Coping And Depression In Residentially Placed Female Adolescents

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COPING AND DEPRESSION IN RESIDENTIALLY PLACED
FEMALE ADOLESCENTS

BY
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for the Degree of Doctor of Philosophy
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ABSTRACT

Coping and Depression in Residually Placed Female Adolescents

Mary L. Hebert, PhD

This study explored coping style and depression among residually placed female adolescents. In addition it sought to address the relationship of these variables to multiple out-of-home placements, a history of physical and/or sexual abuse, and life stress within the context of developmental theory. This study represents an extension of the research for the residually placed female adolescent, a greatly under explored clinical population in the literature. Descriptive information regarding age, age of first placement, depression, stress, and percentage of physical and/or sexual abuse are presented. Historically, research regarding this specific population has focused on outcome data and program analysis. This study sought to focus on the understanding of the clinical characteristics of adolescent females in residential care.

A sample of 28 residents consented to complete the measures involved in the study. These included the Millon Adolescent Clinical Inventory, Life Events Questionnaire, and Coping Response Inventory - Youth form. Multiple Regression Analysis, t-tests, and Mann Whitney U Tests were
included in the analysis of the data. The findings generated support for the use of both approach and avoidant styles of coping simultaneously during times of stress. In addition, depression and avoidant coping styles were found to be positively correlated. This finding is consistent with other research and clinical theory that poor coping skills can facilitate depression. This research also identified differences between the group of residents with histories of multiple forms of abuse versus those who had experienced singular forms of abuse or no abuse histories. Generally, the multiply abused group of residents, had greater difficulty accessing more positive adaptive coping strategies. While the entire sample reported high levels of life stress, the multiply abused group demonstrated yet higher scores in regards to life stress. These findings provide consistency with other research regarding the prevalence of physical and sexual abuse, depression, stress, and multiple placement histories for adolescent females in residential care. In addition to this descriptive data, it provides support to other research regarding the interaction of depression with coping styles amongst this population.
Dedication

I would like to extend my sincerest appreciation first and foremost to the young ladies who so graciously and eagerly agreed to participate in this study. Your time, willingness, and enthusiasm for the topic of this study was greatly appreciated. Without you it would not have been possible. I thank you for sharing your precious thoughts and feelings with me and I wish you all the very best in your futures. In addition, I would like to thank the parents of the residents who participated. It was the few of you amongst the many who were asked and supported their child's willingness to participate. I greatly appreciate your support. Each one of you made this study possible for me. Thank you.

I would also like to thank the programs that participated in this study; for their willingness to 'let me in' and make room for my research amidst the hectic and demanding schedules guaranteed in residential programs. Thank you to the directors, therapists, teachers, and secretaries...Your assistance was so very much appreciated particularly in light of the enormous amount of red tape involved in gaining access to facilities. Your common interest and enthusiasm for this research and for these special young women was wonderful. I thank you.

Many thanks to my committee members, my mentor Cheryl Thompson-Sard, PhD, Shawn Utsey, PhD, Sylvia Pollock, PhD, and Angela Raimo, PhD. I would like to thank Cheryl and Sylvia in particular for their thoroughness, critical feedback, and constant support of a study that was difficult to pull off given the many challenges acquiring a sample. Thank you for believing in the inherent value of my topic. You are both tops.

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Thank you to my friends who know the challenges of accomplishing this task and provided their friendship, humor, and support, including Dr. Terri Siclare, Dr. Cathy Bladt, and Dr. Gary Matloff. A special thanks to a dear
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To my three beautiful children Elizabeth, Paul Jr., and Thomas, you fill my life with sheer joy every single day. I am so completely blessed to be your mommy. I cherish you all.

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CHAPTER I
INTRODUCTION

Each year thousands of children are placed outside of their home of origin into alternative living arrangements. In 1991, the Bureau of the Census issued a population report regarding the diverse living arrangements of children. It was reported that 195,000 children were living in foster homes. Meyers (1997) reported a 21% increase in out of home placements from 1995 to 1999, estimating that one half million children would be in placement as of the year 2000. Frequently, the children involved with foster care have been removed from their homes due to neglect, or instances of physical, sexual, and/or emotional abuse. These are experiences that are known to affect healthy emotional development. The National Center on Child Abuse and Neglect (NCCAN) estimated that 3 million children were reported as alleged victims of child abuse in 1995. Of these, one million were documented as cases of abuse and/or neglect. Due to state wide differences with regard to how abuse and neglect are defined, a range of 13-23 U.S. children per 1,000 were determined to be victims of maltreatment. Specifically, 52% experienced neglect, 25% physical abuse, 13% sexual abuse, 5% emotional abuse, and 23% were classified as having experienced 'other' forms of maltreatment. Meyers (1997) calculated that 42 per 1,000 children from the general population have experienced abuse of some form.

An estimated 2.3 per 1,000 of the victims of maltreatment were removed from their homes due to abuse in 1995. It is not an unusual occurrence for these placements to become disrupted and for children to experience multiple
placements and subsequently, multiple caregivers. In 1995, it is estimated that 1
in 3 children in foster care had experienced a prior foster care placement
(Meyers, 1997).

It is estimated that over 50,000 children and adolescents are treated in
residential facilities each year (Lyman & Campbell, 1996). It is also estimated
that between 15 - 30% of the out of home care population reside in residential
care as opposed to foster care (Whittaker, 2000). There is a strong potential for
both a positive and negative impact of the residential experience on the youth
they serve. Whittaker (2000) discussed the history of the development of
residential care, noting the waning interest and faith in its utility, in lieu of
services termed as 'wrap around', therapeutic foster care, and intensive family
interventions. In light of weak outcome research results from these services and
the increasingly troubled youth that are in need of intensive services, there has
been a renewed interest in residential care and development of residential care
theory and practice. While there may be clinical interest, and need for the
services residential care has to offer, the concerns remain regarding the closing
and downsizing of facilities due to cost-effectiveness. Dyer (Conference
attended, March 1999) cited a 20 - 32% rate of return to foster care after the
experience of intensive services and return to birth parents. The need to
understand the residential population, and develop treatment strategies remains
strong.

Bowlby (1969) states that the individual’s basis for socio-emotional
development lies in his/her relationship with a primary caregiver. Indeed, this
relationship defines the way a child approaches the environment, interacts with
others, and resolves subsequent developmental tasks. Those individuals whose
emotional needs have not been met through this primary attachment, develop a
view of the world as "comfortless and unpredictable; and they respond either by
shrinking from it or doing battle with it" (Bowlby, 1973, p. 208). This ultimately places them at risk for the formation of psychopathology.

A stable environment is seen as essential to healthy emotional development. It has been found that a stable home environment and family relationships enhance an adolescent's identity development, as well as establishes a secure sense of attachment. Multiple placements have been found to be the variable most frequently associated with negative outcomes for children in out-of-home placements (Penzero & Lein, 1993). Developmental theory presumes that the experience of one phase of development may affect another phase at a later point in development. Erikson (1968) addresses the adolescent's psychosocial crisis of ego identity versus identity diffusion. There are a great many psychosocial tasks during this phase of development. The affectual and social demands are many including peer, family, cognitive, as well as physical changes. Adolescents with a history such as that of the residential adolescent population, face particular challenges during this phase, as the foundation from earlier stages have been poorly formed. Adolescence is a critical phase of development filled with anxiety, change, and decision-making. Should a child experience maltreatment as well as multiple disruptions in his/her home environment and primary caregivers, then it follows that the developmental tasks of this critical phase of development will be that much more difficult to master and resolve effectively.

Successful negotiation of this phase of development is achieved through adaptation to the demands of reality and effective coping with the stressors. This requires cognitive and behavioral resources to either decrease demands, resolve them or redefine them to make them more manageable. The purpose of adaptive coping is to increase resources for dealing with stressors and manage the tension experienced internally as a result of external stressors.
Research has demonstrated that a chronic course of disrupted placements leads to patterns of alienation and difficulties forming subsequent trusting relationships (McIntyre, 1991). This pattern of disrupted placements compromise the resources available in the environment. The ability to cope with adverse experiences has been found to be foundational for the development and maintenance of close relationships (Brennan, 1993). Residential youth are challenged by their ability to cope with not only past adversity, but current stressors which confront them. Consequently, the implications for these children's social adaptation are alarming. Unemployment, school failure, relationship problems, teen parenthood, homelessness, and incarceration have all been associated with a history of multiple placements.

It has been documented in the literature that children with a developmental profile inclusive of abuse and multiple placements, experience an increased risk for depression (Toth & Cicchetti, 1996). Less researched is the impact multiple placements have on cognitive processes, the ability to reason, and implement coping skills when confronted with stressors (Kenny, Moilanen, Lomax & Brabeck, 1993). Residential youth in particular have been found to experience increased levels of depression. A history of abuse poses a significant risk for mental health problems (Spaccarelli, 1994). Cicchetti and Rizley (1981) state that child maltreatment inherently involves factors that threaten healthy, adaptive developmental outcomes. Of concern is the increased risk for depression that is reported among children with a history of multiple placements and maltreatment, as well as the impairment of adaptive coping skills. In essence, the stresses inherent in these experiences could lead to troublesome responses which in turn leads to further problems and psychopathology (Spaccarelli, 1994). Internalizing problems, such as depression and anxiety, as well as externalizing problems, such as substance abuse, as
well as interpersonal conflicts, such as academic, and behavioral acting out are all potential difficulties these children could face. Additionally, among the general population, adolescent girls experience an increased risk for depression beginning at 15 years of age. Differences in the experience of depressive mood between males and females begin to emerge at 13 to 14 years of age. Girls are estimated to be at twice the risk for depression when compared with their male counterparts. This risk continues throughout the life span (Nolen-Hoeksema & Gigas, 1994). The adolescent girls in this study possess particular risk factors for mental health difficulties given their histories of maltreatment, multiple placements and their sex.

A relationship has been established between the occurrence of stressful events and negative affects (Tesser & Beach, 1998). Given the multiple stressors residential youth have experienced, it is postulated that they are at risk for depression and have hampered coping skills. It has been reported that those who have experienced more stressful life events show a tendency to adapt less well (Moos, 1995). Further, those who have experienced such stress also demonstrate less successful psychological adaptation and an increased risk for depression. Research regarding the resiliency of maltreated children versus non-maltreated children indicates that the maltreated group demonstrate less resilience and less successful adaptation over time (Cicchetti & Rogosch, 1997). Crittenden and Ainsworth (1989) stress the impact of one's experience with attachment figures on the perception of what is threatening and on patterns of coping responses.

This study addresses the experience of a chaotic history inclusive of out of home placements and abuse, and the relationship to depression and coping ability. An inherent precursor and outgrowth of this history of abuse and placement instability are inadequate significant relationships with significant
caregivers. Developmental theory, specifically pertaining to attachment, proposes that the foundation for resilience in the face of adversity or stress is laid down by one's early relationships with parent figures (Brennan, 1993). Erikson presents the importance of the ego's ability to successfully integrate organismic demands and social interactions throughout the course of development (Erikson, 1968). In Erikson's epigenetic model of development, the initial conflict is basic trust versus mistrust. This period of development lays out the opportunity for the integration of a secure and trusting relationship with a significant other. If this stage is successfully negotiated, then competency emerges from a secure and trusting attachment base. It is proposed that the population in this study which is understood to have had disrupted attachments and impaired experiences of trust in relationships with others, have experienced deviations from an average expectable developmental course. Subsequently, they are at risk for depression and a compromised ability to cope effectively with stress.

Brennan (1993) asserts that emotional health is only possible when the person is able to establish healthy social relationships. A healthy affective and cognitive life is key to establishing such relationships. Consistent significant relationships serve as the precursor to ego development. Chronic failed placements from parent/foster parent-child relationships places youth at risk for disrupted attachment relationships (McIntyre, 1991). Repeated disruptions in the parent-child connection takes a toll on the child's sense of emotional well being and sense of self-worth (Cooper, Peterson, & Meir, 1987). Abused children with a history of multiple placements are at social-emotional risk for impaired relationship formation, aggressive behavior, withdrawal, and hypersensitivity to cues in their environment signaling danger. These factors can inhibit the formation of healthy attachments to adults and peers (Cooper, Peterson, & Meir,
For residential youth it is proposed that their histories of maltreatment and the absence of a 'facilitating environment' have contributed to deviation from a secure base, leaving these adolescents prone to depression, difficulty managing, and difficulty responding to conflict and anxiety; and consequently, difficulty accessing appropriate and effective internal and external resources. It has been found that the ability to relate positively in an interpersonal context may buffer the negative impact of the history of abuse and neglect (Toth & Cicchetti, 1996). This study will seek to further clarify how the impact of maltreatment and placement instability may be related to the adolescent's sense of competency in coping with stressors associated with this critical stage of development.

It follows that disruptions in the security of one's primary relationships and chronic exposure to the stress resulting from maltreatment leads to an increased susceptibility to depression. While the emotional ramifications of such a history are documented (King, Naulor, Setal, Evans, & Shain, 1993; Papini & Roggman, 1992) the impact on cognitive variables has not been as thoroughly explored. In a paper outlining the critical issues relevant to residential treatment Small, Kennedy, and Bender (1991) discuss severe attachment disorders and abuse as defining issues relevant to adolescents in residential care. In spite of the clinical observation that these variables have had a significant impact on the adolescent's functioning, and obvious need to address this issue, the research on this population is very limited. Small, et al. (1991) calls for relevant empirical research regarding the increasingly troubled group that is entering residential settings.
Significance of the Study

The purpose of this study is to further the understanding of coping style and depression among residentially placed female adolescents. In addition, it is hoped that this study will enhance the understanding of the impact that multiple placements and abuse has had on residentially placed female adolescent in terms of coping skills and levels of depression. An enhanced understanding will serve to assess, treat problems, and pathology that place these adolescents at increased risk for potential maladaptive coping strategies that may skew development. Developmental theory will be used to conceptualize the difficulties adolescents with a chaotic history experience regarding depression and coping skills. The literature well documents that a secure attachment base buffers the impact of emotional distress and promotes feelings of competence. Secure attachment promotes the course of normal development (Papini & Roggman, 1992; Kenny, et al., 1993). Given the expectation that normal development is predicated upon secure attachment, it is worthy to explore the effects of chaotic histories on cognitive variables such as coping styles. It is assumed that abuse and multiple caregivers will affect adolescent females coping style and mood regulation.

