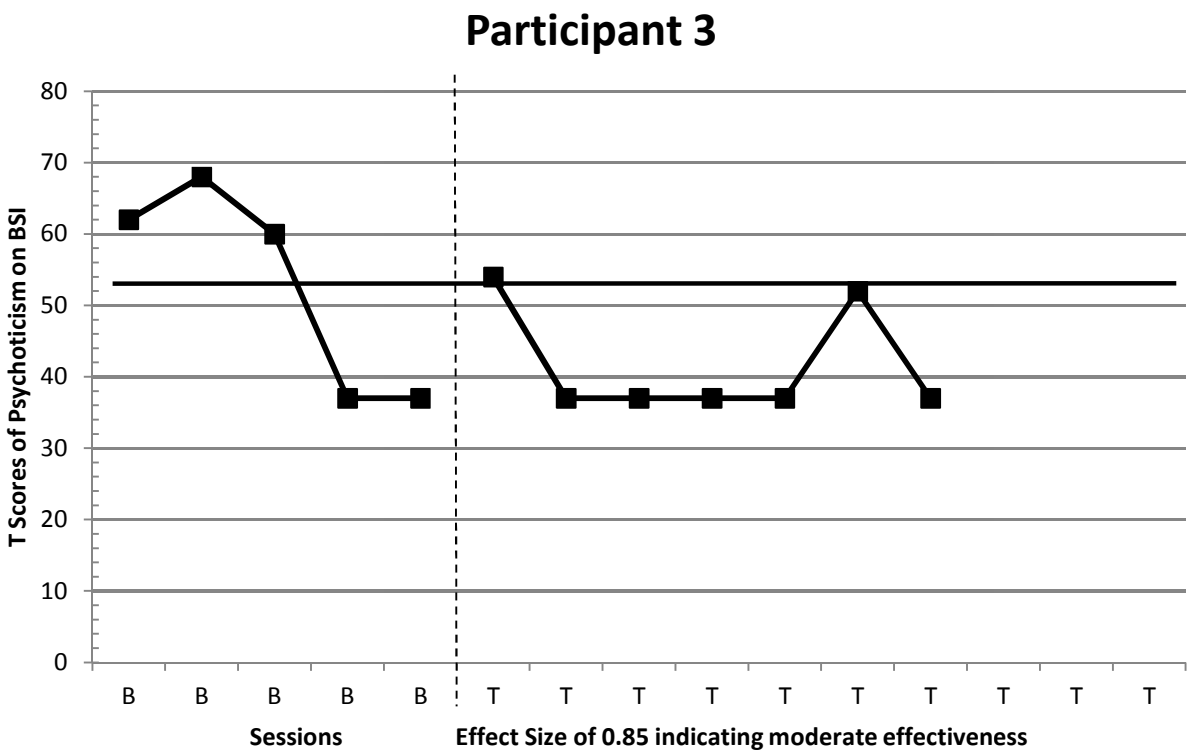

Participant 3
T Scores of Hostility on BSI
80
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 0.85 indicating moderate effectiveness




**Effect Size of 0.85 indicating moderate effectiveness (scores are not clinically relevant)**




**Effect Size of 1.00 indicating very effective (scores are not clinically relevant)**


Participant 3
T Scores of Psychoticism on BSI
80
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 0.85 indicating moderate effectiveness

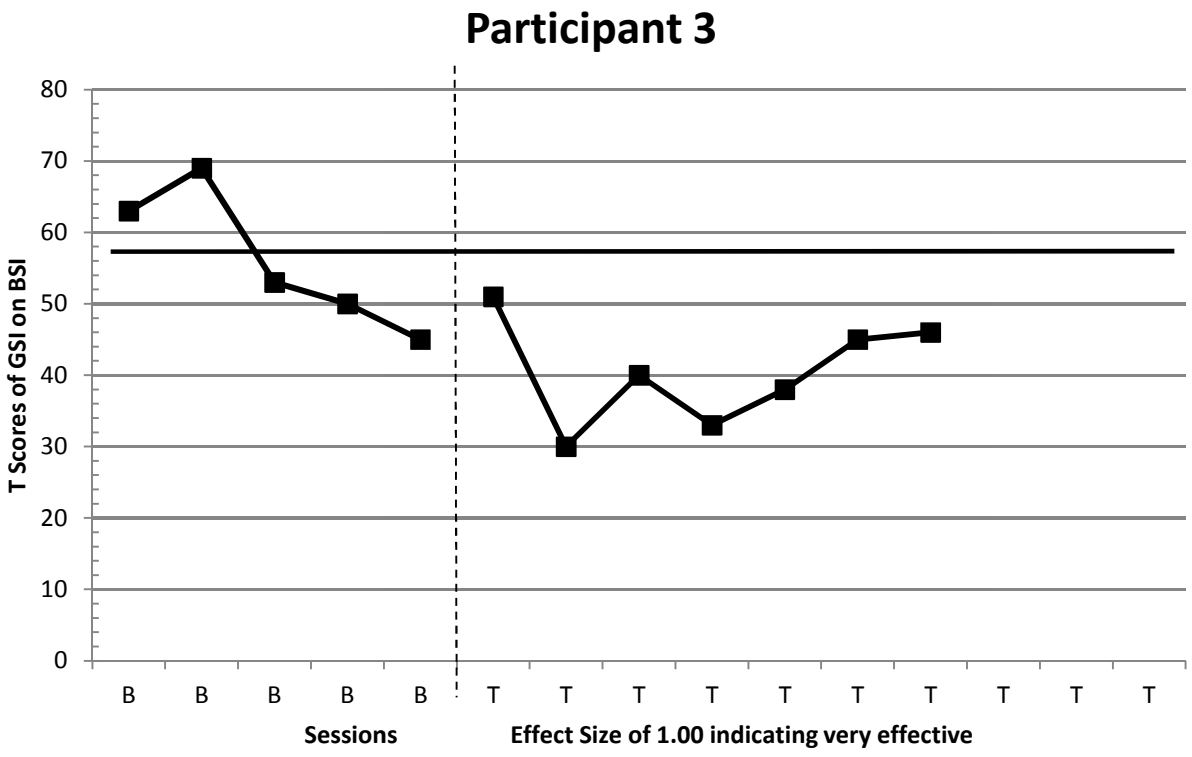
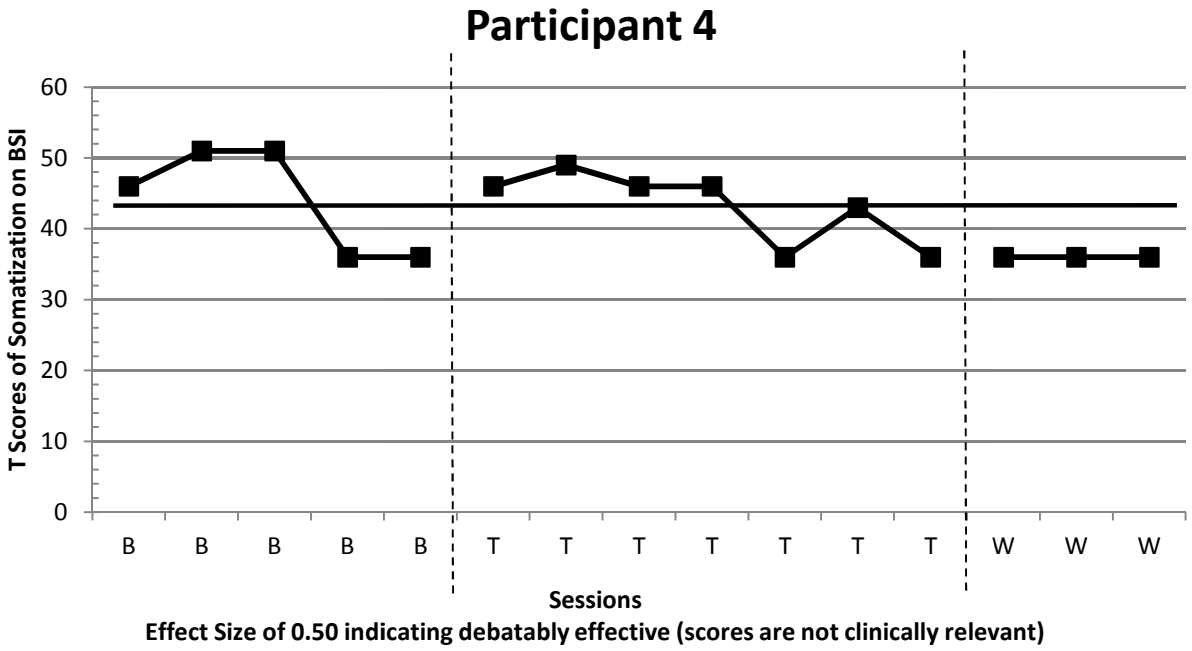
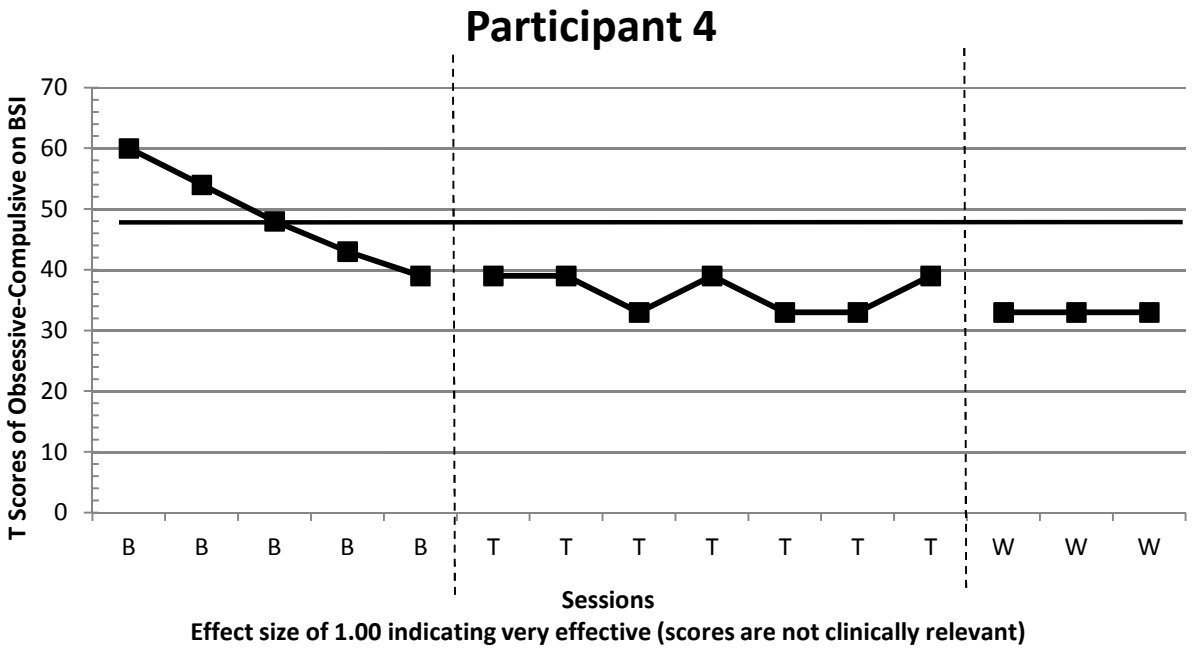
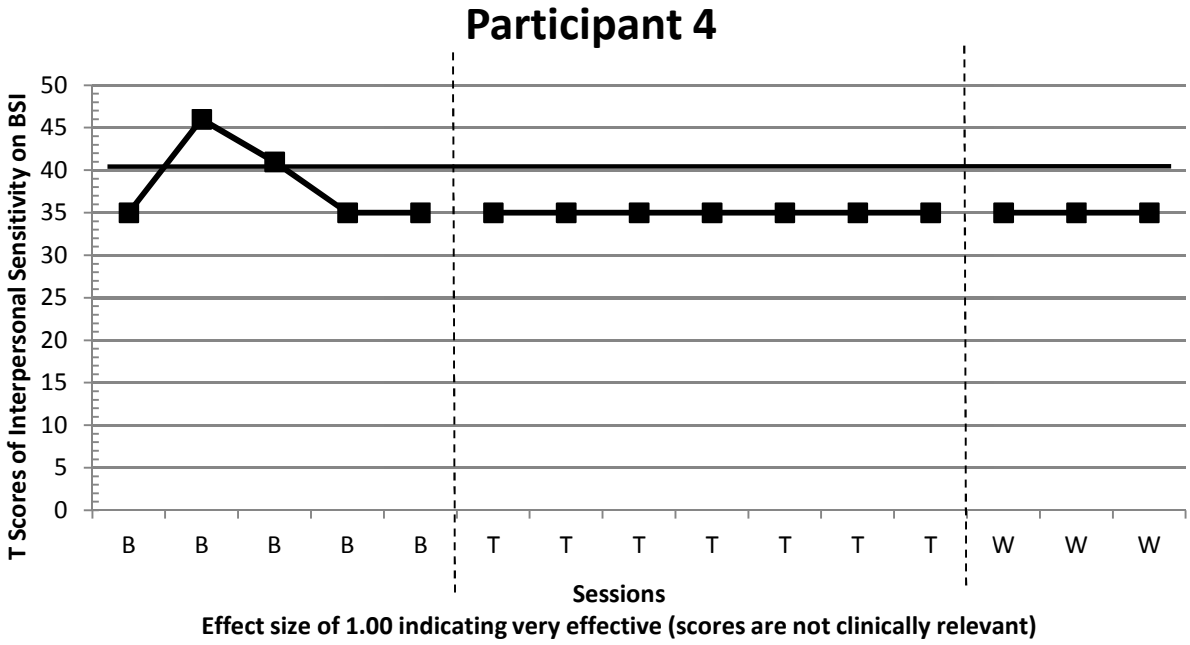

Participant 3
T Scores of GSI on BSI
80
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 1.00 indicating very effective

Figure 4.

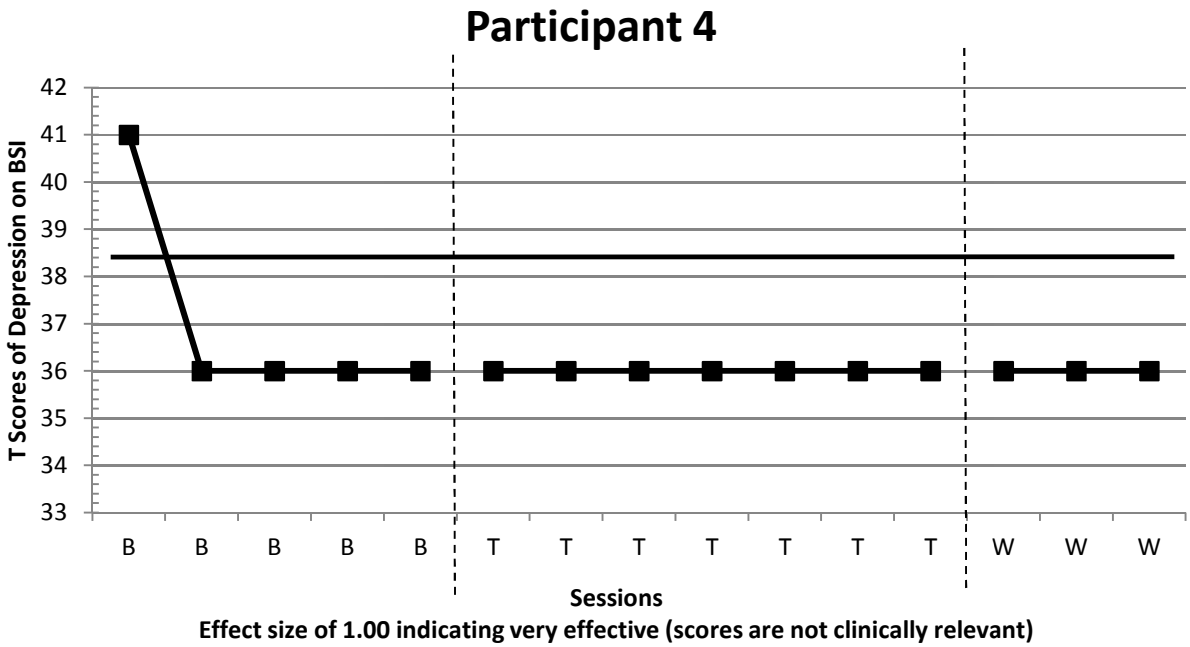
*Graphical Representation of Percentage of Data Exceeding the Median for Ratings of Clinically Relevant Psychological Symptoms by Participant Roman Engaging in Narrative Therapy Sessions.*



