



Service use patterns and mental health symptoms among adolescents exposed to multiple types of trauma



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ARTICLE INFO

Article history:

Available online 16 January 2015

Keywords:

Adolescence
Mental health
Trauma
Service use

ABSTRACT

Few studies have explored how different trauma experiences influence service use. This study explores patterns of service use amongst 6483 adolescents aged between 13 and 18, and examines if such patterns are associated with trauma profiles, demographic variables, and mental health disorders. Data from the National Comorbidity Survey – Adolescent Supplement (NCS-A) were used. A latent class analysis identified four adolescent trauma sub-groups: ‘high risk’, ‘sexual risk’ ‘non-sexual risk’, and ‘low risk’. Regression analysis was used to explore the relationship between service use, trauma classes, and mental health outcomes. Significant relationships were found between service use, trauma sub-groups, demographics and mental health outcomes. Despite the effectiveness of mental health services, only a minority of adolescents exposed to different traumas use such resources. However, this study may go some way towards providing an understanding of the trauma backgrounds, demographic predictors and mental health disorders associated with service use.

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Introduction

Over the last 3 decades usage rates for mental health services have been gradually increasing. For example, in the United States in 1987 less than one person in every hundred (0.73) received outpatient treatment for depression, increasing in 1997 to 2.33 (Olfson et al., 2002), in 1998 to 2.37, and 2.88 in 2007 (Marcus & Olfson, 2010). That said, despite these increases, some have concluded that the uptake of mental health services remains relatively low. The efficacy and availability of mental health services aimed at treating adolescents has been well documented, with better outcomes found for those who are treated against those who go untreated (Weisz & Kazdin, 2010). However, despite their effectiveness and availability, evidence suggests that only as few as a third of adolescents with mental health disorders receive any form of treatment (Merikangas et al., 2011). And for those who begin appropriate treatment, high levels of missed appointments and therapy terminated prematurely, represent significant barriers to the efficacy of such services (Gearing, Schwalbe, & Short, 2012; Gopalan et al., 2010). For example, in a sample of over 500 ethnically diverse children exposed to trauma, premature therapy termination was found to be significantly high, particularly amongst African-Americans (Fraynt et al., 2014). For those who do not use mental health services, evidence has consistently shown ‘attitudes’ to be one of the more significant barriers in preventing them from doing so (Mackenzie, Erickson, Deane, & Wright, 2014). Negative attitudes towards mental health services have

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been found to be significantly higher among young adults (15–24 years), with 35% and 25% of younger Americans and Canadians respectively expressing such views (Jagdeo, Cox, Stein, & Sareen, 2009).

In the case of physical disorders it is widely accepted that the population can benefit from programmes directed at increasing knowledge of symptoms, interventions and treatments. Despite this, improving negative attitudes towards mental health disorders and treatments has received less attention. Research has shown that it is possible to improve such attitudes about mental health disorders using ‘mental health literacy’ programmes, aimed at different cohorts (Jorm, 2012). For adolescent populations school programmes have proved effective, with an increase in recognising ‘primary healthcare’ as a suitable resource, with females and older adolescents demonstrating lower levels of negativity (Skre et al., 2013).

In addition to such ‘mental health literacy’ programmes, there is agreement that usage rates could be improved if mental health services were to move away from the more traditional psychiatric services provided by institutions to modern, community-based forms of treatment (de Almeida & Killaspy, 2011). This shift would make services more accessible to all (Killaspy, 2007), would help protect human rights and prevent stigmatisation of using such services (Thornicroft & Tansella, 2003), and would, on the whole, be more cost effective (Roberts, Cumming, & Nelson, 2005). While all these are essential to providing modern mental health services, of perhaps greater importance are the outcomes such a shift would have for service users, with evidence showing adherence to treatment, symptom improvement, and better subjective quality of life (Bond, Drake, Mueser, & Latimer, 2001).

