

Narrative group therapy with outpatient adolescents

by

David Charles Kaptain

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Program of Study Committee:
Jacques Lempers, Major Professor
Mary Huba
Ronald Werner-Wilson
Norman Scott
Harvey Joanning

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ABSTRACT

Adolescent substance abuse remains a major public health concern. The comprehensive, detrimental effects of teenage drug use, coupled with troubling relapse rates, highlight the need for innovative, effective, and helpful treatment interventions. Adolescents in treatment and the adults that work with them are subject to often negatively influential societal discourses that limit treatment effectiveness as well as the development of adolescent treatment satisfaction and therapeutic alliance. Narrative therapy is promoted in theoretical and clinical literature as a viable way of addressing these problems.

Preliminary work has been done in the area of narrative therapy with adolescents, and particularly with substance abusing and chemically dependent adolescents. However, empirical and qualitative research regarding narrative therapy with teens is scarce. Studies examining narrative therapy in regard to the promotion of treatment satisfaction and therapeutic alliance are virtually non-existent. This study presents preliminary empirical and phenomenological research that indicates a positive adolescent response to narrative therapy. These responses involve the development of greater, subjective understanding of and increased resistance to substance abuse and behavioral problems. Finally, the information presented in this study points to the development of a potentially useful group treatment model of narrative therapy with adolescents having substance abuse and other behavior or emotional problems.

CHAPTER 1. INTRODUCTION

Narrative therapy has been promoted as a mode of therapy which is empowering, socially sensitive, and able to free individuals and families from the subjugating dominance of oppressive narratives and discourses in their lives. This approach to problems is situated in the theoretical contexts of social constructionism and post-modernism, and lends itself to a wide variety of therapeutic circumstances (Parry & Doan, 1994; Freedman & Combs, 1996; Smith & Nylund, 1997).

This paper is a report on a qualitative-quantitative research project involving narrative therapy approaches with chemically dependent and behaviorally disordered adolescents in an outpatient clinical setting. Of interest is the effect of narrative therapy on adolescent satisfaction with treatment and on the development of the therapeutic alliance (Horvath & Greenberg, 1994) between therapists and adolescent clients. The project assessed these constructs by conducting quantitative measurement of adolescent client satisfaction with outpatient mental health and substance abuse treatment and by measuring therapeutic alliance. Qualitative information about adolescent reactions to and thoughts about narrative therapy was gathered and examined with phenomenological analysis.

Statement of the Problem

Adolescent substance abuse remains a major public health issue (Winters, 1999; Liddle, Dakof, Parker, Diamond, Barrett, & Tejada, 2001). National estimates of adolescent substance abuse indicate, with some exceptions, a steady increase since 1992 (Winters, 1999). The widespread, damaging effects of adolescent substance abuse are well-established: school failure, delinquency, motor vehicle accidents, arrests and incarceration, increased risk for human immunodeficiency virus (HIV) and other physical problems (Liddle et al., 2001; DiClemente, 1990; Hansell, & White, 1991; Loeber, 1990).

Along with steadily increasing rates of substance abuse, relapse rates of substance abuse behaviors in adolescents who have received treatment remain high (Center for Substance Abuse

Treatment, 1999). The odds of remaining abstinent from substances are against teens after having received substance abuse treatment, because of the associated difficulty in changing problem behavior patterns and peer groups, and often because of being subject to community- or family-based dysfunction that contributes to relapse of substance abuse (Brownell, Marlatt, Lichtenstein, & Wilson, 1986; Marlatt, 1985). Adolescents who receive substance abuse treatment are often explicitly or implicitly coerced into receiving care, causing concerns about their perceptions of the treatment process and corresponding barriers in their motivation to change (Kaminer, Tarter, Bukstein, & Kabene, 1991; Prochaska & DiClemente, 1992; Winters, 1999).

Because participating in substance abuse treatment may not be their first choice, many adolescents have difficulty in being satisfied with the process and also have problems connecting effectively with treatment staff. At the same time, treatment staff and other concerned adults have a hard time connecting with adolescents (Morrison, 1993), due in part to influential discourses that work against collaboration between teens and adults (Newcomb, 1996). Improved ideas, approaches and techniques are needed in order to raise the effectiveness of treatment interventions with adolescents. This can be done by promoting teen satisfaction with the services they receive, and by promoting the therapeutic connection between teens and treatment staff. Improving adolescent services in this way is an important step in addressing the high relapse rate in teen substance abuse treatment. Narrative therapy is a treatment approach that holds great potential for improving interventions with adolescent substance abusers, giving them a greater chance of success.

Rationale for narrative therapy with adolescents

Several factors contribute to narrative therapy being a viable alternative in adolescent substance abuse and mental health treatment settings. Narrative therapy is geared to notice the subjugation or marginalization of individuals by outside forces, narratives, or discourses, and to be sensitive to the negative influences of problems in people's lives. These terms are discussed in detail in the literature review section of this paper. This therapeutic model was initially promoted by White

& Epston (1990) during the last decade, but has gained popularity with many others in recent years. Several authors have examined narrative therapy, specifically with regard to its benefits and positive impact with adolescents and their families (Biever, McKenzie, Wales-North, & Gonzales, 1995; Dickerson & Zimmerman, 1992; Holcomb, 1994). There are aspects of narrative therapy which make it salient to therapy and intervention with adolescents (Dickerson & Zimmerman, 1992; Smith & Nylund, 1997) and which are particularly useful to chemically dependent adolescents (Hicks, 1997; Sanders, 1997).

Narrative therapy with adolescents is inherently respectful of the individual through its focus on the problem as a separate entity, rather than on the individual-as-problem. Adolescents are often used to being considered a “problem”, in conjunction with the popular social stereotype of adolescence as being a time of “storm and stress” (Newcomb, 1996), or as a time, defined by its dysfunction, when adolescence itself is considered a risk factor for the development of problems (Hill & Fortenberry, 1992). This societal discourse limits teens’ ability to separate themselves from their problems. The narrative therapy technique of externalizing problems for adolescents is a method that makes it possible for them to see their relationship with the problem, rather than seeing themselves as the problem. This allows them to be free to develop new, preferred narratives, or stories of themselves, that are less problematic.

The stance of the narrative therapist in relation to the client is also respectful. The therapist is not an objective, omnipotent expert, but rather is a subjective, co-author or consultant in developing new narratives with the client. These collaborative aspects of narrative therapy make it particularly useful for intervention with adolescents, as they often find themselves in conflict with adults and authority figures as a function of their developmentally appropriate bids for independence (Dickerson & Zimmerman, 1992). It is an approach that enables the therapist to be viewed as less antagonistic than the primary conceptualization of adults the troubled adolescent may have in her or his current narrative. This alternatively helpful connection with the therapist, also known as the working or

therapeutic alliance (Barnard & Kuehl, 1995; Horvath & Greenberg, 1994), is vital to the meaning and helpfulness of the relationship between the therapist and the adolescent client. Because of these advantages, narrative therapy is a developmentally appropriate way to conduct interventions for adolescents.

Lack of narrative therapy studies

Recent studies have begun to explore narrative therapy with adolescents in a systematic way (Fristad, Gavazzi, & Soldano, 1999; Kelly, Blankenburg, & McRoberts, 2002), but literature in this area is scarce. While some limited progress has been made in efficacy research, this writer has found no studies that attempt to discover or examine phenomenological information of adolescents' responses to narrative therapy. More exploratory studies are needed to examine the effective potential of narrative therapy in working with youth, and to further develop qualitative understanding about what works in narrative interventions with adolescents.

Rationale for this study: researcher's experiences with narrative therapy

In response to Zimmerman and Dickerson's (1994) challenge to examine the possibilities of utilizing narrative therapy in one's own work, this writer began using narrative therapy methodologies in certain treatment contexts. The writer assigned patients with the task of answering questions regarding their problem in an essay or written format. Consequently, this writer has gathered a number of individual written accounts from adolescents responding to their problems from a narrative stance; these written accounts, called "therapeutic documents," were inspired by efforts of narrative therapists to help clients document their progress in a more permanent fashion, and to help them take a stand against their problems (Chen, Noosbond & Bruce, 1998; Nylund & Thomas, 1994; White, 1995; White & Epston, 1990; Parry & Doan, 1994).

This application of narrative therapy in the clinical setting yielded promising results, which contributed to the writer's desire to further explore a mode of treatment that might prove beneficial with certain clients.

The clients were encouraged to “externalize” their particular problem, and the essays included some memorable comments and responses. Freedman and Combs (1996, p. 203) recommend this writing process, claiming that naming the problem is a way to recognize the problem's plans for people, and Parry & Doan endorse using this kind of externalizing conversation from the outset of therapy (1996, p. 52). Externalizing and naming the problem serves to reinforce the notion of the problem-as-problem, rather than the person-as-problem.

The assignment asked participants to respond to questions regarding the problem they identified and named (typically, “addiction,” “drugs,” or “chemical dependency”), and these responses were collected and examined by the therapist. Clients were observed to have adopted a different perspective and attitude toward their problems, as can be seen in the following comments:

- "My addiction wanted to see me in pain. It wanted me to hurt and push my friends and family away so I would keep using more."
- "My addiction didn't want me to go to [AA] meetings, to feel safe, or to love myself. It wanted me to die, be depressed, to be angry."
- "It doesn't like when I'm happy or when I have fun. It still wants to control my every move. It wants to make me relapse and keep using."
- "Since I know that my disease only wants bad things to happen to me, and wants me to use drugs and be in misery again, I know that I need to have a defense against using. I need to be prepared . . . because that's stuff my disease hates. I deserve to be sober, so I have to talk about and work on my sexual/physical abuse so my addiction doesn't team up on me with them."

The responses presented here indicated a move toward taking action against the problem, against chemical dependency, something ultimately desired in a treatment context. These positive experiences with narrative therapy in the substance abuse treatment clinical setting warranted further

investigation on the part of the therapist seeking additional effective and positive treatment options for adolescents; in this case, the writer of this paper.

Purpose of the study

This study was designed to quantitatively evaluate adolescent client responses to narrative group therapy, by measuring treatment satisfaction and therapeutic alliance. This study also sought to gain specific, qualitative understanding of the ways that adolescents respond to narrative therapy through phenomenological analysis of data obtained through interviews with teens who had experienced narrative therapy. Still another purpose that emerged from the process of designing and implementing this study was the promotion of a model of narrative group therapy that can easily be implemented in any clinical setting that serves teens. By examining adolescent client responses to narrative techniques in the clinical setting, this study sought to provide therapists with specific examples of easily understandable, transferable, and therapeutic narrative group therapy interventions for adolescents.

Research questions

From a quantitative perspective, this study examined the question: does exposure to narrative group therapy in a clinical setting systematically affect adolescents' treatment satisfaction and therapeutic alliance? A secondary quantitative goal was to examine that, if narrative therapy does affect adolescents' treatment satisfaction and therapeutic alliance, are these effects more significant for substance abusers? Yet another quantitative goal was to examine the relationship between certain predictor variables and participants' responses to narrative therapy treatment interventions. It may be useful to researchers and clinicians to be aware of the factors that may predict differing levels of response to narrative therapy in adolescents, and how these predictors may affect therapeutic alliance and satisfaction with chemical dependency and mental health treatment. Do predictors such as gender, age, age of substance abuse onset, and individual levels of substance abuse severity affect

adolescents' response to narrative therapy? Better understanding of if or how these factors influence adolescent response to narrative therapy could lead to better, more informed, and effective interventions when using a narrative stance with this population.

From a qualitative perspective, this study examined the phenomenological meanings of the narrative therapy experience for adolescents in clinical substance abuse and behavioral health treatment. What does participating in narrative therapy mean to adolescents? Qualitative methods were employed to discover emerging themes, meanings and responses to narrative therapy in general, and in regard to specific narrative treatments.

Hypotheses

A small but growing body of literature indicates that because of narrative therapy's unique approach to dealing with problems, adolescents with a variety of difficulties respond well to narrative therapy interventions (Smith & Nylund, 1997; Bievers, McKenzie, Wales-North & Gonzalez, 1995; Holcomb, 1994; Zimmerman and Dickerson, 1994; Fristad, Gavazzi, & Soldano, 1999; Cowley, Farley, & Beamis, 2002; Kelly, Blankenburg, & McRoberts, 2002). Narrative therapy has been utilized to treat a wide variety of problems (Parry & Doan, 1994; Freedman & Combs, 1996), making it useful in both adolescent substance abuse and behavioral health treatment. Alcoholics Anonymous (AA), has a strongly narrative approach (Rappaport, 1993; Davis & Jansen, 1998), and is significantly effective in treating alcoholism (Emrick, et al., 1993; Montgomery, Miller & Tonigan, 1995; Snow, Prochaska & Rossi, 1994). Further review of the literature also indicates that narrative therapy is inherently respectful to the client and encourages collaboration, or alliance with the therapist, rather than antagonism (Glueckauf, Liss, McQuillen, Webb, Dairaghi, & Carter, 2002). This therapeutic or working alliance promotes client satisfaction with therapy, which some consider the "bottom line" in defining successful therapy (Barnard & Kuehl, 1995). The change process in counseling and therapy necessarily begins with the promotion of a higher degree of client satisfaction with the treatment and therapy process. Satisfaction measures in mental health treatment have high face validity, and appeal

as indices of treatment acceptability (Pekarik & Wolff, 1996). These notions are all formative in the construction of the hypotheses of this study. Thus, the following hypotheses involve assessment of narrative therapy's effect on adolescents' satisfaction with their treatment experience and on therapeutic alliance. These hypotheses were addressed in this study, as shown below:

- First, adolescents in behavioral health treatment who receive narrative therapy interventions will be more satisfied with their treatment than those who do not receive narrative therapy interventions.
- Second, adolescents who receive narrative interventions will demonstrate higher levels of therapeutic alliance than those who do not receive narrative therapy interventions.
- Third, of the teens in this study that receive narrative therapy, participants who are primarily substance abusers will be more satisfied with their treatment than those who are not primarily substance abusers.

A specific hypothesis was not constructed for the predictors chosen in this study because these predictors have demonstrated different effects on adolescent substance abuse treatment responses across different studies (Winters, 1999).

Design of the study

Liddle & Dakof (1995) presented a critical review of controlled treatment outcome studies occurring since 1979 on family therapy for adolescent and adult drug abuse. While finding that various types of family therapy have demonstrated effectiveness in treating substance abuse, especially with adolescents, the authors highlighted the fact that efficacy in substance abuse treatment research is difficult to assess because of methodological limitations such as defining treatment success, therapist and researcher bias, and difficulties in monitoring individual and family change (Liddle & Dakof, 1995). It is important to note that this project was designed as an initial,

exploratory study because of the lack of current narrative therapy research available from which to draw from in examining its effectiveness in working with adolescents (Kelly, Blankenburg, & McRoberts, 2002), and is not intended as an efficacy study of narrative therapy. Quantitative and qualitative approaches were implemented to attempt to establish systematic as well as subjective, meanings-related effectiveness of narrative therapy in treatment work with teens. This study involved the use of questionnaires to assess substance abuse severity, treatment satisfaction, and therapeutic alliance. Qualitative interviews with adolescent participants in narrative therapy interventions were included to construct a phenomenology of their experience.

Structure of the paper

Through literature review, this paper will first discuss some general information about the project's theoretical base of postmodernism and social constructionism. The paper continues with some terms and techniques of narrative therapy, and follows with a further review of current narrative therapy literature and research. This review contains some criticisms of the narrative movement by traditionally oriented scholars, along with reviews by others that have found it very useful in therapy.

The paper will describe the treatments developed and implemented to conduct the research, and then present the findings of the project regarding using narrative therapy as an aid in promoting both client satisfaction with outpatient substance abuse and mental health treatment, and in the development of therapeutic alliance between teens and treatment staff. This paper will present methods, findings and discussion specific to both the quantitative and qualitative components of the study.

Basic assumptions of the study

It is assumed that though not all of the participants in this study were voluntary in their involvement with substance abuse or behavioral health treatment, their participation in the study was voluntary. It is also assumed that all participants completed questionnaires and instruments honestly and to the best of their knowledge and ability. A further assumption is that participants' responses to

questions in the qualitative interviews were complete and honest, and an accurate reflection of their perceptions and opinions of their narrative therapy experiences.

CHAPTER 2. LITERATURE REVIEW

Context of Narrative Therapy

Postmodern background to narrative therapy

In last fifteen to twenty years, society has seen a trend to postmodernism, an acknowledgement of the inability of science to truly identify and objectify reality (Anderson, 1990). This stance is different from an exclusively modernist, empiricist view—that through careful science and research methodology, the "truth" can be discovered. It is becoming apparent to researchers and clinicians alike that individual, social, and scientific perceptions of reality are impacted by context and subject to as wide a variety of interpretations as there are individuals. For postmodern thinkers, no single claim to truth is universally respected any longer (Parry & Doan, 1994, p. 10). Even traditional, empirical science is influenced by this dynamic (Gergen, 1994, chap. 2). The writer for this study subscribes to the postmodern school of thought to the extent that it challenges the status quo, and opposes the widely-held notion that science and psychiatry, scientists and clinicians, may construct the absolute foundations of reality. Local understanding and knowledge are just as important, and oftentimes more salient, to issues of inter-individual relationship than empirically-driven generalizations. This becomes especially important in the therapy context, as is described further below. The writer of this study does not subscribe, however, to the radical notion that all reality is contextual and subjective, as some postmodern scholars would profess (Anderson, 1990).

The result of this type of thinking for individual and family therapy involves removing the therapist from the traditionally enjoyed position of scientifically-backed authority and influence in the helping relationship. The postmodernistic stance puts the therapist or clinician on a level similar to the client – an inherently collaborative position that can enable people to feel that they are a significant part of the solution, rather than recipients of some prescriptive cure for their problems.

Postmodern thought has given rise to such therapeutic interventions as Collaborative Language Systems (Anderson & Goolishian, 1988), which in fact place clients in the expert position, relative to knowledge about their own problems. This and other postmodern therapies, such as narrative (White & Epston, 1990), solution-focused (O'Hanlon & Weiner-Davis, 1989), solution-oriented (deShazer, 1988), and reflecting team therapy (Anderson, 1987), derive from the more focused postmodern theoretical view of human interaction and knowing, called social constructionism.

Social constructionism

Social constructionism is the theoretical supposition that reality is "socially constructed" through the interactions of human communication. Individual and social reality is constructed through the use of language in a recursive, reciprocal pattern of individuals' interactions with the realities of others. These realities, or narratives, interact to set the stage for the process of social constructionism. Hoffman (1990, p. 3) states that this process involves "An evolving set of meanings that emerge unendingly from the interactions between people. These meanings are not skull-bound and may not exist inside what we think of as the individual 'mind'. They are part of a general flow of constantly changing narratives."

Social constructionists focus on how people interact to, construct, modify, and maintain what their society holds to be true, real, and meaningful (Freedman & Combs, 1996, p. 27). In this view, the intersubjective meanings of events, information, learning, and experience interact to form individual and communal foundations of reality. Social constructionism, then, does not rely on individual cognition and perceptions as the determiners of an individual's reality. The construction of individual and societal reality is inextricably linked to inter-individual interaction. The vehicles through which this process is carried out are language and communication.

Language and communication are also the principal components of the therapeutic process. Because of this, the social constructionist point of view is extremely useful to the postmodern

therapist. In the therapeutic context, constructionism becomes a powerful format for “co-constructing” reality with clients. New ideas about, views of, and solutions to problems are developed through simultaneous input from client and therapist through language and communication with each other in therapy.

Outside of the therapy context, the social construction of problems in people's and adolescents' lives is often dominating and oppressive (White & Epston, 1990), contributing to the life and sustainability of problems. Having a problem from the traditional, empiricist perspective can mean you are a problem. In the therapy context, problems can be constructed as outside of, or separate from, the troubled individual, thereby relieving the individual of guilt and freeing him or her to oppose the problem. This approach to reality, the social construction of the meaning of problems in people's lives, sets the context for utilizing narrative therapy.

Narrative Therapy

Narrative therapy is a relatively new approach to dealing with individual and family problems. It is considered in the field to be one of the new, evolving therapeutic models (Becvar & Becvar, 1996, p. 282). Despite its newness, it has quickly come to occupy a prominent position in the field of family therapy (Sprenkle & Piercy, 1992). Narrative therapists work with issues considered in mainstream mental health to be some of the most difficult to treat, including childhood conduct problems, anorexia, marital problems, adjustment to AIDS, and schizophrenia (Carr, 1998). Narrative therapy has even been used to develop a model of treatment for men who batter (Jenkins, 1990).

With its different perspectives on people and problems, narrative approaches have enjoyed growing popularity in the therapy field. These perspectives are different from traditional approaches to individual and family therapy in their primary descriptions of problems. Narrative therapy does not see problems as essential aspects of people (i.e., psychoanalytic traditions), or as resulting from dysfunctional communication patterns or relationships (early cybernetic and family systems models),

but resulting rather from the impact of problems, and from wider discourses or influences that oppress and limit people's lives.

White and Epston (1990) are widely considered to be the founding thinkers in this narrative model of therapy. They cite the works of postmodern, poststructuralist writers such as Foucault and Derrida as influential in the development of their narrative model. White and Epston's model often seeks to notice how an individual or family has been affected by wider or more privileged discourses or narratives, which stem from social status and power-related differences in opinions, perspectives, and knowledge.

Foucault (1975, 1980) examined the influence of privileged, professional, and official labels (discourses) in mental health, corrections, and society in general. He argued that these discourses are constructed through professional practices and expert-related jargon to create labels which work to subjectify individuals and groups to maintain an oppressive status quo. He coined the term "emancipating subjugated knowledges" to describe the process of liberating society from the damaging influence of these discourses. Though Foucault discussed this emancipation as occurring on a societal level (Fish, 1993), White and Epston adapted this notion to the more individually focused level of the therapy context (1990, pp. 25-32). Derrida (1981, 1988) describes deconstructing language and literature to expose the transient and insubstantial nature of reality. White and Epston take this idea and apply it to the process of collaboratively deconstructing problematic narratives or stories that people have of themselves.

These guiding ideas helped White and Epston arrive at a model of therapy that privileges no viewpoint or story over any other, and that in fact helps people discover if they have been unfairly influenced by oppressive discourses or problems. The authors incorporated the postmodern theoretical bases of social constructionism and deconstruction to create a therapy which promotes the right context for clients to participate in a new co-creation of their reality that is less problem-focused

or problem-dominated. These premises inform and influence the terms and techniques of narrative therapy.

Basic terms of narrative therapy

This section highlights some important general terms and techniques found in the literature of narrative therapy. When considering the main tenets of narrative therapy, it is helpful to understand the following terms: narrative, discourse, ultimate truth stories or oppressive unitary discourses, and emancipating subjugated knowledges. Three techniques of narrative therapy are also important in understanding narrative therapy. These are: externalizing the problem, using relative influence questioning, and noticing unique outcomes.

A narrative is the socially constructed story of an individual or family, including past, present and future contexts. The narrative is not limited to the story itself, but more importantly, includes the meanings ascribed to the story by the individual or family. It is the individual's or family's beliefs and perceptions of "the way that it is" regarding themselves and their successes or problems.

A discourse is a societal or culturally-bound narrative which is much wider and influential on a larger scale. An example of a societal discourse is the stereotypical view that adolescence is a time of "storm and stress"; that adolescents are naturally emotionally turbulent and at odds with existing structures of authority. Another example of a societal discourse would be the cultural definitions of what it means to be normal or mentally ill (Fish, 1993).

Ultimate-truth stories or oppressive unitary discourses are discourses that are highly influential to the individual and family through the process of socialization in Western society. These discourses are unitary – they operate to the exclusion of most or all other perspectives and influences in a person's or group's life. These stories dictate what is normal and acceptable for individuals and families, and can objectify and limit one's view of reality (their narrative), or how to deal with it, to a view that is consistent with the dominant societal discourse. The prominent Western notion that individual dysfunction is primarily individually based and can always be successfully addressed on

the individual level, or only by an expert interventionist, is an example of this type of discourse. “If you’re screwed up, it’s your fault—you fix it,” or, “Only I can tell you how to fix it”. Other, more evident examples of ultimate-truth stories include the institutional entrenchment of racism and gender and economic inequity as oppressive unitary discourses. The mention of these societal problems gives one an idea of how widespread and damaging the influence of oppressive unitary discourses are.

Emancipating subjugated knowledges is the process of enabling problem-dominated narratives or stories to be re-storied or re-defined as less problematic and less subject to a particular oppressive discourse. The narrative approach to therapy helps clients move from being influenced by problem-dominated stories or discourses, or perhaps even fulfilling these discourses, to more preferred stories (Zimmerman & Dickerson, 1994). In White & Epston’s model of narrative therapy (1990), this is done through the processes of externalizing the problem, relative influence questioning, and searching for unique outcomes. These techniques have the result of defining the problem as the problem, not the person or the family as the problem.

The above-mentioned levels of oppressive discourse as they relate to adolescence, chemical dependency, and mental health problems will be addressed in the present study through some techniques of narrative therapy, adapted to the group setting.

Basic techniques of narrative therapy

The technique of externalizing the problem involves assisting the client in viewing their problems as influencing themselves in negative ways, as opposed to viewing themselves as the problem. This, in effect, places the problem “outside” of clients and enables them to see themselves as more powerful as a result of their understanding of the nature of the problem and viewing that problem as an entity separate from themselves. An easily recognizable example of externalizing the problem is viewing chemical dependency as a separate entity that brings unpleasant and negative consequences upon anyone who would choose to invite it around.

Relative influence questioning builds upon externalization by asking questions having to do with the influence of the problem. Questions focus on when, where, how, with or through whom does the problem work most effectively? When and in what context is the problem ineffective? How does the client respond when the problem is effecting its dirty work? These types of questions help the client or family envision the problem as having limits and certain contexts in which it works more or less effectively.

Externalizing the problem and relative influence questioning create opportunities for clients to notice unique outcomes. Unique outcomes are examples from past experience in which the problem had little or no influence on the person. These outcomes are discovered by discussing the problem in the manner described above, and serve to reinforce the notion that the problem has limits, and those limits often are within the realm of personal influence by the client. Unique outcomes are used in therapy to build new narratives for clients in which the problem is less influential and oppressive.

The basic terms and techniques are useful when considering the narrative mode of individual and family therapy. White & Epston (1990) have eloquently expanded upon the above in their model of narrative therapy, but the approach is not limited to their interpretation. This review gives a basic framework from which to examine variations on the narrative theme in the literature.

Narrative literature and adolescent discourses

With its unique perspectives on oppressive discourses regarding adolescents, narrative therapy is promoted as an alternative to traditional methods of dealing with adolescents and their families. As more scholars in the field consider and develop narrative therapy, more and varied narrative interpretations of discourses particular to adolescents are being proposed.

A unique benefit gained from this constructionist, narrative stance is the acknowledgement of multiple understandings of any given event or context. In this view, conflicts and misunderstandings are seen as developing not from the character of individuals, but from different understandings and

differing ideas of the meanings of events and behaviors (Bievers, McKenzie, Wales-North & Gonzalez, 1995). This stance, in effect, gives equal time to the perceptions of adolescents and their parents or significant adult authority figures regarding any particular problem or conflict, therefore working against the dominant societal discourse of adolescents as less able or mature enough to make the “correct” meaning out of any particular situation or conflict. This latter attitude is related to the popular “storm and stress” model of adolescence which has been, until recently, widely accepted among researchers and the public in general.

Bievers et al., (1995) also addressed the oppressive societal discourse against adolescents by quoting another author’s adversarial perspective of individual and family therapy with adolescents as “blood sport” in which the therapist rarely ends up on the winning team (Trepper, 1991). By mentioning Trepper’s negative view of therapy with teens, Bievers et al., highlight the action of the oppressive discourse, both in the way that it influenced Trepper’s thinking, and in the way that his privileged, expert opinion promotes and sustains the strength of the discourse. These authors detail several methods of facilitating conversations with adolescents which are consistent with the narrative mode of therapy. The guiding intention of these methods is to elicit a cooperative and collaborative atmosphere, not the power struggles that so many therapists come to expect when dealing with adolescents.

Given the often-held view of adolescent therapy as being an exercise in frustration (as a result of the societal discourse of “storm and stress” and the accompanying antagonistic nature of adult/adolescent interactions), it is useful for the informed therapist to have access to the narrative model, which promotes effective connection with the client. The ability to connect with clients when using this model comes in part from the therapist’s enhanced awareness of societal processes and discourses at work in the client’s life, such as the negative cultural discourse of adolescence as a traumatic and conflict-filled period of development. Connecting with clients through better

awareness of influential or oppressive discourses is emphasized and facilitated by a social constructionist, narrative stance.

Narrative therapy and philosophy have also been examined as an effective way to address adolescent chemical dependency and adult interaction with chemically dependent adolescents (Holcomb, 1994). Holcomb detailed the efforts of the staff at a residential treatment center for addicted adolescents to become more aware of and effective at working with the problem of chemical dependency in adolescents. The article also addressed the necessary adult understanding of the adolescent context and adolescent narratives in order to be able to successfully facilitate change. Again, the focus is on different perceptions and understandings of multiple perspectives, adult and adolescent, to a particular problem or situation. A major theme of Holcomb's article is the associated positive change in staff perceptions and procedures regarding their clients after adopting the narrative philosophy, which is seen as a direct result of the staff's attempts to perceive and understand previously disregarded perspectives, thereby addressing the unfair discourse against adolescents.

Dickerson & Zimmerman (1992) propose a model of narrative therapy with adolescents and their families which includes examination of the previously mentioned societal discourse of adolescents-as-problems. These researchers trace this societal discourse as having a restraining effect on parents' ability to see their adolescents as able to make their own decisions, and to see that making decisions is a necessary trial and error process of growing up. The parents' narrative becomes a reflection of the dominant societal discourse defining adolescents as immature, irresponsible, and problematic. These ideas then also have the effect of restraining adolescents from seeing similarities between their parents' ideas and their own, encouraging defensiveness and blaming parents and adults in general for their problems (1992). This process sets in motion a reciprocal meaning-making process which can evolve into a problem-saturated story or narrative for that family; e.g., persistent family conflict or adolescent defiance. This reciprocal process arises from the interactions between adolescents and parents who are subject to the restraining or societally-determined ideas about each

other. The end result is an interaction of adolescent and parental narratives which works to produce an overall antagonistic and counterproductive narrative for the family.

Zimmerman and Dickerson (1994) narrow their focus in a later paper. They begin to discuss individual narratives, rather than societal narratives, as primarily influencing the development of problem patterns of interaction in families with adolescents. In this evolution of their model, the authors describe individual narratives as consisting also of judgments and expectations of others' intentions and expectations; and vice-versa, others' narratives consist of their expectations for individuals. Given this context of meaning, they contend that individuals justify their behavior at any given time as the only response possible with the mitigating circumstances of the behavior and expectations of others. Put simply, in problem-dominated family narratives, family members tend to base and justify their behavior on the behavior and perceived intentions of others.

Turning the focus back on discourse-influenced parental responses toward adolescents, Zimmerman & Dickerson (1994) go on to describe how parental narratives tend to be overspecialized in regard to their adolescents. Overspecialization refers to narratives that allow for little deviation or variance from what is expected behavior in the adolescent. In terms of development, when adolescents naturally move to attempting to define their own narratives in contrast to the highly developed narratives of their parents, overspecialization can limit development and encourage adolescent rejection of most or all of parental narratives. A developmentally appropriate parental response might be to modify and redefine their narrative according to the developmental level of the adolescent, to allow for more understanding of "out of bounds" or unexpected behaviors.

Another discourse that works against people, particularly against adolescents, is the normative societal acceptance of substance use/abuse. This discourse can be described as paving the way for the action and development of addiction in adolescents' and families' lives. The common adolescent notion that cigarette smoking and alcohol use define adulthood is a prime example of how this discourse works to subjugate adolescent knowledges of what it means to be an adult. Coupled

with the oppressive discourse of adolescents as problems, the societal discourse of acceptable substance misuse creates a fertile context for the development of addiction in adolescents. Adolescents are taught to understand substance use as an indicator of adulthood, and then are stigmatized and blamed for becoming problem users and addicts. Society proscribes the use of alcohol, tobacco and other recreational drugs for youth; yet many adults not only accept these activities as normal but also passively or actively support often significant alcohol and drug use, especially among older adolescents (Feldman & Elliot, 1990). Teens are required to sort out the conflicting messages of seeking out substances as a part of successful adulthood; it is expected that they should "just say no," or that they should be able to establish patterns of moderate use of socially acceptable drugs (1990). It was with a contextual awareness of the subjugating influences of these discourses that the study presented in this paper was developed.

The above literature review defines narrative therapy as especially applicable for adolescents and their families, especially in light of the described dominant, societal discourse regarding adolescents.

Narrative therapy research

Though scarce in the literature, some studies have attempted to examine narrative therapy qualitatively and systematically. St. James O'Connor, Meakes, Pickering & Schuman (1997) conducted qualitative research with families experiencing narrative therapy. Utilizing theme development of ethnographic data in their study, the authors found that the participating families experienced narrative therapy as very helpful. Five out of eight of them agreed that the therapy led to a feeling that they are "on the right track" with respect to dealing with problems, and that the therapy helped them feel more responsible for and able to deal with their problems.

One study attempted to empirically evaluate narrative family therapy's effectiveness in addressing and effecting change in existing family dysfunction. Besa (1994) used a research design with multiple baseline analysis to examine families participating in narrative family therapy.