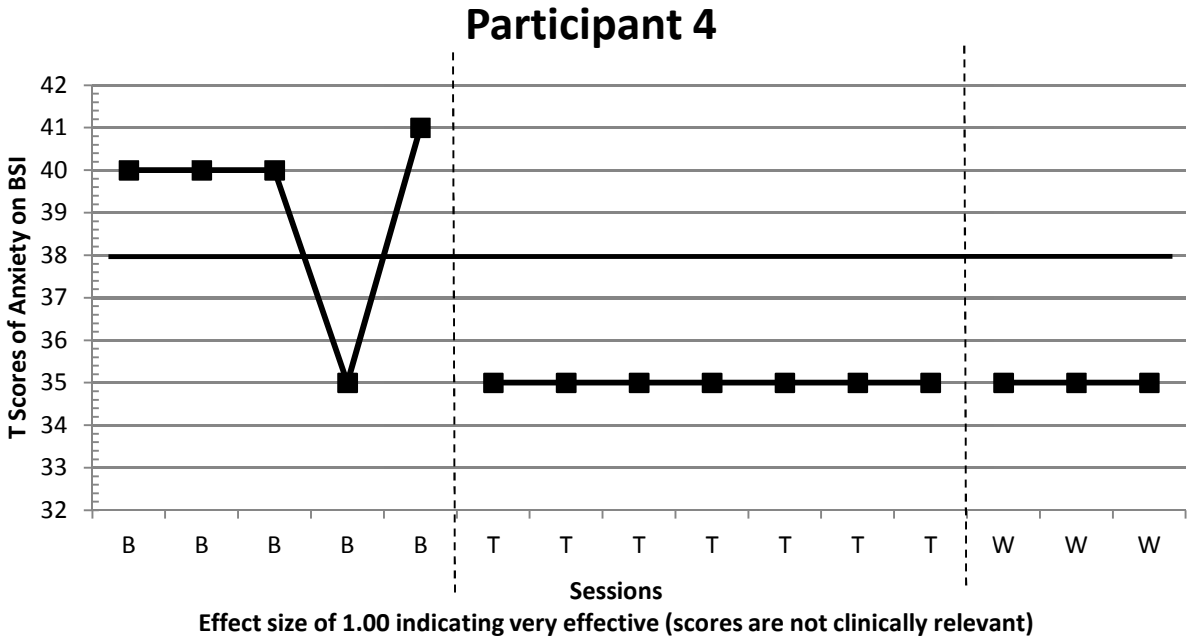





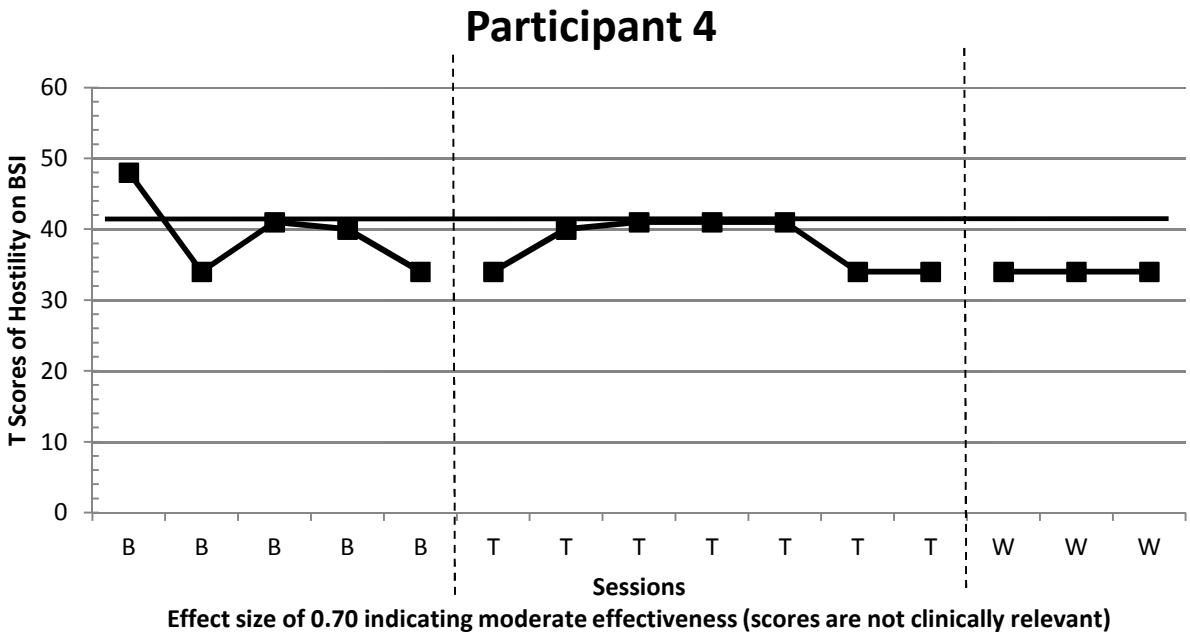

**Effect size of 1.00 indicating very effective (scores are not clinically relevant)**



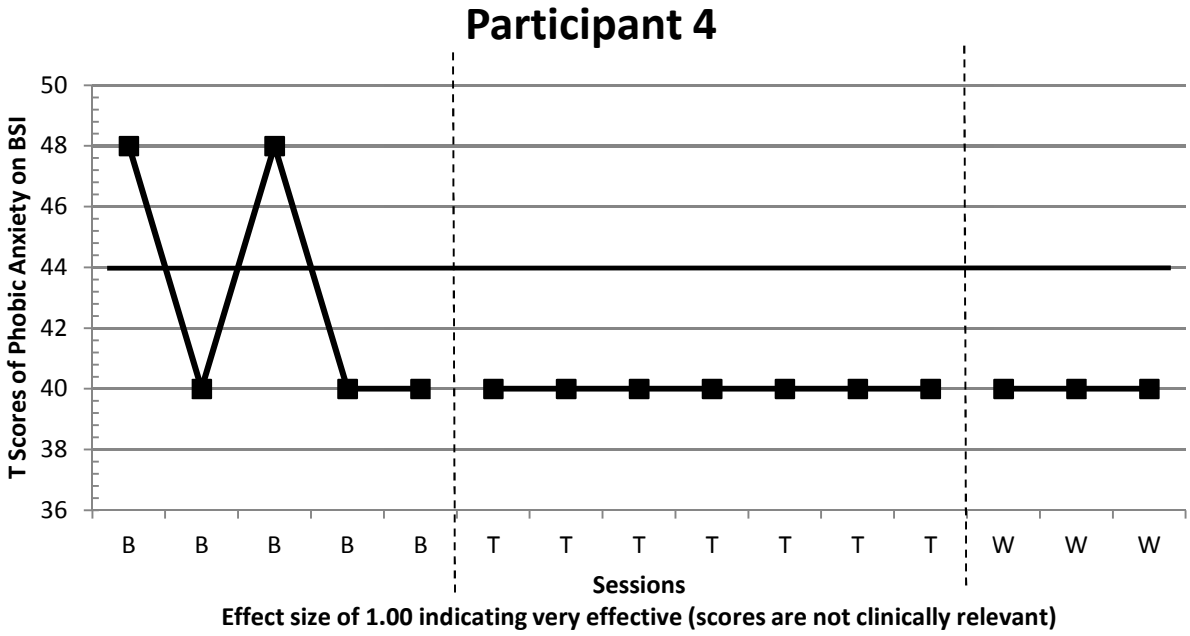

**Effect size of 1.00 indicating very effective (scores are not clinically relevant)**

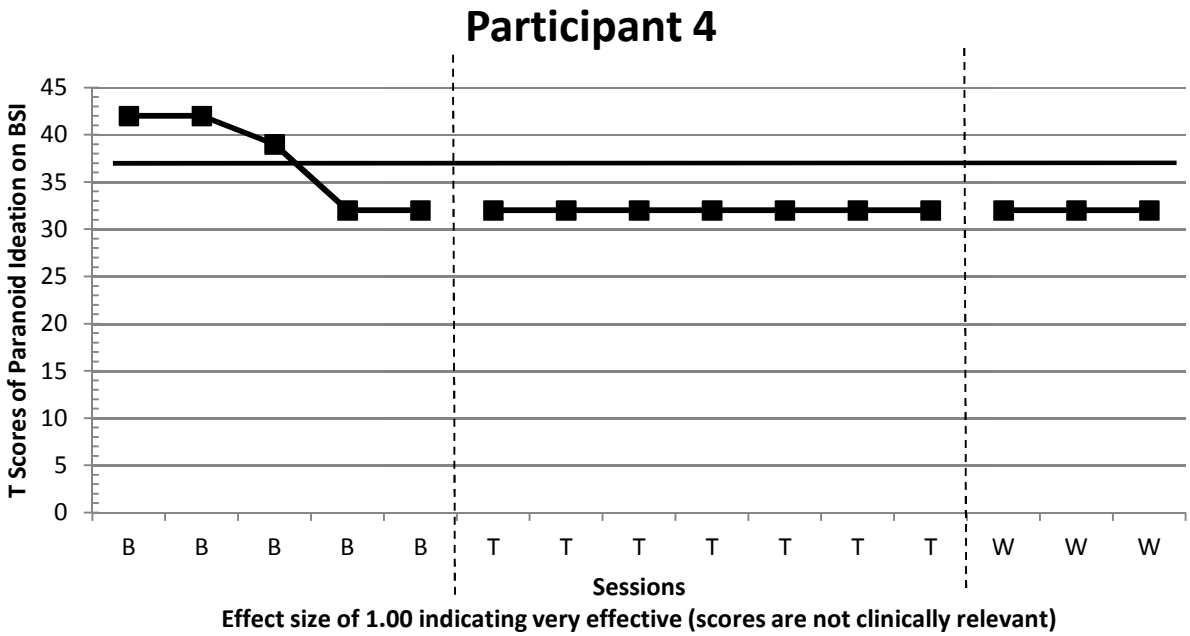


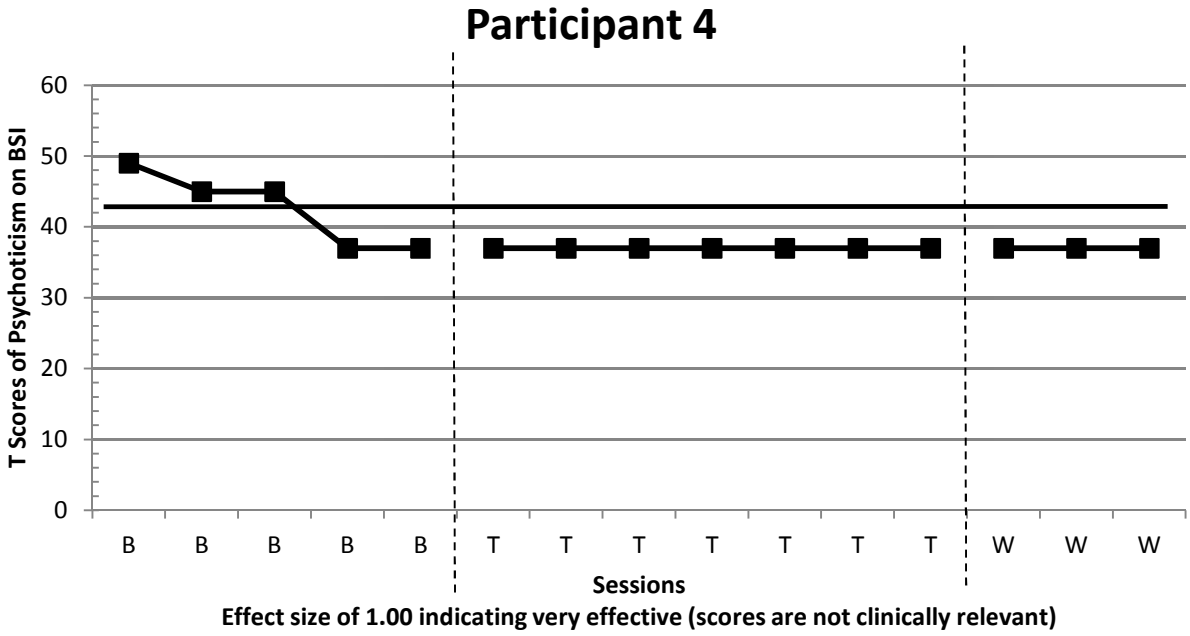

**Effect size of 1.00 indicating very effective (scores are not clinically relevant)**




**Effect size of 0.70 indicating moderate effectiveness (scores are not clinically relevant)**


Participant 4
T Scores of Phobic Anxiety on BSI
50
48
46
44
42
40
38
36
B B B B B T T T T T T T W W W
Sessions
Effect size of 1.00 indicating very effective (scores are not clinically relevant)


Participant 4
T Scores of Paranoid Ideation on BSI
45
40
35
30
25
20
15
10
5
0
B B B B B T T T T T T T W W W
Sessions
Effect size of 1.00 indicating very effective (scores are not clinically relevant)


Participant 4
T Scores of Psychoticism on BSI
60
50
40
30
20
10
0
B B B B B T T T T T T T W W W
Sessions
Effect size of 1.00 indicating very effective (scores are not clinically relevant)

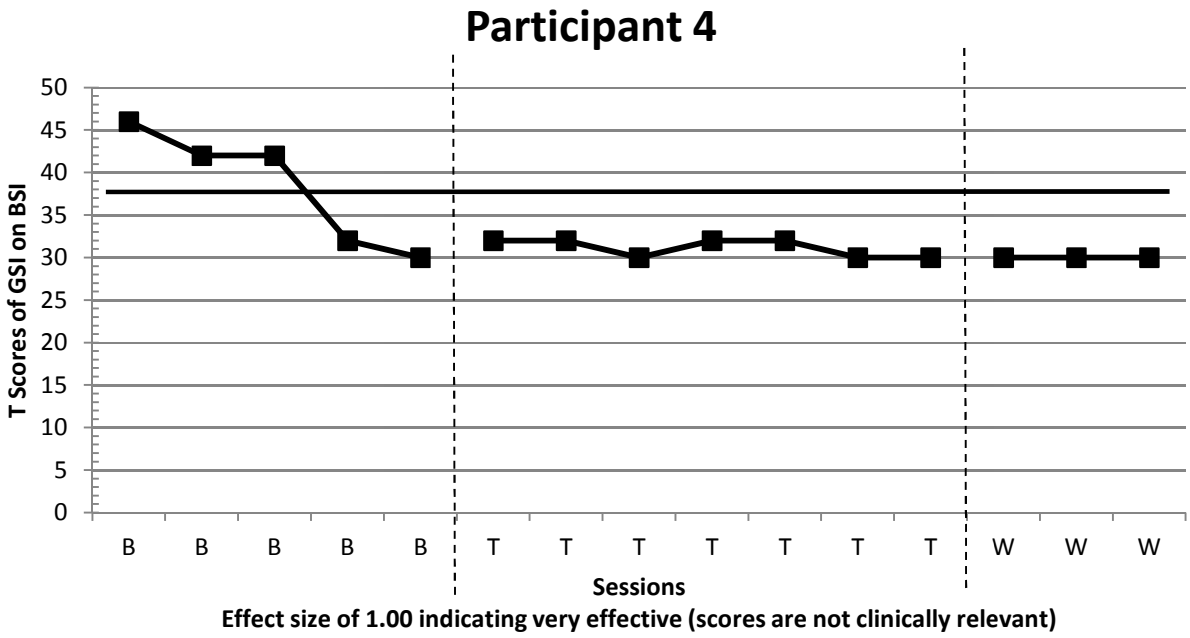
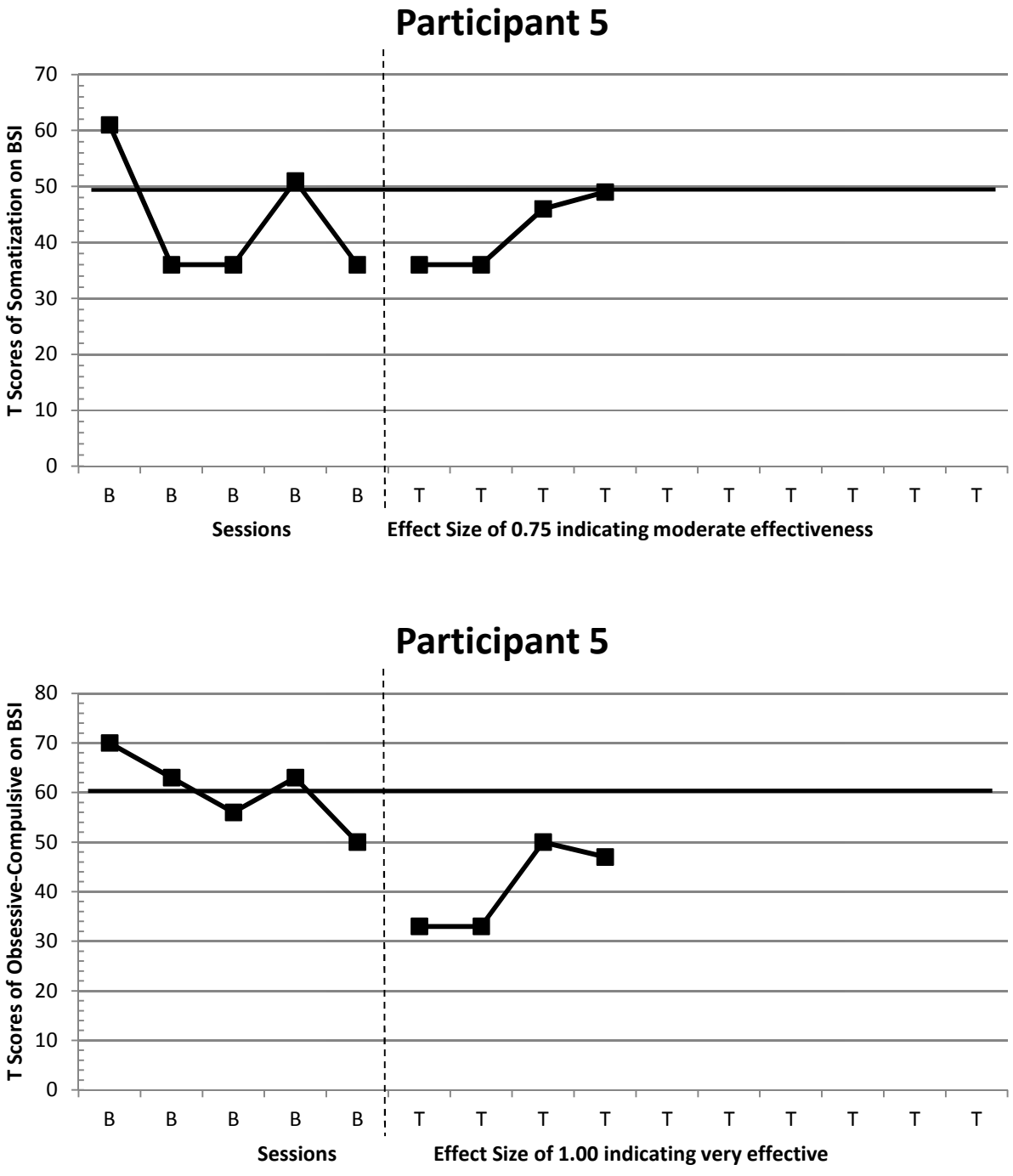
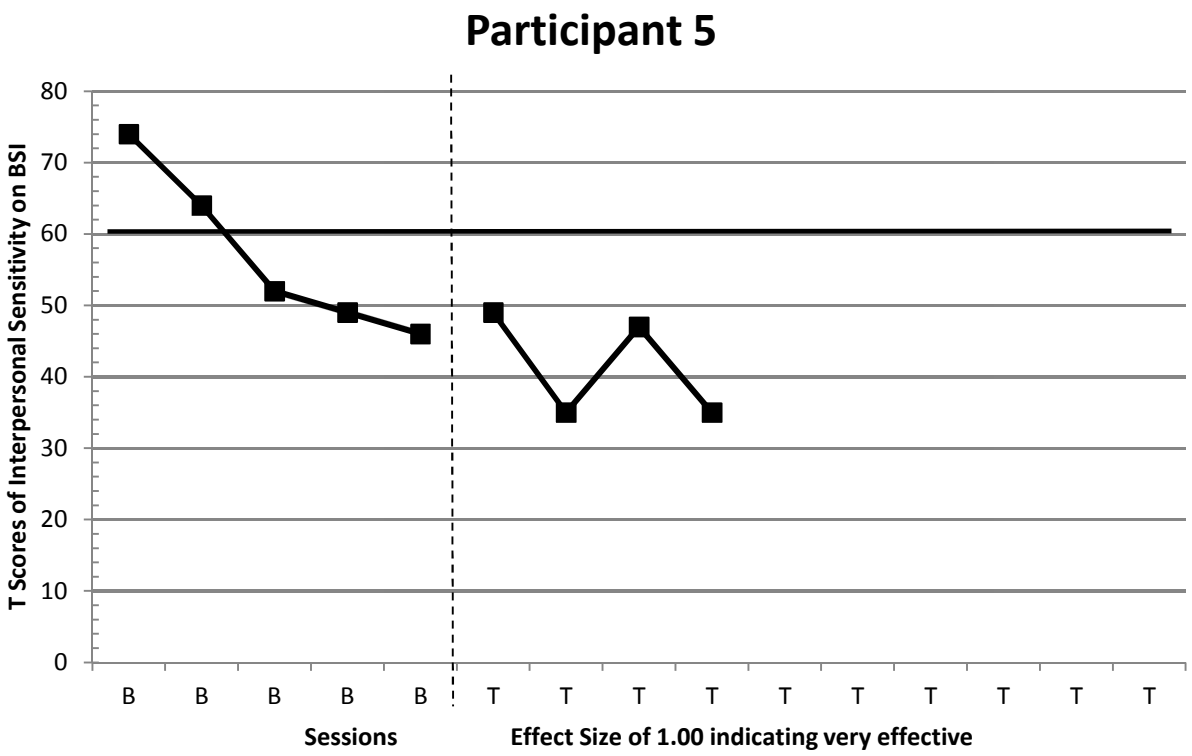
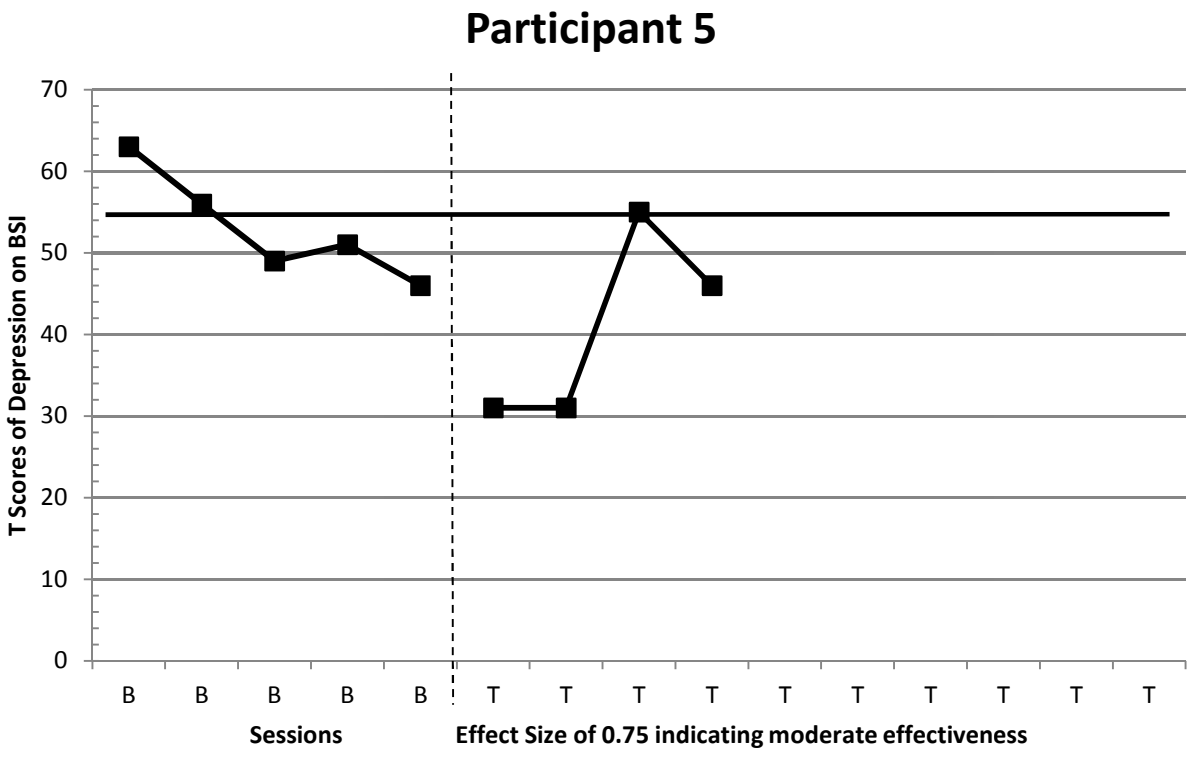

Participant 4
T Scores of GSI on BSI
50
45
40
35
30
25
20
15
10
5
0
B B B B B T T T T T T T W W W
Sessions
Effect size of 1.00 indicating very effective (scores are not clinically relevant)

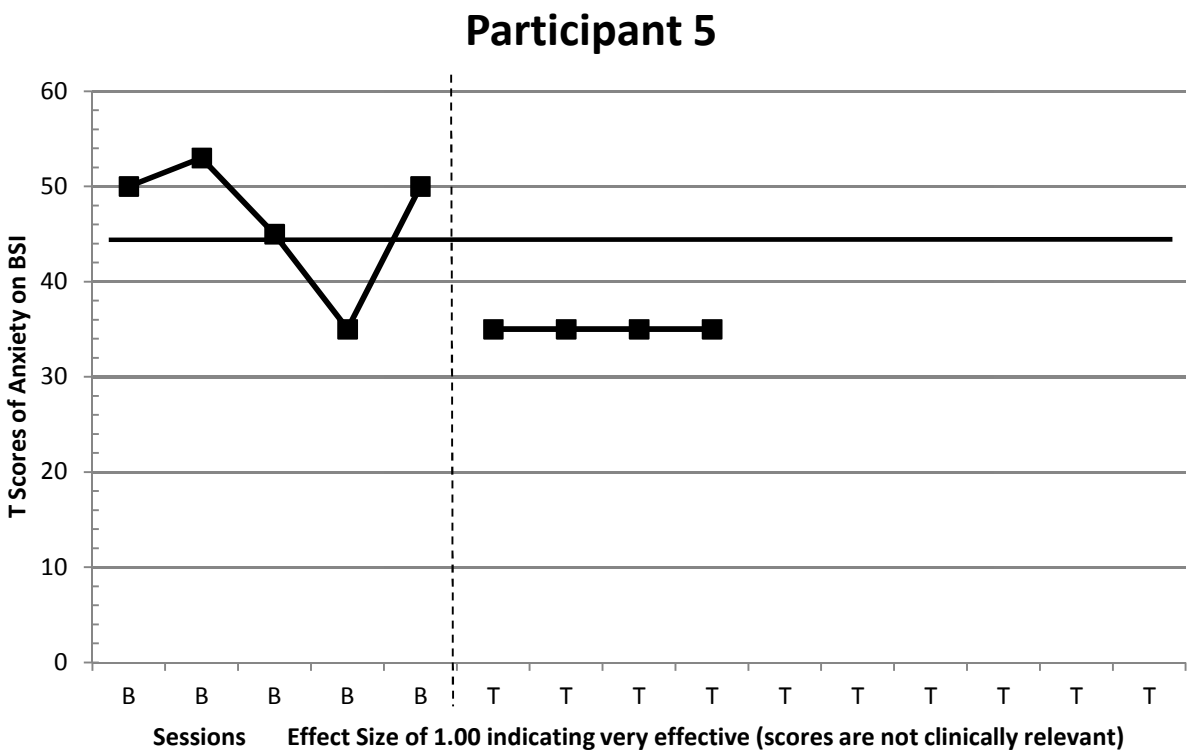
Figure 5.

