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# Enhancing adolescents' motivation for treatment in compulsory residential care: A clinical review☆

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ABSTRACT

Youths in compulsory residential care show a high prevalence of various mental health problems but often lack motivation to engage in therapeutic treatment. Although the self-determination-theory (SDT) and the transtheoretical model of change (TTM) offer a useful framework for treatment motivation, they do not describe which interventions therapists can use to improve treatment motivation in juveniles, nor do they focus specifically on treatment motivation in a compulsory residential care setting. This article provides an overview of opportunities to enhance adolescents' motivation for treatment in compulsory residential care. Results show that in the reviewed literature, increasing autonomy and competence has received relatively little attention compared to relatedness. In addition, results show that treatment motivation can be enhanced in several different ways, ranging from interventions on an individual to an organizational level. This may indicate that enhancing motivation for treatment in a residential setting needs intervention on multiple levels, involving youths, therapists, group workers and parents. Scientific evidence, however, is limited. Regarding the lack of studies that examine the need for autonomy and competence, future studies should focus on these basic needs for motivation.


## 1. Introduction

Adolescents in compulsory residential care are in need of protection against themselves (e.g. suicidal behavior, drug abuse) or against their environment (e.g. domestic violence, sexual exploitation) (Hamerlynck, Doreleijers, Vermeiren, & Cohen-Kettenis, 2009; Warner & Pottick, 2003). Compulsory residential care, in all of its forms (i.e. juvenile justice institutions, juvenile sex offender programs, residential substance abuse treatment) provides a secured setting assuring adolescents do not withdraw or are withdrawn from the care they need.

Adolescents in compulsory residential care often experience serious mental health problems (Vermeiren, Jespers, & Moffitt, 2006). Prevalence rates show 49% of youth in compulsory residential care are diagnosed with a disruptive behavior disorder (e.g. conduct disorder, attention-deficit/hyperactivity disorder (ADHD)) and 31% are diagnosed with affective or anxiety disorders. A majority of 92% of youths in residential care receive more than one psychiatric diagnosis (Connor, Doerfler, Toscano, Volungis, & Steingard, 2004). In addition, studies show that up to 90% of girls in compulsory residential care experienced various forms of interpersonal trauma (e.g. physical abuse, sexual abuse, violence or neglect) (Foy, Ritchie, & Conway, 2012; Hamerlynck et al., 2009; Smith, Leve, & Chamberlain, 2006). These experiences are related with the occurrence of mental health problems, such as depression, posttraumatic stress disorder (PTSD), anxiety, aggression, conduct problems, substance abuse, suicidal ideation and oppositional behavior (Kerig, Ward, Vanderzee, & Moeddel, 2009; Kilpatrick et al., 2000; Ruchkin, Henrich, Jones, Vermeiren, & Schwab-Stone, 2007; Wasserman & McReynolds, 2011).

Regardless of the heterogeneity in mental health problems among this population and the specific therapeutic treatment that each type of disorder requires, a common problem of these adolescents is that they often lack motivation for therapeutic treatment (Englebrecht, Peterson, Scherer, & Naccarato, 2008; Harder, Knorth, & Kalverboer, 2012; Van Binsbergen, 2003). Motivation can be defined as the fundamental to change consisting of three components; readiness, willingness and ability (Miller & Rollnick, 2002). Motivation can be intrinsic, arising from the individual because treatment is intrinsically rewarding. Conversely, motivation is extrinsic when behavior is driven by extrinsic pressure such as court mandate. Youths who are predominantly

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extrinsically motivated for treatment engage in treatment in order to earn external rewards such as privileges or to avoid sanctions. Even though extrinsic pressure can be useful in leading youths to compulsory residential care, therapeutic treatment in compulsory residential care may require intrinsic motivation to be effective (Miller & Rollnick, 2002).

Adolescents in compulsory residential care may suffer from low levels of treatment motivation as a result of the enforced admission into residential care. Moreover, low motivation may also have arisen from the adolescents' (mental health) problems and earlier negative care experiences. However, multiple studies show that treatment motivation is important for recruitment, engagement and retention in compulsory treatment (Karver, Handelsman, Fields, & Bickman, 2005; McMurran, 2009; Parhar, Wormith, Derkzen, & Beauregard, 2008; Rosenkranz, Henderson, Muller, & Goodman, 2012). Moreover, treatment motivation is considered to be a precondition for effective treatment (Miller & Rollnick, 2002; Olver, Stockdale, & Wormith, 2011). Consequently, enhancing adolescents' treatment motivation is an important goal in compulsory residential care. In the case of traumatic experiences that are highly prevalent among youngsters in compulsory residential care (e.g. Foy et al., 2012; Hamerlynck et al., 2009) it is key to enhance treatment motivation for specific evidence-based interventions, such as Trauma Focused Cognitive Behavioral Therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2012) or Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 1995, 2001). This is important because research extensively shows the negative effects of untreated trauma later in life (e.g., Felitti et al., 1998). Thus, youths in compulsory residential care show a high prevalence of various mental health problems, often co-occurring with traumatic experiences alongside lacking motivation to engage in therapeutic treatment.