Family progress was measured by comparing the ongoing incidence of adolescent problem behaviors to baseline measures (prior to narrative therapy interventions) of adolescent problem behaviors in the family at three different phases of the therapy. The families tracked the occurrences of target behaviors by self-report during baseline, intervention and follow-up phases of the study. The baseline measures were created in the first phase (baseline phase), in which parents were trained by the researcher in the initial therapy session to track and record specific problems, such as arguing, not doing homework, or attention-seeking behaviors. The intervention phase occurred as the therapist began to introduce basic techniques of narrative therapy into family therapy sessions. The follow-up phase occurred one month after cessation of therapy.

Families recorded problem behaviors on a tracking form during each phase of therapy. Incidence of targeted problem behaviors in each family at intervention and follow-up phases were compared to their baselines.

The researcher found that five of six families participating in narrative family therapy demonstrated improvement in family conflict as demonstrated by an 88% to 98% decrease in target behaviors during intervention and follow-up phases of narrative therapy, therefore attributing the improvements to the introduction of narrative techniques in the therapy.

This attempt to demonstrate empirically the effectiveness of narrative therapy is interesting, but in the classical, quantitative sense, is methodologically flawed. Each family rated itself on the chosen outcome measures, as opposed to being rated by an outside observer who might be able to evaluate outcomes consistently, without being subject to the ongoing interaction or perceptions in the family. The researcher acknowledged this, but stated that empirical reliability in this study was not applicable due to the qualitative nature of the intervention and information being gathered. The study did, however, reflect the narrative attitude of “the client as expert,” giving much credit to the families in understanding their own processes of change.

A recent prospective study utilized counseling combining narrative therapy practices with motivational interviewing practices (McCambridge, & Strang, 2004) to promote contraceptive behaviors in high-risk female adolescents. They found that over a third of the females in their study initiated contraceptive practices after participating in the counseling interventions, but stated that more systematic evaluation of the counseling techniques was indicated to establish the techniques' efficacy in working with high-risk adolescents (Cowley, Farley, & Beamis, 2002).

One study appears to have attempted to address the previously-mentioned scarcity of readily usable narrative techniques in working with adolescents. Fristad, Gavazzi, & Soldano (1999) used a psychoeducational model of intervention with mood disordered adolescents and their families. This model relied heavily on narrative externalization of the problem to help clients differentiate themselves from their problems, and to facilitate improved communication between parents and children, and between family members and their therapist (1999). The authors found that the model increased family understanding of adolescents' problems, and decreased expressed emotionality in the family regarding problems.

Another recent study utilized narrative therapy techniques in a group therapy format to accomplish treatment interventions for delinquent girls (Kelly, Blankenburg, & McRoberts, 2002). This study used qualitative methods for theme development and quantitative methods to assess personal characteristics of adolescent girls such as coping skills and self esteem in relation to having participated in narrative therapy. The study results suggested that narrative therapy had a positive effect on coping and self esteem. This study did not assess adolescent perceptions of the usefulness of narrative therapy, and did not assess treatment response factors such as treatment satisfaction or therapeutic alliance.

This writer has not discovered in the literature any further examples of narrative therapy being empirically evaluated and studied in research projects. Even qualitative studies specific to narrative therapy are scarce, which would suggest to this writer that a qualitative-quantitative study of

narrative therapy is a viable area of interest in the field of adolescent mental health treatment, and would warrant further research such as the study presented in this paper.

Critiques of narrative therapy

Narrative therapy and other post-modern therapies are not without their critics. When ecosystemic (Keeney, 1982) and other post-modern therapies were beginning to be introduced, Watzlawick (1982) responded by stating that therapists were in danger of giving up traditional modalities of family therapy such as structural-strategic and pragmatic therapy, in favor of the preaching of "starry-eyed guru-types." Indeed, White and Epston have been widely acclaimed as the founding fathers of narrative, and have obtained "guru-type" status within the wave of post-modern zeitgeist in family therapy.

Despite its rise in status, narrative therapy has been chided for losing necessary focus on family and intra-psychic processes as targets in family therapy (Minuchin, 1998, 1999; Schwartz, 1999). Others state that the popular wave of narrative therapy is contributing to a detrimental loss of focus on systemic and cybernetic understandings of individual and family therapy processes (Bertrando, 2000).

Narrative therapy has been accused of essentialism, or moving back to unoriginal, humanistic stances on knowledge (Burnette, 1995). Burnette makes the case that this essentialism in narrative therapy takes the form of focusing too much on the essential self while at the same time claiming to be a postmodern therapy, which by his definition, if narrative therapy is to stick to its postmodern claims, should focus more on the indeterminacy of reality and the discursive distribution of power in Western society, rather than on the development of individual or personal agency (1995). Fish (1993) shared this theoretical critique in stating that narrative therapy draws only selectively from the postmodern, poststructuralist influences of Foucault and Derrida, which have a much wider focus than can ever be achieved in the therapy setting.

Narrative therapy has also been criticized for apparently privileging its own views over all other therapeutic modes – a stance that goes against the very founding ideas of narrative therapy (Doan, 1998). In fact, narrative therapists themselves have begun to caution subscribers to narrative theory and practice to not reify narrative therapy to the exclusion of other effective and helpful models of therapy (Amundson, 2001; Amundson, Webber & Stewart, 2000). Narrative therapists of late have been called to focus on the utility of their practice and the effectiveness of their approach, rather than on whether it is “better” or not (Amundson, 2001). In light of these critiques, and with respect to the core beliefs of narrative therapy, this study seeks not to privilege its views or techniques over others, but to offer a viable alternative to clinicians treating adolescent chemical dependency and other mental health problems.

Implications and Connections Inherent to Narrative Therapy

The therapeutic alliance

The therapeutic alliance has long been considered in professional literature, but only in relatively recent years has this concept been applied to marital and family therapy (Pinsof & Catherall, 1986). The therapeutic alliance, also known as the working alliance, is defined as a relationship between therapist and clients predicated upon the development of collaboration and trust, agreed upon goals, and faith in the therapist and procedures of therapy (Barnard & Kuehl, 1995).

While many are interested in the therapeutic relationship between therapists and children in treatment, specific research in this area by clinicians has been neglected (Shirk & Saiz, 1992). The quality of children’s affective relationship with therapists has been associated with collaboration (alliance) in therapy, but not enough research has been conducted on the kinds of therapeutic techniques which promote therapeutic alliance in young clients (Shirk & Saiz, 1992). A recent study found therapeutic alliance to be positively associated with therapy outcomes in family therapy with adolescent epilepsy patients (Glueckauf, Liss, McQuillen, Webb, Dairaghi, & Carter, 2002). Other

authors have emphasized the need for counselors to develop a strong therapeutic alliance with adolescents in order to be effective helpers for teens in crisis (Manley & Leichner, 2003).

Other recent developments of the thinking in therapeutic alliance have taken on a decidedly postmodern stance (Bird, 1993; Barnard & Kuehl, 1995). Therapists are called to focus less on technique and more on self-examination, and to facilitate an on-going evaluation of the therapeutic process with clients; in this way promoting therapeutic alliance.

The notions of searching for techniques and developing effective therapist stances that promote therapeutic alliance flow well with narrative therapy, which emphasizes the therapist as consultant and co-creator of meaning in the therapeutic relationship, but also focuses on specific techniques to facilitate the narrative process. Narrative therapy has been identified as an effective way to develop strong therapeutic alliance in adolescents (Manley & Leichner, 2003). Given the apparent complementary relationship between narrative methods and therapeutic alliance, narrative therapy could be expected to have a positive effect on therapeutic alliance in teens.

Alcoholics Anonymous

Much has been written on the effectiveness of Alcoholics Anonymous (AA), the non-clinical self-help program which promotes 12 steps of recovery for alcoholics. Aspects of this program are fundamentally narrative. This notion is described in subsequent paragraphs in a discussion of AA's effectiveness, and the narrative aspects of the program are delineated.

AA is a successful model for self-help groups (Borkman, 1989) that was originally developed in 1935 to deal exclusively with alcoholism. Today, the 12 Steps and the 12 Traditions of AA have been modified and replicated to address almost any pervasive addictive or behavioral problem. Groups deriving from the traditions of AA range from Emotions Anonymous to drug-specific groups such as Cocaine Anonymous and Marijuana Anonymous. More generally, Narcotics Anonymous (NA) addresses the addictive use of all chemicals other than alcohol. The wide variability of groups

following AA's lead is testimony to its effectiveness as a model in changing people's lives. This success has been reflected in the research literature.

A meta-analysis of previous research by Emrick, et al., (1993) examined 107 different studies of AA. They found that greater involvement in AA predicts reduced alcohol consumption. Participation and involvement in AA has been found in other studies to be related to positive outcomes (Montgomery, Miller & Tonigan, 1995; Snow, Prochaska & Rossi, 1994). Length of AA attendance has been found to be related to, and has been determined to be a significant predictor of, the length of sobriety (McBride, 1991; Cross, et al., 1990). Though not without critics, AA has demonstrated adequate evidence that the AA model of self-help and personal development is effective for many alcoholics in producing long-term change (Davis & Jansen, 1998).

A key to AA's success is its focus on alcoholism as a distinct problem which affects individuals, rather than as a problem resulting from some moral or personal failing by the individual. AA describes addiction and alcoholism as originating outside the person, as a progressive disease. This adherence to the medical model of addiction is well known (Lewis, 1991). AA takes this concept further, however, by describing this problem not only as a disease, but also as a malevolent and intentional agent. It describes alcoholism as "cunning, baffling and powerful" (AA World Services, 1976, p. 58), and ascribes to it unlimited, damaging influence on individuals if left untreated. This description of addiction is in effect a narrative externalization of the problem. Individuals in the AA program are free to view themselves as being affected by a problem that is separate from and external to themselves, not intrinsic to themselves or the result of a moral failing. This narrative externalization provides a powerful metaphor for change within the program of AA, by giving individuals an opponent to fight that is separate and external from themselves.

Other aspects of AA are inherently narrative. AA has been called a "normative narrative community" (Rappaport, 1993; Davis & Jansen, 1998). This notion is developed by acknowledging the consistent exchange of personal stories (narratives), which is so fundamental to the AA program.

Through telling, re-telling, and hearing each other's narratives, which detail their transformations from active alcoholics to ones in recovery, members participate in the social construction of AA as a viable vehicle for change. They also participate in the social construction of themselves and others as survivors of, and activists against, addiction. Again, this process is heavily laden with externalized references to the problem as separate from the individual; it seems that AA has long understood the power narrative notions and interventions have in facilitating recovery, although the terminology associated with narrative therapy has not been used in conjunction with the AA model.

Since AA, arguably the best non-clinical movement for the treatment of alcoholism and addiction, relies heavily on narrative externalization and storytelling to promote recovery from addictions, it is reasonable to expect narrative interventions to be systematically effective in helping chemically dependent adolescents to change.

Applicability of Narrative Therapy to the Treatment Setting

Making narrative therapy understandable for clinicians

Articles describing narrative therapy approaches to individual and family therapy with adolescents are often esoteric and heavily laden with theoretical aspects of narrative therapy. While they are helpful for understanding the theory base and for encouraging therapists to think using a narrative framework, these efforts give too few descriptions of the actual use of specific, narrative therapeutic techniques with adolescents, such as externalization, relative influence questioning, and emancipating subjugated knowledges. Furthermore, articles on narrative therapy often seek to discuss narrative theory and technique through descriptions of individual, case study-type examples. These discussions tend to focus a great deal on theoretical musings and a therapist-centric view of client reactions to narrative therapy, rather than on client realizations (directly from the client's perspective) as well. Many descriptions of the effectiveness of narrative therapy with children and adolescents are anecdotal in nature with little research to support clinical enthusiasm (Kelly, Blankenburg, & McRoberts, 2002). Zimmerman & Beaudoin (2002) acknowledge that it is often

difficult to teach narrative thinking to therapists and clinicians in an effective manner. Models of easily understood and applicable narrative therapy are needed to offer clinicians working with adolescents an alternative approach that improves therapeutic effectiveness, as well as providing insights as to how teens view narrative therapy.

Predictors

The literature on adolescent substance abuse treatment provides support for the chosen predictors for the study described in this paper. Multiple studies have been conducted examining adolescent substance abuse treatment (Blood & Cornwall, 1994; Kaminer, Tarter, Bukstein & Kabene, 1991; Brown, Meyers, Mott & Vik, 1994; Knapp, Templer, Cannon & Dobson, 1991; Cady, Winters, Jordan, Solberg & Stinchfield, 1996; Rounds-Bryant, Kristiansen, Fairbank & Hubbard, 1998). These studies have examined variables such as: participation, gender effects, motivation, family history of substance abuse and addiction, age, types of treatment, and severity of substance abuse as factors affecting the treatment process. As mentioned, the present study examined the following variables as predictors of client response to narrative therapy: severity of substance abuse, age, age of onset of substance abuse, and gender.

Severity of substance abuse may have an effect on adolescent response to narrative therapy. Greater severity of abuse has been found to be associated with a higher degree of treatment completion (Blood & Cornwall, 1994) as well as a higher rate of drop out (Rush, 1979) in adolescent populations, indicating differential effects across treatment settings. This study examined differences in response to narrative therapy associated with levels of use. Blood & Cornwall (1994) found that higher levels of alcohol and drug abuse in male adolescents predicted better response to treatment. These adolescents may have perceived more reasons for change due to the extent and consequences of their abuse, in essence admitting to having a problem (or in narrative terms, having a relationship with it). In contrast, the Rush (1979) study found that heavy use predicts a higher rate of treatment drop out, or lack of awareness of a problem. Because narrative therapy inherently seeks to promote

resistance to problems through exposing negative consequences and actions of problems, it holds potential for assisting heavy users, whether they are ready for change or not.

Age of clients in adolescent treatment has been found to be related to positive response to substance abuse treatment. Feigelman (1987) found that older adolescents were more likely to complete an outpatient substance abuse program, and Hubbard et al. (1985) found that younger adolescents fared the worst in an outpatient treatment program. However, the opposite was indicated in a study by Friedman, Glickman, & Morrissey (1986) which found that younger age at admission to treatment predicted treatment completion.

In regard specifically to narrative therapy, scholars have been called to examine developmental influences on the effectiveness of this approach (Jankowski, 1998; Strand, 1997). Focus is directed appropriately on different levels of cognitive and emotional development in adolescents when determining effectiveness or appropriateness of the narrative approach. The study presented in this paper sought to examine any differences between younger and older adolescents in response to narrative therapy. This writer's clinical experience suggests that younger adolescents respond less to narrative interventions than their older counterparts. Therefore, age at the time of exposure to narrative therapy was included as a predictor.

Age of onset of substance abuse has been indicated as a predictor of faster escalation of substance abuse and developmental problems (Nowinski, 1990), and may affect a teen's response to treatment interventions. Rush (1979) found that early onset (starting at age 11 or younger) of substance abuse predicted less positive response to treatment, and adolescents who started using later were more likely to complete treatment. This writer's experiences with adolescents who have started using substances prior to age 11 or 12 suggest that they deal with a greater number of consequences and more severe consequences of their using. Age of onset was included as a predictor.

Gender effects in adolescent substance abuse treatment have been demonstrated, but differences between males and females have been unclear. Some studies have shown greater levels of

alcohol abuse in male adolescents than in females (Hovens, Cantwell & Kiriakos, 1994), while others have found the opposite (Alford, Koehler & Leonard, 1991). Boys and girls presenting for treatment differ widely in areas such as incidence of physical and sexual abuse, criminal behavior, and internalizing disorders (Rounds-Bryant, et al., 1998), variables which are likely to affect response to treatment. Gender differences in response to narrative therapy may also exist.

In light of the above trends in the narrative and adolescent substance abuse treatment literature, the study outlined and presented in this paper sought to provide easily understandable, applicable techniques and interventions for effective implementation of narrative group therapy with drug abusing and troubled adolescents in the clinical setting. A user-friendly model of narrative group therapy that specifically describes the techniques therapists and group facilitators can use could have great potential for improving the likelihood of narrative therapy being applied in more clinical settings of individuals and programs working with adolescents. This study also sought insights into if and how certain variables might predict adolescents' responses to narrative therapy, to guide clinicians in regard to when and with which groups of teens narrative is most likely to be effective.

CHAPTER 3. METHODOLOGY

Introduction

The methodology for this study combined quantitative and qualitative research methods and analyses to investigate not only the potential for an empirical basis to understand the effects of narrative therapy with adolescents, but also to increase understanding of the meanings that teens ascribe to their experiences with narrative interventions. This chapter reviews the quantitative and qualitative methodology employed in this study.

Participants and treatment setting

Participants in this study were patients in two different adolescent outpatient programs available through a hospital-based behavioral health service in a medium-sized city in the Midwestern United States. Both programs are considered to be outpatient treatment, which consists of clients attending day treatment, Monday through Friday, or evening outpatient care on Tuesday and Thursday evenings. The patients in the Tuesday-Thursday program are diagnosed as primarily chemically dependent. Patients admitted to the day-treatment program are diagnosed primarily with a psychiatric diagnosis, and have a chemical abuse or dependency diagnosis as secondary, if at all. This variety of primary client problems provided two different groups for comparison in evaluating the secondary hypothesis of the study: adolescents with a primary chemical abuse or dependency diagnosis, and those with a primary psychiatric diagnosis. Again, the secondary hypothesis states that those clients who receive narrative therapy interventions who are primarily chemically dependent will be more satisfied with their treatment than clients who are not primarily chemically dependent. This effect was expected because of the strongly narrative aspects of AA and other successful 12-step-related approaches to interventions with substance abuse.

Diagnoses common to these programs, besides chemical abuse and dependency, include internalizing, externalizing, and psychotic disorders. Internalizing disorders often seen include Major

Depressive Disorder, Anxiety Disorder and other mood disorders. Externalizing disorders common to these programs include Oppositional-defiant Disorder and Conduct Disorder. Psychotic disorders sometimes seen in the outpatient programs include various drug-induced psychoses, Schizophrenia, and psychoses not otherwise specified. Criteria for admissions to either program include having a recent history of being a threat to self or others through a variety of behaviors, ranging from suicidal behavior to aggression or repeated driving while intoxicated, and other drug and alcohol abuse problems. Other presenting problems generally include family, school, and other psychosocial dysfunction. The definitive difference between each program is in the primary diagnoses: admission to the Tuesday-Thursday program requires a substance-related primary diagnosis, and admission to the day treatment program requires a behavioral health-related primary diagnosis.

Regardless of the psychiatric disorder-labels applied to these teens, most are affected by significant environmental and family factors as well. Many have suffered family communication problems and neglect. Others have experienced emotional, physical and sexual abuse, occurring either while at home or while on the run. Some of them come to treatment with Post-traumatic Stress Disorder as a result of these events. This complex assortment of environmental and psychiatric factors contributes to a challenging and demanding treatment setting. Expecting an unfair and oppressive or otherwise dysfunctional adult response to their problems, patients often demonstrate oppositionalism and resistance to the treatment process. Since narrative therapy is inherently collaborative and non-threatening, Extended Outpatient and Adolescent Partial were excellent arenas for examining the ability of this mode of therapy to promote problem-solving and general adolescent resistance to problems – rather than toward everyone else.

The Tuesday-Thursday outpatient treatment program consisted of 3 hours of treatment twice a week. This outpatient level includes chemical dependency education and treatment groups. Individual and family therapy may be offered as well, dependent on the client's needs. This level of

outpatient treatment includes random urine analysis for drugs of abuse to determine whether there is any concurrent drug use.

The day treatment program services are greater in length and intensity than the Tuesday-Thursday program, and focus more on emotional and behavioral health rather than on substance abuse issues. Patients in this program participate in educational and therapy groups, teacher-supervised school activities, and individual and family therapy when indicated.

Demographics

Ninety-nine participants were included in this study. Of these participants, the majority, or 80 participants (80.8%), were Caucasian. The following ethnic groups were represented by the indicated number of participants: African American (3), Asian (3), Hispanic (2), Native American (3), and mixed race or other (8).

The age of participants ranged from 12 to 19, with the largest percentage of participants being 15 (24.2%).

Gender distribution of participants was 44 males (44.4%) and 55 females (55.6%).

The diagnosis of participants was specified by their level of involvement with substance abuse. Thirty-nine participants (39.4%) were reported, by themselves, to be non-involved with illegal drugs. These individuals presented to treatment with diagnoses including depression and anxiety-related problems, conduct problems, and psychosis. The remaining 60 participants were designated by the SASSI instrument to be either substance abusers or substance dependent: 17 were identified as substance abusers (17.2%), and 43 were identified as substance dependent (43.4%).

Participants were randomly assigned to narrative and non-narrative groups. The non-narrative group had 50 participants (50.5%), and 49 participants received narrative therapy as part of their treatment (49.5%).

Fifty participants reported no legal charges or current involvement with the law (50.5%), while 47 (47.5%) participants indicated they were in trouble with the law.

Twenty-seven participants reported having never tried drugs or alcohol at all (27.3%). The range of the age of onset (first use) of those who had used substances was age nine to age 18. The largest percentage of users started at age 14 (18.2%).

Tables 3.1-3.6 display the means and standard deviations of the predictor and outcome variables for different groups of participants within the study. The groups consisted of: participants who were substance involved (substance abusers and chemically dependent); participants who were chemically dependent; participants who were substance abusers; participants who were non-involved with substances; participants who received narrative therapy; and participants who did not receive narrative therapy.

Table 3.1: Descriptive statistics of variables for participants who were substance involved*

| Total number of participants: 60 (26 males, 34 females) | | | |
|---|----|--------|----------------|
| Predictors: | N | Mean | Std. Deviation |
| AGE | 60 | 15.670 | 1.336 |
| CURUSE | 59 | 1.610 | 1.682 |
| ONSET | 60 | 12.950 | 1.721 |
| SASOAT | 60 | 8.400 | 2.101 |
| TOTFVA1 | 60 | 7.117 | 4.088 |
| TOTFVA2 | 59 | 2.847 | 3.619 |
| TOTFVOD1 | 58 | 18.086 | 12.212 |
| Outcomes: | | | |
| TOTSAT1 | 60 | 19.183 | 2.494 |
| TOTSAT2 | 59 | 15.542 | 2.744 |
| TOTGOAL1 | 59 | 31.610 | 7.656 |
| TOTTASK1 | 57 | 33.982 | 6.768 |
| TOTTASK2 | 58 | 16.879 | 6.768 |

AGE: chronological age
 CURUSE: current frequency of substance abuse
 ONSET: age of first use of substances
 SASOAT: score on Substance Abuse Screening Inventory (SASSI)
 TOTFVA1: Factor 1 of SASSI subscale Face Value Alcohol
 TOTFVA2: Factor 2 of SASSI subscale Face Value Alcohol
 TOTFVOD1: Factor of SASSI subscale Face Value Other Drugs
 TOTSAT1: General treatment satisfaction/satisfaction with staff
 TOTSAT2: Satisfaction with personal change
 TOTGOAL1: Goal-related therapeutic alliance
 TOTTASK1: Task-related therapeutic alliance
 TOTTASK2: Therapeutic alliance as comfort level with staff

*Substance Involved includes substance abusers and chemically dependent participants

Table 3.2: Descriptive statistics of variables for chemically dependent participants

| Total number of participants: 43 (16 males, 27 females) | | | |
|---|----|--------|----------------|
| Predictors: | N | Mean | Std. Deviation |
| AGE | 43 | 15.530 | 1.369 |
| CURUSE | 42 | 1.830 | 1.834 |
| ONSET | 43 | 12.840 | 1.758 |
| SASOAT | 43 | 9.140 | 1.712 |
| TOTFVA1 | 43 | 7.558 | 4.404 |
| TOTFVA2 | 42 | 3.429 | 3.934 |
| TOTFVOD1 | 41 | 20.219 | 12.762 |
| Outcomes: | | | |
| TOTSAT1 | 43 | 19.023 | 2.521 |
| TOTSAT2 | 42 | 15.405 | 2.732 |
| TOTGOAL1 | 43 | 31.209 | 7.498 |
| TOTTASK1 | 41 | 33.780 | 6.502 |
| TOTTASK2 | 41 | 16.659 | 4.246 |

AGE: chronological age
 CURUSE: current frequency of substance abuse
 ONSET: age of first use of substances
 SASOAT: score on Substance Abuse Screening Inventory (SASSI)
 TOTFVA1: Factor 1 of SASSI subscale Face Value Alcohol
 TOTFVA2: Factor 2 of SASSI subscale Face Value Alcohol
 TOTFVOD1: Factor of SASSI subscale Face Value Other Drugs
 TOTSAT1: General treatment satisfaction/satisfaction with staff
 TOTSAT2: Satisfaction with personal change
 TOTGOAL1: Goal-related therapeutic alliance
 TOTTASK1: Task-related therapeutic alliance
 TOTTASK2: Therapeutic alliance as comfort level with staff

Table 3.3: Descriptive statistics of variables for participants who were substance abusers

| Total number of participants: 17 (16 males, 27 females) | | | |
|---|----|--------|----------------|
| Predictors: | N | Mean | Std. Deviation |
| AGE | 17 | 16.000 | 1.225 |
| CURUSE | 17 | 1.060 | 1.088 |
| ONSET | 17 | 13.240 | 1.640 |
| SASOAT | 17 | 6.530 | 1.841 |
| TOTFVA1 | 17 | 6.000 | 2.979 |
| TOTFVA2 | 17 | 1.412 | 2.152 |
| TOTFVOD1 | 17 | 12.941 | 9.182 |
| Outcomes: | | | |
| TOTSAT1 | 17 | 19.588 | 2.451 |
| TOTSAT2 | 17 | 15.882 | 2.826 |
| TOTGOAL1 | 16 | 32.687 | 8.220 |
| TOTTASK1 | 16 | 34.500 | 7.607 |
| TOTTASK2 | 17 | 17.412 | 3.607 |

AGE: chronological age
 CURUSE: current frequency of substance abuse
 ONSET: age of first use of substances
 SASOAT: score on Substance Abuse Screening Inventory (SASSI)
 TOTFVA1: Factor 1 of SASSI subscale Face Value Alcohol
 TOTFVA2: Factor 2 of SASSI subscale Face Value Alcohol
 TOTFVOD1: Factor of SASSI subscale Face Value Other Drugs
 TOTSAT1: General treatment satisfaction/satisfaction with staff
 TOTSAT2: Satisfaction with personal change
 TOTGOAL1: Goal-related therapeutic alliance
 TOTTASK1: Task-related therapeutic alliance
 TOTTASK2: Therapeutic alliance as comfort level with staff

Table 3.4: Descriptive statistics of variables for participants who were non-involved with substances

| Total number of participants: 39 (18 males, 21 females) | | | |
|---|-----|--------|----------------|
| Predictors: | N | Mean | Std. Deviation |
| AGE | 39 | 14.490 | 1.430 |
| CURUSE | 39 | .030 | .160 |
| ONSET | 12* | 12.750 | 2.137 |
| SASOAT | 29 | 6.720 | 2.605 |
| TOTFVA1 | 39 | .205 | .522 |
| TOTFVA2 | 39 | .077 | .480 |
| TOTFVOD1 | 39 | .128 | .522 |
| Outcomes: | | | |
| TOTSAT1 | 38 | 20.447 | 2.708 |
| TOTSAT2 | 39 | 16.333 | 2.343 |
| TOTGOAL1 | 37 | 34.486 | 7.430 |
| TOTTASK1 | 38 | 35.263 | 7.661 |
| TOTTASK2 | 39 | 18.205 | 3.088 |

AGE: chronological age

CURUSE: current frequency of substance abuse

ONSET: age of first use of substances

SASOAT: score on Substance Abuse Screening Inventory (SASSI)

TOTFVA1: Factor 1 of SASSI subscale Face Value Alcohol

TOTFVA2: Factor 2 of SASSI subscale Face Value Alcohol

TOTFVOD1: Factor of SASSI subscale Face Value Other Drugs

TOTSAT1: General treatment satisfaction/satisfaction with staff

TOTSAT2: Satisfaction with personal change

TOTGOAL1: Goal-related therapeutic alliance

TOTTASK1: Task-related therapeutic alliance

TOTTASK2: Therapeutic alliance as comfort level with staff

* indicates non-substance involved participants who nevertheless used at least once

Table 3.5: Descriptive statistics of variables for participants who received narrative therapy

| Total number of participants: 49 (16 males, 33 females) | | | |
|---|----|--------|----------------|
| Predictors: | N | Mean | Std. Deviation |
| AGE | 49 | 15.22 | 1.47 |
| CURUSE | 49 | .82 | 1.42 |
| ONSET | 33 | 13.21 | 1.80 |
| SASOAT | 49 | 7.92 | 2.46 |
| TOTFVA1 | 49 | 4.12 | 4.58 |
| TOTFVA2 | 49 | 2.00 | 3.66 |
| TOTFVOD1 | 49 | 9.71 | 12.62 |
| Outcomes: | | | |
| TOTSAT1 | 48 | 20.15 | 2.29 |
| TOTSAT2 | 48 | 15.89 | 2.42 |
| TOTGOAL1 | 48 | 33.65 | 7.16 |
| TOTTASK1 | 48 | 34.70 | 7.07 |
| TOTTASK2 | 49 | 17.367 | 3.855 |

AGE: chronological age
 CURUSE: current frequency of substance abuse
 ONSET: age of first use of substances
 SASOAT: score on Substance Abuse Screening Inventory (SASSI)
 TOTFVA1: Factor 1 of SASSI subscale Face Value Alcohol
 TOTFVA2: Factor 2 of SASSI subscale Face Value Alcohol
 TOTFVOD1: Factor of SASSI subscale Face Value Other Drugs
 TOTSAT1: General treatment satisfaction/satisfaction with staff
 TOTSAT2: Satisfaction with personal change
 TOTGOAL1: Goal-related therapeutic alliance
 TOTTASK1: Task-related therapeutic alliance
 TOTTASK2: Therapeutic alliance as comfort level with staff

Table 3.6: Descriptive statistics of variables for participants who did not receive narrative therapy

| Total number of participants: 50 (28 males, 22 females) | | | |
|---|----|--------|----------------|
| Predictors: | N | Mean | Std. Deviation |
| AGE | 50 | 15.180 | 1.508 |
| CURUSE | 49 | 1.140 | 1.607 |
| ONSET | 39 | 12.670 | 1.752 |
| SASOAT | 50 | 7.560 | 2.434 |
| TOTFVA1 | 50 | 4.660 | 4.762 |
| TOTFVA2 | 49 | 1.490 | 2.493 |
| TOTFVOD1 | 48 | 12.042 | 13.257 |
| Outcomes: | | | |
| TOTSAT1 | 50 | 19.220 | 2.888 |
| TOTSAT2 | 50 | 15.820 | 2.804 |
| TOTGOAL1 | 48 | 31.792 | 8.103 |
| TOTTASK1 | 47 | 34.298 | 7.250 |
| TOTTASK2 | 48 | 17.458 | 3.649 |

AGE: chronological age
 CURUSE: current frequency of substance abuse
 ONSET: age of first use of substances
 SASOAT: score on Substance Abuse Screening Inventory (SASSI)
 TOTFVA1: Factor 1 of SASSI subscale Face Value Alcohol
 TOTFVA2: Factor 2 of SASSI subscale Face Value Alcohol
 TOTFVOD1: Factor of SASSI subscale Face Value Other Drugs
 TOTSAT1: General treatment satisfaction/satisfaction with staff
 TOTSAT2: Satisfaction with personal change
 TOTGOAL1: Goal-related therapeutic alliance
 TOTTASK1: Task-related therapeutic alliance
 TOTTASK2: Therapeutic alliance as comfort level with staff

Instruments and Data Collection

Quantitative instruments

Upon admission to treatment, participants completed a questionnaire designed to assess levels of substance abuse in adolescents, the Adolescent Substance Abuse Subtle Screening Inventory-A2 (SASSI) (Miller, 2001). The author of this instrument granted permission for it to be used in the study described in this paper (see Appendix J). Each adolescent involved in the study

completed the SASSI. Upon discharge, clients completed the Treatment Satisfaction Questionnaire (TSQ), a measure created for the purposes of this study.

Substance Abuse Subtle Screening Inventory

The Adolescent Substance Abuse Subtle Screening Inventory-A2 (SASSI) consists of 72 true-false items, and two specific scales for alcohol and other drug abuse levels. This instrument is a standardized assessment of levels of substance abuse and chemical dependency.

The SASSI demonstrates good face and construct validity. Its author reports a success rate of correctly identifying 98% of chemically dependent subjects in a residential treatment program, and 87% of chemically dependent subjects in an early-stage outpatient treatment program. In regard to reliability, the author has reported alphas for the individual clinical scales on earlier versions of the SASSI ranging from .86 to .92 (Piazza, 1996).

The SASSI contains ten subscales for which the authors compiled items through discriminant function analysis (Miller, 2001). These subscales measure factors including: family and friend risk factors, attitudes, symptoms of substance abuse, obvious attributes of chemical dependency, subtle attributes of chemical dependency, defensiveness, supplemental addiction measures, corrections-related traits, a validity scale, and a secondary classification scale. In addition to the discriminant function-derived subscales, the SASSI includes two additional scales. These scales are the face value alcohol (FVA) scale and the face value other drugs (FVOD) scale. Items on these specific scales consist of 4-point Likert type items ranging from “never” to “repeatedly,” and measure frequency of problems associated with drug and alcohol use.

Age, age of onset of substance abuse, gender, and substance abuse severity information gathered from the SASSI were to be used for a quantitative regression analysis. The scales chosen to assess substance abuse severity in the present study included the obvious attributes of chemical dependency scale (OAT), the face value alcohol (FVA) scale and the face value other drugs (FVOD) scale. These specific scales were chosen because of their high face validity in measuring severity of

participants' substance abuse. These factors served as the predictors of scores on the project's outcome measure of participants' satisfaction with the experience of substance abuse or mental health treatment and therapeutic alliance, the Treatment Satisfaction Questionnaire (TSQ).