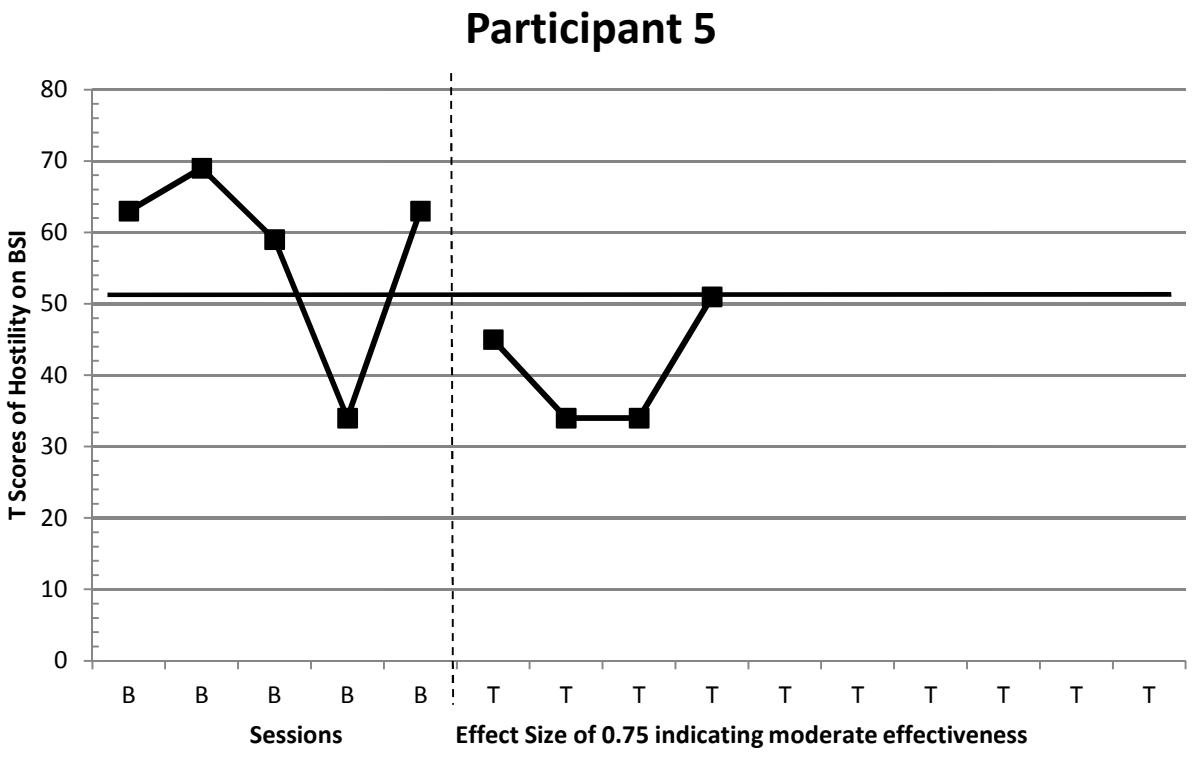
*Graphical Representation of Percentage of Data Exceeding the Median for Ratings of Clinically Relevant Psychological Symptoms by Participant Omar Engaging in Narrative Therapy Sessions.*

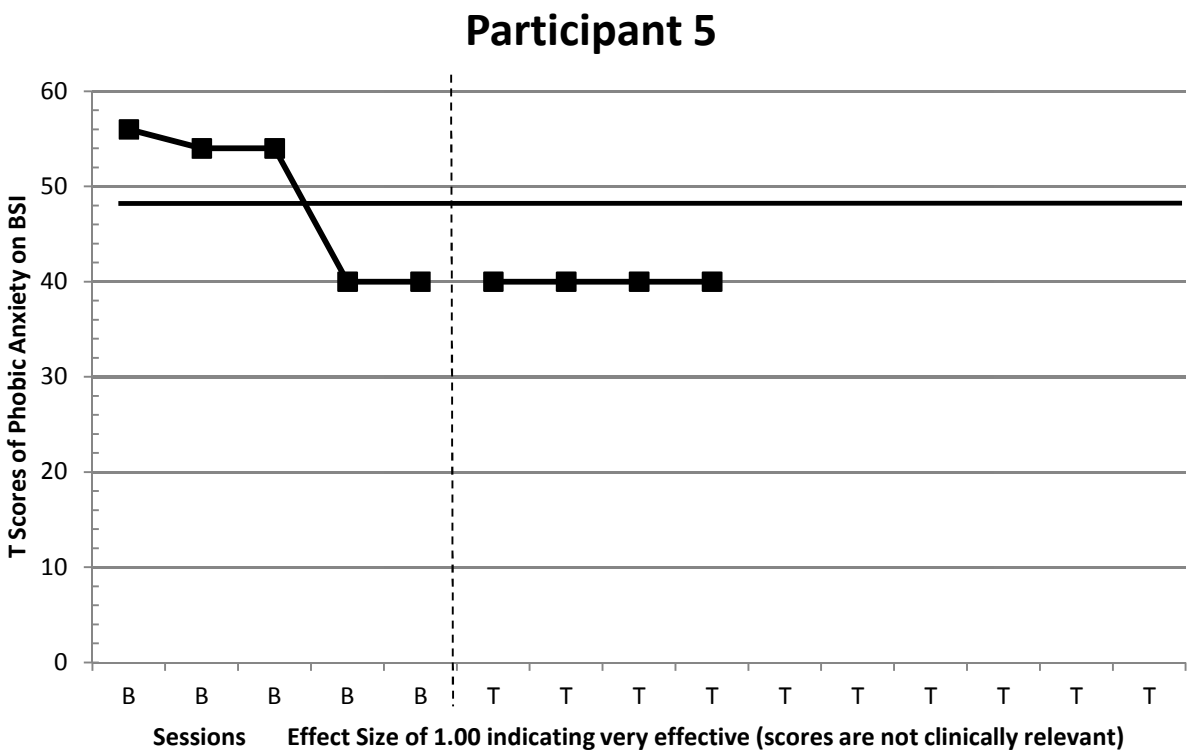


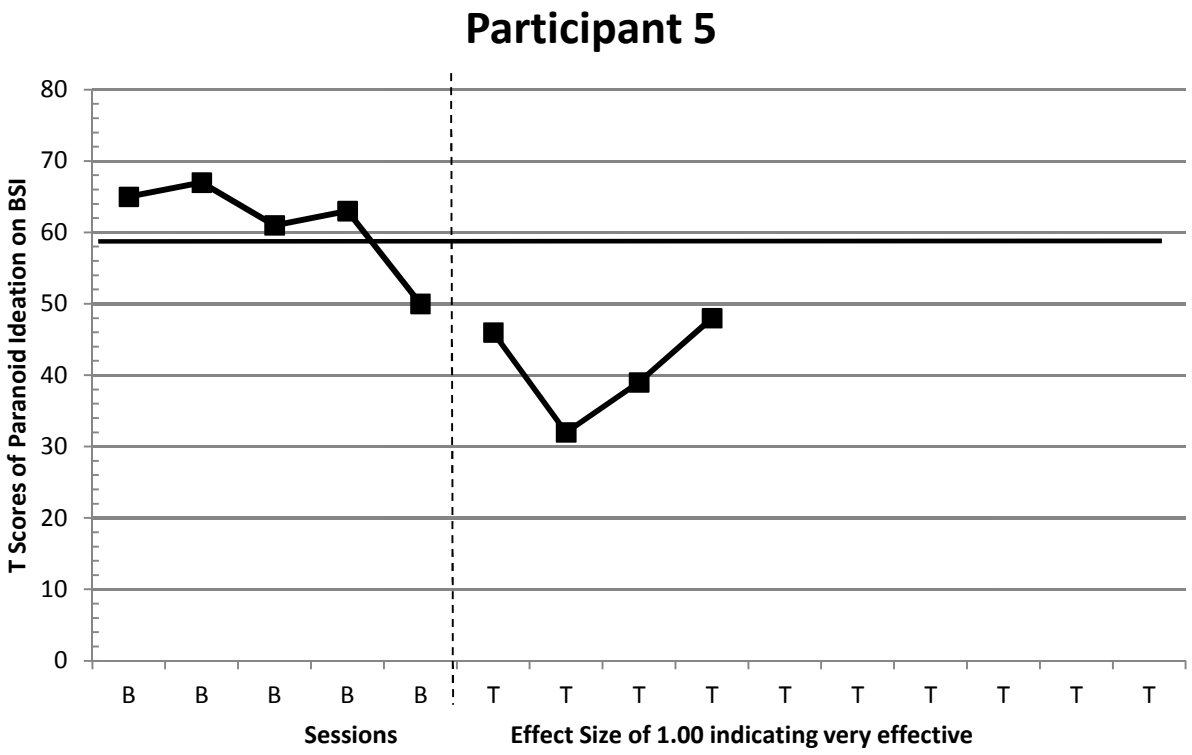

Participant 5
T Scores of Interpersonal Sensitivity on BSI
80
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 1.00 indicating very effective

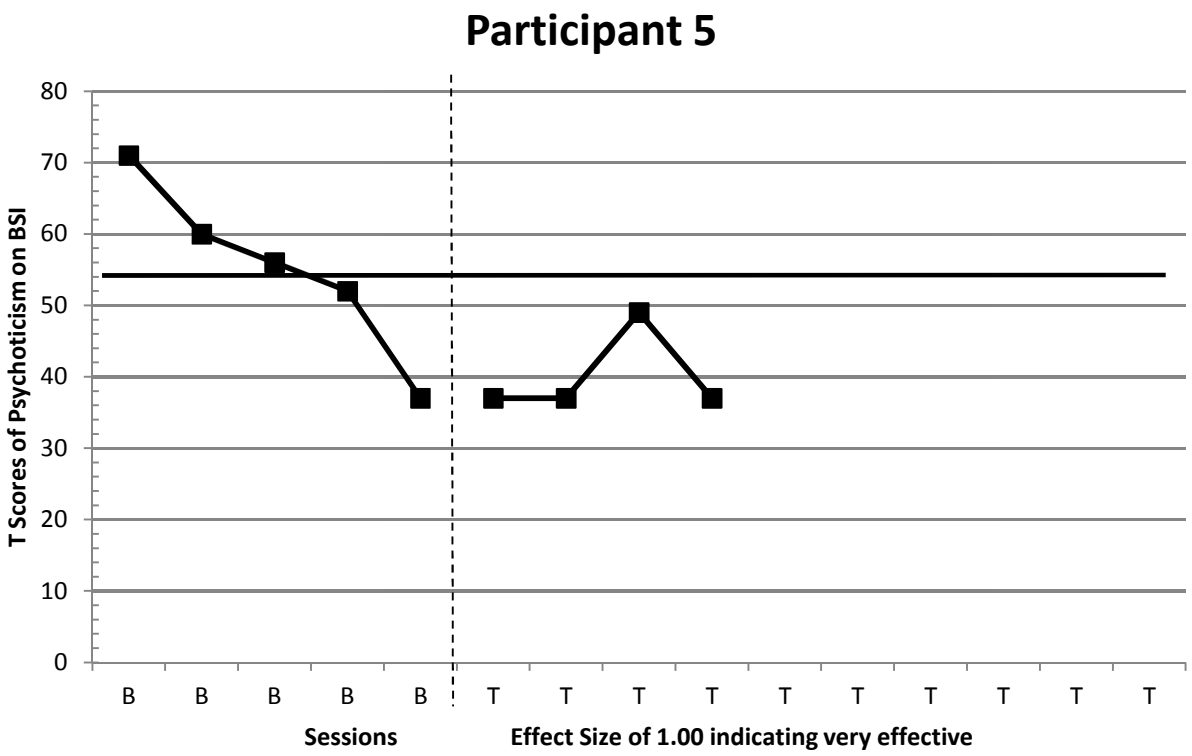

Participant 5
T Scores of Depression on BSI
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 0.75 indicating moderate effectiveness


Participant 5
T Scores of Anxiety on BSI
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 1.00 indicating very effective (scores are not clinically relevant)


Participant 5
T Scores of Hostility on BSI
80
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 0.75 indicating moderate effectiveness


Participant 5
T Scores of Phobic Anxiety on BSI
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 1.00 indicating very effective (scores are not clinically relevant)


Participant 5
T Scores of Paranoid Ideation on BSI
80
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 1.00 indicating very effective


Participant 5
T Scores of Psychoticism on BSI
80
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 1.00 indicating very effective

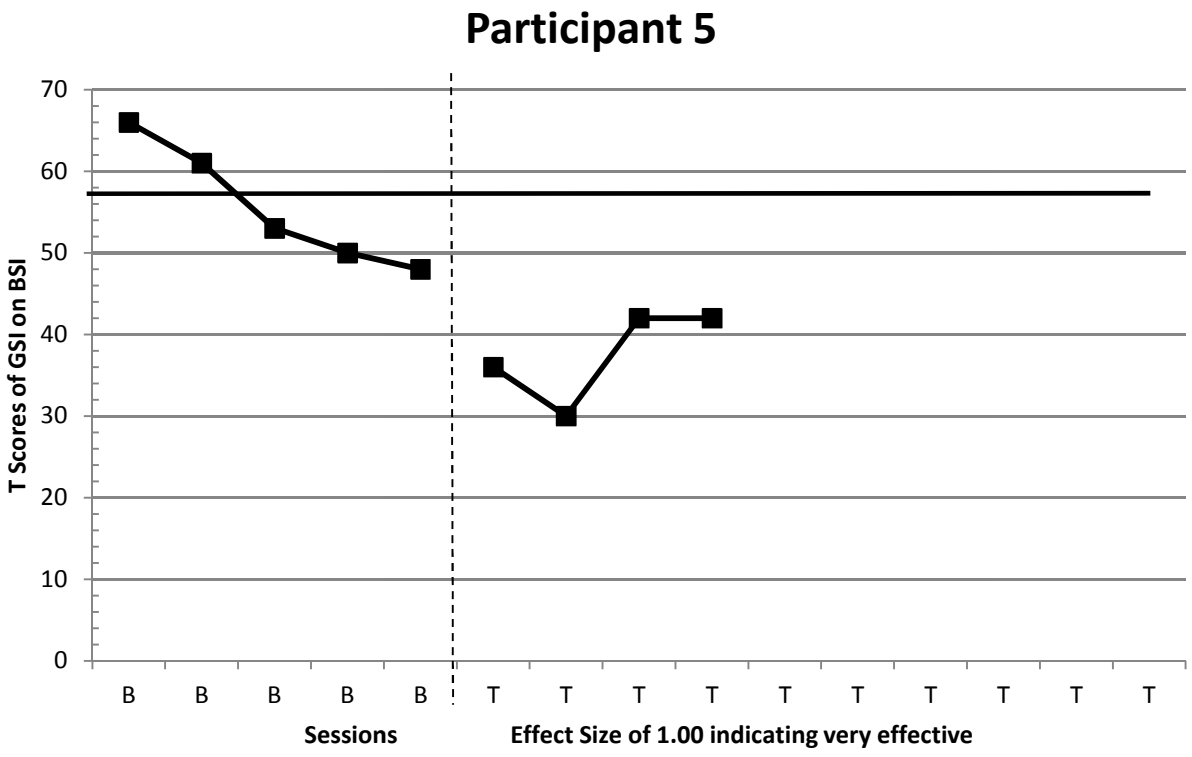
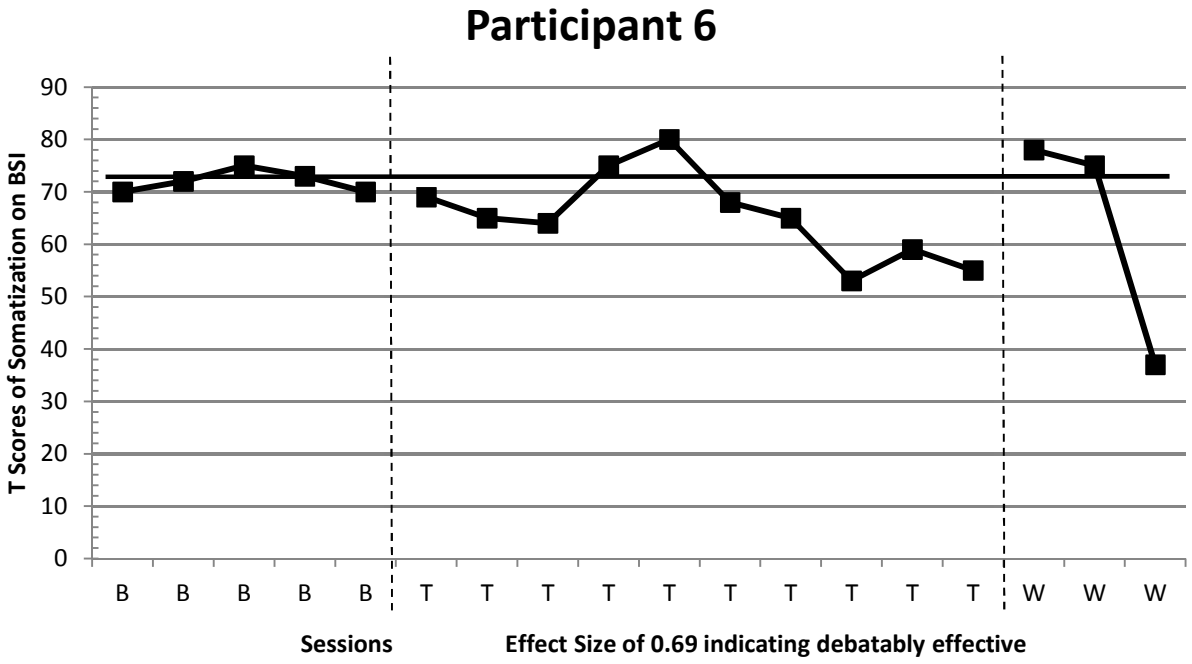
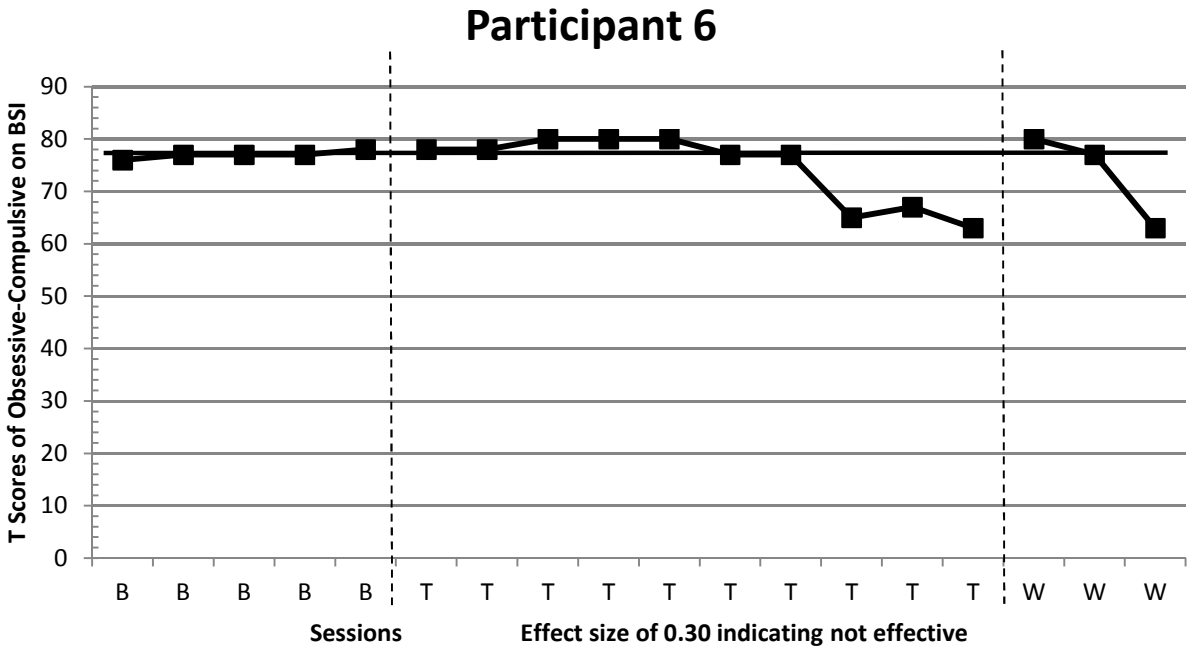
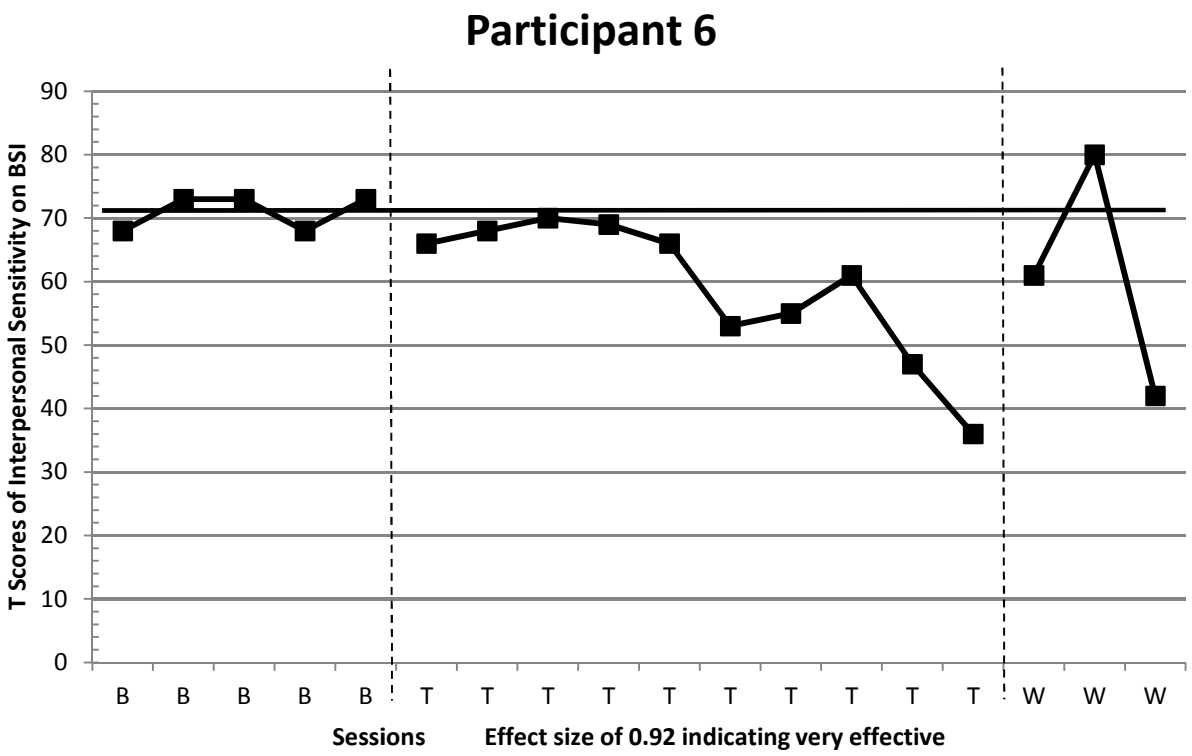

