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Children's Stories: A Narrative Resource

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CHILDREN'S STORIES: A NARRATIVE RESOURCE

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Narrative therapy is grounded in the principle that individuals create personal narratives, or life-stories, out of their experiences in order to organize and create a frame of reference for understanding these experiences. The nature and tone of these narratives influence real-life patterns. Narrative therapy focuses on exploring problematic narratives, and collaborating with the client to create new, more positive personal narratives.

Narrative therapy has been used with individuals, children, families, couples, and groups; yet its research base is limited. Likewise, there is limited literature on eliciting the initial problem-saturated narratives in work with children. Literature on the topics of child-centered practices and children's disclosure, however, supports the notion that children often have a difficult time sharing their stories with others, especially with adults. From a narrative therapy perspective, the consequences of failing to elicit an initial problem-saturated narrative are significant. If one cannot gain access to the problem-saturated story, it is impossible to re-author a more adaptive story. The question then becomes: how does one elicit the problem-saturated narrative with children who are hesitant to discuss their experiences?

This dissertation addressed this issue by creating a therapeutic tool to assist in eliciting children's stories, namely, a collection of stories written by children facing a wide range of difficulties. Clinicians may read these stories with clients facing similar problems to facilitate the

elicitation of the client's narratives. After collection of these stories, children's attitudes to the narrative-collection process was explored; as will clinicians' attitudes to the use of such a tool.

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CHAPTER I

INTRODUCTION

Narrative therapy centers on the exploration and reworking of the stories we tell about our lives. In essence, we create internal stories about our lives in a way to organize our experiences, and these stories both reflect reality and form the basis for future perception and behavior. When our stories become problem-saturated, we feel and act in problematic ways, and we filter our experiences to prioritize the problematic over the functional.

Narrative therapy has been used with individuals, children, families, couples, and groups; yet its research base is limited. Likewise, there is limited literature on eliciting the initial problem-saturated narrative in work with children. Literature on the topics of child-centered practices and children's disclosure, however, supports the notion that children often experience difficulty sharing their stories with others, especially adults. The question then becomes: how does one elicit the problem-saturated narrative with children who are hesitant to discuss their experiences?

This dissertation will address this issue in the context of narrative therapy by creating a therapeutic tool to assist in the gathering of narratives, namely, a collection of stories written by children facing a wide range of difficulties. In the course of this collection, other pertinent information regarding children's attitudes to the narrative-collection process will be gathered; as will information regarding clinicians' perspectives on the use of such a tool.

CHAPTER II

REVIEW OF RELEVANT LITERATURE

Theoretical Origins of Narrative Therapy

Narrative therapy has steadily gained popularity as a psychotherapeutic approach to the treatment of adults, children, and families since its inception in the early 1990's. Michael White and David Epston are generally credited with the creation and dissemination of this approach through their many publications, workshops, and their work at the Dulwich Center in Adelaide, Australia (Relin, 2007). Narrative therapy emerged from a background of primarily postmodernist and social constructivist ideas (Eppler & Carolan, 2005). These movements offer an alternative to the traditions of empiricism and objectivism. Although narrative therapy has expanded beyond these theories, it is helpful to ground a discussion of narrative therapy by presenting its principal influences.

Originally a philosophical movement, postmodernism rejects the notion that there is a universal Reality determined by a set environment; but rather argues that there are multiple "realities" determined by the individual. Likewise, there is no universal Truth, but rather multiple "truths" depending on cultural context, individual subjectivity, and the accepted norms of society. These truths can be powerful, because they are often implicitly accepted as "Truth" and go unchallenged by individuals (Eppler & Carolan, 2005).

Also a primarily philosophical movement, social constructivism builds on postmodernism by specifying that individual realities are constructed through interpersonal interactions; and especially through language used during these interactions. According to social constructivism, language (both verbal and nonverbal) organizes relational interactions into "narratives", which mediate our understanding of lived experiences, and serve as a filter through which we experience future interactions (Eppler & Carolan, 2005). Narratives are stories people frame

about themselves and their lives, which both reflect and create reality for the individual (Zimmerman & Beaudoin, 2002).

O'Connor et al. (1997) suggest that narrative therapy be labeled as "an approach rather than a theory because it describes certain ways of thinking about families rather than an adherence to a series of well-defined concepts about healthy and dysfunctional families" (O'Connor et al., p. 480, 1997). This approach to therapy emphasizes the exploration, evaluation, and potential revision of a person's stories in a manner that fosters improved life functioning. As a relatively recent development to the field, the narrative therapy approach would benefit from considerable examination and development. For the purposes of the current research, narrative therapy will be defined as an approach to therapy that embraces a number of both theoretical guidelines and specific techniques. The discussion to follow will highlight features of the narrative therapy approach that are well established in addition to developing recommendations for issues to be explored in this project.

Narrative Therapy: The Theory

The core construct of narrative therapy is that of narratives, or life-stories. Over the lifespan, individuals build narratives out of their experiences in order to "give a frame of reference for understanding and making experiences understandable" (Etchison & Kleist, p. 61, 2000). Experiences (in this context) may take any form, but narrative therapy places particular emphasis on experiences involving interactions with other people, especially those interactions involving language. Since people are constantly gathering more experiences, their narratives are dynamic and ever-changing (Zimmerman & Beaudoin, 2002). In this sense, narrative therapy offers clients an opportunity to gather experiences that are contradictory to, and potentially more

adaptive than, their problem narratives. These unique experiences will play an important role in the formulation and employment of new, more adaptive narratives.

In the narrative therapy approach, problems occur when lived experiences are not congruent with the dominant narratives. People are constantly exposed to, and subsequently internalize impossible societal standards; yet believe that these standards are justifiably valued ideals of fulfillment and excellence. When the individual's personal experience inevitably falls short of achieving these standards, their narratives become oppressive (Carr, 1998). When this happens, the individual is often unable to separate their own identity from their problems or from the contexts that produce or maintain them. He subsequently begins to think of himself as "a bad person" or "the problem", rather than as a person who is facing external, albeit significant, adversity (Zimmerman & Beaudoin, 2002). These oppressive self-narratives lead to problems such as excessive self-criticism, feelings of powerlessness, anxiety, depression, etc. (Carr, 1998). As this narrative illustrates, a narrative may reflect particular difficulties with adaptation that are reflected in theoretical approaches with which modern practitioners may be familiar. In this case, the tenets and empirical foundations of learned helplessness have already established the notion that negative self-appraisal often becomes a self-fulfilling prophesy (Nolen-Hoeksema, Girgus, & Seligman, 1986).

Narrative Therapy: The Practice

The primary goal of narrative therapy is "re-authoring": a process by which therapist and client collaborate to author a new, more adaptive narrative (Carr, 1998). In his original model of narrative therapy, Michael White laid out nine core practices to aid in this goal: position collaboratively, externalize the problem, excavate unique outcomes, thicken the new plot, link to the past and extend to the future, invite outsider witness groups, use re-membering practices and

incorporation, use literary means, and facilitate taking-it-back practices. Although the degree to which each practice is emphasized varies by author ((Etchison & Kleist, 2000), (Zimmerman & Beaudoin, 2002), (DeSocio, 2005) etc.) it is useful for the purposes of this research to elucidate each core practice to some degree. In the following paragraphs I will therefore discuss White's nine core practices, primarily as summarized by Carr (1998). These core practices represent techniques that are present in the work of many narrative therapy authors, and it is useful to consider them here. Although each of these practices may be used at different points in therapy, at the discretion of the narrative therapist, these practices are presented sequentially for clarity's sake. The reader should not infer an overly linear view of the actual practice of narrative therapy.

The first practice in White's narrative therapy, "position collaboratively", describes how to set up the therapeutic environment and the therapist stance. This practice requires that the therapist adopt a collaborative, co-authoring, consultative position with the client. Since narrative therapy assumes that individual realities are constructed through language and organized by narratives, the narrative therapist does not seek to determine the objective facts, but rather seeks to explore the client's subjective realities through therapeutic conversations. The narrative therapist uses these conversations to gain access to the client's primary and problematic narratives, while privileging the client's language in defining these narratives (Carr, 1998).

As the therapeutic conversation begins to reveal the problem narrative, White recommends beginning the second practice of externalizing the problem (Carr, 1998). This practice is generally recognized as a cornerstone of narrative therapy, and involves complex processes that bear extensive description and analysis. Externalization serves several functions in narrative therapy, the first of which is to establish that problems do not exist within individuals. The therapist begins to teach this concept by asking a particular style of questions (with careful

attention to language), in which person and problem are firmly established to be separate. The client is encouraged to view, and then to use language to describe, the problem in external terms. For example, clients may shift from using language such as "I have a tendency to overreact" to "Sometimes frustration is too strong for me." In this example, the client shifts from a focus of trait-like self-attribution to one of a state-like struggle against an external force: Frustration. By teaching the client to view the problem from a different perspective, the client begins to learn that "the stories of their lives are actively constructed, rather than passively recounted and given" (Carr, 1998, p. 491). This lays the groundwork for the idea that constructing a more adaptive story is possible.

This leads to the second function of externalization, which is to explore the degree to which the problem exerts influence over the individual, her life, and her relationships. The language and style of questions used in this practice also communicate to the client that the problem invites, but does not compel, her to act in certain problematic ways. During this step, the client and therapist explore the negative effects of these actions (O'Conner et al., 1997). For example, the therapist might ask a girl with anorexia "how far has anorexia nervosa encroached upon your life?" or "in that situation, were you stronger than the problem or was the problem stronger than you?" (Carr, 1998, p. 491-2).

The third function of externalization is to remove the weight of blame and increase personal accountability. Externalization allows the client to describe his self and his relationships from a non-problem saturated perspective so that he experiences greater hope and impetus to fight against the problem (Eppler & Carolan, 2005). This shift increases the likelihood that the client will be able to take responsibility for stopping the problem's effects (Zimmerman & Beaudoin, 2002). Moreover, a discussion of how the problem exerts influence over the

individual's behavior inevitably opens space for a discussion of how the individual exerts his own influence over the problem. Externalization of the problem increases, rather than takes away, personal accountability. Once the client can successfully externalize his problems, the therapist can join with him to fight against these problems (Carr, 1998).

The third practice in White's narrative therapy is that of excavating unique outcomes. In this practice, clients are encouraged to intentionally notice experiences that deviate from the problem-saturated narrative. These are occurrences in which events or experiences don't fit the problem-narrative, or in which the problem-story's influence is less apparent or nonexistent. This practice aims to increase personal agency (Carr, 1998), and these occurrences will be the building blocks of authoring new, more positive narratives. Excavating unique outcomes builds on the increased awareness of the problem as influential, rather than omnipotent, which is fostered during the practice of externalization. Once these unique outcomes have been identified, the client is encouraged to account for them, and to re-describe themselves and their relationships in light of this new perspective (Carr, 1998).

The exploration of unique outcomes leads to the fourth practice, "thickening new plots", or the co-construction of alternative narratives. In this practice unique outcomes (and the positive self-attributes revealed by them) are incorporated into a new, more positive narrative. The narrative therapist facilitates this co-construction by asking two forms of questions: landscape of action and landscape of consciousness questions. The former thickens descriptions in terms of events, sequences, time, and plot. The latter help the client explore significance in their narrative by exploring meaning, effects, evaluation, and justification (Carr, 1998).

Once the new, more adaptive narrative has been created in sufficient detail, client and therapist link the new story to the past and extend it into the future (Carr, 1998). In order to link

the new story to past events, the therapist asks questions that help clients "excavate forgotten or marginalized aspects of their experience" (Carr, 1998, p. 495) that were inconsistent with the problem-narrative, but support the new preferred-narrative. For example the therapist might ask, "If I were watching you earlier in your life, what do you think I would have seen that would have helped me to understand how you were able to recently achieve X?" (Carr, 1998, p. 495). To extend the preferred-narrative into the future by asking questions that encourage the client to "imagine alternate ways of being that are consistent with their preferred self-story" (Carr, 1998, p. 495). For example, the therapist may ask "If you found yourself taking new steps towards your preferred view of yourself as a person, what would we see?" (Carr, 1998, p. 495).

The practice of extending the story into the future is similar to solution-focused therapy's use of the "miracle question." In this practice, the therapist asks some form of the following line of questions: "Suppose a miracle happened and the problem that's been troubling you is sorted out and disappears. What is the first thing you'd notice that would let you know the miracle had happened? What would you find yourself doing, and what would others notice you doing?" The purpose of this practice is to form a picture of the "preferred future" without the problem that led the client to seek therapy (Lethem, 2002). There may be an argument for using solution-focused therapy in conjunction with a narrative approach because of their similarities. This blending of approaches certainly has merit but extends beyond the current discussion. In addition, the current work is intended as an exploration of narrative therapy alone, and the attempt to integrate solution-focused approaches at this point would be detrimental to a systematic focus on narrative therapy.

The sixth practice recommended by Michael White's narrative therapy is that of involving outsider witness groups. Similar to the practice of linking to the past and extending to

the future, involving outsider witness groups attempts to enhance the likelihood that the new narrative will take root in the client's life. These groups serve as "witnesses" (i.e. an audience) to the new story, and are usually comprised of members of the client's social network (e.g. family, friends, teachers, etc.) who understand the problem and can offer wisdom or support to the client. In cases where the client does not have a sufficient social network, or when the therapist wants to ensure an extra level of support, a reflecting team of clinicians can be used (St. James O'Connor, Meakes, Pickering, & Schuman, 1997).

The next practice in Michael White's narrative therapy, re-membering and incorporation, is similar to that of involving outsider witnesses, both in purpose and in practice. The goal of re-membering and incorporation is to help clients find members of their network who have parallel experiences to theirs, and to draw on these members as a source of problem-solving and social support. The distinction between these practices is that witness groups do not necessarily need to have experienced similar problems (as they do in re-membering and incorporation), but rather serve as "witnesses" to the client's successful transformation. This practice highlights a way in which narrative therapy challenges traditions held by many individually-oriented schools of psychotherapy that promote individuation, and give more credence to the negative influences of the family of origin than is given to the positive. In narrative therapy, "the family and social network are construed as a resource rather than a liability" (Carr, 1998, p. 497). The principles and empirical foundations of social support have already established the concept that social support can act as a buffer against a wide range of physical and psychological challenges (Leavy, 1983).

The eighth practice in Michael White's narrative therapy is the use of literary means to "document and celebrate new knowledge and practices" (Carr, 1998, p. 489). Therapeutic

documents used in this practice include (but are not limited to) letters of prediction, letters of invitation, self-stories, self-declarations, and letters of reference. Carr warns that the use of literary means is a complex process, and recommends collaboratively discussing a range of possible issues surrounding these documents with the client. Possible issues include: what form documents should take, how and with whom among the client's network these documents should be shared, accuracy of predictions contained in these documents, and missing information (Carr, 1998) (Chen, 1998).

The ninth (and final) practice in Michael White's narrative therapy is that of facilitating taking-it-back, in which clients are given the opportunity to share the positive benefits of therapy with others. This may be accomplished by a variety of methods. The client may meet with other clients directly, or they may allow the therapist to share "their new personal narratives, knowledges, skills, or literary records with other clients facing similar difficulties" (Carr, 1998, p. 498). The goal of taking-it back procedures is twofold: so that present clients may benefit from the experiences of clients with positive therapeutic outcomes, and so that therapists may have a venue in which to share the impact their clients have had on them. Narrative therapy purports that therapy changes both client and therapist, and that "taking-it-back practices let clients know that the benefits of therapeutic conversations are a two-way street" (Carr, 1998).

All of the aforementioned practices are used to help the client gain awareness of how their problem-saturated stories influence them, and the power they have to fight against their problems. This ability is incorporated into a new positive narrative, which is amply reinforced through thickening, re-membering, taking-it-back, etc. Once this new preferred narrative is firmly in place, clients can begin to start living their lives according to this positive narrative, and no longer in accordance to their old problem-saturated stories (Goldenberg & Goldenberg, 2008).

Narrative Therapy: Use with Children and Adolescents

Narrative therapy is particularly well-suited for use with children and adolescents. With the exception of play and other expressive therapies, most models of psychotherapy assume an adult client, and are therefore based on theories of adult levels of understanding and functioning. DeSocio (2005) argues that, in contrast, narrative approaches to psychotherapy are influenced by developmental theory, and therefore particularly suited for children and adolescents. There is significant overlap between narrative theory and social cognitive theories of development, which purport that individuals are social beings that "progress through stages of cognitive development within social contexts" (DeSocio, 2005, p. 54). Language is of particular importance for both narrative and social cognitive theories. In narrative therapy it is the means by which life stories are created and expressed. For social cognitive theories of development, language is the primary measure of cognitive development, and a source of social meaning. According to social cognitive theory, understanding of oneself is gained through relationships with others and mediated by cognitive processes such as selective attention, language, memory, social comparison, self-reflection, and interpretation. The mastery of each of these processes represents an increasingly advanced developmental milestone, and each process contributes to a child's ability to construct and relate stories of their lives (DeSocio, 2005). As children develop, these stories influence their identity formation. DeSocio (2005) concludes that a narrative approach to therapy allows the therapist to more closely tailor interventions to a child's social cognitive level of development, and that narrative therapy may help children construct positive life stories and subsequently, positive identities.

Biblionarrative Therapy

Narrative therapy generally implements verbal processes. Eppler and Carolan (2005) suggest however, that this reliance on purely verbal information may result in incomplete descriptions. They warn that children may be particularly hesitant to tell their story verbally. Child-centered practices, such as play therapy, attempt to mediate this concern by encouraging children to displace their story onto fictional characters, such as puppets or dolls. However, Eppler and Carolan argue that this may not be sufficient for all children.

Instead, Eppler and Carolan propose an innovative narrative therapy technique, Biblionarrative therapy, in which talking and writing about important life-events is united. This technique can be used for both therapeutic and research data collection purposes, but for the sake of clarity, the authors primarily use the term "researcher" when referring to the individual collecting the child's story.

According to Eppler and Carolan, The researcher begins by collecting general and specific information about a child's life-story by conducting an interview. In this process, she asks direct and indirect questions, places the story in context, and provides a safe atmosphere where the story can be told in order to gather a rich account. Next, the researcher helps the child write his story as text. Eppler & Carolan recommend using a modified version of Harold, Palmiter, Lynch, and Freedman-Doan's (1995) storyboard as an open-ended template for this step (See Figure 1 below).

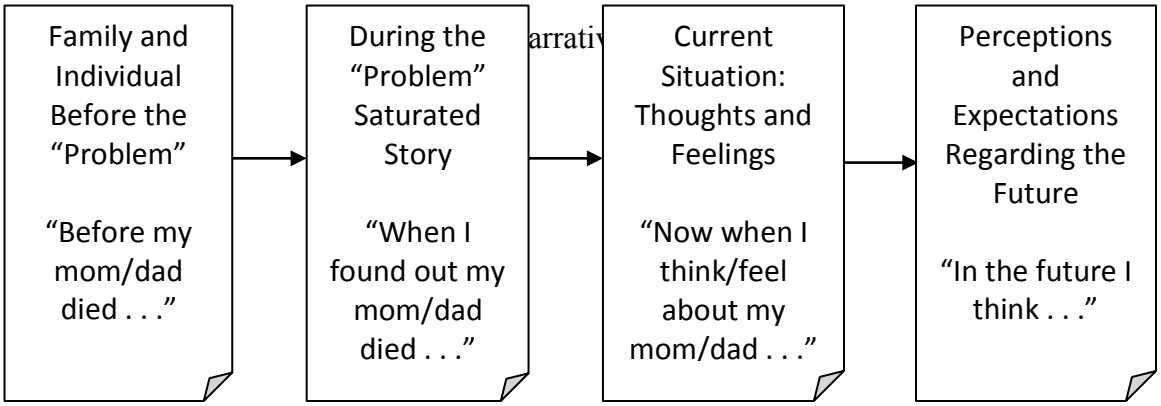


Figure 1. Biblionarrative Storyboard Template (Eppler & Carolan, 2005)

The child is given minimal prompts, and may write as little or as much as they'd like. Eppler and Carolan note that these techniques should be adapted to each individual's cognitive, developmental, and physical needs and abilities.

Eppler and Carolan illustrate the use of this technique with a group of twelve children, aged nine to twelve, struggling with grief. After the child created a Biblionarrative, he or she was interviewed by the researcher to determine what differences the child experienced between recounting their story verbally and writing it down, and which modality the child preferred and the reasons for this preference.

Eppler & Carolan propose a myriad of functions that Biblionarrative therapy may perform, both in a narrative therapy context and in other treatment modalities. For example, they propose that biblionarratives can be used to join with the child, assess what the child considers important to the problem, facilitate externalization and re-storying, and/or assess family dynamics. Eppler & Carolan conclude that Biblionarrative may be a useful addendum to narrative therapy, but that empirical studies should be conducted to explore efficacy.

Bibliotherapy

Another practice that has sought to facilitate therapy through literary means is Bibliotherapy. Before beginning a discussion of this practice, it should be noted that the term "Biblionarrative therapy" coined by Eppler & Carolan (2005) is used to describe a distinct form of narrative therapy, which is independent of the practice of bibliotherapy. In the early 1900s, the term "Bibliotherapy" was created to refer to the practice of using books in help guide the solution of a personal problem (Jackson, 2001). Bibliotherapy may be used to provide information (to clients) about problems, to communicate new values and attitudes, to create an awareness that others have dealt with similar problems, and to provide solutions to problems. Books used in bibliotherapy may be selected from any number of genres (e.g. classical literature, nonfiction, young adult fiction, mystery, romance, etc.), and are not necessarily written with a therapy audience in mind. Rather, clinicians may help clients select a book that they think may mirror some aspect of the client's experience, offer insights into the problem, or otherwise off an opportunity for exploration of meaning between client and therapist. Once the therapist and client have read the chosen book, the client is encouraged to "retell" the story using either oral or artistic means. The therapist and client then explore the feelings, relationships, or behaviors of the book's main character and draws comparisons between the character's experience and the client's own experience (Jackson, 2001).

This method has been used with children and adolescents facing a variety of problems, including: anxiety disorders (Rapee, Abbott, & Lyneham, 2006), simple and complicated grief (Berns, 2003), aggression (Shechtman, 2006), and divorce (Early, 1993). However, bibliotherapy is not a freestanding theoretical model; but rather a specific technique meant to be used as an

adjunct to other therapies (Pardeck, 1994). A review of the relevant literature revealed no specific studies addressing the use of bibliotherapy within a narrative therapy context.

Empirical Support for Narrative Therapy

Empirical support of narrative therapy is still in its infancy. This may be due in part to the relative newness of the approach in general, and also to the fact that, in some ways, the underlying tenets of this approach discourage traditional empirical inquiry (Etchison & Kleist, 2000). Narrative therapy focuses, in part, on the negative influence cultural messages and power structures have on an individual's narrative. Narrative therapists are encouraged to view each individual as a complex being whose reality is different from that of every other human being, and narrative therapy discourages any practice that reduces individuals to points of data (Goldberg & Goldberg, 2008). Traditional quantitative empirical research, by its very definition, uses aggregate data from systematic and careful observations to search for statistically significant differences. Parsimony and a minimization of threats to validity are emphasized (Kazdin, 2004). Given this clash, the majority of support for narrative therapy takes the form of qualitative methodology or case examples. The following is a presentation of the current literature regarding narrative therapy with children.

A literature review on the efficacy of narrative therapy research was conducted by Mary Etchison and David Kleist in 2000. At this time, Etchison and Kleist found only four empirical studies to include in their review. The primary reason the authors proposed for the dearth of research in this area was the disparity between traditional quantitative empirical research methods and the constructivist orientation embraced by those interested in narrative therapy. Since qualitative research methodology emphasizes a depth of understanding individual experience, it is well suited for researching the efficacy of narrative therapy. However,

quantitative research methodology is emphasized in most journal editorial boards, and the validity of qualitative methods is still an emerging area. As such, editorial boards as well as journal reviewers may be reluctant to accept research using alternative research methods (Etchison & Kleist, 2000).

The first of the studies examined by Etchison and Kleist (2000) was Besa's examination of the efficacy of narrative therapy in reducing parent-child conflicts. Besa defined parent-child conflict as "deviant behavior, keeping bad company, abuse of drugs, school problems, and other conduct problems" (as described in Etchison & Kleist, 2000, p. 62). Besa used a single case research design with six families to avoid using methods that relied on classification, pathologizing, or diagnostic categories, which he considered contradictory to the tenets of narrative therapy. Treatment included the use of several narrative therapy techniques, including externalization, relative influence questioning, identifying unique outcomes, and re-storying. Five of the six families showed improvement (decrease in parent-child conflicts as rated by the parents ranged from 88% to 98%). These results indicated that narrative therapy effectively reduced parent-child conflicts in this study and might therefore be applied to other families facing similar conditions (Etchison & Kleist).

The second study reviewed by Etchison & Kleist examined families' perceptions of their narrative therapy experience and the meaning that the families attributed to these experiences. This work was designed in order to identify narrative therapy factors that families found helpful vs. unhelpful. St. James-O'Connor, Meakes, Pickering, and Schuman (1997) implemented an ethnographic research design with eight families presenting with a range of serious problems (e.g. conduct disorders, family violence, grief, attention deficit/hyperactivity disorder). Information from semistandardized interviews was coded using latent and manifest content

analysis designed to recognize themes, commonalities, and differences. St. James-O'Conner et al. found that the following themes emerged during the interviews: (a) externalizing conversation, (b) unique occurrence and alternate story, (c) developing personal agency, (d) consulting and reflecting teams, (e) building the audience, and (f) helpful/unhelpful aspects of therapy. St. James-O'Conner et al. (1997) also observed that all of the families reported some reduction in the presenting problem and that the degree of reduction correlated with the length of time in therapy. This research supports the argument that narrative therapy may be a viable option for family therapy (St. James-O'Conner et al., 1997 as described in Etchison & Kleist, 2000).

The third study reviewed by Etchison & Kleist explored children's attributions or stories about the causes of family arguments between marital partners and between parent and child. Weston, Boxer, and Heatherington (1998) used audio recordings of family arguments within eight different families as stimuli for the children to recall arguments from their own families. Five structured interview instruments were then used to examine arguments between parents, children's perceptions of parent's conflicts and parental divorce, parent-child arguments, and affect. The information from these interviews was rank ordered from most to least strongly endorsed, and then statistically analyzed using a repeated-measures ANOVA. The authors found that children consistently ranked trait items higher than state items for Father, whereas the opposite was true for Mother. The authors noted that some children had difficulty with the open-ended questions, and therefore suggested that "more creative information strategies, such as storytelling and the use of props, would be a more useful method" (as described by Etchison & Kleist, 2000, p.63). They suggest that children's stories or attributions of causes of family conflict may aid family therapy efforts. Finally, they demonstrated that quantitative and

qualitative methodology could successfully be combined in studying narrative therapy (Etchison & Kleist, 2000).

The final study reviewed by Etchison and Kleist, conducted by Coulehan, Friedlander, and Heatherington (1998), examined the components of change in externalization of the problem. Eight family-therapist pairs took part in this study; the range of identified problems included academic failure, noncompliance, violence, and eating disturbances. A combination of videotaped and transcribed interviews and sessions, and postsession questionnaires (from parents, therapist, staff observers, and three master's-level therapists not affiliated with the clinic) were analyzed using a qualitative model. The authors concluded that the data indicated a three-stage model of change in externalization, through which all families who successfully externalized the problem progressed. In the first stage, family members articulate multiple views and descriptions of the problem. In the second stage, the family shifts in affective tone. In the third stage, the family explores positive aspects of each other and the family unit (Etchison & Kleist).