Treatment Satisfaction Questionnaire

The Treatment Satisfaction Questionnaire (TSQ) is simple and derives from an adaptation of existing measures of client satisfaction with mental health treatment. This instrument seeks to measure adolescent client satisfaction with their treatment experience and therapeutic alliance. In this project, the TSQ assesses the treatment satisfaction and therapeutic alliance of clients that have been in outpatient treatment programs. The Treatment Satisfaction Questionnaire was given to all participants to complete at discharge, after either experiencing narrative therapy interventions as a part of their treatment process, or after participating in the normal, non-narrative treatment process only. This measure consists of Likert-scale responses regarding participant satisfaction with their treatment experience, and their opinion of the client-therapist relationship experienced while in treatment.

Treatment Satisfaction Questionnaire items

Satisfaction with therapy has to do with the client's viewpoint and opinion of services received. Chan et al. (1997) state that assessing this viewpoint is crucial in determining whether or not the therapy has given clients the tools necessary to avoid a relapse of chemical abuse. This was an interest of the present study—to determine if narrative therapy helps adolescents feel equipped to address their substance abuse problems.

A number of client satisfaction measures have been developed (Ruggeri, 1994). The process of assessing client satisfaction can be relatively straightforward (Chan et al., 1997), and instruments are often not long. The TSQ is similarly straightforward. Items for the Treatment Satisfaction Questionnaire have been adapted from two different psychometrically established instruments. The Youth Client Satisfaction Questionnaire (YCSQ) of Shapiro, Welker & Jacobson (1997) was chosen

to measure adolescent client satisfaction with their treatment, and the Working Alliance Inventory (WAI) of Horvath (1984) provided items which were adapted for the purposes of the present study.

The YCSQ is a fourteen-item instrument designed specifically for use by youth in mental health treatment and counseling settings. This instrument has demonstrated adequate reliability, producing a Cronbach's alpha of .90 (Shapiro, et al., 1997). All items from this measure were included for the TSQ. Adapted from this instrument were instructions to the clients that allow for both negative and positive responses, to portray the appropriate range of responses (Shapiro, et al., 1997, see Appendix B). The Treatment Satisfaction Questionnaire subscale SAT (measuring satisfaction with treatment) was comprised of the items from the YCSQ.

The WAI is an instrument designed to assess therapeutic alliance. This instrument has also demonstrated adequate reliability estimates, with a reported Cronbach's alpha of .93 (Horvath & Greenberg, 1989). Twelve items of the TASK scale and 12 items of the GOAL scale of the WAI were included to evaluate therapeutic alliance. Reliability estimates for the Goal and Task subscales of the WAI are .89 and .92, respectively (1989). The Treatment Satisfaction Questionnaire subscales TASK (items pertaining to task-related therapeutic alliance) and GOAL (items pertaining to goal-related therapeutic alliance) were comprised of the associated TASK and GOAL subscale items of the WAI.

For the purpose of the study described in this paper, items of the WAI that were utilized in the development of the Treatment Satisfaction Questionnaire subscales TASK and GOAL were adapted from their original wording to better assess therapeutic alliance between adolescent clients and staff members, as opposed to assessing alliance between an individual client and a therapist.

In sum, as a result of combining items from the YCSQ and the WAI, the Treatment Satisfaction Questionnaire contains a total of 38 items, with subscales named SAT, TASK and GOAL. The questionnaire also includes three items at the end to assess age of onset of substance abuse, current age, and gender. See Appendix B for the Treatment Satisfaction Questionnaire.

Reliability

Reliability analysis was conducted for two selected scales of the Substance Abuse Subtle Screening Inventory (SASSI) and all scales of the Treatment Satisfaction Questionnaire. The investigator calculated Cronbach's alpha for the two subscales of the SASSI to provide reliability data for the instrument's measures of alcohol and drug use severity for the study participants. These scales were the face value alcohol (FVA) scale and the face value other drugs (FVOD) scale. These scales measure direct effects of alcohol or other drug use, and address frequency of use and negative consequences of use. Reliability analysis for FVA and FVOD scales in the present study indicated high reliability, with alphas of .91 and .96, respectively.

Cronbach's alpha was calculated for all subscales of the Treatment Satisfaction Questionnaire. The subscales were SAT, TASK and GOAL. The SAT subscale measures treatment satisfaction, and included questions like "Did your counselors have good ideas that helped you?" and "Did counseling help your problems get better?" The TASK subscale measured therapeutic alliance related to client impressions of their alignment with the tasks and activities of counseling. Examples of questions in this subscale are "The staff and I agree about the things I will need to do in therapy to improve my situation" and "I am clear what my responsibilities are in therapy". The GOAL subscale measures therapeutic alliance related to client understanding and agreement with goals of counseling. An example of an item in this subscale is "We have established a good understanding of the kind of changes that would be good for me." These scales demonstrated adequate reliability. Alphas for the SAT, TASK and GOAL subscales were .88, .86 and .82, respectively. See Appendix B for the Treatment Satisfaction Questionnaire.

Qualitative instruments and data gathering

The primary investigator as instrument

The primary investigator of this project is a hospital-based family therapist and substance abuse counselor working with the adolescents having substance and other mental health issues in both

inpatient and outpatient programs at a Midwestern hospital. This writer has developed an increasing interest in narrative therapy as well as in qualitative research. As the administrator of the qualitative interviews in this study, from a social constructionist standpoint, the primary investigator is in essence a qualitative “instrument” in terms of the recursive, interactive nature of the interview format.

In much the same way that it is necessary to describe and discuss the development of quantitative instruments used in research, the primary investigator’s status here as an “instrument” employed in the qualitative data collection of this study necessitates the description and discussion of his development as a narrative therapist and qualitative researcher. Similarly, researchers using phenomenological qualitative methods are called to “bracket,” to contain or make known personal prejudgments about phenomena being studied (Creswell, 1998; Field & Morse, 1985). In an attempt to do this, this writer will describe his experiences with narrative therapy and adolescents further, in order to provide the reader with more background into the thinking, experience and expectations that provided the foundation for the construction of this project. The bracketing process in this project is two-fold: one, in the articulation of the researcher’s stance toward narrative interventions, and two, in the qualitative interview process of allowing participants’ perceptions and reactions to emerge with as little influence as possible from the investigator’s philosophical and experiential preferences toward narrative.

In regard to the investigator’s predispositions to narrative therapy, the reader should recall the previous example of narrative therapy in action with adolescents this writer worked with, described in the introduction. These interactions arose out of an increasing interest in and a study of narrative therapy as an adolescent family therapist and graduate student, and out of a desire to provide an alternative to the regular, behavior-based treatment interventions the writer had learned and grown accustomed to. After a while, these interventions seemed to be based in overwhelming a teen with information and dialogue constructed to blame them for their problems under the guise of “taking responsibility” and “not being in denial”.

This writer observed that those teens that really did seem to benefit from this traditional, blaming-type of treatment intervention were not ones who successfully parroted back traditional treatment euphemisms, but rather were ones who genuinely (largely on their own) developed a stance against their problems, and became willing to take action as opposed to just going along with what their counselors and treatment workers were telling them.

It became apparent to this writer that if narrative interventions could help promote this elusive resistance to problems stance, then he wanted to learn more about it and use it more often with adolescents in treatment. As the writer discussed problems with teens in a narrative fashion (as in the example detailed in the introduction to this paper), and learned more about narrative theory and technique, he became interested in taking these ideas to a group-level as a part of the treatment experience. Thus, the writer developed the four groups in the project and conducted them with adolescents in treatment many times, recognizing their positive remarks and elevated interest during and after those group therapy sessions.

Because of this continued, positive interest and response to narrative on the part of the teens in treatment, this writer became interested in examining this process further, to learn more about why kids like it and to develop a model for teaching others how to conduct effective narrative interventions with teens. So positive had been the kids' reactions to narrative therapy that it seemed possible to systematically demonstrate narrative's effectiveness in terms of treatment satisfaction or other therapeutic reaction measures. In this way, the writer's experiences in therapy with adolescents and his increasing knowledge of narrative theory and intervention interacted to produce this research project.

It is important to know that as a therapist, this writer is much more attuned to utility of practice and intervention than to the exclusive adherence to any model, including narrative. This is in line with recent references in narrative literature on the importance of focusing on what works in narrative therapy, as opposed to perfecting narrative models or preferring narrative over all other

forms of counseling and intervention (Amundson, 2001; Amundson, Webber, & Stewart, 2000). This writer tends to do in therapy whatever is most useful for the particular group or client he is working with at the time, even while being continuously informed by narrative concepts.

In addition to describing for the reader in greater detail the development of the writer's approach to using narrative therapy with adolescents, bracketing was carried out pragmatically with participants during qualitative interviewing. Specifically, this means that as the investigator asking questions about adolescents' experiences with narrative treatment groups, he attempted to not lead participants into particular responses regarding their experience and impressions, but rather let the adolescent respond unimpeded, and not directed other than by the established interview question protocol. This idea is revisited later in the section below.

Interview format and modifications

Qualitative data were obtained in this study by completing twelve participant interviews. The interviews were of a modified, focused, long interview format (see below), and were audio-taped and transcribed for qualitative analysis. Each interview was conducted along the same procedural lines, with some modifications to the established question format during the first few interviews.

Phenomenology of the transcribed data was accomplished through qualitative analysis to discover themes and meanings of themes for the participants who had experienced narrative therapy. For the purpose of this study, the above process was documented and tracked in a journal kept by the primary investigator. This was done to outline for outside observers any changes and adjustments in thinking and procedures regarding qualitative collection, analysis and reporting of data organization and content, lending credibility to the data analysis procedure.

Interview format

McCracken (1988) described a long interview format that is deliberately more efficient, focused and intensive enough to diminish the redundancy of more unstructured qualitative methods. He proposed that the interactive interview format gives the researcher a chance to "step into the mind

of another person, to see and experience the world as they do themselves” (1988). The present investigation sought to create an interview process that was focused, time-limited and effective enough to capture the essence of adolescents’ experience of narrative therapy, while being able to accommodate for short time constraints and limited opportunities available to the investigator for obtaining interviews. The result was a scaled-down long interview that had the following components.

Each taped section of the interview began with a “grand-tour” question, followed by topically-focused “mini-tour” questions. For both grand and mini-tour questions, the investigator asked additional, clarifying questions when necessary to help the participant elaborate upon or be more specific about his or her answers. The grand-tour consisted of asking the participant “What in general has your experience of narrative therapy been like, and what has your response been to having narrative therapy as a part of your treatment here?” The exact wording of this question varied slightly or was paraphrased somewhat differently in each interview, but the main inquiry remained intact across interviews. The investigator made every effort to be non-directive and neutral in interactions with the participants during these interviews, except to solicit further explanation or elaboration of statements or responses.

Focused mini-tour questions followed the opening, grand-tour. These mini-tours asked about responses to each of the experienced narrative therapy treatments specifically, and also asked several, focused questions about the participant’s responses to the treatments in general. These questions asked about any changes in participant’s perceptions and behaviors, and about perceived differences between narrative treatments and other treatment groups they had experienced. The above process lasted about 12 to 15 minutes total, resulting in a shortened yet comprehensive interview protocol for this project.

Modifications

Within the first four qualitative interviews, modifications were made to better capture participant information and streamline the process. In interview number two, the investigator allowed for stopping the audio tape if the participant had a question or “drew a blank” regarding a narrative therapy group in question. If this was necessary during an interview, the investigator would stop long enough to answer the question or remind the participant of the treatment they were having difficulty remembering. This procedure proved to be helpful in two of the interviews. In interview number four, two additional, general questions were added to the list of questions to cover in the subsequent interviews. These questions involved the clients’ perceptions of their problems related to the narrative treatments, and whether or not the treatments would help them deal with problems in the future. This brought the total number of general mini-tours to five. Along with one mini-tour question specific to each of the four narrative therapy treatments, and with the opening, grand-tour question, the total number of targeted questions became ten. As mentioned previously, additional clarifying and interactive questions were implemented along the way, according to the conversational needs of each interview.

Audio-taping procedure

In the audio-taped interview, the investigator and participant discussed perceptions, responses to, and feelings about the narrative therapy experience. Interview questions were added to the list during the initial interviews until a standard set was established as described in the interview format and modifications section later in this paper.

Each interview began with a review with the participant of the narrative therapy process in the study. Prior to tape recording of each participant’s responses, the investigator reviewed each of the narrative therapy treatments the individual participant had taken part in. Each treatment that the individual had experienced was recalled as to content and main points, and any questions the participant may have had were answered. This was done to assist the participant in recalling and

getting back into the mindset of the narrative therapy experience they had. After this short review (3-5 minutes), the investigator began the focused, taped interview.

The recorded participant responses were transcribed for qualitative analysis. See Appendix H for the interview questions used in the qualitative interviews.

Procedures for Treatment

Between spring 2002 and late winter 2003, the project was administered in three phases: the admission phase, the treatment phase, and the discharge phase. Prior to actual administration of the study, staff volunteers for the project were trained in methods specific to narrative therapy. The specific procedures for each phase are detailed below. Some departures in procedure from the original proposal were necessary and are described below.

Departures from the proposal

Some proposed elements of the study were eliminated in the actual administration of the project because of participant and personnel availability, as well as time limitations.

The investigator originally proposed conducting four specific narrative therapy treatments per week in two different day treatment programs (one for primary drug abusers, the other for teens with primary mental health diagnoses) so the two groups of participants could be compared in regard to their responses to narrative therapy. These were five day per week programs. Six different facilitators were to be included in the administration of groups. In regard to personnel, the project lost two, then two more of the original six treatment facilitators. The two that were left were full-time professionals who were able to assist with only two treatments per week each, for a limited period of time. Participant availability also had become a problem as the investigator could no longer rely on consistent numbers of patients in the day treatment program for substance abusers. At the outset of the study, that program was running quite low in patient numbers with no signs of increasing. The day treatment program for mental health remained viable. Additionally, the primary investigator

experienced significant time limitations related to his own work at the hospital, which affected his ability to administrate the proposed protocols for the study.

Because of the above limitations, some changes to the study became necessary. These departures resulted in changing which outpatient programs were utilized, what activities were assigned to the participants, and how the Treatment Satisfaction Questionnaire was administrated. The primary investigator made the adjustments below.

Instead of recruiting participants from the day treatment program for substance abuse, the study utilized participants from the Tuesday-Thursday program for substance abuse, a two-day per week program which had consistent numbers of patients. The study did draw participants from the day treatment program for mental health, but the number of narrative therapy treatments per week was dropped from the originally proposed four, to only two for each outpatient program. This was done to accommodate the inclusion of the Tuesday-Thursday substance abuse program, which only met two days a week. Thus, two narrative therapy treatments per week were conducted in each outpatient program.

Because the investigator's own professional time limits conflicted with the time necessary to administrate the details of the study (e.g., making sure all consents and questionnaires were properly filled out, gift certificates for participation were distributed, and current participants tracked), it became necessary to drop one of the proposed protocols. The investigator chose to eliminate a therapeutic document assignment (see Appendix C), rather than dropping any more group therapy time. This also resulted in reducing the quantity of qualitative responses that needed to be collected and analyzed, since the original purpose of the assignment was to collect additional qualitative data regarding participants' responses to narrative therapy. The investigator determined that this reduction in qualitative data (in this case, the written data from therapeutic documents completed by narrative treatment participants) would not diminish the anticipated salience of qualitative data available from audio-taped interviews.

Some participants who had participated fully in the study were discharged and actually left the hospital premises prior to completing the discharge instrument (the Treatment Satisfaction Questionnaire), either because the discharge happened unexpectedly or because the investigator was unavailable to distribute the questionnaire to them. In order to increase retention of subjects in the study who had completed all of the required instruments, the investigator contacted several participants by phone after they were discharged. This procedure was deemed necessary in order to obtain adequate numbers of completed protocols for the study. The phone interview was used extensively in the testing and development of the Youth Client Satisfaction Questionnaire (Shapiro, Welker & Jacobson, 1997), an instrument described earlier in this paper, from which 14 items in the Treatment Satisfaction Questionnaire were borrowed.

By phone, the investigator obtained responses to the Treatment Satisfaction Questionnaire, and subsequently mailed gift certificates to those participants who had given their responses in this manner. In this way, fewer participants had to be excluded from the study, and more were able to complete all of the protocols and receive their certificates.

Training and treatment administration

When the project was in the planning and proposal phase, six individuals volunteered and agreed to be trained in narrative theory, and in four different narrative therapy treatments. Early on in the process, two of these individuals decided they would be unable to give adequate enough time to both the training process and the administration process of the study. Four of the original volunteers received training in narrative theory and technique, and were slated to facilitate narrative therapy treatments on a rotating basis in both of the described adolescent outpatient programs at Iowa Lutheran Hospital. Specific materials were created by the primary investigator for this training, which covered both theoretical and practical aspects of narrative therapy, as well as detailed instructions for facilitating the narrative treatments (see Appendix E and F). However, two more of

the volunteers were unable to participate because of work obligations. This left the primary investigator and two staff members as the core facilitation team.

Each member of the team, other than the primary investigator, agreed to facilitate each of the narrative therapy treatments twice, for a total of eight treatment sessions. Other than the primary investigator, this process occurred over a four week period for each of the facilitators. In this way, each was able to take a group of outpatients through the four treatments twice. The rest of the narrative therapy treatments over the course of the project were facilitated by the primary investigator.

Human subjects

Prior to conducting the study, it was reviewed and approved by the Iowa State University Institutional Review Board (IRB), and by the hospital IRB where the study was actually conducted. The IRBs concluded that the rights, welfare and confidentiality of participants in the study were adequately protected and that the benefits of any knowledge gained outweighed any risks (see Appendix J).

Phases of treatment

The administration of this project occurred in three distinct phases: admission, treatment, and discharge phases.

Admission phase

When admissions occurred in either outpatient treatment program, patients and family members reviewed and signed a statement of informed consent to participate in the study (see Appendix A). At admission, patients received a packet containing an instruction sheet (Appendix D) and the SASSI instrument, and they were asked to complete it on the first day of their outpatient programming. This initial process was carried out either by each program's treatment staff, or by the primary investigator, depending on who was available at the time. Participants were oriented to the project, and staff or the primary investigator answered any questions the participants had. Also at

admission, the primary investigator randomly assigned patients who agreed to participate in the study to the narrative therapy group or the non-narrative group by flipping a coin.

Minimum goals for participation were met (99 subjects completed all of the required questionnaires and protocol activities). Two participants asked to be excused from the study because they preferred other treatment activities. Another asked to be removed because of not liking the content of the required treatments. Twenty-nine others were removed by the primary investigator because of reasons including: not completing the required materials or activities, dropping out of treatment, or being discharged from treatment prior to completion of protocol activities. Twelve qualitative interviews were obtained as well.

Treatment phase

The treatment phase of the project consisted of the actual administration of narrative therapy treatments, and of obtaining qualitative interviews.

In addition to regularly scheduled outpatient activities, narrative therapy treatments were administered twice a week in each outpatient program to clients randomly assigned to the narrative treatment group. The treatments were administered to participants in the narrative therapy treatment condition sequentially according to number (narrative treatments 1-4), according to the protocols for each treatment described in this paper. In this way, each of the four narrative therapy treatments were completed once in each outpatient program over a two week period. Clients assigned to the non-narrative treatment group did not receive narrative therapy, and participated in normal outpatient programming.

Also during the treatment phase, responses to the narrative therapy interventions and techniques in this study were audio-tape recorded for the purpose of qualitative data analysis. Twelve individual participants were debriefed as to their responses to the narrative therapy treatment sessions.

Discharge phase

At or after discharge, all clients in the study completed the Treatment Satisfaction Questionnaire. Participants who completed the admission and discharge instruments had experienced either the regular course of treatment for each program (the non-narrative group), or if in the narrative treatment group, several examples of group-level narrative therapy (the process and educational groups included in Narrative Therapy treatments 1-4). Participants who appropriately completed both intake and discharge questionnaires were provided a gift certificate worth \$5 at the hospital gift shop. As mentioned previously, several participants gave their answers to the Treatment Satisfaction Questionnaire over the phone because of circumstantially not being able to complete the instrument prior to leaving the hospital on their last day of treatment, either because they had been discharged unexpectedly, or because the primary investigator was unable to get the discharge instrument to them prior to their leaving the hospital.

Narrative therapy treatments

The narrative philosophical basis behind the methods of conducting the narrative therapy treatments in this project is similar to the stance the narrative therapist takes in working with clients individually. It involves viewing clients as possessing valuable perspectives and information that have been previously limited and even hidden by the influential action of various problems and/or oppressive discourses. Because of this oppressive action, teens may not even be aware they possess knowledge and understanding which make them capable agents of informed decision-making with respect to their problems. The facilitator's main task, then, is to reveal through discussion, questioning techniques, and narrative externalization of the problem, what the clients may already know and have experienced, and to help participants see that knowledge and experience from different and new perspectives; categorize that information and those experiences in different ways, and/or attach their knowledge and experiences to new information shared with them by the group facilitator. This narrative, social constructionist approach places the group facilitator in a position of

guide rather than “expert leader,” and validates the experiences, knowledge, and perspectives of group participants who may already view themselves as socially marginalized. This process is in effect, what narrative theorists term “emancipating subjugated knowledges,” especially in terms of exposing to participants the action of the various oppressive discourses and problems examined through the administration of the narrative groups in this project. This process, in turn, promotes a higher degree of therapeutic working alliance between the facilitator and the therapy group participants. Therefore, the narrative therapy treatments in this project were chosen and developed to take the previously individually-based narrative techniques and therapist stances to a group level. They were designed to be effective in emancipating subjugated knowledges through externalization of problems and exposing discourses, and in promoting an associated increase in therapeutic alliance.

The narrative treatments conducted for this study consisted of four treatments, two process-type treatments, and two educational treatments. The process treatments focused on externalizing the problem, while the educational treatments are more informational in nature, and focus on helping participants to make connections between their personal knowledge and experience and the new information presented in the treatment group setting.

The narrative therapy treatments were conducted by counselors and staff employed by the hospital where the outpatient programs were located. Two of these individuals (this includes the writer) are recognized by the State of Iowa as Certified Alcohol and Drug Counselors (CADC), and two are masters-level therapists employed by the hospital (this also includes the writer). All had agreed to participate in the administration of this study, were versed in narrative philosophy and techniques, and were interested in the effectiveness of the narrative approach in addressing adolescent substance abuse and other problems.

Each treatment was identified clearly to the adolescent participants as “narrative therapy.” For the purposes of this paper, the narrative therapy treatments are designated as Narrative Therapy Treatments 1, 2, 3, and 4.

Narrative Therapy Treatment 1

Narrative Therapy Treatment 1 is a process treatment built upon the narrative technique of externalizing the problem, and focuses on externalizing-type references to alcohol in the Alcoholics Anonymous Big Book (AA World Services, 1976). The focal point of this treatment is the Big Book's externalizing reference to alcohol as "cunning, baffling and powerful" (p.58), and defining these terms comprises the greatest part of the discussion. Using a white board and markers, the facilitator encourages participants in a flexible, interactive way to offer meanings for the terms, thereby facilitating a local construction of "cunning, baffling and powerful," using the group's own definitions of these terms as elicited from the members. This process is in effect a group-level adaptation of narrative externalization of the problem.

The treatment begins with the facilitator explaining where the references "cunning, baffling, and powerful" come from; chapter 5 in the AA Big Book (AA World Services, 1976, p.58). At this point the facilitator shares the key purpose of chapter 5, to outline "how it works," that is, how the process of recovery works, how each of the 12-Steps work, and notably, how addiction works. The AA writer's choice of the terms "cunning, baffling and powerful" as descriptors is addressed by the facilitator, and the rationale for this choice becomes more apparent as the group progresses. The facilitator at this time also emphasizes that externalizing alcohol as "cunning, baffling and powerful" is not exclusive to alcohol. Any other particular problem (such as depression, anger, abuse issues, etc.) can be treated this way as well. This necessary aspect of the treatment makes it flexible to accommodate clients with either type of primary diagnosis.

Next, the facilitator writes the word "cunning" on the board, and asks the adolescents to volunteer their own short definitions of the word. Teens may use a dictionary if desired. The facilitator then writes each of these on the board under the word "cunning." This process continues until several (five to ten) definitions are compiled and listed on the board. Definitions sought by the facilitator are ones reflecting the nature and meaning of the word. For example, synonyms for

“cunning” include: sneaky, smart, sly, vicious, covert, fox-like, predatory, etc. The same procedure is followed in turn for the words “baffling” and “powerful.”

Throughout the discussion, it is emphasized that the terms cunning, baffling and powerful are often used to describe living and proactive things, and that together, they reflect a rather malevolent personality. This process is, in effect, active social construction of addiction or other problems as malevolent, intelligent and forceful entities. The problems are externalized effectively as outside, enterprising entities whose personalities exhibit these negative characteristics. This externalizing discussion of drugs of abuse and other problems creates a context in which the group members are able to view chemical abuse and dependency or other problems as agents whose activities can be likened to the efforts and activities of a known enemy, and who influence people by being cunning, baffling and powerful. In addition to recording on the board the group’s responses, the facilitator guides discussion to invite specific, personal examples or vignettes from adolescent members illustrating just how problems have been cunning, baffling or powerful in their life.

Narrative Therapy Treatment 1 ends with a discussion centered on the H.O.W. of recovery (Honesty, Open-mindedness, and Willingness) as a viable way of combating the cunning, baffling, and powerful wiles of substance abuse-related or other problems. This conclusion emphasizes a context of personal agency in resisting problems, as H.O.W. are all individually-based characteristics necessary for success in recovery and change. This context, then, creates in participants an emancipation of subjugated knowledges through socially constructed externalization of problems as “cunning, baffling, and powerful,” because they can see the problems as vulnerable to being opposed.

Narrative Therapy Treatment 2

Narrative Therapy Treatment 2 is also a process treatment built upon the narrative technique of externalizing the problem. It builds on the content of treatment 1, but takes the idea of externalizing problems as malevolent entities a bit further. This is accomplished by having adolescent volunteers in the group play the part of a specific problem or drug of choice in their life, role playing

it as if it had a personality all its own. Volunteers therefore take on the “personality” of their problem, by attempting to think and act like the chosen problem or drug. The group leader facilitates this role play by “interviewing the problem.” This treatment is also suited to address non-drug-related problems such as depression, suicide or anger. Volunteers take on the persona of any particular, disruptive problem in their life, and the treatment continues in the sequence described below.

The treatment begins with the facilitator reviewing the discussion generated in Narrative Therapy Treatment 1, emphasizing the way that addiction and substance abuse appear to be interested in getting at people in a destructive way. The facilitator then invites a group member to play the part of their most influential problem. The facilitator asks the volunteer to imagine that the facilitator is reporter or interviewer of some type, seeking to find out more about the identified problem. The other members are instructed to watch carefully and plan for any questions they might ask that don't get covered in the interview process. The volunteer (playing the part of the problem or drug) is then interviewed by the group facilitator in front of the other group members, answering questions as if he/she is the problem. To provide some homogeneity of procedure in the administration of this treatment, the leader asks questions from a standard question set and guide. These questions were constructed for the purpose of the study (see Appendix G) and represent the most meaningful ones used in this writer's previous experiences with this particular group therapy procedure.

The questions asked have to do with the problem's plans, intentions, feelings, and attitudes towards the volunteer, and the volunteer answers as if he or she is the problem. Other topics discussed may include how long the problem has known the volunteer and what are some of its favorite ways of influencing the volunteer. After five to ten minutes of interviewing (or however long it takes to cover the question set), group members are encouraged to ask questions of and make observations about the problem.

When the interview is over, the group facilitator thanks and excuses the problem and invites comments from the volunteer and group members as to what they gained from the experience of

interviewing the problem. Questions to be asked of the volunteer include: “How did it feel to be your problem?” and, “What was its attitude about you?” Realizations of group members that reflect the seemingly intentional behavior and attitudes of the problem are highlighted and emphasized. If there is time, another interview may be conducted, or the group can conclude with discussion regarding what everyone had learned from the session. The process in this treatment will vary somewhat from episode to episode, dependent on the conversational and processing needs of the therapy group.

Narrative Therapy Treatment 2 gains its emancipating power from personally externalizing the problem in the manner described above. Anecdotally, narrative externalization in a group setting this way has been beneficial to group members in past therapy groups facilitated by this writer. At the very least, members have reported that the process is a useful, alternative way of viewing chemical abuse and dependency and other problems. At times, participants may become angry or otherwise emotional about the realizations they have gained regarding the action of the problem in their life. These emotional reactions can be viewed as emancipation of previously unknown or unrealized feelings/knowledges about the problem in question.

Narrative Therapy Treatment 3

Narrative therapy treatment 3 is more of an interactive, didactic intervention compared to the process focus of the previous two treatments. The narrative focus here comes from emphasizing and highlighting societal discourses that encourage chemical abuse and dependency.

The discourse of acceptable substance misuse is addressed in Narrative therapy treatment 3. In this group the facilitator outlines and describes, with the help of the group members and a whiteboard, the various levels of influence that substance use/misuse enjoys in society. This is done by illustrating an individual’s embeddedness in multiple layers of influence as part of the social structure of society. Developmental sociologist Talcott Parsons described the process of individual socialization and family development as occurring specifically within a multi-layered context of

societal levels (Parsons, et al., 1955). Individuals and families are seen as influencing each other and being influenced by an inter-related set of social levels, ranging from the family, to the community, to the culture, and so on. Narrative therapy treatment 3 utilizes this Parsonian description of the individual's membership in these various societal levels to accomplish the discovery and exposure of the oppressive discourse of acceptable use and abuse of drugs and alcohol in our society today.

The treatment begins with the following introduction, designed to introduce adolescents to the existence of the harmful discourse of acceptable substance misuse. The facilitator states the following: *“Substance abuse and addiction enjoy a rather influential place in our society and world today. Tobacco kills thousands per year in the US alone – yet remains legal. The same is true for alcohol but is worse, because innocent people die in drunk-driving accidents daily (not to mention the individual and family lives it destroys every year). Illegal drug abuse is glorified in popular songs and movies with little mention of the lives it destroys. Tobacco and alcohol are legal to use, and illegal drug use is often seen as “normal” or “a phase” that everyone goes through. So, despite bringing many apparently negative consequences, substance abuse and addiction remain strong and influential at many levels of society. Today we will look at the way drugs and addiction affect each of these levels. We will do this in order to help you decide for yourselves if all this is fair or not.”*

The treatment continues as the facilitator uses the white board to graphically draw out the individual in Parsonian context with increasingly wider levels of influence. These levels include individual, family, community, city, state, country, and world, with increasingly wider, concentric circles representing the various levels. Next, the facilitator points out each level and at each level questions are asked of the group regarding the presence or influence of substance use/abuse at that level, and regarding the apparent effects the substance use/abuse has on individuals or groups of individuals at each level. Specific effects elicited from group members or given by the facilitator are listed on the board at each level.

Starting at the individual level, the facilitator elicits from the group members obvious effects of substance abuse and addiction, and then individual-level effects including: personal and family problems caused by substance abuse, health problems, legal problems, social environment problems and any other individual level consequences adolescents can relate to.

On the family level, effects include: communication problems, marital problems, isolating from family members, various forms of abuse, money problems, unhealthy family dynamics common in chemically affected families, and poor family relationships.

The next level may require more probing questioning techniques on the part of the group facilitator, as adolescents may not have as much awareness of wider effects of addiction and substance abuse. Community-level and city-level effects include death and injury caused to others by drunk driving by organized crime and crimes involved with drug trafficking, by gang activity and subsequent increases in violent crime, as well as littering. Community-level health effects are introduced, such as overdoses, hepatitis and AIDS infection, increases in STD transmission, and higher rates of teenage sexual activity and pregnancy among drug and alcohol abusers.

The next higher level of abstraction is the country/national level. The effects at this level are similar to the previous level, only participants see that they have a wider scope and are more pervasive. This is also the point at which the facilitator shares key national data regarding drug and alcohol use and subsequent effects. These data include: national trends in substance abuse, such as rates of teens using alcohol or other drugs, estimates of the annual costs to productivity and health care caused by drug and alcohol abuse, and the widespread effects of substance abuse and addiction.

Also at the national level the facilitator discusses the influence of the media on adolescents' perceptions of substance and alcohol use. Participants are encouraged to give examples of drug and alcohol references in the popular media, such as in music, music videos, movies and advertising. The facilitator at this time introduces information about the stories behind the recent tobacco settlements; why they occurred and how tobacco litigation was tied to unfair and influential advertising practices

in the media by tobacco companies in order to keep their customer base viable by advertising to youth. Here also the facilitator guides discussion to include examples of alcohol advertising in the media, and the youthful marketing and misleading messages put forth by the alcohol industry as well.

The main point of this section of the group is to emphasize the widespread effects of substance abuse. Also emphasized is the fact that almost never is the “dark side” of substance abuse accurately portrayed in the popular media, and that often times this lack of truthfulness on the part of big business is tied to selling more records, cigarettes, or alcohol.