Participant 5
T Scores of GSI on BSI
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 1.00 indicating very effective

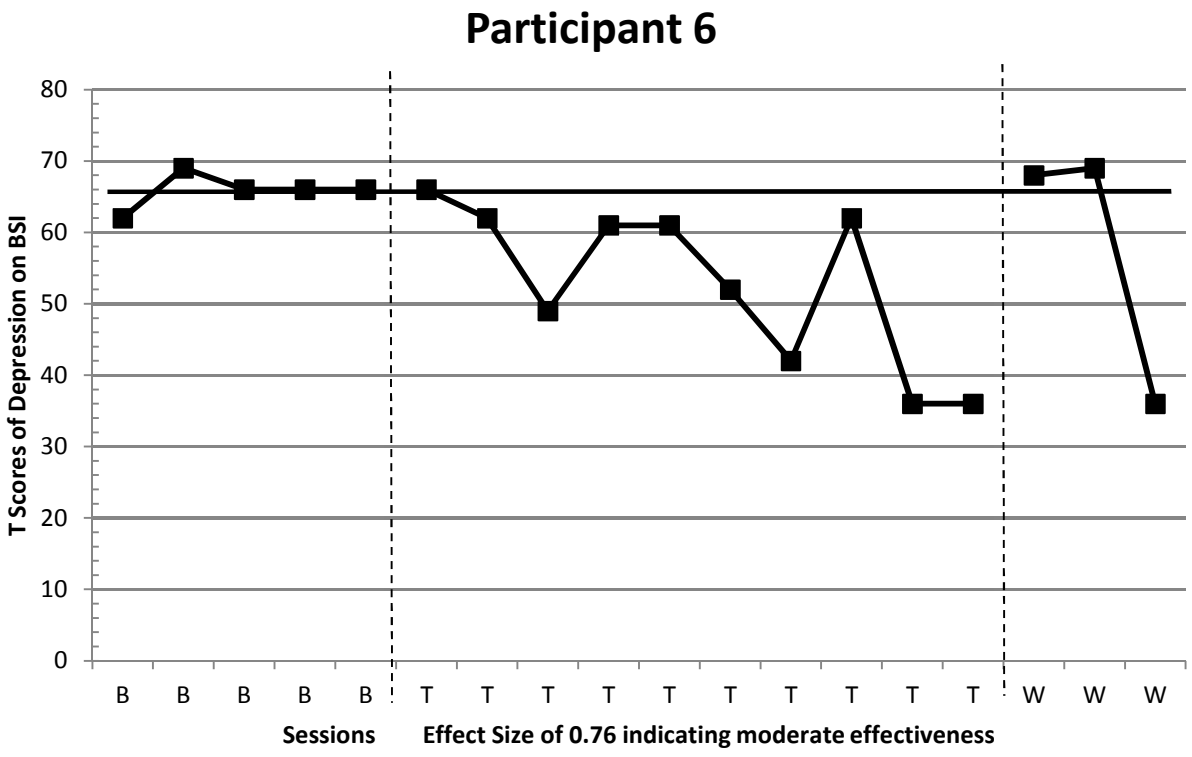
Figure 6.

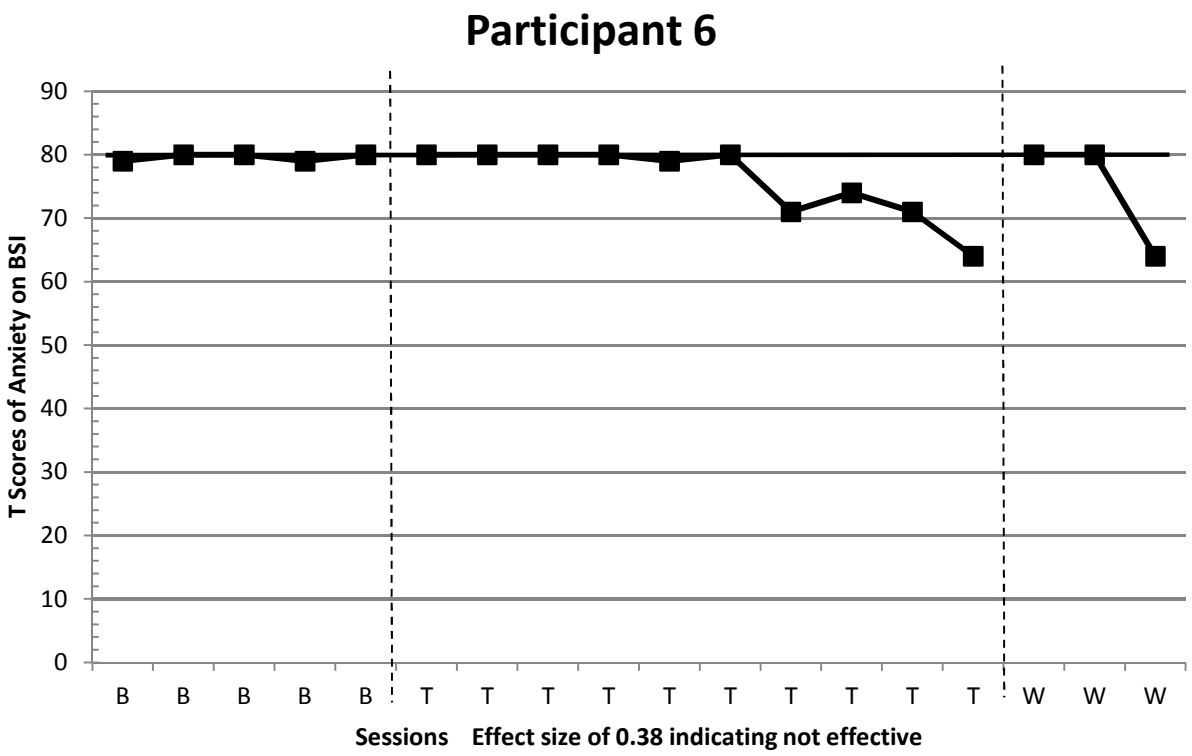
*Graphical Representation of Percentage of Data Exceeding the Median for Ratings of Clinically Relevant Psychological Symptoms by Participant Baylea Engaging in Narrative Therapy Sessions.*

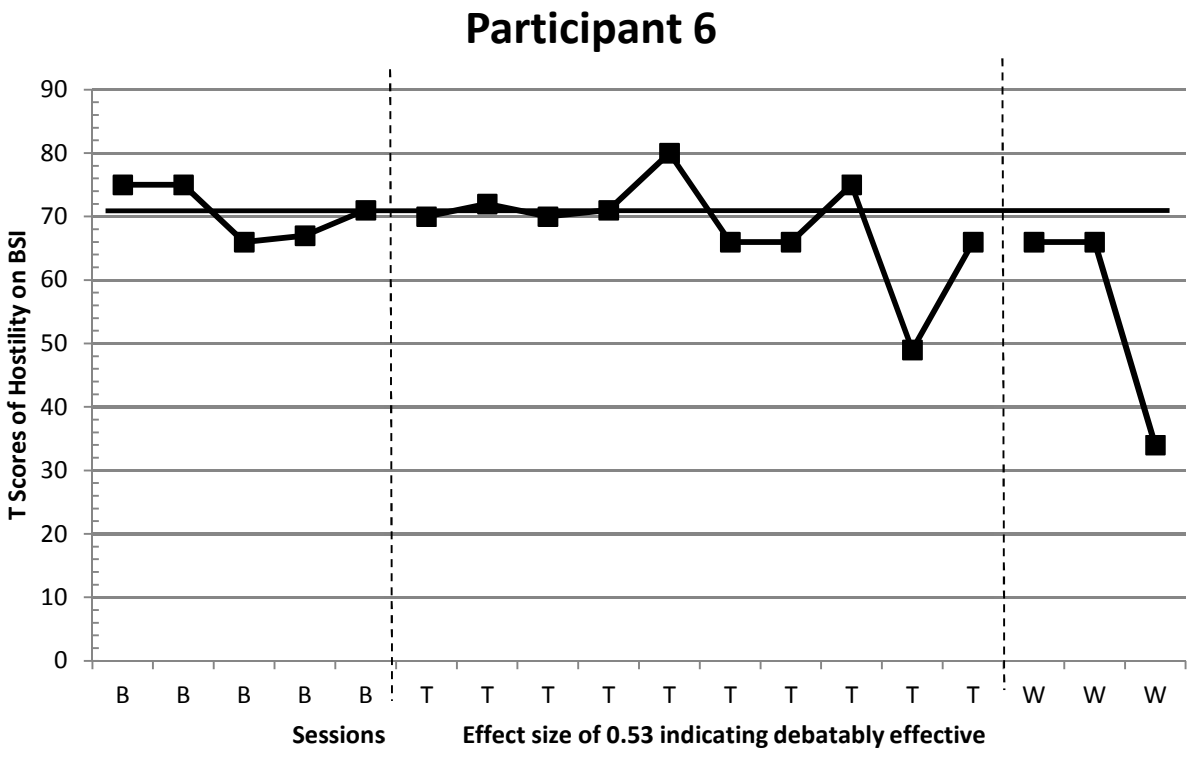


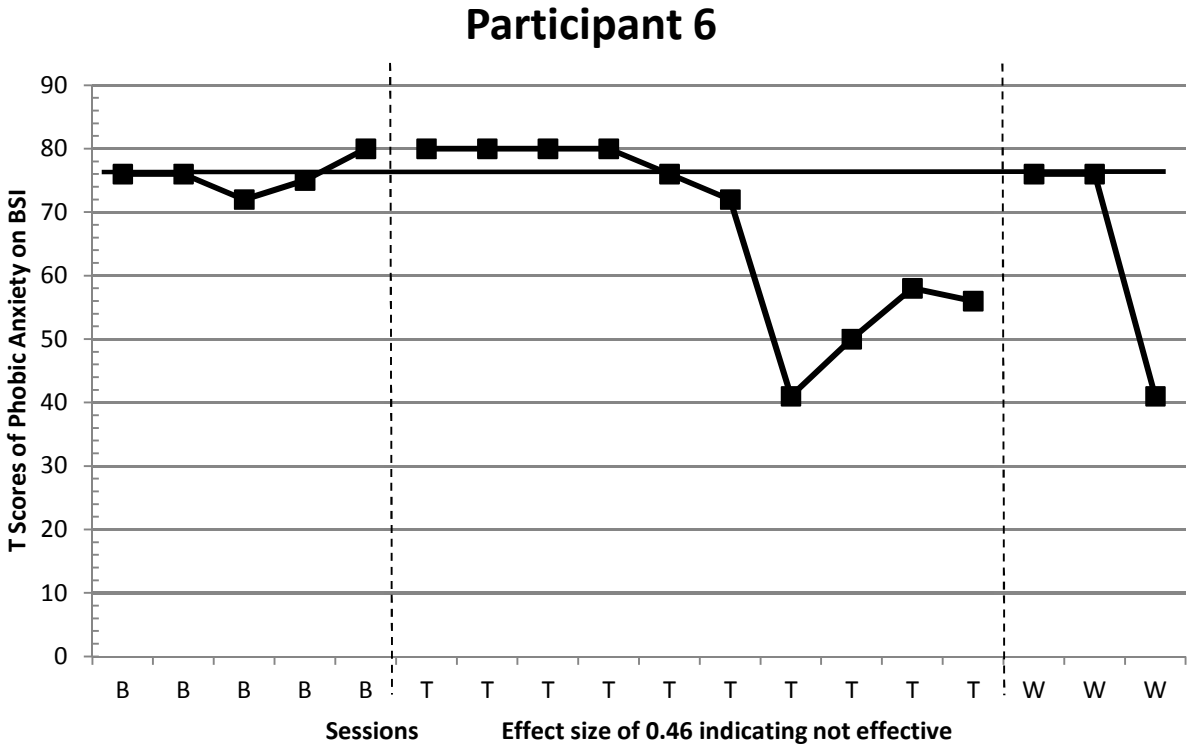



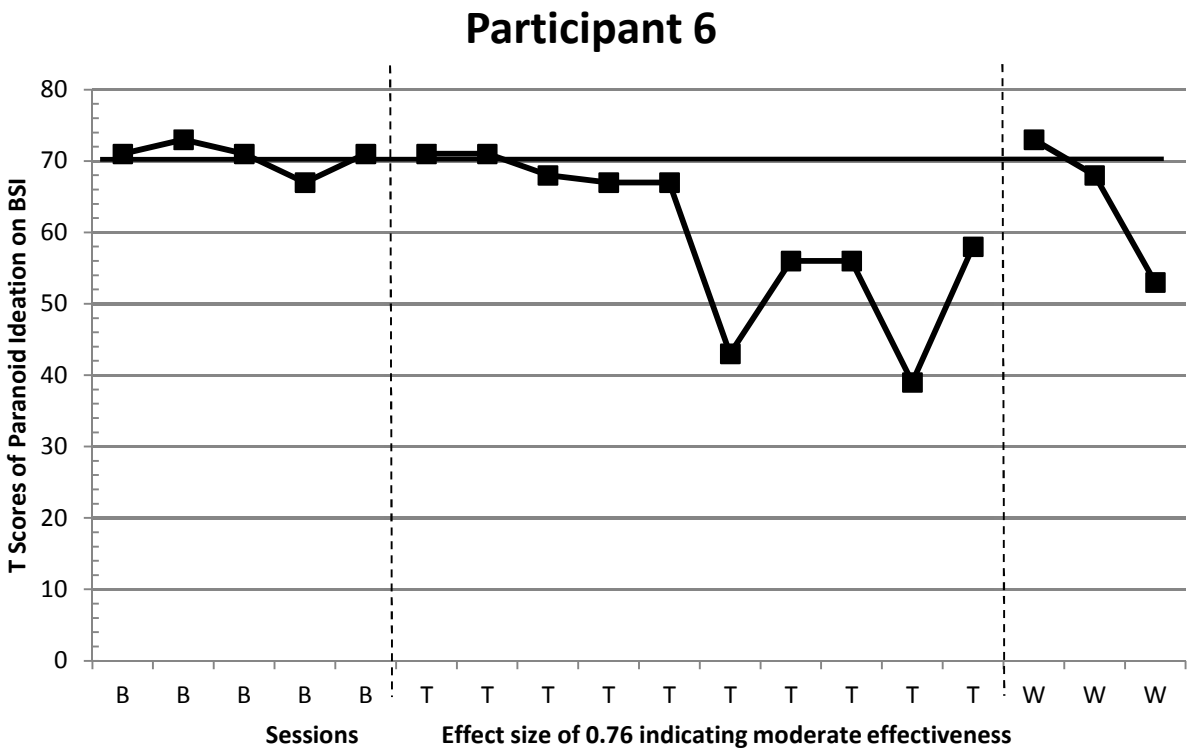

Participant 6
T Scores of Interpersonal Sensitivity on BSI
90
80
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T W W W
Sessions
Effect size of 0.92 indicating very effective

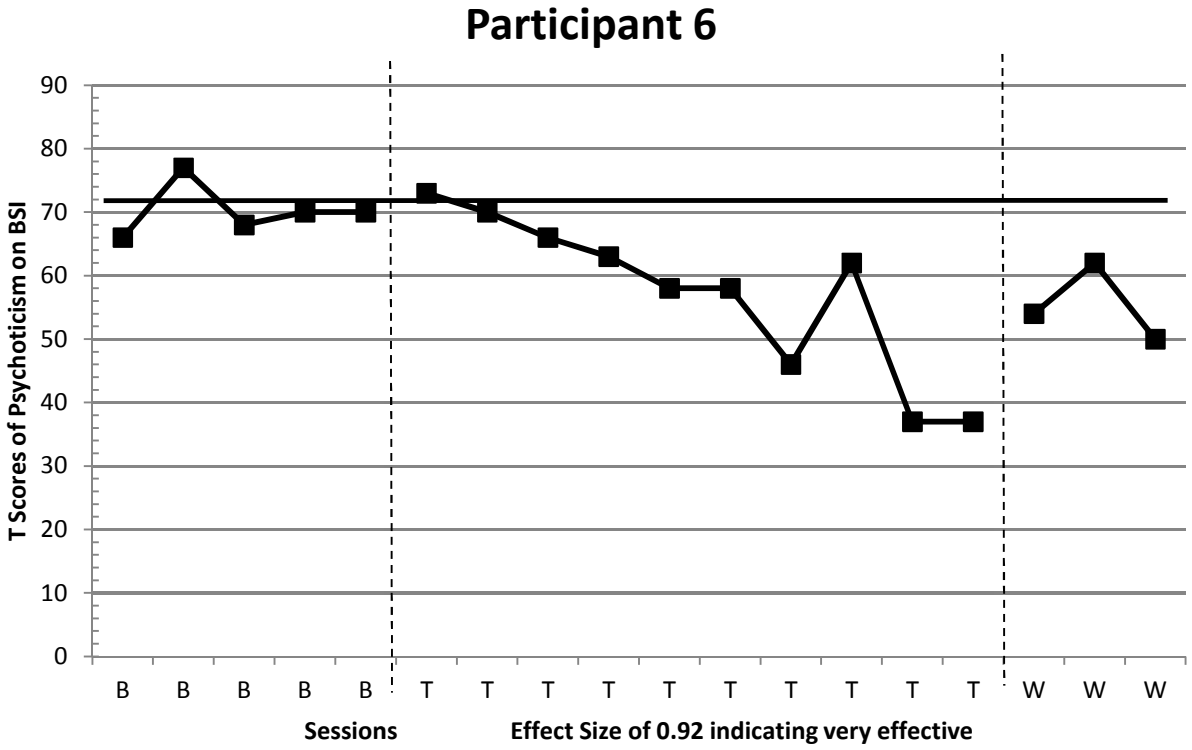

Participant 6
T Scores of Depression on BSI
80
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T W W W
Sessions
Effect Size of 0.76 indicating moderate effectiveness


Participant 6
T Scores of Anxiety on BSI
90
80
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T W W W
Sessions
Effect size of 0.38 indicating not effective


Participant 6
T Scores of Hostility on BSI
90
80
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T W W W
Sessions
Effect size of 0.53 indicating debatably effective


Participant 6
T Scores of Phobic Anxiety on BSI
90
80
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T W W W
Sessions
Effect size of 0.46 indicating not effective


Participant 6
T Scores of Paranoid Ideation on BSI
80
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T W W W
Sessions
Effect size of 0.76 indicating moderate effectiveness


Participant 6
T Scores of Psychoticism on BSI
90
80
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T W W W
Sessions
Effect Size of 0.92 indicating very effective

