



The interrelationships between trauma and internalizing symptom trajectories among adolescents in foster care[☆]



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ABSTRACT

This study examined the interrelationships between changes in trauma and internalizing symptoms among adolescents in foster care. Using three waves of data from the National Survey of Child and Adolescent Well-Being, growth-curve analyses were conducted with a sample of 155 adolescents aged 11–15 in out-of-home care. Findings indicated that the initial level of post-traumatic stress symptoms was significantly associated with the initial level of internalizing symptoms at Wave I and decreases in post-traumatic stress symptoms were significantly associated with decreases in internalizing symptoms from Wave I to Wave IV. Viewing trauma and internalizing symptoms as interrelated affords increased understanding of ways in which adolescents who have experienced high levels of stress express their needs. As such, it may be clinically beneficial to conduct an evaluation of trauma symptoms for adolescents in foster care, regardless of whether there has been a documented history of a traumatic event. Doing so may provide a more comprehensive view into the underlying influences of adolescent behaviors and help capture a broader clinical picture necessary for effective intervention.

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Youth in foster care have been exposed to disproportionately high levels of childhood trauma including the experiences of child maltreatment, subsequent removal from the home, separation from family, and potential instability of current placements (Riebschleger, Day, & Damashek, 2015). It is perhaps unsurprising, then, that adolescents in foster care are a particularly vulnerable group with a high prevalence of mental health concerns (McCrae, 2009). Specifically, compared to peers who are not in foster care but are also considered at-risk, adolescents in foster care often have elevated levels of post-traumatic stress (PTS, McCrae, 2009; Saigh, Yasik, Oberfield, Halamandaris, & McHugh, 2002; Salazar, Keller, Gowen, & Courtney, 2013; van der Kolk, 2005) and higher risk for internalizing symptoms (Greeson et al., 2011; Saigh et al., 2002). Despite the wealth of research documenting the pervasiveness of specific mental health concerns for these adolescents, research examining the longitudinal interrelationships of symptomologies is limited (Tarren-Sweeney, 2013). This is problematic because a complex range of symptoms may result from exposure to trauma, particularly for adolescents (Kolko et al., 2010). Thus, focusing

on the prevalence of a specific problem may fail to provide a full understanding of the interrelationships of symptoms and the subsequent treatment of such concerns. The present study aimed to extend past research by determining the extent to which longitudinal changes in PTS symptoms are linked to changes in internalizing symptoms for adolescents in foster care.

Adolescents who have experienced maltreatment have a heightened risk for developing PTS symptoms (Greeson et al., 2011; Griffin et al., 2011; Kolko et al., 2010). Using cross-sectional data from the National Survey of Child and Adolescent Well-Being, researchers found that adolescents in out-of-home care were at a higher risk for demonstrating clinically significant levels of PTS symptoms (19.2%) compared to those who remained in the home (10.7%; Kolko et al., 2010). Interestingly, however, PTSD is not the most common diagnosis among youth who have histories of trauma (Cook et al., 2005; van der Kolk, 2005). For instance, one study of adolescents in foster care found that prevalence rates of major depression for adolescents in foster care were three times higher than a comparison sample of 18 year olds not in foster care (McMillen et al., 2005). In fact, research consistently documents high prevalence rates for a number of mental health concerns of this population (Garland, Hough, & McCabe, 2001; McMillen et al., 2005). As a result, adolescents in foster care are often ascribed comorbid diagnoses (Garland et al., 2001). Comorbid diagnoses may be problematic, though, because they may unintentionally convey that different symptoms are independent from one another rather than interrelated (van der Kolk, 2005).

Diagnostic criteria may be an important part of this problem. Indeed, scholars have suggested that the *Diagnostic Statistical Manual for Mental*

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Disorders (DSM-5; American Psychiatric Association, 2013) diagnosis for PTSD may not adequately capture the ways in which traumatic stress is manifested among children and adolescents (Cook et al., 2005; Ford et al., 2013; Stolbach et al., 2013; van der Kolk, 2005). Similar to those who introduced the terminology “complex PTSD” to describe the presentation of symptoms in adults with child abuse histories (e.g., Herman, 1992), van der Kolk (2005) introduced the concepts of developmental trauma and developmental trauma disorder (DTD) to address differences in post-traumatic stress symptoms associated with experiencing complex childhood trauma. Complex childhood trauma exposure has been defined as experiencing multiple traumas within the caregiving relationship (The National Child Traumatic Stress Network, 2003).

The symptoms associated with complex trauma may represent efforts to self-regulate distress and control one's environment for a sense of self-protection. When caregivers are unable to protect their children or are “the source of the distress, children are unable to modulate their arousal... [leading to] a breakdown in the capacity to regulate internal states” (van der Kolk, 2005, p. 403). Due to children's and adolescents' vulnerable developmental processes at the age and time of the experience of complex traumas, these PTS responses may have neurological consequences, including a potential impact on internalizing symptoms (Cook et al., 2005; Ford et al., 2013; van der Kolk, 2005).