This literature review by Etchison & Kleist (2000) provides support for narrative therapy, especially in regards to therapy with children and families. The discussion will now turn to a review of more recent research literature.

In 2002, Cowley, Farley, and Beamis reported on their use of a primarily qualitative, case-study approach to examine the impact of a counseling intervention which employed practices from narrative therapy and motivational interviewing on contraceptive use by female adolescents considered at high risk for early childbearing. The authors proposed that, given their collaborative nature, interventions based on narrative therapy and motivational interviewing would be feasible and particularly appropriate for use with adolescents in an early stage of

change. Stages of change, as operationalized, Prochaska and DiClemente (1982), delineated processes through which individuals progress as they change their problematic behavior. Given that over one-third of the subjects decided over time to initiate a method of contraception, the authors suggested a motivational- and narrative-based intervention could be implemented successfully with this population. They furthermore recommended a more systematic evaluation of efficacy with these interventions (Cowley, Farley, & Beamis, 2002).

Moreira, Beutler, and Gonçalves (2008) investigated changes in client narrative as they related to therapeutic outcome across three treatment modalities: cognitive, narrative, and prescriptive. The authors used a process analysis to examine the narrative structural coherence, process complexity, and content diversity in the session of six adult clients (two per treatment modality). The narrative structural coherence coding system measured the way different aspects of experience interrelate to engender a feeling of coherence with one's self. The narrative process complexity coding system measured the client's initial degree of openness to experience. The narrative content multiplicity coding system measured the diversity of content within the client's narratives. Each coding system used a number of 5-point Likert scales. The authors found statistically significant differences in total narrative change between positive and negative outcome cases. Although no statistically significant differences were found between positive and negative outcome within any of the subscales, the authors noted that narrative structural coherence, process complexity, and content diversity were all higher for individuals with a positive therapeutic outcome. The authors proposed that this apparently disappointing finding could be due to the limited sample size (Moreira, Beutler, & Gonçalves, 2008).

Young and Cooper (2008) utilized a collaborative, qualitative approach to explore clients' perceptions of what they found meaningful and useful in therapeutic conversations. The

participants in this study were eight clients; seven of whom were families, one of whom was an individual adult. Clients met with a narrative therapist for a single, videotaped session, after which the client(s) engaged in a re-visiting session with a research assistant. During this re-visiting session, the client(s) and researcher reviewed the session tape, and the client(s) were asked a series of set questions to elicit their thoughts and understandings of significant moments. The authors then reviewed these responses and noted the following themes as contributing to client feelings of increased hope and self-efficacy: (a) effects of the posture, (b) giving people back their words, (c) externalizing conversations, and (d) learning from the re-visiting. "Effects of the posture" described the collaborative nature of the therapist stance of narrative therapy. "Giving people back their words" described the practice of using the client's words to summarize the session at its conclusion. "Externalizing conversations" described the narrative therapy practice of externalization. "Learning from re-visiting" described the actual process of reviewing, and subsequently processing, the session more thoroughly at its conclusion. The authors recommended that each of these elements be integrated into the practice of narrative therapy. They further offered this approach to research as a preferred method of studying narrative therapy, as it is consistent with narrative therapy's emphasis on collaborative inquiry (Young & Cooper, 2008).

There is an abundance of literature presenting various arguments for the use of narrative therapy with different populations, problems, and modalities. This literature generally discusses why and how narrative therapy is appropriate, and then demonstrates this with a case vignette. There is significant variability in the quality of these case studies, and indeed, the degree to which case studies are even considered a legitimate basis for drawing valid inferences is largely debated (Kazdin, 1981). A comprehensive presentation of this literature would neither be

feasible nor valuable for this dissertation. However, an examination of a representative sample of the case study literature provides an important context. Since this dissertation will include participants with a wide range of difficulties, the articles discussed in the following section were selected to illustrate the wide range of clients with whom narrative therapy has been used. More recent publications were given preference over older publications.

Larner (2003) presented a case vignette of a severely depressed 16-year-old girl who was treated with a combination of family, individual, cognitive, narrative, and art therapy. Larner supports an integrative model of psychotherapy, where techniques from different models are selected that fit with each client individually. In the case of Larner's client, narrative therapy helped her to identify and externalize depression, rather than herself, as the problem. She was then able to re-author her experience to create a more positive, adaptive life story. Larner concludes that an integration of practices, including narrative therapy, may be an effective approach to the treatment of adolescents with depression and their families.

McLukie (2005) presented a case for the use of narrative therapy with pediatric obsessive-compulsive disorder. McLukie argued that narrative therapy might be a useful tool in helping the child and his family "challenge beliefs and behaviors that maintain the dominant influence of the problem saturated story" (McLukie, 2005, p. 88). He furthermore argued that the specific process of externalizing is ideally suited to conform to the concrete developmental level of children. McLukie illustrated this position by presenting a case vignette of a 9-year-old girl, who successfully engaged in narrative family therapy with her mother and younger sister. According to McLukie, the collaborative nature of the model and its externalizing techniques had a significant impact on the success of this family. However, he points out that narrative therapy is limited by its lack of empirical research and its heavy reliance on language and questioning.

When used with young children, McLukie recommends that narrative therapy be supplemented by play-based interventions.

Hurley (2006) explored the use of narrative therapy with children traumatized by exposure to violence. According to Hurley, there is a tendency for clinicians to focus on externalizing behavior in children exposed to violence, rather than on the child's internal experience. She argues that treatment geared towards minimizing upsetting behavior may help the child control his behavior, but does not allow him to process the traumatic experience. Research on children exposed to violence has demonstrated that "violence permeates all aspects of children's lives and becomes the dominant narrative in their lived experience" (Hurley, 2006, p. 51). Hurley suggests that narrative therapy, combined with internalized other interviewing (a form of therapeutic conversation, based in psychodynamic theory, in which the therapist engages the child's "internalized other"), may be well suited to addressing these issues. Hurley illustrated this with a case vignette in which narrative therapy was used with an eight year-old boy suffering from post-traumatic stress symptoms associated with witnessing extreme domestic violence. She presented excerpts from a single session in which the child successfully begins the process of excavating unique outcomes and revealing marginalized aspects of his self. Hurley concludes that narrative therapy (combined with internalized other interviewing) may provide a medium by which children exposed to trauma can reconstruct their trauma-damaged narratives, and emerge with a more cohesive self-identity.

Cashin (2008) proposed that narrative therapy may be used in the treatment of adolescents with Asperger's disorder and presented a case vignette of a nine year-old boy with Asperger's disorder as support. This population exhibits a unique set of challenges, as individuals with autism intrinsically experience the world differently than neurotypical

individuals. Autism is characterized by impairments in communication, social skills, and cognitive and behavioral flexibility that disrupt social and occupational functioning. Functioning in each of these domains does not remain at a fixed level in each individual, but rather fluctuates in relation to external or contextual pressures. Since individuals with autism frequently experience a mismatch between their abilities and the demands society places on them, the narrative therapy model may be particularly salient to them. Likewise, the propensity for individuals with autism to think in concrete, specific terms lends itself to externalization. By transforming the problem into a concrete, external entity, narrative therapy renders the problem far more manageable. Cashin adds that the focus narrative therapy places on the present "allows the therapist and individual to work on the isolation of a discrete problematic chunk of behavior" (Cashin, 2008, p. 53). He concludes that narrative therapy could be a valuable approach to therapy with children with Asperger's disorder.

Eliciting Narratives from Children in Therapy

Given the limited amount of research literature for narrative therapy in general, it is not surprising that there is a lack of research literature on the specific goal of eliciting an initial problem-saturated narrative from children in therapy. In order to begin a discussion of this topic, it is therefore necessary to seek support from related areas. Literature from the fields of child-centered therapy and forensic psychology offer insights into the difficulty some children have with the process of discussing their problems.

Proponents of child-centered therapy have theorized that one factor impeding children's communication in therapy may be the power differential between the adult therapist and the child client (Landreth, Baggerly, & Tyndall-Lind, 1999). Child-centered therapy seeks to ameliorate this imbalance primarily by working with children in their own preferred modes of

communication, i.e. play. Both child-centered and narrative therapy proponents acknowledge the importance of this problem. Daigneault (1999) addressed several other similarities:

> Both approaches stress the important of working with the child's own preferred ways of expressing himself or herself and of developing an egalitarian therapeutic relationship with the child. Both narrative and Adlerian approaches stress the important of the child's giving meaning to his or her own stories or scripts. Both approaches see the child as being capable of change and of solving his or her own problems with creativity. Both narrative and Adlerian approaches stress the importance of recruiting significant others to collaborate with the child in reorienting and reauthoring activities.
>
> (Daigneault, 1999, p. 312)

Narrative therapy has therefore made some steps towards creating an environment in which children feel comfortable engaging in open communication. However, very little attention has been paid to the specific problem of eliciting narratives from child clients.

Research in the field of forensic psychology has addressed the issue of eliciting "free-narratives" of childhood abuse. Emphasis in this field is placed on eliciting an accurate, comprehensive account of a certain event in the child's own words with as little prompting from the interviewer as possible. Even in this field, however, there is a lack of literature regarding the most effective strategies for eliciting a narrative (Powell & Snow, 2007). There is, however, literature that proposes reasons why children have difficulty disclosing.

A review of relevant literature conducted by Palmer, Brown, Rae-Grant, and Loughlin (1999) indicated that the strongest inhibitors of disclosure are: (a) fear of the consequences, such as retribution from the offender or betraying their families, (b) self-blame, (c) lack of awareness of social norms regarding abuse, and (d) difficulty in finding the words to talk clearly about the

abuse. This literature review suggests the following factors may contribute to successful disclosure: educational awareness through school programs, anger, timing, proximity to perpetrator, peer influence, and the safety of the environment.

Forrester (2002) specifically examined female girls' experience of disclosing sexual abuse within a relational context. Forrester notes that children's disclosure takes the form of a narrative, and that this narrative plays an important role in determining how children understand and deal with their sexual abuse experiences. In a review of relevant literature, Forrester found that little is known about the process of disclosure of sexual abuse except that "the disclosures are hesitant, truncated, and often delayed" (Forrester, p. 37) and often include silence, recantation, and denial. It is not clear, however, why these disclosures are often so tentative.

In her own research, Forrester (2002) conducted a qualitative examination of the sexual abuse disclosure experiences of ten pre-adolescent and adolescent girls. She found that the greatest concern of these girls was that of jeopardizing their interpersonal relationships by disclosing their sexual abuse narrative. As a consequence, a great deal of the variability in whether and how much the girls disclosed was related to their relationship with the listener. Girls did not disclose to listeners they believed to be untrustworthy or whom they felt were too vulnerable to withstand their disclosure. Forrester indicated that this is supported by social psychology literature, which states that individuals generally protect a secret for two reasons: (a) fear of feeling exposed or vulnerable, and (b) need to protect another.

Since this dissertation addresses children facing a broad range of problems, it is not fruitful to delve too deeply into the literature regarding a particular problem, i.e. disclosure of abuse by children. In doing so, one runs the risk of forming too many assumptions based on the experience of a particular population. However, literature from the fields of forensic psychology

and child-centered psychology provides support for the contention that many children have a difficult time discussing their problems with others, and proposes some reasons why this may be the case.

Interviewer Effects

Before presenting the current study, it is beneficial to briefly examine the interaction between researcher and participant response, and how this interaction may be viewed through a narrative therapy lens. First identified in the 1960s, experimenter effects describe "the potential biasing effects of experimenter behavior and expectancies, particularly as they relate to demand characteristics of participants" (Leong & Austin, 2006). The potential effects that researchers (and clinicians) can have on the their work can be split into two general categories. The first category, noninteractional effects, result from interactions that impact the accuracy of information *collection* but do not affect the participant's actual responses. Examples of effects within this category include effects of the observer, the interpreter, and intentional effects (Rosenthal, 2002). A full presentation of these effects would not add to a discussion of the current study, however the second category, interactional effects, holds a certain degree of relevance to the collection of narratives.

Interactional effects are the result of interactions that impact the participant's actual responses. Interviewer characteristics, such as: sex, age, race, personality, expectations, familiarity with the participant, and experience conducting research have all been demonstrated to significantly impact research results. Similarly, the behavior of the interviewer (e.g. modeling) have all been shown to significantly impact research results (Rosenthal, 2002). The field of forensic psychology has further demonstrated that, not only can experimenter characteristics and behaviors impact research participants' responses; it can also impact the *accuracy* of these

responses. For example; Garven, Wood, Malpass, and Shaw (1998) demonstrated that children were more likely to answer interview questions inaccurately when the interviewer used any of the following interview techniques: suggestive questioning, influence, reinforcement and punishment, and removal from direct experience. Garven, Wood, and Malpass (2000) further demonstrated that approving statements, providing cowitness information, and suggestive questioning had a significant impact on children's accuracy in reporting a witnessed event.

Whether these interactions are due to the participant responding differently or to the researcher actually altering the experimental situation in some way is not always clear. What is clear, however, is that the interviewer herself can play an important role in the determination of a child's narrative. These potential interactions may be minimized by standardizing research collection procedures and making the experience of each research participant as uniform as possible, but they cannot be eradicated entirely (Leong & Austin, 2006). Rather than try to control for this interaction entirely however, a narrative therapy researcher instead might view this as evidence of the social co-construction of narratives. As discussed in the preceding sections, narrative therapy takes the stance that individual realities (and the narratives that reflect them) are co-constructed through interpersonal interactions; and especially through language used during these interactions. In this way, narrative therapy already accounts for the impact of interviewer effects on an individual's narrative.

Current Study

Narrative therapy has been implemented with children and adolescents facing a variety of problems. The use of this approach has been explored primarily through qualitative methodology and case studies. Due to the recent emergence of narrative therapy as an approach and the clash between the theoretical underpinnings of narrative therapy and the methods of traditional

quantitative empirical research, there are significant gaps in the literature. Although the fields of forensic psychology and child-centered therapy have contributed to our understanding of children's disclosure, there is little information regarding the process of eliciting the problematic narrative from children during narrative therapy.

From a narrative therapy perspective, the consequences of failing to elicit an initial problem-saturated narrative are significant. If one cannot gain access to the problem-saturated story, it is impossible to re-author a more adaptive story. At this time, there is no standard method in the field for conducting narrative therapy research and, as such, a systematic outcome study is not feasible. However an exploratory investigation into the extent of this problem and a possible solution may benefit the field by generating hypotheses for future research, as well as providing practitioners with a potentially valuable resource.

The primary purpose of this dissertation therefore was to create a therapeutic tool designed to assist in the gathering of stories, namely, a collection of stories written by children facing a wide range of difficulties. In the course of this collection, other pertinent information regarding children's attitudes to the narrative-collection process was gathered. Finally, this dissertation explored clinicians' attitudes to the use of such a tool.

CHAPTER III

METHODS

Participants and Procedures: Children and Adolescents Participants consisted of 19 individuals (4 males and 15 females between the ages of 10 and 18 years old) recruited from a local community agency. The precise age distribution of child participants is shown in Figure 2 below.

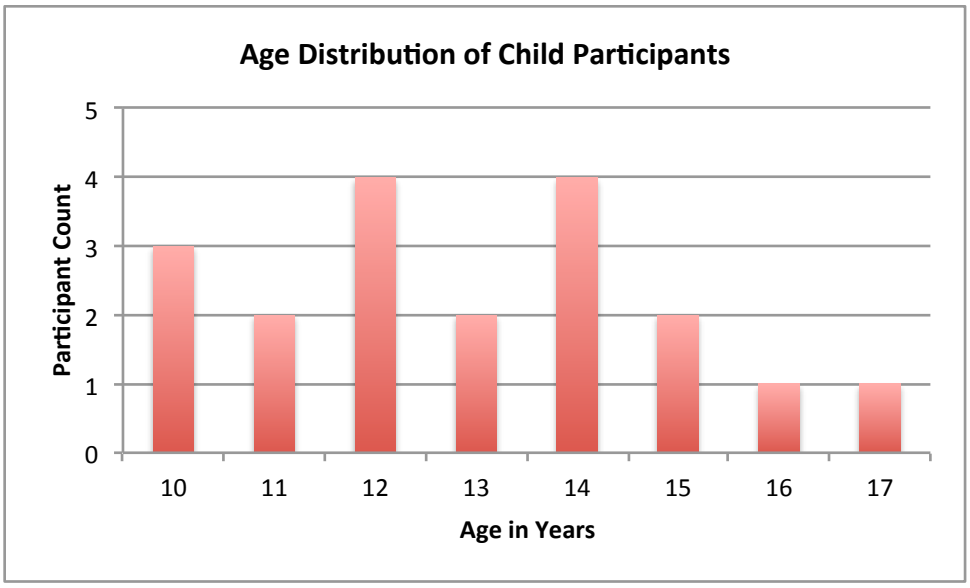


Figure 2
Age Distribution of Child Participants

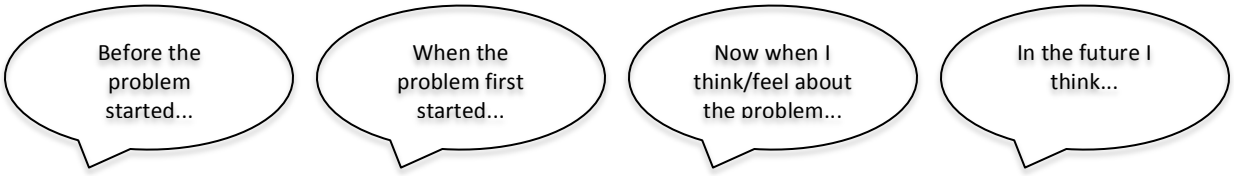
This age range was chosen in view of research showing that children first develop autobiographical skills around age 10, and that these skills develop as they grow older (DeSocio, 2005). Efforts were made to recruit children with a broad range of problems; however children with mental retardation, brain damage, or medical conditions that would restrict movement were excluded, as were children without proficiency in spoken English, due to limitations in ability to construct an autobiographical narrative.

Therapists from the selected agency were provided with Screening Criteria Forms (see Appendix A). These forms included a checklist of criteria that clients must have met in order to be included in the study, along with a short script for discussing client's interest in participation.

If the child and his/her parents or guardians indicated willingness to meet with the researcher, the therapist returned the completed Screening Criteria Form to the researcher, who then contacted interested families to schedule an appointment.

During this appointment, informed consent was obtained to participate in this study from both the parent(s)/guardian(s) and the child (see Appendix B & Appendix C), and the researcher gathered demographic and background information by conducting a semistructured interview (see Appendix D). This interview also served the functions of increasing participants' comfort, building rapport, and priming them to talk about their therapy experiences. The researcher then assisted the participant in writing his/her narrative story, following a modified version (see Figure 3 below) of Eppler and Carolan's (2005) method for collecting biblionarratives (see Figure 1 on page 13).

Biblionarrative Storyboard Provided to Participants:



Underlying Biblionarrative Progression:

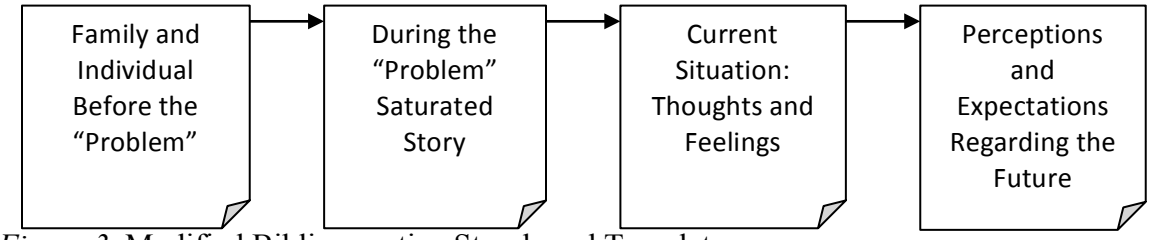


Figure 3. Modified Biblionarrative Storyboard Template

The majority of participants chose to write their story with no assistance from the researcher, two chose to write part of their stories themselves and dictate part to the researcher, and two chose to dictate their entire story to the researcher. Several children also chose to draw illustrations to

accompany their story; however, these illustrations have not been included in analysis. Once the participant's story was complete, he was asked to fill out a post-narrative questionnaire (see Appendix E), which examined the participant's experience of creating the story and attitudes towards the use of stories such as these in therapy. Participants were given discretion over how much information they were comfortable sharing, and were prompted only when a response was brief but given unreservedly. After completion of this questionnaire, children were debriefed and thanked for their participation. These appointments each took approximately one-and-a-half hours to complete, though some lasted as long as two hours.

The potential risks of this study were minimal and proper approval from the Institutional Review Board for the Protection of Human Subjects (IRB) was obtained; it is worth noting several specific safeguards employed to ensure the wellbeing of all child participants. First, participants more likely to experience distress in talking about their experiences were screened out during participant selection. For example, clients deemed by the referring therapist to be actively suicidal, engaging in self-injurious behavior, or judged unable to tolerate discussion of his/her reasons for treatment were not allowed to participate in this study. Second, participants were informed that they were able to withdraw from the study at any time without penalty, and information regarding the degree to which each client participated in this study was not shared with the referring therapist. Third, participants were interviewed only by a trained clinician (the experimenter), who would be more likely to be able to minimize or avoid any experience of distress. In addition, the qualitative nature of this study allowed the experimenter flexibility in responding to participants' emotional needs. Finally, since participants were chosen from families currently enrolled in therapy, should any difficult issues have arisen from this study, participants had a ready venue in which to ameliorate these difficulties.

Story Exclusion Criteria

Powell and Snow (2007) recommend that an effective narrative account be both structurally adequate in terms of the story-grammar elements and sufficiently rich in order for genuine information transfer to take place between the speaker and the listener. However, it is unclear exactly what components a story must include to meet these criteria. For the purposes of this research, stories needed to contain at least a basic explanation of the circumstances leading up to the commencement of therapy, and have at least five full sentences in order to be included. Two stories (each written by children 12 years of age) met the exclusion criteria, as they did not include a basic explanation of circumstances, and were therefore excluded from data analysis. They were, however, included in the compilation of stories distributed to participants in appreciation of their participation. This was done to recognize their contribution to the project and because their exclusion for the research purposes did not diminish their potential value to participants.

In preparing stories for distribution and analysis, it was necessary to engage in some editing for the sake of clarity. However, care was taken to alter the original narratives only where it was necessary to prevent a loss of meaning. For example, in one story the following sentence was edited from: "One day I sen my dad a text message that said lots of mean words about his girlfriend and bad feeling and things I’m not to be saying." to become, "One day I sent my dad a text message that said lots of mean words about his girlfriend and bad feelings and things I’m not supposed to be saying." During this editing process, priority was given to the child's language and great care was taken to preserve the child's "voice" as much as possible. See Appendix F for the final versions of the narratives included in this study.

Participants and Procedures: Clinicians

Once the compilation of stories was generated, a sample of clinicians was surveyed in order to explore the possible relevance and utility of such a tool. Participants for the story-attitudes survey consisted of clinicians recruited using the email database generated from the American Psychological Association (APA) Division 32-The Society for Humanistic Psychology. Initially, participant recruitment was intended to include email databases generated from the following APA divisions: Division 43-The Society for Family Psychology, Division 53-The Society of Clinical Child and Adolescent Psychology, Division 12-The Society of Clinical Psychology, Division 17-The Society of Counseling Psychology, Division 32-The Society for Humanistic Psychology, and Division 35-The Society for the Psychology of Women. However, changes in survey distribution policy by various APA divisions prior to participant recruitment restricted distribution to Division 32. Due to the consequentially low initial response rate, additional participants were recruited through professional contacts using a snowball sampling approach. Clinicians listed by these sources were contacted via an email (see Appendix G) requesting their participation in this study. Included in this email letter were informed consent information and a link directing clinicians who consent to participate to a Qualtrics-hosted survey. Twenty-six clinicians initiated participation in the online survey; however, only 17 of these completed the survey in its entirety, and were therefore included in data analysis. Clinicians were asked to answer several demographic questions and then to read three randomly selected stories (each of the 17 stories created during story-collection were shown at least once) and fill out a short survey. This survey examined their experience of eliciting narratives from children in therapy and their attitudes regarding the therapeutic use of stories such as those they read (see Appendix H).

Measures: Children and Adolescents

Demographic Questionnaire. The purpose of this author-generated questionnaire was fourfold: (1) to provide participants an opportunity to acclimatize to the story-telling process by asking them to talk about concrete, relatively less emotionally-laden topics (e.g. "What are you good at? What do you do for fun?"); (2) to prime participants for writing their story by asking them to reflect on various aspects of their therapy experience (e.g. "How have things changed since you started therapy? What has stayed the same?"); (3) to explore the range of presenting problems (e.g. "What was going on in your life before you started therapy?"); and (4) to collect information regarding participants' overall positive or negative experience of therapy.

Post-Story Questionnaire. This author-generated tool was designed to measure participant perspectives on three central themes: ease of the authoring task, emotional response to the task, and attitude towards reading stories written by other children. It was hypothesized that (a) the length of time participants have spent in therapy and the positive reaction to their therapy experience will be associated with ease of task and positive emotional response to the task, and (b) participants will have an overall positive reaction towards reading stories written by other children.

Measures: Clinicians

Clinician Questionnaire. This tool was designed to gather demographic information including: clinician's current orientations and primary setting of employment; and to measure the following elements: clinicians' use of narratives in therapy, perception of relevance of the stories collected, perception of utility of these stories as a therapeutic tool, and possible reasons for the proposed efficacy of the use of these stories in therapy. It was hypothesized that (a) clinicians' theoretical orientations will be associated with their use of narratives in therapy, (b) perception of relevance of the stories collected will be associated with primary setting of employment, (c)

use of narratives in therapy will be associated with perception of utility of these stories as a therapeutic tool, (d) reasons for the proposed efficacy of the use of these stories in therapy will be associated with clinician's theoretical orientation, (e) clinicians will generally have positive attitudes towards the relevance and utility of stories as a therapeutic tool, and (f) this effect will be stronger with clinicians who use narratives in their own practice.

Given that this is the first study of its nature, it was possible that participant's responses would suggest completely different responses and/or associations than were expected. Additional data analyses were therefore conducted based on an exploratory examination of the data.

CHAPTER IV

RESULTS

Children and Adolescents: Demographic Questionnaire

Specific questions in this questionnaire (Appendix D) were crafted to correspond with the following purposes and themes: purpose (#1) acclimatizing participants to the story-telling process, purpose (#2) priming participants for writing their story, theme (#1) range of presenting problems, and theme (#2) overall positive or negative experiences of therapy. At the same time, it was not possible for each question to precisely match the purpose or theme they were designed to explore. As a result, there was some conceptual overlap in some questions. In addition, it was quite natural for child responses to include references to multiple categories within the same utterance. Results for this measure therefore will be presented by purpose and theme, rather than by individual item. Utterances that had no apparent association with the questionnaire subject material are not reflected in the analyses.