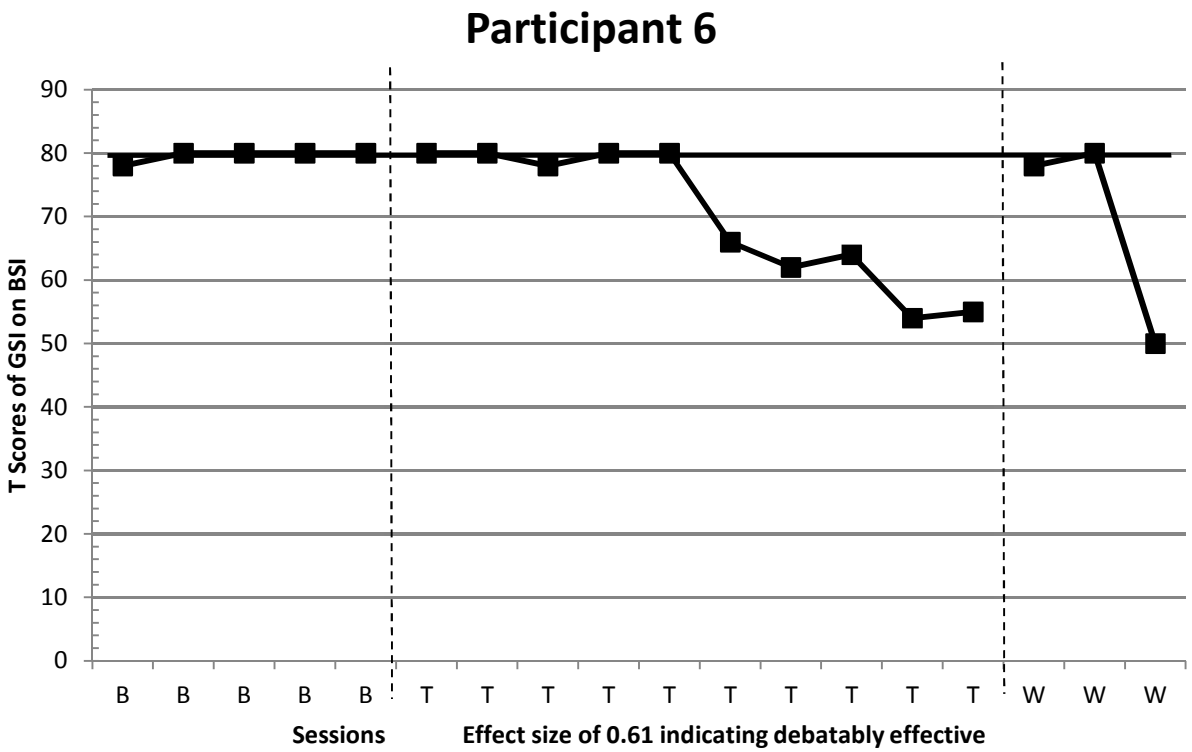
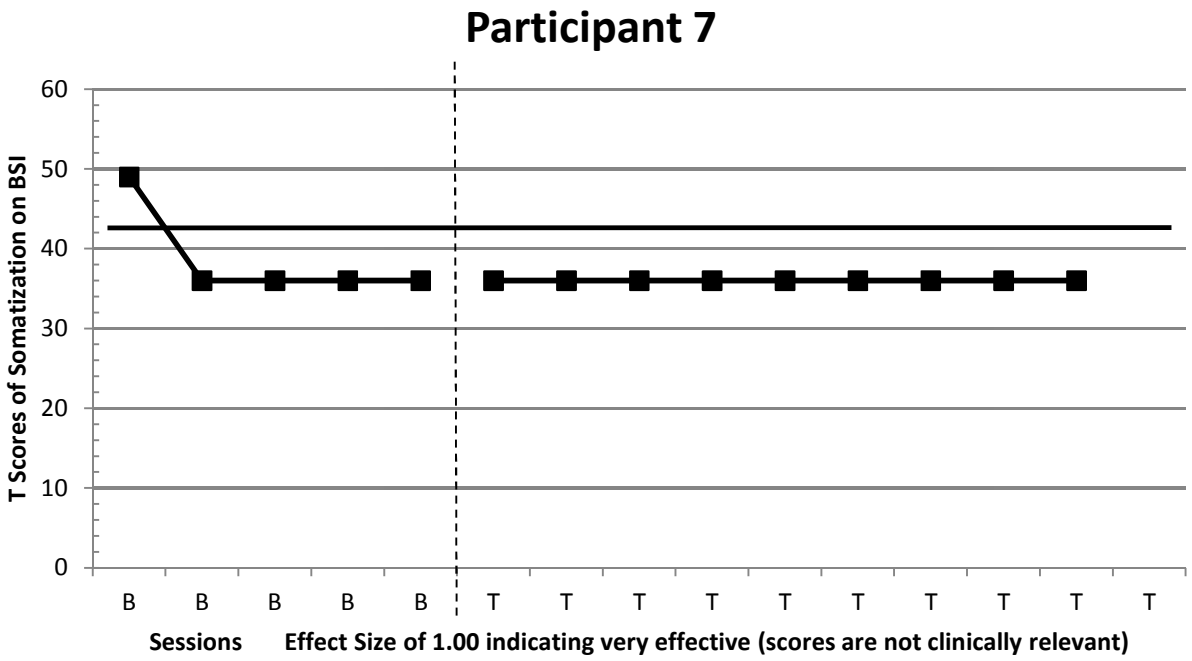
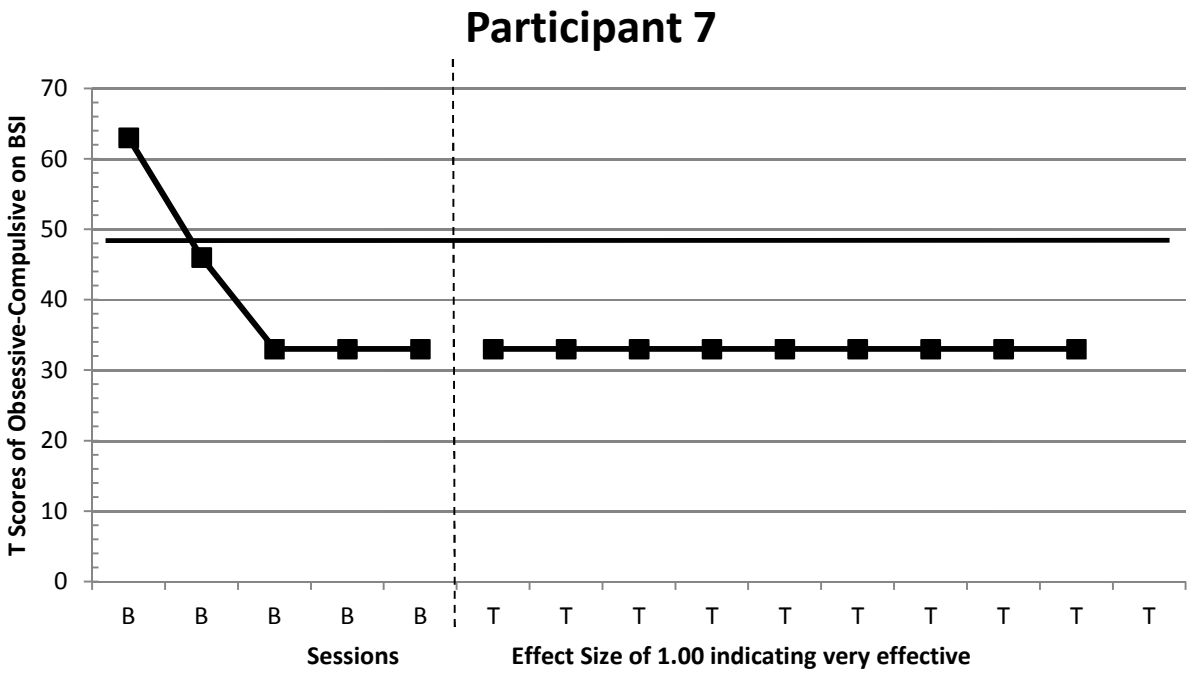
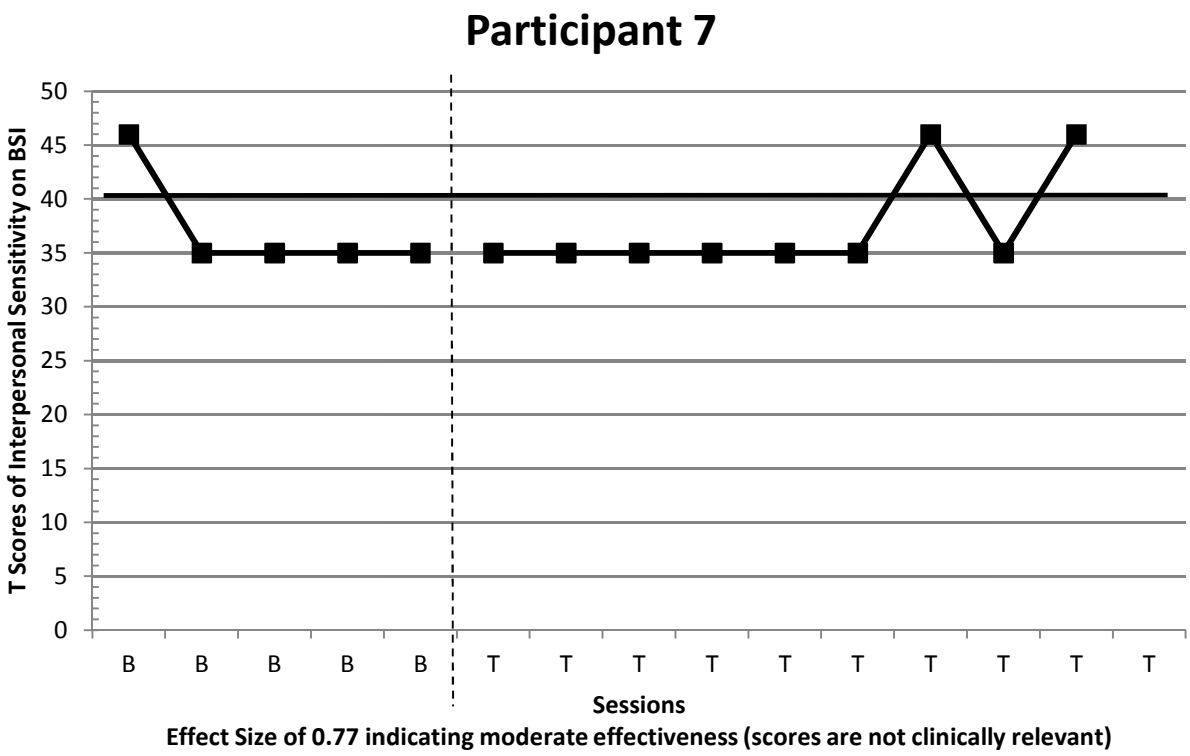

Participant 6
T Scores of GSI on BSI
90
80
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T W W W
Sessions
Effect size of 0.61 indicating debatably effective

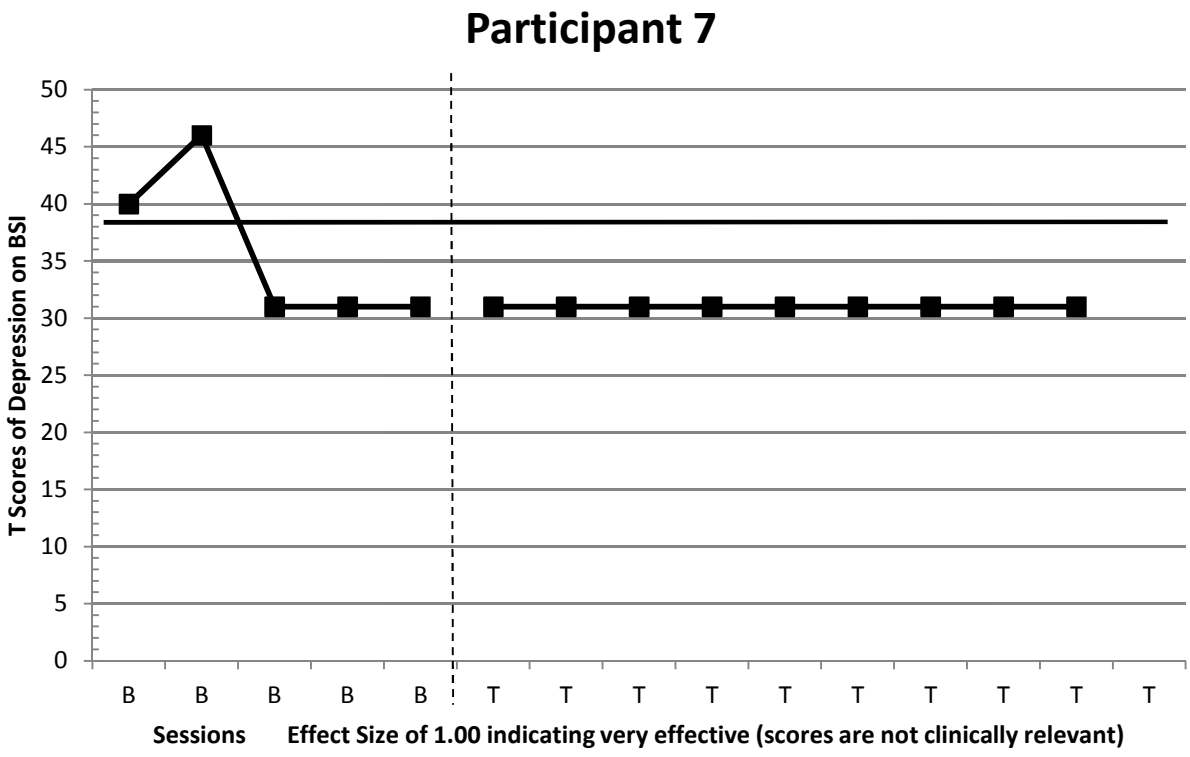
Figure 7.

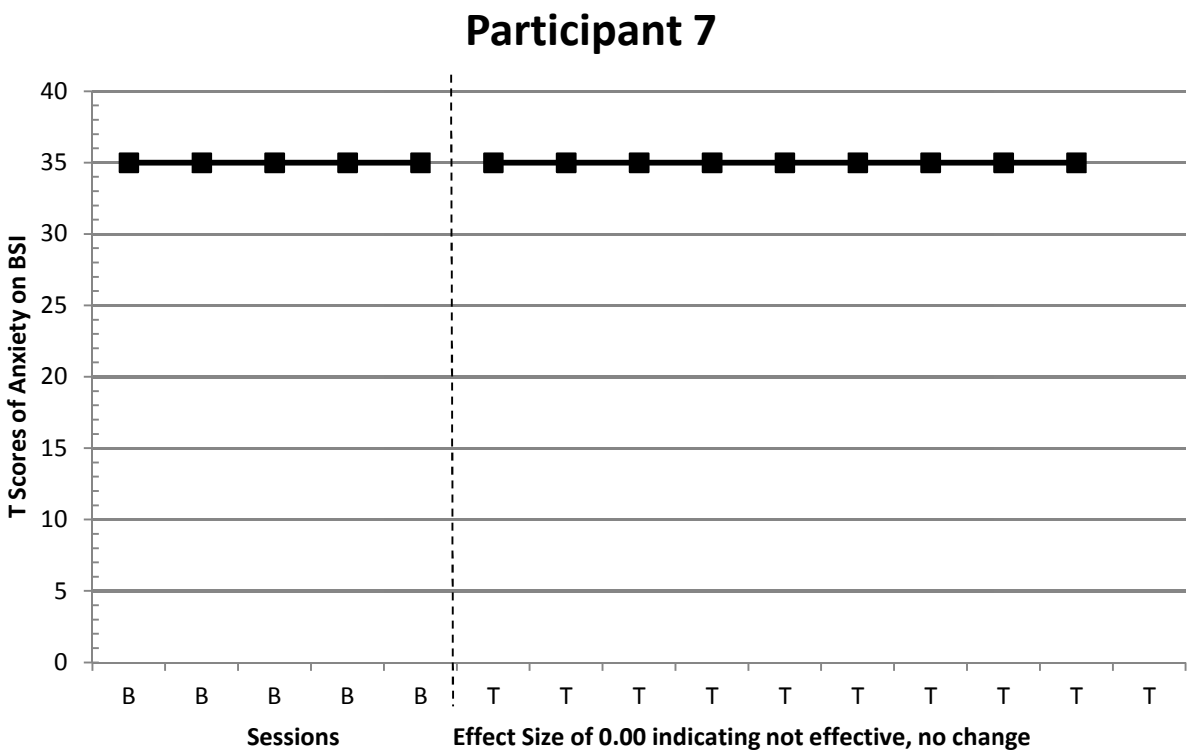
*Graphical Representation of Percentage of Data Exceeding the Median for Ratings of Clinically Relevant Psychological Symptoms by Participant Randy Engaging in Narrative Therapy Sessions.*

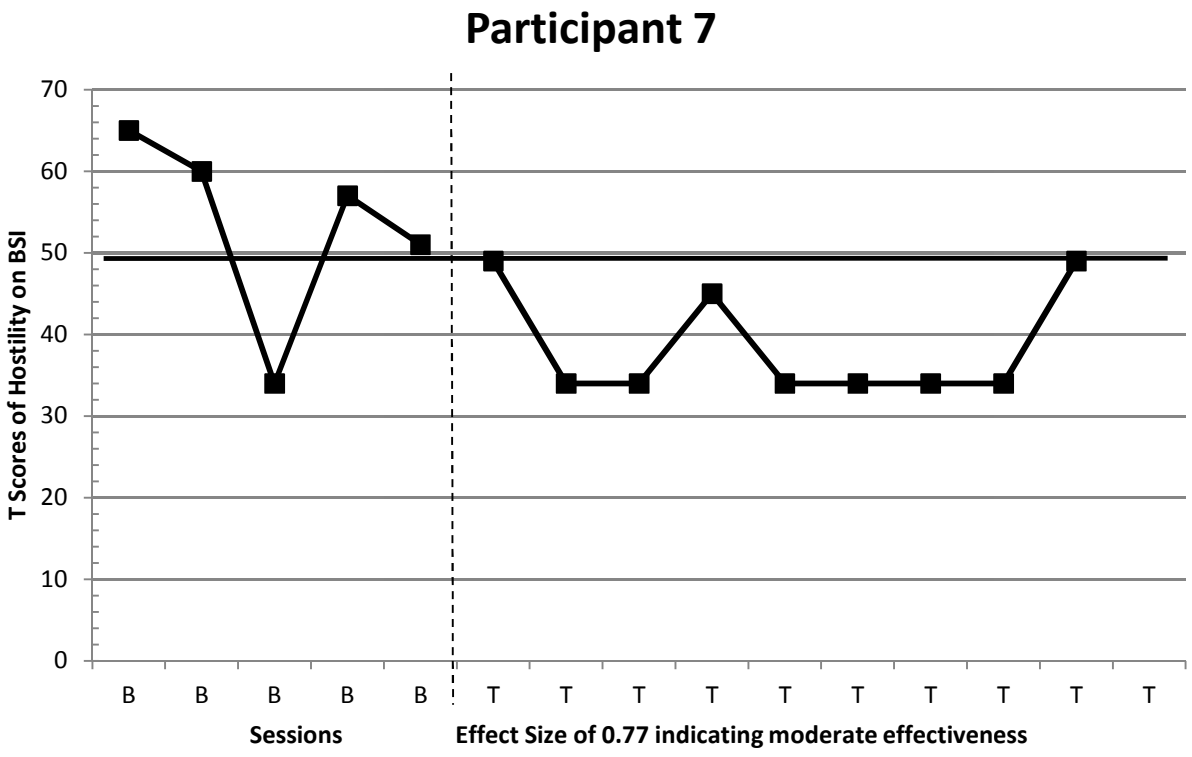


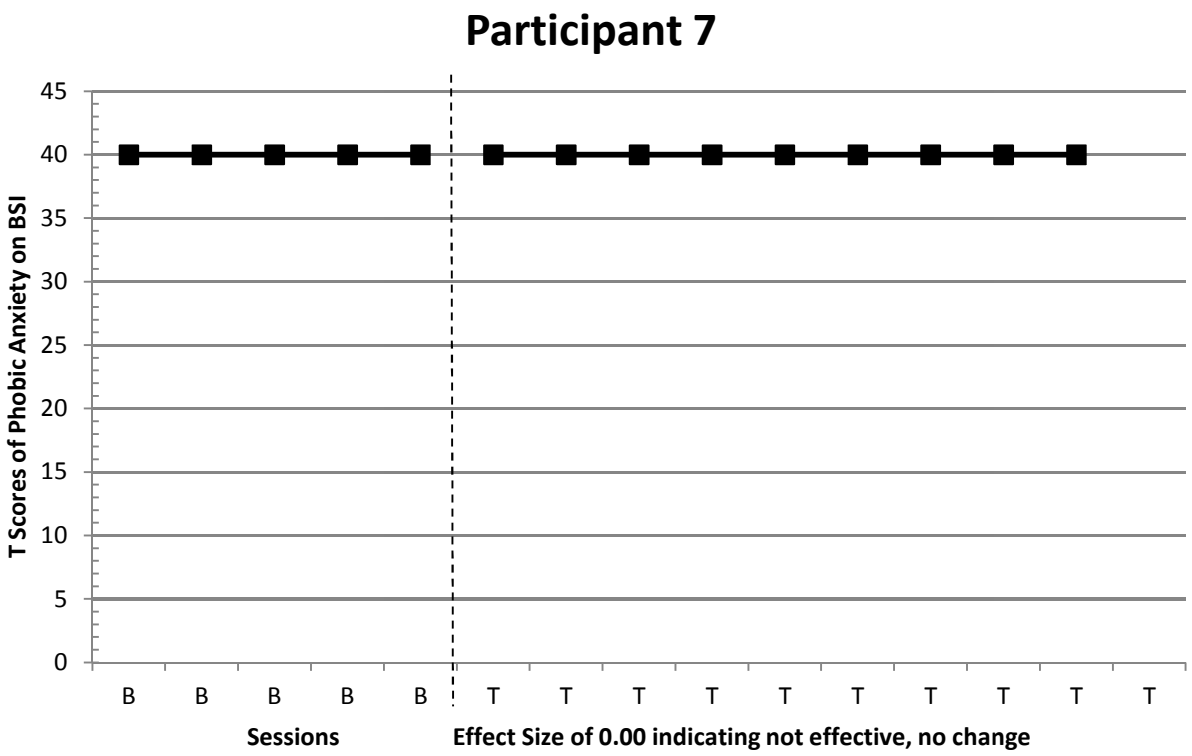



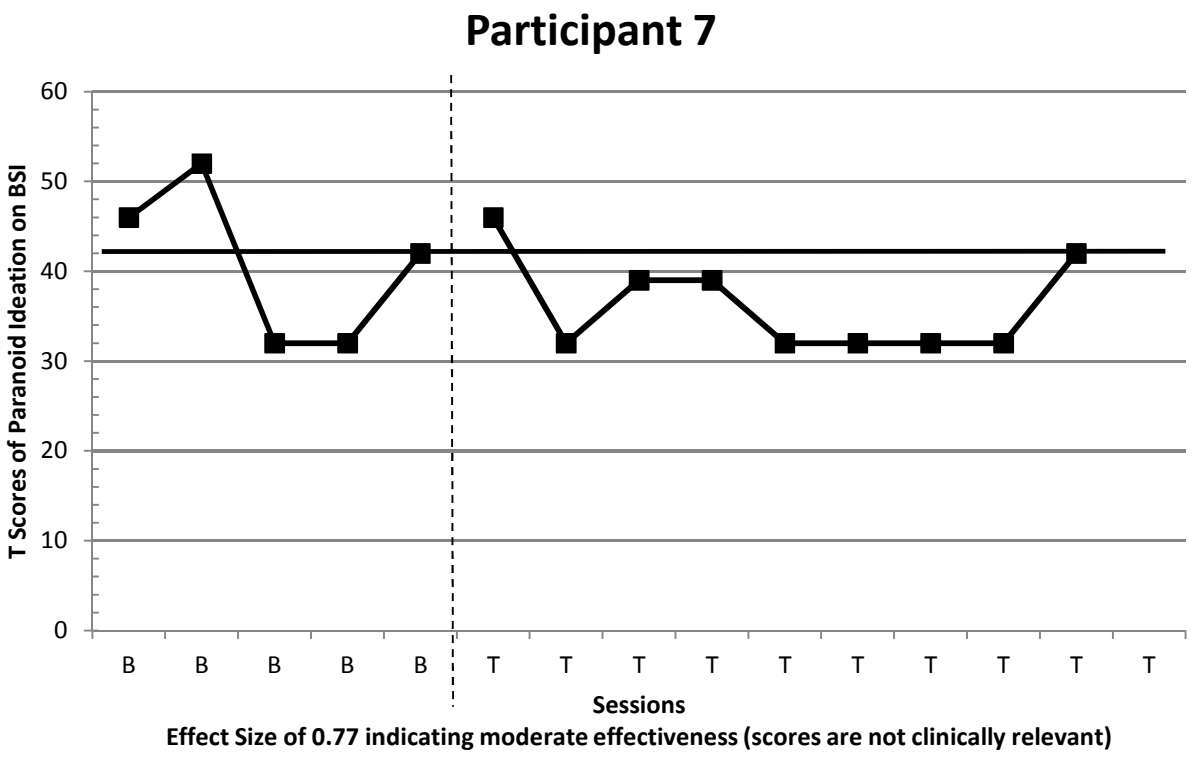

Participant 7
T Scores of Interpersonal Sensitivity on BSI
50
45
40
35
30
25
20
15
10
5
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 0.77 indicating moderate effectiveness (scores are not clinically relevant)

