Chapter 7

Summary and general discussion
Research aims

The central aim of this dissertation was twofold. The first aim was to examine the relationships between a history of exposure to childhood maltreatment, mental health problems and delinquency in youths in compulsory residential care. This aim was addressed by studying, cross-sectionally, the relationships between exposure to early onset interpersonal trauma, symptoms of PTSD/symptoms of complex PTSD and other mental health problems (e.g., depression, anxiety, suicidal ideation) in a sample of girls recruited from three compulsory residential treatment facilities in the Netherlands. By also examining the associations between trauma history and juvenile (sexual) offending in a sample of youths (boys and girls) from juvenile justice sites (57 sites in 18 states in the United States of America), the pathways between childhood maltreatment and antisocial or delinquent behavior was explored. The second aim was to investigate the best treatment choice for youths in compulsory residential care. To address this goal, first, the existent literature of evidence-based treatments for children exposed to childhood maltreatment was systematically reviewed. Second, as none of the interventions available in the Netherlands focuses on the behavioral problems associated with chronic trauma in girls; the theoretical background and design of a stabilization training aimed at reducing problematic behavior in this vulnerable group was described.

As youths often enter compulsory residential facilities hardly aware of their problems and as they are resistant to change, a lack of motivation for treatment is common among youths in these facilities (Harder, Knorth & Kalverboer, 2012; VanBinsbergen, 2003). Therefore, the relationships between childhood maltreatment, trauma-related symptoms, motivation for treatment, and (time to) dropout in girls in compulsory residential facilities were examined.

This chapter addresses the two research aims and presents an overview of the key findings described in the previous chapters. Strength and limitations of this dissertation will also be addressed, as well as implications for treatment approaches. Lastly, directions for future research will be discussed.

Summary of key findings

Five studies were conducted for the purpose of this thesis. The first study (chapter 2) found two relationships between early onset interpersonal trauma and mental health problems, one in which exposure to early onset interpersonal trauma was directly related to mental health problems and one in which symptoms of PTSD mediated the relationship between exposure to early onset interpersonal trauma and mental health problems. However, symptoms of complex PTSD did not significantly
mediate such a relationship. The second study (chapter 3), demonstrated that a number of demographics predicted motivation for treatment. Also, it was found that emotional abuse contributed to motivation for treatment. Furthermore, consistent with previous research (DiGiuseppe, Linscott, & Jilton, 1996) internalizing symptoms (anxiety, depression and dissociation) significantly predicted the level of distress, and dissociation predicted girls’ doubts about treatment. The second study found, against our expectations, no significant predictors for (time to) dropout of compulsory residential care. The third study (chapter 4) showed that, compared to nonsexual interpersonal offenders, sexual offenders were significantly less likely to be female, less likely to be African American, or less likely to meet criteria for a substance use disorder. In addition, sexual offenders were significantly more likely to have a lifetime history of a suicide attempt and a history of sexual victimization. A set of demographic and diagnostic characteristics contributed significantly to sexual offending, as did a history of sexual victimization. Study four (chapter 5), describes psychotherapeutic treatments which focus on a broad range (e.g., PTSD, anxiety, suicidal ideation, substance abuse, aggressive and violent behavior) of psychopathological outcomes following childhood maltreatment. A total of 33 studies published between 2000 and 2012 satisfied the inclusionary criteria and were included. These studies dealt with various kinds of samples, from sexually abused and maltreated children in child psychiatric outpatient clinics or in foster care to traumatized incarcerated boys. A total of 27 studies evaluated psychotherapeutic treatments which used trauma focused cognitive, behavioral or cognitive-behavioral techniques; only two studies evaluated trauma specific treatments for children and adolescents with comorbid aggressive/violent behavior; and four studies evaluated psychotherapeutic treatments that predominantly focused on other mental health problems than PTSD. Study five (chapter 6), describes the theoretical background and design of a recently developed training (Stapstenen) aimed at reducing problematic behavior in girls in compulsory residential care. Over 80% of all girls who are committed to compulsory residential care because of serious behavioral problems have experienced chronic trauma in their past. As these behavioral problems are often accompanied by co-morbid disorders, interventions are needed which address the link between behavioral problems/co-morbid disorders and histories of interpersonal victimization.

