

A Different Approach: Applying a Wellness Paradigm to Adolescent Female Delinquents and Offenders

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Abstracts:

Recent epidemiological and survey research indicates that the incidence of delinquency among adolescent females is increasing. Existing treatment programs, based primarily in research on males fail to consider the unique developmental needs of females. These programs focus on punishment rather than treatment, often reinforcing the behaviors they seek to reduce or eliminate. Programs that incorporate a focus on gender issues, prevention, early intervention, and positive mental health are needed. A wellness paradigm is presented and explored as a promising approach to preventing as well as treating delinquent behaviors among adolescent females. This approach is demonstrated using a case example from an inpatient adolescent treatment program.

Article:

Current social and political attitudes combined with gender bias in the juvenile justice system have created the illusion that adolescent females are at lower risk than males for delinquency (Pepi, 1997). This bias often results in female offenders being referred for psychiatric rather than offender treatment (Westendorp, Brink, Roberson, & Ortiz, 1986), thus making the exact prevalence of female delinquent behavior difficult to determine.

Epidemiologic research by Fergusson, Horwood, and Lynskey (1993), with a large population of 15-year-olds, revealed diagnoses of conduct disorder in as many as 9.5% of females compared to 12.2% of males. These statistics support Pajer's (1998) conclusion, that among adolescent girls, conduct disorder and delinquency are not rare. Further, the rate of violent crimes among girls as well as adult females is increasing (Loper & Cornell, 1996; Mann, 1996; Molidor, 1996). Between 1994 and 1996, rates of female delinquency in most offense categories rose more than rates for males (Department of Justice, 2000), substantially narrowing the reported gender gap in delinquent behavior.

Increasing female delinquency is sobering because of the problematic behaviors themselves and accompanying sanctions, and also because of a myriad of other problems that often exist concomitantly with girls' delinquent involvement (Rosenbaum, 1989). These additional problems include family and relationship dysfunction, higher incidences of violence, drug use, deficiencies in mental health, sexual promiscuity and victimization, teen pregnancy, and dropping out of school (Ellickson & Saner, 1997; Fergusson & Woodward, 2000; Pajer, 1998). The ramifications of female adolescent delinquency do not end with the transition to young adulthood (Bardone, Moffitt, Caspi, & Dickson, 1996; Robins, 1996; Rutter, 1992, 1996). Numerous studies reveal a continuity of problem behaviors throughout adulthood—criminal behavior (Gilfus, 1989; Nagin, Pogarsky, & Farrington, 1997), dysfunctional relationships (Caspi & Elder, 1988), and poor mental health (Robins & Price, 1991; Rowe, Sullivan, Mulder, & Joyce, 1990). These problems create significant social and economic consequences and, not surprisingly, calls from the media, researchers, and even the federal government for new and effective programs, research, and prevention strategies to help adolescent as well as adult female offenders and potential offenders (Department of Justice, 2000; Pajer, 1998). Mental health counselors are in a unique position to develop such programs, based on the developmental, wellness philosophy that underlies the profession (Myers, 1992; Myers, Sweeney, & Witmer, 2001; Pepi, 1997; Weikel & Palm, 1996).

In this article, wellness is presented as a paradigm for understanding delinquent adolescent females and is contrasted to treatment programs within the mental health and juvenile justice systems. The intersection of gender and wellness is explored, gender bias in existing treatment programs for delinquent females is examined,

and gender-appropriate treatment programs are described. Wellness is defined, models of wellness are described, and the Wheel of Wellness is presented as a foundation for assessment, treatment planning, and intervention from a developmental perspective. A case example is described to demonstrate the application of a wellness model in counseling with a delinquent adolescent female.

WELLNESS: A PREFERRED PARADIGM TO MENTAL ILLNESS OR CORRECTIONAL PROGRAMS

Wellness incorporates a commitment to developing functional, practical life behaviors intellectually, spiritually, physically, socially, emotionally, and occupationally (Asuini & Fiddler-Woite, 1996; Myers et al., 2000). Thus, wellness models allow for a holistic view of functioning, consider both healthy and unhealthy behaviors, and empower the client to build on her strengths and develop in positive ways. However, to better understand how the wellness paradigm can be used in counseling with adolescent delinquent females, it is important to understand how delinquent girls are conceptualized as ill and/or criminal and how male and female delinquents are differentially classified as well as the limitations of current treatment effectiveness within the mental health and juvenile justice systems.