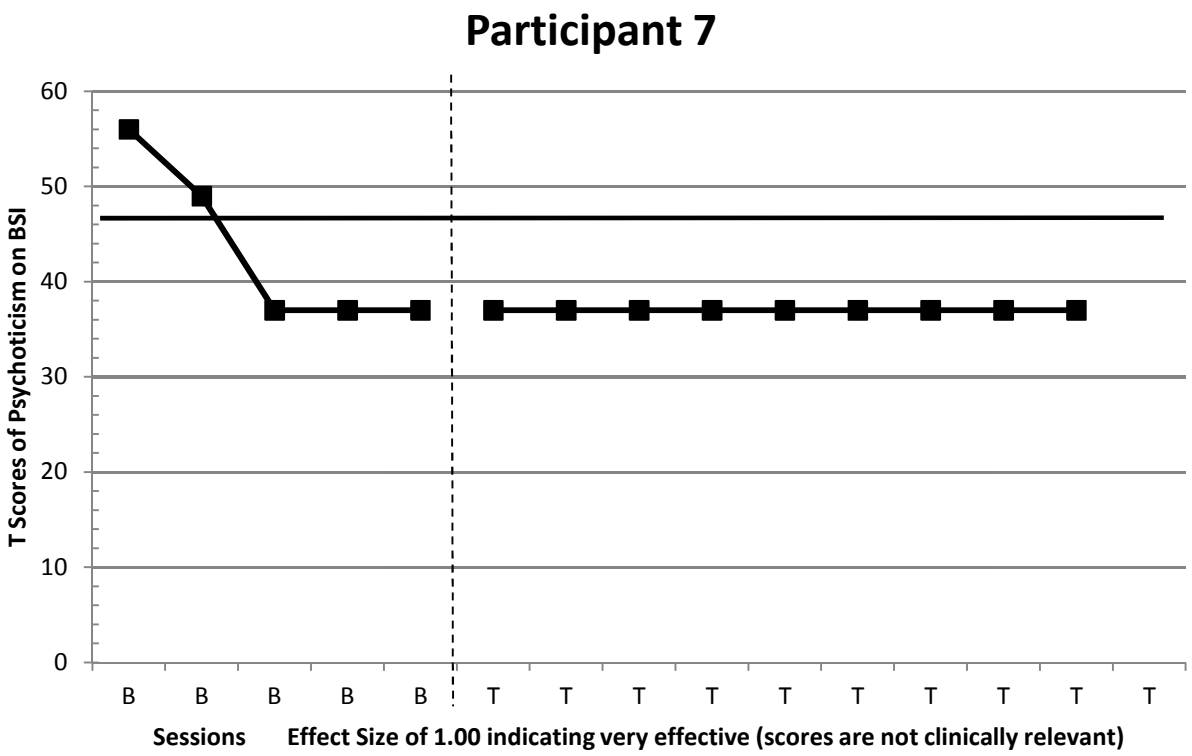

Participant 7
T Scores of Depression on BSI
50
45
40
35
30
25
20
15
10
5
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 1.00 indicating very effective (scores are not clinically relevant)


Participant 7
T Scores of Anxiety on BSI
40
35
30
25
20
15
10
5
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 0.00 indicating not effective, no change


Participant 7
T Scores of Hostility on BSI
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 0.77 indicating moderate effectiveness


Participant 7
T Scores of Phobic Anxiety on BSI
45
40
35
30
25
20
15
10
5
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 0.00 indicating not effective, no change


Participant 7
T Scores of Paranoid Ideation on BSI
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 0.77 indicating moderate effectiveness (scores are not clinically relevant)


Participant 7
T Scores of Psychoticism on BSI
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 1.00 indicating very effective (scores are not clinically relevant)

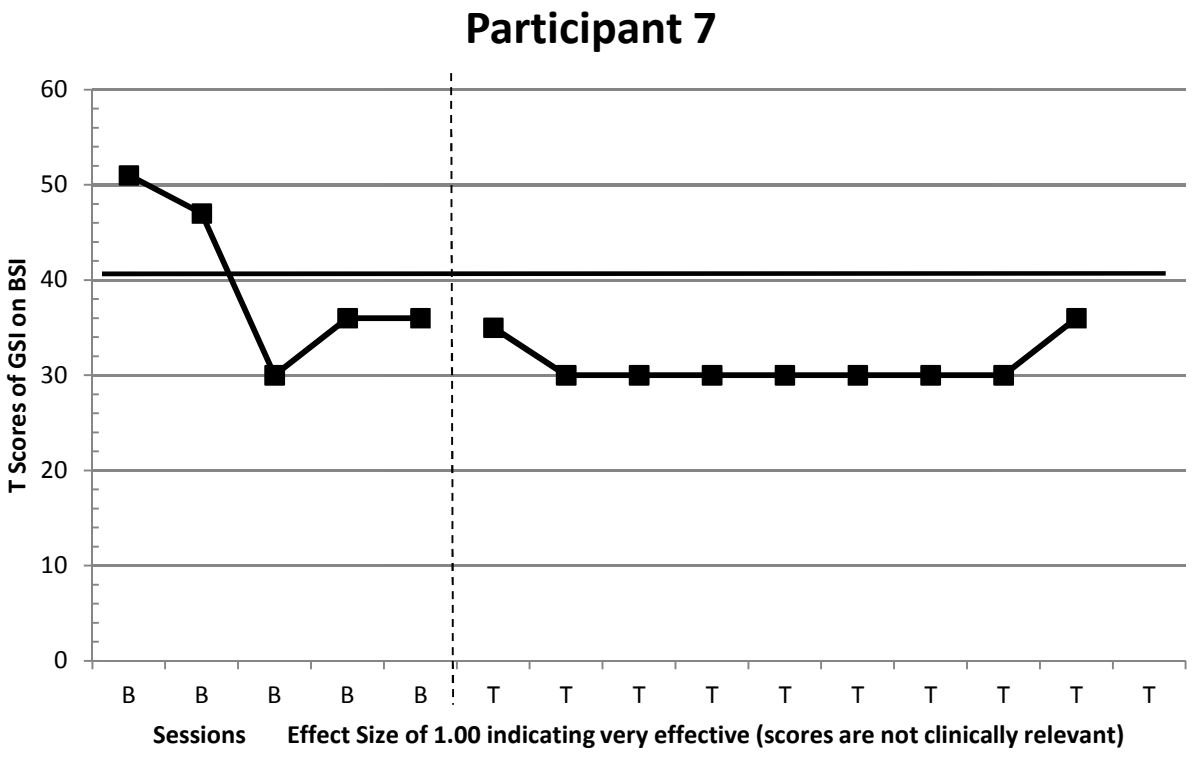
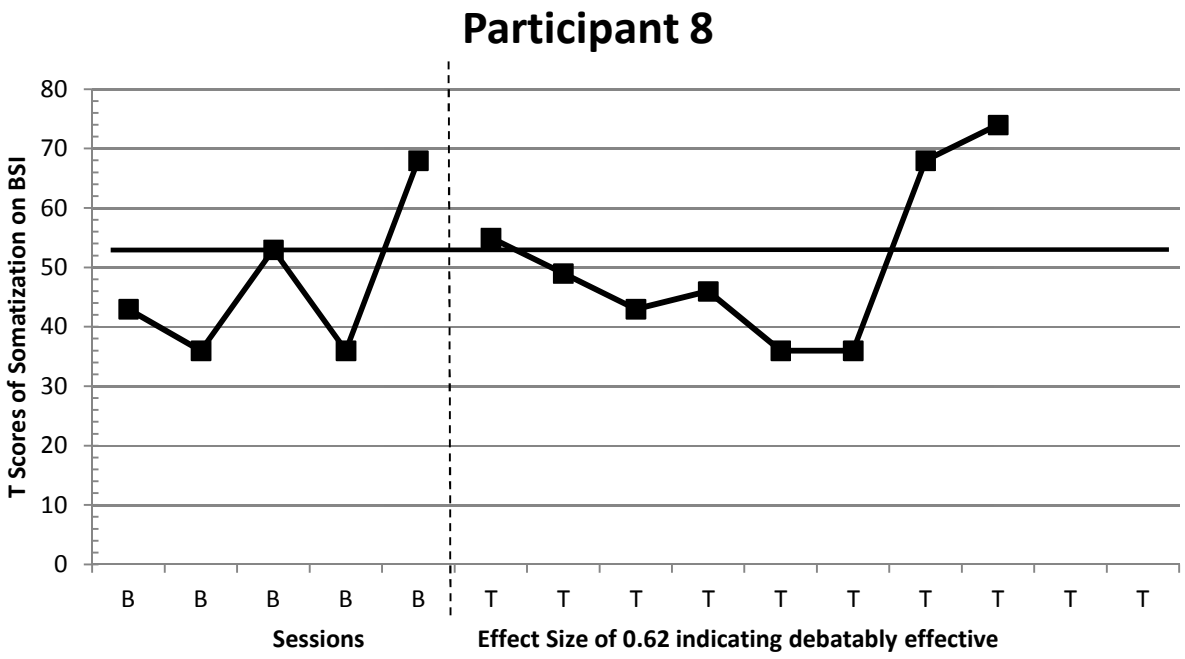
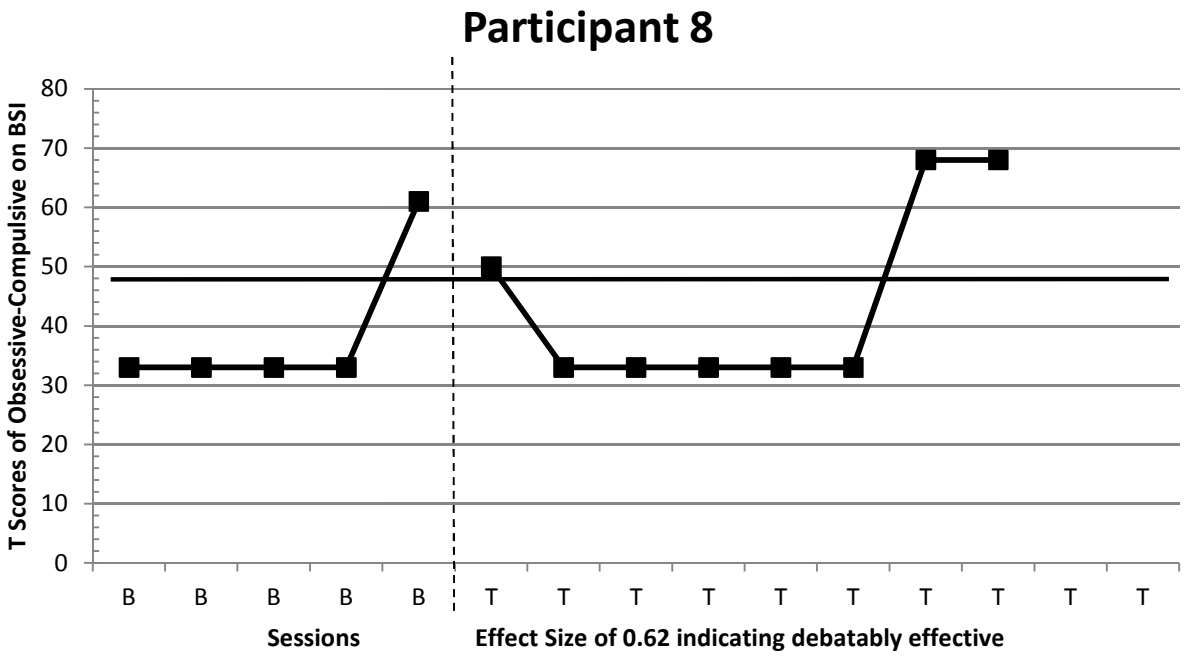
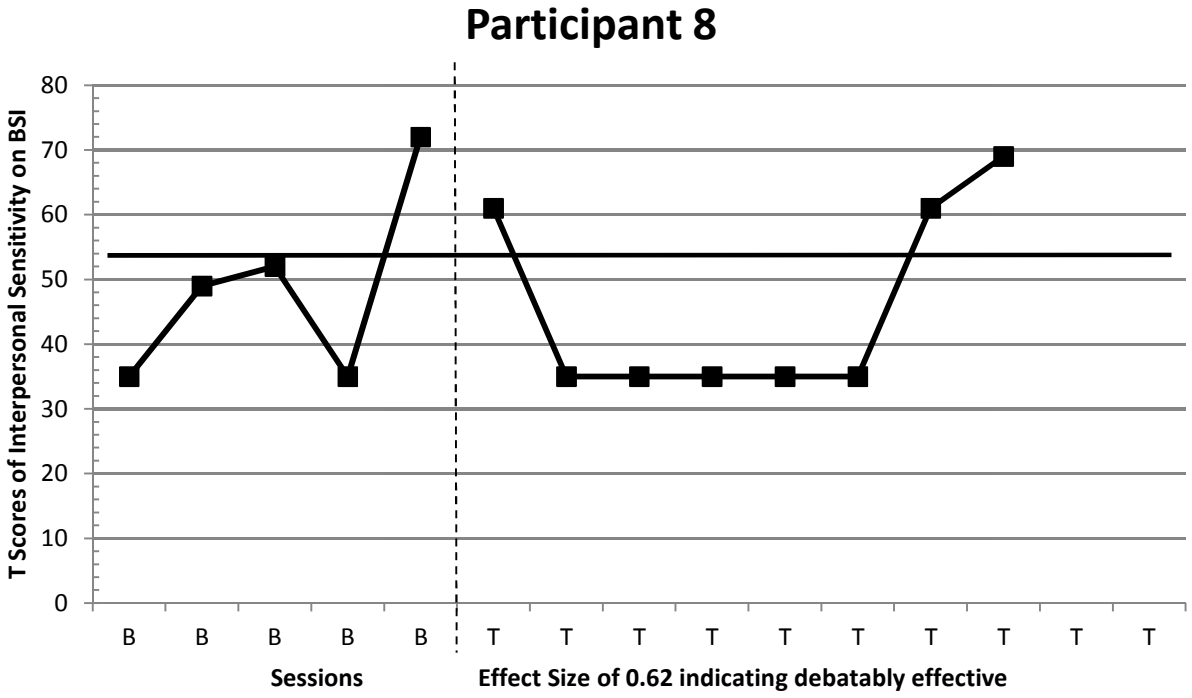

Participant 7
T Scores of GSI on BSI
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 1.00 indicating very effective (scores are not clinically relevant)

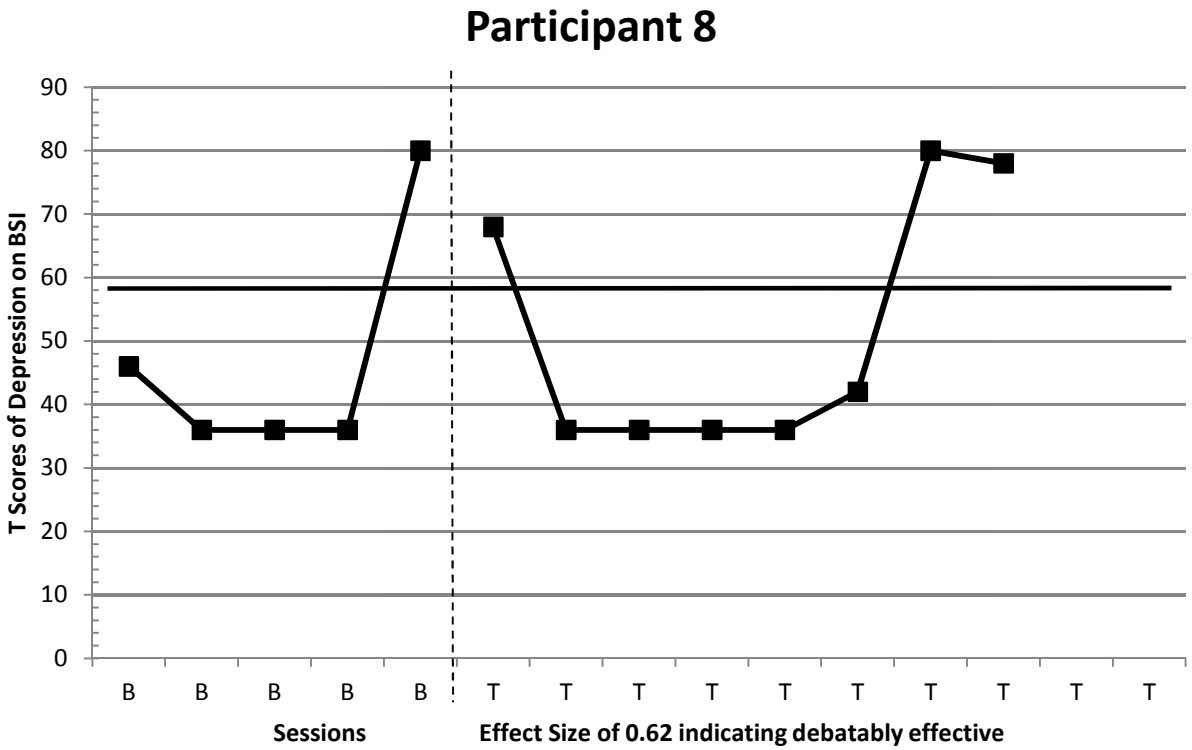
Figure 8.