Conclusion and discussion

The results presented in this thesis expand current knowledge on the relationships between exposure to childhood maltreatment and problematic behavior in youths in compulsory residential care in two essential ways. Results of this thesis showed that early onset of interpersonal trauma was related to the emergence of mental
health problems in several ways. Prior research has already demonstrated that children exposed to interpersonal trauma during their first years of life may show the most negative effects in psychological functioning (Keiley, Howe, Dodge, Bates & Pettit, 2001; Lieberman, Chu, Van Horn & Harris, 2011). However, these relationships have – to our knowledge – not been investigated extensively in girls in compulsory residential care. Also, this thesis paid attention to the concept complex PTSD. Complex PTSD describes a cluster of impairments in predominantly affective and interpersonal self-regulation (Cloitre, et al., 2009; Cook et al., 2005; Van der Kolk, 2005). A risk factor found to be associated with symptoms of complex PTSD is early onset of interpersonal trauma (Van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005). Therefore, this thesis expanded on this topic by investigating the relationships between early onset interpersonal trauma, symptoms of (complex) PTSD, and other mental health problems.

An overall conclusion that emerged from our studies is that youths in compulsory residential care have been exposed to complicated traumatic histories and show a diversity of trauma-related psychopathology (e.g., avoidance versus arousal, symptoms of PTSD versus complex PTSD, internalizing versus externalizing symptoms), therefore clinicians – in selecting treatment for this vulnerable group – should be guided by this complicated pattern.

It is noteworthy with regard to the construct complex PTSD, that the current debate about a new diagnosis for complex PTSD (D’Andrea, Ford, Stolbach, Spinazzola & Van der Kolk, 2012; Resick et al., 2012) has brought attention to broadening current diagnostic conceptualizations for chronically victimized youths. However, the research that addresses the sequelae of complex PTSD is still in an early phase (Resick et al., 2012). Therefore, perhaps it is too early to make a decision about whether or not to recommend a separate diagnosis for complex PTSD in the DSM-5.

However, as with any type of psychological disorder, the diagnostic criteria is a starting point in defining the treatment process; complex PTSD has certain symptoms which are different from the typical symptoms of PTSD (e.g., distrust, low self-perception, and symptoms of a disturbed attachment; D’Andrea et al., 2012). These symptoms have been known to complicate treatment; for example, children are extremely distrustful towards their therapists, are not able to regulate their behavior, or children are not able to talk about their victimization (Lindauer, 2012). Although Resick et al. (2012) state that the construct complex PTSD has overlapping symptoms with other psychiatric disorders (e.g., depressive disorder, borderline personality disorder) each diagnosis manifests a unique constellation of symptoms, and this constellation should guide the decision about whether or not to recommend a separate diagnosis for complex PTSD.
Implications and recommendations for clinical practice and treatment approaches

First, gender-specific interventions are warranted in which the specific needs of girls and boys are addressed (Nooner et al., 2012). Gender differences have been demonstrated in the types of interpersonal trauma experienced (e.g., girls are more likely than boys to experience sexual and emotional abuse) (Gwadz, Nish, Leonard & Strauss, 2007). Additionally, it has been demonstrated that girls react differently to exposure to interpersonal trauma than boys (Kerig, Ward, Vanderzee & Moeddel, 2009; Maschi, Morgen, Bradley & Hatcher, 2008). For example, in girls, the risk of developing PTSD is higher and symptoms of depression and anxiety are more likely to co-occur with PTSD than in boys (Gwadz et al., 2007). Second, as mentioned above, clinicians should pay attention to the diversity in trauma-related psychopathology following interpersonal trauma (e.g., avoidance versus arousal, symptoms of PTSD versus complex PTSD, internalizing versus externalizing symptoms). For example, the phenomenological differences between symptoms of PTSD and complex PTSD should guide treatment selection for youths in compulsory residential care. In treating symptoms of PTSD, treatment implies the focus on the impact of the traumatic events and the processing of the traumatic memories (Cohen, Mannarino, Murray & Igelman, 2006). Whereas when treating youths with symptoms of complex PTSD in compulsory residential care, treatment should focus first on establishing safety and competence, dealing with trauma re-enactment (e.g., youths may react to therapists/teachers or protective interventions with aggressive, fearful or uncontrolled emotional reactions, or avoidance as they tend to see them as unsafe), and integration and physical mastery, before moving on to processing the traumatic memories (Van der Kolk, 2005). Third, adolescents with histories of interpersonal trauma are likely to have impairments in regulating their own behavior; and thereby often acting defensible and oppositional towards staff and/or the system in the secured facility. Considering the above mentioned and taking into account a developmental perspective, adolescents in compulsory residential settings may benefit and learn more from the role-model function of staff than being told or sometimes coerced by staff how to behave (DeSocio, Bowllan & Staschak, 1997). It is also crucial that staff are trained professionally in recognizing and anticipating trauma-related triggers for aggressive, avoidant, dissociated, or other problematic stress reactions in this vulnerable group. Furthermore, staff should also receive professional support and education about how to manage their own reactions and self-regulation, which may get out of balance sometimes due to defensive or aggressive behavior of the youths (Ford, Chapman & Cruise, 2012). Finally, particular attention should be given to juveniles who commit sex offences; as they represent a specific group in the juvenile justice system. Given the heterogeneity within this group (in e.g., history of interpersonal trauma, type of offence and mental health problems)
(Bailey, 2003), clinicians and juvenile justice should address this heterogeneity and should focus on their specific needs in choosing the most appropriate treatment for these youths to prevent them from future sexual reoffending and to treat their mental health problems (Ford et al., 2012).