Purpose #1: Acclimatization. The first purpose of this questionnaire was to provide participants an opportunity to acclimate to the story-telling process by asking them to talk about concrete, relatively less emotionally laden topics (e.g. "What are you good at? What do you do for fun?"). Responses to these questions varied as expected according to the individual child and were interesting, but an analysis of this data would not have contributed to an understanding of the specific study hypotheses. The majority of participants demonstrated some behaviors at the start of the interview process that reflected some hesitancy and/or eagerness, such as fidgeting, exhibiting reticence, etc. As the interviewer progressed through these initial acclimatizing questions and exhibited verbal and nonverbal interest in participants' responses and made encouraging comments, most participants demonstrated behavioral signs of reduced nervousness

and increased motivation (e.g. settling more comfortably into the chair, smiling, becoming more talkative). It appeared that the first purpose of acclimatization was achieved.

Purpose #2: Priming. The second purpose of this questionnaire was to prime participants for writing their story by asking them to reflect on various aspects of their experience before, during, and after therapy (e.g. "How have things changed since you started therapy? What has stayed the same?"). Some responses to these questions contributed to the themes being explored in this questionnaire, and were therefore included in their analyses. Most of the remaining responses varied according to the individual child and would not have contributed to an understanding of the study hypotheses. However, it is interesting to note that 15 of the 17 participants responded to the question "What do you think will be going on in your life in one month? In one year? In the future?" with uniformly positive statements. Such statements included: "things will be way better than now and before", "I'll be getting better grades", "mom and dad will have closer relationship", "I will have a good life and won't have to be fighting with my brother", and "I will be getting good grades and making mom and dad proud". One child gave a neutral response (e.g. "things will stay the same"), and the last child gave a mix of positive and negative statements (e.g. "we'll have a good summer and do things as a family" and "I feel like one of my friends will betray me"). An analysis of these responses is outside the scope of this study; however, the hope-for-the-future expressed by these children may be reflective of the fact that more severe cases were screened out during recruitment, they may indicate a high quality of therapeutic services being received by these children, or they may be reflective of the optimism characteristic of children.

Theme #1: Range of Presenting Problems. One goal of this study was to recruit participants dealing with a wide range of presenting problems such that it would be viable to use the narrative resource created in this study with a wide audience. Therefore, the first theme this questionnaire was designed to explore was the range of presenting problems for participants. Questions contributing to this theme included: "What was going on in your life before you started therapy?", "Who was involved?", and "When was it happening?". Responses relevant to this theme were analyzed by the nature of the presenting problem, and problem types that were endorsed by more then one child were designated as categories. These categories were intended to be sufficiently comprehensive to encapsulate similar ideas, but not to be so broad as to sacrifice the complexity of individual responses. Categories were created according to the situational, behavioral, emotional etc. *problems* that children reported they were facing, rather than by children's reported *reactions* to these problems. For example: one child reported that, subsequent to her parents separating, she would frequently cry to the point of vomiting. This response was categorized as "Parental separation". If no situational trigger was identified *by the child*, then the reaction itself was coded, even if the researcher saw a potential association. This was done to maintain the primacy of the child's experience. That is, relying on the child's interpretation of her experience, rather than the researcher's interpretation for the child. For example, one child reported that she "gets agitated easily" and "is a perfect little angel and fun to be around then smacks (her) brothers and sister in the face and yell(s) at dad"; then went on to describe other specific problems she'd been dealing with in therapy, such as her parents fighting, but did not draw an association between these problems. "Emotional lability" and "Parental conflict" were therefore coded as distinct categories.

Of the 27 types of presenting problems endorsed by the participants, 13 problem types were endorsed by more than one participant and therefore formed 13 primary categories of presenting problems. The category of "Sibling conflict" was the most frequently endorsed (5 endorsements); with the categories of "Separation and reintegration of family" (4 endorsements), "Family conflict" (4 endorsements), and "Conflict between parent and child" (4 endorsements) following in frequency. The endorsement count of each primary category is presented in Figure 4 below.

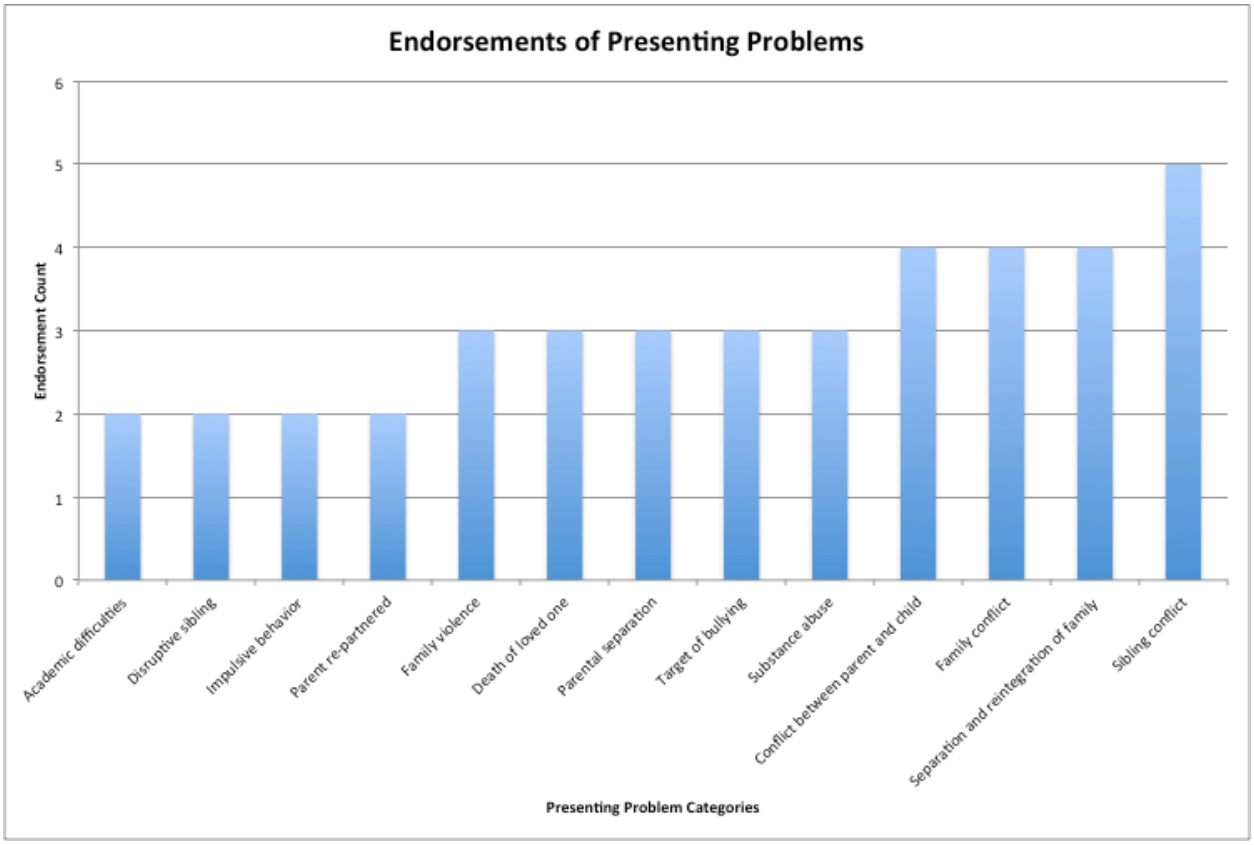


Figure 4
Endorsement counts by presenting problem category

In addition to the 13 primary categories of presenting problems, 14 problem types were endorsed only once and therefore were categorized as "Other". A comprehensive list of reported presenting problems categorized as "Other" is listed in Table 1 below.

Table 1

Presenting Problems Categorized as "Other"

Conflict between parents
Aggressive behavior
Conflict between parents
Depression (child)
Emotional lability
Foster care
Gang violence
Infidelity of one parent
Parental neglect
Physical health concerns
Running away
Self-harm
Spousal violence
Theft

Including those categorized as "Other", a total range of 27 presenting problems was reported by participants. Though this range is not comprehensive of all children and adolescents presenting for therapy (as this would not be feasible to attain), it is sufficiently varied for the purposes of this study.

Theme #2: Experience of Therapy. The second theme this questionnaire was designed to explore was participants' overall positive or negative experience of therapy. This theme was captured by asking participants to respond to the following open-ended questions: (a) "What have you liked about therapy, what's been helpful", and (b) "What has been less helpful? What have you not liked as much?".

Participants demonstrated little-to-no difficulty identifying positive aspects of their therapy experience. Responses relevant to this theme were organized into categories, which varied widely. Overall, 17 distinct aspects were identified; nine of which were endorsed by more

than one participant. "Coping skills", "Processing emotions", "Problem solving", "Ability to confide in therapist" were the most frequently endorsed categories. A comprehensive list of categories and endorsement counts are presented in Table 2 below.

Table 2

Positive Aspects of Therapy as Reported by Participants

	Endorsement Count
Coping skills	5
Processing emotions	5
Problem solving	4
Ability to confide in therapist	4
Therapist characteristics (e.g. nice, young, funny, etc.)	3
Therapist facilitates communication within family	3
Helps family	3
Feeling less stress/worry	2
Not bottling things up	2
Feeling safe with therapist	1
Being creative	1
Straightforward solutions to problems	1
Feeling able to be honest with family	1
Feeling understood by therapist	1
It's fun	1
Talking with other kids in group therapy who have similar problems	1
Individual time with therapist	1

Participants demonstrated significantly more difficulty identifying negative aspects of the therapy experience. This was manifest in hesitancy to answer the question, overly positive initial responses (e.g. "I loved everything about therapy. There wasn't anything I disliked."), and nonverbal indicators of discomfort (e.g. shifting in the chair, looking down towards the floor, etc.). When a participant expressed a hesitancy to answer this question or gave an overly positive initial response, reporting of at least one negative aspect of therapy was normalized, and participants were prompted keep thinking. Prompts included statements such as "There are always things you like a lot and things you might not like as much. What is something you didn't

like as much as the other things?". The majority of children manifested a readily discernable decrease in anxiety when their hesitancy was addressed. For example: participants let their breath out, their muscles relaxed, and they more readily gave an appropriate response. Even after being prompted however, four participants maintained their uniformly positive response.

Aspects of therapy that participants characterized as negative also varied widely. Overall, 18 distinct aspects were identified; only seven of which were endorsed by more than one participant. These results are represented in Table 3 below.

Table 3

Negative Aspects of Therapy as Reported by Participants

	Endorsement Count
Nothing, child reported (s)he likes everything about therapy	4
Too much attention on family member other than child	2
Child feels that (s)he doesn't need therapy	2
Feeling blamed	2
Therapy is "boring"	2
Dislike arguing with family in therapy	2
Don't see progress	2
Family gangs up on one member	1
Dislike missing school	1
Sometimes not in the mood for therapy	1
Dislike spending so much time with family	1
Therapist has weird accent	1
Dislike pretending to care	1
Feeling tired because attend therapy after school	1
Dislike talking about experiences child has had	1
Would like more time with therapist	1
Would like to do more activities	1
Dislike playing with toys	1

Children and Adolescents: Post-Story Questionnaire

This tool was designed to measure three underlying themes: ease of the authoring task, emotional response to the task, and attitude toward reading stories written by other children. The

discussion will now turn to a description of participant responses in each of these three areas. Utterances that had no apparent association with the questionnaire subject material are not reflected in the analyses below.

Theme #1: Ease of Authoring. The theme of ease of the authoring task was captured by asking participants to rate on a four-point Likert scale the authoring task's difficulty, followed by open-ended prompts asking participants what factors they thought contributed to why this task was easy or difficult for them. In response to asking participants to rate the authoring task's difficulty on a four-point Likert scale, 8 participants responded that it was "a little hard", 6 responded that it was "a little easy", and 5 responded that it was "very easy". No participants reported that it was "very hard". This data is represented in Figure 5 below.

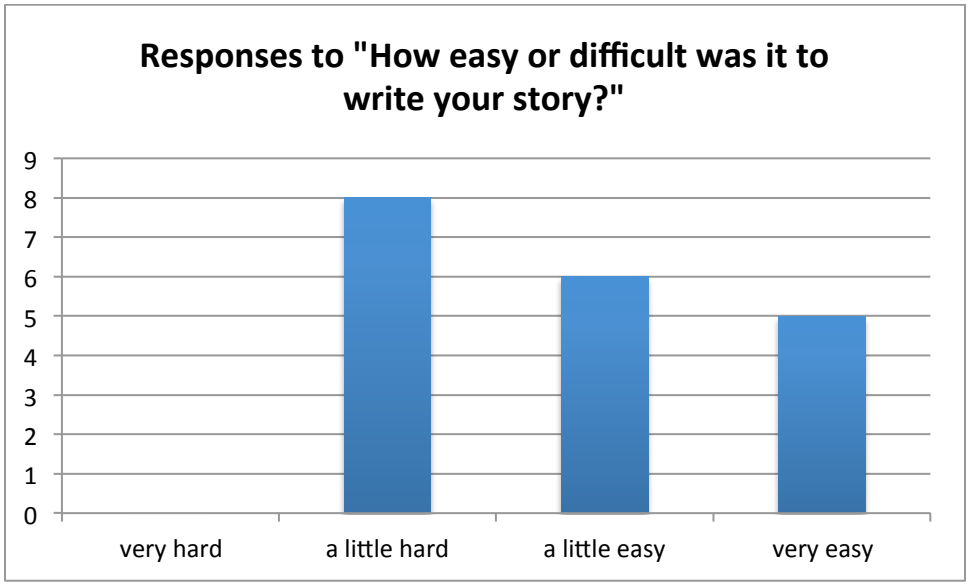


Figure 5
Ratings for ease of authoring task's difficulty

Responses to open-ended prompts to identify what made the authoring task easy or difficult were categorized according to theme. The most frequently reported categories of reasons given for what made the task easier were: it felt good to be helping others (3 endorsements), the story topic

was familiar to the participants (3 endorsements), and that there had been some rehearsal of the story in the form of keeping a journal or talking about it with others prior to this study (3 endorsements). The most frequently reported categories of reasons given for what made the task harder were: it brought up painful feelings (4 endorsements) and that it was hard to remember events and feelings from the past (4 endorsements). One participant chose not to respond to this question. The frequency of endorsement for each response category is represented in Figure 6 below.

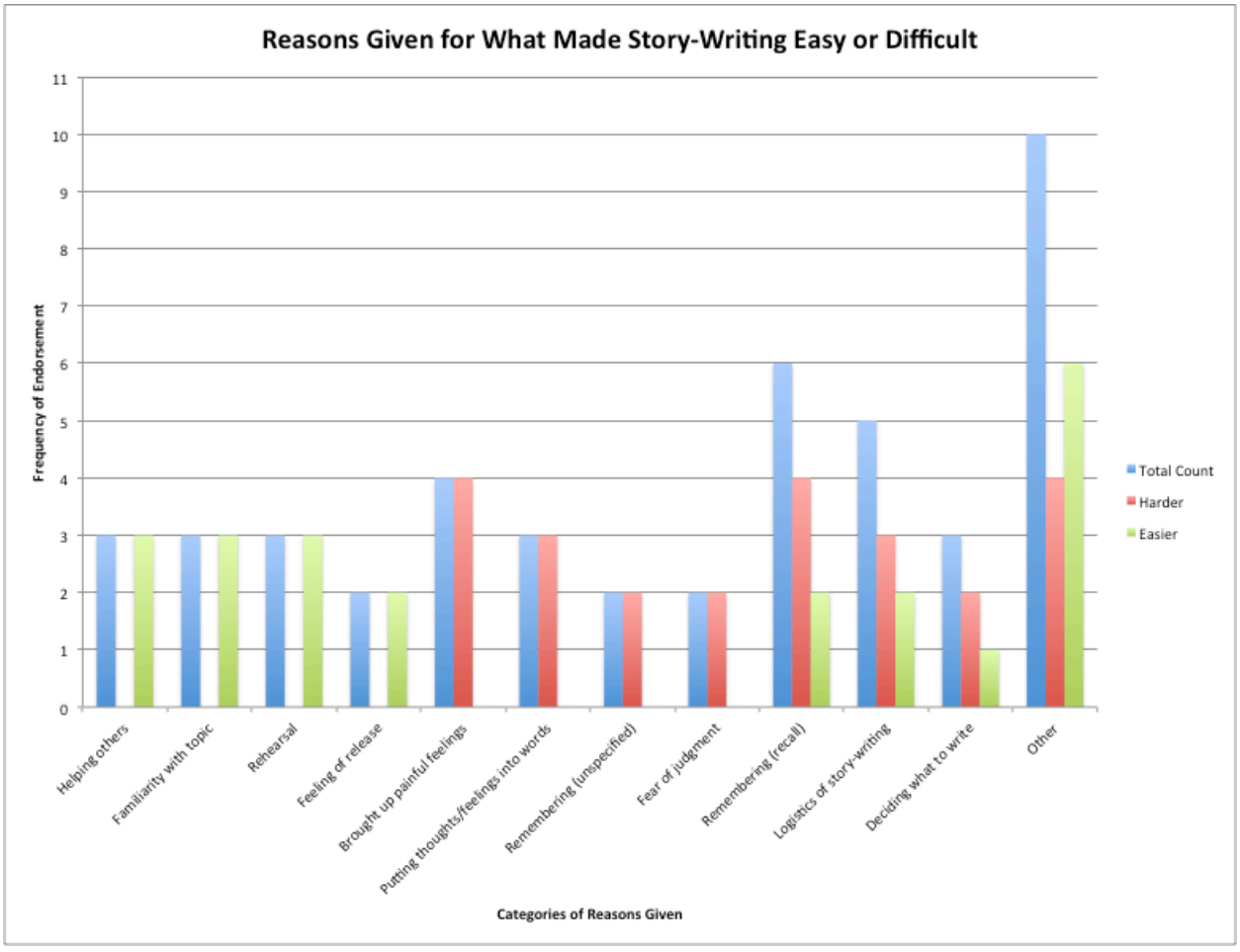


Figure 6
Reasons given for what made the authoring task easy or difficult

There were 10 responses that could not be categorized into the existing factors, as they themselves only appeared one time. These responses were categorized as "Other". Although these responses were each endorsed only once, the content of the responses suggest that they not be overlooked. They are presented in Table 4 below.

Table 4

Responses Categorized as "Other"

Response	*Theme*	*Easier/Harder*
"Because instead of being a set topic, it was about what I wanted it to be."	Self-directed	Easier
"I could relate to it very easily since it was about me."	Relatable	Easier
"I felt comfortable knowing that my privacy isn't gonna be invaded by someone bc it's gonna be kept private."	Confidentiality	Easier
"The questions were pretty straightforward so if the question is logical, I'll give it a logical answer. So that's what helped."	Questions were straightforward	Easier
"It was easy to write it."	Writing (unspecified)	Easier
"What was easy was seeing what you could do in your future."	Having hope for the future	Easier
″I had to think about lots, what's going on before, after, future - all this"	Amount of material to think about	Harder
"I was trying to put emotion in it but I couldn't."	Injecting Emotion	Harder
"I think what made it hard was that...I was writing about how I wanted to share with my friends that our family is different than what we were before - to hope that our family does get there but I won't believe it until I see it. It was kinda hard to put that in words when I don't know what's gonna happen. Hard to find some words for it, but very hard to just hope for it."	Trepidation regarding future	Harder
"What made it hard was admitting what I been doing."	Taking responsibility	Harder

Theme #2: Emotional Response to the Task. The theme of emotional response to the task was captured by asking participants: (1) to rate on a five-point Likert scale the degree to which they felt better or worse after writing their story, and (2) to endorse any, and as many, of

19 possible emotions that they may have felt while writing their story. In general, participants indicated that they felt better or no different after writing their story. No participants indicated that they felt worse. This data is represented in Figure 7 below.

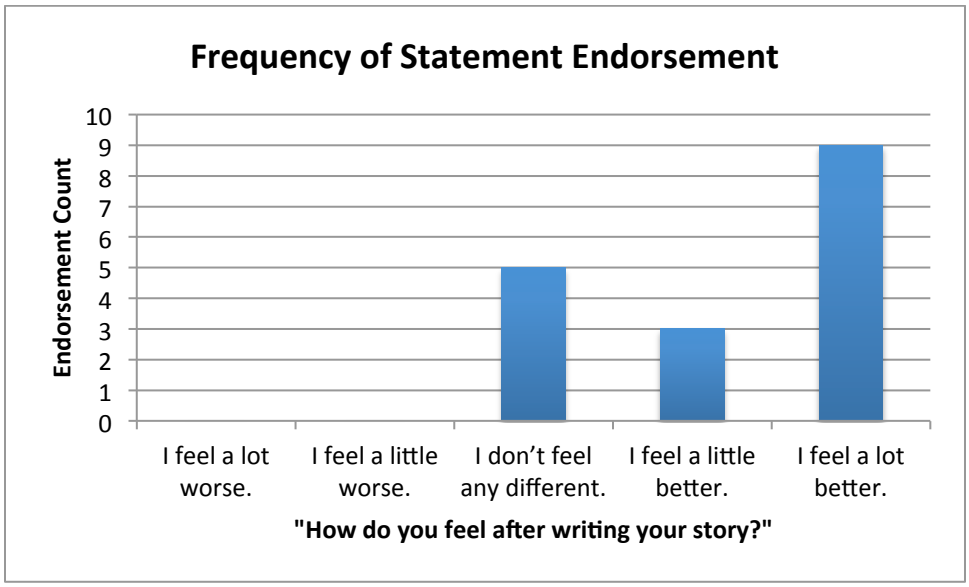


Figure 7
Child participant ratings of how they felt after writing their stories

In endorsing emotions that they felt while writing their story, participants also endorsed considerably more positive valence emotions (104 endorsements) than negative valence emotions (54 endorsements). Happy (10 endorsements), Proud (10 endorsements), and Excited (9 endorsements) were the most frequently endorsed positive emotions. Shy (7 endorsements) and Nervous (7 endorsements) were the most frequently endorsed negative emotions. Figure 8 (presented below) shows the frequencies of all Emotion items. This data indicates that the task of writing their story was a primarily a positive experience for participants, but not one without emotional challenges.

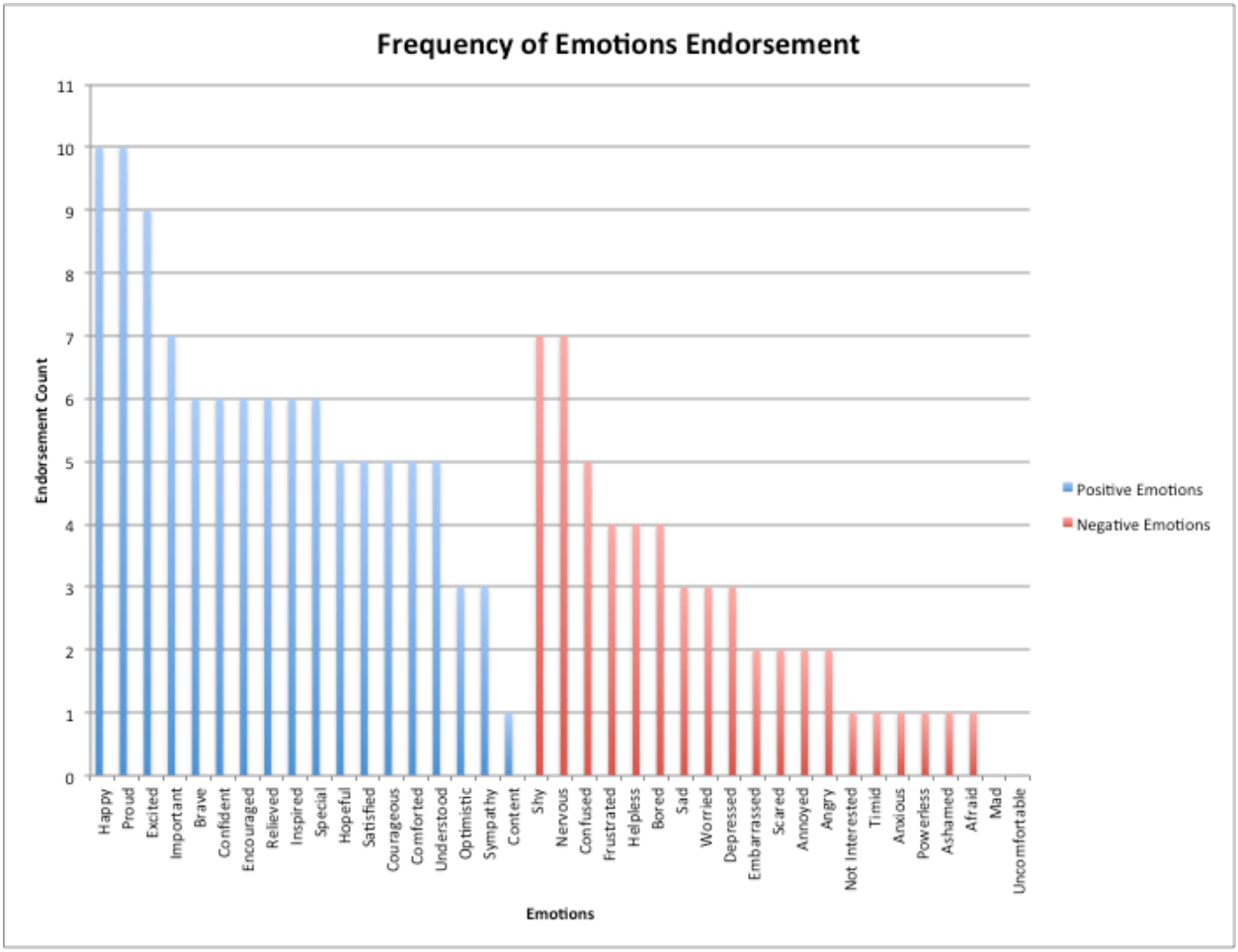


Figure 8
Emotions Endorsement Frequency for Positive and Negative Valence Emotions

Theme #3: Attitude Towards Reading Stories Written by Other Children. The theme of attitude towards reading stories written by other children was captured by asking participants to: (1) rate on a four-point Likert scale the degree to which they would or would not like to read other stories written by children like them, (2) rate on a four-point Likert scale the degree to which they think reading stories written by other children would make it easier or harder to talk about their own story, and (3) respond to an open-ended prompt regarding why they do or do not think that reading stories written by other children would make it easier to talk about their own story.

It is important to remind the reader that one participant whose story (and associated survey responses) was excluded from all other data analyses, as it met the exclusion criteria in that it did not contain at least a basic explanation of circumstances, was nonetheless included in the analysis for this factor. This was done for several reasons: (1) the theme of Attitudes Towards Reading Stories Written by Other Children was analyzed independent of all other themes and responses contributing to these themes, (2) the theme of Attitudes Towards Reading Stories Written by Other Children was not conceptually dependent on having written a story as part of this study, and most importantly (3) it was thought that this participant's responses might add to an understanding of why children may or may not find this therapeutic tool useful, especially as this was a child who found it difficult to convey his story in the conventional manner. The discussion will now turn to an analysis of participants' attitudes towards reading stories written by other children.

When asked to rate on a four-point Likert scale the degree to which they would or would not like to read other stories written by children like them, nine participants responded "Yes, I'd love to", eight participants responded "Yes, I'd like to", and no participants responded "not really" or "not at all". This data is represented in Figure 9 below.