Curry (1991) calls for more advanced diagnostic research regarding "affective and mixed affective-conduct disorders, and more specific measures for adaptive cognitive and coping skills that may serve as predictors of outcome" (p. 350). There is a large body of literature supporting the implications of a history of multiple placements and abuse, and subsequent interpersonal adaptedness. Coping skills and depression are two variables which can severely impact upon the individual's ability to negotiate interpersonal territory successfully. They are also two factors frequently associated with children with a history of instability and maltreatment, characteristics found to be commonplace
among a residential population. (Toth & Cicchetti, 1996). Describing variables which contribute to placing these adolescents at risk or promoting resilience is essential to ensuring adequate functioning once they become of age.

Additionally, this study represents a critical extension of prior research on adolescent development. It focuses on the 13-18 year age span, which has been neglected in the literature in lieu of the undergraduate or college aged population. It also offers an extended view of residually placed female adolescents, a greatly under-explored clinical population in the literature. In addition to the analysis of the hypothesis, descriptive information including age, age of first placement, depression, stress, and percentage of physical and/or sexual abuse are presented. Additionally, this study seeks to explore sexual and physical abuse separately, when in fact it has been far more common for them to be addressed as a singular variable.

The literature cites the lack of research exploring residential populations. Specifically, what continues to be inadequate is the exploration of the characteristics of residually placed youth. Studies tended to focus on outcome data and the programs themselves. Wurtele, Wilson, and Prentice-Dunn (1983) describe the related issues surrounding this still current problem stating "without adequate descriptions of these children, proper placement, treatment, and outcome evaluations cannot be realized" (p. 137). They call for more research on the residential population which will enhance the understanding of the resident's characteristics. In fact, inadequate client description has constituted one of the most frequently recognized methodological limitations of residential treatment evaluation research (Wurtele, et al., 1983; Durkin & Durkin, 1975; Kushner, 1991). This study's focus is on aspects of the residential female's mood, coping responses, and stress, all of which are variables which have not been substantially explored in regard to this
population. Curry (1991) stresses the utility of the residential setting as one which "provides maximum within-program learning that can be generalized to the environment outside the program" (p. 352). The significance of this study is to further the research regarding the understanding of residential youth's affective and adaptive skills so that they may be addressed in treatment more effectively. The purpose of the residential milieu is to "focus on adaptive skills for relating to peers, parents, and the demands of work or school" with the goal of "returning the child to that environment equipped with new adaptive capacities." Curry (1991) specifically calls for the assessment of coping skills as a key factor in achieving the application of research to practice in the residential facilities. Coping skills have the potential to serve as a significant mediating variable in the formation of pathology. Information regarding coping skills can better prepare the resident for their departure from the residential setting as well as grant enhanced opportunity for success in their post-discharge setting.

Statement of the Problem

The purpose of this study is to examine residentially placed female adolescent's with a history of multiple placements, physical and/or sexual abuse. These variables will be examined in relation to their coping styles, level of depression, and life stress.

The independent variables for this study will be number of out-of-home placements; age of first placement; and experience of documented physical and/or sexual abuse. Depression, stress, and approach versus avoidant coping style are the dependent variables in the study. This study will provide descriptive data as well as correlational data regarding the 28 residential adolescent females participating in the study.

Definition of Terms

History of abuse shall be defined in the following manner:
**Physical Abuse:** As a result of physical abuse becoming legally defined by state statutes, a conceptual definition of physical abuse can be understood as the occurrence of non-accidental injuries as a result of commission (physical assault) and omission (failure to protect a child's life, health, & safety) by the child's caregivers (Wolfe, 1987).

**Operationally:** Physical abuse will be defined according to the New Jersey Division of Youth and Family Services required criteria for establishing confirmation of an allegation of physical abuse. The following four elements are required in order to determine an allegation of abuse to be substantiated.

1. whether the victim is under 18 years of age.
2. whether the perpetrator is a parent or caregiver
3. whether the actions of the caregiver or parents were considered necessary, justified, reasonable, and/or appropriate.
4. whether serious harm or substantial risk of serious harm as defined in N.J.S.A. 9:6-8.21c (Appendix D) resulted from the parent's/caretaker's action or inaction. It is noted that the risk of harm must be assessed according to the victim's age, size, emotional state and the capacity to protect him or herself, as well as the presence of any handicaps or physical limitations or conditions (New Jersey Department of Human Services, Division of Youth and Family Services (DYFS), 1998).

Abuse will be substantiated by history. Data regarding abuse history will be gathered from files by residential staff.

**Sexual Abuse:** As a result of sexual abuse becoming legally defined by state statutes, a conceptual definition of sexual abuse can be understood as the occurrence of a child's involvement in a sexual act or situation including incest, exploitation, intercourse, or molestation (Wolfe, 1987).

**Operationally:** Sexual abuse will be defined according to the New Jersey
Division of Youth and Family Services required criteria for establishing confirmation of an allegation of sexual abuse. The criteria for substantiation defined above will also be utilized to operationalize sexual abuse. This information will be gathered from the resident's file.

**Sexual and Physical Abuse:** History of both sexual and physical abuse is a frequent co-occurrence (Wolfe, 1987). It shall be defined according to the conceptual and operational definitions outlined above under physical and sexual abuse.

**Number of Placements:** The number of placements shall be defined as the frequency of residences outside of the adolescent's home of origin. This will include all placements including those from which the subjects were returned to their home of origin, residential, and group home facilities. This will be operationally defined by a numerical count of such placements according to the resident's record.

**Coping Skills:** Coping skills shall be conceptually defined as the behavioral and cognitive skills utilized to assist in the adaptation and management of a stressor. The operational definition will be a score from the Coping Responses Inventory-Youth Form (Appendix A); a self-report inventory assessing cognitive and behavioral aspect of coping.

**Depression:** Depression shall be conceptually defined as a clinical syndrome reflecting a cluster of emotional and behavioral symptoms. These include moods typified by feelings of discouragement or guilt, a lack of initiative, apathy, low self-esteem, futility, and self-deprecation; and behaviors such as tearfulness, suicidal ideation, pessimism, social withdrawal, vegetative symptoms, and anedonia (Millon & Davis, 1993). This will be operationally defined and measured by the Millon Adolescent Clinical Inventory (MACI) (Appendix B); a self-report inventory assessing adolescent's socioemotional
functioning. Scale FF 'Depressive Affect' will be utilized for this variable.

**Stress:** Stress shall be conceptually defined as events in one's environment that require the individual to adjust in their psychological and social responses. When these demands of response change exceed the individual's current abilities, stress or a sense of potential threat from the event may occur (Zeidner & Hammer, 1990).

Stress shall be operationally defined and measured by the Life Events Scale – Adolescents (Coddington, 1972). This is a self report inventory assessing the amount of stress experienced in the past 12 months (Appendix C).

**Age of First Placement:** This will be defined by the age of the child at first removal from the home into which they were born.

Limitations of the Study

Some of the threats to the internal validity of this study include the unique history that each subject brings to her responses to the measures. Historical factors related to their various home environments, school experiences, and genetic predispositions to depression, and prior experiences with testing may all be potential confounds to internal validity Additionally, internal validity could be compromised due to the reliance on self-report measures solely for the data collection for the dependent variables. The subject's motivation to voluntarily participate versus those who refuse, may also play a compromising factor. The overall difficulty acquiring access to this population of adolescents is also a limitation to the study.

The instruments chosen for this study may also threaten internal validity since the rating of the subject's focal stressor must be done by outside raters. Multiple scorers will be used to attempt to control for this and provide interrater reliability. In addition, some measures may ask a question referencing family or
'home'. This occurs for example on the Millon, with one statement reading, I like it at home. This may be confusing to some of the participants since they may not have a strong sense of where home is, and therefore may not know what home to reference in their answer.

In regard to external validity biases in selecting participants or in the qualities of the individuals willing to participate may threaten the generalizing of the findings. Also it is difficult to control for the treatment being received at the program. The variation which unavoidably occurs in individual treatment (ie. different therapists, client-therapist rapport, number of sessions at time of testing) may play a factor in limiting the generalizing of the findings. Another limitation may be related to differences in treatment interventions at various facilities.

This study focuses on a specific group of individuals; female adolescent's in residential placement. The specific population being utilized in the study will limit generalizing of findings to like populations.
CHAPTER II
REVIEW OF RELATED LITERATURE

The purpose of this study is to extend the understanding of female adolescents who have been placed in residential care after a chronic course of maltreatment and multiple out of home placements. Historically, the literature has primarily focused on treatment interventions and outcome studies focusing on discharged adolescents, and on effective interventions; as opposed to the population itself. Overall, the residentially placed female adolescents are a greatly under researched population, in need of more current, multivariate research describing them in residential facilities.

Relatively new to the literature is the clarification of how, and to what extent depression influences adolescent's choices and the degree to which negative life events and a lack of constructive problem solving alternatives increase the risk for depression. Residential youth in particular have been identified as having significant levels of depression, which has been connected to impeded development and coping skills (Raynor & Manderino, 1988). Negative life events such as abuse and multiple disruptions in the home environment and the impact on affect and coping ability may in fact be mediated by a sense of competency in handling life stressors. The ability to relate positively to others may also mitigate against adverse effects of a chaotic history (Toth, & Cicchetti, 1996). The residential adolescent is not necessarily doomed to a life course of continued despair and chaotic problems and relationships. It is essential however that mitigating factors be identified to assist in reducing the risk of a future much like the past. Identifying contributions and hindrances to
their resilience is essential.

This chapter will review and critique relevant literature surrounding the variables being addressed in this study. These will include age of first placement, multiple placements, maltreatment; including physical and sexual abuse, depression, and coping abilities with regard to adolescent girls in residential care. The following will be subsections representing the aforementioned variables.

Residential Care

While foster placement was originally designed to provide temporary respite, it has emerged as a long term situation, offering only permanent instability to the children who have been removed from their homes of origin. The majority of children placed in foster care have experienced abuse or trauma of some sort. While the initial placement out of the home is meant to ensure safety and relief from maltreatment and trauma; it has the potential to retraumatize the child should it become long term care, often involving multiple placements without the development of a sense of permanence. Working clinically with such children, the impact of this experience becomes obvious in terms of the effects on development. The empirical literature has not adequately addressed these issues affecting the residentially placed youth, who have been described throughout this paper as having a profile frequently inclusive of maltreatment and multiple foster home placements.

Residential care can be defined as a milieu where all daily activities involve managing behavior and teaching alternatives to its residents. The theme of its work is establishing relationships with the residents through interactions in the variable contexts that the milieu offers, including therapeutic, recreational, school, and the living environment (Kelly, 1992). The demands on clinicians in such settings have become increasingly challenging as the issues presented in
residential settings have increased in severity (Small, et al., 1991).

Small, et al. (1991) clearly outline the need for research particularly in an age where they define the adolescent entering the group care system as increasingly disturbed and when policy has become detached from practice. They cite frankly the struggle reported by clinicians in working with adolescents in care as challenging. While Small and his colleague’s clinical experiences and shared observations are based on their work with boys in residential treatment, their observations are seen as relevant to this study, since they are not intended to be gender specific. In addition, while not an empirical investigation of the residential population, it does offer more current clinical issues which are pertinent to developing empirical studies.

Small’s, et al. (1991) study stands out since it is among the few dealing with the residential facility, as well as current clinical issues regarding this underrepresented population. Small et.al. reports that a majority of adolescents enter the residential system after a long arduous road, due to their difficulty functioning in less restrictive settings, such as school, the social arena, and within a family setting. There is usually a litany of foster home experiences behind the adolescents by the time they are placed in residential care. Frequently, they are placed after demonstrating their persistent difficulties relating to a ‘family’ environment of a foster home often proved to be too traumatized by their prior experiences to be re-placed into another family setting (Kelly, 1992). Yet, it has been found that among several significant variables, post-discharge placement defined as successful adoptive or foster placements, was most related to successful outcome following residential placement (Burks, 1995). Post discharge placement was found to be more significant than variables including ethnicity, gender, age at admission, number of previous placements, age first seen, intelligence, family involvement in treatment and
placement upon treatment completion. Burks found that of 37 adolescents discharged from residential care, six month follow-up data identified 18 as successful. The involvement of the family for the adolescent is underscored during and following their treatment. These data are concerning, since many adolescents entering the residential system come without a sense of attachment to significant others or without a consistent family group that is invested in the adolescent's treatment. There is a large gap between the adolescent's difficulties existing in a family environment and the significance of becoming integrated into a family unit as a factor in determining future adaptation and functioning. It presents a host of clinical issues that need to be addressed in preparing the adolescent for adaptation beyond the milieu of the residential facility.

The underlying deficits related to this inability to function adequately in these settings are ego deficits, including deficits in delaying gratification and tolerating frustration, and problems controlling their drives (Small, et al., 1991). These are the result of chronic trauma coupled with inadequate, and unstable care-giving experiences. The result is a lack of adequate attachments or support in negotiating current and prior developmental phases. In addition, these adolescents struggle with poor school and social functioning. The weak problem solving skills that the adolescents demonstrate are superimposed on affectual deficits leaving them prone to affective flooding. These difficulties are coupled with problems with cognitive mediation and integration of inner and outer experiences. The clinical presentation is that of scattered, impulsive behavior. The adolescent demonstrates difficulty assessing his/her role in behavioral outcomes.

Dore and Eisner (1993) presented a discussion regarding emotionally disturbed children within which they enumerated variables characteristic of
emotionally disturbed children entering therapeutic foster care services with a history of placement instability. While not residually placed adolescents per se, it is viewed as relevant to the current investigation, given the 24 hour nature of the treatment and the diagnosis of emotional disturbance. The five variables identified in Dore and Eisner's paper are the ability to tolerate intimacy, impulsivity, fear of rejection, aggression, and self-esteem. Relationships to these variables have been found with earlier experiences involving abuse, neglect, insecure early attachments and inconsistent care-giving. These variables are viewed as associated with placement stability and successful treatment outcome.