Behaviorally Derailed Female Adolescents: Ill, Criminal, or Not Well?

Currently, female delinquents are conceptualized as being mentally ill or criminals and consequently tracked into one of two systems, the mental health system or the correctional, juvenile justice system (Westendorp et al., 1986.) Both systems pathologize delinquent behaviors and base treatment in the medical model of care., a model that addresses deficit behaviors, places the locus of responsibility for improvement in the hands of a professional, and thus does not emphasize empowering the client to take action to enhance her own development and functioning (Brickman et al., 1982; Burg & Seeman, 1994). Within this context, it is difficult to determine whether delinquency among adolescent girls is a result of mental illness, criminality, or a lack of wellness. This distinction, or lack of distinction in many cases, contributes to the lack of success found in existing treatment programs.

Internal susceptibility to delinquent involvement, possibly attributed to a mental illness such as conduct disorder, is illustrated in the individual characteristics that contribute to delinquency, including the internalization of problems, resulting in incidences of depression, self-destructive behavior, and social withdrawal (Belknap & Holsinger, 1997). Rutter (1996) suggests that female adolescent delinquent involvement also can be attributed to individual factors such as genetics and heredity. The research of Fergusson and Woodward (2000) indicates that individual behavioral characteristics increase the risk of delinquency for girls; that is, female delinquency involves a causal process in which conduct problems are associated with risk-taking behaviors and, consequently, these risk-taking behaviors increase girls' risks for psychosocial difficulties in the future.

To understand the problem of female adolescent delinquency accurately as criminal behavior, several concepts must be discussed. First, conduct disorder and delinquency are not synonymous terms; delinquent behavior does not necessarily meet the criteria for conduct disorder (Pajer, 1998). Conduct disorder can be differentiated from delinquency in that conduct disorder pertains to engaging in antisocial acts for at least 6 months, whether or not an arrest occurs. Delinquency constitutes youth being adjudicated for committing specific offenses.

Second, delinquent acts fall into two categories, criminal and status offenses. Criminal offenses, behaviors that are illegal regardless of age, encompass a wide range of activities from noninjurious offenses such as theft and burglary to acts that include perpetrating bodily harm (Lensesen, Doreleijers, van Dijk, & Hartman, 2000; Pajer, 1998). Status offenses are actions that become law violations only when committed by a juvenile such as running-away, underage drinking, truancy, violating curfews, and unmanageable behavior (Pepi, 1997). Girls are more likely to commit less violent crimes than are boys (Ellickson & Saner, 1997); however, a study by Pepi indicates that more girls than boys, by a ratio of 12 to 1, were charged with non-violent status offenses. Weiss, Nicholson, and Cretells (1996) suggest that within the context of adolescence, these behaviors may not be particularly extreme. However, the arrest rates for girls show that girls are charged with status offenses more

often than boys because some of the behaviors they are participating in are considered negative when perpetrated by a female (Khowais, 2001).

Delinquency, as a problem related to wellness, is a result of difficulties in three main areas social, familial, and individual characteristics—that contribute to girls becoming involved in delinquent activity (Belknap & Holsinger, 1997; Fergusson & Woodward, 2000; Lenssen et al., 2000). Individual characteristics are the primary focus of much of this discussion. Social factors include poverty, high incidence of school drop outs, and frequent association with delinquent peers.

Belknap and Holsinger (1997) identify a troubled homelife as a precursor to female delinquent involvement and suggest that girls are prone to engage in delinquent activity as a reaction to conflicts at home, often being victims of physical and/or sexual abuse. Additionally, Weintraub and Gold (1991), examined survey data of 1,395 American adolescents, ages 11 to 18, and found that parental monitoring is negatively associated with adolescent delinquent involvement; as parental monitoring decreases, teen delinquency increases. Other studies indicate that parental discipline also corresponds to rates of juvenile delinquency (Ferguson & Woodward, 2000; Newson, Newson, & Adams, 1993; Weintraub & Gold). Unfortunately, effective parental monitoring and discipline often require training and development of efficacious parenting techniques as well as successful application of those techniques (Eddy, Reid, & Fetrow, 2000; Farrington, 2000; Stern & Smith, 1999; Taylor, Eddy, & Biglan, 2000). Parents of delinquent adolescents frequently lack essential parenting skills, engage in and thus promote and model negative health and wellness behaviors (Burg & Seeman, 1994), contribute to conflicts within the home, and fail to contribute to a decrease in delinquent behaviors by their children. Consequently, delinquent adolescents may find themselves forced to participate in formal intervention programs that provide monitoring and supervision in the absence of parental involvement.

