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Childhood maltreatment and motivation for treatment in girls in compulsory residential care☆

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ABSTRACT

The first objective of the current study was to examine the relationship between childhood maltreatment, trauma-related symptoms and motivation for treatment in girls in compulsory residential treatment facilities. The second objective was to examine the extent to which various forms of childhood maltreatment, trauma-related symptoms and motivation for treatment predicted (time to) dropout from these facilities. Participants were 154 adolescent girls recruited from three residential treatment settings in The Netherlands. Multiple linear regression analysis revealed that age and ethnicity were associated with motivation for treatment. Furthermore, emotional abuse contributed to motivation for treatment. In addition, internalizing symptoms (e.g., anxiety and depression) significantly predicted level of distress; symptoms of dissociation predicted doubt about treatment. Logistic regression analyses with multiple imputation and competing risk regression analyses revealed no significant predictors for (time to) dropout. The findings suggest that clinicians and therapists should focus on experiences of emotional abuse, traumatic symptoms and treatment motivation in girls in compulsory residential care settings.

1. Introduction

Compulsory residential care (youth care plus) can be regarded as the most restrictive and intensive type of treatment service in youth care. In The Netherlands, youths can be placed in such facilities under coercion by a judge because of their worrisome development, in order to protect them from themselves or to keep them away from adverse influences from their environment, e.g. prostitution, parental psychopathology, or maltreatment (Hamerlynck, Doreleijers, Vermeiren, & Cohen-Kettenis, 2009; Nijhof, 2011). As youths often enter these facilities hardly aware of their own problems and as they are resistant to change, a lack of motivation for treatment is common in these young people (Harder, Knorth, & Kalverboer, 2012; Van Binsbergen, 2003). As a consequence, dropping out from care seems to be fairly common among them; it is estimated that about 24% of youths in compulsory residential care drop out (e.g., running away or not returning from leave; Boendermaker, 1998; Harder et al., 2012; Lodewijks, 2007). The dropout rate is even higher for girls, as being female has been identified as a significant contributor to dropout by running away from residential care (Sunseri, 2003). The high prevalence of dropout from residential care is alarming, because youths who drop out of care show more negative outcomes on individual, school, home and community functioning than youths who do not drop out (Robbins, Turner, Alexander, & Perez, 2003). In addition, running away from residential care puts youths at serious risk of (re)victimization (e.g., presence in places where criminal activity occurs and sexual exploitation) which in turn may result in symptoms of traumatic stress (Courtney & Zinn, 2009; Thompson, Maccio, Desselle, & Zittel-Palamara, 2007).

An extensive body of research has documented that motivation for treatment is an important predictor of continuation of engagement in treatment (Harder et al., 2012; Orlando, Chan, & Morral, 2003; Rosenkranz, Henderson, Muller, & Goodman, 2012; Van Binsbergen, Knorth, Klomp, & Meulman, 2001). For example, Karver, Handelsman, Fields, and Bickman (2005) state that youths who are willing to participate in treatment are less likely to drop out of treatment.

Motivation for treatment refers to willingness to seek help and preparedness to engage in treatment activities, and to act in accordance with a treatment program (DiClemente, Schlundt, & Gemmell, 2004). The readiness to actually change behavior can develop prior to or during treatment (Prochaska, 1995). Research has shown that individual characteristics of youths, such as age, type and severity of problems, and

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problem recognition, are related to the level of motivation for treatment (Englebrecht, Peterson, Scherer, & Naccarato, 2008; Rosenkranz et al., 2012). For example, younger age was associated with lower levels of motivation for treatment (Rosenkranz et al., 2012), and youths with internalizing behavioral problems had been found to be more motivated to change their internal discomfort than youths with externalizing behavioral problems (Digiuseppe, Linscott, & Jilton, 1996).

Exposure to childhood maltreatment and posttraumatic stress is extremely common in youths who are in compulsory residential care; numerous studies have demonstrated that up to 90% of youths in compulsory residential settings have experienced various forms of childhood maltreatment and about a quarter meet diagnostic criteria for posttraumatic stress disorder (PTSD; Abram et al., 2004; Kerig, Ward, Vanderzee, & Moeddel, 2009; Ruchkin, Schwab-Stone, Koposov, Vermeiren, & Steiner, 2002; Wasserman & McReynolds, 2011; Wood, Foy, Layne, Pynoos, & James, 2002). Compared to boys, girls demonstrate more PTSD symptoms and problems related to depression, anxiety, somatic complaints and suicidal thoughts, even after controlling for variables such as the severity and magnitude of the traumatic events (Hussey, 2008; Kerig et al., 2009). Childhood maltreatment and posttraumatic stress may lead to a range of motivation problems; in particular posttraumatic stress may cause feelings of distrust, doubt about the value of treatment and fear of facing emotions (Greenwald, 2009). However, knowledge about the relationship between childhood maltreatment, trauma-related symptoms and motivation for treatment among youths in compulsory residential treatment facilities is currently lacking (Greenwald, 2009; Rosenkranz et al., 2012).