Small, et al. (1991) described the core deficit of the residential adolescent patient as one of making human connections. They describe the history of disrupted attachments to caretakers and multiple placements that is usually experienced prior to their placement in group care. These attachment disorders render the adolescents ineffective in engaging in and maintaining relationships.

Given the complicated and severe nature of the youth's clinical presentation, Small, et al. (1991) identifies four points regarding treatment in a residential setting that challenges and sets parameters around the treatment or interventions that can be used effectively. These include: the long term treatment need versus the short term setting; the challenge of how to use the milieu effectively to address behavioral issues; to address the underlying relational problems; how to access and utilize family support. This final parameter is supported in the literature as a critical factor related to positive outcome post-treatment, however frequently treatment reveals emotional bonds with a history of disconnection. Finally, Small, et al. (1991) proposes restructuring the goal of treatment from 'cure' to one of 'movement' or 'change',
which would include a commitment to continued life-course work.

A large segment of the research both historically and more currently has emphasized treatment effectiveness and outcome variables, assessing the residents subsequent adjustment to life during and after residential treatment. Wilson and Lyman (1983) concluded from their review of the literature that generally positive responses to treatment were stronger during treatment than upon discharge. However, these studies used global indices of functioning to evaluate adjustment to life during and after treatment. Also, those studies designed with a control group or comparison group did not support similar findings; thus not holding up to greater standards of rigor in design. Wilson and Lyman concluded that their investigation yielded a lack of empirical support for the effectiveness of residential care.

Curry (1986) summarized three major studies looking at outcome. His conclusions were that 60 to 80% of the youth improve or function adequately at follow-up when compared to their functioning when admitted to the treatment facility. Curry also concluded that the level of adaptation at follow-up did not correlate with successful functioning achieved while in treatment.

Collins (1988) similarly found that after reviewing residential care follow up studies dating back to 1966, such treatment proved weak in effecting change in the youth served. Collins study is criticized for having bias however, for leaving out, minimizing, or distorting studies in his reviews that demonstrated positive outcomes, and describing studies being conducted without controls when in fact they did have control groups.

An earlier study by Durkin and Durkin (1975) reviewed and summarized flaws in the design of studies examining residential centers. While financial limitations and the ethical issues related to assigning versus not assigning emotionally disturbed adolescents to residential care versus non-residential care
groups are obvious, Durkin and Durkin summarized their review of studies with problems associated with control groups and outcome measures which lacked in terms of reliability and validity. The lack of rigor in the design of studies regarding outcome make it difficult to conclude what actually resulted in improvement in the patient. It is possible that it was the treatment, versus a host of other intervening variables such as removal from a stressful home environment.

What emerges is an increasing degree of pathology and severity of problems accompanying the adolescent into residential care. Ego deficits, historical experiences including multiple out of home placements and consequently caregivers, and abuse are common issues amongst this population. Disrupted attachments and connections to a family are described as critical to future adaptation, yet remains a critical issue for the adolescent in residential care. Research has the valuable role in continuing to understand these and other variables in an effort to develop treatment efforts. A summary of research regarding residential placement reveals design flaws, a lack of literature due to a variety of reasons such as funding, and difficulty measuring variables all contribute to the inconsistent and minimally helpful research on the adolescents or the facilities in which they are placed, and whether they do in fact help the residents. In addition, the variation in the population the programs serve as well as the nature of the programs themselves make it difficult to design and generalize findings. In tracing the history of research designed to capture a greater understanding of the residential care patient and the programs in which they are placed, the bases of more refined research questions emerge. There has been a movement away from asking whether 'to admit or not to admit' which defined the treatment of the 1950's; to 'what kind of inpatient experience' as the awareness of the uniqueness of adolescent developmental
issues emerged. The 1970's brought with it the emergence of an emphasis on
diagnosis to further refine an accurate match of treatment type and a level of
care that addresses the diagnosis. Concurrent to this growth in the field has
been the movement of the treatment process from primarily custodial to more
defined treatment processes suited to match the patient's needs. A more
complex, multivariate, and current understanding of youth in residential care is
in order. This should be the basis for producing more helpful research in all
areas related to residential treatment. This will assist the practitioner in relating
findings to clinical, daily care of the increasing pathology in the residential
program. Such findings can be applied to treatment, facility design, clinical
accuracy, outcome research, and the establishment of greater sources of
funding.

Abuse, Multiple Placements, and Time of Placement

It is well known clinically and identified in the research that a large
percentage of residential adolescents have a history of abuse and multiple
foster care placements (Small, et al., 1991; Cooper, et al., 1987). Small
estimates that 60% of boys in the residential center from which he works have
some history of abuse. This reflects an increase in the reports of sexual abuse
amongst this population compared to prior estimates of abuse amongst this
population.

Miskimins (1990) reported that in a sample of 12-18 year old residential
males, that 50% had experienced physical and/or sexual abuse. In a study by
Julian, Julian, Mastrine, Wessa, and Atkinson (1992) cost and service usage
patterns for emotionally disturbed adolescents were evaluated for clients with a
history of multiple caregivers, and psychiatric and residential placements. Julian,
et al. (1992) conducted a retroactive file analysis of 40 adolescents. It was
discovered that all of the female participants had experienced sexual abuse as
had approximately half of the males. A major weakness in the design of this study was the small sample size of 40 and the data collection having been conducted by retroactive file analysis.

Mennen and Meadow (1993) conducted a study regarding sexual abuse and symptoms of anxiety, depression, and self-esteem among a residential population of female adolescents, all of whom have had a history of multiple out of home placements. On average the adolescent females in Mennen and Meadow's study had a mean number of 3.68 placements. Mennen and Meadow's study offered greater methodological rigor than Julian, et al. (1992), with a slightly larger sample size of 52 and a varied racial composition (white=19, African-American=20, Latino=11, Asian-American=4). They also utilized a multivariate design with standardized self-report and observer measures. An additional distinguishing factor was the discrimination between physical and sexual abuse experiences amongst the subjects. This latter methodological effort to discriminate between physical and sexual abuse in particular is infrequently conducted in research regarding abuse. Results indicated that of the 52 youth whose results were included in the analysis, 31 had experienced sexual abuse, yielding a rate of 59.6% of the sample. The sexually abused and non-sexually abused girls did not differ significantly with regard to racial composition, age, time in placement, number of previous placements, or number of pregnancies experienced. Of significance was the fact that sexually abused girls had an increased likelihood of a history of substance abuse. In regard to symptom scores, sexually abused girls scored significantly higher on indices of depression, as well as total anxiety scores; including anxiety regarding social interactions and physiological concerns. They were also found to have lower self-worth scores. The therapists rated sexually abused clients as having more frequent symptoms of post traumatic stress disorder,
relationship problems, psychosomatic problems, mood/affect, and sexual problems, as well as problems with self-concept. Of note is the overall agreement of symptom levels as reported by subjects and therapists. Mennen and Meadow underscore the significance of the data on depression and anxiety. They point out that their mean level of depression is above that found in children and adolescents experiencing major depression. Their anxiety levels were assessed using The Revised Children's Manifest Anxiety Scale (RCMAS). Scores from the RCMAS revealed anxiety levels that were one standard deviation above the mean, indicating clinical evaluation is warranted.

Mennen and Meadow (1993) provide an empirical demonstration of the greater psychological distress of sexually abused residentially placed adolescent girls, when compared to their non-sexually abused peers. In addition, their study clarified the need for specific attention to such matters as they manifest themselves in clinical settings. In general the residential youth presents such a myriad of complex issues, it is critical that the specific issues related to a history of sexual abuse be identified and treated, and not be obscured by other issues. The evaluation of physical abuse versus sexual abuse separately in the research is critical for a more refined understanding of the sequelae of sexual abuse dynamics.

The limitedness of the research regarding variables related to abuse as they pertain to the residually placed adolescent reflects a need for more study. Children with a history of abuse pose a specific challenge and treatment needs for the practitioners that make up the clinical staff of residential facilities. The residential youth's proneness to what has been coined 'abuse reactivity' (Small, et al 1991), calls for a greater understanding for how to approach and stimulate change in their level of functioning and adaptation.

Tissue and Korz (1993) conducted a study of posttreatment outcomes for
88 young adults who had attended a psychoeducational center for emotionally disturbed youth when they were 5-14 years of age. A history of child abuse was found to be negatively correlated with adjustment. Academic skills and parental involvement were found to be related to positive adjustment in adult life. These data supports the need for adequate empirical investigation of abuse experiences and appropriate clinical interventions for this population in order to increase the odds for more adaptive functioning upon discharge.

It is a generally agreed upon observation that multiple out of home placements are detrimental to children. In spite of this, empirical investigation regarding this issue only began to emerge recently. McIntyre (1989) cite the lack of literature empirically substantiating the detrimental impact of long-term, unstable foster care. Wurtele, et al. (1983) report that of the 211 children ranging in age from 7-20, the majority fell in the older age range, 13-20 years. Only 6% experienced their current placement in the residential facility as their first out of home placement. 35% had experienced 3-4 placements, and 25% had five or more placements during the past five years. This variable has a significant effect on the residential client.

Pardeck (1983) studied a sample of 4,288 children in foster care throughout the United States. While Pardeck’s study provided an extensive sample, (provided to him by the United States Children’s Bureau), methodology was not described with any detail in the study. He addressed the reasons for child placement, the number of times they experienced re-placement, and the length of time the child had been in care. Demographics of the sample indicate that 75% of the children were between 6 and 17 years old, 25% experienced at least 3 placements, with an equal distribution between males and females. Pardeck found a positive relationship between re-placement and children who enter foster care due to behavioral or emotional problems. This is quite
concerning since those children with challenging emotional and behavioral presentations are most likely to experience multiple placements, with a consequent escalation of problematic symptomatology.

Cooper, et al. (1987) reported on the psychological damage that a history of multiple placements can have on child development. The children were aged 2-14, which is different from this study's focus. However, it is still seen as relevant. Of the 172 subjects, 104 were boys and 68 were girls. All of the participants of the study had been placed at a residential treatment program for abused and/or neglected children. Ethnic and racial diversity is reported in vague terms, although it is explained that the majority of participants were caucasian (66.3%). This study did not have a control group. Data were collected by file examination, including residents who were either current or previous residents of the program. A standard set of data were gathered on each subject. A combination of Pearson correlation coefficients and t-tests were used to analyze the data.

Cooper and her colleagues pointed out that those children moved from placement to placement experience repeated separation traumas compromising their sense of self-worth and identity and ultimately jeopardizing their ability to form healthy attachments with adults. Cooper, et al. (1987) addressed many of the issues relevant to this study.

The importance of being aware of the adolescent's placement history is underscored, as well as its relevance to treatment planning, and responsible long term planning for the adolescent's overall needs. Cooper, et al. (1987) study utilized a sample of male and female abused and/or neglected youth from a residential home for maltreated children. Data were collected from files on the children. Cooper provided information regarding the dangers of the 'foster care shuffle' with over half of the youth in this large sample having been removed.
from their home of origin by their preschool years. The youth had experienced on average 3-4 placements, with some having experienced as many as 12. Cooper and her colleagues found that young children (1-3 years) removed from their home of origin spent the longest time in foster care and experienced the most placements. This instability was predictive of behavior problems. Also, behavior problems were predictive of disrupted placements. This circular situation is highlighted as severely problematic and contributing to the inability to form appropriate attachments with adults.

Coping and Depression

For adolescents who have lost their developmental momentum as a result of chaotic histories, behavioral, cognitive, and affectual variables, need to be explored as multivariate factors. These variables subsequently place adolescents at risk for the perpetuation of poor interpersonal interactions. Such risks will ultimately continue to inhibit a healthier adjustment to society and healthier adaptation to their history of disrupted placements and maltreatment. It has been found that the adolescent’s response to stressors may contribute to successful adaptation to the challenges they face, as well as the developmental tasks that must be negotiated (Ebata & Moos, 1991). Poor social interactions that can result from the implementation of maladaptive coping skills can also maintain dysphoric affect. Poor social interactions, difficulty forming healthy relationships, conflictual or unsatisfactory relationships have the potential for the perpetuation of feelings of isolation and dysphoria. The implications for treatment are important for identifying appropriate interventions to assist the adolescent in their transition out of residential treatment into society. The key is identifying and implementing skills which will transfer from the microcosm of the residential milieu to the society at large.

Ebata and Moos (1991) looked at coping skills among four groups of
youths. These groups included those to be considered "healthy" youth, adolescents with rheumatic disease, conduct problems, and depressed adolescents. They found that adolescents with poorer coping skills have been found to be at an elevated risk for poorer adjustment to future stressors. In fact it has been found that adolescents discharged from residential programs were most likely to experience failure due to interpersonal conflict primarily because of a tendency to alienate others (Munson & LaPaille, 1984). Both adequate interpersonal and cognitive skills are essential to effectively mediate behavior. Effective cognitive skills used to approach problems may actually positively effect social interactions. It would seem appropriate then that the development and maintenance of such skills should be addressed in the milieu of residential treatment.

Coping skills can potentially be utilized as a buffer to alleviate and prevent the further development of psychopathology during this critical phase of psychological development. Kobak, Cole, Fleming, Ferenz-Gillies, and Gamble (1993) propose that adolescence presents an opportunity for change in the attachment relationships. Furthermore, they state that those adolescents equipped with better developed cognitive skills will be better suited to negotiate internal models of self and parents and work to establish a healthier balance between forming connections and developing a sense of autonomy. Subsequently, they will be better equipped to achieve a greater sense of social competence and moderate their level of depressive affect.