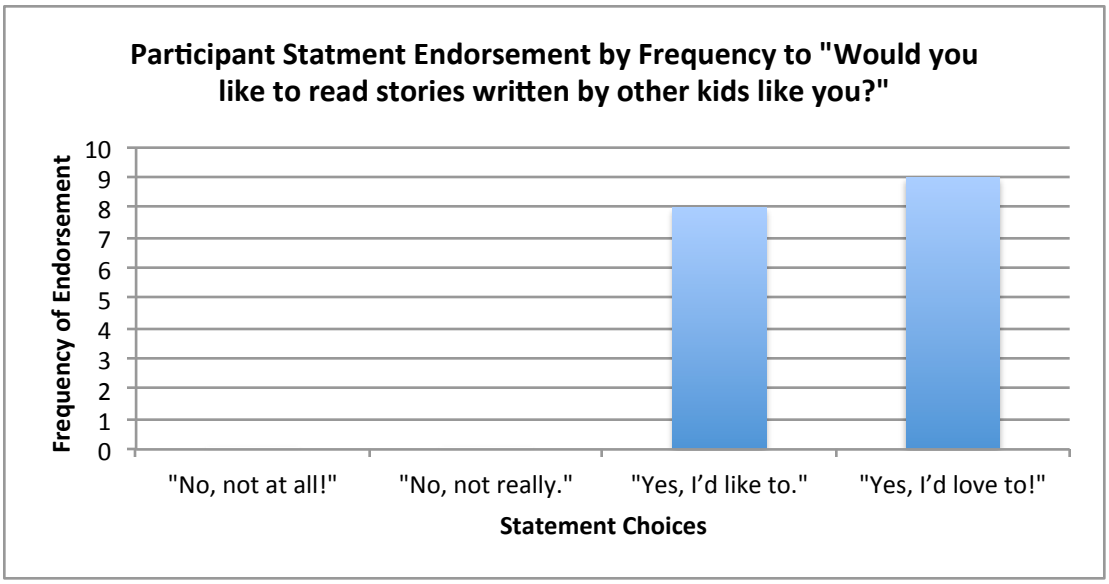


Figure 9
Degree to Which Participants Indicated They Would or Would Not Like to Read Stories Written by Other Children Like Them

When asked to rate the degree to which they think reading stories written by other children would make it easier or harder to talk about their own story, nine participants responded "Yes, a little easier", eight responded "Yes, much easier", and no participants responded "No, a little" or "No, much harder". This data is represented in Figure 10 below.

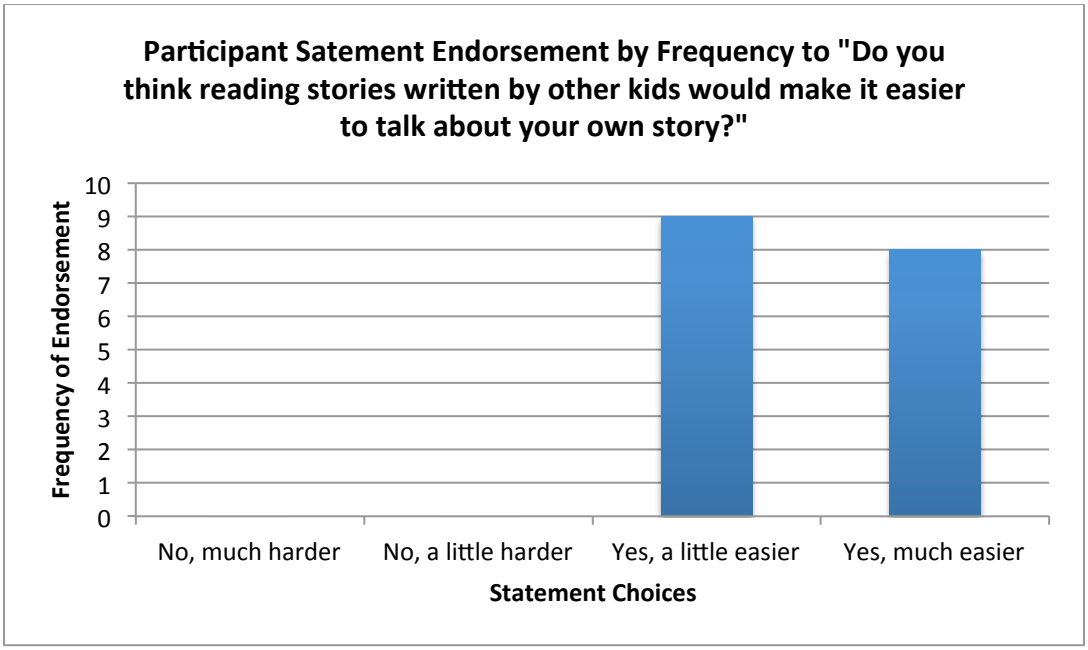


Figure 10
Degree to Which Participants Indicated that Reading Stories Written by Other Children Like Them Would Make it Easier to Talk About Their Own Story

When asked to respond to an open-ended prompt regarding why they think that reading stories written by other children might or might not make it easier to talk about their own story, three responses were given for why it would not matter and 32 responses were given for why reading another child's story might make it easier to talk about one's own story. Of the three responses for why it would not matter, one child indicated that some of the things she was experiencing or had experienced were so bad that reading other children's stories would not be enough to help her talk about her own story; whereas two participants indicated that they are readily willing to tell their story (and so had no need for tools to facilitate self-disclosure) because one of these two participants was not currently experiencing any distress, and the other reported that she simply felt very comfortable sharing her story.

Of the 32 responses given for why reading another child's story might make it easier to talk about one's own story, 29 of these responses fell into one of seven categories (meaning they were reasons endorsed by more than one participant), whereas three responses were uncategorized. The three uncategorized responses were (1) reading is enjoyable and something that a lot of children do, (2) reading other children's stories would illustrate that "people aren't perfect and that's ok", and (3) reading other children's stories would be helpful because it would mean not having to explain "every little detail" while worrying that "people won't understand". Of the seven categories into which most of the responses fell, the most frequently endorsed was comparing the similarities and differences between the participant's and another child's story (8 endorsements), followed by feeling like "I'm not the only one" (6 endorsements) and getting advice for solving the problem (5 endorsements). This data and a comprehensive list of the seven categories (with their endorsement counts) are presented in Figure 11 below.

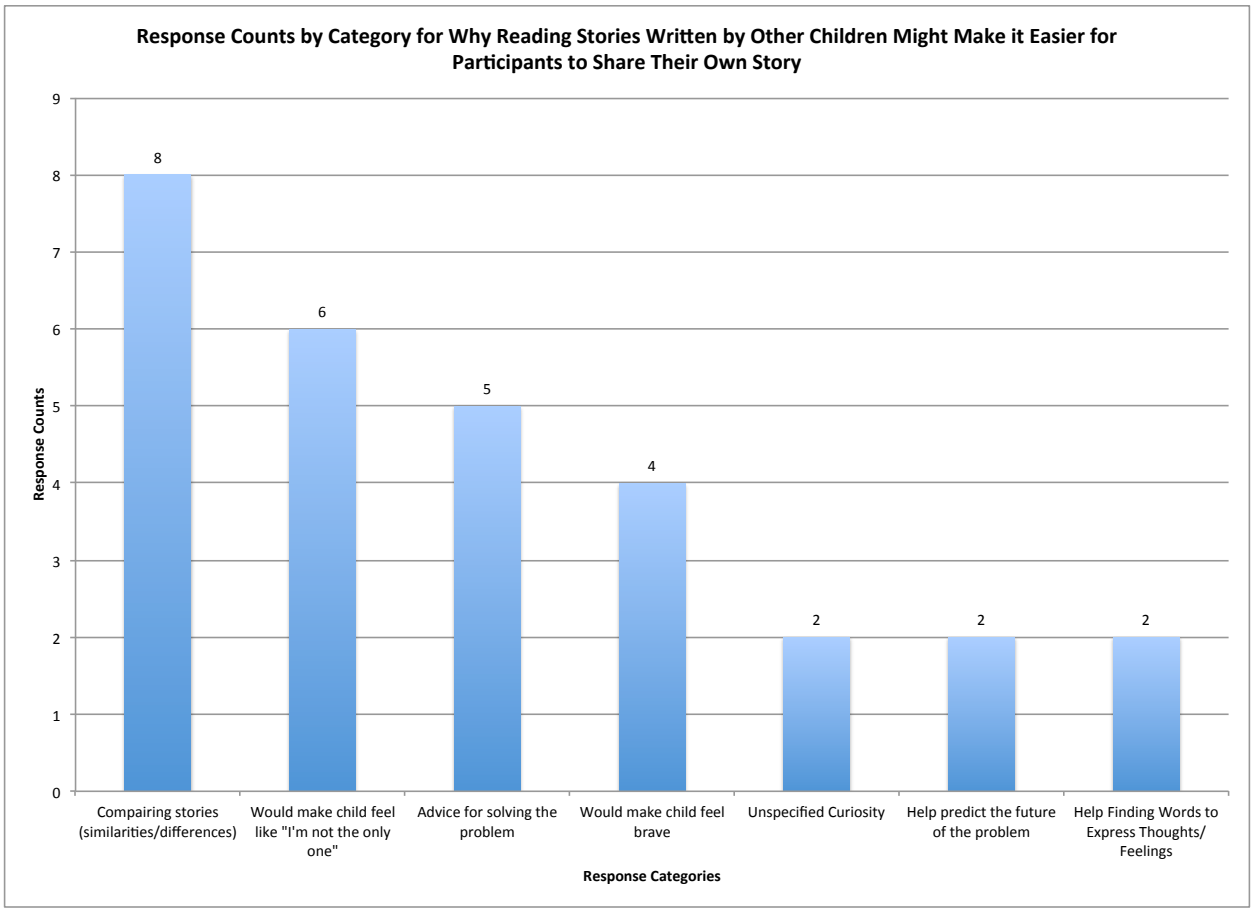


Figure 11
Responses by Category for Why Reading Stories Written by Other Children Might Make it Easier for Participants to Share Their Own Story

All in all, this data indicates that participants had a uniformly positive reaction to reading stories written by other children. Every one of the participants wanted to read other children's stories and thought that reading other children's stories would help them to share their own story. Participants were able to identify several reasons why they thought this to be the case, seven of which were common to more than one child.

This completes the child-participant portion of this study. The discussion will now turn to the results from the clinician survey. This presentation will explore the demographic presentation of clinician respondents, their reported current use of narratives in therapy, their perception of

relevance of the stories collected in this research study, and the perception of utility of these stories as a therapeutic tool.

Clinicians: Demographic Information

The first purpose of the Clinician survey was to gather demographic information on the clinician respondents. This demographic information consisted of: the age range of clinicians, the average number of hours per week they spend conducting therapy, their primary theoretical orientation, their primary work setting, and the average percentage of clients they see who are under the age of 18. The following is a presentation of the results of each of these variables.

The majority of clinician participants were between the ages of 25 and 34, or 60 and 65. The distribution of clinicians by age range is represented in Figure 12 below.

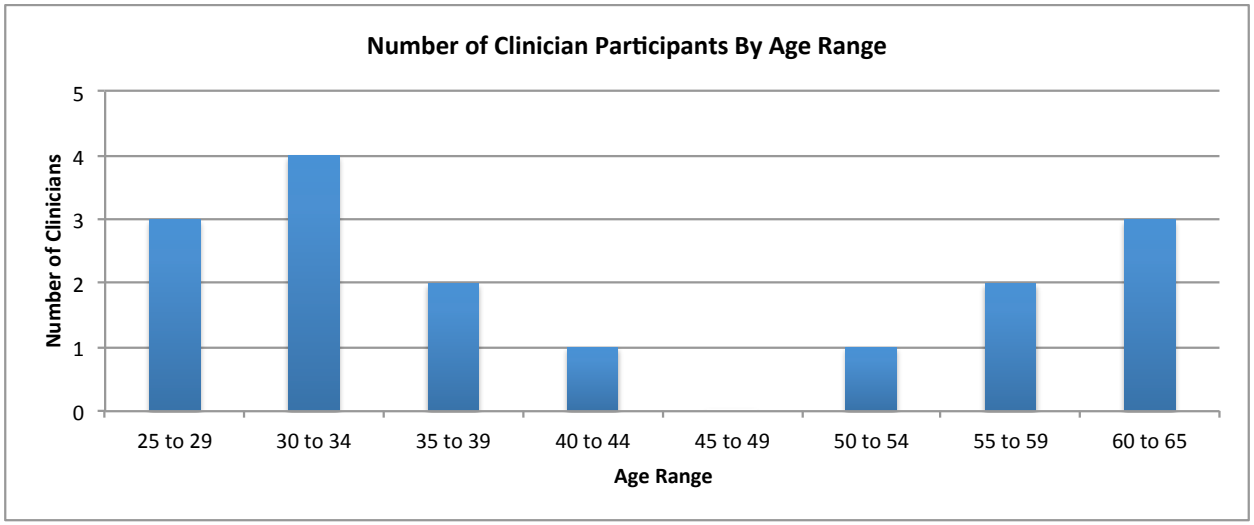


Figure 12
Distribution of Clinicians by Age Range

Clinicians reported a fairly wide range of hours per week spent conducting therapy, with most clinicians reporting averages of between 6 and 25 hours per week. Two clinicians reported spending less than five hours per week conducting therapy, and only one clinician reported

spending an average of more than 26 hours per week conducting therapy. This data is represented in Figure 13 below.

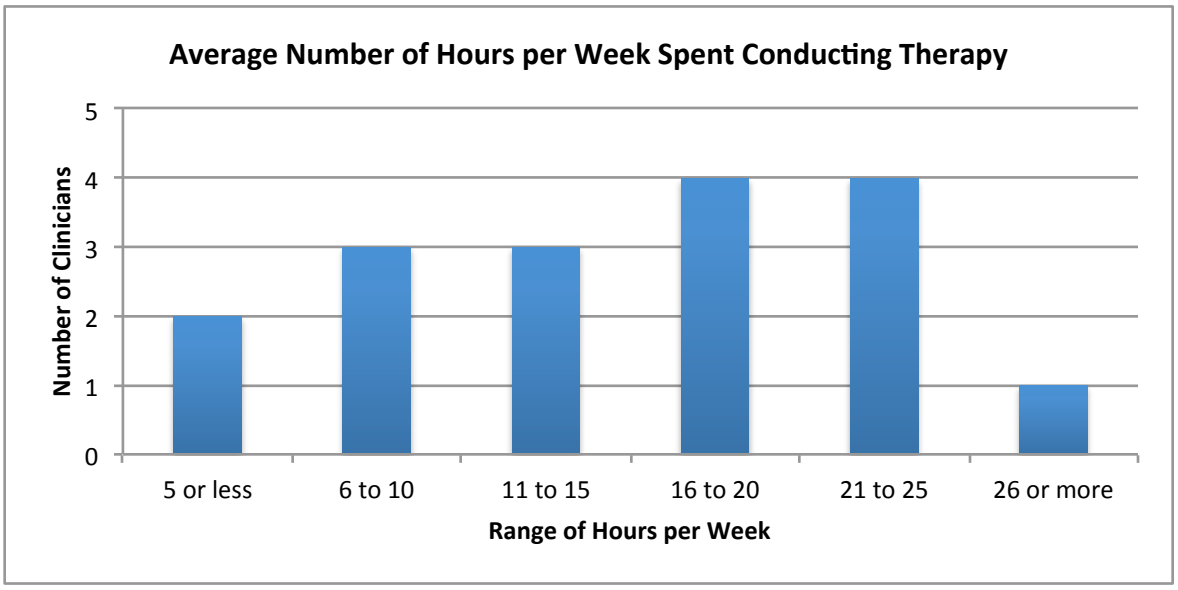


Figure 13
Range of Average Hours per Week Spent Conducting Therapy (group, individual, family, etc.)

Clinicians were presented with seven well-known theoretical orientations (as well as a write-in category of "Other"), and asked to indicate their primary theoretical orientation. The majority of clinicians identified as practicing from a primarily Humanistic (6 respondents) approach. "Other" was the second most frequently endorsed category (4 respondents), with the following write-in descriptors: "Narrative/Relational", "multiple approaches", "transpersonal-integrative," and "existential". A comprehensive list of endorsement counts for each category is presented in Figure 14 below.

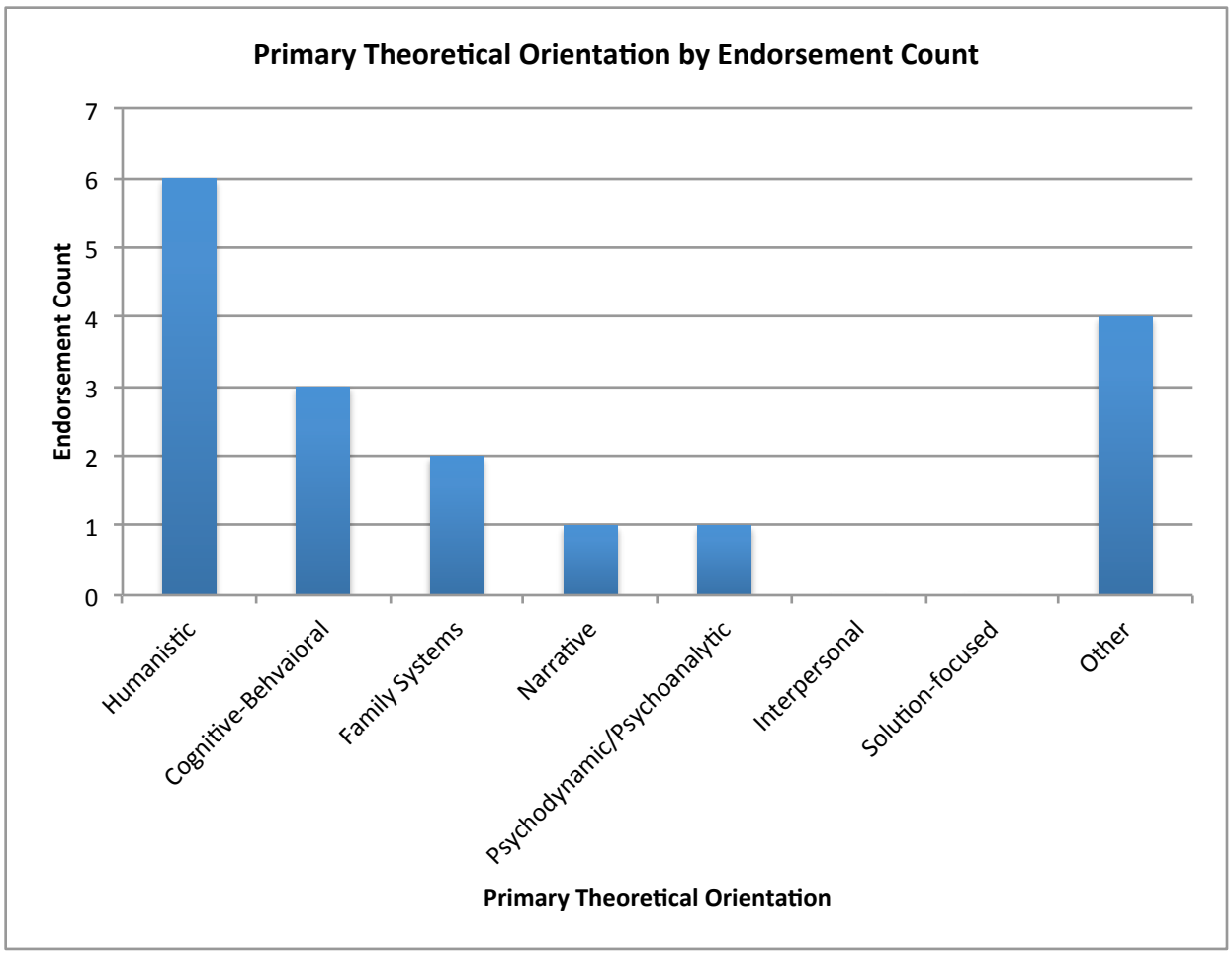


Figure 14
Primary Theoretical Orientations of Clinicians by Endorsement Count

Clinicians were next asked to indicate the setting in which they currently work. In the case of working in multiple settings, they were asked to indicate their primary setting. The majority of clinicians reported working in a Community Mental Health Center (7 respondents). There were no clinicians who reported working in Inpatient: private hospital, School System, or Medical Center. Two clinicians reported "Other" as their work setting, with the following descriptors: "Public health clinic", and "PsyD FT faculty and private practice". A comprehensive list of endorsement counts for each setting is presented in Figure 15 below.

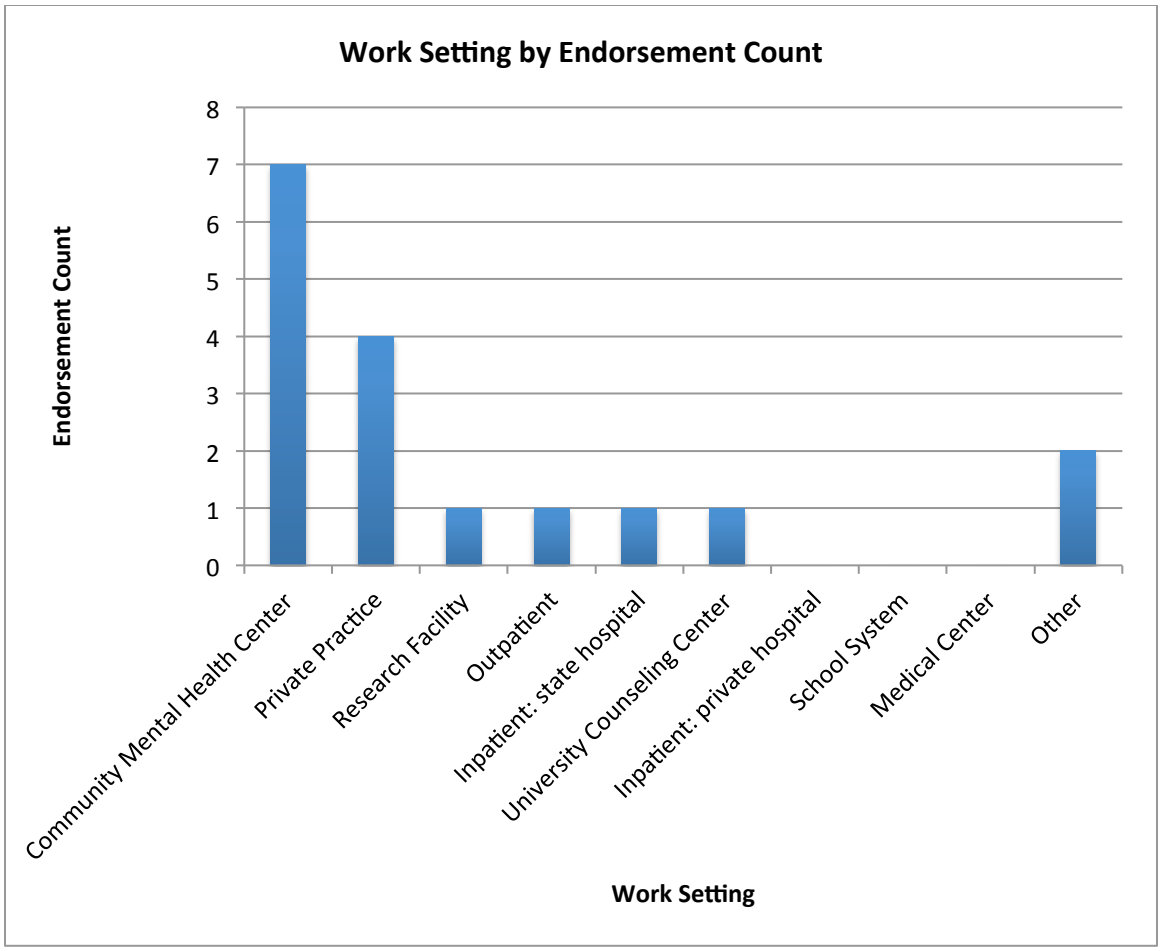


Figure 15
Work Settings of Clinicians by Endorsement Count

Clinicians evidenced a range of responses in regards to how many clients they see each week who are 18 years of age or younger. The majority of clinicians (11 respondents) reported percentages of 41% or more, while the rest (5 respondents) reported 20% or less. Percentage ranges and their associated endorsement counts are presented in Figure 16 below.

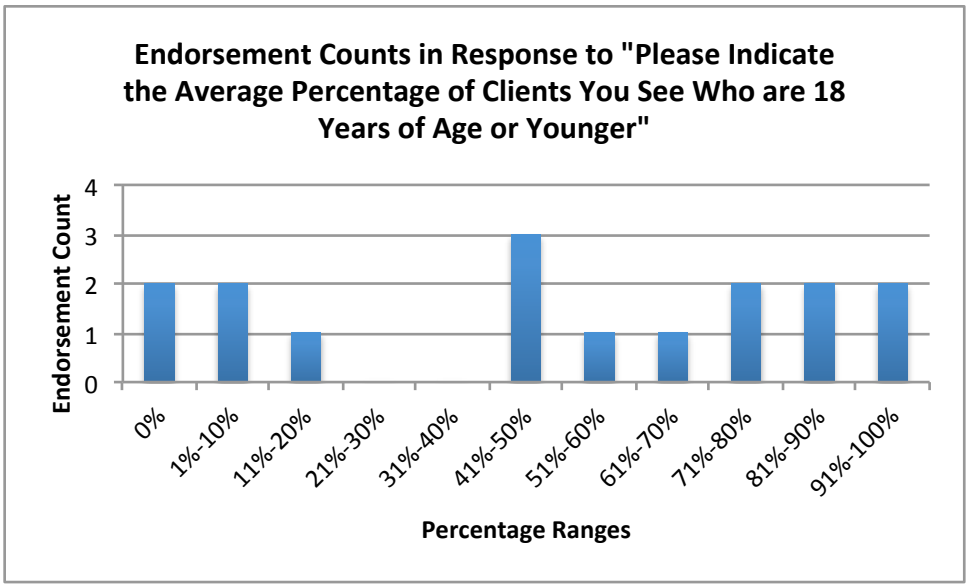


Figure 16
Reported Average Percentage of Clients 18 Years of Age or Younger Seen by Clinicians

Clinicians: Use of Narratives in Therapy

The first element that the clinician survey was designed to measure is that of clinicians' current use of narratives in their own therapeutic practices. Clinicians were presented with a description of the theoretical underpinnings of personal narratives, the relevance of personal narratives to influencing real-life patterns, and how narrative therapy utilizes narratives. They were then asked to indicate the degree to which their primary theoretical orientation emphasizes the elicitation of personal narratives from clients, as well as how frequently they themselves use the concept of personal narratives in their own work. The majority of clinicians (10 respondents) reported that their theoretical orientation places "Some emphasis" on the elicitation of personal narratives from clients (see Figure 17 below). Likewise, the majority of clinicians (8 respondents) reported that they themselves use the concept of personal narratives "Somewhat frequently" (see Figure 18 below).