Differences in Classifying Female and Male Adolescents

Currently, services for delinquent offenders are divided between two primary sectors, the juvenile justice system and the mental health system (Pepi, 1997; Westendorp et al., 1996). Within these systems, differences exist in how adolescents are classified and adjudicated, based on gender (Belknap & Holsinger, 1997). Male delinquency is viewed as a behavioral issue, and adolescent boys are more often referred to rehabilitation programs that encourage behavior modification compared to females who perpetrate similar acts, who are more likely referred to psychiatric treatment and disproportionately diagnosed with conduct disorder. In fact, conduct disorder is the second most diagnosed disorder among adolescent girls (Kann & Hanna, 2000) despite the fact that more boys than girls meet the criteria (Pajer, 1998). As a result, female delinquent involvement is pathologized as a psychiatric disorder instead of being interpreted as a possible reaction and/or coping mechanism to deal with environmental and situational factors as is often the case with male delinquency. Stigmatized within the mental health care system, girls do not receive developmentally and gender appropriate rehabilitative opportunities to confront the factors that contribute to their delinquent involvement and work towards preventing recidivism (Pepi). Although many programs exist within the juvenile justice and mental health systems, interventions are riddled with dynamics that limit the effectiveness of the treatment.

Effectiveness of Treatment Within the Mental Health System

In the current mental health system, treatment options specific to the multifaceted and quantifiable needs of female offenders remain limited, based on outdated and possibly inaccurate assumptions (Ellickson & Saner, 1997; Fergusson & Woodward, 2000) and are insufficient and ineffective (Lenssen et al., 2000). The literature establishes the presence of distinctly different processes of development that are unique and directly correspond to gender (Jordan, 1995; Molidor, 1996; Rosenbaum, 1989), but current treatment options do not take these developmental issues into account (Belknap & Holsinger, 1997). Instead, delinquent behavior is viewed without regard to gender disparities among motivation, effective treatment, and rehabilitation needs of female offenders (Pepi, 1997). Additionally, female delinquency is often attributed to mental deficiencies or psychological disturbances, which may not be accurate as causal factors, as noted earlier (Kann & Hanna, 2000).

Effectiveness of Correctional Programs Within the Juvenile Justice System The juvenile justice system also faces a challenging situation: treating the growing numbers of girls entering the justice system with antiquated

methods that were developed as a response to society's assumption that delinquency is primarily a male problem (Pepi, 1997). Compared to available placements for males, females have fewer options. Most treatment programs are designed to treat males; however, in the programs that have been intended for females specifically, punishment is emphasized instead of rehabilitation. This approach limits the opportunity for girls to receive therapeutic help to enable them to reenter society and resume healthy functioning.

In many correctional programs, the focus is on maintaining girls' positive and cooperative behavior in the immediate environment instead of on building life-skills that will benefit the girls and, hopefully, prevent recidivism when they are released (Weiss et al., 1996). Additionally, often juvenile justice programs encourage the suppression of feelings as this approach aids youth in complying with the program, even though it prevents teens from confronting and working through problems. Moreover, traditional gender roles and stereotypes frequently are reinforced in correctional treatment facilities (Belknap & Holsinger, 1997). Girls are rewarded for assuming stereotypical feminine behavior such as being passive and submissive; simultaneously, females are punished for displaying traditionally masculine traits such as assertiveness. As is true in the mental health system, girls are referred to psychiatric treatment based on medical diagnoses related to delinquent behaviors. These diagnoses result in treatments that are only minimally successful if at all, and thus recidivism rates remain high. Clearly, new approaches are needed, particularly ones that focus on the unique developmental needs of girls (Taylor et al., 2000).

GENDER AND WELLNESS: AN EMPOWERING STRENGTHS-BASED APPROACH

Adolescent girls are increasingly involved in delinquent behavior. Their delinquent involvement is different from that of males, and identifiable factors—including social, familial, and individual characteristics—contribute to female delinquency. As a consequence, intervention programs targeted at prevention and/or rehabilitation need to incorporate consideration of all these factors (Belknap & Holsinger, 1997; Pepi, 1997). Wellness provides a strengths-based treatment approach that emphasizes empowerment and provides a foundation for examining three important issues: (a) the cycle of troubled girls becoming troubled women; (b) gender-specific developmental issues; and (c) gender issues in treatment planning.