A study by Allen, Hauser, and Borman-Spurrell (1996) utilized attachment theory to assist in the understanding of severe adolescent psychopathology. They addressed the concept that attachment organization may play a role in mediating the long term course of psychopathology in adolescence. This study's focus on adolescent pathology and attachment is
seen as particularly relevant to the residential adolescent given their histories of disrupted attachments and pathology. Allen, et al. (1996) compared 66 upper-middle class adolescents with a recent history of psychiatric hospitalization at age 14, to 76 sociodemographically similar high school students. They were interviewed 11 years later at the age of 25. They found that psychopathology of those 14 year olds who were hospitalized was strongly predictive of insecure attachment organizations upon 11 year follow up. The comparison sample had a typical composite of secure and insecure attachment organizations, with 45% of the sample categorized as secure. This is in comparison to 8% in the previously hospitalized group. The previously hospitalized group also reported difficulties with criminal behavior and the use of hard drugs, with unresolved issues surrounding loss and particularly trauma with attachment figures. These findings suggest the connection between a history of trauma and loss with significant attachment figures, and a connection to the subsequent impact on adaptive and maladaptive functioning. It also addresses the plausibility that attachment organization may offer a mediating variable in insulating adolescents from the emergence of more significant pathology. Allen, et al. states (1996), “Adult attachment organizations that lack coherence or security may create enduring vulnerabilities to psychopathology by impairing an individual’s ability both to participate in satisfying social relationships and to appropriately understand and evaluate social interactions” (p. 1).

Allen, et al. (1996) study is valuable in its unique analysis of attachment organization and its connection to pathology in relation to an adolescent sample. It addresses the role of attachment organization and the potential that it may serve as a buffer to a more extensive or prolonged, pervasive course of pathology. Cummings and Cicchetti (1990) state that insecure attachment organization may be a significant influence in determining adaptation and risk
for psychopathology. Future research would be valuable in replicating these findings with more specificity in regard to the definition of 'trauma' with attachment figures and issues of 'loss.' The study does not define these in any detail. Doing so would provide valuable information regarding the impact of childhood stress and its impact on development.

Toth and Cicchetti (1996) also applied attachment theory toward an understanding of depressive symptomatology and lower perceived competence in maltreated and nonmaltreated children. The sample in Toth and Cicchetti's study consisted of 92 children. This sample was comprised of 52 children identified through the Department of Social Services as having been maltreated. They were compared to 40 children without a history of maltreatment. The children's ages ranged from 8 - 12 with a mean age of 9.53 and 9.45 for maltreated and nonmaltreated children respectively. Descriptive information regarding the samples ethnic and gender composition was a 70% African American and Hispanic children, and 43% female. The two groups did not differ significantly in regard to sex, ethnic minority status, poverty status, or single-parent family structure. The children were administered the Relatedness Scales, The Children's Depression Inventory, The Self-Perception Profile for Children, and the Peabody Picture Vocabulary Test - Revised. The self-report nature of the measures, as well as the relatively small sample size should be considered as limitations of the study. While this study differed in regard to the present investigation's focus on adolescence, it is still viewed as relevant given the similar developmental perspective on maltreatment, depression, competence, and adaptation.

Toth and Cicchetti (1996) found that maltreated children with 'non-optimal' patterns of relatedness had elevated depressive symptoms and lower competence, when compared to the nonmaltreated group who had adequate
patterns of relatedness, lower levels of depression, and higher levels of competence. This was particularly true for those children experiencing sexual abuse. Their findings also suggest that relatedness may mitigate against the impact of maltreatment. The results call for the need to explore the relationship of relatedness to adaptation.

It has been found in past research that insecurely attached infants evidenced difficulties later in childhood, including increased dependence, lower ego resilience, and less social competence (Ellicker, Englund & Sroufe, 1992). These findings, as well as Toth and Cicchetti's (1996) evidence of depression and impaired competence and relatedness among children with histories of maltreatment raises concern about the adequate formation of coping skills. Sufficient ego functioning is foundational to the establishment of coping skills, as well as adequate interpersonal relations, and affect regulation. Future research is needed regarding the developmental impact of impaired attachment relations as a result of childhood maltreatment on the development on coping, adaptation, and resilience.

Shonk and Cicchetti (2001) looked at a sample of socioeconomically disadvantaged children, ages 5 - 12. Of the total sample, 146 had a history of maltreatment. Their study was designed to address maltreatment and its relationship to competency and difficulties with academic and behavioral problems. The maltreated and nonmaltreated groups were varied in regard to ethnicity and gender, and did not differ significantly in regard to grade status. The measures used included The Teacher and School-Record Measures Taxonomy of Problematic Social Situations for Children, Teacher's Checklist of Children's Peer Relationships and Social Skills, Teacher's Rating of Perceived Competence, Teacher's Rating Scale of Child's Actual Behavior, Teacher's Rating Scale of Child's Classroom Orientation, The California child Q-Set, Five-
Flag At-Risk Classification Index, and The Child Behavior-Teacher’s Report Form. Results from the investigation yielded evidence of the maltreated group’s elevated risk for academic problems and behavioral problems which place them at risk for dropping out of school, social difficulties, and psychopathology. Significantly, ego resiliency and the ability to respond adequately to stressful situations was compromised in the maltreated group. This is concerning given the critical need for adequate ego resiliency and ego control to develop coping skills needed to proceed developmentally. Shonk and Cicchetti (2001) also discovered the mitigating value of academic engagement on the effects of maltreatment. Social competency and ego resiliency fully mediated the impact of maltreatment on behavioral problems in school and camp environments.

In summary, the findings stress the importance of academic engagement, social competence, and ego resiliency in overcoming the effects of a history of maltreatment. These variables are all associated with the formation of healthy coping skills with the potential to maintain a healthy developmental course in spite of a history inclusive of maltreatment.

Surprisingly, the exploration of coping in children and adolescents is only slightly more than a decade old. Compass, Connor-Smith, Saltzman, Thomsen, & Wadsworth (2001) enumerate the values of coping research regarding coping processes in children and adolescents. It is their belief that it reveals valuable information regarding self-regulation of emotion, cognition, and behavior. Additionally, psychosocial stress poses a significant risk factor in the development of psychopathology in childhood and adolescents. Coping also may be a potential moderating variable on the impact of stress on current and future adjustment and pathology. Of concern, is the potential for maladaptive forms of coping in childhood to take hold and and follow developmental pathways into adulthood. Information about coping and resilience has the potential to aid in the
development of effective interventions.

The review of the literature yields little empirical research on coping skills and depression specific to a residential youth population. Kushner (1991) conducted an observational analysis of 41 male and female adolescents placed in therapeutic foster care. The subjects were predominately white, female, and were temporary wards of the state. More than 40% had a history of psychiatric or residential treatment and had experienced more than one foster care placement. Kushner's study provided a valuable contribution to the research on emotionally disturbed youth, focusing on personality profiles and problem solving skills. Some of the limitations to this study included the small sample size, lack of racial and ethnic diversity among the sample, and voluntary rather than randomly selected subjects. In spite of these limitations however, it provides descriptive information of the emotionally disturbed youth typically found in residential facilities. Given that this information is limited in the literature, its value is in providing a foundation for future research.

Kushner (1991) found that in a study of 41 adolescents, generally both male and female adolescents in therapeutic foster care experienced difficulties with impulsivity, anger, and lack of social competence. With regard to problem-solving skills, the measure used to assess these skills was the Personal Change Questionnaire, described as a relatively new instrument, without extensive normative data or substantial validity and reliability information. This threatens the internal and external validity of the study. Notable findings, albeit ones which warrant further investigation, regarding females included their self-rating as low on decision-making, reflecting a self-perceived problem regarding assessment that reinforces their behavior and in making behavioral choices. An additional finding gathered from on the Millon Adolescent Personality Inventory, was that the females also lacked awareness of their difficulties with impulsivity.
Kushner's findings lend support to the need for problem-solving skills training to enhance coping abilities.

Small and Schinke (1983) conducted a relevant study regarding cognitive problem solving and social competence with 45 boys in a residential setting using a post-test control group design. While this study provided a greater degree of rigor with its use of a control group, the sample of 45 boys only, was relatively small. The youth studied were aged 7-13. This study offers a view of empirical research tied to clinical practice concerned with the eventual adaptive functioning of the youth serviced in a residential facility. The generalizing to this study is obviously limited. Small and Schinke's findings support the inclusion of interpersonal cognitive problem solving in the treatment of residential youth. Their findings concluded that interpersonal cognitive problem solving in addition to social skill training created greater alternative generation. Such training results in more choices being available in response to problems.

Singer, Glenwick, and Danyko (2000) examined 54 adolescents in residential treatment and their responses to peer stress. Analysis of their data showed that coping strategies viewed as adaptive, including cognitive restructuring, positive thinking, emotional regulation, emotional expression, and acceptance tended to be associated with more behavior problems. However, this was to a lesser extent than the other responses to stress which are considered maladaptive, such as rumination, emotional arousal, and impulsive actions. Their findings lend similar concerns to this research in that there seems to be a gap between the report of response to stress and actual outcome of the response. Singer, et al. (2000) found that the use of “effortful engagement” or adaptive strategies did not result in fewer behavior problems. Similarly, they postulated that because of the psychopathology present in the population, that behavior problems characteristic of children in residential
treatment were exacerbated under stress. That is, the report of maladaptive or adaptive coping strategies did not enhance their response to stress.

The investigation of depression in the general adolescent population is over a decade old. Still newer however, is the exploration of depression in specific clinical populations such as residentially placed adolescent females. What has been discovered about depression in the research regarding the general adolescent population calls for the investigation of its occurrence in a population, such as residential youth, given their histories of loss, maltreatment, and stress.

Monroe, Rohde, Seeley, and Lewinsohn (1999) conducted a large epidemiologic sample of 1,470 adolescents randomly chosen from nine high schools in urban and rural areas of western Oregon. They discovered that the break-up of a first romantic relationship was predictive of the onset of a first major depressive episode, although not of a reoccurrence. This finding held for both sexes. The focus on the loss of a significant relationship addresses the impact stressful life events can have on the adolescent. Monroe, et al. (1999) state "...the discovery of factors relating to depression onset during adolescence may ultimately be informative about the developmental pathways through which depression initially emerges, the sources of gender differences in morbidity, and the processes that confer vulnerability to future depressive recurrences" (p. 1).

Of importance is the continuance of an emerging understanding of how depression emerges and proceeds over the life course. This effort is being addressed in the research for the general adolescent population. This study however, seeks to add to the knowledge base regarding depression in a specific clinical sample of female residential adolescents, and how depression potentially effects their functioning and developmental course.

While depression is known to be a prevalent occurrence in the adult
population, and not as common in childhood, adolescence represents a developmental phase when depression increases significantly (Rutter, Izard, & Read, 1986). While the development of an understanding of depression in the general adolescent population continues to emerge, one of the common most facts regarding adolescent depression is the preponderance in adolescent girls (Allgood-Merten, Lewinsohn, & Hops, 1990). In fact, after the age of 15 girls and women are twice as likely to be depressed as boys and men (Nolen-Hoeksema, & Girms, 1994). Jacobson and Rowe (1999) conducted a large, nationally representative, longitudinal study of adolescents. The sample of 2,302 adolescents were from the 7th through the 12th grades, with a mean age of 16. Consistent with the research documenting the increase in depression for adolescent females, Jacobson and Rowe found that genetic factors explained a greater proportion of variation in depressed mood for female adolescents than for male adolescents. While the size and representativeness of the sample, as well as the variety of ethnic and socioeconomic levels are strengths of this study, a limitation was the self-report nature of the instruments regarding depression. It is noted that observational measures should be included in future research.

The age range of 15-18 represents a critical period of vulnerability to depression in females (Hankin, Abramson, Moffitt, Silva, McGee, & Angell, 1998). Hankin, et al. (1998) conducted a 10 year longitudinal study addressing the development of sex differences regarding depression from preadolescence to young adulthood. Hankin, et al. (1998) followed 653 individuals, testing them at the ages of 11, 13, 15, 18, and 21 in an effort to address the developmental timeline more specifically. A limitation to this extensive piece of research is that the subjects resided in New Zealand. While psychiatric diagnosis are noted to be very similar to the United States, rates of depression for their sample were
very similar to other studies of similar age groups, and gender differences have been well documented across a multitude of countries, cultural differences do exist. Thus the generalizing of the findings should be met with some caution.

It is also known that the prelude to the onset of depressive episodes is frequently stressful life events and the experience of loss, creating a vulnerability to depression. Previous experiences with depression frequently are predictive of major depressive episodes in the individual's future. Nolen-Hoeksema, Girgus, & Seligman (1992) note that even moderate levels of depressed mood can have a significant effect on children, adolescents, and adults. Moderate levels of depression can effect interpersonal, school, and work functioning. Additionally, adolescents with moderate levels of depression are at an elevated risk for the experience of a major depressive disorder (Harrington, Fudge, Rutter, Pickles, & Hill, 1990).

Hammen, Henry, and Daley (2000) conducted a two year longitudinal follow-up design in which they looked at females exposure to stressful life events. They found that those young women who had experienced significant childhood adversity, such as family violence, parental psychopathology, and alcoholism, had an increased incidence of depression than those without such experiences. Subjects were recruited from three different high schools in the Los Angeles, California area following high school graduation. They had a mean age of 18.29. Hammen, et al. (2000) also discovered that the young women in the study who had experienced early exposure to adversity had a lower threshold for the amount of stress preceding a depressive reaction. Consequently, they were at risk for depression following less total stress than those women who had not experienced like early adversity. While the findings in this study need further exploration and replication to further clarify the mechanisms involved in stress sensitization, it does address the importance of
assessing the role of childhood experiences and their impact on the susceptibility to depression later in life. The absence of biological factors, adverse events later in life as opposed to childhood events, other forms and number of adverse experiences are all variables that limit this study and need to be included in future research. However, this study provides a longitudinal design using objective measures in a population of women at demographic risk for depression. Particularly relevant to this investigator's study is the sex, age range, and focus on childhood adversity in relation to depression, similarly stressing the importance of a developmental psychopathology models of depression. The knowledge of gender vulnerability, as well as the aforementioned experiences of loss and stressful life events among the general adolescent population, calls for the investigation of depression among the female residential population.