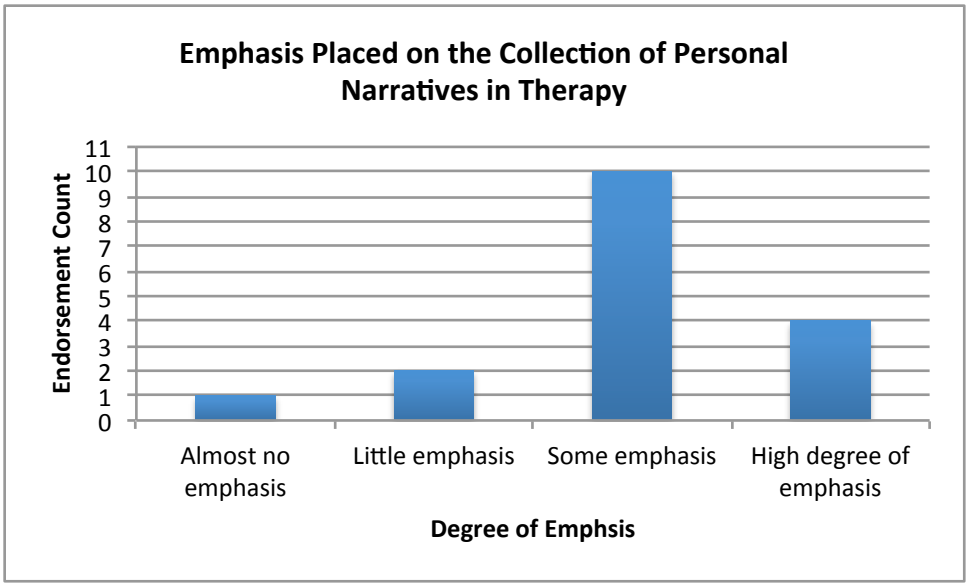


Figure 17
Clinician Endorsements of Emphasis Placed by Theoretical Orientation on the Collection of Personal Narratives in Therapy

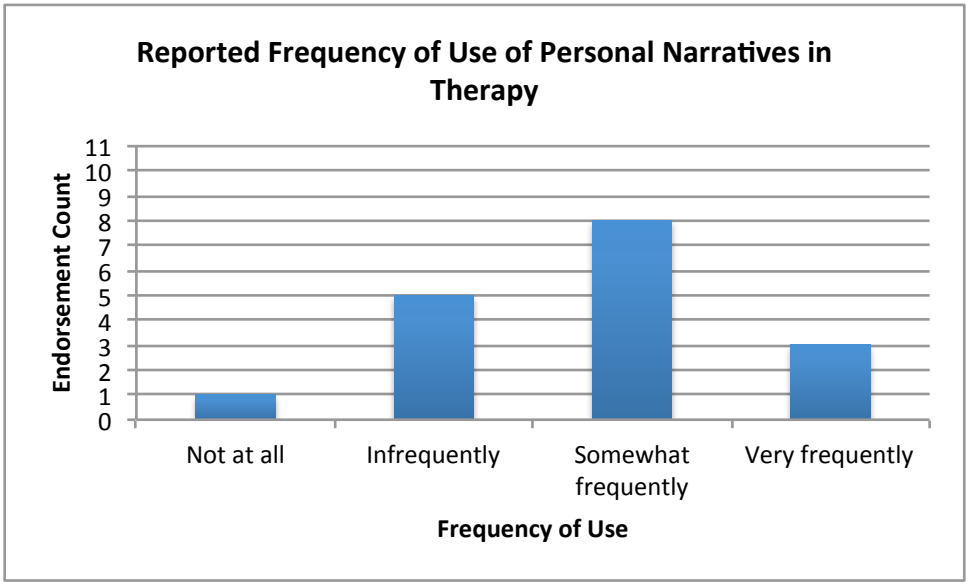


Figure 18
Clinician Endorsements of Emphasis They Themselves Place on the Collection of Personal Narratives in Therapy

Clinicians: Perception of Relevance of the Collected Stories

The second element that the Clinician survey was designed to measure is that of clinicians' perception of relevance of the stories constructed in this study, in regards to their representativeness of the type of clients regularly seen in therapy. This element was captured by: (1) asking clinicians to indicate on a four-point Likert scale the degree to which the stories they read were consistent with those of the clients they typically encounter in their practice, and (2) to explain in what ways these stories were or were not consistent. The majority of clinicians indicated they thought the stories were somewhat consistent (11 respondents). Figure 19 below illustrates these results.

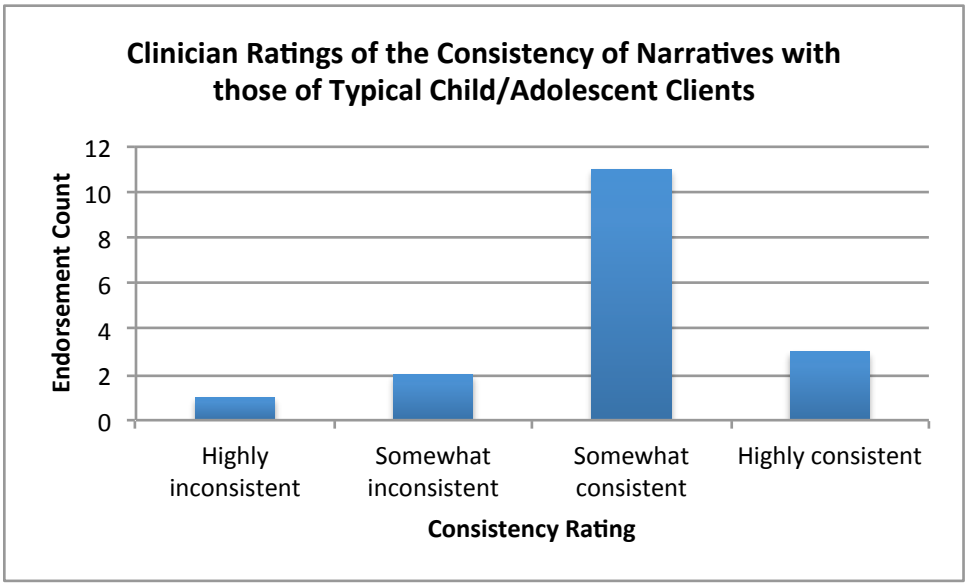


Figure 19
Rating of the Consistency of Narratives

Clinician responses as to why the stories were or were not consistent with those of clients typically seen in practice evidenced several content categories. Eight clinicians indicated that the negative life experiences articulated in the stories were similar to those faced by the children they see in practice, and most especially problems within interpersonal relationships (friends,

family, etc.). Other examples given by clinicians of experiences that were representative of child/adolescent clients included: identity issues, trauma, and experience with foster care. Three clinicians indicated that the responses to these negative experiences were similar in the stories to those seen in practice. Examples of these responses included: attempts to by the child to regain a perception of control, attempts to find meaning in the situation, and seeking solace through contact with animals. Opinions regarding the emotional content of the stories was mixed. Three clinicians indicated the children in the stories were experiencing similar emotional responses to those evidenced by their clients (e.g. helplessness, guilt), whereas one clinician judged the stories to be "overly melodramatic". Reponses were also mixed in regards to the "literary maturity" of the child writers. Two clinicians indicated they judged the stories to be "more articulate than the average child (seen in therapy)" and "unusually well structured for young clients", while one clinician indicated the stories were similar in regards to their "innocent and candid interpretation of (the children's) experiences". Two clinician responses could not be categorized by theme, as they were endorsed only once: one clinician indicated the stories were not representative of those seen in practice as this clinician does not typically see clients under the age of 18 for more than one session, and does not conduct family therapy; and one clinician indicated that the stories were representative of those seen in practice as the stories contained positive life experiences (e.g. memories of good times and hope for the future), as well as negative life experiences. See Figure 20 below for these results.

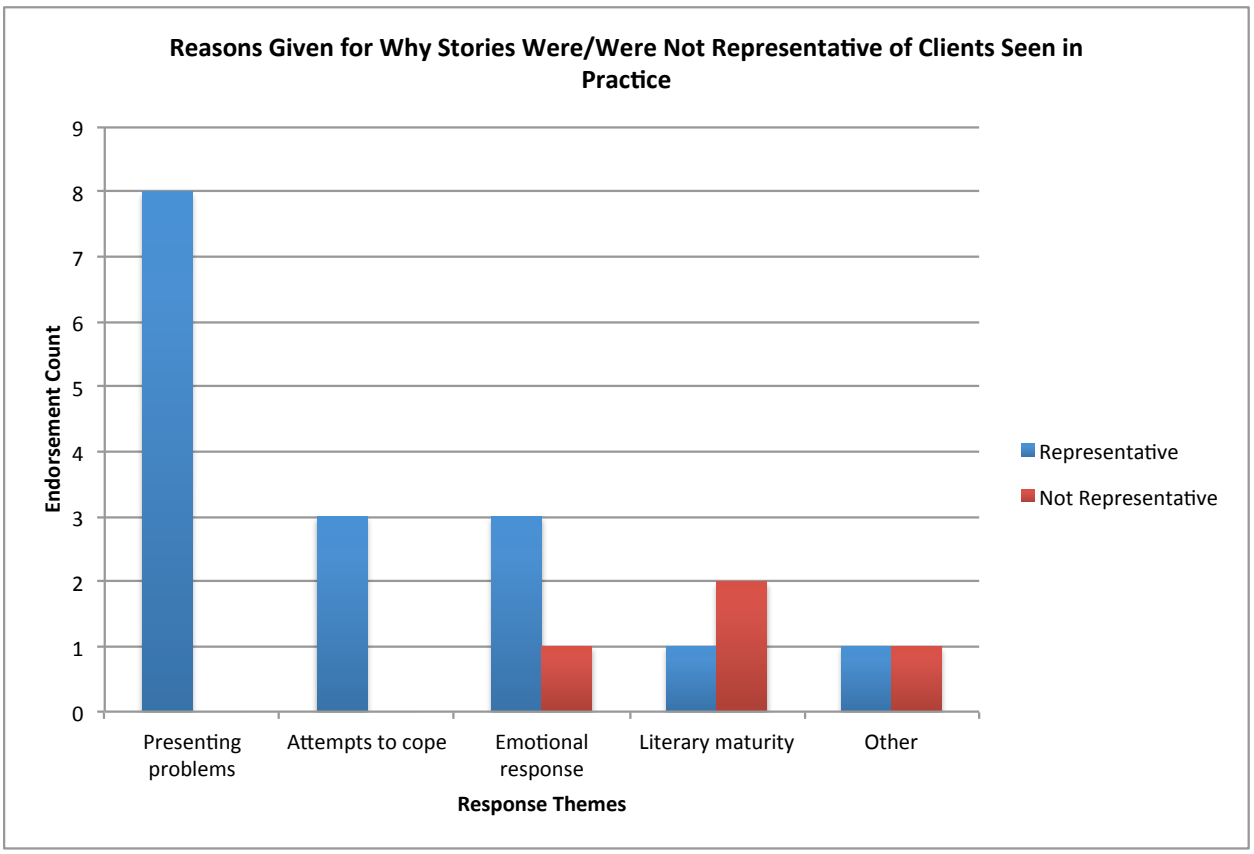


Figure 20
Clinician Responses by Theme for Why Stories Were or Were Not Representative of Those Seen in Practice

Clinicians: Perception of Utility of These Stories as a Therapeutic Tool

The third element that the Clinician survey was designed to measure is that of clinicians' perception of utility of the stories as a therapeutic tool. This element was captured by asking clinicians to respond to several questions.

First, clinicians were asked to indicate on a four-point Likert scale the degree to which they thought children and adolescents would feel more or less comfortable writing or talking about their own problems after reading a story written by another child facing similar circumstances. The majority of clinicians indicated they thought a collection of stories would make children feel a little more comfortable (10 respondents) or much more comfortable (5

respondents). Only two clinicians indicated that a collection of stories would not make children feel comfortable, and no clinicians indicated that a collection of stories would make children feel uncomfortable. These results are illustrated in Figure 21 below.

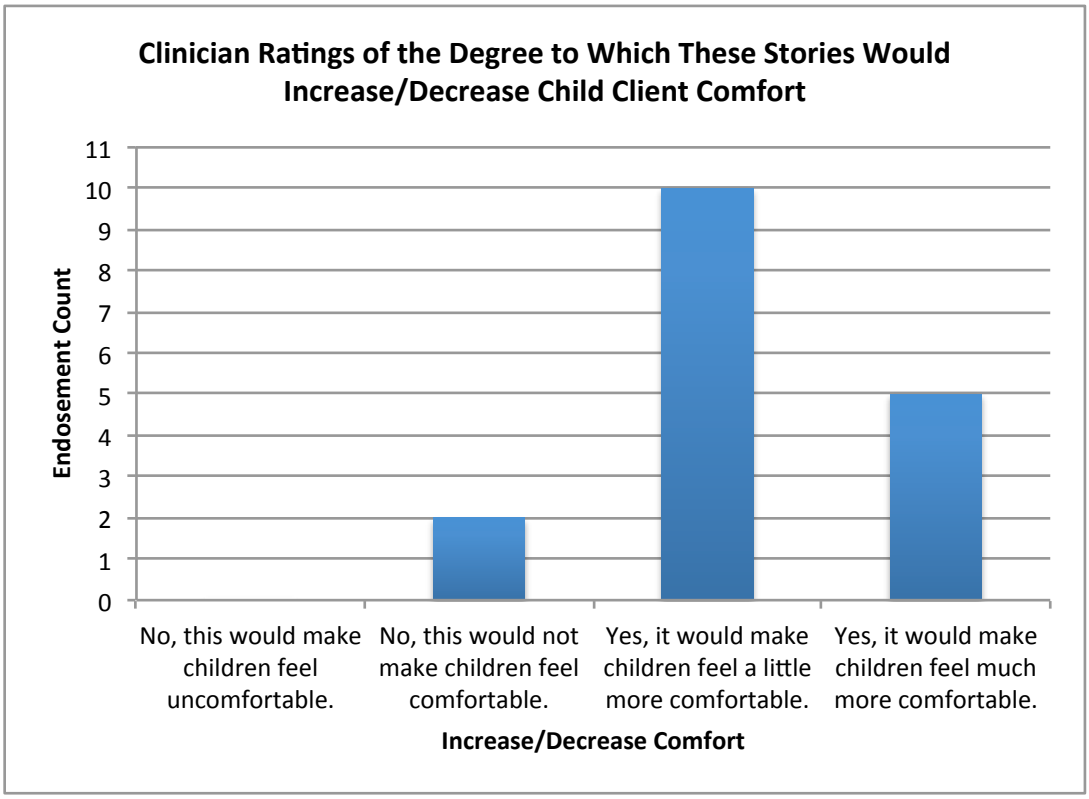


Figure 21
Clinicians Ratings of the Degree to Which Reading a Collection of Stories Might Increase/Decrease Child Client Comfort.

Next, clinicians were asked to rate the degree to which they believe a collection of personal stories written by children (such as those in this study) would aid other clinicians. The majority of clinicians indicated they thought this tool would be either somewhat beneficial (9 respondents) or extremely beneficial (7 respondents) to other clinicians. Only one clinician

indicated that this tool would not be beneficial, and no clinicians indicated that this tool would be detrimental to other clinicians. These results are represented in Figure 22 below.

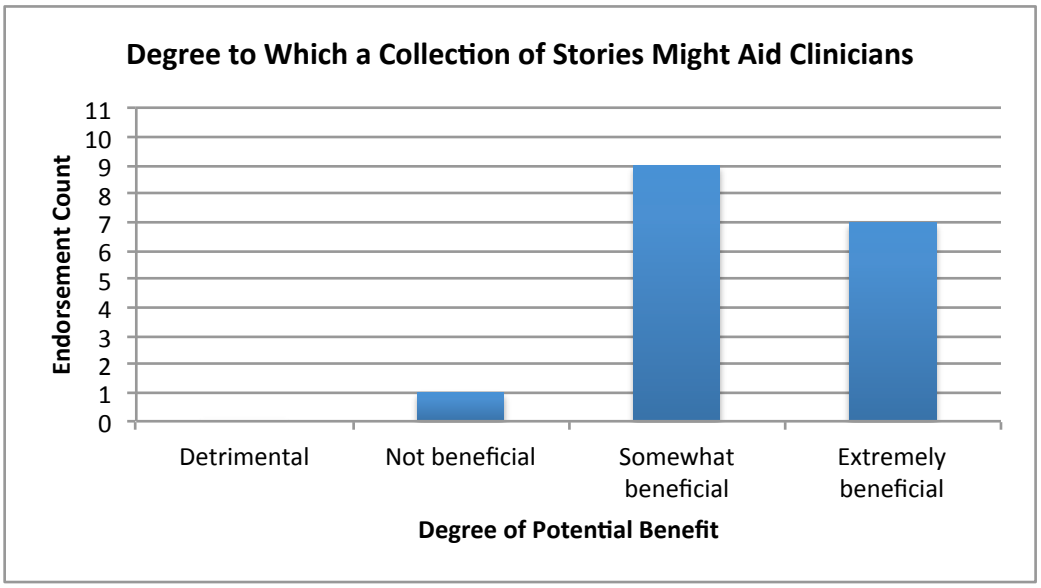


Figure 22
Degree of Perceived Benefit of a Collection of Stories to Other Clinicians

Finally, clinicians were asked to indicate on a four-point Likert scale the likelihood of their using a tool such as this collection of stories in their practice, and to explain the reasons behind their likelihood rating. Responses regarding the likelihood of use varied. The majority of clinicians (7 respondents) indicated they would definitely use a tool such as this, four clinicians indicated they would be likely to use this tool, four clinicians indicated they would be unlikely to use this tool, and two clinicians indicated they would never use this tool in their own practice. These results are represented in Figure 23 below.

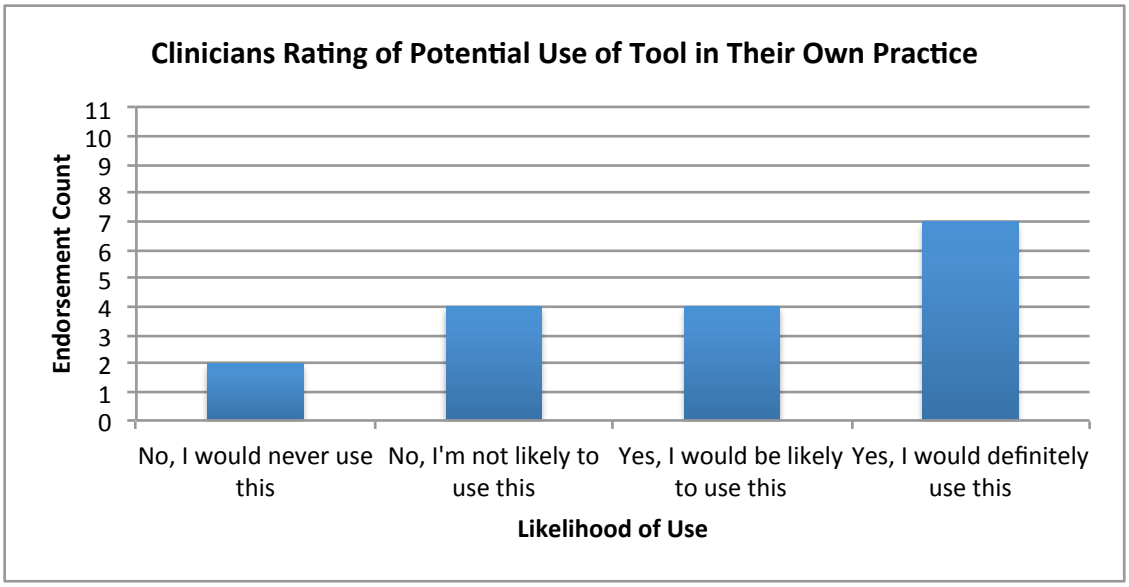


Figure 23
Ratings of Likelihood of Using this Tool in Clinicians' Own Practice

When asked to explain why they would (or would not) be likely to use a collection of stories in their own practice, the majority of responses fell into one of several common themes; however, a significant number of responses were unique in content, and were therefore categorized as "Other". The most common reason given for why clinicians would be unlikely to use this tool was a mismatch in client age (3 endorsements). Other reasons that clinicians endorsed for being unlikely to use this tool included a mismatch in treatment modality (2 endorsements) and concern that reading another child's narrative might displace the client's own narrative (2 endorsements). Opinions regarding the benefit of having another child's story to model how the client might talk about their own story were mixed. Two clinicians indicated that they would be likely to use a collection of stories because it would help model how to talk about one's experiences, whereas one clinician expressed concern that this might create expectancy effects for framing client's own experience. Other reasons given for why clinicians would be likely to use a collection of stories were: they would help destigmatize and normalize various

experiences (2 endorsements), it would help the client feel less alone (2 endorsements), and because of the reasons proposed by the researcher (2 endorsements; for reasons given by researcher, see Table 5 on p. 66). These results are represented in Figure 24 below.

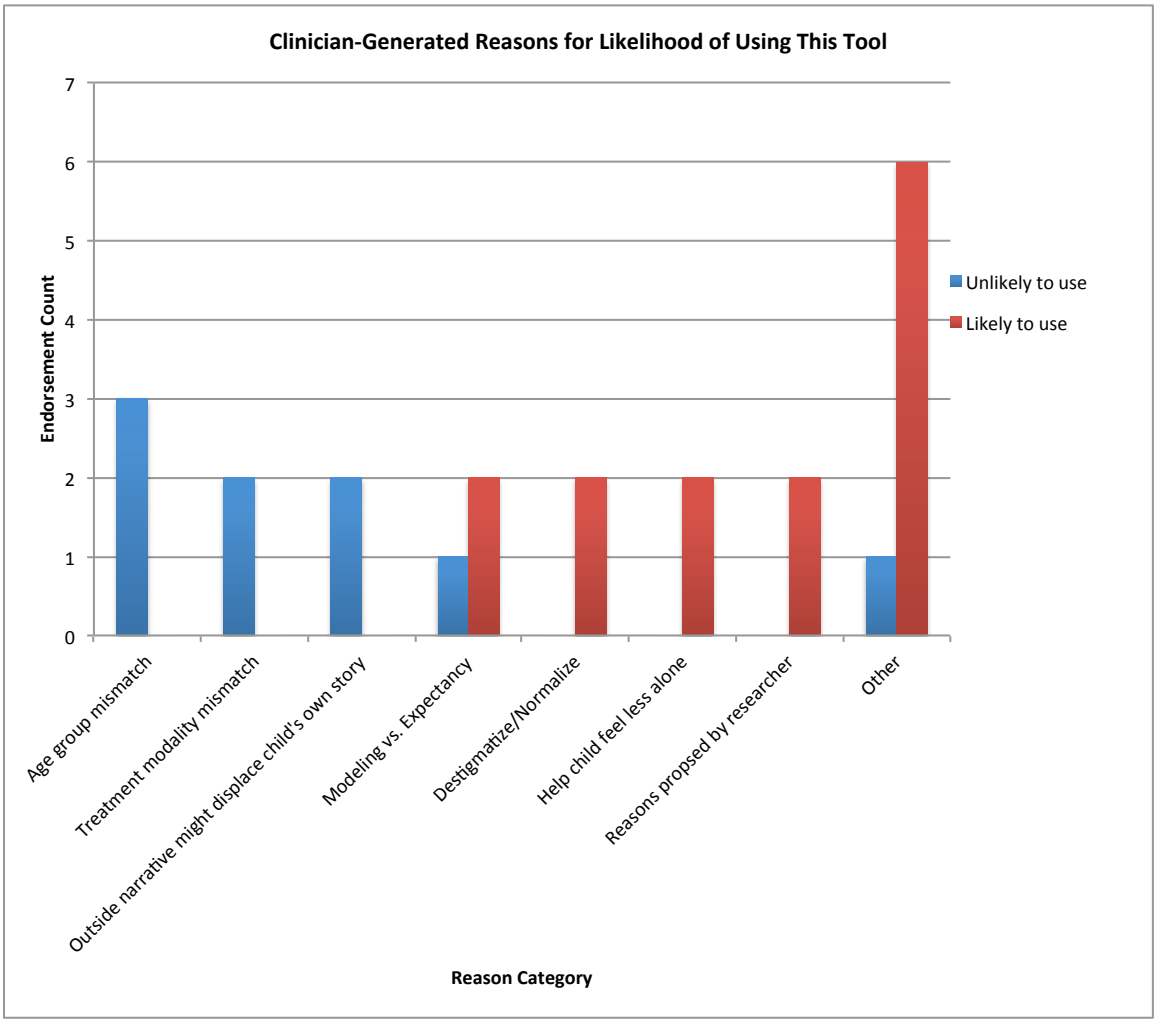


Figure 24
Clinician-Generated Reasons for Likelihood of Using This Tool

As can be seen by Figure 23 above, a significant number of clinicians endorsed reasons that could not be categorized, as they were each mentioned only once. A comprehensive list of these reasons is listed in Table 5 below, as well as the associated likelihood of use.

Table 5

Clinician-Generated Reasons for Likelihood of Use

Clinician-Generated Reason for Use	Likelihood of Use
Child's perspective is limited by developmental level and capacity for self-reflection and accurate perception	Unlikely
Stories provide hope for getting through difficult circumstances	Likely
Opportunity to begin conversations about difficult topics with children	Likely
Because it is collaborative	Likely
Because it is safe	Likely
It's good option for children who prefer other modality of therapy rather than strictly talk therapy	Likely
Clinician would be interested to see the child's response to the stories and to explore associations and reflections in regard to their own lives	Likely

Clinicians: Possible Reasons for the Proposed Efficacy of the Use of These Stories in Therapy

The final element that the Clinician survey was designed to measure is that of clinicians' opinions regarding why these stories may be an effective therapeutic tool. This element was captured by asking clinicians to rate on a four-point Likert scale the degree to which each of five categories are likely to be reasons for this proposed efficacy. These categories and their abbreviations are listed in Table 6 below.

Table 6

Proposed Reasons for Efficacy and Their Abbreviations

Proposed Reason	*Category Abbreviation*
This method utilizes storytelling, which is a familiar mode of communication for children. This may, as with other child-centered practices, minimize the discrepancy between how children prefer to communicate and the manner in which therapy is conducted.	Storytelling
Reading a story of this nature with the therapist may contribute to the formation of a positive, collaborative therapeutic relationship.	Relationship
Reading another child's story may familiarize the client with the language other children have used to describe their experiences, and therefore offer the client a model for organizing and articulating his/her own narrative.	Language
This method would allow the client to explore the therapist's reaction to various life events with minimal risk. The client may feel reassured by watching the therapist's empathic reaction to reading another child's story.	Therapist Reaction
Reading a story written by another child with similar difficulties may help child-clients feel less stigmatized and isolated by their own experiences. It may challenge the "I'm the only one" feeling some children experience.	Stigma/Isolation

When asked to rate the likelihood of each of these categories as a possible reason for efficacy, responses varied. Figure 25 below illustrates this dispersion and shows the endorsement counts for each category. It should be noted that, although it is shown as a response option, no clinicians endorsed "Very unlikely" for any of the reason categories.