The last level discussed in this group is the international/world level. The facilitator encourages participants to consider the effects that drug abuse has on issues such as: the Drug War, illegal drug trafficking, poor/underdeveloped countries, and their people, feeding the habits of the industrial powers of the world, national and international corruption and economics. An important factor of this section of the group is the information shared with the participants regarding the international perspective and issues surrounding drug abuse. This information includes the role of U.S. tobacco companies marketing cigarettes to third world countries, which leads to inevitable health consequences for the people living in those countries; and the disparity between monies provided by the federal government to combat the international trafficking of drugs vs. funding for treatment programs. The participants are then asked how their personal substance use/abuse ties in to the larger picture. This emphasizes that substance abuse and addiction remain strong as long as they are not treated. All the money in the world can be spent to fight drug importers, but as long as there remains a demand (because not enough people get treatment and prevention services), efforts at keeping drugs out of the country will be futile.

To conclude Narrative Therapy Treatment 3, the facilitator invites observations and discussion from adolescents regarding how they feel about the information presented. At this time the facilitator asks questions such as: “Is this whole process fair? If addiction and substance abuse

cause such widespread problems, why is it allowed to continue?” Participants are then encouraged to explain their impressions or ask further questions about the content of the group.

To restate the purpose of Narrative Therapy Treatment 3, the point of the treatment is to expose the true consequences of the societal discourse of accepted and acceptable substance misuse, since the most noticeable effects of this discourse are negative ones; such as the health costs of tobacco use, the injustice of injury and death caused to others by drunk drivers, kids being placed in treatment, various types of individual and family dysfunction resulting from substance abuse, and world-wide problems caused by drugs. These negative effects are highlighted and discussed in the treatment, with an overall emphasis that focuses on the pervasiveness of substance use/abuse and addiction at varying levels of complexity in society. By giving a globalized perspective of the influence of “the problem,” this group exposes the societal discourse of acceptable substance misuse and its resulting effects, so participants can recognize that they have a choice regarding whether or not they use drugs or alcohol, and that these are accompanying consequences to using that exceed what they had imagined.

Narrative Therapy Treatment 4

Like treatment 3, Narrative Therapy Treatment 4 is an interactive, didactic intervention. This treatment addresses the oppressive societal discourse of adolescents-as-problems. The narrative focus in this treatment is the group-level exposure of this unfair discourse to adolescent participants. This is accomplished by educating teens on the myriad negative effects substance abuse and other problems have on the complex process of adolescent development, by introducing and discussing the concept of “arrested development” in the treatment, and by connecting the way arrested development can contribute to the oppressive discourse of adolescents-as-problems.

The facilitator begins by discussing the concept of human development, to focus the group on the phenomenon and to lead into various aspects of adolescent development. The facilitator opens with the following statement: *“Today we will discuss human development and what it means for you*

as kids growing up in the world today. Most simply, development means to change and grow. If no positive changing and growing is occurring, no development is occurring. Many of the problems that have brought you to the hospital have the nasty habit of causing your development to slow down or stop completely. There are actually five areas of your development that can be affected by the problems in your life, no matter what they are. These problems could be addiction, drug abuse, anger, thoughts of suicide, depression or family problems, etc . . . Any of them can cause your development to be slowed down or stopped – arrested. This arrested development can cause you some real problems that you might not have thought about, and this is why we are doing this group today. I want you to know how this arrested development messes up the way you deal with important people in your life, and the way they deal with you.”

After the opening statement, both the group members and facilitator provide input to define the five specific areas of adolescent development impacted by substance abuse and other problems: social, intellectual, identity, spiritual and physical development. To define these areas in the treatment, the facilitator writes each of the five areas on a whiteboard, leaving ample space beneath each term to write down offered definitions. The facilitator then asks the participants to give definitions of each, giving personal examples or information until each area of development is fully defined. Each of the five areas of human development are defined including the information for each area detailed below.

The area of social development focuses on a person’s interaction with peers, significant adults, and authority figures. Healthy peer relationships are highlighted and discussed, such as relationships based on friendship and mutuality rather than on sex or drug-dealing. Emphasis is placed on the ways adolescents negotiate relationships with adults and authority figures such as parents, teachers, coaches and bosses when problems (such as drug abuse, depression, oppositionalism, anger, etc. . .) exist in teens’ lives. Troubled kids will often spend time and energy avoiding significant adult interaction. This avoidance occurs so the adolescent can hide what is going

on, or because of isolating behavior and withdrawal from family and adult interaction. Since the process of social development is one characterized by both successful and unsuccessful episodes of interaction, or trial and error, the fewer episodes a teen has in their “experience base” to which they can refer, the less development occurs, resulting in a failure to mature. This is an example of arrested social development.

The area of intellectual development for adolescents primarily includes school and academics. This section of the group highlights the ways that adolescent problems affect their schooling and their ability to retain new information. Teens easily identify with learning difficulties related to substance abuse, and almost all recognize the effect skipping classes has on learning: one can't learn if one isn't there. The concept of state-dependent learning is introduced, citing studies that have found that the brain best recalls information when it is in the same state as when the information was encoded (Keleman, & Creely, 2003). In other words, if learning occurs when an individual is under the influence of a substance, they must be in the same state in order to recall that information later. Since one can't be high “24-7” (even kids admit this) it is logical that the more time one spends under the influence of substances, the less intellectual development that occurs. Behavioral and emotional problems are finally highlighted as being problematic to intellectual development, as well, and participants are encouraged to give examples of any of these problems highlighted to connect the information to their personal experiences.

Identity development is a multifaceted process that involves how the adolescent views him/herself and how they are viewed by others. Teens in the substance abusing subculture are exposed to others who are at best manipulative and dishonest. At worst, they hang around almost exclusively with others who are anti-authority, anti-social and inherently selfish. Adolescent identity development is powerfully associated with the groups to which they belong. In essence, adolescents become like those they are associating with. Kids who have been in the drug-using subculture readily admit that it is a “use or be used “ environment where they personally, or others they know, have been

hurt, cheated or abused in some way. The emphasis in this section, therefore, lies in pointing out that given enough time, one's identity can be shaped significantly by the limited interactions available in the social groups to which one belongs. If the only group an adolescent belongs to or associates with is a negative and destructive one (whether substance-abusing or not), they can expect to believe that this is what and how they themselves are, or are destined to become. When these concepts are explained this way, many teens will admit this is not what or how they want to be; that they do not want their developing into a mature, likable individual arrested in this way. Again, participants are encouraged to give personal examples of how their own identity development has been affected by problems in their lives.

Physical development is one area that adolescents are generally aware of. The obvious problems caused by substance abuse and addiction, such as lung and heart disease, liver disease and memory impairment are highlighted. Studies are cited that have found that chronic marijuana abuse leads to a multiple physical and cognitive deficits in pot smokers, and how these effects have serious implications for adult functioning (Ashton, 2001; Ehrenreich, Rinn, Kunert, Moeller, Poser, Schilling, Gigerenzer, & Hoehe, 1999). Also discussed at this point are general effects of using substances on fitness, coordination, and athletic achievement. Consequences of other behavioral problems that include decreasing activity levels or discontinuing involvement in sports or other activities are discussed as well. The group members themselves provide many of the examples in this section, and generally can admit to their development being arrested in this area.

Finally, spiritual development is highlighted in the treatment by addressing the degree to which participants feel connected to God or the concept of a Higher Power. Many teens in treatment will relate that as they have developed more and more problems in their lives, they discontinued practicing their spirituality, stopped going to church or praying, habits they many times had earlier in their lives. The spiritual component of the AA 12 Step program is outlined again, and emphasis is placed on how unlikely it is for one to seek spiritual things if one is consistently involved with the

selfish pursuits of drug abuse or other problems. Given that spirituality is promoted in the 12 Step program as a way to overcome deficits in character and behavior, this concept is presented to adolescents as one that does not have to remain arrested.

After detailing the five areas of adolescent development, participants are introduced to the oppressive discourse of adolescents-as-problems, by asking the group the following questions: “What are the teen years supposed to be like? Are they good or bad? Calm or chaotic? Easy or hard?” Upon receiving input that typifies the common understanding of teenage years being turbulent and stressful, the facilitator exposes this discourse by proposing an alternative view. This view consists of seeing adolescence as a time of definite change, but not one that is necessarily stormy and stressful. The main point is to emphasize that because adolescence is a time of such dramatic change, it is often over characterized by adults as a time of unavoidable frustration, stress and conflict. This understanding sets the stage for the next phase of the treatment.

The group facilitator now asks participants to review examples of how their development in each of the previously discussed areas has been arrested. The facilitator encourages each person to comment on as many of the areas of development as possible, giving examples of how their development, personally, has been arrested. As group members list and give examples of the ways their areas of development have been affected, the facilitator begins to connect this information to the existence of the oppressive discourse which affects adolescents.

This connection is accomplished by emphasizing that if teens participate in the arresting of their own development by using drugs and alcohol, having behavior problems, avoiding adult interaction, etc ., they may be inadvertently supporting the discourse of teens-as-problems. As teens share how their problems have brought them into conflict with adults, they provide the examples of how they unknowingly supported the popular view of adolescents as troublemakers. The treatment then is successful at exposing not only how adolescents may have affected their personal development, but also how they have contributed to the oppressive discourse of teens as problems.

The facilitator finishes the treatment by stating *“Growing up is hard enough without adding a bunch of problems to your life. You guys have the power to prove people wrong or right about you – that teens are troublemakers, or that teens are kids just learning how to grow up.”*

CHAPTER 4. FINDINGS: DATA ANALYSIS AND RESULTS

Analysis in this project included quantitative analysis of questionnaires completed by all participants, and qualitative analysis of data collected through audiotape interviews with participants in narrative therapy groups. Several statistical procedures were employed in the quantitative analysis in this study, and specific qualitative procedures were followed as well.

Quantitative Analysis

The quantitative aspects of this project consisted of ANOVA and multiple-regression analyses of the influence of adolescent patients' group-level factors (receiving narrative therapy or not; chemically dependent or not), demographic factors, and substance use severity factors on their responses to narrative therapy interventions. The outcome or dependent variables consisted of adolescent responses to the Treatment Satisfaction Questionnaire, the scale constructed for the purposes of this study, which assessed treatment satisfaction and therapeutic alliance.

Quantitative examination of the data began with appropriate recodes of reverse-order items on the Treatment Satisfaction Questionnaire (TSQ). Factor analysis was conducted for all scales of the TSQ, and selected scales of the Substance Abuse Subtle Screening Inventory (SASSI). Further statistical analysis included correlations, ANOVA, and multiple regression.

Factor analysis

Examination for significant factors in subscales of the SASSI and TSQ involved principal axis factoring with varimax rotation. Factor analysis was conducted on SASSI subscales face value alcohol (FVA, items related to alcohol use severity) and face value other Drugs (FVOD, items related to other drug use severity). Though used as a predictor variable in this study, this writer did not conduct factor analysis on the SASSI subscale OAT (obvious attributes of chemical dependency) because this subscale was already developed by the authors through discriminant function analysis (Miller, 2001), and was comprised of true-false items in the instrument.

Factor analysis was also conducted on Treatment Satisfaction Questionnaire subscales SAT (treatment satisfaction items), TASK (therapeutic alliance items related to tasks of therapy), and GOAL (therapeutic alliance items related to goals of therapy).

Criterion for including items identified in the factor analyses to be aggregated and summed for the purpose of creating factor-related variables included: items having a substantial factor loading on a particular factor greater than .40, and not on any other factors concurrently. The minimum number of items needed to meet these criterion in order to create a factor-related variable was three.

Analysis of the FVA scale indicated two significant item groupings which were aggregated and named according to the content of the items, for use as variables in subsequent analyses of the questionnaire data. The variable TOTFVA1 emerged as a factor related to heavy alcohol use and the individual and social consequences of that use. The items summed to create this variable were: FVA 1, 4, 5, 6, and 8. TOTFVA2 emerged as a factor related to internal motivation to drink alcohol, and individual consequences of drinking. The items summed to create this variable were: FVA 2, 3, 9, 10, and 11. Both of these factors were used in the present analysis as variables measuring alcohol use severity. See Table 4.1 for factor analytic results for subscale FVA.

Table 4.1: Rotated factor matrix of SASSI-A2, Subscale FVA

| Items | Factor | | |
|-------|--------|------|-------|
| | 1 | 2 | 3 |
| FVA1 | .683 | .346 | .203 |
| FVA2 | .390 | .543 | .302 |
| FVA3 | .214 | .661 | .221 |
| FVA4 | .624 | .265 | .366 |
| FVA5 | .718 | .303 | .363 |
| FVA6 | .770 | .179 | .002 |
| FVA7 | .467 | .477 | .478 |
| FVA8 | .839 | .232 | .077 |
| FVA9 | .257 | .759 | .158 |
| FVA10 | .278 | .850 | -.068 |
| FVA11 | .204 | .728 | .391 |
| FVA12 | .100 | .118 | .609 |

FVA: Face Value Alcohol

Analysis of the FVOD scale indicated one clear factor, TOTFVOD1. This factor was used as a variable for a global measure of drug involvement, including individual and social motivations and behaviors associated with drug use. All but two of the items of the FVOD subscale were summed to create this variable. See Table 4.2 for factor analytic results for subscale FVOD.

Table 4.2: Rotated Factor Matrix of Substance Abuse SASSI–A2, Subscale FVOD

| Items | Factor | |
|--------|--------|------|
| | 1 | 2 |
| FVOD1 | .780 | .271 |
| FVOD2 | .948 | .144 |
| FVOD3 | .470 | .624 |
| FVOD4 | .606 | .413 |
| FVOD5 | .789 | .375 |
| FVOD6 | .800 | .399 |
| FVOD7 | .623 | .300 |
| FVOD8 | .818 | .345 |
| FVOD9 | .111 | .796 |
| FVOD10 | .861 | .328 |
| FVOD11 | .799 | .285 |
| FVOD12 | .643 | .489 |
| FVOD13 | .580 | .431 |
| FVOD14 | .669 | .333 |
| FVOD15 | .800 | .352 |
| FVOD16 | .852 | .205 |

FVOD: Face Value Other Drugs

The SAT subscale factor analysis indicated two clear factors. TOTSAT1 was a factor used as a variable to measure satisfaction in terms of client satisfaction with counselors. The items summed to create this variable were: TSQ 1, 2, 3, 4, 5, and 6. TOTSAT2 became a variable that measured general client satisfaction and perception of personal change. The items summed to create this variable were TSQ 9, 10, 11, 13, and 14. See Table 4.3 for factor analytic results for subscale SAT.

Table 4.3. Rotated factor matrix of treatment satisfaction questionnaire, subscale SAT*

| Items | Factor | | |
|-------|--------|-------|------|
| | 1 | 2 | 3 |
| TSQ1 | .750 | .112 | .248 |
| TSQ2 | .692 | .237 | .183 |
| TSQ3 | .589 | .247 | .087 |
| TSQ4 | .433 | -.010 | .377 |
| TSQ5 | .603 | .238 | .181 |
| TSQ6 | .617 | .151 | .121 |
| TSQ7 | .214 | .242 | .672 |
| TSQ8 | .307 | .380 | .431 |
| TSQ9 | .065 | .704 | .421 |
| TSQ10 | .191 | .605 | .039 |
| TSQ11 | .397 | .461 | .348 |
| TSQ12 | .192 | .347 | .411 |
| TSQ13 | .119 | .668 | .165 |
| TSQ14 | .365 | .584 | .173 |

TSQ: Treatment Satisfaction Questionnaire

* items 1-14

Factor analysis of the TASK subscale indicated two factors. TOTTASK1 became a variable measuring therapeutic alliance in terms of client agreement with the responsibilities and tasks of therapy. The items summed to create this variable were: TSQ 15, 19, 21, 22, 23, and 26.

TOTTASK2 became a variable measuring therapeutic alliance in terms of clients' comfort level with task-related staff interactions. The items summed to create this variable were: TSQ 18, 24, and 25.

See Table 4.4 for factor analytic results for subscale TASK.

Table 4.4: Rotated factor matrix of treatment satisfaction questionnaire, subscale TASK*

| Items | Factor | | |
|-------|--------|-------|-------|
| | 1 | 2 | 3 |
| TSQ15 | .667 | .250 | .072 |
| TSQ16 | .597 | -.106 | .399 |
| TSQ17 | .101 | .415 | .307 |
| TSQ18 | .113 | .677 | .459 |
| TSQ19 | .686 | .063 | .026 |
| TSQ20 | .132 | .340 | .834 |
| TSQ21 | .677 | .200 | .137 |
| TSQ22 | .700 | .111 | -.012 |
| TSQ23 | .804 | .187 | .078 |
| TSQ24 | .241 | .685 | .030 |
| TSQ25 | .112 | .651 | .074 |
| TSQ26 | .659 | .262 | .245 |

TSQ: Treatment satisfaction questionnaire

* items 15-26

Analysis of the GOAL subscale measuring therapeutic alliance revealed one clear factor which was named TOTGOAL1, to measure client perception of collaborating with counselors on setting goals for therapy. The items summed to create this variable were: TSQ 28, 32, 33, 34, 36, and 37. See Table 4.5 for factor analytic results for subscale GOAL.

Table 4.5. Rotated factor matrix of treatment satisfaction questionnaire, subscale GOAL*

| Items | Factor | | |
|-------|--------|-------|-------|
| | 1 | 2 | 3 |
| TSQ27 | -.047 | -.011 | .799 |
| TSQ28 | .651 | .236 | .019 |
| TSQ29 | .053 | .816 | .025 |
| TSQ30 | .316 | .422 | -.027 |
| TSQ31 | .231 | .728 | .169 |
| TSQ32 | .636 | .135 | .089 |
| TSQ33 | .553 | .131 | .004 |
| TSQ34 | .670 | .183 | .053 |
| TSQ35 | .251 | .383 | .128 |
| TSQ36 | .754 | .152 | -.027 |
| TSQ37 | .695 | .195 | .277 |
| TSQ38 | .217 | .307 | .510 |

TSQ: Treatment Satisfaction Questionnaire

* Items 27-38

In sum, factor analysis of the five subscales yielded eight variables which were factors specific to the group of participants in this study. Three of the variables measured alcohol and drug abuse severity, two measured treatment satisfaction, and three measured therapeutic alliance. The treatment satisfaction and therapeutic alliance variables were used as the outcome variables in the study.

Correlations

Bivariate correlations were conducted between all variables to detect significant relationships. Gender was coded 1 = male, 2 = female. Legal status was coded 1 = no legal involvement, 2 = legal involvement. Diagnosis was coded 1 = not involved with substances, 2 = substance abuser or chemically dependent. Group type was coded 1 = non-narrative treatment, 2 = narrative treatment. See Table 4.6 for the correlation matrix of the predictor and outcome variables in the present study.

Table 4.6. Correlation matrix

| | | | | | | | | | | | | | | | | | |
|----------|-------|--------|-------|--------|-------|--------|--------|--------|--------|--------|--------|---------|--------|--------|--------|-------|--|
| GROUPTYP | 1.000 | | | | | | | | | | | | | | | | |
| AGE | .015 | 1.000 | | | | | | | | | | | | | | | |
| GENDER | .235* | -.125 | 1.000 | | | | | | | | | | | | | | |
| CURUSE | -.108 | .297** | .070 | 1.000 | | | | | | | | | | | | | |
| ONSET | .154 | .542** | .193 | .067 | 1.000 | | | | | | | | | | | | |
| LEGAL | -.176 | .227* | -.131 | .090 | .177 | 1.000 | | | | | | | | | | | |
| SASOAT | .074 | .167 | -.005 | .181 | .114 | .417** | 1.000 | | | | | | | | | | |
| TOTSAT1 | .176 | -.046 | -.065 | -.138 | .239* | -.145 | -.135 | 1.000 | | | | | | | | | |
| TOTSAT2 | .015 | -.011 | .037 | -.094 | .110 | -.125 | -.010 | .492** | 1.000 | | | | | | | | |
| TOTGOAL1 | .122 | -.107 | .082 | -.179 | .099 | -.175 | .048 | .570** | .618** | 1.000 | | | | | | | |
| TOTTASK1 | .027 | .033 | .077 | -.100 | .138 | -.189 | .015 | .577** | .594* | .817** | 1.000 | | | | | | |
| TOTTASK2 | -.012 | -.108 | .129 | -.164 | .197 | -.135 | -.036 | .499** | .368** | .503** | .403** | 1.000 | | | | | |
| TOTFVA1 | -.058 | .310** | .006 | .404** | -.209 | .235* | .274** | -.224* | -.130 | -.180 | -.093 | -.298** | 1.000 | | | | |
| TOTFVA2 | .082 | .013 | .093 | .067 | -.098 | .230* | .325** | -.121 | -.068 | .010 | -.047 | -.180 | .608** | 1.000 | | | |
| TOTFVOD1 | -.091 | .366** | -.106 | .446** | -.213 | .388** | .311** | -.178 | .091 | -.166 | -.087 | .270** | .781** | .473** | 1.000 | | |
| DIAGNOSR | -.153 | .390** | .028 | .513** | .042 | .416** | .338** | -.235* | -.149 | -.184 | -.089 | -.175 | .729** | .436** | .685** | 1.000 | |

| GROUPTYP | AGE | GENDER | CURUSE | ONSET | LEGAL | SASOAT | TOTSAT1 | TOTSAT2 | TOTGOAL1 | TOTTASK1 | TOTTASK2 | TOTFVA1 | TOTFVA2 | TOTFVOD1 | DIAGNOSR |
|----------|-----|--------|--------|-------|-------|--------|---------|---------|----------|----------|----------|---------|---------|----------|----------|
|----------|-----|--------|--------|-------|-------|--------|---------|---------|----------|----------|----------|---------|---------|----------|----------|

GROUPTYP: whether participant has had narrative therapy or not; no=1, 2=yes
 AGE: chronological age
 GENDER: gender of participant
 CURUSE: current frequency of substance abuse
 ONSET: age of first use of substances
 LEGAL: whether legally involved or not; no=1, 2=yes
 SASOAT: obvious attributes of chem. dep. as measured by OAT subscale of SASSI
 TOTSAT1: General treatment satisfaction/satisfaction with staff

TOTSAT2: Satisfaction with personal change
 TOTGOAL1: Goal-related therapeutic alliance
 TOTTASK1: Task-related therapeutic alliance
 TOTTASK2: Therapeutic alliance as comfort level with staff
 TOTFVA1: Factor 1 SASSI subscale Face Value Alcohol
 TOTFVA2: Factor 2 SASSI subscale Face Value Alcohol
 TOTFVOD: Factor of SASSI subscale Face Value Other Drugs
 DIAGNOSR: Whether participant is diagnosed substance involved or not; no=1, yes=2

* correlation is significant at the .05 level (2-tailed).
 ** correlation is significant at the .01 level (2-tailed).

MANOVA

The first hypothesis stated that adolescents in behavioral health treatment who receive narrative therapy interventions would be more satisfied with their treatment than those who do not receive narrative therapy interventions. The second hypothesis stated that adolescents who receive narrative interventions would demonstrate higher levels of therapeutic alliance than those who do not receive narrative therapy interventions.

The variables of satisfaction with treatment (TOTSAT1, TOTSAT2) and the levels of therapeutic alliance variables (TOTGOAL1, TOTTASK1, TOTTASK2) were determined to be highly intercorrelated (see table 4.6). Because of this finding, one multivariate analysis of variance (MANOVA) was run for the entire sample, with group type (having experienced narrative therapy or not) as the independent variable and the correlated satisfaction and therapeutic alliance measures as the outcome variables to test the two hypotheses. The MANOVA showed no significant multivariate results for group type (having experienced narrative therapy or not): Wilks' Lambda = .927, $F(5, 83) = 1.311$, $p < .267$. Given this non-significant MANOVA result, no follow-up univariate ANOVA analyses were performed.

The third hypothesis in this study was that of the teens that receive narrative therapy ($n = 49$), participants who are primarily substance abusers would be more satisfied with their treatment than those who are not substance abusers. A one-way MANOVA examining the correlated dependent variables (TOTSAT1, TOTSAT2, TOTGOAL1, TOTTASK1, TOTTASK2) by the categorical independent variable for diagnosis (involved with substance abuse or not) was conducted to evaluate this hypothesis. The MANOVA yielded no significant multivariate results: Wilks' Lambda = .950, $F(5, 39) = .407$, $p < .841$.

Regression

Multiple regression models were constructed and run for the outcome variables in the project, using the following predictor variables: age, gender, onset of substance abuse, and substance abuse

severity. Separate analyses were carried out for the entire study sample, and for the group having experienced narrative therapy.

Regression results

Of the regression models run for the outcome variables in the entire study sample, one was significant. In this model, the outcome variable TOTSAT1 was regressed on the predictor variables age, onset, and gender: $F(3, 68) = 2.787, p < .047$. The b associated with gender was $-1.258, t(68) = -1.986, p < .051$. There was a negative relationship between gender and treatment satisfaction as measured by TOTSAT1. The mean TOTSAT1 score for males was 19.86. The mean TOTSAT1 score for females was 19.52. The b associated with onset was $.470, t(68) = 2.267, p < .027$. As age of substance abuse onset went up, treatment satisfaction went up. The b for age ($-.142$) was not significant. R square for this model was $.109$.

Of the regression models run for the outcome variables in the group having experienced narrative therapy, one was significant. The outcome variable TOTTASK1 was regressed on the predictor variables age, gender, onset and SASOAT $F(4, 28) = 3.058, p < .033$. The b for SASOAT was $1.484, t(28) = 2.866, p < .008$. For participants in the narrative therapy treatment, there was a positive relationship between substance abuse severity as measured by SASOAT and therapeutic alliance as measured by TOTTASK1. R square for this model was $.304$.

Qualitative Analysis

From a qualitative perspective, the present study sought to construct an examination of the experience of adolescents when exposed to the narrative therapy processes of externalization and uncovering oppressive discourses. Specific attention was given to how narrative therapy aids in mobilizing resistance against common adolescent problems, including the problems of chemical abuse and dependency. Client realizations, perceived resistance to problems, and overall response to narrative therapy were assessed through the qualitative research tradition of phenomenology.

Phenomenology, as reviewed by Creswell (1998), seeks to discover an “essential structure”, or essence of experience, that defines and highlights the meanings ascribed to experiences. It is one of the major traditions of qualitative research. This perspective meshes well with narrative philosophy, which also emphasizes the importance of meaning in the lives of people. The phenomenological aspect of this study was comprised of the qualitative analysis of debriefing interviews with adolescent participants in narrative therapy groups. The qualitative data took the form of audio-taped responses in the debriefing interviews.

The audio-taped responses were transcribed and analyzed for content and emerging themes, leading eventually to a full description of the subjective experience of clients exposed to narrative therapy treatments. The goal of creating this description was to create transferability of the narrative interventions in this project, in the form of a narrative group therapy model, to similar situations for use by clinicians in various adolescent substance abuse and mental health treatment settings. This transferability will be accomplished through promoting greater understanding of the essential nature of adolescent client experience of narrative therapy. This phenomenology comprised a significant part of the study.

Data analysis methodology

Data analysis in qualitative research is an ongoing activity that occurs throughout the investigative process; it is inductive and recursive, modified and changed according to the themes emerging from the data (Moon, et al., 1990; Stainback & Stainback, 1984). The units of analysis in qualitative research are words, which are examined in the context of audio-tape transcripts, field notes of the researcher, and other documents. The goal of qualitative data analysis is to create a basis for understanding the phenomenon of interest through careful and extensive categorization of the data into manageable groups, domains, and units of meaning. This process must be done in a clearly definable manner, to promote credibility and to give the reader a concrete way to interpret the data and conclusions of the researcher.

Qualitative data analysis in this study is adapted from the work of Tesch (1987) and Moustakas (1994). The goal behind this type of analysis involves creating a way for scholars to deal with a large amount of vague data. It seeks to distill qualitative text into its important essentials, rather than only reducing its volume (Tesch, 1987). This process is accomplished by reading and re-reading the data, noting, coding and categorizing statements into definable units or groups, and then examining the groupings for meaning and content. Tesch (1987) explains that all this must be done methodically, in a systematic and goal-oriented manner, leading to a result that others can accept as representative of the data. Moustakas (1994) advocates for a similar process of data reduction and organization which he terms “horizontalization”. Data reduced to groups or units of similar meaning are described texturally and structurally as to what actually took place and how it was experienced. These descriptions can include verbatim examples from the data (Moustakas, 1994).

After all the data are placed in finalized categories, an in-depth, more conclusive analysis can take place. This includes detailed description and discussion on the content of each category, each category having become an emerging theme or domain of meaning related to the research question; in the case of the study outlined in this paper, phenomenological information about how adolescents respond to group-level narrative therapy interventions. These themes were then be emphasized and highlighted as emerging knowledge of the essence of adolescent clients’ experience of narrative therapy interventions in the clinical setting.

The above-described qualitative procedures are designed to provide in-depth, essential knowledge of adolescent clients’ experiences of narrative therapy. This in-depth knowledge will promote ready transferability of any new understanding of narrative therapy to similar clinical situations.

Qualitative data analysis procedure

Analysis of the qualitative data in this study began with a data reduction process that involved initial review of the data, preliminary coding of the transcribed data, and refining and finalizing a

coding scheme. After coding all of the transcribed data, the investigator used these codes to classify and group statements and responses in the interviews for further qualitative analysis and theme development.

Qualitative investigators recommend getting an overall sense of the data (Creswell, 1997; Tesch, 1990). In order to do this, the investigator began initial review of the data by listening to the audio-taped interviews and reading through the first five transcribed interviews. During the listening and read-through process, the investigator used a journal process to write down one-word or short phrases reflecting notable thematic areas or commonalities in the data. The investigator used a marker to highlight important or interesting comments in the data, and continued to record words and phrases related to the marked passages. This process resulted in a preliminary coding scheme to direct further analysis.

The preliminary coding scheme at this point in the analysis contained many items describing the data. The investigator wrote down twenty-nine words or phrases reflecting comments and responses highlighted in the transcribed qualitative interviews (see Appendix I). These words and phrases captured emerging themes and topics present in the data, providing a basis for a more refined coding system to assist in analysis of the rest of the data.

The investigator refined the preliminary coding system by examining it for commonalities among the recorded statements and phrases, and then by distilling the original twenty-nine items down to nine distinct categories of statements. Four additional categories, one for each specific narrative therapy group were added as well, for a total of 13 specific categories (see Appendix I).

After establishing a refined coding system, the investigator began a second read-through and actual coding of the data. The rest of the transcribed data was read and highlighted at this time. As additional segments of the data were highlighted, the investigator collapsed three related codes in the refined coding scheme into one called "appeal". The included codes were "like", "help" and "size". The investigator made this decision to create a category that better reflected the contextual

happenstance of participant statements fitting these included codes. “Appeal” made a better fit for the data in the collapsed codes according to its appearance in the interviews. Occasionally, during the creation of the final coding scheme, and afterwards during the writing and theme-development process, statements that had been coded one way were coded differently to more accurately reflect their content. This aided the theme-development process as more comments of similar content were grouped together for analysis.

This process created a final coding scheme which contained seven general codes, plus four codes specific to the narrative therapy groups (see Appendix I). Preliminary and finalized coding efforts, stemming from read-through and highlighting of the data, resulted in categorization of most of the participants’ statements in the transcribed interviews. Qualitative analysis continued as the investigator grouped code-specific statements into separate documents to be analyzed for further theme development. In this process, statements and responses of the same code-type in the qualitative interviews were copied and pasted into new documents from the original transcriptions, using a word processor program.

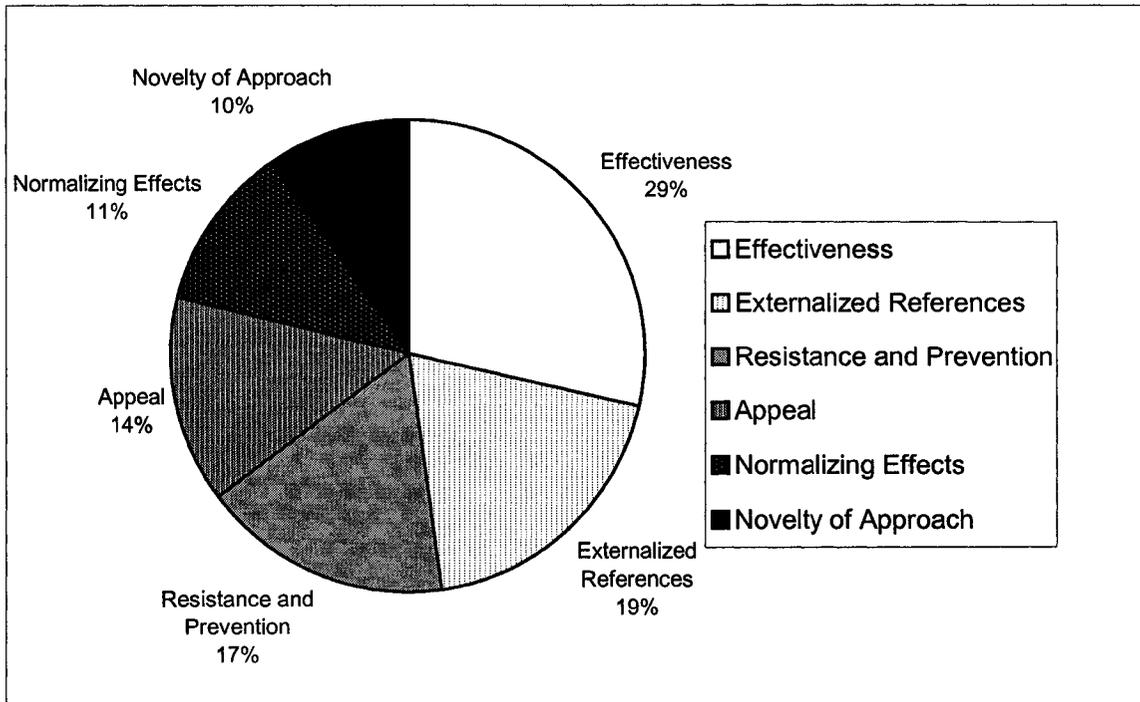
A final adjustment to the coding scheme occurred during writing and theme-development. A qualitative grouping of statements that had been coded as “global” was eliminated from the final coding scheme. The investigator decided to eliminate this group because it was nearly identical in content to another qualitative grouping which was constructed to categorize comments related to one specific narrative therapy group intervention (the ‘circles’ group). All but five short statements in the “global” qualitative grouping were also categorized into the circles grouping, therefore the investigator deemed it appropriate eliminate one of the groupings, and to describe the content of both collections of statements when discussing specific reactions to the narrative group intervention “circles”. Thus, ten separate, code-specific documents were created for further examination.