It has been found in several studies that residential youth have higher levels of depression than non-residentially placed peers. Depression in this population can manifest itself as a multitude of problematic behaviors which can create a sense of chaos and may mask the underlying clinical depression fueling such behavior. It is essential that depression be accurately identified and treated since it can be one of the roots of continuous self-defeating behaviors which perpetuate interpersonal problems, inhibit development of coping skills, and formation of appropriate connections. Beck (1976) developed a cognitively based theory of depression and asserted that depression is a link on a chain of events which is triggered when a person experiences some form of loss. The youth in a residential milieu are laden with experiences of loss, both recently with their placement out of their current situation into the residential facility, and past; usually with a history of multiple foster placements. Consequently, their vulnerability to depression is heightened since it is frequently the experience of
loss which is thought to precipitate depression.

In an effort to begin to empirically document the prevalence of depression in the residential population and subsequently promote treatment planning, Raynor and Manderino (1988), conducted a study of 19 primarily caucasian youth (14 male and 5 female) from a midwestern residential facility. The age range was 13 - 18. The small sample size, and lack of racial and ethnic diversity among the group may compromise the internal and external validity of the study. A strength of this study was the incorporation of three measures of depression in an effort to capture cognitive, affective, and behavioral aspects of depression. The Beck Depression Inventory (BDI) and the Dysfunctional Attitude Scale-Form A (DAS-A) were used to assess level of depression and depressogenic attitudes and cognitive distortions respectively. The third measure was the Behavior Inventory for Depressed Adolescents (BIDA). This was used to measure observer ratings regarding the subjects. Raynor and Manderino included these self-report measures which reported good measures of validity and reliability. A measure based on observer ratings was also included. While more than one source of data is positive, the scale utilized for observer ratings; The Behavior Inventory for Depressed Adolescents (BIDA), does not have validity and reliability information available although it is reported to have adequate psychometric properties. This may compromise the internal validity of the study.

Raynor and Manderino (1988) conducted correlational analysis and found that 63% of the sample report some degree of depression with the majority in the moderate to severe range. This percentage is significantly higher than other studies evaluating depression in psychiatric populations. Raynor and Manderino (1988) cite studies by Yanchyshyn and Robbins (1983) and Carlson and Cantwell (1980) who report findings of moderate to severe levels of depression of 27% and 12% respectively.
Raynor and Manderino (1988) report a moderate correlation of r= .44 between the BDI and the BIDA. This indicates that there was a moderate association between the self-report of depressive symptoms and observer reports of depressed behavior.
CHAPTER III

METHODS

Subjects and Research Setting

The participants in this study were 28 voluntary females ranging in ages from 13-18 years old. They are adolescents in placements in New Jersey and Pennsylvania residential programs. All residents who participated granted their written consent. Their parents/guardians also provided their written consent. Those residents who provided their consent, but whose parents declined consent or whom could not be contacted for various reasons, were not included in the study.

The facilities are all located in suburban settings, in established programs for adolescent females who have met the criteria to be placed in a residential setting for their socioemotional and academic needs. All treatment programs operate with a multidisciplinary team approach. The residents receive individual psychotherapy. Psychiatric treatment is also included for those residents who may require medication. Group and family therapy are also provided. The residents receive academic instruction at on-site schools with teachers trained to work with emotionally disturbed youth.

Procedure

Residents within the age range needed for the study were asked by the researcher if they would like to participate in the study. Their participation was solicited according to the script composed and followed. (Appendix F). Guardians/Parents of the adolescents who have agreed to participate were sent a letter announcing the commencement of the study at the facility and asked for
their permission for their child's participation (Appendix E). The list of parents/guardians was compiled by staff at the facilities. The residents were offered a modest gift certificate for a food selection at a local family restaurant following their participation.

The purpose of the study and all of its procedures were explained. If the guardian of the adolescent was not in the States of New Jersey or Pennsylvania, the individual responsible for providing authorization was consulted. The purpose and procedures of the study was provided to parents and/or guardians. The Guardians/Parents were given a consent form (Appendix E) and the Residents were given an assent form (Appendix G) These forms provided consent as well as an explanation of the purpose and intent of the research. The consent and assent forms were returned to the researcher separately from the testing materials. They were kept apart from the test materials to assure anonymity.

The researcher conducted, scored, and held all tests throughout the duration of the administration of the instruments and course of this study. The researcher's presence allowed for clarification of any instructions or questions the participants may have had. Standardized instructions as provided with the test instruments were used in this study.

The researcher was also available for all debriefing following participation in the testing. Immediately following the participants completion of all test materials, they were debriefed regarding the purposes of the study. This took place in a group setting. A written debriefing summary (Appendix H) was provided to the participants, and was read aloud by the examiner to ensure it was understood. An opportunity for questions and answers was also provided.

The answer sheets were number coded to provide anonymity for the participant's to protect the confidentiality of the data, to track data collection and
for subsequent data analysis. It was explained to the residents in the solicitation statement that they were not to put their name on any of the testing materials. The researcher monitored this to ensure that no names or identifying information, i.e. initials, are placed on the forms. A number code was assigned at the top of the testing forms for each participant. This numbering system began with 001 and proceeded in chronological order accordingly. A master list with the participant’s names and matching number codes was kept by the researcher. This list as well as all testing materials, consent and assent forms was kept in a locked cabinet in the researcher’s office. The master list was stored separately from all questionnaires. The purpose of the master list was to match the participant to the code number in the event that more than one sitting was necessary in order to complete the testing. Also, that list was used to access the correct case file and acquire the data regarding placement and abuse history. Histories were gathered by the staff at the residential facilities. They were given the master list in order to access the correct files. The file data was returned to the researcher in accord with the code number of the resident, not their name. Once the facility staff completed the gathering of the file data, the master list was destroyed. The data regarding the number of out-of-home placements and histories of substantiated experiences of sexual and/or physical abuse were gathered from case files.

The three measures were administered in a group format. The general staff and primary therapists were informed that this study was taking place. They were told that the residents who chose to participate were made aware of the option to inform their therapists or counselors of their participation to assist in processing any emotional reactions as a result of participation in the study. The Millon Adolescent Clinical Inventory (MACI); The Coping Response Inventory - Youth (CRI-Y); and the Life Events Scale - Adolescent (LESA), were
administered during the meetings with the participants.

The focal stressor reported for the Coping Response Inventory-Youth was rated according to weights adapted from Coddington (1972). For stressors not weighted by Coddington, independent raters were assigned weights using the Coddington weights and events as reference points. Two raters in addition to the researcher were used to ensure sufficient interrater reliability. Interrater reliability was calculated by dividing the total number of agreements regarding the scores by the total number of scores. The raters were trained according to the same training procedures used by Moos (1993) in assessing the relationship of the focal stressor to coping responses.

The procedures for training and establishing reliability were discussed with Rudolf, Moos PhD (personal communication, April 30, 1999; February, 2000). A list of 15 stressors not listed in the Coddington inventory (1972) were compiled by the researcher. These stressors were chosen based on the researcher's ten years of clinical experience in working with adolescents. The raters independently rated them using the Coddington weights as reference points. An interrater reliability of .7 was established prior to scoring the focal stressors reported by the sample of residential adolescent females in this study.

The same three raters rated the focal stressors reported on the CRI-Y. A reliability of .8 was established in scoring the focal stressors.

Ethical Considerations

In considering the ethical issues related to conducting research with residentially placed youth, their rights to privacy are of the utmost concern. Particularly, given that a great proportion of the residents involved in the study were below the age of 18, parental/guardian consent was sought prior to approaching the residents. It was stressed that even with parental or guardian consent, the adolescents maintain the right to participate or not and to withdraw
at any point in the study. It was explained that their treatment in their current
program would not be jeopardized in any way as a result of their decision. It
was essential that this be communicated in order to preserve their rights as
voluntary participants. Additional efforts to protect the resident's rights to privacy
included removing all identifying information from the test materials in lieu of
code numbers. Additionally, the residential facility staff gathered the pertinent
file data rather than the researcher being exposed to any unrelated material.

An additional ethical consideration was being mindful of the many
interviews and test protocols, as well as individuals conducting these that the
residents have quite possibly encountered prior to and during their residential
stay. Efforts were made to minimize the time commitment of the test battery and
the intrusiveness of the questions. Particularly sensitive material regarding
abuse history and history of disruptions from their home environments was
collected from the file to minimize intrusiveness and avoid repeated and
potentially upsetting interviews or disruptions to their current treatment. In the
event that any affectual material may arise, all participant's counselors were
informed of each resident's participation to reinforce the availability of a familiar
resource to process any feelings that may arise or have been stimulated as a
result of participation. The residents were made aware of the availability of their
counselors for this purpose.

Instruments

The Coping Response Inventory – Youth

The Coping Response Inventory – Youth (CRI-Y) was used to measure
the type of coping response that the participant uses to respond to stressful
events. This measure is conceptually comparable to the Coping Response
Inventory - Adult (CRI-A) for individuals 18 years of age and older (Moos, 1993).
The CRI-Y was designed to capture the two main conceptual approaches to
categorizing coping responses' including focus of coping (problem-focused or emotion-focused), and method of coping (cognitive versus behavioral). The CRI-Y can be used with individuals 12 to 18 years of age who are classified as healthy youth, youth with psychological, emotional, or behavioral problems, and/or youth with medical problems. Normative data were gathered with the aforementioned populations. It is comprised of 48 items on a 4 point Likert scale. It is appropriate to administer as a self-report inventory or within a structured interview format. For the purposes of this study, it was administered in a self-report format, requiring an estimated 15 minutes or less to complete. A sixth grade reading level is required. The CRI-Y is scored by converting raw scores into T scores either by hand or by computer. The participant is asked to report a focal stressor they have experienced in the last year and answer the questions according to the strategies they chose to rely on to respond to the stressor, ranging from 'not at all' to 'fairly often.'

This measure yields eight different forms of coping responses to stressful life circumstances, as indicated by eight scales. These include: logical analysis (LA); positive reappraisal (PR); seeking guidance and support (SG); problem solving (PS); cognitive avoidance (CA); acceptance or resignation (AR); seeking alternative rewards (SR); and emotional discharge (ED). The first four reflect a coping style utilizing an approach style, and the last four an avoidant style. The first two scales within each of these two styles of coping reflect cognitive strategies of coping, and the second two reflect behavioral strategies. For the purposes of this study the two scales of approach and avoidance were utilized in data analysis. The approach score was obtained by adding the scores of the four sub-scales representing approach scales. The avoidant score was obtained in a like fashion, summing the scores from the four sub-scales representing avoidant scales.
In general, approach coping is problem focused, with the described scale assessing both cognitive and behavioral efforts to master or resolve life stressors. Avoidance coping demonstrates an inclination toward an emotion based approach, utilizing cognitive and behavioral attempts to avoid thinking about a stressor and its ramifications, or to manage the emotions connected to it (Zalaquett & Wood, 1997).

Moos' scale enables the evaluation of the youth's focus of coping, that is whether they approach or avoid a problem versus method, which involves cognitive or behavioral strategies. The result is four coping processes: cognitive approach; behavioral approach; cognitive avoidance; and behavioral avoidance.

**Validity and reliability.** The CRI-Y scales have moderate to high internal consistency with an average alpha of .69 for female youth and .68 for males. The scales are moderately inter-correlated with an average r's of .31 and .37 for girls and boys respectively. Moderate stability is reported with a 12 to 15 month follow up with average r's of .34 and .29 for girls and boys, respectively. It is hypothesized that the moderate test-retest reliability may in part be due to the rapid developmental changes taking place in this population, as well as the reliance on the self-report of a focal stressor which may in fact change in terms of content and severity upon retesting (Zalaquett & Wood, 1997; Moos, 1993).

The internal consistencies for the CRI-Y scales for girls are the following: approach responses; LA .68, PR.79, SG .69, PS .71. For the avoidance responses they are the following: CA .72, AR .59, SR .69, ED .61.

The CRI-Y scales; particularly cognitive avoidance, acceptance or resignation, and emotional discharge, differentiate predictably between distressed and healthy youth. Relationships have also been found between temperament, type and severity of acute stressors, appraisal of stressors, and the coping responses. Chronic stressors have been found to be connected with
avoidant coping. Social resources from family, school, and peers are associated with approach coping. Avoidance coping has been found to be predictive of subsequent stressors (Ebara & Moos, 1991, 1994; Timko, Moos, & Michelson, 1993). The CRI-Y scales have also been found to be predictive of stressor resolution and indices of youth functioning in the areas of depression, anxiety, alcohol and drug use, conduct problems, and self-confidence (Moos, 1993). Specifically regarding an undergraduate population, new college freshmen, parental support is connected to approach oriented coping yielding better adaptation to college (Holahan, Valentiner, & Moos, 1994; Valentiner, Holahan, & Moos, 1994). In a study on adjustment to relocation overseas, youth who utilized more approach coping strategies and fewer avoidant strategies demonstrated healthier adaptation to family relocation (Vercruysse & Chandler, 1992).

The CRI-Y has also been found to be predictive of Global Adjustment indices and situation specific, self rated coping effectiveness in a population of youth with diabetes who were asked to respond to various diabetes-related situations. In this study Reid, Dubow, and Carey (1995) found that higher levels of Approach coping styles, and lower levels of Avoidant coping predicted more positive outcomes.

Zeidner and Hammer (1990) used the CRI-Y to examine coping as a means of adaptation to stress. They looked at 108 junior high school students and administered the CRI-Y and the Stress Test for Children (STC). The sample was not randomly selected and although described as equally male and female, racial composition was not provided. Reliance on self-report measures only, as well as the homogeneity of the sample are limitations to the generalizing of the findings. The measures were administered on two different occasions with a time lapse of 16 weeks between the two testing occasions. Overall the total
scores of test time 1 and test time 2 did not differ significantly. Also, correlations ranged from .70 for the total score to .63 to .69 for the individual sub-scales, indicating that coping resources as measured by the CRI-Y were stable over time. In addition inter-correlations among the coping sub-scales at both testing times showed that they were more highly correlated with themselves than any other sub-scale. This speaks to the discriminating and convergent validity of the CRI-Y sub-scales. The CRI-Y was found to be predictive of self-reported psychological and physical distress symptoms. Zeidner and Hammer's findings support data that coping style is a meaningful predictor of symptomatology; and that indeed coping ability impacts upon one's psychological well-being.