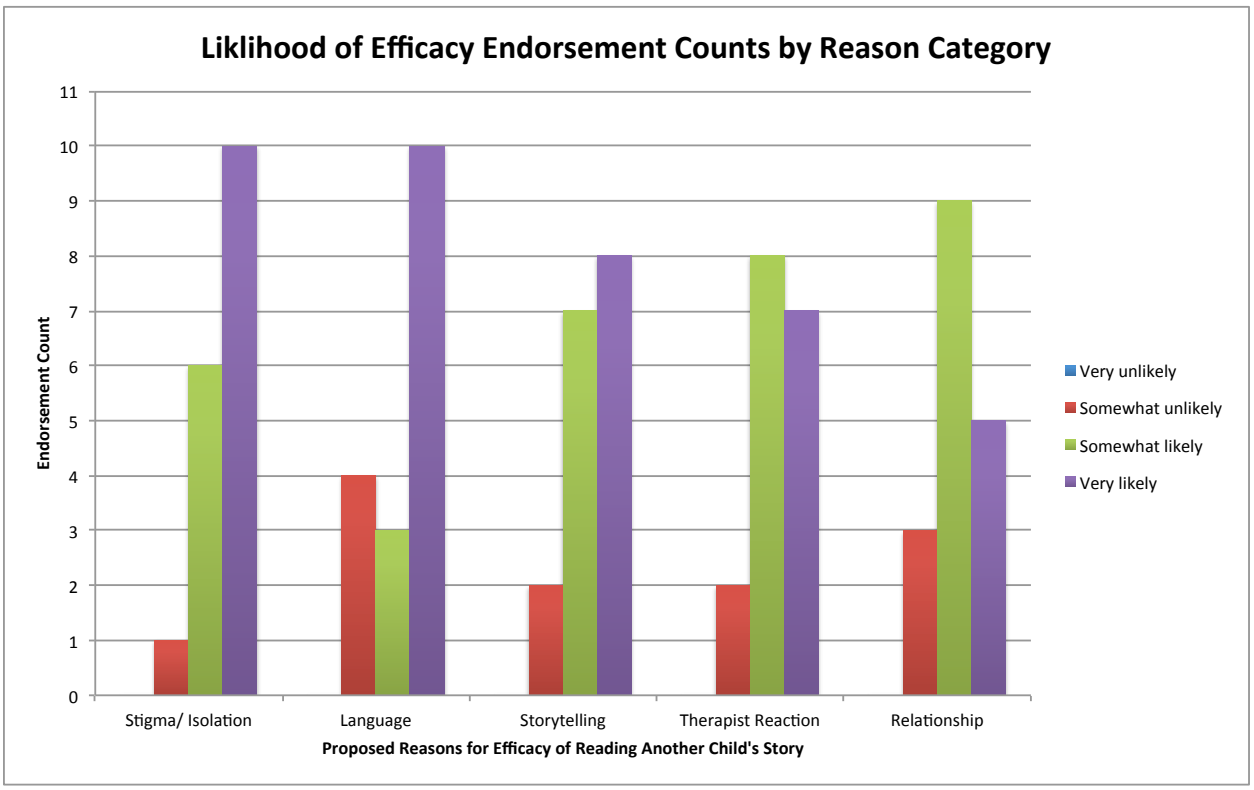


Figure 25
Likelihood of Efficacy Endorsement Counts by Reason Category

Due to the variability of respondents' ratings, an examination of likelihood endorsement rating counts yields little useful information. Condensing this data allows for a more effective and efficient interpretation of results. The following numerical values were assigned to each Likert scale response: Very unlikely (-1), Somewhat unlikely (-0.5), Somewhat likely (+0.5), and Very likely (+1). In this way a neutral rating would have a directional average of 0, and the strength and direction of clinicians' responses for each category are indicated by their magnitude and sign. Examining the average rating and standard errors for each category revealed information regarding the most likely reason for the proposed efficacy of this tool, as well as the uniformity of clinicians' ratings.

Clinicians rated Stigma/Isolation (M = 0.735) as the most likely reason for the proposed efficacy of this tool, followed by Storytelling (M = 0.618), Therapist Reaction (M = 0.588), Language (M = 0.559), and Relationship (M = 0.471). With a standard error of 0.097, Stigma/Isolation was also the most agreed-upon reason category among respondents; followed by Therapist Reaction (SE = 0.118), Storytelling (SE = 0.115), Relationship (SE = 0.125), and Language (SE = 0.154). These results are represented in Figure 26 below.

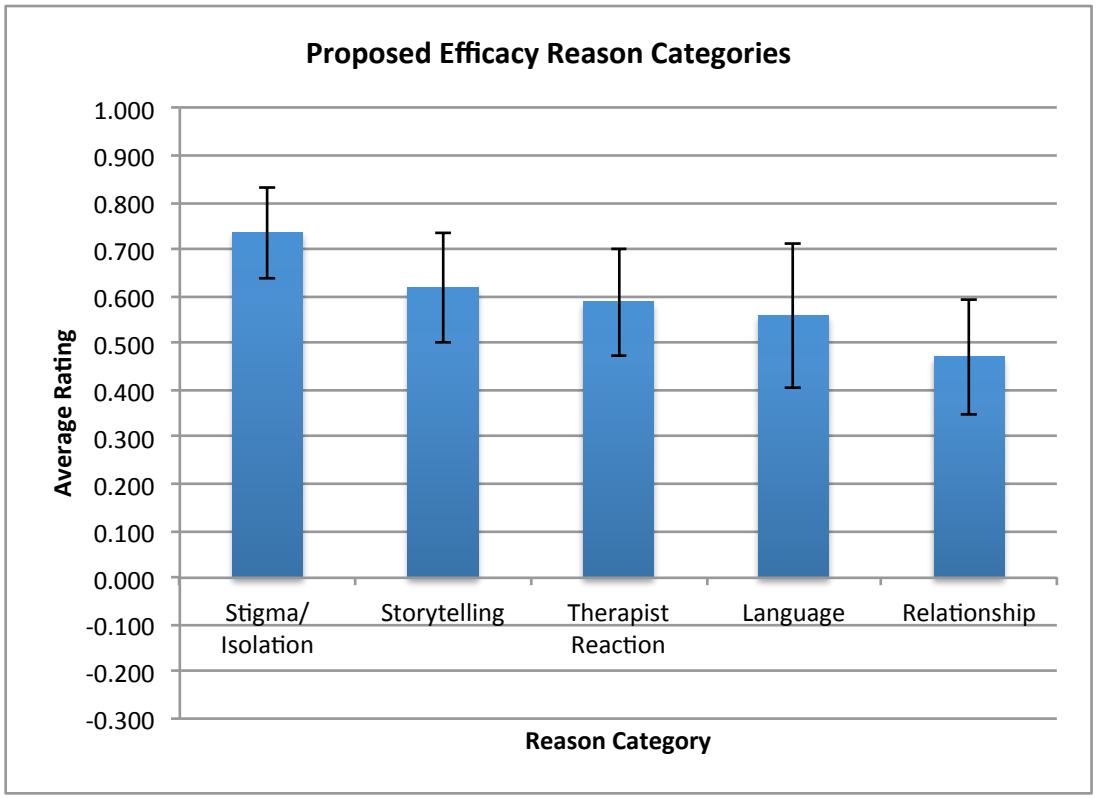


Figure 26
Means and standard errors of proposed efficacy reason categories

Clinicians were also given the option of writing in their own ideas for why reading another child's story may be effective in therapy. Four clinicians proposed the following reasons and likelihood ratings: "Opens up conversations" (Very likely), "Models for children talking or thinking about the problems and their own understanding of them" (Very likely), "Allows child

to compare their experiences to those of others" (Somewhat likely), and "safe, fun and collaborative" (Very likely).

Children and Adolescents: Hypotheses and Associations Between and Among Themes

Hypothesis #1: Length of time child/adolescent participants have spent in therapy and their positive reaction to their therapy experience will correlate with ease of task and positive emotional response to the task. In order to test this hypothesis, experience of therapy was quantified by subtracting the total number of negative aspects of therapy from the total number of positive aspects of therapy, as identified by each child. The resulting difference represents the magnitude and emotional valence of each participant's experience of therapy. Similarly, emotional response to the task was quantified by subtracting the number of endorsed positive-valence emotions (e.g. Inspired, Special, Happy, etc.) from the number of endorsed negative-valence emotions (e.g. mad, sad, confused, etc.) for each participant. The resulting difference represents the magnitude and emotional valence of each participant's emotional response to the task of writing a story. Ease of task was quantified using the participants' Likert-scale rating to the question "How easy or difficult was it to write your story?" and length of time spent in therapy was measured as the length of time (in months) that the child reported having engaging in therapy prior to participating in this study. The means and standard errors for each of these variables are represented in Table 7 below.

Table 7

Means and Standard Errors for Hypotheses Testing: Children and Adolescents

(n = 17)

Variable	M	SE
Time spent in therapy	22.22	6.74
Experience of therapy	1.88	0.53
Ease of task	2.76	0.20
Emotional response to task	2.94	1.53

An initial examination of this data revealed no evidence for associations between Experience of therapy and Emotional response to task (see Figure 27 below), or between Time spent in therapy and Emotional response to task (see Figure 28 below).

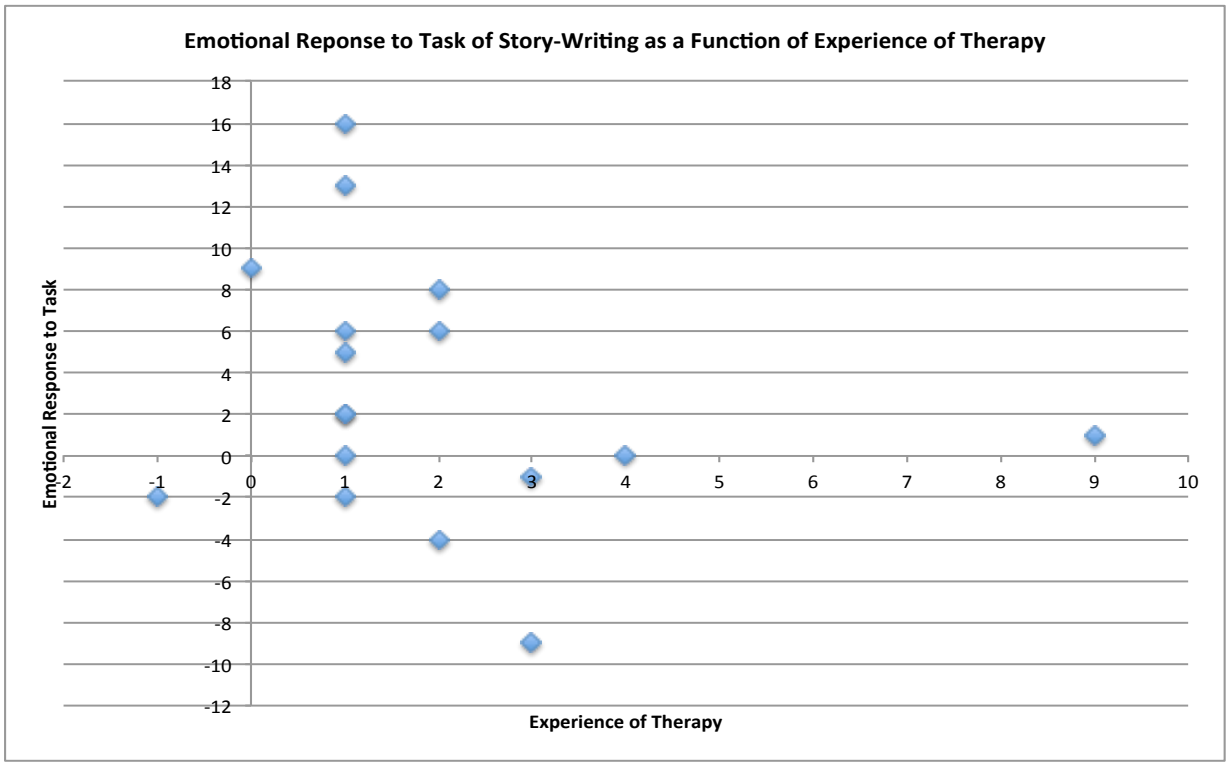


Figure 27
Experience of Therapy and Emotional Response to Task

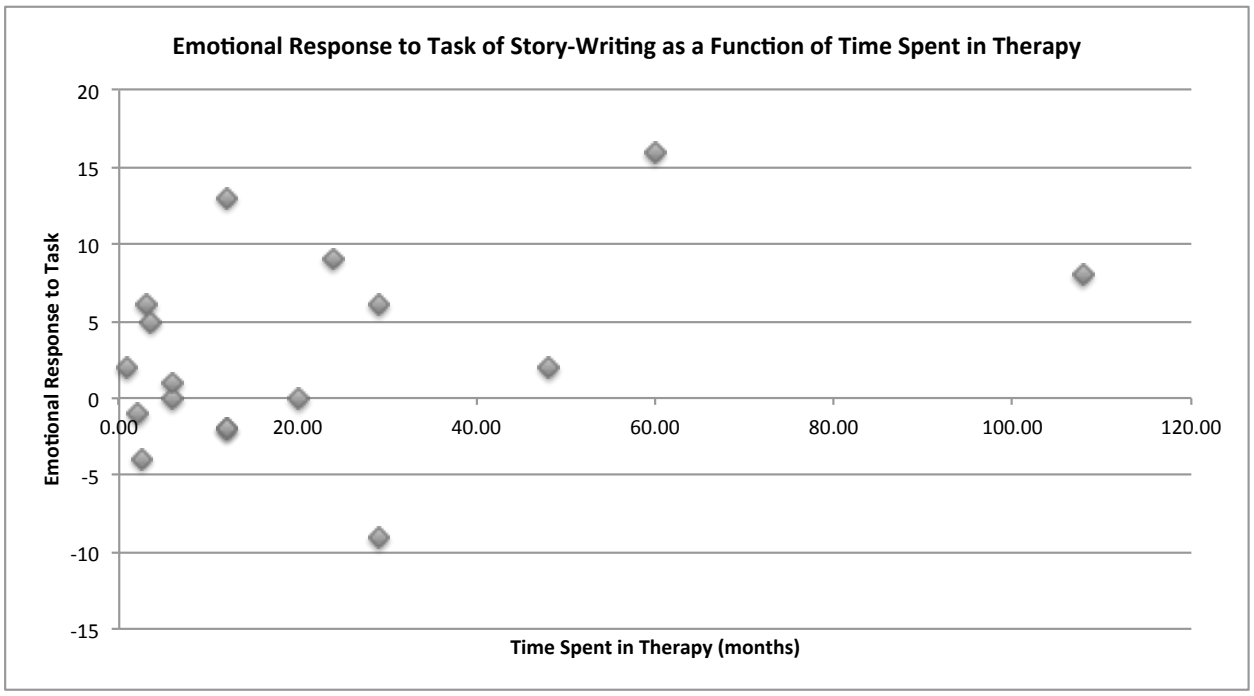


Figure 28
Time spent in therapy and emotional response to task

An examination of the data did reveal a possible association between Experience of therapy and Ease of task (see Figure 29 below). This potential relationship was explored by computing a Pearson product-moment correlation. The weak, negative correlation between these two variables was not statistically significant, r = -.27, n =16, p = .31. Furthermore, it should be noted that, although it was possible to correct for outliers by removing one data point (see Figure 28 below) for the analysis, the data still failed to meet assumptions for homoscedasticity and linearity. This outlier was identified as an outlier (108 months spent in therapy), as it was more than three standard deviations from the mean on the Time Spent in Therapy scale (M = 22.22, SD = 27.80). The results of this Pearson product-moment correlation analysis must therefore be interpreted with caution.

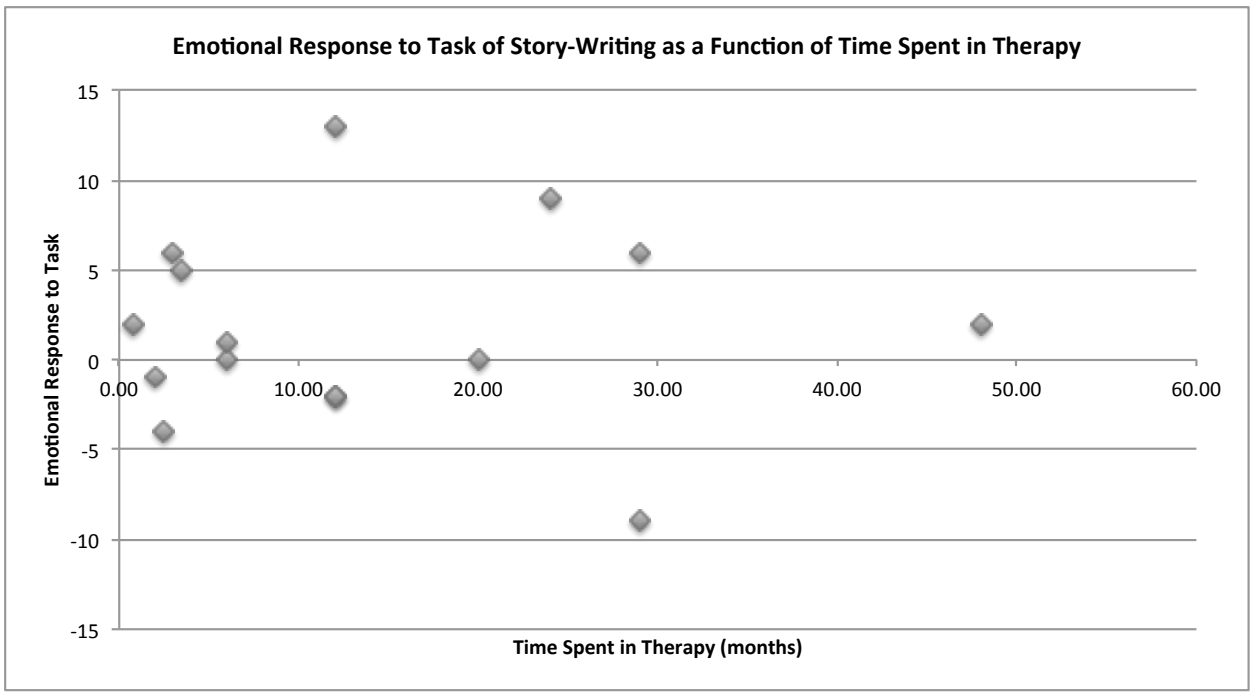


Figure 29
Time spent in therapy and emotional response to task (outlier removed)

An examination of the data also revealed a possible relationship between Time spent in therapy and Ease of task (see Figure 30 below). This potential relationship was explored by computing a Pearson product-moment correlation. One data point was identified as an outlier (108 months spent in therapy), as it was more than three standard deviations from the mean on the Time Spent in Therapy scale ($M = 22.22$, $SD = 27.80$). After correcting for this outlier (see Figure 31 below), the moderate, positive correlation between these two variables was statistically significant, $r = .57$, $n = 16$, $p \leq .05$. It should be noted, however, that the data failed to meet assumptions for homoscedasticity and linearity. The results of this Pearson product-moment correlation analysis must therefore be interpreted with caution.

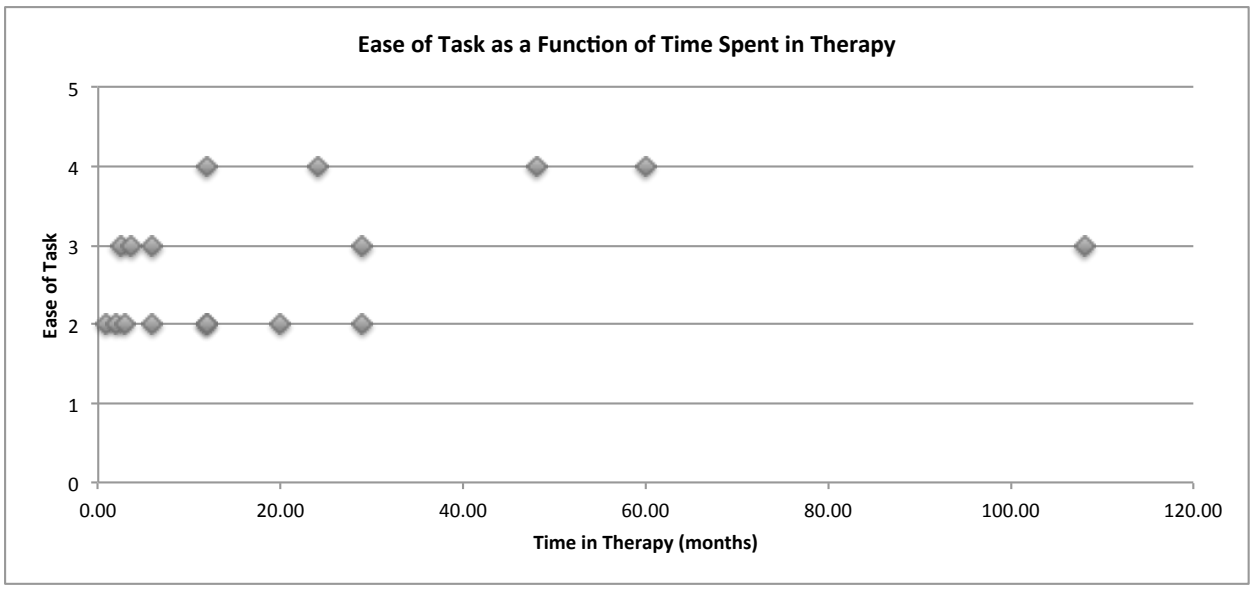


Figure 30
Time spent in therapy and ease of task

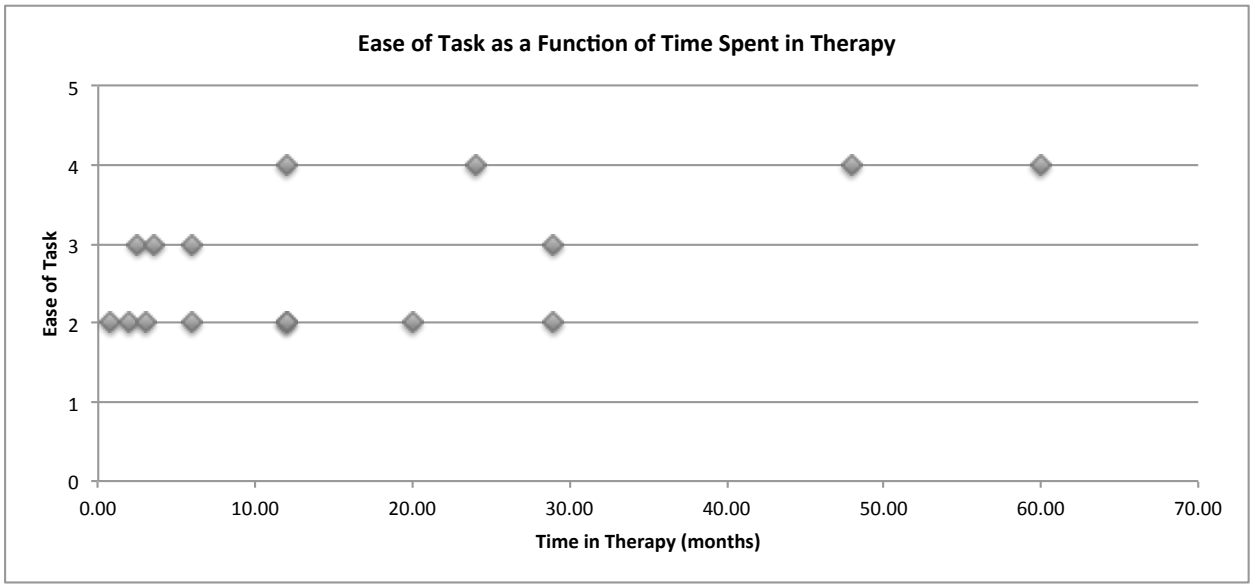


Figure 31
Time spent in therapy and ease of task (outlier removed)

Hypothesis #2: Participants will have an overall positive reaction towards reading stories written by other children. The hypothesis that participants would have an overall positive reaction towards reading stories written by other children was supported. Child and adolescent participants had universally positive responses to the questions "Would you like to read other stories written by kids like you" (see Figure 8 on p. 48) and "Do you think reading another child's story would make it easier or harder to talk about your own story?" (see Figure 9 on p. 49). Furthermore, when asked to expand upon why reading another child's story might make it easier or harder to talk about their own story, only three of the 34 coded responses were reasons why participants thought reading other stories may not be helpful. The remaining 31 responses were all reasons for why participants thought reading other stories would be helpful.

Clinicians: Hypotheses and Associations Between and Among Themes

It was hypothesized that (a) clinicians' theoretical orientations will be associated with their use of narratives in therapy, (b) perception of relevance of the stories collected will be associated with primary setting of employment, (c) use of narratives in therapy will be associated with perception of utility of these stories as a therapeutic tool, (d) reasons for the proposed efficacy of the use of these stories in therapy will be associated with clinicians' theoretical orientations, (e) clinicians will generally have positive attitudes towards the relevance and utility of stories as a therapeutic tool, and (f) this effect will be stronger with clinicians who use narratives in their own practice.

An examination of the data failed to provide evidence for any of the predicted associations; however, the prediction that clinicians will generally have positive attitudes towards the relevance and utility of stories as a therapeutic tool was supported. The majority of clinicians (15 of the 17 respondents) rated these stories as being either Somewhat or Highly consistent with those of children and adolescents typically seen in therapy (see Figure 19 on

p.59), and indicated several reasons why this was so (see Figure 20 on p. 61). The majority of clinicians (15 of the 17 respondents) also agreed that reading another child's story would help children in therapy to feel more comfortable talking about their own stories (see Figure 21 on p. 62). The majority of clinicians (16 of the 17 respondents) rated a collection of these stories as being Somewhat or Highly beneficial to other clinicians (see Figure 22 on p. 63). The majority of clinicians (13 of the 17 respondents) indicated that they would be likely to use such a collection of stories in their own practice (see Figure 23 on p. 64), and indicated several reasons why this was the case (see Figure 24 on p. 65 and Table 5 on p. 66). Finally, the majority of clinicians endorsed all of the presented categories of reasons as being likely causes for the potential efficacy of a collection of stories as a therapeutic tool (see Figure 25 on p. 68), as well as suggesting additional reasons (see p. 69-70).

CHAPTER V

DISCUSSION

Since its inception in the early 1990's, narrative therapy has emerged as a viable approach for the treatment of families, adults, and children (Relin, 2007); yet empirical support for its efficacy has been limited by tensions between its underlying tenets and the methodologies traditionally employed in quantitative research. Specifically, there has not been ample research within the field of narrative therapy regarding methods to aid in eliciting initial problem-saturated stories from children and adolescents. This present study sought to address this issue by creating a collection of children's stories to be used as a therapeutic tool for eliciting children's narrative, and by examining children and clinician's opinions regarding the use of such a tool. Within a broader context, this study has also endeavored to add to an empirical understanding of narrative therapy by employing quantitative and qualitative research methodology to explore these issues. In the course of this research, several notable themes emerged, as did potential areas for further investigation.

A Note on Data Analysis

Before beginning a discussion of these themes and potential areas for further investigation, it is worth commenting on the decision to utilize a Pearson product moment correlation in examining the relationships between Experience of therapy and Ease of task, and Time spent in therapy and Ease of task (see pp. 71-75). In the course of analyzing these relationships, the following issue emerged: would be better to conduct these analyses using the data in its original form (as a set of continuous variables), or to dichotomize the data first? The data being used in these analyses was not ideal for several reasons: it did not meet assumptions for homoscedasticity and linearity, and had an outlier. It was considered that dichotomizing this

data may have two advantages in that (1) it would take care of the outlier by grouping it into the second category, and (2) ANOVA is relatively robust to violations against its assumptions, of which this data violated several. However, the drawbacks to dichotomizing data are substantial and numerous. These drawback include loss of information about individual differences; loss of effect size and power in the case of bivariate relationships; loss of effect size and power, or spurious statistical significance and overestimation or effect size in the case of analyses with two independent variables; the potential to overlook nonlinear relationships; and loss of measurement reliability. (MacCallum, Zhang, Preacher, & Rucker, 2002). Furthermore, dichotomizing the data in this study by utilizing a median split would have meant losing 7 of the 17 data points. Simply eliminating the outlier and conducting a Pearson product moment correlation only meant losing one data point (the outlier). It was therefore decided that conducting a Pearson product moment correlation would be more appropriate than dichotomizing the data.

