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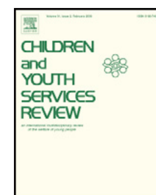

Detained girls' treatment engagement over time: The role of psychopathology and quality of life☆,☆☆

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ABSTRACT

Although treatment engagement is considered important to achieve positive outcomes, it is still not well known why some girls in detention are more engaged in treatment than others. This is the first study to examine to what extent psychopathology and self-perceived quality of life (QoL) are related to treatment engagement. Participants were 108 detained girls ($M_{age} = 16.21$) who completed standardized questionnaires about mental health problems and QoL, and were interviewed with a structured diagnostic interview to assess DSM-IV psychiatric disorders. One and two months after this baseline assessment, the girls reported how much they engaged in treatment. The results showed low levels of treatment engagement and no significant changes in treatment engagement over time. Overall, detained girls with internalizing disorders reported higher treatment engagement scores, while the reverse was true for girls with externalizing disorders. Regarding QoL, the girls with greater satisfaction about their physical and psychological health and about their environment reported higher treatment engagement, while the opposite was true for the domain of social relationships. Our findings emphasize the need for strength-based and motivational approaches and techniques in residential treatment programs for girls, in order to enable change.

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1. Introduction

Detained girls constitute a very troubled and vulnerable, yet understudied, group of adolescents who often display high levels of antisocial behavior (Lederman, Dakof, Larrea, & Li, 2004; Lenssen, Doreleijers, van Dijk, & Hartman, 2000) and persistent, co-morbid psychiatric disorders (Teplin, Welty, Abram, Dulcan, & Washburn, 2012; Van Damme, Colins, & Vanderplasschen, 2014; van der Molen, Krabbendam, Beekman, Doreleijers, & Jansen, 2013). Clinicians and researchers emphasize the need to organize effective treatment services for these girls (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Wasserman, McReynolds, Ko, Katz, & Carpenter, 2005). However, detained girls may not be willing to engage in treatment due to the coercive nature of juvenile justice settings (van der Helm, Beunk, Stams, & van der Laan, 2014), because their psychiatric state may hinder treatment engagement (van Binsbergen, Knorth, Klomp, & Meulman, 2001), or because they seem relatively satisfied with their quality of life (Van Damme, Colins, De Maeyer, Vermeiren, & Vanderplasschen, 2015). Clearly, engaging detained girls in treatment poses great challenges. Empirical evidence on treatment engagement in this population is still scarce though, which is surprising as treatment engagement is considered an important condition for achieving positive treatment outcomes (Shirk & Karver, 2003; Smith, Duffee, Steinke, Huang, & Larkin, 2008). The present study was designed to fill this void by scrutinizing treatment engagement in relation to psychopathology and self-perceived QoL among the understudied group of detained girls.

Treatment engagement is closely related to concepts like motivation, working alliance, collaboration and compliance (Cunningham, Duffee, Huang, Steinke, & Naccarato, 2009). Historically, treatment engagement has typically been defined in a narrow way by focusing on behavioral indicators, such as treatment attendance and retention. More recently, treatment engagement is increasingly defined as a multidimensional construct that not only includes observable behavior, but also attitudes, cognitions, and relational aspects. Based on work in juvenile residential treatment settings, three dimensions of treatment engagement have

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been disentangled: readiness/motivation to change (attitude), bond with staff (relationship), and collaboration on goals and tasks (behavior), with the former being considered to be at the 'heart' of treatment engagement (Cunningham et al., 2009; Englebrecht, Peterson, Scherer, & Naccarato, 2008). Prior work on treatment engagement also emphasized the potential relevance of including therapeutic engagement (cognition) in the definition of treatment engagement (Hawke, Hennen, & Gallione, 2005), as a particular index of someone's engagement in therapeutic activities, such as adopting problem-solving strategies or evaluating one's progress.

Also, treatment engagement is increasingly defined as a dynamic construct. This implies that an individual's treatment engagement can change, and that clinicians do not only need to instigate but also to monitor treatment engagement (Harder, Knorth, & Kalverboer, 2012; van Binsbergen et al., 2001). The few studies on the topic in detained adolescents indicated that poor treatment engagement is very common (Harder et al., 2012), especially among detained girls (Englebrecht et al., 2008). Although levels of treatment engagement may increase or decrease (Harder et al., 2012; van Binsbergen et al., 2001), it is largely unknown why some girls are or become more engaged in treatment than others. As shown below, there is some evidence that psychopathology and self-perceived QoL may help to explain differences in treatment engagement.

Prior work among in- and out-patient adolescent populations indicated that psychopathology can be negatively (Roedelof, Bongers, & van Nieuwenhuizen, 2013; van Binsbergen et al., 2001) and positively (Breda & Riemer, 2012; Leenarts, Hoeve, Van de Ven, Lodewijks, & Doreleijers, 2013) related to treatment engagement. More specifically, the direction of this relationship depends on the type of psychopathology and dimension of treatment engagement (Breda & Heflinger, 2004; Hawke et al., 2005). Adolescents, for instance, are more willing to address their internalizing problems (e.g., depression; Leenarts et al., 2013) than their externalizing problems (e.g., substance abuse; Roedelof et al., 2013). Research has also shown that adolescents with trauma-related symptoms (e.g., distrust, anxiety) may be reluctant to bond with staff (Greenwald, 2000), whereas adolescents with angriness and oppositional behavior may be reluctant to collaborate on goals and tasks (DiGiuseppe, Linscott, & Jilton, 1996).