Lackner (1992) used the CRI-Y in his dissertation, addressing stress, coping, and disordered eating in a sample of non-clinical males and females. He utilized a population of 232 students from a preparatory school in the Northeast. 145 males and 86 females who participated in the study. The age range was 11 to 19 for males and 13 to 19 for female participants. The sample was composed of 78% caucasian students, 5.6% black students, 8.6% Asian students, and 4% Hispanic students. Lackner's findings demonstrated consistency with other research showing a positive relationship of disordered eating and psychological distress, and a reliance on avoidance coping which has been connected with poorer adjustment in both normal and clinical samples. The avoidant style of coping utilized as measured by the CRI-Y, included emotional discharge, cognitive avoidance, and resigned acceptance.

Lackner's findings (1992) provide further evidence of the utility of the CRI-Y as a valid and reliable means of assessing coping responses. However, some methodological shortcomings of Lazarus' research are important to note. These include the reliance on self-report measures only, as well as only correlational analysis of the data. An additional limitation was the failure to
mention randomization of the sample, or how the subjects came to participate.

An interesting finding regarding gender was that girls rely more on support and guidance, an aspect of approach coping, while boys relied more on emotional discharge, an aspect of avoidance coping.

An additional study which provides support for the validity of the CRI-Y was conducted by Erickson, Feldman, and Stetner (1997). They explored the relationship of defense reactions and coping strategies in a non-clinical sample of adolescents. Their findings indicate that defense reactions and coping responses made contributions in predicted general adjustment as measured by the Global Assessment of Functioning (GAF). Erickson and Feldman's research provided an empirical understanding of how unconscious processes such as defenses, and more conscious cognitive and behavioral responses are activated and interact when the individual is challenged. This study included sample of 81; composed of 54% males with a mean age of 16.4 and a range from 12 to 19 years. Racial composition of the sample was primarily caucasian and predominantly middle class. Thus, the homogeneity of the sample compromises the generalizing of the findings of this study.

Ethnicity was a focus of a study by Munsch and Wampler (1993) who employed the CRI-Y to examine the differences among three ethnic groups of early adolescents with regard to responses to stressors in their school environment. The large sample size consisted of 51 African Americans, 222 Anglo Americans, 159 Mexican Americans, 1 Asian American, 6 Native Americans, 16 of mixed heritage, and 9 students with an unidentified ethnic background. The discriminative validity of the CRI-Y was demonstrated in Munsch and Wampler's findings. Although no significant findings were discovered with regard to gender or perceived stressfulness of events between the ethnic groups, a significant main effect was found regarding the cognitive
avoidance and seeking alternative rewards sub-scales of the CRI-Y. African American students reported greater reliance on the coping strategy of seeking alternative rewards than did Anglo-American students. The Mexican-American students did not differ significantly in comparison to these two ethnic groups. There were no significant differences regarding the sub-scales of logical analysis, positive reappraisal, problem-solving action, or emotional discharge. Munsch and Wampler's study is one of very few who focused on racial and ethnic variations in particular in response to stressful events.

The Millon Adolescent Clinical Inventory

The Millon Adolescent Clinical Inventory (MACI) is a 160 item self-report inventory used to assess personality characteristics and clinical syndromes. The response format is true/false and requires a minimum of a sixth grade reading level. It is estimated to take 30 minutes to complete (Millon, 1990). The MACI was used to assess the level of depression. It was designed to access information regarding adolescents personality characteristics and clinical syndromes. It was developed specifically to apply to clinical, residential, and correctional settings as a diagnostic and treatment aid. It is pertinent to a variety of clinical settings including outpatient, inpatient, and residential treatment. It has been normed on 1,017 adolescents from these settings across 28 states and Canada.

There are 27 scales that comprise the categories of personality patterns, expressed concerns, and clinical syndromes. There are also three modifying indices that assist in identifying the test-taking attitudes of the respondent and evaluate whether or not the report can be considered valid. The sub-scale that was used in this study is Depressive Affect sub-scale (FF).

**Validity and reliability.** The reliability of the Depressive Affect sub-scale FF specifically, test-retest scores with an interval of 3-7 days was .81 for scale.
It had a score of .88 in regard to internal consistency.

Generally, the Cronbach alpha reliabilities for the MACI are high, with a range of .73 to .91. Internal consistencies are in the .80s. Correlations against clinician’s impressions are low, with scores between .10 and .20. Test-retest reliability, at 3-7 day intervals yielded a range of .57 to .92, demonstrating strong stability over short increments of time (Millon, 1993).

Many of the MACI scales were inter-correlated with other measures. Specifically, correlations of .75 and .88 respectively between the Eating Dysfunction Scale of the MACI and the Drive for Thinness and Body Dissatisfaction measures on the Eating Disorder Inventory-2. Correlations of .59 were found between the Depressive Affect Scale of the MACI and the Beck Depression Inventory and Beck Hopelessness Scale. Weaker findings resulted between the Body Disapproval scale of the MACI and a bulimia measure with a correlation of .25. Weaker still was a finding of .02 between the Peer Insecurity Scale of the MACI and another measure of social insecurity. Overviews of the MACI call for additional research between its scales and other measures (Conoley & Impair, 1995). A criticism of the MACI is the significant item overlap among diagnostic scales yielding high intercorrelation, thus leaving to question whether this scale actually measures as many dimensions as it proposes (Millon & Davis, 1993).

**Life Events Scale - Adolescents**

The Life Event Scale for Adolescents (LESA) (Coddington, 1972) was designed for use with adolescents aged 12-19. The purpose of the LESA is the quantification of environmental stressors with which the individual has had to cope in the past year. It was used to quantify and increase objective appraisal of adjustment to life events for subjects in the past year.
The LESA is a 50 item self-report measure taking approximately five minutes for the individual to complete. The items are both desirable and undesirable events judged to be stressful for an adolescent and to require social readjustment. Each item is given a life change unit (L.C.U.) value. These units were rated by 243 professionals, including 131 teachers, 25 pediatricians, and 87 mental health workers (Coddington, 1972).

Coddington (1972) established normal values for children of different ages, establishing a normal curve on which the individual's L.C.U.'s can be plotted and compared to a norm for their age range. In the 1972 study 3,526 children and adolescents from the state of Ohio, were administered the Life Events Scale for Children (LESC) and LESA. The results yielded norms for children and adolescents.

The LESA is scored by adding the L.C.U.'s of the events that were confirmed to have occurred by the respondent. This score can then be compared to the norms established by Coddington.

**Reliability and validity.**

Test-Retest reliability data for the LESA was obtained by administering the scale to 33 male adolescents at 3, 7, and 11 month intervals. The results yielded correlations of .69, .67, and .56 respectively for total life events scores. For undesirable life event scores the correlations were .071, .066, .064 (Garrison, Schoenbach, Schluchter, & Kaplan, 1987).

Inter-rater reliability was established by confirmation with the parents of the same 33 male adolescents that such stressors had occurred. This yielded correlations of .45 at 7 months, and .37 at 23 months for the total life event score; and .10 at 7 months and .31 at 23 months for the undesirable life event scores. With desirable life event scores, correlations of .55 at 7 months and .41 at 23 months were found. It is reported that all correlations with the exception of
the 7 month undesirable score were significant at the .05 level or below (Garrison, et al., 1987).

In a study of 677 junior high school students evaluating life events Garrison, et al. (1987) found good test-retest stability on most individual items. The overall test-retest correlations were .64 for total score, .58 for undesirable, and .69 for desirable life events. These are slightly lower than the 3 month test-retest correlations reported by Coddington (1992). Garrison questions the validity of the responses given by the students with regard to time frame, noting the elevated number of events reported by a portion of students, particularly African American students. Garrison calls for further research regarding race and time frame and how it impacts upon response to the LESA.

**Design and Method of Data Analysis**

This exploratory study used the naturally occurring population in a residential facility for adolescent females. The variables were: number of out-of-home placements; age of first placement; experience of physical or sexual abuse; environmental stress; depression; approach and avoidant coping styles. The following hypotheses and analysis were proposed for this study. The goal of the research was to obtain as large a sample size as possible. However, soliciting parental consent for residentially placed adolescents limited access to larger samples.

**Hypotheses**

**Hypothesis 1**

The scores for Approach and Avoidance coping, stress, and number of placements (predictor variables) will account for a statistically significant proportion of variance in depression (criterion variable).

In order to determine if the results of the analysis supported the first hypothesis, adolescent females in residential placement reported depression
was regressed on measures of approach coping, avoidant coping, stress, and the number of out-of-home placements. The proportion of unique variance attributed to each of the predictor variables was reported. A multiple regression analysis was used to measure the amount of variance (MR^2) associated with depression which was accounted by the four predictor variables, Approach and Avoidance coping, stress, and number of placements. The unstandardized regression coefficients (b weights) along with the intersection of the Y axis were reported. The standardized regression coefficients (Beta weights) were also reported. Finally, Sr^2, the amount of unique variance of the criterion measure Depression, were reported for the attribution to each of the predictor variables.

**Hypothesis 2**

Female adolescents in residential settings will report a significantly greater level of depression as measured by the MACI, if they had been sexually abused when compared to female residents who had not been sexually abused.

In order to determine if the results of the analysis supported the second hypothesis, a Mann Whitney U - Test was used because of the small nonequal cells. The null hypothesis was tested at the .05 level using a directional test.

**Hypothesis 3**

Female adolescents in residential settings will report a significantly greater level of depression as measured by the MACI, if they had been physically abused when compared to female residents who had not been physically abused.

In order to determine if the results of the analysis supported the third hypothesis, a Mann Whitney U - Test was used. The null hypothesis will be tested at the .05 level using a directional test.

**Hypothesis 4**

Scores for Depression and Avoidant coping (predictor variables) will
account for a statistically significant proportion of variance attributed to age of first placement (criterion variable).

A multiple regression analysis was used to measure the amount of variance ($R^2$) associated with age of first placement that is accounted for by depression and avoidant coping. The proportion of unique variance attributed to each of the predictor variables was reported. The unstandardized regression coefficients ($b$ weights) along with the intersection of the $Y$ axis were reported. The standardized regression coefficients (Beta weights) were also reported. Additionally, the $R^2$, the amount of unique variance of the criterion measure age of first placement was reported for the attribution of each of the predictor variables.

**Hypothesis 5**

There will be a significant positive relationship between the avoidance coping style as measured by the CRI-Y and focal stressor as reported on the CRI-Y of adolescent females in residential placements.

In order to determine if the results of the analysis supported the fifth hypothesis, a directional (one-tailed) Pearson product-moment coefficient, zero order correlation coefficient, was used. The null hypothesis of no significant relationship will be tested at the .05 level.
CHAPTER IV
RESULTS

Introduction

The researcher examined the experiences of physical and/or sexual abuse and multiple out-of-home placements, and age of first placement with life stress, depression, and coping style in a sample of residentially placed female adolescents. The n of 28 parallels the challenges of collecting a sample from a population of adolescent residentially placed females, and reflects similarly sized samples in professional papers in the review of the literature (Burks, 1995; Kushner, 1991; Miskimins, 1990; Raynor & Manderino, 1988; Small & Schinke, 1983). Given the scarcity of information regarding residentially placed adolescent females, the research was exploratory in nature, with the intent to add to the knowledge base of females in residential treatment with histories inclusive of abuse and repeated placements. The presence of relationships among coping, depression, and life stress variables associated with adolescent females in residential placement were evaluated and analyzed. Descriptive information including the racial composition of the sample, age, age of first placement, number of placements experienced, depression levels, and abuse histories were tabulated.

The results section includes the demographic data and clinical nature of the sample. Also included are the results of the analysis according to the proposed hypothesis. The results are reported under the following subsections: a) Non-Clinical Demographic data, b) Clinical Demographic Data c) Analysis of the a priori hypothesis and d) Supplemental Analysis.
Descriptive Statistics of the Non-Clinical Demographic Data

Although the majority of the adolescent females approached for participation consented to take part in the study, only 28 parents/guardians authorized participation in the study. A total of 101 girls were approached about the study. Ninety-eight (97%) of the 101 adolescent females agreed to participate. Two changed their minds at the time of testing. However, only 28 (28%) of the parents/guardians contacted about the study provided the necessary additional consent.

The ages ranged from 13 to 18, $M = 16$, $SD = 1.36$. The ethnic/racial profile was as follows: 21 Caucasian (75%); 2 Black (7.1%); 1 Hispanic (3.6%); 1 Caucasian/Hispanic (3.6%); 2 Jamaican/Black (7.1%); and 1 (3.6%) did not report their ethnic/racial identification. There was variability in age of first placement: ranging from 2-17 years; and number of placements: ranging from 1-13 placements. The frequencies of the ages, age of first placements and number of placements are reported in Table 1. Table 1 was organized according to the participant's current ages. However, subjects of the same age were placed at different ages and had experienced a different $n$ of placements.
Table 1

Frequencies of Age, Age of First Placement, and Number of Placements of Adolescent Females in Residential Placement

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<th>Age First Placed</th>
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Demographic Clinical Data

The sample subjects were categorized according to depression levels on the basis of Millon's (1993) categorizations. The results demonstrated that 42.9% scored less than 61 on the Base Rate (BR) scale of the Millon Adolescent Clinical Inventory (MACI); not scoring in the significant level for depression. However, 57.1% of the sample scored in the mild to severe range with scores at or above 61 on the BR scale. The frequencies and percentages for levels of depression are reported in Table 2.