Behaviorally Troubled Girls Become Troubled Women

For girls, the problem of adolescent delinquency does not end with the transition to adulthood. Regardless of the specific criminal or status offense, delinquent adolescent females often exhibit other troubling behaviors that do not subside with adjudication, referral, or other sanctions. Fergusson and Woodward (2000) found girls with conduct problems at age 13 experienced adverse educational outcomes, juvenile offending, substance use, mental health problems, and poor sexual health and behavior throughout adolescence. Despite previous assumptions that girls grow out of a deviant stage, as adults, delinquent females continue to experience difficulties such as increased drug and alcohol use, psychiatric problems, higher rates of mortality, criminal behavior, insufficient parenting skills, relationship dysfunction, lower performance in academic and occupational environments, necessary involvement with social service assistance, and adjustment difficulties (Caspi & Elder, 1988; Pajer, 1998; Robins & Price, 1991; Rosenbaum, 1989; Rutter, 1996).

Gender-Specific Developmental Issues Related to Behavioral Challenges

In addition, to contending with the immediate challenges that result from adolescent delinquent involvement and that continue into adulthood, delinquent girls also must deal with gender-specific developmental issues. Recent literature documents specific developmental and gender-specific needs that must be addressed to treat delinquent girls effectively (Ellickson & Saner, 1997; Fergusson & Woodward, 2000; Lenssen et al., 2000). Gender-based determinants that deeply affect adolescent girls include their family history, sense of self in relation to their gender, a background of victimization both socially and personally, the availability of social networks, and variables associated with power and control variants (Acoca, 1998). When these developmental issues are not adequately attended to, girls' development is adversely affected.

Many girls enter the juvenile justice system as victims of abuse, requiring therapeutic assistance for issues beyond their offending behaviors (Lessen et al., 2000; Rosenbaum, 1989). When confounding factors such as

neglect, abuse, or other risk factors are present, interventions for delinquent females may also require attention to developmental issues in addition to gender-specific needs. For delinquent girls who have not had healthy role modeling, developmental needs may include achieving a sense of identity and learning about gender roles; for girls who have been victimized, reclaiming a sense of empowerment may be a crucial developmental task (Pepi, 1997). It is essential that these gender-specific developmental needs be incorporated into treatment planning for adolescent females.

Gender Issues in Treatment Planning

Among the gender issues involved in treatment planning for female offenders, gender bias and female developmental processes must be considered. Gender bias, as evidenced in the disparities between intervention alternatives for males and females, prevents delinquent girls from receiving effective and appropriate treatments (Belknap & Holsinger, 1997; Pajer, 1998; Westendorp et al., 1986). This bias stems from both social and political attitudes that influence public perceptions about the types of problems stereotypically associated with girls (Khowais, 2001). Historically, female delinquency has been linked to sexual promiscuity. Girls have been punished for participating in premarital sexual activity, and patriarchal attitudes within the judicial system and from parents have supported laws that strive to control girls' sexuality (Pepi, 1997). However, this perception of female delinquent involvement is inaccurate.

Female delinquency is not relegated to sexual activity alone. Increasingly, girls are exhibiting behaviors such as violence (Ellickson & Saner, 1997) that are more similar to their male counterparts. Yet, societal perceptions of female delinquency often remain incorrect and misguided paradigms dictate approaches to working with delinquent girls, including how delinquent behavior is conceptualized, the treatment goals that are created, and the norms that define acceptable behavior. Public sentiment also impacts treatment options available to females through policies and procedures that are predicated on societal and political pressure about what is appropriate for female offenders and how much money will be allocated to programs. Thus, treatment for female offenders must incorporate not only gender-specific and developmental needs, but responses to gender bias within society, systems, and programs as well.

Gender-appropriate treatment planning also should include consideration of female developmental processes. Jordan (1995) proposed that developmental processes for girls, including psychological growth, are unique, emphasizing relationships and connections over more masculine norms of self-development (Gibson, 2000). Instead of developing in sync with male-normed theories of development that culminate in autonomy, independence, and individualistic achievement, females develop psychologically, intellectually, and morally within a relational context, valuing and learning from relationships with others (Gilligan, 1982; Scott, 1982). For girls, a sense of identity is developed through connectedness with others (Rose & Nicholas, 1992.) These relationally based perspectives of female development differ from male developmental norms by reframing a relational context of development as positive instead of as a weakness or deficit as in traditional, masculine development.