Phenomenology

The qualitative, phenomenological focus of this study sought to establish and elaborate upon the “essence” of the adolescent experience of narrative therapy. This focus on essence is primary in all phenomenological studies (Moustakas, 1994). Six of the above mentioned, code-specific documents are representative of six distinct themes of reactions, perceptions and meanings that participants experienced as a result of their involvement in narrative therapy. These were the general code groups, and are considered in this study to be steps toward the essence of what adolescents experience in narrative therapy treatments. The investigator also aggregated comments specific to each narrative therapy group, to provide essential information about participants’ responses to these interventions. These four treatment-specific documents provided the basis for expanding upon what it meant for adolescents to be a part of each of the narrative treatments, and provided evidence for the utility of replicating these types of groups in other treatment settings with teens.

Following generally accepted practices for describing and expanding upon phenomenological information (Moustakas, 1994; Polkinghorne, 1989; Creswell, 1998), this discussion will provide a textural description (what exactly was experienced) and a structural description (how it was experienced) by adolescent participants in narrative therapy. Thus, what follows are six textural descriptions of themes of adolescent responses to group-level narrative therapy interventions, and a textural description corresponding to each of the four narrative therapy treatments. In addition to each textural description is a structural description constructed from participant comments and reactions in regard to each area of interest, to provide meaningful information as to how each category was experienced by participants. The six specific qualitative data themes are components of the essential experience of narrative group therapy as related by adolescents in this study. See Figure 1 for a graphical representation of the percentages of comments related to each thematic area.

Figure 1. Distribution of themes in comments made regarding narrative therapy



Themes of adolescent experiences of narrative therapy treatments

Appeal

Narrative therapy groups in this study produced a sense of positive appeal for participants. Participants liked and enjoyed narrative therapy, felt they were being helped, and found the smaller group size useful. Statements reflecting the experience of appeal represented 14% of the total, categorized statements in the qualitative data (not including statements and quotes which were categorized in regard to the four, specific narrative group interventions, because some duplication of statements necessarily occurred). The structure of how participants experienced this notion is detailed below.

Liking the groups and finding them enjoyable was reflected most simply by statements to this effect:

- “so I thought that was really good, and I enjoyed it.”

- “Yeah, I enjoyed it.”
- “Yeah. And I liked it. Everything was good in it.”
- “I found it very informative and enjoyable.”
- “But it was different, and I'd never done that before, and I liked it.”
- “Actually I really liked that group”
- “Yeah, I like that, because it really did make the biggest effect on me.”
- “They're good groups. I liked them. If I hadn't had known any of that stuff I think they probably would have been pretty good groups.”
- “I enjoyed participating; they kind of give you a different look on life”
- “Um, if I could do it over again I would do it over again, that's how much I liked it.”
- “I enjoyed these groups a lot. It was really helpful.”

Participants also felt helped by these groups. Some examples of teens feeling like the narrative group experience helped in some way include quotes reflecting the general ability of the narrative mode to be effective for those who experience it:

- “I think they'll help people.”
- “So this group has been more helpful than other groups.... You know more about other people and yourself.”
- “That was really helpful, because you got to see how, like, that person, that was being the feeling, how they interpret it, how their feelings were being, and it was really interesting to see other people's point of view, and then to help them and that person.”
- “It kind of helps you with reality, saying that these different problems can cause, why these different problems can cause what you do.”
- “I think they're helpful, It makes you realize all of the stuff you wouldn't have realized when you're using. . . “

Other statements reflected more personal, individually-based impressions and feelings about the relative ability of narrative-type groups to help a person sort out problems, reflect on emotions, recognize problems, cope, express feelings and obtain a positive, rather than negative outlook:

- “I think it's helped my treatment. “
- “I think that, well, it helped me to kind of figure out where some of my problems, like, came from.“
- “...it just helped me to think about a lot of things that I had stuffed, and that I should have talked about and that I should still talk about.”
- “Well, it helped me to think more about the problem, and think of it in a different way, and I really liked it, because you kind of think outside the box, and you're not just thinking about everyday problems, you're thinking about problems like relaxation, and you know, abuse, and things like that. That really helps me with figuring out why I'm feeling this way, you know, what emotions I'm feeling and things like that.”
- “I really do think that these groups will help me think about my problems more, and help me talk to people more and not just stuff it in until I use drugs, or get angry, or use bad coping skills. It will help me reach out, talk to people about it more, um, I can look at it with more of a positive outlook, there was a negative outlook from before. So I believe that these groups will help me.”
- “Talking about them, getting them out in open air, has really kind of helped me, like an extra weight is taken off. I feel like I'm getting lighter, lighter with the problems.”

One girl felt particularly positive about having been helped in the groups. She had developed an increased sense of understanding and awareness about her problems, and summed it up by saying, “I wanted to thank you, though, because you really helped me with these groups, to come up with these things, and to ah, help me understand more you know, why my dad's and alcoholic, and you know his problems and issues and things like that, and I just want to say thank you.”

Size of the groups was important to participants in the study. Most of the narrative groups were relatively small, having from three to six individuals participating at any given time. The group size was not a result of planned downsizing compared to the common size of other adolescent groups (usually more than six), but rather was a result of participant availability. Usually half or less of the teens available at any given time ended up being selected for narrative therapy, hence the smaller

groups. Though narrative therapy groups in this study were not purposefully smaller in size, participants found that they appreciated this aspect of their narrative experience:

- “Um, I don't think, I mean, if I would have been in the big group, I wouldn't have had enough time to focus on what was really, sort of, my drug problem, and what y'know, how I got so deep in that sort of stuff ...”
- “I like it. And it's not a big group, it's a little group, and as long as there's a little group you get more chance to talk, and express yourself, and that's what helps.”
- “Especially the other kids my age and not a whole bunch of them--you know, one on one assistance is what I like the most, because I can understand things a lot more, and I can express things more easily.”
- “Yeah. I like it because it was a lot smaller, and like, me personally, I get really uncomfortable when there's a large group of people, and I don't talk about my issues then, it's just, you know, I like it better when there's three or four people, but when I go upstairs, into that big group, I kind of shut down. And, um, I'm trying to work on that.”
- “Being a small group, it was easier to talk to start with, like, if you don't want to talk in a small group's easier.”
- “Now that I've noticed that other people do have these problems, just within a small group of kids, that maybe I could talk to some other people.”

Participant statements reveal that an essential experience of narrative therapy for adolescents is one of positive appeal. Participants experienced this by liking the groups, feeling that they had been helped, and appreciating the smaller size of the groups.

Novel experience

Participants in narrative therapy groups found the experience a novel one. The structural elements of this essential experience included adolescents noticing that narrative therapy is different (seeing things from a different angle; a new way to look at problems), finding narrative therapy as interesting, fun and better than other therapy experiences they had participated in. Ten percent of the comments in the qualitative data were categorized as reflecting the experience of narrative therapy being novel.

Several comments reflected the experience of these groups being unique and different than previous or current experiences of therapy. Teens seemed to appreciate this difference:

- “And um, with this group, it's just like, it's different.”
- “The outlook is different, like here, it's a more positive outlook.”
- “Probably different ways, I don't know. I've done a lot of groups, like you said, but, um, I don't know, I think you just did them in different ways, you know, they weren't like all the same from what I've done before.”
- “Um, my experience in the narrative groups are that they are different ways of looking at problems.”
- “Um, like, being able to come to group and seeing what the next group's going to be different, or how we're going to look at the same problem from a different angle. Or, shed different light on it.”
- “Oh. Yeah, just that these groups are a little more detailed, in how it affects, er, just different ways to look at it like I'm supposed to be....”
- “And I learned that, it's just, I mean it's not like just black and white, but there's a lot of gray area and different shade of what I think, be it whether all kinds of angles, or you look at it from one angle and it looks different. But it was different, and I'd never done that before, and I liked it.”
- “And cause, I thought it was different...I really thought it was unique and different.”

For some, this experience of being in a different kind of therapy led to increased realizations about the problem or issue they were working on. These realizations seemed to make an impression on the participants and promote clarity about their problem:

- “Well, it helped me to think more about the problem, and think of it in a different way.”
- “like when I looked at it from a different point of view. It just, I don't know, it just kind of made me realize that I do have a problem with anger.”
- “Probably when I played anger and stuff, that like gave me a whole different view of like, how anger works, inside somebody.”
- “Um, they have opened my mind up to new ways to think of my problem, to look at that.”
- “I enjoyed participating; they kind of give you a different look on life, a different perspective, and you learn different issues that you never really knew about.”

Some kids experienced interest and intrigue during their participation in narrative groups.

Examples of how they experienced this included:

- “Because there's...it kind of like stood out the most, like, was the most interesting, to like, you just keep moving up, it just showed me like what one person could like actually do if they're using.”
- “For me the groups were very interesting, with me being in placement, I've learned how they look at things and how people like not in placement but in treatment look at things, but basically the ending point was the same thing. I just learned it two different ways.”
- “Like, being the problem was weird. Like I never saw, like, anger, like, as like a thing that was in your life, like a thing that you're powerless over.”

Beyond perceiving the narrative groups as interesting, some participants also thought they were fun:

- “They were fun!”
- “Um, I think, I've had these kind of groups but I think you just put them in different, you know, you used different techniques with them, it made them more fun, you know. Uh, like funner to learn different things. I've never seen like the one, like interviewing your anger or whatever, I've never seen anyone do that kind of group so I thought that was neat. But, I just think that it was neat how you did different techniques, and it makes it more fun, I guess.”

Some participants compared their narrative experience to past counseling and evaluated it as an improvement over what they had experienced in therapy previously or currently:

- “I'd say these groups were better, because they pinpointed on kids more than adults. And adults can use them as well, but it kind of helped me understand...”
- “Because it's a lot better than most of the stuff we do.”

Participants' reflections of narrative therapy as a novel experience were all positive in nature. These responses ranged from seeing narrative therapy as enabling them to view problems from a different angle than what they had already been presented with, to promoting a brand-new realization of the nature of their problems. Some even stated these group experiences were substantively better than other therapy groups they had participated in. Adolescents saw narrative therapy being a different, interesting, fun and better group experience. The novelty of the narrative experience for them stood out to them in positive ways.

Effectiveness

Another essential experience of narrative therapy for participants was one of noticing various aspects of the approach as being effective. Twenty-nine percent of the comments were categorized as describing an experience of effectiveness. The structure of this sense of effectiveness included feeling that the approach explained things well, and showed or revealed problems and issues effectively, at an in-depth level. Participants also reported eye-opening realizations that led to changed minds and being inspired to make more effort at working on problems. These various impressions of effectiveness led some to state they thought that the groups should be done more often, in other areas of the hospital.

Ways that participants experienced narrative therapy as in-depth and instructive included:

- “Instead of six or seven questions each, you ask, you know, 20 or 30 questions each, you know, it's a lot more in depth, and you, I mean, you just search through your problems and what's been going on a lot more.”
- “Yeah, this one, actually, um, where when something was said, it stuck in my head, you know, and it didn't just come in one ear and blow out the other.”
- “You learn more about other people and yourself.”
- “I feel that they're good to show other kids that are struggling with problems and aren't willing to come forward, because then they have a better understanding of what's happened to them or if other kids come up with better ideas, they say, yeah, and remember that for next time.”
- “And I think that's a good way, because I came in not knowing the words very well, so it was, learn new words, and good definitions for the words, and it also helped show that with my depression that it was what it was, and I could recognize the identity.”
- “I found this group more informative.”
- “but it kind of helped me understand...you know, a good teacher, or someone that could explain things really well.”
- “I mean, I've heard it before, but we went into a lot of detail, and that, like drug wars and more stuff, it made more sense.”
- “Oh. Yeah, just that these groups are a little more detailed, in how it affects, er, just different ways to look at it like I'm supposed to be...”

- “Yeah, every time we talked about it in groups it showed you how you would have more problems, like if you start drinking or something.”
- “I learned from them, I guess.
- “Like, how I view cunning, baffling, and powerful, like the definitions of it. Like, I learned more, like, to give examples, like, and we compared them to, like, cunning is like a fox, and stuff like that. I learned from that.”
- “I can like relate it to my life, which helps put it in a better, it gives me a better understanding of what's going on, and it teaches me like, or helps review it, like, I can better handle that situation or that problem.”
- “it was easy to understand and stuff like that.”
- “and you learn different issues that you never really knew about.”
- “Cause I've learned, like, y'know, it's more of an issue than what it seems to be. now with my depression issue, I can take what I have learned with these groups, and look at them, do the H.O.W resolution, honesty, openness, and willingness.”
- “I liked it because it was easier to understand, and it gives me some ideas to work on.”
- “Yeah, I paid a lot more attention, and the diagrams really helped, because I am a visual type person, and I could see it very easily, and that I could understand that, actually, instead of like someone lecturing me on it, when you can have someone who can put a diagram out, and put solutions and what the problem is and everything else [on it].”

The instructive experience of the narrative groups promoted increased reflection upon

problems by participants:

- “Um, I got a good look at both the good and the bad about it, and it made me think more about it.”
- “Um, It just made me think more about, um, things that went on, like with my family, that have upset me, like, um, you know, like our relationship and not doing things together and stuff like that, a lot of times I just blew it off and didn't really think about it, but really, yeah, I just stuffed those feelings in and I'd be upset about it but I would just say, yeah, it's no big deal. That kind of...I was thinking about those things.”
- “Mm-Hmm. Um, kind of makes me think... I need to get my anger--well, I've got my anger under control, but there're still things that I get angry about that I blow out of proportion.”
- “Um. I think that group...well, it helped me a lot to think about how the drugs, um, like drugs, and like my disrespect and stuff I had for my family, how that took over a lot, um, my emotional and especially my physical...I had a lot of physical problems after I started using drugs.”

- “Um, It's got my thoughts. I mean, I was thinking about it, and I think my thoughts have changed, because I'd like to go and now show my best friends the cunning, powerful and baffling one.”
- “But like, open minded is kind of an issue with me, so, you know, being able to go down the list and just think about it, and things like that, just helped me out a lot with my issues.”
- “Um, they have opened my mind up to new ways to think of my problem, to look at that.
- Yeah. Because when I'm using, or if I ever do use again, I'll be like, wait a minute, I'll start thinking stuff.”

Participants came away from these groups feeling like they had been taught something that was clearly articulated and easy to understand. They appreciated the details given by the narrative groups, and that ideas and concepts had been shown to them effectively. They found themselves thinking more about their problems as well.

Participants also experienced ideas, realizations, and epiphanies as a result of participating in narrative groups. Some changed their minds about their problems, and felt inspired as a result of these new understandings:

- “And I think kind of, it helps you realize what um, what...what the drugs had done to you.”
- “Because it was like an eye-opener, it was like, 'wow, this is really, this is something like my depression”
- “And it made me understand, kind of, myself a little bit better.”
- “Yeah, I would go so far as to say a big impact on me.”
- “I was really, like, wow, this is really what's happening. If felt like an eye-opener.”
- “Well, I have depression, too, and it was like, seeing it. It was like, 'Oh my gosh, I can relate to that! I can really, really, relate to that!”
- “So it helped me realize that, damn, you know, I'm like becoming...I lost my morals because of it, you know, it helped me realize that. So it helped me realize where are you standing, like, with all of your, like, mental development and physical development, and it helped me realize stuff like that.”

- “So I thought that was really, really, like you said, wow, an eye opener. You wouldn't think something like that until you heard it from that thing. From that thing's point of view.”
- “It was just like, a big shock. I really didn't think you know, before you do the interview, you don't think, 'wow, this thing has bigger plans for me,' but after you hear its point of view, you're just like, oh my God, you know, you know, it was that creepy.”

These dramatic impressions for participants were accompanied by changes in thinking,

awareness, behaviors, and plans for approaching problems in the future:

- “And, It's changed my thoughts on that totally, because at first, you know, I thought, well, maybe I should try it just once to see if I like it, and I won't do it ever again. But then I realize that you can get addicted the first time, and . . . “
- “Well, it changed my basic outlook on things, because, like, I used to think that a lot of things were just, I mean, I was the only person that was causing them, and nothing was helping the problem, it was just all my fault.”
- “How does it affect how I see my problems? Well, like I said, it makes you realize that your problem is really bigger than you thought. Like I never thought I had a problem until I actually sat down and thought about and talked about it.”
- “Well, it kind of helps me pinpoint the actual problem, you know, if you were abused or something, or even just little things like your brother's irritating you, you can go through the cunning, baffling, and powerful list, and decide you know, where it's coming from, what you're feeling, and things like that.”
- “Because looking at how someone could talk about it as being a problem, sit there, as they're the problem, and the relief that they had made me just want to maybe just sit down and say something about mine and maybe help me. It was kind of just inspirational to me.”
- “It kind of made me realize, like, you know, why would people want to do this? I mean, to now, just to say, it's like I wouldn't want to do drugs because look at what they can do.”
- “Yeah. I think that when I first came in here that um, I'll be out of here, and I had no problem, and everything else. But now, I see that I had a really big problem area and I could fix it.”

One participant described the realization promoting change process in more personal detail as

follows:

- Yeah, like before this group, I just came into this group, and I was just going to go through the motions, and as soon as I got out of this group I was going to start drinking again, or you know, smoking weed again, and get off probation, whatever, and like, I

was going to quit taking anger pills, you know, and then I would become psychotic and stuff, and with this group I realized that, without all that, I'm a much better person, I have more opportunities, and now through soberness, you know, sobriety or whatever you want to call it, I'm a better person. And that's what this group has helped me understand.

Another said:

- Um, it kind of changed my behavior towards life, or like my attitude towards life, cause before I came in here, it was like, you know, life sucks, nothing that is really good. But going through these groups has kind of helped me realize that, you know, that life, like, you've got to face it as it is, or otherwise, you know, you're not going to be able to get through it. Yeah, a reality check.

One even felt he would be able to apply these ideas to a possible future career in the helping professions:

- Yes, and, you know, when I grow older, I kind of want to be a therapist myself, so you know, I can relate back to this, when I am studying my career, and I can use this myself. You know, if I become a therapist, and, you know, I think that the kids that are out there that are in therapy should know that whole H.O.W. thing, because it's really helping them out and nobody else.

The narrative therapy experience for participants was effective in several distinct ways. They felt like they had been instructed in an in-depth and memorable way, and the notions and ideas they were taught were impressive and eye-opening. These impressions led to changed thoughts and minds about problems, and some felt inspired and encouraged because of what they had learned.

Normalizing effects

Another essential participant experience of narrative therapy was one of normalization of problems. Statements reflecting normalizing effects comprised 11% of categorized statements. The structure of this process was reflected in comments which described problems being made less confusing and demystified for participants. Other responses reflected an experience of being less personally targeted in the narrative groups, becoming more open, and feeling less alone with problems.

Participants described how their problems became more understandable to them, and less mysterious than before:

- “It also helped show that with my depression that it was what it was, and I could recognize the identity.”
- “That one helped me understand that not all problems are you know, really easy to work out, and that with that group I understood that, you know, a lot of feelings and emotions are in your problems, and it's not just because someone, you know, touched you that you're mad, or that someone hit you. It's that you felt hurt, and that you felt sad. It's things like that.”
- “because most kids think they're in treatment because they're in trouble and they have to, and their parents think they're messed up, and that's what I thought, at first. I thought that I was in huge trouble with my behaving and that's why I went to therapy. But, you know, I learned that it's not, it's just so I can get better and have a better future, and if I go to therapy you know, I can become a better person, but if I didn't get help, I'd probably be living on the streets, you know?”
- “the problem will get lighter and not so hard to deal with, and you don't have to use a negative way to deal with it, and everybody has something in their life that's cunning, baffling, or powerful.”
- “Yeah, I think so. Like, in a group setting like that, like they [problems] didn't, they seem like, I don't know, not more real, do you know what I mean? Something I can deal with, I guess.”

Another apparent aspect of the normalizing experience for participants was one of feeling less targeted or threatened by the group process. This experience appeared to promote increased openness to the group as a result. Comments reflecting feeling less personally confronted and experiencing increased openness included:

- “it wasn't necessarily about yourself and your problems, it was more of a broad theme, and I enjoyed that, because things weren't focused on one person, constantly. You are just a kid, general, about the problem.”
- “It's not all about me.”
- “Um, the way that placements had used it, they would approach one of our issues, and make us talk about it, before they would start to agree about it, whereas here, you guys just talked it up, and it happened to be an issue that everyone had in the room, so everyone was relating here, there it was singly, and it felt better here, because you didn't have to feel like you were the only one that had those issues.”
- “The outlook is different, like here [the hospital], it's a more positive outlook, and it has to do with a more common issue, and there [residential treatment] it was like, the worst outlook you could have on it, um, one of your own issues, not a common issue to teenagers.”

- “Like, when I am in a group, and we talk about a problem like that, like not specifically talking about my problem, but they’re talking about the problem, and I can like relate it to my life, which helps put it in a better, it gives me a better understanding of what’s going on, and it teaches me like, or helps review it, like, I can better handle that situation or that problem.”

Participants also noticed that they were less alone in their problems, that others had problems as well, and that it is normal to experience difficulty of one kind or another:

- “Before, I didn’t think that anybody else had the same problem as me, and I couldn’t talk about it because nobody else could help me. Now I’ve noticed that other people do have these problems.”
- “And then people were saying, I mean, ‘wow, that’s a lot of like, where I’m at, that’s how I act.’ ”
- “I mean, the people in here, really, like, hearing their problems, it helps, because like, some of their problems are similar to mine, and I know how to deal with some of them better than they do, so, and they know how to deal with some of my problems better than I do.”
- “so seeing that, knowing that I’m not the only one that has the problem, like with everyone doing alcohol, I’m not the only one with that kind of problem, because I know other people have alcohol problems.”
- “They were about your issues, but they kind of like involve the whole entire, more everyone’s issue.”
- “It categories our problems so that we don’t think that we’re not normal. Like, if you don’t know what they’re coming from, or how other people see them, and sometimes I kind of think, wow, that’s not normal, but seeing that my problems fall under a category means other people have them, too.”
- “Yeah, because sometimes problems can be confusing, and then you see other people have your same problems, and they have better ways of dealing with them and it doesn’t seem so confusing anymore. Because you’ve found a way to help you with your problems. The people in the group are really supportive of you.”
- “Yeah, you’re not the only one.”

As participants in narrative groups, teens understood their problems better than before, and felt like the process was less personally focused than in other group experiences. This helped some to feel more open to the process and able to talk more about their problems. Another aspect of the normalizing experience that helped participants to be more open was the experience of recognizing

that others have problems, too. Comments reflected experiences of feeling less “not normal” and more encouraged to be finding some common ground from which to approach problems.

Externalized references

A notable category of essential participant experience in narrative therapy groups involved group members’ references to problems in an externalized fashion. These references made up 19% of the qualitative statements. The structure of these responses reflected well this basic component of narrative therapy, that clients can experience their problems as more outside of themselves, external, as a result of participating in narrative therapy interventions. Some comments reflected the experience of consequently becoming better aware of the significance and effectiveness of their problems:

- “Um, you get to take a look at where the problem is coming from, you leave yourself out of it, and you focus on where the problem started, how big the problem's getting, what the problem's doing to your life, and what it planned on doing”
- “You wouldn't think something like that until you heard it from that thing. From that thing's point of view.”
- “Because I could see how it had worked into my life, how depression came in without [my] really realizing it, and what it has done to me.”
- “And then you got to talk to the feeling [problem], and that really helped because you got to see what that feeling was thinking and how that person interpreted it.”
- “I meant, like, um, you have to stand up for, like, well, if you were depression, what would you want in life? What do you want to get out of the people you affect?”
- “Well, because it kind of made me think about what the problem's actually thinking and how it worked a little bit.”
- “It kind of helps you with reality, saying that these different problems can cause, why these different problems can cause what you do.”
- “Well, my anger is unexpected. Somehow I blow up on little things, when I shouldn't, and I don't know how it gets me, I seriously don't, and I'm working on it right now.”
- “And somehow I was thinking to myself that, 'man, this is not another thing to blow off, you got to really work on it,' because it's very strong and you don't know it. And it has a lot of plans, so....”

Several comments identified problems as intentional agents, capable of planning and thinking about how to influence or attack a person:

- “Umm, I did anger. It helped me see that, like, it planned on having me erupt. Like if I keep it bottled in for a while, then it will erupt and take off and ...even though it don't really deserve to.”
- “Cause I really think anger's an asshole. Because when I interviewed anger, and I finally heard what it had to say on its own, without me being involved in it, it shows you that it basically moves on to the weaker ones, it doesn't give a damn about you, it just is trying to come out and ruin more of you.”
- “It [depression] was, it was just, it had me all trapped up in my own thoughts and I was being so self-centered, that I wasn't looking out to what I needed to do, be with my family and friends. I just became a person locked away in her own room.”
- “...I was manipulated.”
- “mood swings, which were trying to get to me, and I learned that mood swings, what it was trying to do to me. . . because I know that if I get moody, then, you know, that's, mood swings, that's what he wants. He wants to see stuff like that.”
- “Actually I really liked that group, because, ah, I don't know, it made me think how my drug is pretty much a sly type of person and how, you know, like all the stuff it tries to, er, tries to get me to do, and just thinking about it as a person kind of bugged me. And I liked it, I thought it was a good group, kind of creepy.”
- “It showed me, that, well, what happens is that it made me look at it from anger's point of view, like what it does to me, what it makes me do.”
- “I learned, and other things that, like, things that anger uses, like tools, like it'll have other emotions or other things that might offend me, or depression, or something like help it, so, or like, work with it, to really get me down. It's like, I have to remember that. It does help me.”
- “Yeah. Um, it's kind of like it wants to do what it wants to do. It wants me to hurt myself, it'll let me hurt myself. Which my body knows that it's wrong, but on the surface it's like, whatever, just let her do. It kind of like has a hold of my body.”

Participants described the experience of recognizing problems better, and viewing them as intentional, able entities that can indeed affect them if left unchecked or unrecognized. For some, this experience was as extensive as naming or identifying their problem, personifying it as “an asshole” or a “sly type of person” that is to be watched or countered in some way. Seeing problems in this externalized way prompted participants to view their problems as an opponent. These realizations set

the stage for the last identified area of essential participant experience of narrative therapy – resistance and prevention.

Resistance and prevention

For participants, viewing problems in an externalized way led to a posture of resistance and prevention. Statements reflecting the experience of resistance and prevention comprised 17% of the qualitative comments. The structure of this experience included an increased sense of general resistance to problems, and an awareness of subjective ability to diffuse specific problems or to prevent them from acting. General resistance comments and reactions included:

- “...I'm gonna change so I'm back where I used to be.”
- “It really just helped me to know how they worked, and I could use my coping skills to get back at them [problems].”
- “Yeah, because I don't let another person do anything like that to me. Just thinking of it like that, I don't know.”
- “The only person who has control of my life is me, not my emotions, or mood swings, or other people. I mean, that's not right.”
- “That's how I deal with my problems, was those things, and then we did, then you could think about, well, I don't always have to deal with the problems that way, because there are other people that have those problems, that don't use drugs, alcohol, or anger as a way...”
- “But they're talking about the problem, and I can like relate it to my life, which helps put it in a better, it gives me a better understanding of what's going on, and it teaches me like, or helps review it, like, I can better handle that situation or that problem.”
- “And it gives me some ideas to work on. And how I can work on them, like if I am by myself and I need to calm down I can use some of those solutions.”
- “and I know that its powerful, that its so strong, and I can't control it, but then if I try to stop it, then I can control it.”
- “Uh, I'd see that I need to control them, and I need to work really hard, and I just gotta use my coping skills, and I just got to talk to an adult about it.”
- “It kind of, when you snap back into it, you know, talking to yourself, you say, ok, I know what's going to happen now, and I can prevent it.”

General resistance to problems became more specified for some participants. They were able to identify their particular problem and envision specific ways to resist it or prevent it from acting:

- “Well, I learned that I, you know, have control over, you know, mood swings, which were trying to get to me, and I learned that mood swings, what it was trying to do to me. And, I look at it now, and I try not to get so moody and stuff, because I know that if I get moody, then, you know, that's, mood swings, that's what he wants. I'm trying a lot harder so mood swing doesn't get to me”
- “Well, now that I know it plans on doing that, I can, you know, go to my room, if I feel I'm about ready to erupt, 'cause I know what's going to happen. So I can take my anger and put it into something else, instead of into a person that didn't deserve it. So, it's kind of helped me realize what was going to happen, so I don't have to, like, go through what it planned on me doing.”
- “It made me realize my addiction might cause more problems, and if I stopped, then other people would treat me differently.”
- “Just, like, if I want more to drink, I'll just remember these groups and just realize how much problems I could have when I start doing it, like whenever I do, in the future.”
- “Um, I think, with the anger part of it, it just, like, when I start to get anger, I remember that group, . . . I think back . . . I think back to that group, and, like, what I learned”
- “Yeah, like not viewing anger as part of me, like, anger isn't part of me, it's an emotion. It's not me, who I am. I don't have to be angry; I have control over it.”
- “With these groups I can take the information that I have learned, and it's like if I'm at home with my brother, I can explain to him why I don't care for what he does. Cause I've learned, like, y'know, it's more of an issue than what it seems to be.”
- “Well, I learned about how I can control my anger and my depression, and I learned that it doesn't deal with mental, it deals with the whole body. And somehow we can stop it ourselves before it can turn into a big deal. And it just, you know, gave me the idea that I need to work really really hard on controlling my issues.”

One participant's realizations in this regard were particularly personal. Her sense of urgency in dealing with her anger came through clearly:

- “But now, I see that I had a really big problem area and I could fix it, and so I have to work ten times harder, since this is my second time in here, but I know that the first time I was in here, I blew it off. But now I really need to gain my control of my anger and my depression before it goes way too far and I do something that I do not want to do.”

She also was able to think beyond the immediate need for controlling her anger to avoid making any more serious mistakes; she thought further ahead to her potential life as a mother and co-worker:

- When I get older, I am going to want a family, and I know that I've been abused by my father, but you know, Yeah, I might have the same thing going on, and I'm afraid I am going to hit my child, and I don't want that to happen, so I am going to try, and try , and try really hard not to do that. Even at my job, when people irritate me, I'm going to ignore it, calm down, and like, think about it, instead of reacting really fast, and then in a wrong way.

Participant reactions to the externalization process of narrative therapy included developing a general attitude of resistance to problems. Participants also found that their particular problem was externalized in such a way as to promote action on their part to resist the problem or its effects. Some of these reactions were quite personal in nature, with implications for current and future life circumstances.

Reactions to specific narrative therapy treatments

In addition to the essential themes of participant experiences in narrative therapy, the investigator gathered qualitative data related to each particular narrative treatment. During the interview process, participants were asked about each treatment specifically, and they gave comments related to each treatment intervention. In the following sections, participant responses to each narrative treatment will be discussed in terms of salient information in addition to data identified in previous sections of this paper. Adolescents related in their interviews reactions to the treatments specifically that stood out from the rest of the qualitative data previously discussed. The reactions should be considered separately from the essential themes to illustrate the focused impact of each narrative treatment. These specific reactions will be examined below.

Narrative therapy treatment 1, "Cunning, baffling and powerful"

Additional participant reactions to the Cunning, Baffling and Powerful treatment focused on the similarity and interrelatedness of problems in being hard to deal with, and the usefulness of the

Honesty, Open mindedness and Willingness (H.O.W.) solutions for dealing with problems. Here we will review the participant experience of realizing many problems are alike, and the experience of learning a structured solution to dealing with identified problems.

Comments that reflected the experience of recognizing that problems are similar and interrelated included:

- “Um, that group showed a lot of how different problems, not just alcohol, can be 'cunning, baffling, and powerful'. And I think that's a good way . . . and it also helped show that with my depression that it was what it was, and I could recognize the identity.”
- “Because I'm just . . . I just enjoyed that one a lot. It was just my favorite one because I like looking at that problem like it was suicide, depression, whatever, it showed how every problem kind of interrelated by being 'cunning, baffling, and powerful' .”
- “Well, it kind of helps me pinpoint the actual problem, you know, if you were abused or something, or even just little things like your brother's irritating you, you can go through the cunning, baffling, and powerful list, and decide you know, where it's coming from.”
- “. . . the cunning, baffling, and powerful one, it really helped me because I realized that a lot of problems are cunning, baffling, and powerful . . .”
- “Um, All three of those things. I related to my situations, not just my depression, but adoption, abuse, and a lot more . . .”
- “Um, there were a lot [more] of things that [it] kind of goes to, than just drugs, in my mind, I thought of other problems that I have there too, that are cunning, baffling, and powerful.”
- “and how like I used to think of cunning, baffling, and powerful like just alcohol-related, like about drugs, because I was like in AA, and like how it fits like other problems, or involved in that. . . .”
- “Well, it's just not alcohol. It's for every problem. If you look at anger, depression, family problems, everything else. And I was surprised by that. Geez, I mean, I didn't even know cunning, baffling, and powerful at all, so . . .”