Several social psychological theories have been developed in order to understand motivation. The two most dominant theories offering a framework for treatment motivation among forensic populations are the self-determination-theory (SDT; Deci & Ryan, 1985, 2000) and the transtheoretical model of change (TTM; Prochaska & DiClemente, 1986).

The SDT approaches the level of treatment motivation as a continuum ranging from fully externally regulated to completely intrinsically regulated or self-determined. According to this theory, motivation consists of three basic needs (autonomy, competence, and relatedness) that need to be fulfilled in order to become or stay intrinsically motivated. In other words, youths need to believe their engagement in therapy and resulting outcomes are self-determined or self-caused (autonomy), along with feeling effective and capable of performing tasks at varying levels of difficulty (competence), as well as feeling connected to, supported by, or cared for by other people (relatedness) (Deci & Ryan, 1985, 2000). Where the SDT conceptualizes treatment motivation as a gradual process from amotivation towards intrinsic motivation, the TTM describes treatment motivation as a longitudinal process across different stages along which motivation can be developed and improved: precontemplation, contemplation, preparation, action and maintenance (Prochaska & DiClemente, 1986). According to the TTM, interventions to change behavior are more effective if they are matched to each individual stage of change (Table 1). Since youths in compulsory residential care often show low levels of treatment motivation, interventions aiming to enhance treatment motivation of youths in compulsory residential care would preferably match the stage of precontemplation and contemplation. However, despite the extensive amount of research on the TTM and its prominence in practice, empirical evidence for the stages of change is lacking (Whitelaw, Baldwin, Bunton, & Flynn, 2000).

Both theories assume that motivation for treatment is a dynamic concept instead of a permanent state of mind (McMurran, 2009). However, although these theories shed a light on the basic needs of motivation and the stages of change needed to be assessed in order to enhance treatment motivation, they do not describe which interventions therapists can use to improve treatment motivation in juveniles, nor do they focus specifically on treatment motivation in a compulsory residential care setting. In the current review we examine factors that can be used to increase the motivation of youths in compulsory residential care. Thus, the research question of this study is: *What factors enhance treatment motivation among youths in compulsory residential care*?

**Table 1**
The Transtheoretical Model of Change, adapted from Prochaska and Diclemente (1986).

| Stage | Description |
|---|---|
| Precontemplation | The juvenile is not considering change. The juvenile is often unaware of the problem. |
| Contemplation | The juvenile is not prepared to take action at present, but is considering change. |
| Preparation | The juvenile is actively considering changing his or her behavior in the immediate future. |
| Action | The juvenile practices the desired behavior. |
| Maintenance | The juvenile works to sustain the behavior change. |

## 2. Method

### 2.1. Search strategy

A systematic search was performed by the third author (scientific information specialist). Fig. 1 provides a schematic overview of the systematic search strategy. The electronic databases PubMed, PsycINFO (via EBSCO) and Picarta were searched from inception to 4th March 2014 in order to identify relevant publications. Search terms related to youths, residential care and motivation were used. Even though a search for "motivation-enhancing interventions" would seem relevant, we chose to review all articles about motivation in order to prevent the exclusion of articles that contain relevant factors to enhance motivation that are not interventions. In PubMed we used both MeSH Terms and textwords. In PsycINFO search terms from the Thesaurus and textwords were used. Picarta was searched with free text terms in Dutch to retrieve Dutch-language publications. Duplicates were removed after each set of results was imported. The full search strategies for all the databases can be found in the Appendix A.

### 2.2. Selecting for eligibility

Retrieved studies were deemed eligible for inclusion if they were English- or Dutch-language studies. There were no restrictions for research design or the country of origin of publications. Articles published prior to 2000 were excluded because of the major changes in policy and organizations for compulsory residential care, and therefore study populations, that took place over the past decades. The first author reviewed titles and abstracts based on the following predefined inclusion criteria: 1) the studied population contains youths who are aged between 12 and 18 years old, 2) the study focuses on compulsory residential care, 3) the studied population is characterized by mental health problems and 4) the study examined treatment motivation. If inclusion criteria could not be sufficiently determined through the article's title and abstract, the content of the article was inspected to determine its relevance for inclusion. In case of unavailability of the full text, the article was excluded.

### 2.3. Selecting for relevance

After the first selection by the four inclusion criteria we excluded articles that, according to the abstract, did not answer the research question of the current review. The articles that met all four inclusion criteria did not necessarily discuss interventions or techniques to improve treatment motivation. For example, articles reporting the level of treatment motivation of youths in residential care were eligible, but did not answer the research question and were excluded during this phase. To ensure the accuracy of extraction and interpretation of articles, the second author independently screened the abstracts. Discrepancies in