To summarize, gender is an important factor when considering the problems delinquent girls contend with, specifically, the cycle of troubled adolescent females becoming troubled adults, gender-specific developmental issues, and gender issues in treatment that involve gender bias and female processes of development. Current treatment options fail to attend to these areas appropriately, and therefore, are ineffective in addressing the needs of female offenders. New treatment paradigms are needed that consider the influence of gender upon delinquent involvement, incorporate positive perspectives of female developmental processes, and target gender-specific needs of delinquent girls.

INCORPORATING A WELLNESS PARADIGM

Myers, Sweeney, and Witmer (2001) highlight the frustration of mental health counselors and other health care professionals with ineffectual, illness-based, medical models of treatment and emphasize the need for new methods that focus on life-span development and prevention. Regarding specifically treating adolescent female offenders, other researchers also note poor outcomes with traditional, nonstrengths-based models of intervention

(e.g., Pepi, 1997; Taylor et al., 2000). In response to calls from various sectors for effective alternatives, new methods of treatment are being developed based on a wellness approach. Applying this approach requires an understanding of the meaning of wellness and the models that expand on the concepts of wellness.

Defining Wellness

Various disciplines have explained wellness as a state of being in which optimal health is achieved, including positive physical and psychological functioning (Cruse & Nicholas, 1992; Myers et al., 2000, 2001; Ryff, 1989). This optimal health encompasses proactive behavior that leads to an individual achieving his or her maximum potential by integrating the mind, body, and spirit (Myers et al., 2001). Several models of wellness have been developed such as those by Heiller (1984) and Dunn (1961) in disciplines such as medicine, public health, and psychology. Wellness models incorporate multidimensional and multidisciplinary approaches to conceptualizing and working with clients by attending to influential factors of holistic health such as culture and age (Cruse & Nicholas; Witmer & Sweeney, 1992) and employ a systems approach, recognizing that change in one area of functioning impacts other areas. Additionally, models of wellness emphasize the prevention of illness and pathology and thus provide an alternative paradigm for conceptualizing and treating offenders. Although many models of wellness include prevention and strengths-based perspectives, they fail to recognize the influence of gender and are not based in counseling.

A Holistic Model for Treatment: The Wheel of Wellness

One holistic approach that incorporates attention to gender is the Wheel of Wellness model (Myers et al., 2001; Sweeney & Witmer, 1991). The model is based in Adlerian theory and attends to various influential factors such as gender differences, life-span development, and the effect of external forces upon health and well-being (Myers et al.). Combining theory and empirical data from various disciplines, the Wheel of Wellness comprises five life tasks essential to optimal health: spirituality, self-direction, work and leisure, friendship, and love. Self-direction incorporates 12 additional tasks necessary for wellness including gender identity and cultural identity. Myers and colleagues (2000) illustrate how this approach can be practically integrated into wellness-based treatment through four phases: (a) introducing the wellness approach and defining wellness as it pertains to the individual client, (b) assessing a client's level of wellness in the five major areas, (c) implementing a treatment plan by identifying dimensions of wellness to be modified, and (d) evaluating both short- and long-range progress.

The Wheel of Wellness model illustrates the interconnectedness of various aspects of being for adolescent females. Moreover, the five life tasks provide a basis for assessing and understanding their developmental and gender-specific needs. Attention to helping these clients establish a sense of gender identity, one of the subtasks of self-direction, coupled with encouraging and responding to ongoing psychological, intellectual, and moral developmental processes are necessary priorities (Ellickson & Saner, 1997; Fergusson & Woodward, 2000, Lessen et al., 2000).

The Wheel of Wellness allows for an individual's meaning to be considered in conceptualizing various domains of wellness, incorporating values and cognitive style. Additionally, this approach provides the practitioner flexibility to emphasize various areas of wellness as they are relevant to the environment and the client. Possible psychological pathology and/or criminal behavior are not neglected; rather they are explored within the context of developing from deficient wellness in various domains of the Wheel of Wellness. As such, treatment options are developed that directly correspond to the domain that requires enhancement, while indirectly strengthening domains that exhibit healthy functioning.