Group participants experienced the cunning, baffling and powerful characterization as applicable to a wide variety of problems, and reported that this was an effective way to look at their problems in an understanding way. This treatment appeared to promote for members a better awareness of the nature of problems as challenging and similar in effect.

Participants also found that the H.O.W. solution offered in the treatment to be a memorable and effective solution to dealing with problems. These comments included:

- “And so now, when I think of something, like, alcohol being cunning, I can think of this talk, to prevent it, I'm going to use honesty to prevent the cunning part. And I am just going to go through the cunning baffling and powerful and use H.O.W.”
- “The how is a good one. I never thought, I always think, 'how could I fix problems?' and what am I to do to make problems better, and the 'H.O.W.' was just a good way of looking at what you need to do to make it better.”
- “Then you gave, ...us how to fix it, and what you need to do by being honest, open, and willing, so I thought that was really good, and I enjoyed it.”
- “I kind of liked the 'H.O.W.' on that, because, um, cause, I mean, I've always been honest, and I don't like lying and stuff, so that's never been a problem with me. But like, open minded is kind of an issue with me, so, you know, being able to go down the list and just think about it, and things like that, just helped me out a lot with my issues.”
- “I think that the kids that are out there that are in therapy should know that whole H.O.W. thing, because, it's really helping them out and nobody else . . . “
- “I learned that the easiest way to deal with it is the H.O.W., and if you really do deal with it that way, the problem will get lighter and not so hard to deal with, and you don't have to use a negative way to deal with it . . . “
- “Then, the solution for that would be H.O.W., which is honest, open, and willing. That really helped out a lot.”

After experiencing increased understanding of their problems by viewing them as ‘cunning, baffling and powerful’, group participants reported feeling satisfied with or otherwise positive about the H.O.W. solution for dealing with problems.

Narrative therapy treatment 2, “Interviewing the problem”

Several participants reported this treatment to be the most helpful one of the four narrative treatments. Here we will examine the effectiveness of group members examining their own and their peers’ reactions to the actual process of interviewing the problem as conducted through the administration of the treatment.

Comments reflecting the experience of being the problem or seeing the problem be interviewed included:

- “I really enjoyed that group, because it was like, you have to stand and [explain] what you think depression is, and you have to defend yourself. Or, be interviewed and questioned, and you have to really think about where you stand, from a, what like you think depression is to you, and you have to explain it to other people.”
- “I think it's because I like interviewing people. It made them think, and it got me thinking of, 'well, if I ask this question, how will they respond?' Or, 'how should they?’”
- “That was really helpful, because you got to see how, like, that person, that was being the feeling [problem], how they interpret it, how their feelings were being, and it was really interesting to see other people's point of view . . . “
- “. . . and seeing that with the person that is doing the interview, after they do it seems like they're relieved, like, 'wow,' you know, it was just weird, like kind of how their anger was just out, everything was just out, then, and they looked at it as if they were the anger. I guess it kind of would be that they got it out and now it's maybe not so strong anymore, cause now they know why.”
- “Because looking at how someone could talk about it as being a problem, sit there, as they're the problem, and the relief that they had made me just want to maybe just sit down and say something about mine and maybe help me. It was kind of just inspirational to me.”
- “Probably when I played anger and stuff, that like gave me a whole different view of like, how anger works, inside somebody . . .”
- “Yeah. It showed me, that, well, what happens is that it made me look at it from anger's point of view, like what it does to me, what it makes me do.”
- “You mean where I interviewed depression? It was interesting. I was really, like, wow, this is really what's happening. It felt like an eye-opener. And that this makes me realize just how powerful it actually is, and that it has a mind of its own.”
- “Well, I have depression, too, and it was like, seeing it. It was like, 'Oh my gosh, I can relate to that! I can really, really, relate to that!’”

Participants reported that both seeing their peers play the part of a problem, and/or doing it themselves was productive. It was productive to provide personal realizations about what the problem was doing to them, and to witness, as well as experience firsthand, the emotional response participants have as members of this narrative treatment. Participants specifically mentioned relief, interest, relating to others and new realizations as some of the notable reactions to this treatment.

Narrative therapy treatment 3, “Landscape of Action”, or “Circles”

Participants experienced the Circles treatment in two main ways. Group members reported that they received a more globalized view of substance abuse and the various levels of society that are affected by this problem, highlighting the scope of the problem as well as how many other problems and issues are created by substance abuse. Participants also experienced a more complex and comprehensive view of the individual’s role in the substance abuse related problem array, and of what the individual can do to change their role in or interaction with that system.

Comments reflecting the experience of recognizing a more global view of substance abuse problems included:

- “Well I always thought that drugs were...like from one angle, like, right around my area, I mean, I knew that the country and cities have it but I didn't really think about it until then, I mean, the whole general warfare thing, I never thought of that, so I kind of learned something new. And um, I think that we should be spending more money on counseling and rehab instead of wasting our money on drugs, because no matter what, I mean, the government, or whatever, tries to stop drugs, it's always going to be there. Because, I mean, it's supply and demand. Oh well. Yeah.”
- “Uh, that youth and adults have to make the choice to quit because otherwise it's still going to go on here. That was basically what I got about it. But it's not only coming from the United States, it's comes from international, like you don't really think about where the drug comes from, it doesn't really come from us, it comes from overseas, as well, and the only people who can stop that are the people who are using, if they want to stop. If nobody over here wants to use, then they won't bring it over here anymore.”
- “I never really thought about where the drug came from. And then when we did that I was like, wow, where did it come from? You know, you never know, it could have had hepatitis in it or something, because that comes from overseas a lot of the time, yeah, and knowing that it could have, was just kind of...weird.”
- “Is that the one with alcohol and drugs? That was more like, reality, because I know that's what the world's facing now, is the problems of drugs and alcohol, so it was more, it's better expressing how you felt about it. Kind of like, relief.”
- “It kind of made me realize, like, you know, why would people want to do this? I mean, to now, just to say, it's like I wouldn't want to do drugs because look at what they can do. It's like a bigger problem than people really say it is.”
- “I think that if people would sit down and realize that, if they actually went to that group, they would see that it's not just their problem, it's the whole entire, it's facing, it's affecting everyone else . . . maybe they would understand.”

- “The diagram, I can see very well that--y'know, which one was the best and how it involved everyone, not just me--my whole family, and the world and everything else.”
- “I learned that it starts out to be you, but then it somehow it, uh, other things evolve, like the family, community, national, international, and all that crap. I didn't know that. I thought it was just, you know, my little small group, but really, it deals with the whole world, what's going on.”
- “I realized that there are a lot more problems in this world than we've time to look at. I mean, we tend to shut a lot of problems out because it's--we don't really want to talk about them, but there's a whole lot of problems out there that need dealing with.”

For participants, this globalized view of substance abuse and its associated problems was accompanied by heightened awareness of their own or the individual's own role in the larger problem:

- “You, um, you realize how, with the circle, where you started with you and got into the world or international, you realize that you can start problems and that it can, even if it's just from you, it can go internationally. You can start one problem and it goes internationally. You can add to the drug war, you can add to the violence in the community, the vandalism, stuff like that. I never realized that, also.”
- “People don't see the things that just, maybe look at how many people are affected by just one person, ignorance.”
- “Um. That one meant, it showed how one person can cause many different things to happen, or if you do drugs or alcohol or tobacco, that you do affect everything up to the um elections, and, when people think of other people.”
- “Well, just like I said, I said I really, or people say that you're not really, or you can easily say that you're not really a big part of it, you're just one person, and it can affect a lot of things. I mean, I've heard it before, but we went into a lot of detail, and that, like drug wars and more stuff, it made more sense.”
- “I learned that one person, it all starts out with one person, like then you get more people, it all like becomes like bigger and bigger, and out of one person, probably somebody else in your neighborhood, and then like, it just adds up.”

Understanding the individual's role in the bigger problem led some to ideas of how they could make an impact on the problem individually:

- “Well, it taught me that if I don't do drugs, I am helping out with the [drug] problem. And if I don't buy them, then the money doesn't go towards the drug people, you know.”

- “And mostly, if I don't do drugs, I'm not helping [the drug use problem] so that way it helped me realize, I don't even want to try drugs, because I don't want to help them. I don't even want to deal with anything like that, you know, so if I'm asked, just say no.”
- “If one person can make a small change in them self, then maybe other people will see that if one person can make a change in themselves, then they can change, too.”
- “Yeah, because if like I change, and I use my coping skills to get over my depression and my anger, then it's going to change my family, because they don't have to be worrying about me having anger outbursts, or me trying to kill myself, because they'll know that I'm a happy kid, and the therapy here has really helped me. Because I feel a lot better about myself, and a lot happier.”

Adolescents participating in the narrative treatment Circles found that they were exposed to an wider view of the problem of substance abuse in society today, where they saw more about how large the problem is, and other problems that are caused by it. They also reported experiencing improved understanding of the individual's role in the big picture of substance abuse, including what the individual can do to not add to that problem.

Narrative therapy treatment 4, “Arrested development group”

Participants' experiences of the Arrested Development treatment centered on two areas. These included increased awareness of human development issues and topics as presented in the treatment, and increased awareness of dynamics particular to the way that adults and teens view each other. Teens were able to identify areas of development that were discussed in the treatment and relate how their particular problems affected those areas. In addition, group members identified not only unfair assessments that adults may tend to give teens, but also unfair generalizations teens may make about adults.

Participants could explain how problems made negative impacts on their development:

- “It showed the um, like, um, when you have behavior problems, alcohol, drugs, and stuff like that, it shows you what area of your life it is complicating, you know, your growth, your development, your social life, stuff like that.”
- “So it helped me realize where are you standing, like, with all of your, like, mental development and physical development, and it helped me realize stuff like that.”

- “That when we have our emotions and the way that we deal with our problems affects us every day for, until we decide to change that for physical, mental, and emotional health.”
- “Um, using drugs affects all of them ways, using alcohol affects other, depression, self esteem, all that, when those problems come into your life and you don't deal with them right . . . you don't grow in those areas no more.”
- “Well, I learned about how I can control my anger and my depression, and I learned that it doesn't deal with mental, it deals with the whole body.”
- “And that if one thing in our development stops, the rest of it kind of stumbles and we turn out bad at the end of life.”

Other reactions to the arrested development treatment were related to adults' and teens' views of each other. Participants reported both increased understanding of how and why adults view kids the way they do, and increased understanding about what they could do about it. Also reported was a new awareness of how they view adults. Examples of participants understanding how adults see teenagers included:

- “Um, I think it's a good one that all people should like look at it, because it does show how maybe their parents thought of them, or what they think of us now, and maybe that could change some opinions toward other people.”
- “It made me think about the situations where, like, adults, um, put me in just a category of, you know, disrespectful, and stuff like that, and it makes you realize why they do it, or why you know . . . I'm just thinking that it made me realize why that adults may think that way about the kids' by their actions, you know, because a lot of that does have to do with us. You know, with what kids are doing.”
- “And I do think that adults are, you know, looking at putting all teenagers into one group, and usually it's just a little bit of them. But that one little bit, that's what you hear about the most. That's what mainly adults look at.”
- “I thought that group gave us, gave me a good idea of how adults look at children, or how people that don't work with children every day, how they, um, see us.”
- “Um, I think that adults see children as a constant problem, creating more drugs and alcohol problems, and I think adults just think teenagers, especially 15, 16 yr. Olds, I think they see them as, 'they don't any of the work, they're always going to be free wheeling it, party hopping, you know, go out to parties late nights, and drink.' But they don't see that some teenagers don't do that, that they only focus on the bad ones and not the good, usually.”
- “Well, it was explained great, and I mean, you gave an outlook that, the reason why parents look at us like we're you know, not trustworthy or things like that, is probably

because we have a bad reputation, because of bad kids, you know, one kid can ruin it for a whole group.”

This awareness of why adults see kids the way that they do was accompanied by increased understanding of how teenagers can work to positively affect this sometimes inaccurate view:

- “And you just have to work extra hard to get your parents' respect, and if they don't give it to you, you've just gotta live with it. You've gotta show them that you're not gonna steal, cheat, lie, and things like that, and then it'll all be ok.”
- “Uh, I felt that, right now, as being where I am at in my position, adults usually view us as troubled, uh, always in trouble, bad kids, and the only people who can change it is us kids, if we start doing better things for ourselves, they're going to stop viewing teenagers like that. Mmm, that's basically it.”
- “I think that would kind of go towards that too, saying that if kids went out and got therapy, or counseling, or whatever, that maybe that would help from them wanting to make bad decisions, so therefore, it wouldn't make us more stereotyped; less stereotyped.”
- “And somehow we can stop it ourselves before it can turn into a big deal, and not let the older people stereotype us into something that we won't like.”

In essence, the participant experience of becoming more aware of how and why adults view teenagers the way they do was augmented in a positive way by promotion of an awareness in group members of their own ability to counteract the (at times) negative view adults have of kids.

Understanding in participants of why adults see things they way they do appeared to evolve a step further for some, to promoting teens' awareness of the way they themselves see adults.

Examples of comments reflecting this experience include:

- “And also, parents also, kids look at parents as though they're bad people, as well, and I think we should give parents, or any adult, another chance, since you know, people make mistakes, and you know, they have troubles raising kids, and they have issues, and I don't think we should hold them accountable for every adult.”
- “At first I didn't want to think about it as "why should I have to prove anything to them," but then I started to think about it, and we view adults in ways too, like if some kids are hurt by adults, they think all adults are that way. And if, like, your parents do one thing wrong, they do everything wrong sometimes, so we do that, too, if you really think about it.”

Participant experience of the Arrested Development narrative treatment reflected increased understanding of the way problems affect adolescent developmental issues, and understanding of how adults and teens often view each other. These realizations appeared to be helpful in promoting awareness of adolescents' agency in relation to their problems as well as in the area of adult-teen relationships and dynamics.

CHAPTER 5. SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

Adolescent substance abuse remains a major public health concern. The comprehensive, detrimental effects of teenage drug use, coupled with troubling relapse rates, highlight the need for innovative, effective, and helpful treatment interventions. Adolescents in treatment and the adults that work with them are subject to often negatively influential discourses that limit treatment effectiveness and the development of adolescent treatment satisfaction and therapeutic alliance. Narrative therapy is promoted in the literature as a viable way of addressing these problems.

Some interesting work has been done in the area of narrative therapy with adolescents, and particularly with substance abusing and chemically dependent adolescents. However, empirical and qualitative research regarding narrative therapy with teens is scarce. Studies examining narrative therapy in regard to the promotion of treatment satisfaction and therapeutic alliance are virtually non-existent. The results of the study described in this paper are meant to meaningfully augment the literature. This study has presented both preliminary empirical, and interesting phenomenological research which indicates positive responses to narrative therapy, which highlight the need for further examination of narrative therapy interventions with teens in the clinical setting. The information presented here is a step in the right direction toward developing and describing a usable treatment model of narrative therapy with adolescents having substance abuse and other behavior or emotional problems. These findings are intended to guide professionals in the research and implementation of effective and easily understood narrative models for application in clinical work with teens.

Study limitations

Context

This was a regionally-limited study of outpatient, clinical adolescents in a medium-sized Midwestern city, with a relatively small sample size (n=99).

Self-selection bias

The quantitative and qualitative data in this study may have been influenced by an artificially positive bias toward the investigator and the study in general, in that participants volunteered or agreed to take part in the study. Because the study only obtained data from adolescents that agreed to participate, and not from any that refused, the data might reflect responses from individuals who are by nature more likely to give amenable or positive comments about their treatment satisfaction or therapeutic alliance. This process could produce inflated responses regarding treatment satisfaction and alliance not attributable to narrative therapy.

Facilitator training and retention

Four of the original six narrative group facilitators were unable to participate because of professional obligations to their positions at the hospital. This fact unfortunately limited the number of different facilitators to the remaining two, and the primary investigator. The administration of a similar study in the future should include the utilization of research associates or graduate students interested in narrative therapy, who can necessarily devote enough time and commitment to both the training and the facilitating of groups. This approach would ensure adequate cohesion and the consistency of the facilitation team. It would also allow for further examination of the efficacy of narrative approaches across different facilitators.

Limited number of narrative therapy groups

Lack of group administrators also necessitated fewer groups per week in each of the study populations. Participants were limited to two narrative groups per week. While much of the qualitative data suggests that the groups were still impressive and helpful to participants, an increased

number of narrative interventions per week could have produced more pronounced empirical evidence for the efficacy of narrative therapy with adolescents in the clinical setting.

Primary investigator administrated most of the groups

The lack of group facilitators also contributed to the fact that the primary investigator necessarily administrated most of the narrative therapy groups. This limitation resulted in only eight of the total number of participants that received narrative therapy and completed all of the study protocols (n=49) having been facilitated by group facilitators other than the primary investigator. So the majority of the subjects that entered into the quantitative analysis were those who had participated in narrative therapy facilitated by the primary investigator. To some lesser extent, this was true as well for the qualitative data, though four of the twelve qualitative interviews were conducted with participants who had received narrative therapy from facilitators other than the primary investigator.

The group facilitation limitation from a quantitative perspective is concerning in terms of the generalizability of findings to another clinical setting. Questions would arise regarding the efficacy of narrative interventions. Were those participants that received narrative therapy significantly more satisfied and therapeutically aligned than their peers who didn't because of the narrative therapy, or because of facilitator effects such as skill level and length of experience in working with teens? If the number of subjects that had received narrative therapy which were included in the empirical analysis was more evenly distributed among several different group facilitators, a better case could be made for the efficacy of narrative, if statistically significant findings had been realized, as opposed to the action of possible facilitator effects moderating participant response to the therapy.

From a qualitative perspective, in terms of the interview data, the facilitator limitation may be less of a problem. Because four of the twelve qualitative interviews were conducted with participants that had experienced narrative therapy with group facilitators other than the primary investigator, a comparison was made between the qualitative responses in the interviews corresponding to these four

participants, and the qualitative responses corresponding to the eight other interviews with participants who had experienced narrative therapy with the primary investigator.

These groups of responses were compared as to the average number of question and answer interactions that occurred in the actual interview process. The average number of interactions in the qualitative interviews with the four individuals who had narrative with someone other than the primary investigator was 70. In contrast, the average number of question-answer interactions in the interviews with the eight participants that had narrative therapy with the primary investigator was 59. Based only on the average number of interactions in the interviews, it is clear that those who had narrative therapy with the alternate facilitators were not burdened with a lack of comments regarding their therapy. Though the average number of interactions in the qualitative interviews is only a rough approximation of possible facilitator effects on participant responses to narrative therapy, it is useful for discussion here in terms of why, qualitatively, the limited number of group facilitators in the present study may be less of a problem.

Another issue, from a qualitative perspective provides argument for the transferability of the qualitative data obtained in this study to other clinical contexts in treatment with adolescents. The thematic responses of participants to narrative therapy as outlined through the phenomenological analysis in this study can be viewed as the successful, therapeutic, narrative social construction of problems and discourses, rendering these problems and discourses less potent in adolescents' lives. Since narrative therapy is based in social constructionism (the recursive, reflexive process of building local reality through language and communication), participant responses here were the result of the collaborative co-creating of new ideas and meanings with teens related to the solving of their problems. This process would transfer to any context in which a practitioner, who is versed in and excited about conducting narrative therapy with teens, is able to carry out narrative interventions in a group format. It is possible that adolescents would collaboratively respond in a similar fashion and demonstrate the kinds of qualitative gains witnessed here.

Primary investigator conducted the qualitative interviews

In this study the primary investigator carried out the qualitative interviews of narrative therapy participants. Though every attempt was made to not lead participants to respond in any particular manner to questions in the qualitative interviews, the fact that the primary investigator, who administered most of the narrative therapy treatments (eight out of the twelve interview participants had experienced at least three or more narrative therapy treatment groups with the primary investigator) may have influenced the way some participants responded. Participants may have felt implicitly encouraged to give positive responses to interview questions due to not wanting to offend the investigator or simply because of personal familiarity with the investigator.

A method of safeguarding against such possibly artificially positive responses would be to invite and allow for negative or unsatisfactory comments by asking a question such as “Would you change anything about these treatments?” or “Was there anything you were unhappy about regarding these treatments?” Another interview procedure, in addition to giving permission for participants to make negative comments, would be to have an uninvolved third-party conduct the interviews. This could effectively address possible participant perceptions of needing to give favorable responses in interviews. In this way, participants would likely feel more free to share any negative remarks about their experiences, because they would be conversing with one who is not connected with the study. Such procedures would be appropriate in a future study involving the solicitation of qualitative comments regarding participants’ perceptions of narrative therapy treatments.

Conclusions

Quantitative conclusions

Hypotheses

No support for the hypotheses of the present project was found. The first hypothesis stated that adolescents in behavioral health treatment who receive narrative therapy interventions will be more satisfied with their treatment than those who do not. Examination of the means indicated that

narrative therapy recipients were more satisfied with their treatment than participants who had not received narrative therapy, but the differences were not statistically significant.

The second hypothesis stated that adolescents who receive narrative interventions would demonstrate higher levels of therapeutic alliance than those who do not receive narrative therapy interventions. Participants who had received narrative therapy demonstrated higher scores on the therapeutic alliance measures than those who had not received narrative therapy, but again, the differences were not statistically significant.

Nor was the third hypothesis supported by the data. This hypothesis stated that of the teens in this study that received narrative therapy ($n = 49$), participants who are primarily substance abusers would be more satisfied with their treatment than those who are not substance abusers. The MANOVA conducted for the narrative therapy subgroup yielded no significant multivariate results.

Predictors

This study examined participants' responses to narrative therapy in terms of predictors that may affect treatment satisfaction and therapeutic alliance. Of the regression models constructed for the narrative therapy treatment group, one was significant. This model regressed an outcome variable for task-related therapeutic alliance (TOTTASK1) on the predictors of age, gender, onset, and SASOAT (obvious attributes of chemical dependency). For participants that had received narrative therapy, substance abuse severity, as measured by SASOAT, predicted increased therapeutic alliance. This finding demonstrates that teens in the narrative therapy treatment group of this study, who had greater levels of obvious attributes of chemical dependency, developed greater levels of task-related therapeutic alliance with staff members.

Qualitative conclusions

The essence of the narrative therapy experience in this study

The qualitative themes of participants' responses in this study can be summarized in a single paragraph that describes the essential experience of the adolescents that participate in the narrative

therapy treatments. This paragraph expresses as well the teens perceptions of narrative therapy. Following accepted rhetorical structures for presenting phenomenological research in study reports (Creswell, 1998, p. 177), the following paragraph is presented in a boxed format.

The essential experiential aspects of adolescent narrative group therapy

Narrative therapy groups for adolescents in this study were positively appealing for participants. They liked and enjoyed narrative therapy, and felt that both they and their peers were being helped to sort out problems, express feelings and obtain a positive, rather than a negative outlook. Narrative therapy groups were a novel experience in which teens noticed that narrative therapy is different, fun and better than other therapy they had experienced before. Some kids were interested and intrigued by narrative groups, and others found them to be revealing of problems in an in-depth and eye-opening way. Some experienced changed minds and felt inspired to work hard on their problems. Teens in narrative groups viewed problems as demystified and less confusing. They felt less personally targeted in the narrative groups, felt less isolated and more open; they felt less “not normal,” realizing that others have problems, too. Finally, adolescents saw their problems as opponents; entities that can be watched or countered in some way. They saw their problems as external to themselves and gained an attitude of resistance to their problems, which prompted plans of action on their part to resist the problems and their effects.

Discussion

Quantitative findings

Hypotheses conclusions

Significant findings were not demonstrated for the first, second or third hypotheses of the present study. The present lack of significant findings is likely related to the relatively low intensity of narrative therapy interventions in the study, and to the relatively small number of participants in the empirical analyses.

It is possible that if the participants in this study had been provided increased access to narrative interventions, significant results might have been demonstrated for narrative therapy effects on treatment satisfaction and therapeutic alliance. The participants in the study who received narrative therapy encountered the treatments twice a week at most. Potential narrative therapy effects may have been diffused in the overall course of mental health and substance abuse treatment interventions that the participants experienced while taking part in the study.

The small number of subjects available for inclusion in statistical analyses further limits the ability of the present study to detect potential effects of narrative therapy. These possibilities, and issues related to them, are discussed in the directions for future research section of this paper. The present findings do indicate the need for more research in narrative group work with adolescents.

Regression analysis conclusions

Regression analysis for the group that received narrative therapy indicated that increased attributes of chemical dependency in teens that receive narrative predicts increased task-related therapeutic alliance. This finding suggests that substance abuse severity may improve some teens' ability to be open to and benefit from narrative interventions. Narrative therapy may reach these teens in task-oriented way, related to its ability to externalize escalating chemical dependency problems in a way that encourages adolescents to take action or develop stances against the problem. This finding is similar in spirit to the AA sayings "sick and tired of being sick and tired," or "hitting

rock-bottom” which describe the chemically dependent person’s action-provoking realization that his or her problems are only getting worse, and that they need to do something about it. Also in a similar vein, a recent study found more severely substance involved youth were more motivated for abstinence and more likely to attend and affiliate with 12-step groups (Kelly, Meyers, & Brown, 2002). Narrative therapy may be able to help speed kids along to task-related recovery activities through improved therapeutic alliance. This finding provides support for continued research in narrative therapy with substance abusers in particular.

Correlations

Several significant correlations were demonstrated in the data. We will consider each of them in turn. Diagnosis was correlated with age. This relationship indicated that the older participants were in this study, the more likely they were to have had involvement with substances. This finding is consistent with the developmental likelihood that as teens get older, the more access or opportunity they may have to become involved with drugs or alcohol. The finding is consistent with survey data that indicates that teen alcohol use escalates dramatically with age (The National Center on Addiction and Substance Abuse, 2003).

Diagnosis was also correlated with current level of substance abuse. Kids with a substance involvement or chemically dependent diagnosis were more likely to have increased levels of current drug use.

Legal status and diagnosis were correlated. Those participants who were diagnosed as chemically involved or dependent were more likely to have legal problems. This follows, as many teens who are referred for mental health or substance abuse treatment at the hospital are there because of some legal charges, often related to their substance involvement in the first place (e.g., possession charges, OWI).

Diagnosis was correlated with obvious attributes of chemical dependency as measured by the OAT scale of the SASSI instrument. Participants with substance involvement or dependency were

more likely to demonstrate increased “obvious attributes” of chemical dependency. These attributes as measured by the SASSI instrument included scale items describing problems with authority and affiliation with antisocial peers. These correlations were fairly straightforward and make sense intuitively when considering the effects that increased involvement with substances has on teens.

Diagnosis correlated negatively with treatment satisfaction/satisfaction with staff. This correlation may indicate that participants who are more involved with substances are more likely to be dissatisfied with their treatment experience. This relationship is often evident in teens who have been forced into treatment because of various legal or family issues related to their use of drugs and alcohol. Involuntary participation in treatment is understandably reflected in lowered treatment satisfaction in general.

Diagnosis also correlated highly with the three substance abuse severity variables derived by factor analysis from subscales of the SASSI. Substance involved adolescents were much more likely to score high on these measures of substance abuse severity.

Age was correlated with current level of substance abuse. Older participants in this study were more likely to demonstrate higher levels of current substance abuse. This relationship is similar to diagnosis and age correlating, as observed earlier. Age correlated with legal status. Older participants were more likely to be involved with the law. Age also correlated with two substance abuse severity variables derived by factor analysis from subscales of the SASSI. The older participants were, the more likely their substance abuse patterns were to be more pronounced.

Onset of substance use correlated with treatment satisfaction/satisfaction with staff. As age of onset of substance abuse increased participants in the study were more likely to be satisfied with their treatment. This relationship could indicate that due to less total time of substance involvement because of later onset of use, participants may have incurred less cumulative, negative effects of substance abuse (including a negative view of counselors). Consequently, their involvement with treatment could be more likely to be satisfying.

Legal status correlated with obvious attributes of chemical dependency (OAT subscale) as measured by the SASSI instrument, as well as with all three substance abuse severity variables derived by factor analysis from subscales of the SASSI. These relationships make sense, considering that, as mentioned previously, the OAT subscale contains items that reflect problems with authority and antisocial peer group associations as well as substance involvement items. Participants with legal problems were more likely to demonstrate obvious attributes of chemical dependency as well as higher substance use severity.

Treatment satisfaction/satisfaction with staff correlated negatively with one substance abuse (alcohol-related) severity variable derived by factor analysis from subscales of the SASSI. As alcohol-related substance abuse severity went up, treatment satisfaction dropped. This relationship could indicate that as participants are more highly involved in drinking, the less they are able to be happy about being in treatment, and consequently less satisfied overall. This correlation is similar to diagnosis being negatively correlated with treatment satisfaction as described earlier.

In general, the dependent variables for treatment satisfaction and therapeutic alliance were highly correlated with each other, necessitating MANOVA as described previously. The substance abuse severity variables also correlated with each other.

Regression analysis

Of the regression models constructed for the entire study sample which regressed each of the five outcome variables in this study on the predictor variables of age, gender, and different predictors of substance abuse severity, only one yielded significant results. This model regressed the treatment satisfaction/satisfaction with staff variable on age, gender, and onset of substance abuse. This model demonstrated a negative relationship between gender and treatment satisfaction, and a positive relationship between age of substance abuse onset and treatment satisfaction.

In regard to gender, the above model suggests that being a female in this study predicts lower treatment satisfaction. Reasons for this finding are unclear, and require further research to investigate

possible influences on adolescent females' responses to outpatient substance abuse and mental health treatment.

In regard to age of onset of substance abuse, the above model suggests that for participants in this study, increased age of onset of substance abuse predicts increased treatment satisfaction/satisfaction with staff. Starting substance abuse later in life (increased age of onset) may contribute to improved levels of satisfaction with substance abuse and mental health treatment. Teens who start to use drugs later than their peers who start earlier may be more amenable to the positive aspects of working on their problems and other benefits of being in treatment. The longer a teen uses drugs because of an earlier age of onset, the longer they have had to accumulate problems such as negative interactions with adults or increased levels of substance dependency, making them less open to the benefits of treatment. This dynamic would be diminished for teens who have used for a lesser period of time, hence a result of improved treatment satisfaction for adolescents having later onset of substance abuse.

Quantitative findings summary

In review, none of the hypotheses for this study were supported by the data. The empirical analyses were limited by low intensity of narrative therapy interventions, and by the relatively small number of subjects.

Findings of the regression analyses in this study suggest that gender may be related to treatment satisfaction, but more research is required in this area. Also indicated is a positive relationship between age of substance abuse onset and treatment satisfaction. For participants who received narrative therapy, regression analysis indicated a positive relationship between substance abuse severity and task-related therapeutic alliance, which provides preliminary support for the notion that narrative therapy might be a promising approach for increasing therapeutic alliance in more severe adolescent substance abusers.

The findings of the regression analyses provide some support for the notion that narrative therapy in a group format may be effective in promoting adolescent therapeutic alliance, gaining results that have implications for overall treatment efficacy, and in increasing the possibility of improved outcomes in programs that utilize narrative therapy. More specifically, the findings indicate that narrative therapy may be helpful in therapeutically engaging substance-abusing teens. These findings are preliminary, and indicate the need for further research in narrative therapy with teens, to establish more conclusive connections between the implementation of narrative interventions and improved treatment results for adolescents, and for which populations (substance abusing or not) narrative therapy is most useful.

Qualitative, phenomenological information about the adolescents' impressions of their experience with narrative therapy groups augments the present quantitative data. Phenomenological findings are discussed below.

Qualitative findings

Discussion of the qualitative findings of this study will center on each of the qualitative theme categories of participant responses to narrative therapy, as well as on the collections of reactions to each of the specific narrative treatments. We will discuss the practical, and when appropriate, theoretical implications of these findings, as well as their applicability to further research and clinical usefulness in mental health and substance abuse treatment of adolescents.

Qualitative themes

Appeal

The appeal of narrative therapy treatments for adolescents centered on the areas of liking the experience, feeling helped, and appreciating the smaller group size. Teens actually liking and feeling helped by their therapy is enormously important in terms of promoting stability of any changes they accomplished while in therapy, as well as encouraging them to be open to any help they may seek in

the future. Group size appears to be a separate issue, though deserving of consideration in the planning of further narrative work with teens.

Liking the narrative groups was a common response among participants. This finding coincides well with the investigator's perceptions of adolescents' engagement and participation in these groups. Kids do appear to like these interventions as gauged by their positive involvement and interest, and paying attention and giving examples for discussions in groups. In my experiences of conducting narrative groups, rarely has a teen expressed negative reactions to narrative. The participants in this study support these observations with their positive statements about the groups. Any intervention that can take the negative experience of struggling with problems in the first place, and construct a positive experience for adolescents is worth looking into further and applying in a variety of treatment settings.

Similarly, the participants' essential experience of being helped through narrative therapy groups is particularly salient to the adolescent mental and behavioral health treatment and therapy setting, because of the aforementioned difficulty in establishing collaborative rapport and therapeutic alliance with teens. Any group experience or approach that promotes in teens a sense of having been helped can potentially contribute to overall therapy effectiveness, at least from the standpoint of how kids positively view their treatment, in many therapeutic settings. New ideas, ways to cope or different views of things which are considered as helpful, may be more likely to persist in a client's life after they leave the counseling or treatment setting. The comments reflecting the experience of having been helped in this study appeared to relate to behaviors the participants planned to implement in the future to cope with their problems, as participants described specific ways they planned to deal with or otherwise handle their particular problems.