Mental health services aimed at adolescents need to be considered differently than those for adults due to their unique developmental issues, differences in beliefs and values, and influences exerted on them by their peers (Winters, 1999). With this in mind resources available for adolescents, as with those for adults, fall into two main categories; psychosocial and pharmacological (US Department of Health and Human Services, 1999, chap. 2). Psychosocial services can include treatment by mental health professionals, such as psychotherapy. Pharmacological services provide appropriate disorder-specific medications (e.g. anti-depressants, anti-psychotics), and can be offered separately or as part of a psychosocial combined programme. Adolescents also have access to a range of service types in addition to the traditional mental health treatments. It has long been recognised that schools play a key role in the recognition and treatment of mental disorders amongst children and adolescents (Hoagwood & Erwin, 1997). A role also reflected in past service use rates for children, with 70% of those who have made use of mental health services doing so within schools (Burns et al., 1995). Burns et al. (1995) also showed that of those using mental health services 40% used mental health specialty services (e.g. seeing a psychiatrist), and just 4% used another service type available to adolescents; juvenile justice services. U.S. adolescents who have mental disorders (Grisso, 2008) and extensive trauma histories (Ford & Blaustein, 2013) now make up a significant proportion of juvenile offenders, resulting in mental health services being offered within the juvenile justice system. However, the presence of such a range of resources is immaterial if only a third of adolescents with mental health issues access them (Merikangas, He, Brody, et al., 2010; Merikangas, He, Burstein, et al., 2010) and at usage rates as low as those found in adult populations (Wang et al., 2005). It is therefore vital that studies examine not only rates of service use, but also patterns of utilisation; asking what is it that causes those in the adolescent population to seek help in the first place.

There is an increasing amount of research that suggests trauma exposure is all too common amongst children and adolescents (Fairbank, 2008), with repeated exposure to single and multiple traumas highly prevalent (Finkelhor, Ormrod, & Turner, 2007; Ford, Elhai, Connor, & Frueh, 2010). Common trauma experiences in adolescence include the death of a loved one, threats of violence and witnessing injury and death (Briggs et al., 2013; Shevlin & Elklit, 2008). Over the decades research has shown that adolescent trauma holds its own specific risks for poor psychological outcomes, with various sequelae such as depression, personality disorders and PTSD identified (Carr & Francis, 2009; Gibb, Chelminski, & Zimmerman, 2007; Green et al., 2010; Guadiano & Zimmerman, 2010; Mullen, Walton, Romans-Clarkson, & Herbison, 1988). A natural assumption to make, and one supported unequivocally in research, is that a link exists between traumatic experiences and mental health service use (Briggs et al., 2013; Elhai, North, & Frueh, 2005).

Previous studies in the area of mental health service use have several limitations. First, the mental health service use and traumatic experiences link notwithstanding (Briggs et al., 2013; Elhai et al., 2005); more data is needed with regards to this link within the adolescent population. Second, the data that do exist are overflowing with studies exploring the link between service use and specific types of trauma, particularly childhood sexual and physical abuse (Bonomi et al., 2008; Chartier, Walker, & Naimark, 2007; Tang et al., 2006). Research is needed to explore patterns of service use and all types of interpersonal and non-interpersonal trauma profiles. Third, there is a lack of trauma research where a person-centred approach is taken, particularly within this age group (Ford et al., 2010; Shevlin & Elklit, 2008), using analytical methods such as latent class analysis to identify those who share similar trauma profiles and to then investigate patterns of service use amongst these adolescent subgroups. And fourth, a limited number of studies explore parent–adolescent agreement (concordance) on reports of service use (Waters, Stewart-Brown, & Fitzpatrick, 2003; Williams, Lindsey, & Joe, 2011). Parent and adolescent concordance in this area plays a pivotal role in forming a family's service use continuum (Williams et al., 2011). Discordance on matters such as reporting the extent of an adolescents emotional and behavioural problems, identifying treatment areas (Yeh & Weisz, 2001), and treatment receptiveness (Bussing, Zima, Mason, Porter, & Garvan, 2011) can eventually lead to an increased risk of poorer treatment outcomes (Ferdinand, van der Ende, & Verhulst, 2006).

In addressing previous limitations the goals of this study were to 1) identify adolescent subgroups who share similar trauma experiences; 2) explore concordance between adolescent self-report and parent reports on service use; 3) examine service use patterns amongst these adolescent subgroups; and 4) identify sociodemographic correlates of service use, trauma groups, and mental health disorders.

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