Wellness Research

Thus far, the research pertaining to wellness and the efficacy of wellness models has been empirically supported primarily with adult populations and has demonstrated gender differences in various levels of wellness (Connolly, 2000; Riff & Heidrich, 1997). Unfortunately, a paucity of research exists pertaining to wellness in general adolescent populations; however, some studies have been done with segments of the adolescent population such as college students and middle school students (Hermon & Hazier, 1999; Myers et al.,

2,000). The available data indicate that aspects of wellness such as mental health, risk taking, and general health are affected by gender (Garrett, 1996; Steiner, Pavelski, Pitts, & McQuivey, 1998) as well as social influences (Sussman, Dent, Stacy, Burton, & Flay, 1995).

Several studies provide evidence that certain areas of adolescent wellness such as relationships and behavior can be targeted and modified with appropriate interventions (Ansuini & Fiddler-Woite, 1996). For example, Sussman et al. (1995) found that wellness levels in middle school students were negatively affected by participation in poor health practices, but that wellness levels were both positively and negatively affected by social influences. Also in the results of this study, behavior difficulties related to deficits in wellness. In another study, with high school students, Steiner et al. (1998) found that adolescent females experienced more significant difficulties in mental health, sexual risks, general health, and dietary behaviors than males. These studies underscore the potential value of the wellness paradigm in treating offender populations.

PREVENTING MENTAL ILLNESS AND CRIMINAL BEHAVIOR: A WELLNESS APPROACH

Using a holistic, developmental perspective, the Wheel of Wellness (Myers et al., 2001; Sweeney & Witmer, 1991) offers a strengths-based paradigm for treating female offenders. The Wheel offers a preventive approach towards delinquent behavior and concomitant mental illness through identification of areas of strength as well as deficient wellness as a basis for implementing treatment that emphasizes developmental and gender-sensitive factors. The benefits of this approach are twofold: (a) preventing delinquency from developing in adolescent girls through enhancing present strengths, and (b) interrupting the cycle of offending from adolescence to adulthood by treating current offenders effectively and with respect to developmental and gender-specific needs.

The holistic emphasis of wellness on the spirit, mind, and body corresponds to treating delinquent girls' relational, physical, and psychological needs, instead of simply treating the mind, as does the mental illness model of delinquency. Likewise, the wellness approach encourages the integration of the psyche and behavior, expanding the limited scope of treatment for girls provided in the correctional model of delinquency that focuses on behavioral aspects of female offenders. Wellness models provide structures with which to conceptualize the motivation for delinquent behavior and develop appropriate treatment interventions.

CASE EXAMPLE USING THE WHEEL OF WELLNESS

In the following case example, the Wheel of Wellness is practically integrated into a treatment plan with an adolescent female offender. The client, "Marcie," is a 15-year-old Caucasian female who has been adjudicated for assault. She has a history of perpetrating various status and criminal offenses such as running away and theft. She was remanded to residential psychiatric treatment after she ran away from her foster home, violating the terms of her probation for previous offenses. Having an extensive history of sexual victimization, perpetrated by both family members and acquaintances, Marcie's records from the Department of Social Services and the Department of Juvenile Justice also indicate a lengthy history of physical and emotional abuse, family instability, drug use, foster care placements, and time spent in juvenile detention. Information from previous therapeutic services revealed various diagnoses of conduct disorder, antisocial disorder, and oppositional defiant disorder.

Marcie was very upset about being taken from her foster family, whom she regarded as "truly caring" about her, although she stated that she ran away after becoming very upset when her foster parents caught her smoking and grounded her. This incident was the "last straw" for Marcie, who reportedly had become increasingly irritated with her foster parents because of their "strict rules." Upon admission to the unit, Marcie expressed suicidal ideation; thus, the immediate treatment goal was to stabilize her emotionally, psychologically evaluate her for possible mental illness, and determine whether she should be returned to foster care or placed in a long-term group home facility. The counselor assigned to Marcie met with her daily, alternating between formal and informal sessions according to the structure of the residential milieu. Formal counseling sessions were held throughout the week, and the counselor participated in daily activities with Marcie and the other residents

in daily routines such as eating meals and attending school. Following the method proposed by Myers and colleagues (2001) of incorporating the Wheel of Wellness into treatment in four phases, the counselor adhered to the following structure in working with Marcie over the span of 3 months.