Though not by design, the narrative treatment groups in this study were fairly small. The smaller size in the narrative groups of this study proved to be useful to participants. Several felt that this enabled them to be more open and willing to talk, that they could identify more with peers in the

groups, and that this would help them be more open in other settings. Though the investigator has observed narrative therapy to be effective in larger group settings, such as 10 to 12 adolescents, here the smaller number of participants was a plus. This may indicate that group-level narrative therapy is particularly suited for smaller groups, or that smaller groups in general are helpful to teens. Either way, implementing narrative therapy groups with less participants (anywhere from four to eight group members) may be an effective way to augment the effectiveness of narrative interventions in general. Qualitative data comparing reactions from participants in both larger and smaller narrative groups is needed to clarify this notion.

Novelty of approach

In much the same way as narrative therapy is appealing to teens, the novelty of narrative therapy groups for adolescents is beneficial to promote a memorable experience of therapy. Moolchan & Ruckel (2002) cite the importance of developing a novel approach to group therapy interventions for adolescent smoking, because of multidimensional heterogeneity of issues and the high level of clinical challenge presented by this population.

Teens reported they thought their narrative experience was different, interesting, fun and, in some cases, better than other groups they had been in. For adolescent participants to experience a treatment and therapy group as fun is not necessarily a rarity, but certainly is a benefit sought by treatment personnel who work with kids. If teens can view their counseling as fun, they will likely be more engaged and consequently retain more of what they learned and discovered. This reaction may be even more important for kids that have been through previous or multiple episodes of mental health or substance abuse treatment. The very fact that they are back in treatment indicates a continued struggle with problems, and a need for a more effective or improved desire to resist their problems. Several teens commented directly about how the narrative experience in this study was notably different and more positive than other treatment groups they were familiar with, indicating the utility of narrative interventions in making a positive impression on teens.

Effectiveness

Many of the qualitatively categorized comments in the study were related to the effectiveness of the narrative approach. Participants felt that the groups revealed and explained their problems well, at an in-depth level. Some felt they had their eyes opened in a new way that led to changes in thinking and behaviors in relation to dealing with their problems. For some, the effectiveness of the approach actually led to a clearly articulated desire and intention to adjust or change behaviors. All of these reactions are important in the currently demanding and focused managed health care context. This context seeks to define success of treatment in terms of least amount of days required to stabilize a patient, or fewest counseling sessions needed to resolve a problem. Because the course of narrative therapy can be relatively short, it has been noted as a potentially helpful way to promote effectiveness in the managed care setting (Kelly, 1998). As has been postulated in this paper, positive client satisfaction with treatment can be a measure of treatment success; as clients view their treatment as more effective, the more satisfied they are likely to be, and the more successful their outcomes may be. Potentially measurable outcomes for narrative therapy informed practice could be shorter length of stays in treatment, lowered re-admissions, or other measures of client and family satisfaction with treatment. If narrative therapy can continue to show qualitative and quantitative effectiveness in the adolescent treatment setting, more providers may be willing to learn about and incorporate narrative theory and interventions into their services. As therapists and counselors continue to search for ways to enhance service effectiveness (Chen, Noosbond, & Bruce, 1998; Horne, 1996; Kottler, 1994), easily learned and implemented narrative interventions could gain ground as one additional way to increase treatment effectiveness.

Normalizing effects

Normalizing effects of narrative therapy groups appeared to have an impact on both problems, and persons individually. Participants found their problems to be more understandable and less mysterious as to origin and properties. They reported seeing them plainly as more common a

part of the human experience than they may have realized. These reports are similar to the aforementioned process of “emancipating subjugated knowledges” in which clients begin to see themselves as less influenced by problem-dominated narratives that had convinced them that their problems are all their fault, or unique to them only. This focus on problems rather than persons led participants to feel more normal and less targeted in the therapy process. Problems appeared to become less oppressive and participants appeared to become more hopeful.

Participants also reported feeling themselves, and witnessing their peers, becoming more open to the discussion and dialogue of therapy as a result of these normalizing effects. This effect is in stark contrast to the old, “tear ‘em down and build ‘em back up again” model of group intervention (especially in adolescent substance abuse treatment), which is centered on the firmly established power base of the therapist or treatment workers as the experts who, at their discretion, are free to use what ever demeaning or blaming methods they deem necessary to “help” their clients. This process is similar to another narratively-identified discourse called “adultism”. Zimmerman & Beaudoin (2002) refer to adultism as a discourse that allows authority figures (usually adults) to act one way (disrespectfully, for example), but kids and adolescents are prohibited from responding likewise. This dynamic only serves to create distance and opposition in teens, who often end up going through the motions to just get through the treatment process.

Instead of promoting normalizing effects in the treatment process as we have examined here, these more traditional models promote pathology-based labels and discursive proofs of these labels in the group therapy context, administrated by the expert therapist. Progress in these programs is measured by client compliance with and adjustment to the therapeutic discourse being touted through these arguably coercive methods. Though progress has been made in the last decade at improving client engagement in substance abuse treatment by addressing this unevenly structured power and expertise dynamic through improved understanding of the varying stages of change that clients go through in preparing to get better (Prochaska, Norcross, & DiClemente, 1994), adolescent programs

routinely suffer from the same old hang-ups, due largely in part to our now familiar oppressive discourse on adolescents. Narrative theory and interventions can bring a usable, informative postmodern influence to the landscape of traditional adolescent treatment interventions. This influence can serve to promote efforts to engage youth in the treatment setting, rather than to “discourse” them into compliance.

Externalized references leading to resistance and prevention

More clinicians are writing about using the process of externalization specifically to augment other therapy practices (Griffin, 2002). Participant comments related to seeing their problems as externalized, and comments about consequential resistance and prevention themes, together made up 36% of the total categorized qualitative comments in the study. For participants of this project, experiencing externalization of their problems enabled them to realize the significance and effectiveness of their problems in causing harm and difficulty in their lives. This externalization also took the form of viewing their problems as agents of harm and destruction, opponents worthy of resistance.

In this study, resistance manifested as emotional responses to narrative group experiences, individual plans to oppose problems, recognition of times and situations that problems cause the most trouble or harm, and increased general attitudes of personal agency in the face of problems. Narrative interventions had the effect of mobilizing resistance to and focus on problems rather than on other people or issues in adolescents’ lives. In this way we found that the process of externalization led effectively to resistance and prevention, as kids resisted problems and made preventative plans against them as well. Groups can be a powerful medium for conducting primary prevention with children and adolescents (Kulic, Dagley, & Horne, 2001). Narrative therapy can potentially contribute to the effectiveness of group-based prevention efforts.

As mentioned previously, the adolescent treatment setting is quite challenging and demanding at times, and treatment personnel, therapists, parents and any other adult authority in a

teen's life can be a potential target of resistance rather than a collaborative helper in finding the solutions to problems. Because narrative interventions can help change the focus of such resistance to the real problem, programs of intervention with adolescents should consider the potential for narrative therapy to help adolescents more effectively direct their energies of resistance toward the problems that brought them to treatment in the first place.

Narrative therapy treatments

Having discussed each of the qualitative themes or areas of import related to participant experiences of narrative therapy, attention turns to further discussion of each particular narrative treatment intervention. These treatments will be discussed in terms of both expected and realized effects of the intervention related to the narrative concepts they were built upon.

Narrative therapy treatment 1

Narrative therapy treatment 1, "Cunning, baffling and powerful", was intended to focus specifically on the process of the externalization of the problems for the clients. This didactic, collaborative presentation amounts to active social construction of problems as malevolent forces to be confronted. After accomplishing this, the treatment then provides a useful way to address such problems through contrasting "cunning, baffling and powerful" with the individually-based "honesty, open mindedness and willingness" (H.O.W.) solutions at the conclusion of the group. The H.O.W. solution is a part of common addiction treatment and self-help nomenclature, having its origins in the concepts and ideals of Alcoholics Anonymous. Kids appreciated this solution-augmented approach. They described realizing how formidable their problems were, then reported feeling encouraged by having received the proper tools to oppose their problems. It appears to be helpful to not only expose the seriousness of adolescent's problems through the process of externalization, but to provide a useful countering device to promote teens' ability to resist problems. Providing "a way out" in conjunction with the clearer view of how bad problems can be is a hopeful and progressive approach to dealing with the difficulties that teens come to treatment with. This is a good procedure to adopt

when detailing for kids the damaging nature of their problems, to provide a sense of agency and individual effectiveness in the face of such negatively potential-filled opponents (problems).

Narrative therapy treatment 2

Narrative therapy treatment 2, “Interviewing the problem”, also focused on externalization, though this was accomplished in an experiential rather than didactic way, as in treatment 1.

Participant responses to treatment 2 were specifically positive in regard to individuals having a memorable or eye-opening experience, and several stated that this was their favorite group. The group builds on the externalizations of treatment 1, and adds the narrative techniques of relative influence questioning and noticing unique outcomes.

Treatment 2 is an adaptation of White and Epston’s (1990) group procedure for interviewing the problem, in which group members normally play the part of a problem common to the group or known to the players. In the present adaptation, the person with the problem plays the part of their own problem, and through the role-play experiences first hand the “voice of the problem” speaking out through them. In the present study, this form of personally externalizing the problem for individuals who volunteer to do so in the group context appears to be a powerful way to separate the individual from their problem. As the participant volunteers hear their problem speak poorly about them, they appear to gain even more personal and insightful realizations than if they were listening in a group setting to a problem speak in general about its motives, plans and actions against people. This process is the main strength of the present approach, and participants expressed both appreciating being able to do it themselves and seeing others carry out this personalized role-play in group.

Part of the effectiveness of the approach in this form of externalizing also comes from discovering the influence of the problems and noticing unique outcomes through the interview process. The relative influence of a problem in one’s life becomes apparent through questions posed to the problem such as “What happens to this person when you are with them?” or “Did you tell this

person what would happen to them because of you?” The way the person playing the part of their problem answers relative influence questions reveals how that problem has affected and influenced them in negative ways. Unique outcomes are developed through the questions like “What kinds of situations make you weak?” or “What will you do when this person invites you out of his or her life?” How the person playing their problem responds to outcome-related questions provides both a review of past times the problem has been ineffective, and a kind of prognosticative process in which the individual and the group members can see the potential for the problem being less influential in the future given certain behavioral adjustments or conditions.

A reason that narrative treatment 2 was found to be most effective or favored by participants may have been because of the three-part interaction of these narrative therapy core functions of externalizing, relative influence questioning, and noticing unique outcomes. The narrative methods were presented in a memorable, experiential manner which was impressive to adolescent participants. These are some of the more utilitarian and easily replicated techniques of narrative therapy, and can be potentially easily trained and incorporated into any program that utilizes the group therapy format with adolescents.

Narrative therapy treatment 3

Narrative therapy treatment 3, “Landscape of action” or “Circles” focused on exposing the problematic discourse of acceptable substance abuse in society today, rather than on externalization as in the first two groups. As in treatment 1, the interactive, didactic approach to the group appears to be helpful in presenting narrative concepts to teens. Participants reported increased awareness of the pervasive and entrenched nature of substance abuse in our Western society, especially in the arenas in national and international economics and commerce, and in the industrial complex in the United States that supports and promotes use of tobacco and alcohol. Many participant comments reflected new realizations and interest in the interrelated and multi-level components to this problem. These

were the intended effects of this treatment, to help kids become more aware of the scope of substance abuse and the damaging influences it engenders, from the individual to the world-wide level.

An additional intended effect of narrative treatment 3 involved participants gaining a new perspective of the individual's potentially influential role in the complex system of problems related to substance abuse. While the treatment was intended partly to illustrate the individual's embeddedness in this oppressive discourse, some teens also came away from the group with new knowledge of their own ability to influence this problematic system, either in support of it or in opposition to it. Some comments were specific in relation to participants developing the belief that they would be potentially contributing to the wrongness of the drug traffic underworld by continuing their previous activities, and that this is unacceptable. Others were more focused on what their own individual contribution to not participate in the substance abuse discourse would look like.

Both of the effects demonstrated by treatment 3, that of exposing the discourse and highlighting the individual's potentially positive or negative influence on it, hold considerable promise not only for substance abuse treatment, but for prevention of substance abuse as well. Group interaction-based prevention is effective with kids (Kulic, Dagley, & Horne, 2001). Because many prevention efforts are targeted at youth, and since kids already involved with substance abuse (or contemplating it) appear to respond well to this narrative intervention, discourse-based prevention efforts could be successful as well. Adolescents seem to appreciate the wider perspective that examining discourses can bring to the treatment setting, and giving them credit to understand and be able to evaluate their own potential or realized involvement in them could augment prevention efforts, too.

Narrative therapy treatment 4

Narrative therapy treatment 4, "Arrested development" also focused on discourses, in this case the oppressive discourse of adolescents-as-problems. This group intervention appeared to accomplish the intended effect with participants. Participant experience of this narrative group

indicated that kids developed increased understanding of the way problems can affect their development. As teens were exposed to the oppressive discourse of adolescents-as-problems, they reacted with ideas and understanding as to how they could reverse or otherwise resist the effects of this discourse through changed behavior, and consequently, changed impressions of how adults view them. These effects were expected, and are consistent with the intended client responses to the narrative process of emancipating subjugated knowledges (in this case, kids' general expectations of being viewed negatively by adults). The effects can be viewed as a kind of "re-storying" of a problem-dominated adult-teen dynamic that is not only common in society in general, but possibly much more pronounced in adolescents who have been having various mental health, substance abuse, or behavioral problems. The re-storying occurs in teens becoming aware that they can in fact influence the previously inaccessible, unfair discourse toward them by adjusting their behavior.

This process of re-storying was demonstrated in an unexpected way as well. Even as participants began to more clearly understand how and why adults view teens the way they do, some also realized that teens tend to overspecialize their views of adults in an unfair way. This was an unexpected result of the discussions generated by the arrested development group, and was helpful in raising teens awareness of their own impressions and attitudes towards others, especially adults.

While the intended effect was for teens to be exposed to the oppressive discourse of teens-as-problems, which was achieved, the re-storying process appeared to work both ways. Some participants began to examine their own attitudes toward adults in a way that counteracted the problem-dominated narrative that can exist between adolescents and adults. This dynamic is very important in the treatment setting where adults are responsible for the administration, supervision and coordination of the clinical program an adolescent is involved in. If narrative interventions can promote in teens an increased awareness of the often unfair way that kids and adults view each other, these interventions should be utilized more in the clinical setting to promote collaboration with adults, and promoting a "giving them [adults] a break, too" attitude in teens. Because this process works

both ways, it not only could hold great potential to increase treatment efficacy and positive response in adolescents, but also has potential to promote collaborative, “non-expert” attitudes in the adults responsible for their care.

Family and group therapists are called to privilege adolescent clients’ experiences, and to monitor their own biases toward teens (Garrick, & Ewashen, 2002; Bowling, Kearney, Lumadue, & St. Germain, 2002). Simply learning narrative and postmodern theory in such a way as to be able to effectively administrate the types of groups described in this study facilitates the development in staff members of a less offensive, more effective approach to kids. This kind of attitude change in staff is likely to promote client satisfaction and effectiveness of clinical programming, regardless of the type or level of problems they may be presenting with.

In summary, when considering all four of the narrative therapy treatments in the present project, it is important to note that each one in essence is social constructionism in action. All of the treatments, whether they are didactic or experiential in nature, rely on collaborative input from the adolescent participants they are designed to serve. This input is accommodated and reflected back to the teens with moderating information from the facilitator regarding the topics at hand in a recursive, flexible, language-based communication process that gets things accomplished. The treatments provide the format and structure in which this can happen. The narrative social construction of problems as opponents, and the social construction of oppressive discourses as actually being accessible by teens for modification by their behavioral choices is a powerful approach to utilize in mental health and substance abuse treatment settings.

Directions for Further Research

As the focus of this study was both quantitative and qualitative in nature, so should be the implications for future research. As an initial, exploratory study, despite its limitations, this project has brought forth questions that could be addressed through additional, more comprehensive studies.

Areas of continued interest should be client satisfaction with treatment and therapeutic alliance, improving outcomes, qualitative participant responses to narrative, and improving the climate of the clinical setting through narrative staff training and education. Because narrative therapy demonstrated some preliminary, client-specific effectiveness in terms of adolescent substance abusers, future projects should focus on the above areas of interest in regard to that population in particular.

Treatment satisfaction and therapeutic alliance

As mentioned, a limitation of the study was the relatively few narrative interventions carried out per participant, per week during the administration of the project. Future studies that are more comprehensive, both in terms of frequency of narrative therapy exposure, and number of clinicians trained in and practicing narrative therapy theory and techniques, could be more effective in making an impact on clients. Narrative therapy effects on client satisfaction with treatment and therapeutic alliance could be addressed more comprehensively with a randomized study similar to the present project, in which narrative interventions are accomplished with more frequency and with more narrative therapists. Increasing the number of participants by accessing multiple study sites could be another way to evaluate narrative therapy with adolescents in a more comprehensive manner. More robust results and information about narrative therapy effects on adolescent treatment satisfaction and therapeutic alliance would likely be achieved.

Even though such a study would greatly increase the administrative and logistical load on the primary investigator or research team, a larger project like it could be effectively accomplished through funding by a research grant that enables the employment of multiple therapists, clinicians and research associates toward carrying out the necessary research and oversight tasks.

Outcomes

In the outcome-focused arena of managed healthcare, studies examining narrative therapy for possible effects on outcomes in mental health and substance abuse clients are a potential area of

interest. If narrative interventions can be shown to demonstrate improvement in outcomes other than satisfaction or alliance with the therapist, then possibly more programs and treatment teams would be willing to invest in narrative training and implementation of narrative interventions. An example of improved outcomes could be measured by a randomized study that compares narrative and control groups on a pre and post-treatment type measure of depression or perhaps a more outwardly focused behavioral problem like anger management or other conduct related problems. Regardless of the problem addressed, narrative therapy could demonstrate replicable success in improving behavioral health outcomes, making this an appropriate future research focus.

Meanings of narrative therapy experiences for adolescents

Given the compelling participant responses to narrative therapy seen in this study, more qualitative research on adolescent impressions, ascribed meanings, and reactions to narrative interventions is indicated. Narrative therapy on a group level appears to be a powerful tool in helping construct for teens a different and less problem-dominated view of themselves and their difficulties. More studies which qualitatively categorize and examine comments about how kids perceive and absorb narrative ideas regarding their problems would be useful in applying narrative therapy to wider and more varied clinical situations. This dynamic may be as simple as the promotion of wider acceptance of narrative therapy in working with teens, resulting from increased credibility of narrative due to the cumulative evidence of more studies which highlight adolescents' reactions to narrative therapy. More qualitative studies on participant reactions to narrative would serve to promote this modality as a viable method of engaging and encouraging change in kids.

Treatment program improvement

Many adolescent treatment programs would benefit from adopting narrative stances and practices into their approach. Whether in the form of staff training and development in the postmodern and narrative approach to client-therapist interactions (i.e., 'the client is the expert'; and 'the problem is the problem'), or in the form of using narrative interventions such as the ones

implemented in this project, narrative modes and processes hold wide potential for improving and transforming adolescent treatment programs.

In the same manner as Holcomb (1994) described narrative theory, philosophy, and methods making a favorable impact on an adolescent residential treatment setting, future research could focus on site-specific change and improvement of treatment efficacy related to the incorporation of narrative ideas and therapy to the local setting. Holcomb's article addressed not only the qualitative effectiveness of narrative ideas in the clinical work with adolescents in his treatment center (not unlike what has been demonstrated in the present study), but also the positive effects that narrative theory and philosophy had on the staff there as well. Though not incorporating narrative technique to the extent as has been accomplished in the present project, Holcomb's article showed how narrative ideals such as de-emphasis on labeling were instrumental in bringing about corresponding changes in staff and supervisors' attitudes regarding kids and their treatment. Future research opportunities exist in the gathering of qualitative information about the way that staff and clinicians can be affected by gaining increased understanding and skill with narrative concepts, such as uncovering oppressive discourses, externalizing the problem and helping clients notice and develop future unique outcomes. In this case, research data would consist of qualitative, phenomenological or ethnographic information about staff reactions to and realizations about the way narrative has impacted their practice with adolescents. Research on staff perceptions of clinical atmosphere and practice changes could be helpful toward the further development of narrative therapy in the clinical setting.

Research with adolescent substance abusers

Finally, program and treatment-focused research specific to the population of adolescent substance abusers is indicated. Considering the present findings that suggest that increasing severity of substance abuse predicts the development of therapeutic alliance in adolescents who receive narrative therapy, more investigation should center on narrative therapy's utility in the substance abuse treatment setting. Each of the above areas of research interest should be carried out within the

context of adolescent substance abuse treatment in particular, to further expand clinical understanding of narrative's usefulness in the treatment setting.

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APPENDIX A

Informed Consent–Parents

Narrative therapy with outpatient adolescents

Explanation of the study

Your child is being asked to participate in a research project to study *narrative therapy*.

Narrative therapy is a type of counseling. In narrative therapy we discuss problems in his/her life which are not caused because something is wrong with them personally.

If you consent to have your child participate, the length of time he/she will be involved in the project will be limited to the length of time they are in outpatient treatment programs at Iowa Lutheran Hospital Adolescent Behavioral Health Services. Between 60 and 120 participants will be included in this study. Children will be randomly selected (like a flip of the coin) to participate in *narrative therapy*. All children participating in this study will complete two different questionnaires. One questionnaire is a measure of drug and alcohol use, and another measures how satisfied your child is with the treatment he/she received at Iowa Lutheran Hospital Adolescent Behavioral Health Services. Children randomly selected to participate in narrative therapy will participate in some additional activities. These include: *narrative therapy* group sessions, completing a therapeutic document assignment, and participating in audio taped interviews about how he/she feels about *narrative therapy*. All written and audio taped information is kept absolutely confidential and will be destroyed after the study is completed.

Risks, discomforts and possible injury

There are no known risks for participation in this study. In the unlikely event that emotional discomfort or injury occurs, additional counseling and therapy services are available through Iowa Lutheran Hospital. Any problems can be referred to the Iowa Methodist, Iowa Lutheran and Blank Children's Hospital Institutional Review Board at 515.241.5790 or to the principal investigator,

David Kaptain at 263.2411. David's supervising professor at Iowa State is Jacques Lempers, and he can be reached at 515.294.4565.

Possible benefits

Some benefits of participating are expected. Possible benefits include your child being able to better understand the process of substance abuse and addiction, and feeling better prepared to deal with any other problems in general.

Alternative therapy

Other appropriate therapies are available at Iowa Lutheran Hospital Adolescent Behavioral Health Services, such as: recreational therapy, educational groups, 1 to 1 interaction with staff members, spirituality groups, presentation groups, group therapy, family therapy and family night groups.

Confidentiality

This study is completely confidential, and no written or taped information will be made available for public viewing. Publication of findings may result from this project for the purpose of advancing knowledge. Some anonymous data from the study will be shared with the SASSI Institute, Springville, IN. Your child will never be identified personally in any reports from this study. Every effort will be made to keep personal medical data confidential, and all written and audio taped information will be destroyed at the end of the study. Any names, or numbers assigned to participant information in the study will be used expressly for identification, and will be removed and/or destroyed at the end of the study.

People to whom questions can be addressed

Additional information about your child's rights as a research participant is available from the Iowa Methodist, Iowa Lutheran and Blank Children's Hospital Institutional Review Board at 515.241.5790 or from the principal investigator, David Kaptain at 515.263.2411. Jacques Lempers can be reached at 515.294.4565.

Payment for participation

Participants who complete all questionnaires and assignments will be given a gift worth approximately \$5 for their help with this project.

Additional costs

There will be no additional cost to you or your child for participating in this research study.

Explanation of ability to withdraw from the study

Your child's participation in this study is completely voluntary, and is not a requirement of treatment at Iowa Lutheran Hospital Adolescent Behavioral Health Services. You can withdraw your child, or your child can withdraw from participation at any time without affecting treatment or incurring any other consequences. Also, the principal investigator may withdraw your child from the study if he feels it is in your child's best interest.

Consent to participate

I understand that this study will be supervised by David Kaptain and whomever he may designate as his assistants. I have read and discussed the explanation of this study. With the knowledge of the nature and purpose of the study, the possible attendant risks and discomforts, the possible benefits and the possible alternative methods of treatment, I willingly consent to have my child participate in this study. I will receive a copy of this consent form.

Parent or Guardian _____

Date _____

Investigator _____

Date _____

Informed Consent–Participant

Narrative therapy with outpatient adolescents

Explanation of the study

You are being asked to participate in a research project to study *narrative therapy*. *Narrative therapy* is a type of counseling. In narrative therapy we discuss problems in your life which are not caused because something is wrong with you personally.

If you consent to participate, the length of time you will be involved in the project will be limited to the length of time you are in outpatient treatment programs at Iowa Lutheran Hospital Adolescent Behavioral Health Services. Between 60 and 120 participants will be included in this study. You will be randomly selected (like a flip of the coin) to participate in *narrative therapy*. Everyone participating in this study will complete two different questionnaires. One questionnaire is a measure of drug and alcohol use, and another measures how satisfied you are with the treatment you received at Iowa Lutheran Hospital Adolescent Behavioral Health Services. Everyone randomly selected to participate in narrative therapy will participate in some additional activities. These include: *narrative therapy* group sessions, completing a therapeutic document assignment, and participating in audio taped interviews about how you feel about *narrative therapy*. All written and audio taped information is kept absolutely confidential and will be destroyed after the study is completed.

Risks, discomforts and possible injury

There are no known risks to you for participating in this study. In the unlikely event that an emotional problem or injury occurs, you can get additional counseling and therapy services through Iowa Lutheran Hospital. Please call Iowa Methodist, Iowa Lutheran and Blank Children's Hospital Institutional Review Board at 515.241.5790, or to the researcher, David Kaptain at 263.2411 to report any problems. David's supervising professor at Iowa State is Jacques Lempers, and he can be reached at 515.294.4565.

Possible benefits

Possible benefits include learning more about substance abuse and addiction. You also may feel better prepared to deal with any other problems as well.

Alternative therapy

Other therapies are available at Iowa Lutheran Hospital, such as: recreational therapy, educational groups, 1 to 1 talks with staff members, spirituality groups, presentation groups, group therapy, family therapy and family night groups.

Confidentiality

This study is completely confidential, and the public will see no written or taped information. Some findings from the study may be published to share what we have learned about narrative therapy. However, you will never be identified personally in any reports from this study. Some anonymous data from the study will be shared with the SASSI Institute, Springville, IN. Every effort will be made to keep your personal medical information confidential, and all written and audio taped information will be destroyed at the end of the study. Any names, or numbers assigned to the information you give in the study will be used only for identification, and will be removed and/or destroyed at the end of the study.

People to whom questions can be addressed

Additional information about your rights in this study is available from the Iowa Methodist, Iowa Lutheran and Blank Children's Hospital Institutional Review Board at 515.241.5790 or from the researcher, David Kaptain at 263.2411. Jacques Lempers can be reached at 515.294.4565.

Payment for participation

If you complete all the questionnaires and assignments, you will receive a gift worth about \$5 for your help with this project.

Additional costs

There will be no extra cost to you for participating in this research study.

Explanation of ability to withdraw from the study

Your participation in this study is completely voluntary. You do not have to participate just because you are in treatment at Iowa Lutheran Hospital. You can decide not to participate at any time without affecting your treatment or getting into any trouble. Also, the researcher may take you out of the study if he feels it is in your best interest.

Consent to participate

I understand that this study will be supervised by David Kaptain and whomever he may designate as his assistants. I have read and discussed the explanation of this study. With the knowledge of the nature and purpose of the study, the possible attendant risks and discomforts, the possible benefits and the possible alternative methods of treatment, I willingly consent to participate in this study. I will receive a copy of this consent form.

Patient _____

Date _____

Investigator _____

Date _____

Witness _____

Date _____

APPENDIX B

Treatment Satisfaction Questionnaire

Some kids like their counseling and some don't. Some kids partly like it and partly don't.

The way you answer these questions will have no effect on your counseling or discharge date. Please give your opinion about your counseling experience by answering the following questions.

1. Did your counselor(s) understand you?

1. All no
2. Mostly no
3. Mostly yes
4. All yes

2. Did your counselor(s) have good ideas that helped you?

1. All no
2. Mostly no
3. Mostly yes
4. All yes

3. Did you like your counselor(s)?

1. All no
2. Mostly no
3. Mostly yes
4. All yes

4. Did you have a bad time in counseling or did you have a good time?

1. All bad
2. Mostly bad
3. Mostly good
4. All good

5. Did your counselor(s) care about you?

1. All no
2. Mostly no
3. Mostly yes
4. All yes

6. Did your counselor(s) understand the kind of people in your family and neighborhood?

1. All no
2. Mostly no
3. Mostly yes
4. All yes

- 7. Do you feel differently now because of counseling?**
 1. All no
 2. Mostly no
 3. Mostly yes
 4. All yes

- 8. Did counseling change the way you feel about yourself?**
 1. All no
 2. Mostly no
 3. Mostly yes
 4. All yes

- 9. Do you act differently because of counseling?**
 1. All no
 2. Mostly no
 3. Mostly yes
 4. All yes

- 10. Did counseling change the way you get along with your family?**
 1. All no
 2. Mostly no
 3. Mostly yes
 4. All yes

- 11. Did you learn things that helped you in counseling?**
 1. All no
 2. Mostly no
 3. Mostly yes
 4. All yes

- 12. Did you understand what your goals were in counseling?**
 1. All no
 2. Mostly no
 3. Mostly yes
 4. All yes

- 13. Did counseling help your problems get better?**
 1. All no
 2. Mostly no
 3. Mostly yes
 4. All yes

- 14. All in all, how do you feel about your counseling?**
 1. All bad
 2. Mostly bad
 3. Mostly good
 4. All good

Please answer the following about your treatment staff members

15. The staff and I agree about the things I will need to do in therapy to improve my situation.

- 1 Not at all true 2 A little true 3 Slightly true 4 Somewhat true
5 Moderately true 6 Considerably true 7 Very true

16. What I am doing in therapy gives me new ways of looking at my problem.

- 1 Not at all true 2 A little true 3 Slightly true 4 Somewhat true
5 Moderately true 6 Considerably true 7 Very true

17. I find what I am doing in therapy confusing.

- 1 Not at all true 2 A little true 3 Slightly true 4 Somewhat true
5 Moderately true 6 Considerably true 7 Very true

18. I believe the time staff members and I are spending together is not spent efficiently.

- 1 Not at all true 2 A little true 3 Slightly true 4 Somewhat true
5 Moderately true 6 Considerably true 7 Very true

19. I am clear on what my responsibilities are in therapy.

- 1 Not at all true 2 A little true 3 Slightly true 4 Somewhat true
5 Moderately true 6 Considerably true 7 Very true

20. I find what the staff and I are doing in therapy is unrelated to my concerns.

- 1 Not at all true 2 A little true 3 Slightly true 4 Somewhat true
5 Moderately true 6 Considerably true 7 Very true

21. I feel that the things I do in therapy will help me to accomplish the changes that I want.

- 1 Not at all true 2 A little true 3 Slightly true 4 Somewhat true
5 Moderately true 6 Considerably true 7 Very true

22. I am clear as to what the staff want me to do in these sessions.

- 1 Not at all true 2 A little true 3 Slightly true 4 Somewhat true
5 Moderately true 6 Considerably true 7 Very true

23. We agree on what is important for me to work on.

- | | | | |
|-------------------|---------------------|-----------------|-----------------|
| 1 Not at all true | 2 A little true | 3 Slightly true | 4 Somewhat true |
| 5 Moderately true | 6 Considerably true | 7 Very true | |

24. I am frustrated by the things I am doing in therapy.

- | | | | |
|-------------------|---------------------|-----------------|-----------------|
| 1 Not at all true | 2 A little true | 3 Slightly true | 4 Somewhat true |
| 5 Moderately true | 6 Considerably true | 7 Very true | |

25. The things that the staff is asking me to do don't make sense.

- | | | | |
|-------------------|---------------------|-----------------|-----------------|
| 1 Not at all true | 2 A little true | 3 Slightly true | 4 Somewhat true |
| 5 Moderately true | 6 Considerably true | 7 Very true | |

26. I believe that the way we are working with my problem is correct.

- | | | | |
|-------------------|---------------------|-----------------|-----------------|
| 1 Not at all true | 2 A little true | 3 Slightly true | 4 Somewhat true |
| 5 Moderately true | 6 Considerably true | 7 Very true | |

27. I am worried about the outcome of these sessions.

- | | | | |
|-------------------|---------------------|-----------------|-----------------|
| 1 Not at all true | 2 A little true | 3 Slightly true | 4 Somewhat true |
| 5 Moderately true | 6 Considerably true | 7 Very true | |

28. The staff perceive accurately what my goals are.

- | | | | |
|-------------------|---------------------|-----------------|-----------------|
| 1 Not at all true | 2 A little true | 3 Slightly true | 4 Somewhat true |
| 5 Moderately true | 6 Considerably true | 7 Very true | |

29. I wish the staff and I could clarify the purpose of our sessions.

- | | | | |
|-------------------|---------------------|-----------------|-----------------|
| 1 Not at all true | 2 A little true | 3 Slightly true | 4 Somewhat true |
| 5 Moderately true | 6 Considerably true | 7 Very true | |

30. I disagree with the staff about what I ought to get out of therapy.

- | | | | |
|-------------------|---------------------|-----------------|-----------------|
| 1 Not at all true | 2 A little true | 3 Slightly true | 4 Somewhat true |
| 5 Moderately true | 6 Considerably true | 7 Very true | |

31. The staff does not understand what I am trying to accomplish in therapy.

- | | | | |
|-------------------|---------------------|-----------------|-----------------|
| 1 Not at all true | 2 A little true | 3 Slightly true | 4 Somewhat true |
| 5 Moderately true | 6 Considerably true | 7 Very true | |

32. The goals of these sessions are important for me.

- | | | | |
|-------------------|---------------------|-----------------|-----------------|
| 1 Not at all true | 2 A little true | 3 Slightly true | 4 Somewhat true |
| 5 Moderately true | 6 Considerably true | 7 Very true | |

33. The staff and I are working towards mutually agreed upon goals.

- | | | | |
|-------------------|---------------------|-----------------|-----------------|
| 1 Not at all true | 2 A little true | 3 Slightly true | 4 Somewhat true |
| 5 Moderately true | 6 Considerably true | 7 Very true | |

34. As a result of these sessions I am clearer as to how I might be able to change.

- | | | | |
|-------------------|---------------------|-----------------|-----------------|
| 1 Not at all true | 2 A little true | 3 Slightly true | 4 Somewhat true |
| 5 Moderately true | 6 Considerably true | 7 Very true | |

35. The staff and I have different ideas on what my problems are.

- | | | | |
|-------------------|---------------------|-----------------|-----------------|
| 1 Not at all true | 2 A little true | 3 Slightly true | 4 Somewhat true |
| 5 Moderately true | 6 Considerably true | 7 Very true | |

36. The staff and I collaborate on setting goals for my therapy.

- | | | | |
|-------------------|---------------------|-----------------|-----------------|
| 1 Not at all true | 2 A little true | 3 Slightly true | 4 Somewhat true |
| 5 Moderately true | 6 Considerably true | 7 Very true | |

37. We have established a good understanding of the kind of changes that would be good for me.

- | | | | |
|-------------------|---------------------|-----------------|-----------------|
| 1 Not at all true | 2 A little true | 3 Slightly true | 4 Somewhat true |
| 5 Moderately true | 6 Considerably true | 7 Very true | |

38. I don't know what to expect as a result of my therapy.

- | | | | |
|-------------------|---------------------|-----------------|-----------------|
| 1 Not at all true | 2 A little true | 3 Slightly true | 4 Somewhat true |
| 5 Moderately true | 6 Considerably true | 7 Very true | |

Please answer these final questions:

39. At what age did you first start to use drugs or alcohol?

40. Male or Female?

41. How old are you now?

APPENDIX C

Therapeutic Document Assignment

Instructions: Pick the one biggest problem in your life right now and write a paper about it answering the numbered questions below. Examples of problems you might choose could include:

- Drug abuse and/or addiction
- Anger/aggression
- Abuse issues
- Depression
- Suicide thoughts
- Self-harm
- Poor self esteem
- Family problems
- Stress
- Other _____

Fill in the blanks below with the problem you picked. Then, answer the questions about the problem. Use the rest of this page and the back, and add pages if you need more room. One and a half pages minimum.