Strengths and limitations of the studies in this dissertation

This dissertation has a clear and important strength, this thesis presents relevant implications and recommendations for clinical practice (see previous section). Successfully carrying out new implications and recommendations in compulsory residential settings can be very challenging (Van Yperen & Veerman, 2008). One reason may be that scientific researchers introduce pre-developed implications or recommendations to a system of care and ask clinicians to implement them (Blevins, Farmer, Edlund, Sullivan & Kirchner, 2010). This thesis therefore was a clinician-driven research project, in which clinicians cooperated and advised the scientific researchers (e.g., advice on development of Stapstenen, how to inform participating staff/clinicians about study results) and thereby increasing the likelihood of an effective translation of the implications and recommendations to clinical practice.

Despite the above mentioned strength of this thesis, a number of limitations of the studies in this dissertation needs to be addressed. First, the empirical studies in this dissertation relied on youths’ self-reports of their histories of interpersonal trauma and mental health problems. There is an ongoing debate about the use of self-report studies in juvenile justice populations, as youths may over- or under-report their problems, their memory may limit the information that can be captured (Snyder & Sickmund, 2006). Nevertheless, the empirical studies in this thesis relied on this method of data gathering as the use of self-report has also a number of advantages (e.g., less time consuming, cost-effective, non-invasive); in addition, it has been demonstrated that the self-reports of youths in juvenile justice settings are as reliable as those of adolescents in community and clinical samples (Kenny & Grant, 2007). Second, as the empirical studies of this thesis were characterized by a cross-sectional design, conclusions about the development of mental health problems and delinquent behavior among youths in compulsory residential facilities should be interpreted with caution. More explicitly, as exposure to interpersonal trauma and the assessed outcomes were measured simultaneously, it may be difficult to determine whether the exposure proceeded or followed the assessed outcome. Third, the studies did not take into account victimization that may have occurred during incarceration. Whereas, violent, destructive, and/or hostile behavior among youths in compulsory residential facilities is considered to be a serious problem; it
is considered to create an unsafe environment, and consequently may interfere with
treatment and rehabilitative goals (Van der Helm, Stams, Van Genabeek & Van der
Laan, 2012).

Directions for future research

Several recommendations for research can be made to optimize treatment efforts of
youths in compulsory residential care.

Future studies should focus on protective factors in victimized youths in
compulsory residential care. Protective factors may lessen the likelihood of
revictimization, reoffending, and psychopathology. Moreover, these factors may
exist at multiple levels (e.g., individual, interpersonal, neighborhood) (Menard,
2002) and may be of great importance in treatment and preventive work with this
youths.

Furthermore, although the systematic review (chapter 5) in this thesis evaluated
the effectiveness of evidence-based treatments for girls and boys exposed to
childhood maltreatment, future research should focus on the evaluation of gender
differences in response to evidence-based treatments.

Finally, longitudinal studies are needed to examine the efficacy of a phase-
oriented treatment approach (chapter 5 and 6) for youths exposed to chronic
interpersonal trauma.