Phase 1. Introducing and Defining Wellness as it Pertains to the Client

After the initial intake session, the counselor talked with Marcie about the goals of therapy including determining what changes Marcie wanted to make and finding ways to help achieve those changes. The concept of wellness was explained as a way to find out the areas in which one is doing well, and strengthening these areas as a method of enhancing other areas in which he or she may not be functioning well. When encouraged to talk about how she felt about this approach, Marcie displayed skepticism and denied having any areas in which she felt efficacious; however, she stated that this was a different approach to the therapy she was used to receiving and agreed to co-construct some ideas about what she wanted to work on. These goals included feeling better to "get out of here" and finding a way to return to her foster family. Responding to the client's anticipated reluctance to engage in the therapeutic process, these initial goals were accepted and validated and used as a springboard to address other areas of wellness in the ensuing phases.

The counselor also explained the five major areas of wellness to Marcie (spirituality, self-direction, work and leisure, friendship, and love) and asked the client how these areas related to her. Marcie reported understanding what each domain entailed, but explained that she did not perceive herself as being "well" or having a support network to encourage her. She disclosed believing that "there is a God," but stated that she wasn't "sure what to do anymore" and repeated feeling worthless, ineffectual, and undesirable.

Phase 2. Assessing the Client's Level of Wellness in the Five Major Areas

During phase two, the second session, the counselor specifically assessed Marcie's levels of wellness in the five major areas using a qualitative interview. The counselor explained each area of the Wheel of Wellness and asked Marcie to talk about what each area meant to her, how she perceived herself functioning in each area, and what each area would look like if she could design an ideal life for herself.

For spirituality, Marcie stated that she practiced reading the Bible and praying. Her foster parents had introduced her to a Protestant faith, and Marcie enjoyed participating in group activities within the church the family attended. She said that she wanted to practice daily spiritual activities because she had not been following through with her regular routine of prayer and reading, and she missed these activities. In the self-direction domain, Marcie admitted to feeling hopeless about the future, lacking a sense of control over life choices, and not caring about herself physically. Pertaining to the domain of work and leisure, Marcie identified schoolwork as an area in which she had experienced success, maintaining a "B" average over the past two years; but recently her grade point average had dropped to a "C." Academically, Marcie derived a sense of acceptance from her teachers and claimed, "school is something I'm pretty good at." Marcie stated that over the past few months she had withdrawn socially, but previously had enjoyed hanging out with friends, drawing, and journalizing in her leisure time.

In the friendship domain, Marcie did not have any close friends whom she could trust; however, she attributed this to her actions over the past 3 months during which she had "pushed people away." She identified having a "real friendship" with her social worker in the past, explaining that the relationship was true friendship because her social worker was "loyal, kind, and liked me even though she knew I screwed up." For the love domain, Marcie expressed loneliness, mistrust, and pessimism. She stated that no one had ever wanted her or treated her like a "kid should be treated." Marcie disclosed feeling taken advantage of and having gotten "a bad deal" from life, and that she was tired of trying to get close to people.

After the assessment interview, based on Marcie's self-report and information derived from her chart, the counselor identified the domain of work and leisure as the area in which Marcie illustrated the most wellness, followed by the domains of spirituality and friendship. Self-direction and love were the areas in which Marcie

demonstrated the least amount of wellness. When asked, Marcie agreed with the counselor's perception of the domains in which she seemed to be most to least "strong."

Phase 3. Implementation of a Wellness-Based Treatment Plan

From the assessment information, a wellness-based treatment plan was developed. Prioritizing the developmental and gender-specific needs of relationship, communication, and establishing gender-identity, Marcie and the counselor co-constructed goals. Enhancement of the domains of work/leisure, spirituality, and friendship were selected as primary emphases to accentuate strengths Marcie already exhibited, and as a way of utilizing existing assets to strengthen the less robust areas of self-direction and love. Encouraging Marcie to pursue, further develop, and use her strengths indirectly affected the areas she identified as having deficient wellness. The following goals were created for Marcie:

- To enhance the work/leisure domain by maintaining a "B" average for the year. Capitalizing on her academic success, Marcie will identify one subject she is particularly interested in and explore career options related to this subject. Additionally, Marcie will give herself time alone to draw 3 days a week. These activities will assist Marcie in further developing confidence in her academic and creative abilities, investigating options available to her in the future that utilize skills she presently has, and incorporating her creativity in productive, enjoyable ways.
- To enhance the domain of spirituality by creating a daily schedule for Marcie to spend 15 minutes concentrating on her spiritual needs. Marcie will create a list of different ways in which she can nourish and express her spirit. Additionally, she will find a female role model—such as an author, musician, and/or character with whom she can identify spiritually—and talk about her perceptions of this person and her life with the counselor. In these tasks, Marcie will participate in spiritual activities that provide outlets for personal expression and develop a gendered sense of identity as a female who is a spiritual person through learning about other women who have incorporated spirituality into their lives.
- To enhance the friendship domain through creating lists of "What I can offer as a friend," "How I offer these things to my friends," "Why I need friends," and "Ways to make 'true' friends." From these self-identified informational lists, Marcie will develop meaning and purpose for establishing friendships and will develop and demonstrate interpersonal skills. These cognitive activities will assist Marcie in identifying things she can offer to others and help her see herself as appropriately needing and deserving intimacy with others.

Phase 4 Evaluation of Progress

Marcie was discharged from the residential treatment facility after 3 months and returned to her foster family. Upon leaving, Marcie had embraced the tasks related to spirituality, setting time aside each night to read spiritual books, listen to music, and journal. As a result, she developed an interest in spiritual writings authored by women. Marcie stated she felt less "guilty" about neglecting this aspect of her life because she had established times to incorporate these activities in her daily routine. In her schoolwork, Marcie began to incorporate spiritual themes in her writing assignments and investigated careers as a writer and a teacher. The exercises related to friendship led to discussions with the counselor about Marcie's perceptions of self-worth, values related to love, and considering her strengths in surviving an abusive history. When discharged, Marcie had begun to take steps towards developing perceptions of herself and others based on the strengths she recognized in herself. Discussions of responsibility and consequences for her behavior occurred during treatment and were framed in the context of her ability to make choices and utilize her strengths for positive or negative outcomes.

CONCLUSION

The problem of female delinquency is complex, as are the issues involved with treating offenders. Rates of female delinquency continue to increase; and the problems within the two treatment systems juvenile justice and mental health, are pervasive and contribute to ineffectual treatment. Female adolescent delinquency is a problem with immediate and future consequences both for individual girls and for society at large that must care for delinquent girls who presently or in the future require assistance in a variety of ways. Delinquent girls cannot be treated with a one-size-fits-all method of treatment. Interventions must be specific, intentional, and responsive to their gender-specific and developmental needs. Based on the profession's commitment to holistic, developmental treatment, mental health counselors are able to undertake the task of creating treatment that incorporates a more systemic view of female offenders and that emphasizes strength building, skill enhancement, empowerment, and prevention.

The wellness approach is a complementary fit to this task as it provides an alternative approach for practically and effectively responding to the problem of increased female delinquency. It provides an orientation to holistic, developmental treatment and conceptualizes individuals as having potential and strengths instead of, or at the very least in addition to, weaknesses and psychological deficits. It also emphasizes the prevention of pathology and maladaptive behavior, assuming a proactive, instead of a reactive, approach to the problem of female delinquency.

Corresponding to the developmental context in which this wellness approach occurs, enhancing various domains of the Wheel of Wellness involves a longitudinal perspective about progress, acceptance of the cyclical nature of therapy and an understanding that development is not strictly a linear process, readiness to adapt treatment goals, and emphases depending on the needs of the client. Various factors such as the client's cognitive ability, state of crisis, rapport with the counselor, and ability to engage in dialectic thinking will affect the implementation of specific interventions. Throughout the intervention process, the counselor should be aware of an overarching context of adolescent female developmental needs and extenuating factors particular to each individual that require immediate attention.

Although incorporating a wellness paradigm holds promise, a paucity of research is available on specific areas of wellness that are present in delinquent girls; therefore, more empirical research is needed to evaluate the effectiveness of using the wellness model with adolescent females in diverse populations and varied socioeconomic levels. In further incorporating a wellness approach to treating female offenders and expanding the research on the effectiveness of wellness-based treatment, mental health counselors are in a unique position to develop such programs and track their effectiveness in preventing as well as treating the problems of female adolescent delinquency. Mental health professionals have a responsibility to lead the way in designing and implementing treatment for girls that encourages positive developmental growth, confronts the specific factors that contribute to female delinquency, and responds to the unique needs of delinquent girls. It is beneficial individually and globally to explore new interventions that may better the lives and futures of these young women and their communities.

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