A prior study among detained girls compared the girls' QoL scores with the QoL scores of the 12–20-year-olds from the World Health Organization (WHO)'s international field trial, consisting of boys and girls from the general population, as well as from in- and out-patient health care facilities (Van Damme et al., 2015). Detained girls perceive their QoL almost as good as the 12–20-year-olds from the WHO trial on the domains of physical health, social relationships and environment (Van Damme et al., 2015). As such, it can be argued that if detained girls do not perceive any burden themselves, they may lack problem recognition, and cannot be expected to engage in treatment only because 'non-significant' adults (e.g., clinicians, judges) think that they need treatment. Yet, this assumption contrasts the scant empirical research in adult clinical samples, indicating that QoL is positively related with hope, which — in turn — is important to increase levels of treatment engagement (Gudjonsson, Savona, Green, & Terry, 2011; Klag, Creed, & O'Callaghan, 2010).

Before highlighting the aims of the current study, it is important to describe how 'treatment' was defined and why we decided to define it as such. Because treatment in a youth detention center (YDC) consists of both an elementary program (offered to all girls) and a client-specific program (purposefully offered to address a concrete problem or need), the particular content of treatment was so diverse that we could not systemize all information. In line with prior work among detained minors (Colins, Hermans, & Vermeiren, 2012a, Colins et al., 2012b), we, therefore, perceived the stay in the YDC in itself as 'treatment'. Put differently, 'treatment' in this study refers to any particular combination of group-based services and services tailored to the needs of individual girls (e.g., in terms of psychiatric comorbidity, and low IQ; Abram, Teplin, McClelland, & Dulcan, 2003; Kroll et al., 2002). Because well-circumscribed treatment programs are rarely available in youth detention facilities all over the world (Colins et al., 2010; Desai et al., 2006), our broad definition increases the ecological validity of studying treatment engagement among detained adolescents and facilitates comparison with prior work (Simpson, Frick, Kahn, & Evans, 2013).

The overall aim of the present study was to examine how 'baseline levels of psychopathology and QoL at the start of detention (T0)' and 'time from T1 until T2' influenced 'treatment engagement at T1 and T2' (i.e., one and two months after the baseline assessment of psychopathology and QoL), after controlling for socio-demographic and detention-related covariates. We included multiple dimensions of treatment engagement (i.e., readiness to change, bond with the staff, collaboration on goals and tasks, and therapeutic engagement), different types of psychopathology (i.e., internalizing as well as externalizing problems/disorders), and multiple domains of QoL (i.e., physical health, psychological health, social relationships, environment). The selection of socio-demographic and detention-related covariates was based on prior indications that age (Fraynt et al., 2014), origin (Leenarts et al., 2013), socioeconomic status (SES; de Haan, Boon, de Jong, Hoeve, & Vermeiren, 2013), family situation (Barnett et al., 2002), school attendance (Lee et al., 2012), detention history (Broome, Joe, & Simpson, 2001) and time in detention (Harder et al., 2012; van Binsbergen et al., 2001) are likely to influence youngsters' treatment engagement.

2. Method

2.1. Setting

The study was conducted in an all-girl YDC, being the only one in Flanders, Belgium. Girls are referred to a YDC by a juvenile judge when charged with a criminal offense or because of a problematic educational situation (e.g., truancy, running away, aggression, or prostitution). Placement in a YDC represents the most severe measure the youth court can impose. Only girls demonstrating the most severe criminal and behavioral problems are assigned to a YDC. The institution has both a restrictive and a rehabilitative function. The infrastructure (e.g., high fences, barred windows, closed doors, isolation rooms), the rigorous regime (e.g., a clearly structured day schedule, strict rules, limited and scheduled contact with family members), and the constant supervision and monitoring by the staff, are meant to ensure a safe environment and to protect the youngsters and society. The educational, pedagogical, and therapeutic program aim to promote youngsters' resocialization and reintegration (Agentschap Jongerenwelzijn, 2011).

2.2. Participants

Participants were 108 girls who were placed in the above described YDC. Girls were eligible to participate if they met the following criteria: (i) being adjudicated to be placed in the YDC for at least 1 month; (ii) having sufficient knowledge of Dutch; and (iii) having sufficient cognitive abilities to read and/or understand the questions. The first criterion was set to provide sufficient time to approach and assess the girls. Between February 2012 and June 2014, 215 girls entered the YDC. In total, 46 girls were excluded based on the above criteria: 11 girls were adjudicated to be placed in a YDC for less than one month, 28 girls did not have sufficient knowledge of Dutch, and 7 girls did not have sufficient cognitive abilities. The remaining 169 girls were eligible to participate. Two girls could not be approached due to acute psychiatric crisis, and 20 girls and/or their parents refused participation, resulting in a baseline (T0) sample of 147 girls (participation rate = 87%). Of this sample, 9 girls and/or their parents refused to participate at T1 and T2, and 30 girls left the YDC before T2, resulting in a final sample of 108 girls (i.e., 73% of the baseline sample).

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