The facility coordinators who had access to student files supplied the listings of physical and/or sexual abuse. It was found that while 25% did not have any documented or substantiated history of abuse, the remaining 75% of the sample had. The frequencies and percentages of physical and/or sexual abuse are reported in Table 3. The four subgroups of abuse were also categorized based on levels of depression. The frequencies and percentages are reported in Table 4. The mean depression score was (\( M = 67.24, SD = 22.45 \)). The mean score for the Focal stressor as reported on the Coping Response Inventory – Youth (CRI-Y) was (\( M = 60.25, SD = 28.44 \)).

According to Coddington (1981), scores on the Life Events Scale for Adolescents (LESA) greater than 135 for a 13 year old, 170 for 14 – 16 year olds, and 200 for 17 – 19 year olds indicate significance. The mean score of the residential adolescent females was 320.67. The adolescent girls in this sample had a significantly elevated life stress score of 71.4%.
Table 2

Levels of Depression for Residentially Placed Adolescent Females

<table>
<thead>
<tr>
<th>Level of Depression</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Depressed</td>
<td>12</td>
<td>42.9</td>
</tr>
<tr>
<td>Mildly Depressed</td>
<td>2</td>
<td>7.1</td>
</tr>
<tr>
<td>Moderately Depressed</td>
<td>9</td>
<td>32.1</td>
</tr>
<tr>
<td>Severely Depressed</td>
<td>5</td>
<td>17.9</td>
</tr>
</tbody>
</table>

Table 3

History of Abuse

<table>
<thead>
<tr>
<th>Form of Abuse</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual abuse</td>
<td>6</td>
<td>21.4</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>1</td>
<td>3.6</td>
</tr>
<tr>
<td>Sexual and Physical abuse</td>
<td>14</td>
<td>50</td>
</tr>
<tr>
<td>No abuse</td>
<td>7</td>
<td>25</td>
</tr>
</tbody>
</table>
### Table 4

**Contingency Table of Abuse History with Millon Depression Categories**

**Abuse History**

<table>
<thead>
<tr>
<th>Depression Categories</th>
<th>Sexually Abused</th>
<th>Physically Abused</th>
<th>Physically &amp; Sexually Abused</th>
<th>No Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Depressed</td>
<td>2 16.7</td>
<td>0 0</td>
<td>6 50.0</td>
<td>4 33.3</td>
</tr>
<tr>
<td>Mild</td>
<td>1 50.0</td>
<td>0 0</td>
<td>1 50.0</td>
<td>0</td>
</tr>
<tr>
<td>Moderate</td>
<td>2 22.2</td>
<td>0 0</td>
<td>5 55.5</td>
<td>2 40.0</td>
</tr>
<tr>
<td>Severe</td>
<td>1 20.0</td>
<td>1 20.0</td>
<td>2 40.0</td>
<td>1 20.0</td>
</tr>
</tbody>
</table>

---

**Testing of the Hypotheses**

The results of the analysis of the hypotheses follow.

**Testing Hypothesis 1**

There will be a significant amount of variance attributed to depression as measured by the MACI (criterion variable) of adolescent females accounted for by approach coping and avoidance coping as measured by the CRI-Y scales, stress as measured by the LESA, and number of out-of-home placements (predictor variables). The correlations among the measures of the depression scores, Approach scores, Avoidance scores, number of placements, and Life stress are reported in Table 5. The zero order correlations between the measure of depression with the approach and avoidance scores were in the expected directions as follows. A positive relationship between depression and the avoidance measure was significant beyond the .10 level using a directional test, $r, (df = 28) = .26, p = .09$. The correlation between the measure of depression with
the approach assessment was $r = -.19$, ($df = 26$), $p = .17$. The other correlational relationships were non-meaningful relationships.

Table 5

**Correlation Matrix of Depression, Approach, Avoidance, Life Events and Number of Out of Home Placements**

<table>
<thead>
<tr>
<th></th>
<th>Depression</th>
<th>Approach</th>
<th>Avoidance</th>
<th>Stress</th>
<th>N of Placements</th>
</tr>
</thead>
<tbody>
<tr>
<td>MACIBR</td>
<td>1.0</td>
<td>-.19</td>
<td>.26*</td>
<td>.07</td>
<td>-.12</td>
</tr>
<tr>
<td>CRIAPP</td>
<td>1.00</td>
<td>.61**</td>
<td></td>
<td>.09</td>
<td>-.08</td>
</tr>
<tr>
<td>CRIAVOID</td>
<td></td>
<td>1.00</td>
<td></td>
<td>-.00</td>
<td>-.23</td>
</tr>
<tr>
<td>LIFEIEN</td>
<td></td>
<td></td>
<td>1.00</td>
<td></td>
<td>.06</td>
</tr>
<tr>
<td>NOUTPL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.00</td>
</tr>
</tbody>
</table>

**Note.** *p < .10, **p < .001

The results of the multiple regression analysis are reported in Table 6 and Table 7. The four independent measures (approach coping, avoidance coping, life stress, number of out-of-home placements) accounted for 27.3% ($MR = .52$, $MR^2 = .273$) of the variance associated with depression, $F (4.23) = 2.16$, $p = .11$. The results of the multiple regression analysis indicated that the two predictor measures, Approach and Avoidance accounted for significant proportions of unique variance which attributed to the criterion measure of depression. The Approach measure accounted for 19.8% of the variance towards depression, $t = 2.57$, $p = .017$. The Avoidance measure accounted for 21.0% of the unique variance towards depression, $t = 2.74$, $p = .011$. The measures of stress and number of out of home placements did not contribute
any measurable quantities of unique variance to the prediction of the criterion measure of depression. When the two noncontributing measures, life events and N of placements are removed from the regression equation, the overall F-ratio becomes significant beyond the .02 level, \( MR = .51, MR^2 = .260, F (2,25) = 4.34, p = .02 \). The variance of depression accounted for by approach and avoid increased to .19 and .22 respectively.

Table 6

**Equation 1: Multiple Regression of Depression on Approach, Avoidance, Stress and Number of Out of Home Placements**

<table>
<thead>
<tr>
<th>Variables</th>
<th>b</th>
<th>SEb</th>
<th>Beta</th>
<th>t</th>
<th>Sr²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approach</td>
<td>-.82</td>
<td>.33</td>
<td>-.56</td>
<td>-2.5*</td>
<td>.198</td>
</tr>
<tr>
<td>Avoid</td>
<td>1.0</td>
<td>.39</td>
<td>.59</td>
<td>2.57*</td>
<td>.210</td>
</tr>
<tr>
<td>Life Events</td>
<td>.01</td>
<td>.01</td>
<td>.12</td>
<td>.67</td>
<td>.014</td>
</tr>
<tr>
<td>N of Placements</td>
<td>-.26</td>
<td>1.29</td>
<td>-.04</td>
<td>-.20</td>
<td>0</td>
</tr>
<tr>
<td>Constant</td>
<td>51.93</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* *p < .05*
Table 7

Equation 2: Multiple Regression of Depression on Avoidance and Approach

\[ MR = .51 \quad MR^2 = .258, \ F (2,25) = 4.33, \ p = .02 \]

| Variables | b  | SEb | Beta | t    | Sr2
|-----------|----|-----|------|------|----
| Approach  | .80| .31 | -.55 | -2.6*| .20
| Avoid     | 1.0| .37 | .60  | 2.7* | 2  
| Constant  | 54.98 |

Note. \( p < .05 \)

Testing Hypothesis 2

Female adolescents in residential settings will report a significantly greater level of depression as measured by the MACI if they had been sexually abused, compared to female adolescent residents who had not been sexually abused.

The results of the data analysis did not support the third hypothesis. Since there was a discrepant frequency count for the two groups (mean rank of 12.36 for non-abused subjects, mean rank of 14.5 for abused subjects), a non-parametric test, the Mann-Whitney \( U \) Test was used (Roscoe, 1975). The results of the nonparametric \( U \)-test did not support the second hypothesis. The mean rank of 7 non-abused adolescent females, \( R = 12.36 \), and the mean rank of 20 abused adolescent females, \( R = 14.57 \), were not significantly different beyond the .05 level, \( U = 58.5, z = .64, p = .52 \).

Testing Hypothesis 3

Female adolescents in residential settings will report a significantly greater level of depression as measured by the MACI, if they had been physically abused when compared to female residents who had not been physically abused.
Results of the data analysis did not support the third hypothesis. Since there was a discrepant n for the two groups (Mean Rank of 10.14 for non-abused and Mean Rank of 12.13 for abused), the non-parametric Mann-Whitney \( U \) test was used, \( U = 43.0, z = .67, p = .50 \).

**Testing Hypothesis 4**

There will be a significant proportion of variance attributed to age of first placement (criterion variable) with levels of reported depression as measured by the MACI, and avoidance coping as measured by the CRI-Y (predictor variables) by female adolescents in residential placements.

There were directional correlations significant beyond the .10 level between age of first placement with avoidance, \( r = .28, df = 26, p = .08 \) and depression, \( r = .26, df = 26, p = .09 \) (see Table 8).

**Table 8**

*Correlation Matrix of Age of First Placement, Depression, and Avoidance*

<table>
<thead>
<tr>
<th></th>
<th>Age of First Placement</th>
<th>Depression</th>
<th>Avoidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of First Placement</td>
<td>1.00</td>
<td>.20</td>
<td>.28*</td>
</tr>
<tr>
<td>Depression</td>
<td>1.0</td>
<td></td>
<td>.26*</td>
</tr>
<tr>
<td>Avoidance</td>
<td></td>
<td>1.0</td>
<td></td>
</tr>
</tbody>
</table>

*Note.* \( p < .10 \)

The results of the standard regression equation are reported in Table 8. The measure of avoidance and depression accounted for 9.4% of the variance attributed to age of first placement, \( M^2 = .306, M^2 = .094 \), a nonsignificant relationship, \( F(2,25) = 1.29, p = .29 \). Moreover, the unique variances attributed
to the predictor variables did not significantly contribute to the explanation of variance attributable to first placement.

Table 9

Multiple Regression of Age of First Placement Regressed on Depression, and Avoidance

<table>
<thead>
<tr>
<th>Variables</th>
<th>b</th>
<th>SEb</th>
<th>Beta</th>
<th>t</th>
<th>Sr²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>.029</td>
<td>.04</td>
<td>.14</td>
<td>.71</td>
<td>.018</td>
</tr>
<tr>
<td>Avoidance</td>
<td>.08</td>
<td>.07</td>
<td>.24</td>
<td>1.21</td>
<td>.057</td>
</tr>
<tr>
<td>Constant</td>
<td>6.83</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Testing Hypothesis 5

There will be a significant positive relationship between the avoidance coping style as measured by the CRI-Y and focal stressor as reported on the CRI-Y of adolescent females in residential placements.

The results of the analysis did not support the fifth hypothesis. The result was a negative correlation between the measures of avoidance coping and the focal stressor, \( r = - .13, \text{df} = 26, \ p = .51 \). Moreover, the coefficient of correlation was in the opposite direction than was hypothesized.

Supplemental Analysis

In reviewing the data, it was noted by the researcher that the adolescents who experienced multiple forms of abuse demonstrated higher scores on the focal stressor reported on the CRI-Y. The mean score for the focal stressor for sexually abused only and physically abused only groups was \( M = 44 \) and \( M = 43 \) respectively. However, the mean score for those adolescent females who
had experienced both physical and sexual abuse was $M = 72.36$. This information led the researcher to conduct a supplemental analysis. Comparisons were performed to compare the adolescent females who reported multiple abuses (sexual and physical) with the remainder of the sample. Since this was an a posteriori analysis, a non-directional $t$-test was used with significance established at the .05 level. Additionally, since the $n$ of 28 was small, the researcher corroborated the $t$-test comparisons with Mann-Whitney $U$ tests. According to Roscoe (1975, p. 236) the $U$ test is "especially appropriate for use with small samples." Therefore in each supplemental analysis, the $U$ test was reported to corroborate the $t$-test analysis. The results of the $U$-test for the focal stressor were significant beyond the .01 level (MR non-multiply abused = 10.36, MR multiply abused = 18.64), $U = 40.0$, $z = 2.67$, $p < .01$.

A summary of the comparisons of the 14 multiply abused residential adolescents who reported histories of multiple abuses, with the 14 females who reported one type of abuse or no abuse are found in Table 10. There were significant findings that were indicative of the emotional and social impact of the effects of multiple abuse.
Table 10

Comparison of Residentially Placed Multiply Abused Adolescent Females with All other Residentially Placed Adolescent Females on Coping, Depression, Stress Assessments, and Placement History

<table>
<thead>
<tr>
<th>Scale</th>
<th>Multiply Abused Adolescents</th>
<th>Other Adolescents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>M</td>
</tr>
<tr>
<td>Logical Analysis</td>
<td>14</td>
<td>45.43</td>
</tr>
<tr>
<td>Positive Reappraisal</td>
<td>14</td>
<td>48.14</td>
</tr>
<tr>
<td>Seeking Guidance/Support</td>
<td>14</td>
<td>51.5</td>
</tr>
<tr>
<td>Seeking Alternative Rewards</td>
<td>14</td>
<td>50.21</td>
</tr>
<tr>
<td>N of Out/Home/Placements</td>
<td>14</td>
<td>5.42</td>
</tr>
<tr>
<td>T on Approach</td>
<td>14</td>
<td>28.64</td>
</tr>
<tr>
<td>Focal Stressor Subscale</td>
<td>14</td>
<td>72.35</td>
</tr>
<tr>
<td>Age First Placed Out of Home</td>
<td>14</td>
<td>10.28</td>
</tr>
</tbody>
</table>

Note: *p < .05  **p < .01
The mean score for the multiply abused adolescents on Logical Analysis (LA), a sub-scale on the CRI – Y ($M = 45.43$, $SD = 9.64$) was significantly less than the mean LA score for the other female adolescents ($M = 55.21$, $SD = 8.18$) beyond the .01 level of significance, $t = 2.90$, $df = 26$, $p = .008$. The results of the $U$-test were significant beyond the .01 level ($MR$ non-multiply abused = 18.50, $MR$ multiply abused = 10.50), $U = 42.0$, $z = -2.58$, $p < .01$. Therefore the multiply abused students were described as not being able to use the cognitively adaptive coping strategy of logical analysis to the degree that the other residentially placed adolescent females were able to use it.