From a developmental trauma perspective, internalizing symptoms may be viewed as means of adaptation or an attempt to “numb” feelings associated with trauma (Jones et al., 2013). Indeed, internalizing symptoms are often comorbid with PTS (Kolko et al., 2010). For instance, among a sample of adolescents in the general population, those who experienced a traumatic event and had PTS symptoms demonstrated significantly higher internalizing scores on the Child Behavior Checklist (CBCL; Achenbach, 1991) compared to adolescents without PTSD (Saigh et al., 2002). Further, in a study of Australian children aged 4–11 in foster care, Tarren-Sweeney (2013) examined mental health symptom complexity. Resultant profiles indicated PTS was often comorbid with internalizing symptoms. These findings highlighted the importance of better understanding the interrelationship between PTS and internalizing symptoms. However, because these studies were cross-sectional, additional research is needed to understand the complexities of such interrelationships over time (Kisiel et al., 2014).

Although no known study of adolescents in foster care has tested the interrelationships of PTS and internalizing symptom trajectories simultaneously, some researchers have analyzed changes in these symptoms separately. Regarding PTS, a study of children aged 2–14 involved with the child welfare system found trauma symptoms decreased over a 3 year period following a child welfare system investigation (McCrae, 2009). Specific to internalizing problems, findings from a study of adolescents aged 13–16 in out-of-home care found that internalizing symptoms demonstrated a downward trend; however specific covariates influenced the trajectories (McWey, Cui, & Pazdera, 2010). Unfortunately, little is known about the interrelationships of PTS and internalizing symptom trajectories. As such, we proposed to examine the trajectories of PTS and internalizing symptoms and test the longitudinal interrelationships between the two.

1. Factors associated with trauma and internalizing symptoms

Research suggests adolescent gender may be associated with mental health symptomology (Tarren-Sweeney, 2013). One study found that adolescent girls in foster care who experienced trauma were more likely to report clinically significant PTS symptoms compared to boys (Collin-Vézina, Coleman, Milne, Sell, & Daigneault, 2011); however, another study reported no significant gender differences in trauma symptoms among adolescents in foster care (Salazar et al., 2013). No known study has examined the effect of gender on PTS symptom trajectories over time for adolescents in foster care. The type of maltreatment experienced also may be related with mental health symptoms (Tarren-

Sweeney, 2013). For instance, one study found that adolescents who experienced sexual abuse, physical abuse, or neglect demonstrated faster decreases in internalizing symptoms compared to those who experienced other forms of maltreatment (McWey et al., 2010). While inconclusive, these studies suggested that it may be important to take gender and type of maltreatment into account when testing trauma and internalizing symptom trajectories.

2. The current study

Post-traumatic stress and internalizing symptoms are common responses to traumatic experiences. Unfortunately, extant research tends to focus on the prevalence of each mental health concern separately rather than examining the ways in which these symptoms are interrelated. This limited focus is problematic because it may fail to provide a full understanding of the interrelationships of symptoms and the subsequent treatment of such concerns. The purpose of this study was to examine the trajectories of trauma and internalizing symptoms, and test the extent to which trauma symptoms and internalizing symptoms are interrelated over time. First, we examined trajectories of PTS and internalizing symptoms over a period of three years after adolescents were placed in out-of-home foster care. Even though individual trajectories of PTS and internalizing symptoms could be different due to variations in participants' gender and type of maltreatment experienced, we expected a decrease on average in these symptoms based on previous studies specific to youth in foster care. Then, the longitudinal intercorrelations between PTS and internalizing symptoms were examined. On the basis of earlier research, we hypothesized that changes in PTS symptoms would be associated with corresponding changes in internalizing symptoms. Specifically, we predicted that decreases in PTS symptoms would be associated with decreases in internalizing symptoms over time. Further, adolescent gender and type of maltreatment were tested as covariates.

3. Method

3.1. Sample and procedures

Data from the National Survey of Children and Adolescent Well-Being (NSCAW; National Data Archive on Child Abuse and Neglect, 2002) were used for this study. The NSCAW is a longitudinal study of a nationally representative sample of U.S. children who were subjects of child welfare system (CWS) abuse or neglect investigations. The NSCAW sample was divided into two groups: (a) children and families who had some degree of CWS involvement but whose allegations of maltreatment may or may not have been verified ($n = 5504$), and (b) and adolescents who had been removed from the home due to maltreatment and were residing in an out-of-home placement for approximately one year at Wave I (long-term foster care [LTFC], $n = 727$). The scope of this study was specific to adolescents in out-of-home care, therefore, data from the LTFC sample were used. The age of the participants in the LTFC sample ranged from birth to 15 at the beginning of the survey. Because the focus was adolescents, only those aged 11 to 15 at Wave I ($n = 155$) were included in the study.

The sample consisted of 67 Caucasian adolescents, 63 African Americans, and 25 of other racial backgrounds. Regarding ethnicity, 19 identified as Hispanic. Caseworkers reported neglect as the most severe type of maltreatment in 54% of the cases, followed other types of maltreatment (19%), “physical abuse” (14%) and sexual abuse (13%). Half of the sample ($n = 78$) were female ($n = 77$ males). At Wave I, the average age was 12.9 (SD = 1.4). Data on trauma and internalizing symptoms were taken from Waves I, III (18 months later) and IV (36 months later).

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