Support for Narrative Therapy Practices

Most discernable of these themes was the hope and excitement expressed by the children and adolescents who contributed by writing a story for this study. Although some appeared shy or hesitant at first, almost every single participant expressed joy and incredulity that their words and stories were to be included in "an actual, real book" to be read by adults, therapists, and other children like them.

Perhaps one of the elements influencing children's self-disclosure is the perceived motivation behind the one asking. Given the "official" nature of participant recruitment and lack of deception, the children in this study could be fairly assured that my motivations were consistent with what I was telling them: to help clinicians find ways to help more children. None of the participants in this study appeared to doubt these motives per se, but rather expressed

incredulity that an adult professional would think what they had to say was so important and that they might actually be able to help other children like them. Similarly, all child and adolescent participants reported feeling better or no different after writing their stories, and endorsed experiencing a much greater number of positive valence emotions than negative valence emotions after writing their stories.

These reactions provide support for the narrative practices of documenting and celebrate new knowledge and practices, and facilitating taking-it-back. In these practices, gains made in therapy are solidified through clients documenting their progress and sharing what they have learned with others. In this study, children were asked to do just that, and reacted positively. It is notable that children demonstrated this positive response regardless of how long they had been in therapy, and independent of the degree to which they reported actual change in the circumstances that brought them to therapy. Rather, it seemed to be the actual act of writing and sharing their stories that cause this degree of enthusiasm. Granted, children who were judged to be at high risk or vulnerable were not recruited for participation in this study. It is therefore possible that a different effect might be seen with children struggling with more severe issues. However, the fact remains that the children in this study at least appeared to benefit from practices similar to those of narrative therapy.

It is also interesting to note that child participants experienced some degree of difficulty finding negative aspects of their therapy experience. It is reasonable to postulate three factors that might have contributed to this reluctance: (1) these children may have experienced a natural reluctance to criticize or "betray" the therapist with whom they may feel an attachment; (2) despite reassurances of confidentiality, they may have perceived the researcher as affiliated with the agency in which they receive services, and may therefore have worries that the

researcher would "report back" to their therapist; and finally (3) it is possible that their experience in therapy really was a generally positive one.

Reasons Why it May be Challenging for Some Children to Talk about their Story

Although the fields of forensic psychology and child-centered therapy have contributed to our understanding of children's disclosure, there is little information regarding the process of eliciting the problematic narrative from children during narrative therapy. In this present study, children's responses to what made the task of writing their story easy or difficult suggests some reasons why it may be difficult for children in therapy to share their initial problem-saturated narratives.

Before beginning a discussion of these reasons however, it is important to point out several situational differences between the children in this study and the children for whom this therapeutic tool is intended. Although there was some mirroring between the processes of exploring the range of presenting problems and assisting participants in writing their stories, and the narrative practice of collecting the initial problem-saturated narrative, these two processes have notable differences. First, though each is concerned with gaining an initial understanding of the circumstances that lead the child to attend therapy, the initial problem-saturated narratives would, by necessity, have contained a great deal more details and descriptive components than those elicited in this study. Additionally, all participants in this study had been in therapy for a minimum of several months and were already accustomed to sharing their story with a therapist. Therefore the many of the difficulties associated with collecting an initial narrative were not encountered during data collection in this study. Still, the authoring task did present participants with some difficulties that might be similar to those typically encountered during elicitation of the initial problem-saturated narrative.

Some of the common reasons that children in this study gave for why the authoring task was difficult were concepts that are inherent in any task of this kind: it was difficult to remember details about events and circumstances, there was a lot of material to think about, and simply the logistics of writing a story were challenging for some children. Of more interest to this study were the reasons children gave why writing their story was difficult, which might be mediated by utilizing a therapeutic tool such as the collection of stories created here. These reasons included: it brought up painful emotions, it was difficult finding the words to express different thoughts and feelings, it was hard taking responsibility, and it was hard to risk hoping for the future. Again, these difficulties may be unavoidable in a sense, but reading other children's stories before or concurrent with writing one's own might lessen the effects of these hurdles. Children and clinicians' responses regarding why a collection of stories might be an effective therapeutic tool provided some insight into how these specific difficulties might be addressed.

Potential Benefits from this Therapeutic Tool in Eliciting the Initial Narrative

One of the major purposes of this study was to explore children and clinicians' attitudes regarding the possible utility of a collection of stories as a therapeutic tool. When asked whether they would like to read stories written by other children, all of the child participants indicated that they would, and the majority indicated that they thought reading such stories would make it easier to talk about their own stories. When asked why they thought such a tool may be effective at helping other children share their stories, some children's responses seemed to indicate ways in which this tool might address some of the reasons they themselves gave for what made their own stories difficult to write. Figure 8 below shows a list of these possible pairings.

Table 8

Possible Pairings of Child- and Clinician-Generated/Endorsed Reasons for Benefit of Reading Other Child's Story with Child-Generated Reasons why Writing Story was Difficult

Child-Generated Reasons why Writing Story was Difficult	Child-Generated Reasons for Possible Benefit to Reading other Children's Stories	Clinician-Generated/Endorsed Reasons for Possible Benefit to Reading other Children's Stories
Brought up painful emotions	Feeling like "I'm not the only one"	Remove stigma/isolation
	Help child to feel brave	
Afraid to hope for the future	Help predict the future of the problem	
Taking responsibility	Stories would illustrate that "people aren't perfect and that's ok"	Allow the child to gauge the therapist's reaction
Fear of Judgment	Stories would illustrate that "people aren't perfect and that's ok"	Help contribute to the formation of a positive, collaborative therapeutic relationship
	Wouldn't have to explain "every little detail" while worrying that "people won't understand"	Allow the child to gauge the therapist's reaction
Difficulty finding words to express different thoughts and feelings	Reading is enjoyable and something that a lot of children do	Familiarize the child with the language other children have used to describe their experiences
		Models for children talking or thinking about the problems and their own understanding of them
	Help finding the words to express thoughts and feelings	Utilizes storytelling, which is a familiar mode of communication for children

In addition to the above pairings, several of the reasons children and clinicians endorsed as to why such a tool might help them share their own stories reflected tenets behind the

Narrative practices of re-membering and incorporation, and involving outsider witnesses. In these practices, members of the child client's network who have parallel experiences to theirs are sought out, and the child draws on these members as a source of problem-solving and social support (Carr, 1998). In this study; several child participants endorsed "Comparing the similarities and differences between theirs and another child's story" and "getting advice for solving the problem" as possible reasons for the utility of a collection of stories, and one clinician endorsed "allows child to compare their experiences to those of others". All of these reasons may be viewed as attempts to incorporate unknown child authors into the child client's network, via written stories.

In response to the open-ended prompt asking clinicians to state why they would or would not be likely to use such a tool in practice, one clinician brought up a concern that is worth addressing. This clinician wrote:

> My main concern about using such stories would be that child and adolescent clients might default their own unique perspectives and experiences to conform to what the stories convey. While I think such stories may help to destigmatize/normalize some problems for some kids (depending on the problem), I think that it may create expectancy effects leading the child to use the story as the way of framing their own experience because they think that the therapist wants them to do so rather than what the child really thinks and feels.

The concern expressed by this clinician brings up the distinction between *influencing* and *confirming.* To delve into an examination of what potential sources may or may not *influence* a child's narrative would be to ignore one of the central tenets of narrative therapy: namely, that any and everything in a child's world has the potential to shape his narrative. Narratives are not a

reflection of an absolute reality, nor are they fixed representations of a child's experience. They are fluid; they are constantly changing as the child gains more experiences, and especially as he engages in social interactions involving language. What is important for a successful narrative therapy experience is not that the therapist gain access to the child's "true" narrative, but rather that she gain access to the child's *current* narrative, in order that she may determine and rework aspects that may be problematic to the child's life. On the other hand, inducing a child to feel that he must shape his narrative to fit those with which he is presented would be counter to the narrative therapy approach of valuing the primacy of the child's experience. The degree to which a child, after having read other children's stories, feels inclined to *incorporate* this story into his narrative vs. feeling pressure to *conform* his narrative to the structure of those with which he was presented may prove an important distinction. The potential risk for conforming might be mediated by presenting a variety of stories, told in a variety of ways, so as to convey the message that there are many different ways in which one might tell one's story.

Limitations of the Present Study and Suggested Topics for Future Study

This study was limited by a low response rate for the clinician survey, and the distribution of theoretical orientations reported by clinician participants was not reflective of the diversity within a national sample. A recent survey of over 2,200 North American psychotherapists reported Cognitive Behavioral Therapy as the most frequently endorsed theoretical orientation; followed by family systems, acceptance/mindfulness based, psychodynamic/analytic, and Rogerian/client-centered/Humanistic (Cook et al., 2010). In contract, the majority of clinicians who participated in this study reported practicing from a humanistic orientation. Due to the limitations of confidentiality, it is not possible to specify which responses were by division 32 (Society for Humanistic Psychology) members and which

were by participants recruited through professional contacts. However, the timeframe of participant recruitment indicates that at least 7 of the 17 respondents included in data analysis were from division 32. It is therefore unsurprising that such a high proportion of participants endorsed "humanistic" as their primary theoretical orientation. Given the small sample size, the unrepresentative homogeneity of respondents, and the number of variables being studied; the statistical power to detect associations among variables and differences between groups was very low. It is possible that these associations and differences do not, in fact, exist at all; or that they are affected by factors not measured in this study. However, a larger number of respondents with a more representative distribution of theoretical orientations may have given more evidence for either position.

Furthermore, the clinician survey was limited by the restrictions inherent in any survey; namely, that the researcher cannot ask for clarification or extrapolation. Because of this, the information gleaned from open-ended questions varied tremendously. While some clinicians gave clear, thorough, and detailed responses; others were unspecific and brief. For example, when asked why they might be likely to use a collection of stories as a therapeutic tool, responses ranged from " It would depend on the child and the circumstances of the child." from one clinician, and the following response from another clinician:

> I think it would be very powerful for children to read in another child's own words about going through a difficult time. It normalizes the struggles children face, allows them to feel they are not alone, models how to talk about it and provides hope for getting through it.

Conducting a series of semistructured interviews examining the same concepts included in the clinician survey of this study would offer most opportunity for expansion and clarification of clinicians' perspectives regarding the use of this tool.

The child-participants portion of this study was also limited by two factors: the methodology discrepancy between eliciting negative vs. positive experiences of therapy and the lack of a control group in examining children's attitudes towards reading other children's stories. First; although it was possible to elicit both negative and positive examples from child participants' experiences of therapy, children experienced notably more difficulty in providing negative aspects of their therapy experiences. It is possible that this reluctance is evidence that these experiences were less salient than were children's positive experiences. In analyzing these responses, it was not feasible to weight these responses according to their importance or impact, as information to this effect had not been gathered during the interview process. However, a follow-up study would benefit from an analysis of this data. Second, although the child participants in this study expressed a uniformly positive reaction to reading stories written by other children, it is possible that their reactions were biased by the fact that they had just written a story themselves, and had therefore invested time and energy into this project. To account for this potential bias, it would be necessary to utilize a control group of children who did not write a story themselves before answering questions regarding their interest in reading stories written by other children.

Seemingly the most logical next step in the line of research initiated by this study would be to expose other children to the collection of stories created in this study, and to examine their subsequent responses. Pertinent research questions might include: "what are children's emotional response to reading other children's stories?", "do children generally feel better or worse after

reading other children's stories?", "are there statistically significant differences in regards to ease of authoring between children who first read other children's stories, and children who do not?", and "do children who read other children's stories endorse the same reasons for why this might make it easier to talk about their own stories as did the children in this present study?", etc. This final potential research question might lend itself to a factor analysis using the response categories for why a collection of stories may be an effective therapeutic tool, as generated by this study. A follow-up study of this kind would also likely benefit from a combination of qualitative and quantitative research methodology, such as has been employed in the present study. Further studies might focus on collecting a wider range of stories and examining whether matching the problem topic of a story (e.g. coping with divorce) to the target child's presenting problem has any bearing on the efficacy of a collection of stories as a therapeutic tool. It seems possible that the more closely the target child could identify with the character in a story, the more effective this story would be. However, it also seems possible that children would identify with less tangible aspects of children's stories; such as feeling different from one's peers, having to make sacrifices, dealing with painful emotions, etc.

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APPENDIX A

Screening Criteria Form for Therapists

Please wait until it is determined that all of the criteria listed below are met before you speak with the child and ask if he or she is willing to participate in this research project.

Age:_____(Must be within 10-18 years)

Is the child currently in therapy? ☐ YES

Current GAF:_____(Child) *(Minimum 51 or above, which are moderate symptoms in academic, occupational, or social functioning)*

Does the child have mental retardation or is he/she considered borderline intellectual functioning? ☐ NO

Does the child have a physical impairment or illness that would prevent him/her from writing a short story? NO ☐

Does the child currently engage in self injurious behavior or is actively suicidal? ☐ NO

Do you judge this child as able to tolerate discussion of his/her reasons for treatment? ☐ YES

If the above criteria are met please use the following script to discuss this research project with the client and his/her parent(s) or legal guardian(s).

"There is a therapist in this agency who is interested in making a book of stories written by children and teenagers who are working in therapy to overcome a variety of difficulties. She won't include the names of anyone who participates in this project, so that she can protect their privacy. I thought that you would be a good person for her to talk to. How would you feel about talking to her?

If the child and parent(s)/legal guardian(s) agree to speak with the researcher, please say the following:

"This is what will happen. First, I will give the researcher your and your parents' (or legal guardians') name and phone number. She will talk to your parents/guardians about the research and if they agree that it would be okay for you to talk to her, she will then set up a time to meet with you to talk about your experiences. How do you feel about that?"

If the child and parent(s)/legal guardian(s) agree, please return this form to the researcher along with the following:

Child's Name:_____

Parent(s)/Guardian(s):_____

Phone Number: _____

Any special concerns the researcher should be aware of:_____

_____

_____

APPENDIX B
Children's Stories: A Narrative Resource
Parent/Guardian Informed Consent Form

Your child_____, has been invited to participate in a research project. This project will create a tool to use in therapy with children and teenagers and will look at what factors may help children to speak openly during therapy. This research is being conducted by Hart K. MacCardell of Indiana University of Pennsylvania (IUP), as part of her work towards a Doctoral Degree.

If you agree that your child may help with this project, you will be asked to talk a little about why you decided to enroll your child in therapy. Your child will then be asked to write an autobiographical story about the events leading up to his/her enrollment in therapy, his/her current experience of the problem, and his/her thoughts about the future. The book made up of these stories may greatly help other children who are in therapy for similar difficulties. It might help your child to talk about his/her experiences, and to know that (s)he is helping other children in similar situations. After creating this story, your child will be asked to answer some questions about what (s)he thinks about this project. All of this will take about 90 minutes.

I will be sound-recording what we say during our meeting so that I can remember exactly what you and your child says. To protect your and your child's privacy, I will change your name, your child's name, the names of anyone your child talks about, and the names of places your child mentions when I write about this project. I won't talk to your therapist about what you or your child says during this project, but **you** are welcome to talk to him/her about it if you would like. I will write about this project in my doctoral dissertation and possibly in a book or journal article in the future.

After I've finished with this project, all papers with your child's name on them will be destroyed, as will the sound-recordings. The written copies of what we say in our meeting will be kept in my locked home files for three years after I finish this project. The signed forms will be kept in a separate sealed envelope. There will be no way for anyone to know that your child was a part of in this project or what (s)he said.

Your privacy is very important. However, if your child reveals in the interview that (s)he is being hurt or abused or that (s)he is planning to hurt his/her self or someone else, I will have to tell someone in order to protect your child. If that happens and I am worried that your child is in danger, I will talk to you (the parent/guardian) before breaking your privacy.

Because this is a project about emotional and behavioral difficulties, it is possible that your child may experience some negative memories and/or feelings of upset about events in their past. Should you or your child become upset; you should talk to your therapist.

Your child doesn't have to be a part of this project. Your child will not have to answer any questions (s)he does not want to. Your child can stop at any time (s)he wants, without any consequences. (S)he just has to say that (s)he wants to stop the interview, and the interview will stop right away. You and your child are welcome to ask questions at any point.

Each child who finishes this study will be entered in a raffle to win one of two $25 Target gift card as a thank you for helping.

If you or your child has any questions, you may contact the principle researcher, Hart MacCardell, MA or the faculty supervisor, John A. Mills, Ph.D., ABPP. If your child or you want to know what we find out from this project, you may contact the researcher to get a summary of the findings after the research is completed. The responsible institution for this research is Indiana University of Pennsylvania. Contact information is provided below:

Researcher:

Hart K. MacCardell, M.A.
Doctoral Candidate
Department of Psychology
Indiana University of Pennsylvania
1020 Oakland Avenue
Indiana PA 15705
214.915.4766
H.K.Maccardell-Fossel@iup.edu

Faculty Supervisor:

John A. Mills, Ph.D., ABPP
Professor/Psychologist
Department of Psychology
Department of Psychology
Uhler Hall, Room 104, 1020 Oakland Avenue
Indiana PA 15705
724.357.4520
jamills@iup.edu

By signing this form I am showing that I have read and understand the information on this form, including the possible risks and benefits to participation, and I give consent for my child to volunteer to participate in this study. I understand that my child's participation in this study, or my decision for my child not to participate, will not in any way change any therapy services I am currently receiving. I understand that what my child says will be kept completely private and that (s)he can stop participating at any time. I have been given an unsigned copy of this Informed Consent Form to keep.

_____
Parent/Guardian Name (please print)

_____ _____
Signature Date

I certify that I have explained to the above individual the nature and purpose, the potential benefits, and possible risks associated with participating in this research study, have answered any questions that have been raised, and have witnessed the above signature.

_____ _____

Researcher Date

This project has been approved by the Indiana University of Pennsylvania Institutional Review Board for the Protection of Human Subjects (Phone: 724-357-7730).

APPENDIX C
Children's Stories: A Narrative Resource
Child/Teen Informed Consent Form

My name is Hart MacCardell. I am a therapist at Salesmanship Club Youth and Family Centers, and I am going to school to become a psychologist. As part of my work for school I need to complete a research project. I would like you to help me with my research project. I am going to tell you about my project so that you can decide if you want to help me. It is OK for you or your parent(s)/guardian(s) to ask me questions while I'm explaining my project to you.

My project is to create a book of stories written by children and teenagers who are struggling to defeat different problems. These stories will be read by other kids dealing with similar problems to help them feel less alone and make it easier for them to talk about these problems. Your therapist at Salesmanship Club Youth and Family Centers, with the permission of your parents, gave me your name because (s)he thought you would be a good person to talk to about this. If you agree to help with this project I will ask you to talk and write about what your life was like before you started therapy, what's it's like now, and what you think it may be like in the future.

You don't have to answer any questions you don't want to and you can stop at any time.

Helping with this project, or not, will not affect your therapy. I won't talk to your therapist about what you say during this project, but **you** are welcome to talk to him/her about it if you would like.

I will sound-record your answers to make sure I get them right. To protect your privacy, I will change your name, the names of anyone else you talk about, and the names of places you talk about when I write about this project. You and I will decide together on a name I can use for you when I write about this project.

After the project is finished, all the papers with your name on them will be destroyed. The sound recordings will also be destroyed. I will keep all signed Informed Consent Forms and all other materials in a locked file in my office. The results of this study will be written in a doctoral dissertation, and possibly in a book or journal article. You will be entered in a drawing for one of two $25 Target gift cards as a "thank you" for participating in this project.

Being in this project may make you feel good that you can help adults and therapists do their job better and help other kids and teens who struggle with the same problems as you. It may also make you feel good to talk about your experiences. If talking about or writing your story makes you feel bad, you can tell me, your parent(s)/guardian(s), or your therapist so that you can get help from them.

If you have any questions you can contact me, Hart MacCardell, or you can ask your parent(s)/guardian(s) to contact me. If you want to know what this project found out, you can ask me to tell you about it after it is finished. Here's how you can reach me:

Hart K. MacCardell, MA
Indiana University of Pennsylvania
Psychology Department
Oakland Ave.
Indiana, PA 15705
Phone: (214) 915-4766

If you would like to help me with my project, please write your name below to show that you agree with this sentence:

I have had a chance to ask questions, and I agree to be a part of this project.

_____
Participant Name (please print)

_____ _____
Signature Date

I certify that I have explained to the above individual the nature and purpose, the potential benefits, and possible risks associated with participating in this research study, have answered any questions that have been raised, and have witnessed the above signature.

_____ _____
Researcher Date

The supervisor of this project can be contacted for any further questions:
Dr. John Mills, Psychology Department, Oakland Ave., Indiana, PA 15705
Phone: (724)357-4520

This project has been approved by the Indiana University of Pennsylvania Institutional Review Board for the Protection of Human Subjects (Phone: 724-357-7730).

APPENDIX D

Children's Stories: A Narrative Resource

Child/Teen Demographic Questionnaire

1. What are you really good at? What do you do for fun?

2. Who is in your family? Who do you live with?

3. What was going on in your life before you started therapy? Who was involved? When was it happening?

4. Who decided it was time to start therapy? How did they know it was time?

5. How long have you and/or your family been coming to therapy? How many weeks/months/etc.?

6. What have you liked about therapy, what's been helpful?

7. What has been less helpful? What have you not liked as much?

8. What have you and/or your family learned from therapy?

9. How have things changed since you started therapy? What has stayed the same?

10. What do you think will be going on in your life in one month? In one year? In the future?

APPENDIX E

Children's Stories: A Narrative Resource

Story-Attitudes Questionnaire: Child Version

1. How difficulty was it to write your story? It was…

1	2	4	5
Very hard	A little hard	A little easy	Very easy

2. What made it that way? What was easy or hard about it?

3. How did it feel to write your story? Circle as many as you felt:

Hopeful	Sad	Frustrated	Relieved	Sympathy
Embarrassed	Important	Timid	Anxious	Inspired
Confident	Brave	Content	Special	Excited
Nervous	Not Interested	Satisfied	Mad	Comforted
Scared	Worried	Uncomfortable	Courageous	Helpless
Depressed	Powerless	Ashamed	Confused	Understood
Excited	Shy	Optimistic	Afraid	Happy
Annoyed	Encouraged	Angry	Proud	Bored

4. How do you feel after writing your story?

1	2	3	4	5
I feel **a lot** worse.	I feel a little worse.	I don't feel any different.	I feel a little better.	I feel **a lot** better.

5. Would you like to read stories written by other kids like you?

1	2	4	5
No, not at all!	No, not really.	Yes, I'd like to.	Yes, I'd love to!

6. Do you think reading stories written by other kids would make it easier to talk about your own story?

1	2	4	5
No, much harder!	No, a little harder.	Yes, a little easier.	Yes, much easier!

7. Why or why not?

APPENDIX F

Collected Stories

Story #1 "Annabella"

My dad left us and did not tell us about his girlfriend. My mom and dad been fighting and screaming at each other.

I hurt myself. I had lots of things going on in my head. I been saying words I'm not supposed to be saying. One day I sent my dad a text message that said lots of mean words about his girlfriend and bad feelings and things I'm not supposed to be saying.

Now when I think about it I feel bad at first and then OK, because I feel ok when I'm at my dad's house and telling people what happened and what we did.

I think in the future it will be good because I feel OK and no more fighting, hurting my self or saying bad/mean words.

Story #2 "Shishi"

I felt sad and was crying. Before that my dad and my mom were not getting along and I was sad. Since we got our dog I was excited she's been helping me since I been looking at her face and she reminds me of when I had happy times with my mom and my dad and then whenever I cry, she cries and she jumps on me and cuddles with me. I haven't seen my brother, Rocky cry since my dad has been away but then I been telling him "it's ok to cry Rocky" and my other brother, Bill is like "how about me? I'm crying too" and then like "you too Bill you just let all the tears out, all the bad stuff out" and that's it. Me and my brothers and my sister have been getting along well. My sister and me hadn't been getting along. We'd been fighting, hitting each other, and hurting each other. Since my dad left, my sister and I have been thinking that "should

we be bad, or should we be good?" and then we said "we should be good so mommy can't be all stressed out". Me, Rocky, and Bill had been throwing toys at each other, hitting each other, and doing bad stuff. Then I thought about it, "should I be nice to my brothers or not nice to my brothers?" So I said "nice to my brothers" because, as Gaby said, so we won't get our mom stressed out.

When the problem first started it was at night at school time. I woke up because I had to go use the restroom. And then I heard my mom and dad saying, "What are you doing? Why are you doing this? Why are you calling this lady?" And then I went close to the door, and my brothers were little and were still there, just looking. Then my mom, she came out the door and I just backed away and I pretended I just barely woke up. I said "Mom, what's wrong?" and then she just pushed me and then I was crying. I woke up my sister and my sister said "Leave me alone I'm trying to sleep" and then I fell asleep in my room. And then in the morning my mom said, "what did you hear?" and I told her "I heard you and dad saying 'What are you doing? Why are you calling this woman?'" And my mom said, "Oh, I'm sorry you heard that". And then at night, it was dark and still gonna be schoolday. And then I told my mom that I couldn't go to sleep while my dad was still at work, and then my mom she's like "Why?" and I said "Cause I heard the fight" and then she's like "ok tell me what happened and tell me what's wrong" and I told her that I'm scared that it was my fault that I made them fight. And then my mom called my dad and she said "Hurry up and come at the house so you can comfort your daughter" and then my dad said "I'm already here". And then he went upstairs. He told me "Why are you crying?" and I said "because I heard you and mommy fighting" and then he said "Oh, it's ok I know how you feel" and then I went to bed and then I think I slept with my mom and dad. I forgot. And that's it.

The first thing I felt about is that my mom and my dad might divorce, and that did happen. And the other thing that I thought is that it was all my fault and that I should be the one who should be sorry. But my dad told me it wasn't my fault, it was just their fault because they'd been screaming and he said that he doesn't want to be hitting my mom cause he'll be going to jail. When my dad left I felt that I was gonna die because my dad was not in my life anymore. I told Gaby that I was scared and she said "you could sleep with me" and I'm like "ok". I asked my grandma,"do you think they will get back together?" and my grandma said "maybe". I told my cousin , Erin, all about my life and what happened and she's like, "it's ok, I'm right here. Don't worry, I won't be gone" and then I was crying because I'm glad that my cousin said that.

In my family I feel like I'm left out because since it started nobody has been talking. I'm like, "Oh is it my fault because I told mom and dad this and that?" and they haven't been talking because they're sad. And then my brothers, they're just playing and I been saying "hi what's wrong" and they just run away. My sister, she has been teasing me. And she been saying "haha no one wants to talk to you because it's all your fault". And then I was crying and then whenever my sister got over it, she's like "I'm sorry whenever I said that. " And she has been nice.

In the future I think I'll be a great mother and I'll take care of my kids and do anything for my husband so he won't be gone and look at another woman like my dad did. I would have a great life just like my mom did with us and with our dad. And I might, in the future, I might be an artist and I might teach my kids how to draw so they might be artists. I might have a wonderful husband and wonderful kids that love each other and that always love each other. I would see my mom someday with my kids and see my dad someday with my kids, and I could

just leave them with my mom or my dad so they could have time with grandma and grandpa. I could see how they feel. If they don't feel comfortable with my mom or my dad I'll ask them "Are you comfortable with my mom and dad?" If they say "no" then I will say "Why?" And if they say "Because I'm scared", then I will say "well ok if you don't want to go to my mom's or my dad's you don't need to go. You just have to tell me." And the other thing that I could see my dog.