*Graphical Representation of Percentage of Data Exceeding the Median for Ratings of Clinically Relevant Psychological Symptoms by Participant Jesse Engaging in Narrative Therapy Sessions.*




Participant 8
T Scores of Interpersonal Sensitivity on BSI
80
70
60
50
40
30
20
10
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 0.62 indicating debatably effective


Participant 8
T Scores of Depression on BSI
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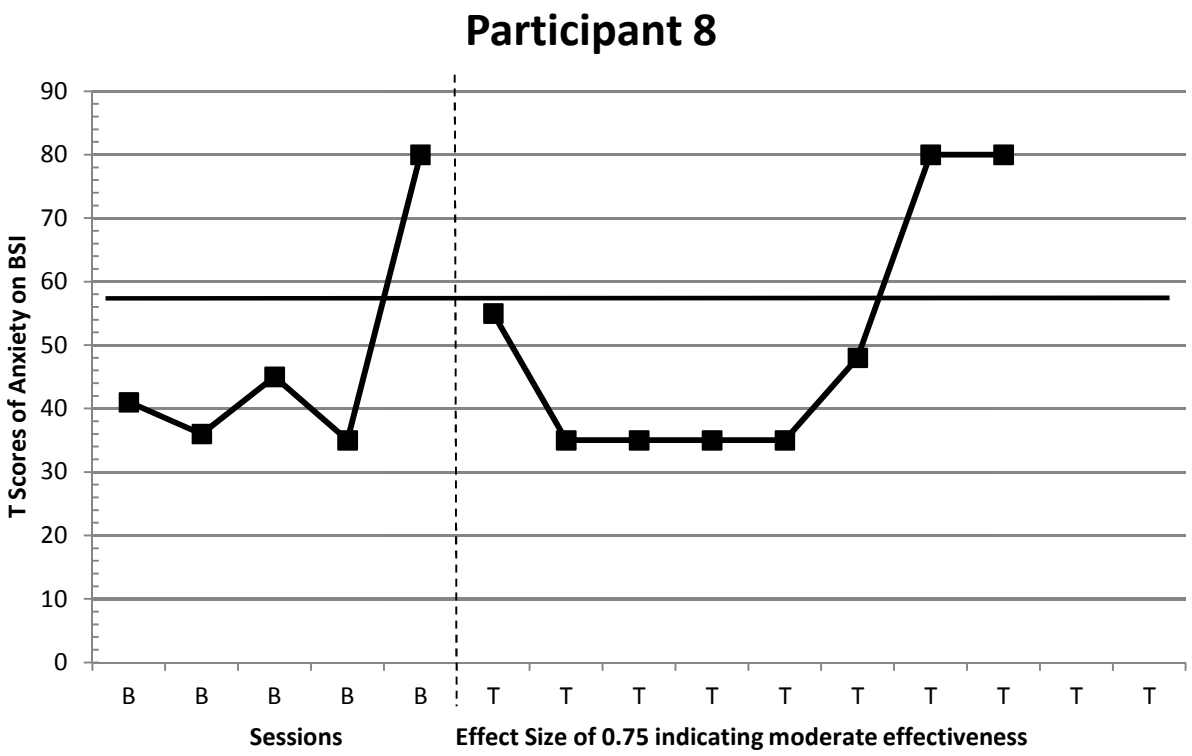
Effect Size of 0.62 indicating debatably effective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T Scores of Anxiety on BSI
90
80
70
60
50
40
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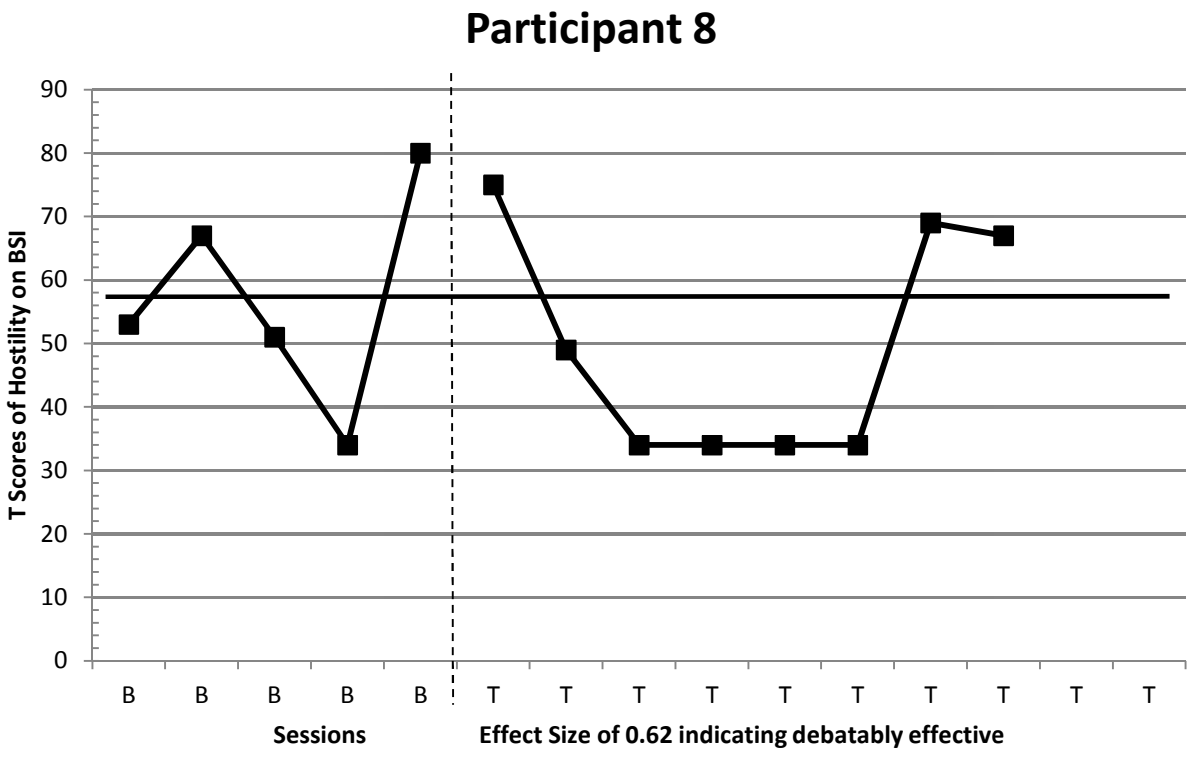
Sessions
Effect Size of 0.75 indicating moderate effectiveness


Participant 8
T Scores of Hostility on BSI
90
80
70
60
50
40
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20
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0
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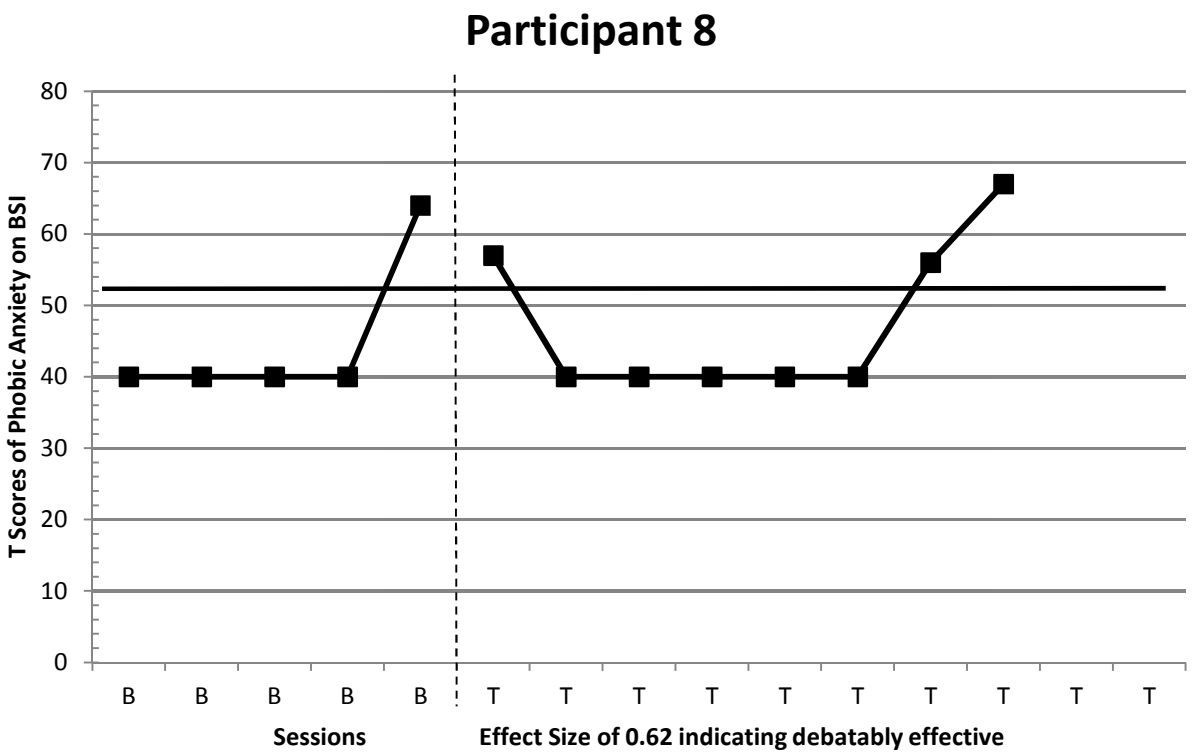
Sessions
Effect Size of 0.62 indicating debatably effective


Participant 8
T Scores of Phobic Anxiety on BSI
80
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40
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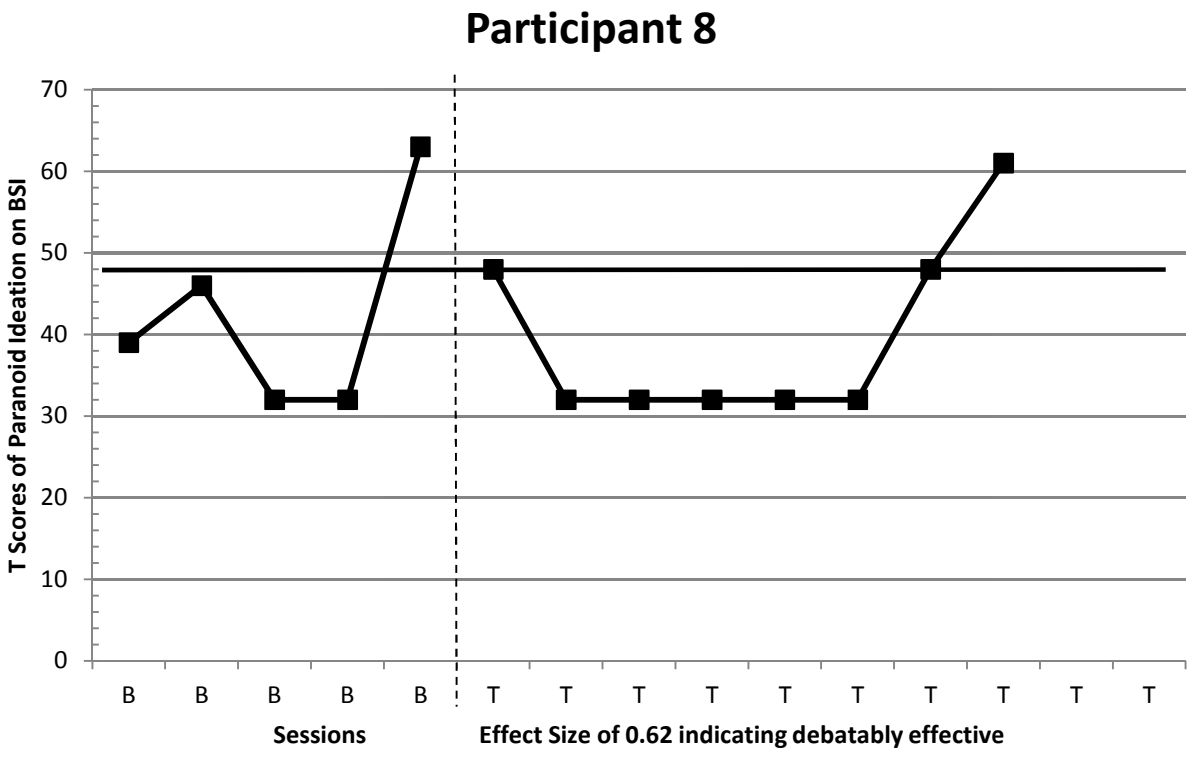
Sessions
Effect Size of 0.62 indicating debatably effective


Participant 8
T Scores of Paranoid Ideation on BSI
70
60
50
40
30
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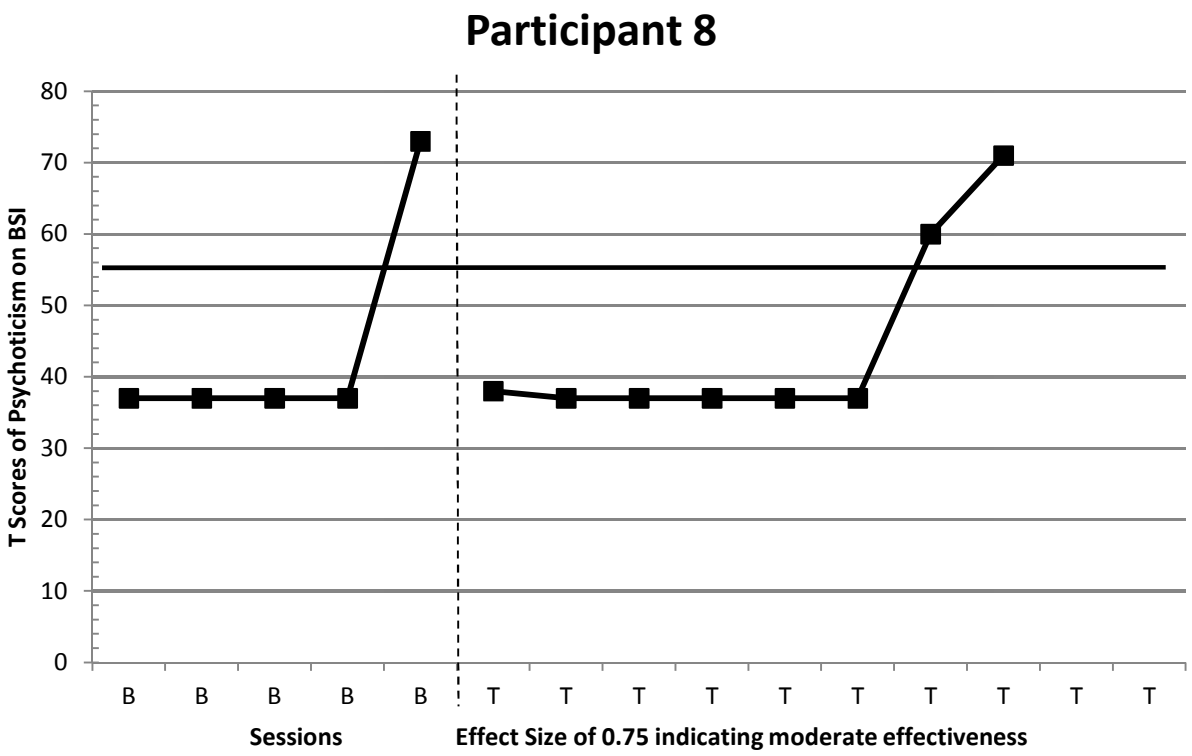
Sessions
Effect Size of 0.62 indicating debatably effective


Participant 8
T Scores of Psychoticism on BSI
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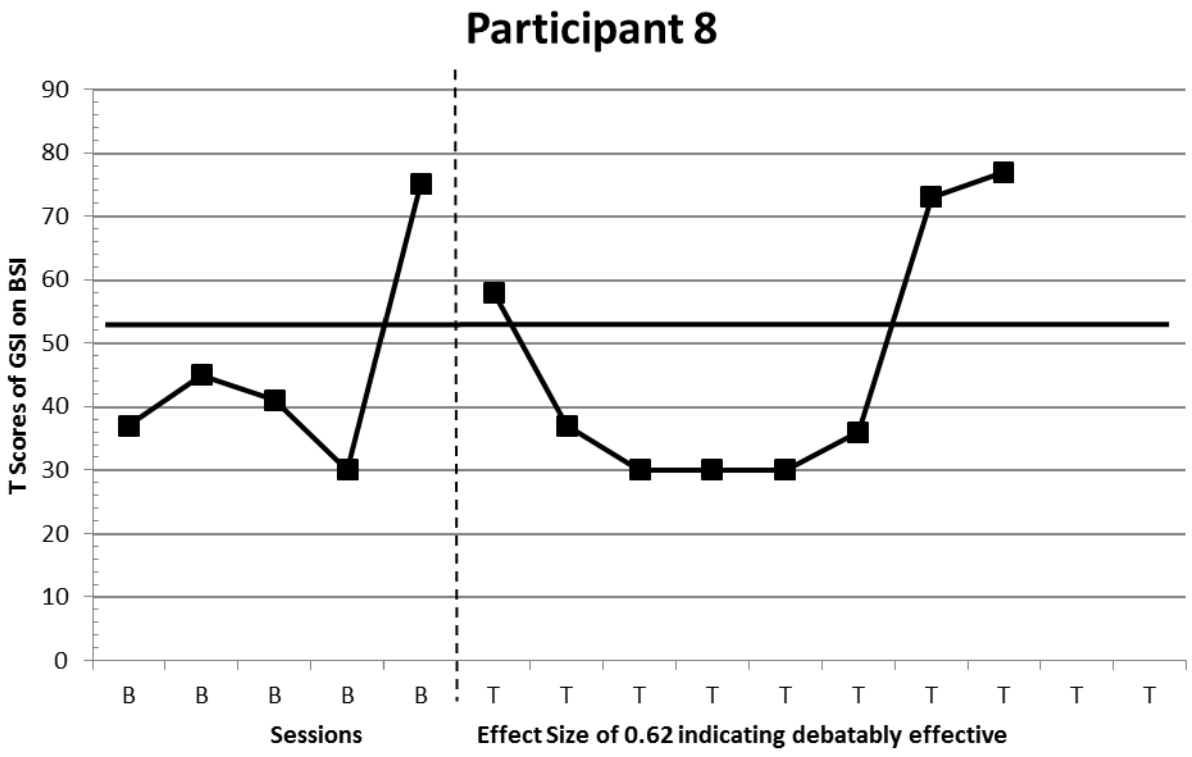
B B B B B T T T T T T T T T T
Sessions
Effect Size of 0.75 indicating moderate effectiveness


Participant 8
T Scores of GSI on BSI
90
80
70
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50
40
30
20
10
0
B B B B B T T T T T T T T T T
Sessions
Effect Size of 0.62 indicating debatably effective

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TEXAS A&M UNIVERSITY
CORPUS CHRISTI

**ERIN L. SHERMAN, MAcc, CRA, CIP, CPIA**
Research Compliance Officer
Division of Research, Commercialization and Outreach
6300 OCEAN DRIVE, UNIT 5844
CORPUS CHRISTI, TEXAS 78412
O 361.825.2497 • F 361.825.2755

Protocol Number: 56-13
Title: The Effectiveness of a Narrative Therapy Intervention with Youth at a South Texas Juvenile Boot-Camp Facility: A Single-Case Research Design
Review Category: Full Board Review
Expiration Date: September 5, 2014

**Approval determination was based on the following Code of Federal Regulations:**
Criteria for Approval has been met (45 CFR 46.111) - The criteria for approval listed in 45 CFR 46.111 have been met (or if previously met, have not changed).

(a) In order to approve research covered by this policy the IRB shall determine that all of the following requirements are satisfied:

(1) Risks to subjects are minimized: (i) By using procedures which are consistent with sound research design and which do not unnecessarily expose subjects to risk, and (ii) whenever appropriate, by using procedures already being performed on the subjects for diagnostic or treatment purposes.

(2) Risks to subjects are reasonable in relation to anticipated benefits, if any, to subjects, and the importance of the knowledge that may reasonably be expected to result. In evaluating risks and benefits, the IRB should consider only those risks and benefits that may result from the research (as distinguished from risks and benefits of therapies subjects would receive even if not participating in the research). The IRB should not consider possible long-range effects of applying knowledge gained in the research (for example, the possible effects of the research on public policy) as among those research risks that fall within the purview of its responsibility.

(3) Selection of subjects is equitable. In making this assessment the IRB should take into account the purposes of the research and the setting in which the research will be conducted and should be particularly cognizant of the special problems of research involving vulnerable populations, such as children, prisoners, pregnant women, mentally disabled persons, or economically or educationally disadvantaged persons.

(4) Informed consent will be sought from each prospective subject or the subject's legally authorized representative, in accordance with, and to the extent required by §46.116.

(5) Informed consent will be appropriately documented, in accordance with, and to the extent required by Human Subjects Protection Program Institutional Review Board

APPROVAL DATE: September 5, 2013
TO: Mr. James Ikonomopoulos
CC: Dr. Robert Smith
FROM: Office of Research Compliance
Institutional Review Board
SUBJECT: Initial Approval
§46.117.

(6) When appropriate, the research plan makes adequate provision for monitoring the data collected to ensure the safety of subjects.

(7) When appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.

(b) When some or all of the subjects are likely to be vulnerable to coercion or undue influence, such as children, prisoners, pregnant women, mentally disabled persons, or economically or educationally disadvantaged persons, additional safeguards have been included in the study to protect the rights and welfare of these subjects.
Provisions:
Comments:

This research project has been approved. As principal investigator, you assume the following responsibilities:

1. Informed Consent: Information must be presented to enable persons to voluntarily decide whether or not to participate in the research project unless otherwise waived.

2. Amendments: Changes to the protocol must be requested by submitting an Amendment Application to the Research Compliance Office for review. The Amendment must be approved by the IRB before being implemented.

3. Continuing Review: The protocol must be renewed each year in order to continue with the research project. A Continuing Review Application, along with required documents must be submitted 45 days before the end of the approval period, to the Research Compliance Office. Failure to do so may result in processing delays and/or non-renewal.

4. Completion Report: Upon completion of the research project (including data analysis and final written papers), a Completion Report must be submitted to the Research Compliance Office.

5. Records Retention: Records must be retained for three years beyond the completion date of the study.

6. Adverse Events: Adverse events must be reported to the Research Compliance Office immediately.

Letter of Facility Authorization and Information Sheet

Dear Assistant Chief of the Residential Services of the Nueces County Juvenile Justice Center and to whom else this may concern,

During the spring and summer semesters we are proposing to evaluate a new counseling approach called narrative therapy that focuses on improving clinically relevant psychological symptoms. A total of 10 cadets from the juvenile justice boot-camp facility are requested to participate in narrative therapy sessions.

This information sheet and a signed letter of authorization from the director of the juvenile boot-camp facility will allow approval for the researcher to contact the legal guardians of potential participating cadets for consent, as well as requesting the consent of the participating youth. This information sheet and a signed letter of authorization will also give permission to the researcher to use the boot-camp facility to provide narrative therapy sessions and collect data for the research study. The researcher will provide the boot-camp staff with this information sheet that will explain the study to be conducted. If you have any questions, please feel free to contact Mr. James Ikonomopoulos at 425-4684.

While we need parent permission, we will leave the decision for the child to participate in the study up to them. Upon receiving the permission form, Mr. James Ikonomopoulos will explain to the child, at a level they can understand, the purpose and nature of the counseling approach. The child will have the opportunity to ask questions about the counseling approach and research study. We will let the child know that they may stop participating in the counseling sessions at any time during the study.

**Description of the Counseling Approach**

The counseling approach is to be conducted as part of a research study. The purpose of the study is to find out whether this counseling approach will help youth cadets in juvenile boot-camp improve their overall functioning, and progress upon any clinically relevant psychological symptoms. We also want to know which parts of the counseling approach helped the child the most.

In order to evaluate the effectiveness of the counseling approach, a second selection process will occur in which the 10 cadets will be randomly assigned to one of two counselors for treatment. Cadets receiving treatment will participate in the 18 week narrative therapy intervention during the summer and fall semester. The cadets participating in the narrative therapy intervention will meet one hour a week on Saturdays or Sundays during counseling, or as time allotted by the facility. The counseling format will include discussions and activities designed to promote improvement in functioning, behavior, and beliefs cadets have about themselves.

All of the participating cadets will be administered a brief assessment before each of their narrative therapy sessions. The assessment is designed to measure which variables, if any, contributed to changes in your child’s functioning from scores measuring clinically relevant psychological symptoms.

The results of the evaluations will be used to determine what specific factors influence positive changes in cadet's scores measuring clinically relevant psychological symptoms. We will use this information to develop a comprehensive and effective narrative therapy intervention for youth cadets in a juvenile boot-camp facility.

**Benefits**
Participation in this counseling approach may yield the following benefits

- Decreases in somatization (i.e. distress arising from bodily dysfunctions)
- Decrease in obsession-compulsion
- Decrease in interpersonal sensitivity
- Decrease in depression
- Decrease in anxiety
- Decrease in hostility
- Decrease in phobic anxiety
- Decrease in paranoid ideation
- Decrease in psychoticism
- Increase in self-esteem
- Increase in self-understanding and awareness of strengths
- Gain more self-satisfaction with self

**Confidentiality**
Any information that is obtained in connection with this research will remain confidential and will be disclosed only with your permission or as required by U.S. or state law. Only those individuals directly involved in this research will have access to the information obtained during the course of this study. When the results of the research are published or discussed in professional conferences, no information will be included that would reveal the child's identity.