1. What does _____ want from you?
2. How does _____ feel about you?
3. What are _____ 's plans for you?
4. What does _____ fear about you? What is it afraid of?
5. Now that you realize these things about _____ , how does this help you take a stand against it?

APPENDIX D

Instructions for Participants in the Narrative Therapy Research Project

Congratulations! You are a participant in an actual research study conducted through Iowa State University. Your help is very important to the success of this project. We are studying how Narrative Therapy helps kids stand up to their problems.

Your help in this project does not affect your treatment. You will not be discharged sooner or later because of the way you respond to the questionnaires or how you participate in your treatment and therapy groups. Your progress in treatment is up to you. We only want you to be honest and to put real thought into your answers. Your answers to the questions are completely confidential and will not affect how long you stay or how soon you go home.

In one questionnaire (SASSI), you will be asked to report on your substance abuse habits. Please remember that you will not get out of treatment sooner by giving false information. In fact, the SASSI test is good at detecting if you are trying to look like you have used less drugs or alcohol than you really have (lying), and you may be asked to fill it out again if necessary.

Participants who complete all of the questionnaires appropriately will receive a gift worth **5 Dollars**. Please read the following instructions carefully:

1. When admitted, fill out the **SASSI**. Turn this in to your staff members.
2. Participate in your assigned treatment groups when they are conducted during your treatment.
3. If you are in the Narrative Therapy group, complete the Therapeutic Document assignment when given the OK to do so, and turn in to staff.
4. Complete the Treatment Satisfaction Questionnaire at discharge.

The SASSI, the Therapeutic Document assignment (if assigned), and the Treatment Satisfaction Questionnaire must be completed in order for you to be eligible for the gift.

Thank you very much for participating.

APPENDIX E

Training Handout

The basics of narrative therapy

“The person is not the problem. The problem is the problem.”

“If we talk to it, it might slip up and give us the solution.”

Theoretical Background: Narrative therapy is situated in Postmodernism

1. Modernist/Foundationalist: Most therapeutic traditions fall into this category
 - Careful empiricism can detect truth in people’s lives
 - The descriptions we have of reality accurately reflect reality
 - Truth is separate from the individual
 - Epistemological question is how to know the truth
 - The therapist is the expert with ability to fix the client
2. Postmodernist/Constitutionalist
 - Concerned with how people’s lives are constructed – Social Constructionism
 - The descriptions we have of reality shape reality
 - {Subjective} truth comes from likely connections and believable accounts
 - Epistemological question is how to give meaning to experiences
 - Therapist is co-author with the client in therapy
3. Social Constructionism
 - Reality is constructed as people interact through the process of language. Reality is “languaged” into existence and subsequently maintained or altered through continuing conversations.
 - Therapeutic change involves using language to modify or co-author reality
 - Therapeutic intervention involves collaboratively re-authoring people’s stories
 - Emphasis on respectful collaboration

Major tenets of narrative therapy

- Humans interpret things. The stories of our lives (narratives) give meaning to our experiences
- The stories of our lives (narratives) determine which experiences get selected out in helping shape a story
- Narratives shape our lives. The self-narrative provides the structure of our life.

- The self-narrative is not neutral in effect.
- Different stories or self-narratives are not equal in effects.
- It is impossible for us to interpret our experiences in a vacuum. We always pay attention to context to make meaning possible.
- Our lives are multi-storied. No single narrative can be free of ambiguity or contradiction.

Basic narrative therapy terms

Narrative: The socially constructed story of an individual or group of individuals. Includes meanings, and past, present and future contexts

Discourse: A societal or culturally-bound narrative. Influential on a wide scale.

Ultimate truth story/oppressive unitary discourse: Highly influential cultural discourse that affects individuals and groups through the process of socialization in society. Dictates what is normal and acceptable for individuals and groups.

Emancipating subjugated knowledges: Re-storying or re-defining problem-dominated narratives as less subject to the dominant, oppressive discourse.

Main concepts of narrative therapy

Internalizing Conversations

- Can be pathologizing of lives and relationships by selecting out experiences which conflict with the problematic, internal conversation/concept of self, and by emphasizing experiences which support pathology
- Can be totalizing of lives and relationships (e.g. dysfunctions describe the truth of a person's identity)
- Can erase context

Externalizing Conversations

- Co-authored with the therapist to create a less problematic narrative
- Emphasizing of context
- Done to assist people in naming the problem they have been subject to. Creating a definition they can work with. (i.e. addiction becomes "a drug problem" or depression becomes "the blues")
- Encourages clients to look at the effects of certain beliefs and practices in their lives that "cooperate" with the problem
- Assists people in identifying alternative practices.

Relative Influence Questioning

- Determining how the problem has influenced the person's life (family, social, work or school life, emotions)
- Evaluating the effects of the problem (positive or negative)
- Justifying the evaluations of the problem

Unique Outcomes

- Determining how the person has influenced the problem
- Identifying specifics surrounding the unique event to highlight ways the person took charge of the problem.
- Elaborating the unique outcome to great detail to further separate the person from the problem-dominated narrative

Landscape of Action

- Historical context (past, present and future) of the problem and unique outcomes
- Events, sequences of events, time, plots, persons present; who, what, where, when and how questions
- Done to establish patterns of unique outcomes

Landscape of Consciousness

- Questions to reflect on the feelings associated with unique outcomes
- Addresses preferences, meanings, commitments, motives, values, beliefs regarding the unique outcomes
- Given enough elaboration and examination, these form commitments of life-change

Notes

APPENDIX F

Narrative Therapy Research Project Group Facilitator Instructions

Narrative Therapy Group 1, “Cunning, Baffling, and Powerful”

Narrative Therapy Group 1 is a group constructed from externalizing-type references to alcohol in the Alcoholics Anonymous Big Book (AA World Services, 1976). In this group, the facilitator leads a discussion on the Big Book's externalizing reference to alcohol as "cunning, baffling and powerful" (p.58). Using a white board and markers, the leader facilitates a local construction of the terms cunning, baffling and powerful, using the group's own definitions of these terms as elicited from the members.

Introduction

The group begins with the leader explaining where the references “cunning, baffling and powerful,” come from, chapter 5 in the AA Big Book (AA World Services, 1976, p.58). Further teaching is included at this point to reinforce the notion that the referenced chapter was written with the purpose of outlining “how it works,” that is, how the process of recovery works, how each of the 12-Steps work, and notably, how addiction works. The fact that the writers chose “cunning, baffling and powerful” as descriptors is emphasized, and that there is a reason for this which will become more apparent as the group progresses. The leader at this time also emphasizes that externalizing alcohol as “cunning, baffling and powerful” is not exclusive to alcohol. Any other particular problem (such as depression, anger, abuse issues, etc . . .) can be treated this way as well. This necessary aspect of the group makes it flexible to accommodate clients with either type of primary diagnosis.

Socially constructing definitions of addiction

Next, the leader writes the word “cunning” on the board, and asks the adolescents to volunteer their own, short definitions of its meaning. Teens may use a dictionary if desired. The

leader then writes each of these on the board under the word “cunning.” This process continues until several (five to ten) definitions are compiled and listed on the board. Definitions sought by the leader are ones reflecting the nature and meaning of the word. For example, synonyms for “cunning” include: sneaky, smart, sly, vicious, covert, fox-like, predatory, etc . . . The same procedure is followed in turn for the words “baffling” and “powerful.”

Throughout the discussion, it is emphasized that the terms cunning, baffling and powerful are often used to describe living and proactive things, and that together, they reflect a rather malevolent personality. This process is, in effect, active social construction of addiction or other problems as malevolent, intelligent and forceful entities. The problems are externalized effectively as outside, enterprising personalities. This externalizing discussion of drugs of abuse and other problems creates a context in which the group members are able to view chemical abuse and dependency or other problems as agents that are out to get them, or anyone else, through their cunning, baffling and powerful influences on people. In addition to recording on the board the group’s responses, the leader guides discussion to invite specific, personal examples or vignettes from adolescent members illustrating just how problems have been cunning, baffling or powerful in their life.

Group Therapy 1 ends with a discussion centered on the H.O.W. of recovery (Honesty, Open-mindedness, and Willingness) as a viable way of combating the cunning, baffling, and powerful wiles of substance-related or other problems. This conclusion emphasizes personal agency in resisting problems, as H.O.W. are all individually-based characteristics necessary for success in recovery and change.

Narrative Therapy Group 2, “Interviewing the Problem”

Narrative Therapy Group 2 builds on the processes of group 1, taking the idea of problems as malevolent entities, a bit further. This is accomplished by having adolescent volunteers in group play the part of a specific problem or drug of choice, role playing it as if it had a personality all its own. Volunteers therefore take on the "personality" of the problem, by attempting to think like and act like

the chosen problem or drug. The group leader facilitates this role play by "interviewing the problem." This group therefore is suited to address non-drug related problems such as depression, suicide or anger. Volunteers take on the persona of any particular, disruptive problem in their life, and the group continues as follows.

Introduction and set up

This group begins with the group leader reviewing the discussion generated in Narrative Therapy Group 1, emphasizing the way that addiction and substance abuse appear to be interested in getting at people in a destructive way. The leader then invites a group member to play the part of their most influential problem. The leader asks the volunteer to imagine that the leader is reporter or interviewer of some type, seeking to find out more about the identified problem. The other members are instructed to watch carefully and plan for any questions they might ask that don't get covered in the interview process. The volunteer (playing the part of the problem or drug) is then interviewed by the group leader in front of the other group members, answering questions as if he/she is the problem. Use the standard question set provided as a guide for questioning.

The questions asked have to do with the problem's plans, intentions, feelings and attitudes towards the volunteer, and the volunteer answers as if he or she is the problem. Other topics discussed may include how long the problem has known the volunteer and what are some of its favorite ways of influencing the volunteer. After five to ten minutes of interviewing (or however long it takes to cover the question set), group members are encouraged to ask questions of and make observations about the problem.

When the interview is over, the group leader thanks and excuses the problem and invites comments from the volunteer and group members as to what they had gained from the experience of interviewing the problem. Questions to be asked of the volunteer include: "how did it feel to be your problem?" and "what was its attitude about you?" Realizations of group members that reflect the seemingly intentional behavior and attitudes of the problem are highlighted and emphasized. If there

is time, another interview may be conducted, or the group can conclude with discussion regarding what everyone had learned from the session. When this process is most effective, the volunteer may be angry or emotional about the realizations they have gained regarding the problem.

Narrative Therapy Group 3, “Landscape of Action” or “Circles”

Narrative therapy group 3 is more didactic in nature. The narrative focus here comes from emphasizing and highlighting societal discourses that encourage chemical abuse and dependency.

The discourse of acceptable substance misuse is addressed in Narrative Therapy Group 3. In this group the leader outlines and describes, with the help of the group members and a whiteboard, the various levels of influence that substance use/misuse enjoys in society. This is done by illustrating an individual's embeddedness in multiple layers of influence as part of the social structure of society.

The group begins with the following introduction, designed to introduce adolescents to the existence of the harmful discourse of acceptable substance misuse. The leader states the following: *“Substance abuse and addiction enjoy a rather influential place in our society and world today. Tobacco kills thousands per year in the US alone - yet remains legal. The same is true for alcohol, but worse, because innocent people die in drunk-driving accidents daily (not to mention the individual and family lives it destroys every year). Illegal drug abuse is glorified in popular songs and movies with little mention of the lives it destroys. Tobacco and alcohol are legal to use, and illegal drug use is often seen as “normal” or “a phase” that everyone goes through. So, despite bringing many apparently negative consequences, substance abuse and addiction remain strong and influential on many levels of society. Today we will look at the way drugs and addiction affect each of these levels. We will do this in order to help you decide for yourselves if all this is fair or not.”*

The group continues as the leader uses the white board to graphically draw out the individual in Parsonian context with increasingly wide levels of influence. These levels include individual,

family, community, city, state, country, world and so on with increasingly wide circles representing the various levels. Next, the leader points out each level and at each level, questions are asked of the group regarding the presence of or influence of substance use/abuse in that level, and about what apparent effects the substance use/abuse has on individuals or groups of individuals in each level. Specific effects elicited from group members or given by the leader are listed on the board at each level.

Individual level

Starting at the individual level, the leader discusses and elicits from the group members, obvious effects of substance abuse and addiction. Individual level effects include: personal and family problems caused by substance abuse, health problems, legal problems, social environment problems and any other individual level consequences adolescents can relate to.

Family level

On the family level, effects include: communication problems, marital problems, isolating from family members, various forms of abuse, money problems, unhealthy family dynamics common in chemically affected families, and poor family relationships.

Community level

The next level may require more direction by the group leader, as adolescents may not have as much awareness of wider effects of addiction and substance abuse. Community and city level effects include death and injury caused to others by drunk driving, organized crime and crimes involved with drug trafficking, gang activity, increases in violent crime, and littering. Community level health effects are introduced, such as overdoses, hepatitis and AIDS infection, increases in STD transmission, and higher rates of teenage sexual activity and pregnancy among drug and alcohol abusers.

National level

The next higher level of abstraction is the country/national level. The effects at this level are similar to the previous level, only emphasized as wider still, and more pervasive. National trends in substance abuse, such as rates of teens using alcohol or other drugs are introduced by the leader. Estimates of the annual costs to productivity and health care caused by drug and alcohol abuse are also given. The leader places emphasis on widespread effects of substance abuse and addiction.

International level

The last level discussed is the international/world level. The leader introduces issues such as the Drug War, illegal drug trafficking, poor countries and people feeding the habits of the industrial powers of the world, national and international corruption and economics, all supported by the abuse of drugs. Also introduced to the group is information regarding US tobacco companies increasing marketing to third-world countries in response to mounting pressure and declining sales in the US, leading to inevitable health consequences for the people living there. Further information regarding the disparity between monies provided by the federal government for drug interdiction vs. funding for treatment programs is given as well at this level of discussion. This emphasizes that addiction remains strong as long as it is not treated. All the money in the world can be spent to fight drug importers, but as long as there remains a demand (because not enough people get treatment and prevention services), interdiction efforts will be futile.

To conclude the group, the leader invites observations and discussion from adolescents regarding how they feel about the information presented. The leader asks questions including: Is this fair? If addiction and substance abuse cause such widespread problems, why is it allowed to continue? The point of the group is to expose the true consequences of the societal discourse of accepted and acceptable substance misuse, so teens can make informed decisions about whether or not they want to be a part of this unfair process.

The most noticeable effects of substance involvement are negative ones, such as the health costs of tobacco use, the injustice of injury and death caused to others by drunk drivers, kids being

placed in treatment, or various types of individual and family dysfunction resulting from substance abuse. These negative effects are highlighted and discussed in the group, with an overall emphasis that focuses on the pervasiveness of substance use/abuse and addiction at all levels of complexity in society. By giving a globalized perspective of the influence of "the problem," this group exposes the societal discourse of acceptable substance misuse and its resulting effects on all levels of society.

Narrative Therapy Group 4, "Arrested Development"

Narrative Therapy Group 4 addresses the oppressive societal discourse of adolescents-as-problems, through educating teens on the comprehensive, individual-level effects of substance abuse problems and other adolescent problems on the complex process of adolescent development. This is accomplished by teaching the concept of "arrested development" in a group setting.

Introduction and part 1

In this group, the leader begins by discussing the concept of human development, to orient the group to various aspects of adolescent development. The leader opens with the following statement: *"Today we will discuss development, and what it means for you as kids growing up in the world today. Most simply, development means to change and grow. If no positive changing and growing is occurring, no development is occurring. Many of the problems that have brought you to the hospital have the nasty habit of causing your development to slow down or stop completely. There are actually five areas of your development that can be affected by the problems in your life, no matter what they are. These problems could be addiction, drug abuse, anger, suicide thoughts, depression or family problems, etc . . . Any of them can cause your development to be slowed down or stopped – arrested. This arrested development can cause you some real problems that you might not have thought about, and this is why we are doing this group today. I want you to know how this arrested development messes up the way you deal with important people in your life, and the way they deal with you."*

After the opening statement, both the group members and leader provide input to define the specific areas of: social, intellectual, identity, spiritual and physical development. To define these areas in the group, the leader simply asks the members to give definitions of each, and also adds his/her own information until each area of development is fully described. The collaborative definitions of each area are placed on a white board to help with retention (similar to how “cunning, baffling and powerful” were defined and listed in Narrative Therapy Group 1).

Social Development

The area of social development focuses on such concepts as interaction with peers, significant adults and authority figures. Healthy peer relationships are highlighted and discussed, such as relationships based on friendship and mutuality rather than on sex or drug-dealing. Emphasis is placed on how adolescents negotiate relationships with adults and authority figures such as parents, teachers, coaches and bosses. Problems (such as drug abuse, depression, oppositionalism, anger, etc....) in teens' lives will discourage rather than encourage these types of interactions, as troubled kids will often spend time and energy avoiding significant adult interaction. This occurs so the adolescent can hide what is going on, or, because of isolating behavior and withdrawing from family and adult interaction. Since the process of social development is one of trial and error, the fewer trials a teen has to draw from, the less development occurs resulting in arrested social development.

Intellectual Development

Intellectual development for adolescents primarily includes school and academics. This section of the group highlights the ways that adolescent problems affect their schooling and information retention. Teens easily identify with learning deficits and difficulty related to substance abuse, and also easily relate to skipping classes as causing problems in learning. The concept of state-dependent learning is introduced, citing studies that have found that the brain best recalls information when it is in the same state as when the information was encoded. In other words, if learning occurs when an individual is under the influence of a substance, they must be in the same

state in order to recall that information later. Since one can't be high "24-7" (even kids admit this) it is logical that the more time one spends under the influence of substances, the less intellectual development that occurs. Behavioral and emotional problems as well are highlighted as being problematic to intellectual development.

Identity Development

Identity development is a multifaceted process that involves how the adolescent views him/herself and how they are viewed by others. Teens in the substance abusing subculture are exposed to others who are at best manipulative and dishonest. At worst, they hang around almost exclusively with others who are anti-authority, anti-social and inherently selfish. Adolescent identity development is powerfully associated with the groups to which they belong. In essence, adolescents become who they are associating with. Kids who have been in the drug-using subculture readily admit that it is a "use or be used" environment where they personally, or others they know, have been hurt, cheated or abused in some way. The emphasis in this section, therefore, lies in pointing out that given enough time, one's identity can be shaped significantly by the limited interactions available in the social groups to which one belongs. If the only group an adolescent belongs to or associates with is a negative and destructive one (whether substance-abusing or not), they can expect to believe that this is what they are, or are destined to become. When these concepts are explained this way, many teens will admit this is not what they want to be, that they do not want their development arrested in this way.

Spiritual Development

Spiritual development is highlighted in the group by addressing how connected, or not, the teens feel to God or the concept of a Higher Power. Many teens in treatment will relate that as they have developed more and more problems in their lives, they discontinued spirituality practices such as going to church or praying, habits they may have had earlier in their lives. The spiritual component of the 12 Step program is highlighted, and emphasis is placed on how it is unlikely that one would

seek spiritual things if one is consistently involved with the selfish pursuits of drug abuse or other problems. Given that spirituality is promoted in the 12-Step program as a way to overcome deficits in character and behavior, this concept is constructed for adolescents as one that does not have to remain arrested.

Physical Development

Physical development is easily discussed as adolescents are generally aware of the physical problems caused by substance abuse. Highlighted are the obvious problems caused by substance abuse and addiction, such as lung and heart disease, liver disease and memory impairment. Cited are studies that have found that chronic marijuana abuse leads to a thickening of synaptic membranes in the brain, which has been associated with cognitive deficits in pot smokers. Also discussed here are general effects of using substances on fitness, coordination and athletic achievement. Consequences of other behavioral problems that include decreasing activity levels or discontinuing involvement in sports or other activities are discussed as well. The group members provide many of the examples in this section, and generally can admit to their development being arrested in this area.

Part 2

After detailing the five areas of adolescent development, members are introduced to the oppressive discourse of adolescents-as-problems, by asking the group the following questions: "What are the teen years supposed to be like? Are they good or bad? Calm or chaotic? Easy or hard?" Upon receiving input that typifies the common understanding of teenage years being stormy and stressful, the leader exposes this discourse by proposing an alternative view. This view consists of seeing adolescence as a time of definite change, but not one that is necessarily stormy and stressful. The main point is to emphasize that because adolescence is a time of such dramatic change, it is often overspecialized by adults as a time of unavoidable frustration, stress and conflict. This understanding sets the stage for the next phase of the group.

The group leader now asks members to give examples of how their development in each of the previously discussed areas has been arrested. The leader encourages each member to comment on as many of the areas of development as possible, giving examples of how their development personally has been arrested. As group members list and give examples of the ways their areas of development have been affected, the group leader begins to tie this information to the existence of the oppressive discourse affecting adolescents.

This process is accomplished by emphasizing that if teens participate in the arresting of their own development by using drugs and alcohol, having behavior problems, avoiding adult interaction, etc . . . they may be inadvertently supporting the discourse of teens-as-problems. As teens give examples of how their problems have brought them into conflict with adults, they provide the examples of how they unknowingly supported the popular view of kids as troublemakers. The group then is successful at exposing not only how adolescents may have affected their personal development, but also how they have contributed to the oppressive discourse of teens as problems. The leader finishes the group by stating *“Growing up is hard enough without adding a bunch of problems to your life. You guys have the power to prove people wrong or right about you – that teens are troublemakers, or just learning how to grow up.”*

APPENDIX G

Question set and guide for “Interviewing the Problem” (Narrative treatment 2)

- “How long have you known this person?” When and where did you first meet?”
- “How often do you and this person hang out?”
- “What does this person usually do when you are together?” What kinds of things happen to this person when you are with him or her?
- “Do you interfere with this person’s thinking? Judgment? Opinion of him or herself?”
- “In what areas of this person’s life are you causing the most problems? Family? Friends? School?”
- “In which of these areas do you think you have the upper hand most often?”
- “Do you work with anyone or anything else when you are with this person?”
- “Is there anything that makes this person more likely to hang out with you at one time or another?”
- “How does this person feel about you?” How do you feel about this person?”
- “Did you tell this person about what you would be doing to his/her life?”
- “How do you feel about the bad things that have happened to this person because of his/her involvement with you?”
- “What about this person is troublesome for you? Is there anything about this person that makes you worried?”
- “Does this person ever disagree with you? What would happen if this person invited you out of his/her life?”
- “How do you feel about the fact that we have learned more about you today?”

APPENDIX H

Question set/guide for qualitative interviews

Grand tour question: “What has your experience of and reactions to narrative therapy groups been like?”

Mini-tour questions:

“Which was your favorite group, and why?”

“Has attending these groups helped you change your thoughts, beliefs or behaviors?”

“Is there any difference between these groups and others you have done?”

“How does talking about problems in these groups affect the way you see your problems?”

“Do you think these groups will help you deal with your problems in the future?”

APPENDIX I

Coding Schemes

Preliminary Coding Scheme

Liked it, appealing, pleasant

Helpful (current and future), pleasant

Individual group references (unsolicited)

People more open

Exposure of drug issues

Deciding not to do drugs

Increased global view

If one person changes. . .

Starts with one person

Realizing, eye-opener

Group size

Externalizing references

Problems inter-relating

Different, different angles

New way to look at problems

See things in a different way

Uniqueness

H.O.W. (solution)

Explained things well

Solutions

Giving the older generation a break

Resistance

Prevention

Do the groups more, in more areas

Effort-inspiring

Normalizing problems (demystifying them, less personal)

Arrested Development group

Understand where adults come from

Changed minds

Refined coding system

Codes

Like: liked, appealing, pleasant

Help: helpful currently and in the future

Size: group size matters

Global: exposure of wider view, inter-relatedness of problems, individual's role in the big picture

Effect: effectiveness of approach, explained things well, effort-inspiring, opinion that groups should be done more often, etc. . . , changed minds, realizations, eye-opener, in-depth, showed. . .

Ext: externalized references

R/P: resistance and prevention, deciding not to do drugs, fighting the problem, solutions, H.O.W.

Norm: normalizing problems, demystifying problems, less personal, participants more open

Novel: novelty of approach, different, different angles, new way to look at problems, fun, better, interesting

Final coding scheme

Appeal: perceptions of liking the groups, being helped, and usefulness of small group size

Global: exposure of wider view, the inter-relatedness of problems, individual's role in the big picture (dropped)

Effect: effectiveness of approach, explained things well, effort-inspiring, opinion that groups should be done more often, changed minds, realizations, eye-opener, in-depth, showed things.

Ext: externalized references

R/P: resistance and prevention, deciding not to do drugs or other behaviors, fighting the problem, solutions, H.O.W.

Norm: normalizing problems, demystifying problems, less personally-directed, participants more open, feeling less alone with problems, understanding adults more

Novel: novelty of approach, different, different angles, new way to look at problems, fun, better, interesting

AD: comments about "arrested development" group

ITP: comments about "interviewing the problem" group

Circles: comments about the "circles" group

CBP: comments about "cunning, baffling and powerful" group

APPENDIX J



Route 2, Box 134
Springville, IN 47462

(800) 726-0526
Training: (800) 697-2774
Fax: (800) 546-7995
www.sassi.com

October 1, 2001

David Kaptain
Iowa Lutheran Hospital
700 E. University
Des Moines, IA 50316

Dear David:

Enclosed are 100 Adolescent SASSI-A2s, a scoring key and a User's Guide. The SASSI Institute is pleased to support your research by providing these materials. As we have discussed, I would appreciate it if you could share your data with us for our ongoing analyses. If you wish to do so, please contact me after you have completed collecting the data.

Best wishes in your research endeavors, and please contact me if I can be of further assistance.

Sincerely,

A handwritten signature in black ink that appears to read "Frank".

Frank Miller, Ph.D.
Research Coordinator

FM/mb
Enclosures

INSTITUTIONAL REVIEW BOARD

1215 PLEASANT ST., SUITE 303
DES MOINES, IOWA 50309
(515) 241-5790
FAX (515) 241-4185

October 9, 2001

David Kaptain, MS, CADC
Iowa Lutheran Hospital
Dual Diagnosis Unit
700 E. University Avenue
Des Moines, IA 50316

Dear Mr. Kaptain:

The Institutional Review Board of Methodist/Lutheran & Blank Children's Hospital met on October 8, 2001 and approved the following protocol and informed consent.

Narrative Therapy - Narrative Therapy with Substance Abusing Adolescents: A Dissertation and Treatment Model Proposal

Approval of a study should not be interpreted as a granting of any hospital privileges to any of the investigators participating in the study. Individual investigator participation is restricted to Methodist/Lutheran & Blank Children's Hospital where he/she has been granted applicable privileges.

Your protocol has been given the following ID Number: **IM2001-045**. Please refer to this number when making inquiries regarding your research study.

Your study has been approved for the period from November 8, 2001 to November 7, 2002. The continuation review for this study will be scheduled for October 10, 2002. You will receive a continuation form to complete prior to this date. Each investigator is responsible for notifying the IRB whenever approval of the study or investigator is withdrawn by the sponsor, FDA, or HHS. Additionally, each investigator shall notify the IRB in the event that the investigator discontinues the study at any time other than the scheduled completion date, and an investigator is required to report promptly to the IRB, within 24 hours, any fatalities and life-threatening or serious adverse events occurring in subjects enrolled in a protocol or variance from the approved protocol. At the conclusion of the study, the IRB may require such follow-up information and documentation of a completed or discontinued study as it may determine appropriate.

This IRB operates in accordance with all applicable federal, state and local laws and regulations.

Please contact me if I can be of further assistance.

Sincerely,



IOWA STATE UNIVERSITY
OF SCIENCE AND TECHNOLOGY

Institutional Review Board
Office of Research Compliance
Vice Provost for Research and
Advanced Studies
2810 Beardshear Hall
Ames, Iowa 50011-2036
515 294-4566
FAX 515 294-7288

TO: David Kaptain

FROM: Human Subjects Research Office

PROJECT TITLE: "Narrative Therapy with Outpatient Adolescents"

RE: IRB ID No.: 02-424

APPROVAL DATE: April 24, 2003

REVIEW DATE: April 24, 2003

LENGTH OF APPROVAL: 1 year

CONTINUING REVIEW DATE: April 3, 2004

TYPE OF APPLICATION: New Project Continuing Review

Your human subjects research project application, as indicated above, has been approved by the Iowa State University IRB #1 for recruitment of subjects not to exceed the number indicated on the application form. All research for this study must be conducted according to the proposal that was approved by the IRB. If written informed consent is required, the IRB-stamped and dated Informed Consent Document(s), approved by the IRB for this project only, are attached. Please make copies from the attached "masters" for subjects to sign upon agreeing to participate. The original signed Informed Consent Document should be placed in your study files. A copy of the Informed Consent Document should be given to the subject.

If this study is sponsored by an external funding source, the original Assurance Certification/Identification form has been forwarded to the Office of Sponsored Programs Administration.

The IRB must conduct **continuing review** of research at intervals appropriate to the degree of risk, but not less than once per year. Renewal is the PI's responsibility, but as a reminder, you will receive notices at least 60 days and 30 days prior to the next review. **Please note the continuing review date for your study.**

Any **modification** of this research project must be submitted to the IRB for review and approval, prior to implementation. Modifications include but are not limited to: changing the protocol or study procedures, changing investigators or sponsors (funding sources), including additional key personnel, changing the Informed Consent Document, an increase in the total number of subjects anticipated, or adding new materials (e.g., letters, advertisements, questionnaires). Any future correspondence should include the IRB identification number provided and the study title.

You must promptly report any of the following to the IRB: (1) **all serious and/or unexpected adverse experiences** involving risks to subjects or others; and (2) **any other unanticipated problems involving risks** to subjects or others.

ACKNOWLEDGMENTS

The writer would like acknowledge the invaluable assistance, support and encouragement of the following individuals, without whom the completion of this project could not have been realized.

Amy Ohelert and Kevin Brown, who took their professional and personal time to train for and administrate narrative therapy treatments. Diane Benjamin, Dee Van Horn, and Shirley Falz of the Adolescent Partial program for arranging their schedules, assisting with consents and questionnaires, and supporting the addition of narrative treatments to their program. Andrea Murray and Kim Easley of the Extended Outpatient program, for arranging their schedules and encouraging their patients to participate.

Dr. Lempers for encouraging me to pursue a doctorate in the first place.

I am grateful for the encouragement and support of my family. My wife Holly, for incredible editorial and transcription support, patience, encouragement, and sacrifice. My kids, Alex, Elea and William for putting up with Daddy being in the basement all of the time. My extended family for prayer, encouragement and support.

Most importantly, I give thanks and praise to my Lord and Savior, Jesus Christ, for giving me strength, wisdom and endurance when I had little left.

Thank you all from the bottom of my heart. I truly could not have completed this endeavor without you.