Story #3 "Mihielle"

Before I thought my life was perfect. I had everything I wanted. I had the greatest relationship with my papi, but not so much with my mum. Things were great, and everything seemed too incredible.

My papi has always been sick, and I knew very well that his time wasn't going to be long before he would have to leave me. Strangely enough, I was correct. My papi went into a coma for eight months then died on August 6th. Everyone was devastated, everyone but me. I was sad but happy at the most. No one saw his death like I did. I saw no more suffering, for there was nothing left to see in a closed casket. I never got why people wanted him to be alive; he suffered so much with heart problems and surgeries, I guess he was so overwhelmed with pain that he just gave up. My mum stayed home alone and cried for hours every night, she was too emotional. People wondered why I didn't cry, but I clearly always stated my reasons. We went to therapy for almost two years to get where we are now.

Now that I've been coming to therapy, things are much better. I get why people were depressed about his death. I feel as if this problem actually opened my eyes to see what life is truly about.

Story #4 "Jessica"

My life was good before the problems started. After my 3rd birthday my mom and I would go to the mall and play at home and the park a lot. We would also visit her friends a lot. I loved visiting her friend Jenny because I got to see Charlie (her dog). Charlie was a good dog. Whenever she heard my name, even if Jenny was talking on the phone about me, Charlie would get so excited that she would start barking and looking out the window for me. I always had fun.

When I was about 3 or 4 my mom started having issues. She was diagnosed as being bipolar. She always denied it but she doesn't believe it when someone tells her that she is. She has always been mean, had mood swings, and even lays guilt trips on me and my brother for things in the past. She is always telling me and my brother to forget about the past but she can't do it herself. Even though it is hard to get over losing someone, she still can't get over her dad dying about 30 years ago. All we ever hear about him is, "my dad died when I was 12". My grandma died a year ago and even though I still think about her a lot, I have been able to let go and accept it. Me and my brother were very close to her.

I feel that the problem has started to get better but is still hard to face. My mom has stopped slapping me in the face, I don't have any more fingerprint bruises, and she is not cussing as much but it is still bad. She still lays guilt trips on us a lot though.

I think that one day I will have a masters or a Dr. degree in veterinarian work. I think about what it would be like and I see myself as a foster parent to baby animals, maybe volunteering at the zoo and animal shelters too. I see myself still close to friends, we'll still hang out a lot and do some of the same work and will relate to each other very well.

Story #5 "Kate Rose"

Before the problem started…

I was at home. I had no worries. I was carefree. I had been noticing my gramma had been getting stricter. I still loved the country music my grampa had introduced me to. My brother was still the annoying 9-year-old brother he wanted to be.

When the problem first started…

My gramma got more stricter. Me and my brother ran away from home. We came home to spankings. My grampa said that CPS (Child Protective Services) said that my gramparents are NOT allowed to spank us. One Christmas we took ornaments off of the tree. After that we got caught stealing money.

Now when I think/feel about the problem…

I FEEL guilty.

In the future I think…

I WILL change. I want to be the BIGGEST COUNTRY STAR of all time. I love singing. I sing all the time.

Story #6 "JROD"

Before any of my Problems started my uncle was still alive. He was with me a lot. My mom was at work and my dad would be inside watching over my sisters. My mom was never really home, she would come and leave to go back to school. So in the long run my uncle was more than just an uncle, he was a brother and father-like figure to me. Then he died.

When the problem first started…

I was too young for my parents to say anything to me, but I remember going and being at my Uncle's funeral. I didn't want to believe he was gone, he said he would never leave my side. Then I questioned God about why he took him from me. I gave up believing in God and the kid who I once was had died and a new me began to form. Conflict began to grow and grow, fight after fight, day after day. I lost control of my self. I was alone and being alone made me think (my uncle was alone when he died) so if I die Ill do it avenging his death and if I die Ill bring everyone with me.

Sometimes I'll think about it but I accepted the fact the he's gone and dead and he's never coming back. It broke my entire world and shattered me to pieces but its time to grow up to be someone my uncle will be proud of; show him that no matter how hard my dreams are I will succeed because I am his nephew and I've grown and got so far I will not give up. I will make him proud.

QUOTE: "Those who look back on the past, and Those Who look on The present, are guaranteed to never see the future": -JFK-

I don't think. I know in the future I will be Somebody. My dream is to become part of Young Money. I have the skills and techniques needed to RAP but I don't have the resources. In the future I want to be a rapper.

Story #7 "Selena"

Before any problems for the family started, we were actually a pretty happy family. No one was fighting or yelling or anything. But of course we were only kids at the time and I guess our parents didn't want to expose us to anything that could change us. Also that could change them or our family as a whole. So it was pretty much just all good.

When things started happening, it was the day my dad and my mom started fighting. I remember the first time they ever fought was after my uncle died and as time went on a change started to happen. I could see it. I remember my dad had left for a whole week because my mom's drinking was going too far because she depressed or whatever was wrong. When the problems started getting worse was when we moved out of the suburbs and moved to close to the city. I don't really remember the reasons they fought, but I do remember much of what happened. I remember one night my mom had went to a beer store and she lied to my dad, saying she was doing the laundry. Well he found out and he went outside and found her with her beer or something like that, then he threw his cane at my mom but only to knock the beer out of her hand and it ended up hitting her wrist and it ended up being a fist fight. That was the second time he left. Another time a fight happened was when we moved a block away from the house we just moved into my mom got super drunk one night with our neighbors, and she took me the neighbor and two of her kids to the store, and she was really drunk and was smoking a cigar in the car and we were so close to getting in a accident but I yelled and my mom woke up from whatever she was under. I remember going home that night and telling my dad and that's when we moved a block. Then he decided to move to another state and send for me, my sis, and mom later. That's when my dad made a big mistake and things got real bad.

I look back everything that happened and I wish it never happened for me being 9-10 yrs old and the only one almost always around when they fought because my sis or bro were at a friends house and I felt had to stay because my dad is handicapped and I already saw what my mom was capable of doing. Me being the age I was feeling I had a huge responsibility to watch my parents. I am so ashamed and disappointed in them for putting our family in danger and exposing us as kids to so much. I feel that everything that happened then made us who we are now and even thought it wasn't necessary to me I think in god's eyes it was.

Now I feel that in the future we will learn to let the past go, be a stronger family and go on to the life we had before anything went on, but also I hope to see our family strong and proud to be a family together and for no one to see us fight because I have 3 friends who've seen our family go down in flames. And I want to be able to have friends come over without seeing so much drama with our family because they have their own problems with their families. I want to share with all my friends how our family became a family again and whatever there families are going through I hope that our family sets a good example for them and they learn from that.

Story #8 "Tragedy"

Before the problem started I was a happy young girl so carefree and so playful (but I've always been very quiet). I lived a happy life with my 2 best friends always by my side, my parents were great and so happy too. And I was just so happy with my sister, always such a girl. But then my dad decided to leave with my brother and I didn't know what to feel. I really didn't know what was going on so I was just all "whatever". But what I didn't know was that my mom was cheating on my dad. Even if he was gone, they still weren't divorced yet or anything. But poor little clueless me knew nothing of the meaning of cheating. So I just went with the flow. We

were living in the city at the time. So when my dad moved to another state we went to live with my Grandpa. My mom was still seeing that man but for me I was too young to even realize the wrong she was doing. My grandpa smokes a lot so I guess it triggered my mom or something because she started smoking and drinking. And whenever my dad called she would make sure we didn't tell him. 4 months later we come to live with my dad as a family again. My dad didn't know my mom cheated on him until my mom left for a couple of days. My sister being older than me told my dad about what she saw happening. They were about to divorce but I suppose they love each other so much that they didn't. So we lived happy for a while living together but I believe my brother caused whatever fight we had.

I met a girl, hearing she wanted to fight me, but it turns out it was a lie and we became the best of friends. My dad got me interested in the Lord when I saw him going to church and working with youth. I moved again 2 years ago and that is when I found myself changing my style and things like that. I finished the 5th and 6th grade in elementary school. I don't remember why I did it but I first started to cut myself in the 5th grade so I was labeled the Emo girl. I got my first detention in 6th grade and I cried so hard. (Now came summer) I met these 2 boys . I knew who they were cause one of my friends liked the one guy. When I met those two I hated them, I thought they were complete jerks. But then 7th grade came and I found myself to start liking the other boy. I knew it was wrong of me to like the kid given the fact that he liked my sister, three of my friends, and then me. I suppose he was really confused or something. But I didn't care, I really liked him so I decided to date him. We've been going out for 5 months now and I wondered why he even likes me so I asked and he said I was just like him: bubbly, goofy, and into the same stuff.

So during these 5 months I've noticed a difference in everyone around me. My parents fight but not as much as they used to, but I don't think it'll ever change. My sister and brother are all grown up in my eyes and I don't know, they seem stranger, like everyone does to me. There's also been a change in me I've noticed, and I feel like no one understands me. I don't even know who I am. And I'm still trying to figure that out. But I think my real problem has nothing to do with my family, it's just me in particular. It's an unexplainable thing to me because I feel like when I try to explain it I can't seem to find the right words.

Story #9 "Casey"

Before all the problems of fighting and anger started in my family, we were all very close to each other. We didn't fight as much as we do now, and we all got along.
The fighting wasn't controllable. We didn't really notice it so we let it continue for many years. But now when I look back, I wish we had stopped the fighting before it got any worse. But problems need to be solved before they get out of hand and you should be able to try and fix what's going on before you can't at all. You should take it from me, my family isn't as close as we should be and I regret it. If I could I would want to always try and fix family problems

When I talk about my problems, or even think about them, it really hurts me inside. I feel like a horrible person for letting the problems continue. Letting other people know what your thinking really helps. Some things you can and can't fix. But it's still worth a shot. I never wanted to try. I thought I would get over everything to where my family and I never can talk about old things because it is painful remembering the things we did then. So you should always put your problems first! Your family loves you like crazy! Don't ruin it over one silly fight.

In the future I think children will be different. Now all you hear about is kids doing/buying drugs. Hopefully talking to somebody you trust can help. No, not everything will be solved but some can. So instead of giving up on someone or even yourself, take action and fix those problems. If you really try you will change everyone's perspectives. Children in the future aren't anywhere near to what we are now. That's at least what I think. For example my friend is in the 7th grade. He is very much into drugs. But I finally talked him into telling someone. And you would be amazed by what he has turned out to be the last few months. Even the most messed up child can be fixed with a little love. For me, speaking to people has made my life A LOT easier! Trust me you should act NOW and fix everything instead of messing up your life and even your families!

Story #10 "Cristian"

I was able to control myself. I remember taking therapy when I was in first grade. I was even able to behave pretty well. But then something big happened at my school. I found myself in the principal's office. I knew I was in big trouble. Then after that I think my mind went blank and I continued to misbehave.

I got in trouble a lot and I went to an alternative school. After that I don't think I quite learned my lesson, I made through the whole third grade but in the fourth grade I went back to the alternative school but it was a different one. Well after that I finally learned my lesson. I started the first three months with only getting into trouble six times. I even got a ticket. And that's how my problem started.

I feel that I have changed my behavior over time and I'm proud of it! And now when I remember about the alternative schools I went to I think I never want to go to an ugly place like

that. Now school is never tedious and when I think deeply about the problem I just balk where I am and think about how my behavior has improved. I feel proud I was able to change my nasty ways. I'm really happy!

In the future I think I will be able to achieve the goals I want to achieve now. Which are finishing my studies and being able to go to college and become a professional soccer player. And I will have a good and healthy life.

Story #11 "Jose"

It was my first year of middle school and I'd made friends from other schools, forgetting my old friends forever. Chrissy, Noal, Ellie, Jenny, and Keith were my new friends now. Jokes became fights not long after we met up again in my second middle school year. Our friendship was like a windy day and out of nowhere a blizzard starts.

"Hey Jose!" I hear Chrissy call for me. "Ye...Umf!" I respond when I get hit in the face with mashed potato. "What in the..." I start. "It's just a joke no need to worry about it. Okay?" says Chrissy. "Um...yeah sure." I say and out of the corner of my eyes I see my old friends. Linda, Marie, Esmina, Jolina, Aaron, and Hilly. "Would Linda do this to me?" I ask myself. But there is no time to answer as I am hit with beans in my face. I laugh but my left hand grabs a grape and throws it like a bullet. "Ow!" Chrissy says. "What the heck is wrong with you!" yells Noal. "Haven't you ever heard of not hitting girls!" says Keith. "It was just a joke!" I say. "Shut up!" yells Ellie. "Don't talk to me" says Jenny. "I won't need to" I think to myself, "not anymore."

Now I sit with my true friends. Our group is the best! We don't care what other people think we do our own thing! People come up to us and say "A jock, a nerd, a emo, a hyper active,

a band addict, a drawing freak, and that idiot sitting together?" "Yup." says Linda and we go back to what we're doing like we're the rebels of the school. No one tells us what to do, We go against things we think are wrong. And protect each other like a family. Every once in a while I get stuck in the lunch line with my fake friends. And when we get our lunch I take off to a different direction. "Jose" I hear Chrissy call. She can talk to the back of my head all she wants but she can't stop me from hanging out with real friends. Just like in elementary school.

In the future I think it'll be easier to make better friends and figure out what type of person everyone is.

Story #12 "Jasmine"

Once upon a time there was 4 girls left alone at a house. There was a grandmother and a dad who said we have to take care of these four girls by ourselves. There was a girl who was named Asia who was 9 months old, a girl named Jasmine who was 2 years old, a girl named Arielle who was 3 years old, a girl named Tayla who was 4. When the grandmother saw the 4 children she screamed “Noooooooo!” Because she didn’t want to take care of any more children.

When the children were growing up they decided to start getting messy. And the grandmother said “If you keep getting messy I will put you out of the house!” When we got a whipping we had to clean and Nana found out that she can take us to the therapist!!! Once Nana took us to the therapist she met Miss Emily and Miss Emily talked to us and then Nana, and when we left Miss Emily said she will see us every Saturday.

Story #13 "Keri"

Before the problem started…

The family was very happy when we lived with our cousins, aunt, nana, papa, and dad.

When the problem first started…

When we separated with our cousins, papa and aunt. All of a sudden we cried every time when they left from our house to spend a night. Nana would always scream when we cried.

Now when I think/feel about the problem…

I felt more upset because she screamed at us when we cried.

In the future I think…

The whole family will live in one big house. Get along with each other until we die.

Story #14 "Milan"

I was attending P. Academy and I had all good grades & just a few problems. Then I went on to J.H. Preparatory, and I started getting worse, because I felt I didn't fit in. Then I went to another school where it was good my first and second years. Then problems in family and school occurred.

People started picking on me at school and I didn't like it. So I started being disrespectful to my teachers & somewhat my mom. I was being put in school suspension at least once a week. It was hard for me.

I feel that I have progressively gotten better. I think I have delt with my problems in a more efficient way by making my own good choices.

In the future I think I would progress faster and learn how to deal with things thrown at me in a more calm manner. In the future I would be a much more well-behaved person.

Story #15 "Rachel"

One night before we went to bed me and my brother started fighting. It was when we were cleaning our house and me and my sister were cleaning the restrooms and my brother was vacuuming and my mom was sweeping and mopping. And so I went to the bathroom that my sister was in to get something. But then my brother was doing something. And I had told him, “Excuse me” and when he did not move I told him again.

So I told my mom and she said that I did not give him enough time to move. And she talked to me and my brother. Then she told my brother to go to bed and then she told me that me and her have to talk. And she asked me what should we do in order for me to stop being mean to my brother. And she said “Should we get help or what should we do?” And I told her that we should get help. And that’s when we started coming to therapy.

Sometimes when my brother and I got into a fight I would think that my mom would get mad at me. So then I told my mom and she explained to me how come she would always get mad at me. And she told me that I would always start it. And I understood where she was coming from.

In the future I think that the relationship with my brother will be better than it was before I started therapy. And if one day my brother needs help then I will help him. And I will thank him for being nice to me and helping me with my homework.

Story #16 "Felicity"

Once upon a time there was a family of 3: a mom and 2 sisters. They were having issues in the family. The sisters were always arguing: Felicity always had trouble getting her homework done and did not have the best grades. Anna was ok with homework, getting it done, and ok in

school. There was a lot of arguing in the house and fussing mostly about homework with Felicity and mom, and then there were sibling arguments with Felicity and Anna. And so the mom decided to go to therapy so they could fix this issue. And so they got Miss Red as a therapist. At first Felicity and Anna were not very attentive listening with Miss Red. They were always goofing around and playing around. But then, once Anna stopped going to see Miss Red, it was only mom and Felicity. Felicity started to feel upset because mom was always talking about what *she* can fix, instead of what *the family* can fix. And Felicity did not like that because she felt she was being attacked. She just wanted to see what the family could do instead of what she could because when there's a problem with the family, everyone has to try to fix the problem instead of 1 hero. And so Miss Red decided to give Felicity and mom separate times, and when they would take turns, Felicity was very happy she got quality time to talk about what she was feeling with Miss Red because did not feel comfortable talking when mom was there. And then they started sometimes talking together and Felicity explained to her mom about what she was feeling about her always talking about Felicity and Felicity couldn't defend herself. Then the mom started listening to Felicity and they compromised and decided it wasn't all about Felicity. They just started communicating more and the therapy talking was less about Felicity and more about the family, what can the family do instead of what Felicity can do. And Felicity was very very happy that they started doing that. And then they all started working as a family. The End.

Story #17 "Ivey"

Hi, my name is Ivey. I wanted to show you ways you can turn your life around instead of closing up your feelings. So I've decided to let you see the way I did mine and maybe you can figure it out with your counselor and family.

Before I started counseling me and my family was a hot mess. Me and my older brother were always fighting. We had no ways to forgive each other because we couldn't handle how terrible our relationship was. We started growing apart and hating each other. Our mother was becoming so sad that we couldn't even love each other. And my family members were passing away and we were so sad and we were having all this different grief and feelings and we weren't sharing our emotions with each other. So finally we decided to go to counseling.

That was going to take a while to figure out the right counseling place.

It started when me and my brother were getting jealous of who got to spend more time with our mom 'cause our parents were divorced. So we started saying hurtful things about each other, like when my brother would be playing around I wouldn't enjoy the way he was playing because he would resort to violence. Then we would start moving apart like the waves of the ocean. Besides that big problem my grandpa wasn't exactly showing how hurt he was and how much he needed to see a doctor. Later on that lead him to a death of stomach cancer. A few months later my uncle's dog that lived with my grandparents that was attached to my uncle and my grandpa also passed away a few months later due to cancer. Basically, you could say that a lot of my family members were passing away. Our family cat died because my other uncle's American Bulldog, Brodi, killed her when he was just playing because he never knew how to act around cats. We didn't exactly know our cat Scarlett was back there because my mom was focusing on getting the dog away from our bunnies because bunnies can die of stress and they

were getting really stressed out and scared. And my mom got scratched trying to pry the dog off our cat because he had his claws sunk in our cat's chest and she was clawing my mom trying to get away from him. And my mom took her to the vet but it was too late. We buried Scarlett in our backyard but I still didn't ever get over her death. Because a few days later I found myself sobbing in a car. It's a lot to handle for just a 9 year-old girl.

Once I even saw a dead bird hanging from a string because of its wing was caught on a string and it couldn't escape. Animals like this die for no good reason. For example, this year on the fourth of July my dog Murray at my dad's house got out through the gate because someone left it open. Then she got hit by a car and died. But of course I didn't know about all this because the next morning my dad called my brother and said, "Murray's died in a terrible accident and everyone's really sad, your stepmom and step-sister are crying". But what he thought dad said was, "Your step-mother's died in a terrible accident." So my brother told my mom and she talked to my dad and he said, "No, Murray died and got hit by a car." So my brother was about to tell me because I was asleep. My mom said "No she'd be mad about you waking her up". She said, "I'll tell her." Then a few weeks passed by and I still hadn't known yet. Until we went to counseling and our counselor asked "Is there anything new?" And I said "no" and my brother said "yeah our dog, Murray, got hit by a car" and he was smiling and I was like, "you're joking" but my mom said otherwise and the room got quiet. I broke down in tears because she was a fun-loving dog and didn't deserve to die.

Nowadays when my family members pass away, I think, "well Ivey, just remember this when people pass away. There's always a good that's going to happen next. Even though how sad it might be, just remember they're in peace and that's all that matters." Well I've done a lot of writing on people who passed away and I've completely forgot about my brother. Anyway,

me and my brother are still having some issues from today but we have definitely worked things out. There's things that have changed and things that have stayed the same but the counseling has made a difference in our life. Our bond has become greater and we no longer have been departing like the waves of the ocean. We stick together like glue but still we're like fire and water. But love is stronger than all those tings.

In the future due to all of the things that I've dealt with I have decided to open a business that takes care of animals when owners are at work or when dogs or any kind of animal feel left out. It's a place where they can do some of the things that humans do but still be safe for them. They won't be eating human food they'll be eating things that are like animal-safe food that humans would usually eat, but that are safe for their stomach and won't make them sick. Or maybe a scientist – that would be so cool to be a scientist. I love school and that's important. Plus I do a lot of studying on the ocean and marine biology so maybe I'll be an oceanologist.

APPENDIX G

Children's Stories: A Narrative Resource
Clinician Cover Letter

Dear Clinician,

My name is Hart MacCardell and I am a doctoral student in clinical psychology at Indiana University of Pennsylvania. I am inviting you to participate in a voluntary research survey as part of my doctoral dissertation. The purpose of this survey is to collect data from clinicians regarding your opinions on the utility of a certain therapeutic resource tool.

Your participation is voluntary and may be withdrawn at any time without repercussion. This survey should take approximately 20 minutes to complete. First, you will be asked to answer several demographic questions. You will then be asked to read and respond to three stories written by children currently in therapy. This survey is of minimal risk to participants. Reading these stories may cause a level of discomfort comparable to that of listening to clients in therapy.

All participant information will be kept confidential and protected. A numerical code will be used on each survey in order to track the survey packet, but participant's names and survey codes will not be cross-referenced in any way. Research data will only be reported in aggregate form. All data will be retained for at least three years in compliance with federal regulations.

If you have any questions, you may contact the principle researcher, Hart MacCardell, MA or the faculty supervisor, John A. Mills, Ph.D., ABPP. If you would like to know the results of this project, you may contact the researcher to obtain a summary of the findings after the research is completed. Contact information is provided below:

Researcher:
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Doctoral Candidate
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Indiana, PA 15705
Phone: (214)915-4766

Faculty Supervisor:
John A. Mills, Ph.D., ABPP
Indiana University of Pennsylvania
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Oakland Ave.
Indiana, PA 15705
Phone: (724)357-4520

By clicking on the link below and completing the survey, you are consenting to participate in the study described above.

Your participation is most sincerely appreciated,

Hart MacCardell, MA

This project has been approved by the Indiana University of Pennsylvania Institutional Review Board for the Protection of Human Subjects (Phone: 724/357-7730).

APPENDIX H

Story-Attitudes Questionnaire: Clinician Version

1. What is your age? _____years old.
2. Please indicate the average number of hours that you spend conducting therapy (group, individual, family, etc.) each week: ___hours
3. Please indicate your own **primary** theoretical orientation:
    a. Narrative
    b. Solution-Focused
    c. Cognitive-Behavioral
    d. Psychodynamic/Psychoanalytic
    e. Humanistic
    f. Interpersonal
    g. Family Systems
    h. Other – Please specify: _____
4. Please indicate the setting in which you currently work. If you work in multiple settings, please indicate your primary setting:
    a. Private practice
    b. Research Facility
    c. Outpatient
    d. Inpatient: state hospital
    e. Inpatient: private hospital
    f. School System
    g. University counseling center
    h. Community Mental Health Center
    i. Medical Center
    j. Other – Please specify: _____
5. Please indicate the average percentage of clients you see who are 18 years of age and younger:___%

    Narrative therapy is grounded in the principle that individuals create personal narratives, or life-stories, out of their experiences in order to organize and create a frame of reference for understanding these experiences. The nature and tone of these narratives influence real-life patterns. Narrative therapy focuses on exploring problematic narratives and collaborating with the client to create new, more positive personal narratives.
6. To what degree does your orientation emphasize the elicitation of personal narratives from clients?

1	2	3	4
Almost no emphasis.	Little emphasis.	Some emphasis.	High degree of emphasis.

7. How frequently do you utilize the concept of personal narratives in your own work?

1	2	3	4
Not at all.	Infrequently.	Somewhat frequently.	Very frequently.

The following are examples of personal narratives written by children and adolescents who are currently enrolled in therapy. Please read each carefully and answer the following questions.

[3 randomly selected stories will be presented above the following questions]

8. Are these stories consistent with those of the child/adolescent clients you typically encounter in your practice?

1	2	3	4
No, highly **in**consistent.	No, somewhat **in**consistent.	Yes, somewhat consistent.	Yes, highly consistent.

9. Please tell us in what ways these stories are (or are not) characteristic of the children/adolescents you see in practice:

10. *In your opinion*, would children/adolescents feel more comfortable writing or talking about their own problems after reading a story written by another child facing similar circumstances?

1	2	3	4	5
No, this would make children feel uncomfortable.	No, this would not make children feel comfortable.	It wouldn't make a difference one way or another.	Yes, it would make children feel a little more comfortable.	Yes, it would make children feel **much** more comfortable.

11. To what degree do you believe a collection of personal stories written by children, such as those you read would aide clinicians?

1	2	3	4
Detrimental.	Not beneficial.	Somewhat beneficial.	Extremely beneficial.

12. Several reasons have been proposed for why children may feel more comfortable writing or talking about their own experiences after reading a story written by another child facing similar circumstances. Please indicate the degree to which you believe each of the following is a likely reason:
    a. This method utilizes storytelling, which is a familiar mode of communication for children. This may, as with other child-centered practices, minimize the discrepancy between how children prefer to communicate and the manner in which therapy is conducted.

1	2	3	4
Very unlikely.	Somewhat unlikely.	Somewhat likely.	Very likely.

    b. Reading a story of this nature with the therapist may contribute to the formation of a positive, collaborative therapeutic relationship.

1	2	3	4
Very unlikely.	Somewhat unlikely.	Somewhat likely.	Very likely.

c. Reading another child's story may familiarizing the client with the language other children have used to describe their experiences, and therefore offer the client a model for organizing and articulating his/her own narrative.

1	2	3	4
Very unlikely.	Somewhat unlikely.	Somewhat likely.	Very likely.

d. This method would allow the client to explore the therapist's reaction to various life events with minimal risk. The client may feel reassured by watching the therapist's empathic reaction to reading another child's story.

1	2	3	4
Very unlikely.	Somewhat unlikely.	Somewhat likely.	Very likely.

e. Reading a story written by another child with similar difficulties may help child-clients feel less stigmatized and isolated by their own experiences. It may challenge the "I'm the only one" feeling some children experience.

1	2	3	4
Very unlikely.	Somewhat unlikely.	Somewhat likely.	Very likely.

f. Additional reason(s):

13. Would you use a tool such as this in your own practice?

1	2	3	4
No, I would never use this.	No, I'm not likely to use this.	Yes, I would be likely to use this.	Yes, I would definitely use this.

14. Please explain **why** you would (or would not) be likely to use a collection of stories, such as those you read, in your own practice:

Thank you very much for taking the time to complete this survey.
Your contribution to this study is greatly appreciated.

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