**Voluntary Participation and Withdrawal**
The child is free to choose not to participate and may withdraw from this counseling approach at any time during its course. If the child decides not to participate or decides to withdraw from the study it will not harm the child or their relationship with those individuals directly involved in this study.

**Questions**
If you have further questions about this project, you may contact Mr. James Ikonomopoulos at 425-4684.

Any questions regarding the child's rights as a research subject may be addressed to the Texas A&M University-Corpus Christi Institutional Review Board. All research projects that are carried out by investigators at Texas A&M University-Corpus Christi are governed by requirements of the university and the federal government.
Thank you for your support!

James Ikonomopoulos
Mental Health Counselor

Authorization

I have read this form and give permission for the researcher to contact the legal guardians of potential participating cadets for consent, as well as requesting the consent of the participating youth. By signing this letter of authorization, I will also give permission to the researcher to use the juvenile boot-camp facility to provide narrative therapy sessions and collect data for the research study. The purpose, procedures, benefits, and risks have been explained to my satisfaction. My signature indicates that I have received a copy of this authorization form.

Name of Juvenile Boot-Camp Facility Director: _____

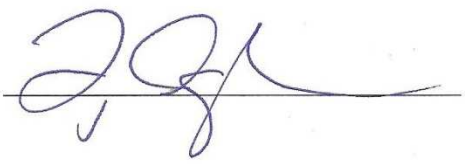
Signature of Juvenile Boot-Camp Facility Director: _____

Date: _____

Authorization

I have read this form and give permission for the researcher to contact the legal guardians of potential participating cadets for consent, as well as requesting the consent of the participating youth. By signing this letter of authorization, I will also give permission to the researcher to use the juvenile boot-camp facility to provide narrative therapy sessions and collect data for the research study. The purpose, procedures, benefits, and risks have been explained to my satisfaction. My signature indicates that I have received a copy of this authorization form.

Name of Juvenile Boot-Camp Facility Director: Lynn McCaughan

Signature of Juvenile Boot-Camp Facility Director: 

Date: 6-17-13

**ASSENT FORM**

The Effectiveness of a Narrative Therapy Intervention with Youth at a South Texas Juvenile Boot-Camp Facility: A Single-Case Research Design

**Introduction**

My name is James Ikonomopoulos and I am a doctoral student at Texas A&M University – Corpus Christi. I am doing a research project about the effectiveness of a counseling approach called narrative therapy. Research is a way to test new ideas. Research helps us learn new things.

I would like you to help with my study because it has been identified by boot-camp staff that you may benefit from this counseling approach.

**What will I be asked to do?**

If you want to help with my study, I will ask that you participate in some tasks for the next 18 weeks. These tasks include filling out a questionnaire that measures how you are feeling, and also meeting your assigned counselor for narrative therapy sessions. Within the 18 weeks, this study will ask that you only fill the questionnaire on how you are feeling for the first 5 weeks, and then the following 10 weeks you will still be filling out the questionnaire, but you also will be meeting with your assigned counselor for narrative therapy sessions. After those 10 weeks, you no longer will be participating in the narrative therapy sessions, but will continue to fill out the questionnaire on how you are feeling for the remaining 3 weeks.

**What are the risks to me?**

The risks to you are minimal such as fearing to expose personal experiences in regards to narrative therapy sessions. The risks to you are no bigger than the risks you have each day.

**What good can happen?**

Participation in this counseling approach may yield the following benefits

- Decreases in somatization (i.e. distress arising from bodily dysfunctions)
- Decrease in obsession-compulsion
- Decrease in interpersonal sensitivity
- Decrease in depression
- Decrease in anxiety
- Decrease in hostility
- Decrease in phobic anxiety
- Decrease in paranoid ideation
- Decrease in psychoticism
- Increase in self-esteem
- Increase in self-understanding and awareness of strengths
- Gain more self-satisfaction with self

**Do I have to be part of the study?**

No. You do not have to be part of the study. Your parents said you can be in the study, and you do not have to because they said you can. I am a part of the study because I want to.

**Who will know I am part of the study?**

No one will know you are part of the study. Your name will be kept secret from everyone except your counselor and your parents. You can stop being part of the study whenever you want to. You can tell your parents, your counselor, me, or any adult that you would like to stop, and it is OK.

**Signature**
Now that I have asked my questions and think I know about the study and what it means, here is what I decided:

_____OK, I'll be in the study. _____ No, I do not want to be in the study.

I have been told about the research study. I had a chance to ask questions. I know I can ask questions at any time. I want to be in the study.

If you sign your name below, it means that you want to be in this research study.

| _____ | ___ | _____ |
|---|---|---|
| Your Name (Printed) | Age | Date |

_____
Your Signature

| _____ | _____ |
|---|---|
| Printed Name of Witness | Date |

_____
Signature of Witness

| _____ | _____ |
|---|---|
| Printed Name of Person Obtaining Assent | Date |

_____
Signature of Person Obtaining Assent

**PARENTAL CONSENT FORM**

The Effectiveness of a Narrative Therapy Intervention with Youth at a South Texas Juvenile Boot-Camp Facility: A Single-Case Research Design

**Introduction**

The purpose of this form is to provide you (as the parent of a prospective research study participant) information that may affect your decision as to whether or not to let your child participate in this research study. This form will also be used to record your consent if you decide to let your child be involved in this study.

If you agree, your child will be asked to participate in a research study. During the spring and summer semesters we will be evaluating a new counseling approach called narrative therapy that focuses on improving clinically relevant psychological symptoms. A total of 10 cadets from the juvenile justice boot-camp facility have been selected to participate in narrative therapy sessions. Your child has been invited to participate in this counseling approach. The purpose of this study is to examine the effectiveness of this narrative therapy approach for reducing clinically relevant psychological symptoms in participating youth-cadets. Your child was selected to be a possible participant because it had been identified from boot-camp staff that your child may benefit from this counseling approach.

**What will my child be asked to do?**

If you allow your child to participate in this study, we will leave the decision for the child to participate in the study up to them. Upon receiving the permission form, Mr. James Ikonomopoulos will explain to your child, at a level they can understand, the purpose and nature of the counseling approach. Your child will have the opportunity to ask questions about the counseling approach and research study. We will let your child know that they may stop participating in the counseling sessions at any time during the study. I will ask that your child participate in some tasks for the next 18 weeks. These tasks include filling out a questionnaire that measures how they are feeling, and also meeting their assigned counselor for narrative therapy sessions. Within the 18 weeks, this study will ask that they only fill the questionnaire on how they are feeling for the first 5 weeks, and then the following 10 weeks they will still be filling out the questionnaire, but they also will be meeting with their assigned counselor for narrative therapy sessions. After those 10 weeks, they no longer will be participating in the narrative therapy sessions, but will continue to fill out the questionnaire on how they are feeling for the remaining 3 weeks.

Description of the Counseling Approach

The counseling approach is being conducted as part of a research study. The purpose of the study is to find out whether this counseling approach will help youth cadets in juvenile boot-camp improve their overall functioning, and progress upon any clinically relevant psychological symptoms. We also want to know which parts of the counseling approach helped your child the most.

In order to evaluate the effectiveness of the counseling approach, a second selection process will occur in which the 10 cadets will be randomly assigned to one of two counselors for treatment. Cadets receiving treatment will participate in the 18 week

narrative therapy intervention during the summer and fall semester. The cadets participating in the narrative therapy intervention will meet one hour a week on Saturdays or Sundays during counseling. The counseling format will include discussions and activities designed to promote improvement in functioning, behavior, and beliefs cadets have about themselves.

All of the participating cadets will be administered a brief assessment before each of their narrative therapy sessions. The assessment is designed to measure which variables, if any, contributed to changes in your child's functioning from scores measuring clinically relevant psychological symptoms.

The results of the evaluations will be used to determine what specific factors influence positive changes in cadet's scores measuring clinically relevant psychological symptoms. These clinically relevant psychological symptoms include somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. We will use this information to develop a comprehensive and effective narrative therapy intervention for youth cadets in a juvenile boot-camp facility.

**What are the risks involved in this study?**
There may be minimal risks involved in participants fearing to expose personal experiences in regards to narrative therapy sessions. The risks associated in this study are minimal, and are not greater than risks your child ordinarily encounters in daily life.

**What are the possible benefits of this study?**
Participation in this counseling approach may yield the following benefits

- Decreases in somatization (i.e. distress arising from bodily dysfunctions)
- Decrease in obsession-compulsion
- Decrease in interpersonal sensitivity
- Decrease in depression
- Decrease in anxiety
- Decrease in hostility
- Decrease in phobic anxiety
- Decrease in paranoid ideation
- Decrease in psychoticism
- Increase in self-esteem
- Increase in self-understanding and awareness of strengths
- Gain more self-satisfaction with self

**Does my child have to participate?**
No, your child doesn't have to be in this research study. You can agree to allow your child to be in the study now and change your mind later without any penalty.

**What if my child does not want to participate?**
In addition to your permission, your child must agree to participate in the study. If your child does not want to participate he/she will not be included in the study without penalty. If your child initially agrees to be in the study he/she can withdraw at any point during the study without penalty.

**Who will know about my child's participation in this research study?**
This study is confidential and confidentiality will be maintained by providing participants with a pseudonym that either may be selected by the researchers or one of the participant's own choosing. Research records will be stored securely and only researcher will have access to the records. The records of this study will be kept private, in a file cabinet, locked in the control room of the juvenile boot-camp facility. No identifiers linking participants to this study will be included in any sort of report that might be published.

**Whom do I contact with questions about the research?**
If you have further questions about this project, you may contact Mr. James Ikonomopoulos at 425-4684 or Mr. Lynn McCaughan at 561-6001.

Any questions regarding your child's rights as a research subject may be addressed to the Texas A&M University-Corpus Christi Institutional Review Board. All research projects that are carried out by investigators at Texas A&M University-Corpus Christi are governed by requirements of the university and the federal government.

**Whom do I contact about my child's rights as a research participant?**
This research study has been reviewed by the Research Compliance Office and/or the Institutional Review Board at Texas A&M University – Corpus Christi. For research-related problems or questions regarding your rights as a research participant, you can contact Erin Sherman, Research Compliance Officer, at (361)825-2497 or erin.sherman@tamucc.edu.

**Signature**
Please be sure you have read the above information, asked questions and received answers to your satisfaction. You will be given a copy of the consent form for your records. By signing this document, you consent to allow your child to participate in this study.

**Signature of Parent/Guardian: _____ Date: _____**

**Printed Name: _____**

**Printed Name of Child**: **_____**

**Signature of Person Obtaining Permission: _____ Date: _____**

**Printed Name: _____**

**Brief Symptom Inventory**

**BSI**

**"Here I have a list of problems people sometimes have. As I read each one to you, I want you to tell me HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU <u>DURING THE PAST 7 DAYS INCLUDING TODAY</u>. These are the answers I want you to use.** *[Hand card and read answers.]* **Do you have any questions?"**

0 = Not at all  1 = A little bit  2 = Moderately  3 = Quite a bit  4 = Extremely

**<u>DURING THE PAST 7 DAYS, how much were you distressed by:</u>**

| | |
|---|---|
| **1. Nervousness or shakiness inside** | **0 1 2 3 4** |
| **2. Faintness or dizziness** | **0 1 2 3 4** |
| **3. The idea that someone else can control your thoughts** | **0 1 2 3 4** |
| **4. Feeling others are to blame for most of your troubles** | **0 1 2 3 4** |
| **5. Trouble remembering things** | **0 1 2 3 4** |
| **6. Feeling easily annoyed or irritated** | **0 1 2 3 4** |
| **7. Pains in the heart or chest** | **0 1 2 3 4** |
| **8. Feeling afraid in open spaces** | **0 1 2 3 4** |
| **9. Thoughts of ending your life** | **0 1 2 3 4** |

**<u>DURING THE PAST 7 DAYS, how much were you distressed by:</u>**

| | |
|---|---|
| **10. Feeling that most people cannot be trusted** | **0 1 2 3 4** |
| **11. Poor appetite** | **0 1 2 3 4** |
| **12. Suddenly scared for no reason** | **0 1 2 3 4** |
| **13. Temper outbursts that you could not control** | **0 1 2 3 4** |
| **14. Feeling lonely even when you are with people** | **0 1 2 3 4** |
| **15. Feeling blocked in getting things done** | **0 1 2 3 4** |
| **16. Feeling lonely** | **0 1 2 3 4** |
| **17. Feeling blue** | **0 1 2 3 4** |
| **18. Feeling no interest in things** | **0 1 2 3 4** |

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0 = Not at all  1 = A little bit  2 = Moderately  3 = Quite a bit  4 = Extremely

**DURING THE PAST 7 DAYS, how much were you distressed by:**

| | |
|---|---|
| **19. Feeling fearful** | **0 1 2 3 4** |
| **20. Your feelings being easily hurt** | **0 1 2 3 4** |
| **21. Feeling that people are unfriendly or dislike you** | **0 1 2 3 4** |
| **22. Feeling inferior to others** | **0 1 2 3 4** |
| **23. Nausea or upset stomach** | **0 1 2 3 4** |
| **24. Feeling that you are watched or talked about by others** | **0 1 2 3 4** |
| **25. Trouble falling asleep** | **0 1 2 3 4** |
| **26. Having to check and double check what you do** | **0 1 2 3 4** |
| **27. Difficulty making decisions** | **0 1 2 3 4** |

**DURING THE PAST 7 DAYS, how much were you distressed by:**

| | |
|---|---|
| **28. Feeling afraid to travel on buses, subways, or trains** | **0 1 2 3 4** |
| **29. Trouble getting your breath** | **0 1 2 3 4** |
| **30. Hot or cold spells** | **0 1 2 3 4** |
| **31. Having to avoid certain things, places, or activities because they frighten you** | **0 1 2 3 4** |
| **32. Your mind going blank** | **0 1 2 3 4** |
| **33. Numbness or tingling in parts of your body** | **0 1 2 3 4** |
| **34. The idea that you should be punished for your sins** | **0 1 2 3 4** |
| **35. Feeling hopeless about the future** | **0 1 2 3 4** |
| **36. Trouble concentrating** | **0 1 2 3 4** |

0 = Not at all  1 = A little bit  2 = Moderately  3 = Quite a bit  4 = Extremely

**DURING THE PAST 7 DAYS, how much were you distressed by:**

| | |
|---|---|
| **37. Feeling weak in parts of your body** | **0 1 2 3 4** |
| **38. Feeling tense or keyed up** | **0 1 2 3 4** |
| **39. Thoughts of death or dying** | **0 1 2 3 4** |
| **40. Having urges to beat, injure, or harm someone** | **0 1 2 3 4** |
| **41. Having urges to break or smash things** | **0 1 2 3 4** |
| **42. Feeling very self-conscious with others** | **0 1 2 3 4** |
| **43. Feeling uneasy in crowds** | **0 1 2 3 4** |
| **44. Never feeling close to another person** | **0 1 2 3 4** |
| **45. Spells of terror or panic** | **0 1 2 3 4** |

**DURING THE PAST 7 DAYS, how much were you distressed by:**

| | |
|---|---|
| **46. Getting into frequent arguments** | **0 1 2 3 4** |
| **47. Feeling nervous when you are left alone** | **0 1 2 3 4** |
| **48. Others not giving you proper credit for your achievements** | **0 1 2 3 4** |
| **49. Feeling so restless you couldn't sit still** | **0 1 2 3 4** |
| **50. Feelings of worthlessness** | **0 1 2 3 4** |
| **51. Feeling that people will take advantage of you if you let them** | **0 1 2 3 4** |
| **52. Feeling of guilt** | **0 1 2 3 4** |
| **53. The idea that something is wrong with your mind** | **0 1 2 3 4** |

| | "IN THE PAST 6 MONTHS…" | Never or almost never | Sometimes | Nearly all the time |
|---|---|---|---|---|
| 1 | I felt that everything was OK in my life | 1 | 2 | 3 |
| 2 | I argued with my teachers or parents | 1 | 2 | 3 |
| 3 | I used drugs or alcohol | 1 | 2 | 3 |
| 4 | I enjoyed getting together with my friends or family | 1 | 2 | 3 |
| 5 | I lost my temper | 1 | 2 | 3 |
| 6 | I felt good about myself | 1 | 2 | 3 |
| 7 | I argued with adults | 1 | 2 | 3 |
| 8 | I did what adults asked me to do | 1 | 2 | 3 |
| 9 | I did things to bother people | 1 | 2 | 3 |
| 10 | If someone told me to do something, I did the opposite | 1 | 2 | 3 |
| 11 | I felt very angry | 1 | 2 | 3 |
| 12 | I felt like getting back at others | 1 | 2 | 3 |
| 13 | I broke the rules at school or at home | 1 | 2 | 3 |
| 14 | At night, I stayed out later than I was allowed | 1 | 2 | 3 |
| 15 | I got so mad that I threw things at home or at school | 1 | 2 | 3 |
| 16 | I felt comfortable meeting new people | 1 | 2 | 3 |
| 17 | I did things that were against the law | 1 | 2 | 3 |
| 18 | I was very lonely | 1 | 2 | 3 |
| 19 | I had fun with friends | 1 | 2 | 3 |
| 20 | I felt very tense | 1 | 2 | 3 |
| 21 | I got into trouble at school or at work | 1 | 2 | 3 |
| 22 | I felt nervous | 1 | 2 | 3 |
| 23 | I felt depressed or sad | 1 | 2 | 3 |
| 24 | I stayed away from home without telling my parents where I was | 1 | 2 | 3 |
| 25 | I did not study or turn in my homework | 1 | 2 | 3 |
| 26 | I worried about a lot of things | 1 | 2 | 3 |
| 27 | I worried a lot about the future | 1 | 2 | 3 |
| 28 | I had trouble falling asleep | 1 | 2 | 3 |
| 29 | I felt upset | 1 | 2 | 3 |
| 30 | I had trouble concentrating | 1 | 2 | 3 |
| 31 | I felt like crying for no reason | 1 | 2 | 3 |
| 32 | I did something I knew was bad | 1 | 2 | 3 |

Dear "Your honor,"
This Cadet want's to start off by saying ~~sir~~ good morning your honor.
When you Sent me here to boot Camp Dec 20, before Chrismas my mind went blank because of the fact that i had to be without my grandparent's on Christmas Day. I was Crying but i couldnt do nothing about it because of the Choices i made and what this cadet did. but im very Sorry for that and i will never do it again. Im tired of making my grandpa & grandma Cry Every time i do Something wrong. but this Cadet would Like to Say thank you for setting up a Court date to hear me out. when i got hear Sir i told my self that this Cadet Could do what Ever he want's and they always told me no you Can't. So i started to realize that im Staying hear longer then this Cadet was Supposed to. So that's when this Cadet Started to get this Cadet's Head ~~act~~ together. It took 180 Day's for this Cadet to get to Level 2, and only took me 80 Day's to get to level 3, and now this Cadet's a Level 4 about to go on my forlough's. Boot Camp ~~thought~~ taught me alot of tools sir and if you dicide to let me out i will use those tools ~~for~~ to better myself out in the free. Boot camp taught me that the Choices we make dictate the life we lead to thine own Self be true. It also taught me how to be a respectful young man and im going to use that respect towards my grandParent's and other people.

Your honer, this Program has helped ~~me~~ me
alot and I feel that i am redy to go home and
this Program has help me change my
way of thinking. and helped me to have
respect for Authority. And i also really
miss my family and my mom need's me at
home. to help my mom take care of my and
raise mNephew. I also have a JOB waiting for me
when i get out with my Brother. and i have
no desire to use drug's any more or get
into trouble with the Law i Belive that
i have learned my Lession and should Be
given a 2nd chance to prove my self worthy
of Becameing a Productive member of
society. and to Be releced to my family
i will follow all my Court orders and
Probation rule's and will report and i am
also Be willing to Be on hose arrest.
I Just would like to retun to my family

IDK!

Okay so How are you going to pick a man over your son and just cuz he said I can't live there Because I start trouble You Shouldn't ever pick a man over me and My brothers! I still can't believe that you did that but it's okay I still got my grandparents and that's all I need. I feel like she Dont want me or loves me because if she did then she wouldn't Pick her boyfriend over me you don't understand how I feel. it hurts me in the inside so bad.

6.

# My Son

Well my Son was born on 10-17-13
I Wasn't there when he was
born but when I get out
I am going to take care of
him and behave so I don't
End up back in here. This
Place sucks. I am going to
Spoil my son I will
get him whatever he
want's he's my whole world
My mom says he looks
like me and then he is
big I can't wait till
I see him. I really am
changing Im not doing the
Stuff I used to do.
like talk mess to the DI's
and try to fight everybody
Naa that aint me
anymore it's not that
im a punk I just want
to do good and get
out.

5.

School Problems!

sometimes i struggle with my school work i dont understand it im not smart I am stupid! thats why my dumbass been in the 6th grade 3 times. i feel stupid but i just dont understand the work maybey i need more help than others. At least i try the work tho.

# from my heart

Mom I am sorry for always disapointing you and makeing you sad and make you not eat and Get sick. I Just want you to be proud of me fore once Im sorry mum it's all my fault that you are not happy and im sorry for them always calling you and telling you bad news I cry every night because of the stuff I do that hurts you and im sorry that you don't know what to do with me anymore. I just want you to be happy and not mad at me anymore Can you please forgive me for all the bad stuff I have done and made you feel?? I want you to know that I have thought about ways that I can be better I just want to get out and be with my son and yall IM not the same person I used to be I don't cuss out the staff anymore or try to fight everyone I am trying to better myself all I want is to be able to talk to my dad and see my son but that probably won't happen.

Always remember these.

- for your anger lasts only a moment but his favor last a lifetime. weeping may come at night but happiness and rejoice comes in the morning.
- Do not repay anyone evil for evil, be carful to do what is right in the eyes of everyone.
- Do not be overcome by evil, but overcome evil with good.
- love your enemy, and neighbor as you love yourself.

Acutermeit