Given that girls are more likely to have experienced childhood maltreatment and to develop posttraumatic stress than their male counterparts (Dixon, Howie, & Starling, 2005; Kerig et al., 2009), the first objective of the current study was to examine the relationship between childhood maltreatment, trauma-related symptoms and motivation for treatment among girls in compulsory residential treatment facilities. The second objective was to examine the extent to which various forms of childhood maltreatment, trauma-related symptoms and motivation for treatment predicted (time to) dropout of the residential treatment facilities. As demographics, a history of out-of-home placements and homelessness has been identified by previous studies (e.g., Abbey, Nicholas, & Bieber, 1997; Sunseri, 2003) as related to motivation for treatment and dropout, these factors were also included in the analyses. Gaining greater understanding of associations between trauma, symptoms, motivation and dropout is essential for developing effective treatment strategies for enhancing girls' retention in treatment, and eventually helping them recover from their severe mental health problems.

2. Method

2.1. Participants

The participants were 154 girls, recruited from three compulsory residential treatment facilities (youth care plus; LSG-Rentray in Almelo and Eefde, and De Lindenhorst in Zeist) in The Netherlands. The girls' ages ranged from 13 to 18 years (mean = 16.0, SD = 1.2). Over half of the girls had a Dutch ethnic background (51%), almost half (46%) had a non-Dutch ethnic background (e.g., Surinamese, Moroccan, and Antillean), and the ethnic background of only a few (3%) was unknown. The girls' histories were characterized by several out-of-home placements (e.g., to other family members or foster care; 60%), homelessness (30%), police contacts of family members (45%), and histories of physical or psychological problems of family members (62%). About one third of the mothers (31%) and 19% of the fathers had only finished primary or secondary school, and up to 19% of the mothers and 13% of the fathers were unemployed or unable to work because of sickness or disability.

2.2. Procedure

The current study was part of a larger study involving the development and effectiveness of a stabilization training '*Stapstenen*' for traumatized girls in compulsory residential treatment facilities. '*Stapstenen*' is a stabilization training for 12 to 18-year-old girls who are severely traumatized. The training is designed for girls who are not able to control their behavior and/or display high levels of avoidance. '*Stapstenen*' is based on psycho-education and (non-exposure) cognitive behavioral treatment (Leenarts, Kroneman, Beer, Doreleijers, & Lindauer, 2012). LSG-Rentray and De Lindenhorst are youth care plus institutions offering treatment for girls in a secured setting. The three facilities were involved in the study as they requested to implement an evidence-based stabilization training. To study the effectiveness of '*Stapstenen*' a nonrandomized approach was used. The recruitment of the control and experimental condition occurred in two *separate* phases, in the first phase the control group was recruited and in the second phase recruitment of the experimental group took place. The control group received treatment as usual and recruitment took place from September 2009 until August 2012 (sample of the current study). Recruitment of experimental group will start in May 2013, this group will receive the '*Stapstenen*' training.

All girls who were admitted to one of the three facilities between September 2009 and August 2012 were asked to participate (N = 156) (control group), with the exception of those who had a short-term crisis placement and those who had an IQ lower than 75. The girls were individually approached by their treatment coordinators and a member of the research staff, who explained the aims and the nature of the study. Following Dutch legislation, active informed consent was collected and, if the girls were younger than age 16, parental informed consent was obtained as well. Two girls refused participation. It is important to note that due to conflicting schedules all girls were assessed at different time points after facility intake; however, all girls were assessed within three months after intake.

Information about dropping out was collected in October 2012 via the digital information systems of the participating facilities. The study was approved by the Medical Ethics Committee of the VU University Medical Center, Amsterdam, The Netherlands.

2.3. Assessments

2.3.1. Demographics

Girls reported age at time of study enrollment, race/ethnicity, and whether they had a history of out-of-home placements and homelessness. History of out-of-home placements and homelessness were assessed on a Likert type five-point rating scale ranging from 1 = never true to 5 = very often true. Information about time between entrance into the facility and point of assessment was calculated by subtracting date of entrance into the facility from date of assessment. Time of entrance was collected via the facility's intake staff person.

2.3.2. Childhood maltreatment

In order to elicit the girls' histories of maltreatment, they completed the Dutch version (Thombs, Bernstein, Lobbestael, & Arntz, 2009) of the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998). The CTQ is a self-report questionnaire about histories of abuse and neglect which consists of 28 items assessed on a Likert type five-point rating scale ranging from 1 = never true to 5 = very often true. The questionnaire yields scores for childhood physical abuse, emotional abuse, physical neglect, emotional neglect, and sexual abuse as well as a minimization/denial scale. Earlier research on this questionnaire in Dutch adult (Thombs et al., 2009) and adolescent (Bernstein, Ahluvalia, Pogge, & Handelsman, 1997; Bernstein et al., 2003) psychiatric samples, revealed satisfactory psychometric characteristics. In the current study, Cronbach's alpha of the subscales ranged from .64 to .93 (mean = .80). The CTQ variables were dichotomized, as we were interested in whether