The mean score for the multiply abused adolescent on Positive Reappraisal (PR), a sub-scale on the CRI – Y ($M = 46.14$, $SD = 8.86$) was significantly less than the mean PR score for the other female adolescents ($M = 57.21$, $SD = 10.79$) beyond the .01 level of significance, $t = 2.97$, $df = 26$, $p = .006$. The results of the $U$-test were significant beyond the .01 level ($MR$ non-multiply abused = 18.71, $MR$ multiply abused = 10.29), $U = 39.0$, $z = -2.72$, $p < .01$. Therefore, the multiply abused residential adolescent females were described as not being able to utilize the cognitively adaptive coping strategy of positive reappraisal to the degree that the other adolescent females were able to use it.

The mean score for the multiply abused adolescent on Seeking Guidance and Support, a sub-scale on the CRI – Y ($M = 51.5$, $SD = 8.87$) was significantly less than the mean SG score for the other female adolescents ($M = 62.07$, $SD = 13.03$) beyond the .05 level of significance, $t = 2.54$, $df = 26$, $p = .018$. The results of the $U$-test were significant ($MR$ non-multiply abused = 17.82, $MR$ multiply abused = 11.18), $U = 51.5$, $z = -2.14$, $p < .03$. The multiply abused residential adolescent females were described as not being able to use the behaviorally adaptive coping strategy of seeking guidance and support as
effectively as the other subjects in the study.

The mean score for the multiply abused adolescent on Seeking Alternative Rewards (SR), a sub-scale on the CRI – Y (M = 50.21, SD = 9.89) was significantly less than the mean SR score for the non-abused female adolescents (M = 59.57, SD = 10.88), beyond the .05 level of significance, t = 2.38, df = 26, p = .025. The results of the U - test were significant beyond the .05 level (MR non-multiply abused 18.0, MR multiply abused = 11.0), U = 49.0, z = -2.26, p < .02. The multiply abused residential adolescent females were described as not being as adept at utilizing the behaviorally adaptive coping strategy of seeking alternative rewards as effectively as the other subjects in the study.

The mean score for the multiply abused adolescent on the number of out of home placements (M = 5.42, SD = 3.65), was significantly more than the mean number for the non-abused female adolescents (M = 2.78, SD = 1.92), beyond the .05 level of significance, t = -2.39, df = 26, p = .024. The results of the U - test were significant beyond the .05 level (MR non-multiply abused 11.29, MR multiply abused = 17.71), U = 53.0, z = -2.10, p < .04. The multiply abused residential adolescent females experience a greater number of placements than their non-abused peers.

The mean score for the multiply abused adolescent on the CRI – Y Approach (M = 28.64, SD = 12.72), was significantly less than the mean score for the non-abused female adolescents (M = 43.78, SD = 14.65), beyond the .05 level of significance, t = 2.92, df = 26, p = .007. The results of the U - test were significant beyond the .01 level (MR non-multiply abused 18.50, MR multiply abused 10.50), U = 42.0, z = -2.6, p < .01 Thus, the multiply abused female adolescents in residential treatment did not utilize adaptive approach strategies as effectively as other subjects.
The mean score for the multiply abused adolescents on the Focal Stressor reported on the CRI – Y ($M = 72.35$, $SD = 29.44$), was significantly higher than the mean score for the other female adolescents ($M = 48.14$, $SD = 22.28$), beyond the .05 level of significance, $t = -2.45$, $df = 26$, $p = .021$. Thus the multiply abused female adolescents in residential treatment demonstrated an elevated experience of stressors in their lives in the past year.

The mean score for the multiply abused adolescent for age of first placement out of her home of origin ($M = 10.28$, $SD = 5.75$), was at a significantly earlier age than the mean score for the non-multiply abused female adolescents ($M = 14.07$, $SD = 1.86$), beyond the .05 level of significance, $t = 2.34$, $df = 26$, $p = .027$. The $U$ - test however, did not demonstrate significance ($MR$ non-multiply abused = 16.50, $MR$ multiply abused = 12.50), $U = 70.0$, $z = -1.31$, $p < .20$. It was noted that the discrepancy between the $t$-test and the $U$-test for the age of first placement may be explained by Levine’s test for homogeneity of variances, $F = 24.19$, $p = .001$, in that the homogeneity of variance assumption was violated. The results were, however, in the expected direction. Therefore, these findings warrant further investigation. The above findings were unique to the analysis, as the other $t$ - tests were corroborated by the use of the non-parametric $U$ - test.
CHAPTER V

RESTATEMENT OF THE PROBLEM, DISCUSSION, LIMITATIONS, AND DIRECTIONS FOR FUTURE RESEARCH

Restatement of the Problems

While both researchers and clinicians have investigated residential treatment experiences for children and adolescents, the literature remains surprisingly sparse when compared to the magnitude of the emotional and social impact on the development of the child and adolescent in residential treatment. Changes and pressures from the health care system as well as the natural tendency to want to demonstrate change and effectiveness have produced a tendency toward outcome studies, treatment description, and policy research. As reviewed in the professional literature, there is a need for additional research to both better understand the etiologies and personality traits of female adolescents in residential programs as well as the impact of factors leading to residential placement on depression, coping strategies, and reported stress. The characteristics of the residential female population are important descriptives if effective intervention strategies are going to be implemented. The purpose of this study was to examine a number of specific variables regarding residentially placed female adolescents. These variables were chosen based on pre-existing literature, as well as the clinical experience of the researcher to be significant variables associated with the treatment challenges the residential adolescent female confronts.

The researcher examined the relationship of avoidant and approach styles of coping, depression, life stress, and historical variables including
physical and sexual abuse, the number of out-of-home placements, and age of first placement away from the home of origin. The potential developmental impact of these variables can be extensive. The researcher sought to further the understanding the impact these variables have on the developmental course of the female adolescent in residential care. The data were intended to assess the impact of abuse on maladaptive and adaptive coping, depression, and stress. The small sample size (N = 28) limited the inferences and generalizing of the findings.

Discussion

Hypothesis One stated that there will be a significant degree of variance attributed to depression accounted for by approach coping and avoidance coping, stress, and the number of out-of-home placements the residentially placed female experienced. An analysis of the data supported the direction of the hypothesis, as a positive relationship between depression and both the approach and avoidant coping styles were demonstrated. The latter two variables also accounted for the most significant degree of explained variance for depression. Approach and avoid were positively correlated with one another. The analysis of the data supported the tendency for these two forms of coping to be utilized. Together, they accounted for a greater degree of variance than they would have singularly, acting as a stronger predictor for depression than they would have standing alone. Hypothesis 1 supported the positive relationship between avoidant coping and depression. Thus, when depression is elevated avoidant coping is as well.

This finding is consistent with previous research and clinical theory that poor coping skills can facilitate depression. In addition, research and clinical data revealed the impact that poor social interactions can result from the implementation of maladaptive coping skills and consequently can maintain
dysphoric affects. The clinical significance of this finding is that the interaction between depression and coping warrants particular attention in the residential milieu. Without addressing coping skills in treatment, the residential adolescent remains vulnerable to continued struggles with dysphoric affect and subsequently poor interpersonal interactions. Both adequate interpersonal, cognitive, and coping skills are essential to effectively mediate behavior. Effective cognitive skills used to approach problems may actually positively effect social interactions and subsequently alleviate or inoculate the residential adolescent from depression.

Residential adolescents have typically experienced maltreatment and rejection by multiple caregivers, therefore they are vulnerable to the emotional repercussions that loss may trigger for them. At the time of testing, some of the adolescents spoke freely about their histories of severe abuse. One resident spoke vividly and casually about her history of rape and abuse during the time which this researcher met with them to discuss participation. The impression that was left, was that these were issues that apparently continued to be at the forefront of treatment. Consequently, more adaptive coping strategies are needed to navigate stressors and personal strategies that could facilitate better social adaptation. More positive social interactions and relationships may provide a buffer against problems associated with residential youth who have experienced multiple out-of-home placements; such as homelessness, incarceration, unemployment, relationship problems, school failure, and teen parenthood (Penzerro, 1993). Brennan (1993) discussed the underlying relevance of adaptive coping to substantial relationships of healthy attachment. The frequency of multiple placements demonstrated in the data as well as 75% of documented/substantiated abuse in the sample from this investigation reflected histories of maltreatment and disrupted attachments. McIntyre (1991)
and Penzerro (1993) discussed the significance of disrupted, chaotic histories and their connection to patterns of alienation and difficulties forming subsequent trusting relationships. This repetitious experience for the residential adolescent during formative developmental years compromises resources available in their environment to develop and incorporate healthy adaptive strategies into their identity. The purpose of adaptive coping is to increase resources for dealing with internal and external stressors and manage the tension experienced internally as a result of external stressors. The adolescents in residential programs have demonstrated behaviors beyond the tolerance of society. Managing behavior is a significant issue in treatment. In light of the data, greater probability of depression and poor coping strategies has the potential for a negative impact on social relationships. Additionally, the adolescent females in this study reported extraordinarily elevated stress levels including experiences of rape, multiple deaths, incest, and multiple disruptions in their environment. High levels of stress are associated with escalated behavioral problems.

It seems that adolescent females in residential care are able to access both forms of coping styles. That is, they are able to do this cognitively for the purpose of report on this measure. However, the question remains, can they translate these cognitions into action and apply the adaptive skills to stressful situations? Prior research has demonstrated that in spite of the ability to report adaptive coping skills, this was not associated with decreased behavioral problems.

Hypothesis Two states that a greater degree of depression will be found with the adolescent females who have been sexually abused when compared to their peers who have no reported history of sexual abuse. The hypothesis was not supported by the results of the analysis. However, there were high levels of depression in the total sample.
This hypothesis was generated in an effort to look at physical abuse and sexual abuse as separate variables. It has been far more common for physical and sexual abuse to be addressed under the one category of abuse. In fact, only one study by Mennen and Meadow (1993) could be found regarding residually placed adolescent females that addressed sexual abuse and physical abuse as separate variables. Mennen's et al. study reported 59.6% with histories of sexual abuse. This is comparable to this researcher's study with 50% of the sample reporting histories of an experience of sexual and physical abuse, and 21.4% experiencing solely sexual abuse. Thus, 71.4% of the sample had documented/substantiated incidences of sexual abuse. Mennen, et al. (1995) found that the residential adolescent who had experienced sexual abuse when compared to the residential females who had no reported history of sexual abuse, scored significantly higher on indices of depression. Mennen, et al. used self-report as well as therapist scores to obtain their data. The scores from these two sources were in agreement. In fact, Mennen's study found that the mean level of depression found in the sexually abused females was higher than their peers experiencing major depression.

Given Mennen's, et al. (1995) significant findings, it appears that this is worth exploring in future research to see if it is a finding that is replicated in a larger sample. There is a lack of data regarding abuse in this population. Small, et al. (1991) stressed the need for such research given the tendency toward 'abuse reactivity'; or the specific issues related to residential youth regarding their histories of abuse and neglect. This he suggests, is key in understanding how to approach and stimulate change in the residential adolescent's level of functioning and adaptation.

The generally high levels of depression, as well as moderate levels of depression in the sample are significant. Given the potential impact depression
can have on the individual's current and future functioning, it is critical that this be addressed in the residential setting. Depression has the potential to impede the developmental course, inhibit appropriate social interaction and development of coping skills. It is also frequently associated with other issues, such as anxiety and the development of future pathologies, and therefore should be considered a 'flag' for the identification of other comorbid issues. Additionally, prior experiences with depression, as well as even moderate levels of depression are considered variables associated with vulnerability to future issues related to depression.

Hypothesis Three states that there will be a greater level of depression when the adolescent in residential treatment had experienced physical abuse, as compared to those without this history. Again the analysis of the data did not support this hypothesis. Like sexual abuse, physical abuse did not provide a distinguishing variable to account for the experience of depression. While no previous research addressing physical abuse separately was found, the need for such research was cited in several studies. The prevalence of child abuse experiences in the histories of residential adolescents has been documented sufficiently to warrant its thorough investigation. Tissue and Korz (1993) conducted a study on post-treatment outcomes for 88 young adults who attended a psychoeducational center for emotionally disturbed youth when they were 5 – 14 years old. Tissues, et al. reported that a history inclusive of child abuse was found to be negatively correlated with adjustment. The analysis of the data suggest the need to continue to include abuse as a variable in determining more specific treatment needs for residential adolescents in an effort to enhance post-treatment success.

It is also possible that the adolescents in residential care who have
experienced singular episodes of abuse may not be as affected as those who experience multiple episodes and types of abuse. Additional variables not accounted for in the data are the time of the abuse; the relationship to the perpetrators; the responses to the abuse revelations by significant others; and the severity of the abuse. These are but some of the factors surrounding the experience of abuse that may have influenced the difficulty detecting the relationship of abuse to depression. Participants were solely voluntary, and whose parents were willing to allow their children to participate. Parents who consented to evaluation also may be more open than other parents who may be more defensive about to their child care roles or simply inaccessible due to lack of stability and transience. The parents may also be the perpetrators of the abuse and therefore uncomfortable with this variable in the study, and they consequently did not agree to allow their child to participate. This factor could have affected the acquisition of a larger proportion of the sample who had histories of each form of abuse.

Hypothesis Four states that the age when the adolescent female was first placed will be predictive of depression and avoidance coping. This hypothesis was not supported. The age of the residential adolescent female when first placed away from their home of origin did not significantly contribute to avoidance coping, or depression. It is possible that the small sample size affected the ability to detect the influence of age of first placement on coping and depression.

Developmental theorists such as Bowlby state that these formative years are critical to the formation of secure attachments from which the child builds healthy emotional and cognitive skills. This, as well as Cooper's, et al. (1987) study contradicts the findings of the current study. It would be important for future research to explore the significance of the age of the first placement away
from the home of origin and its relationship to maladaptive and adaptive coping, and towards depression. This information would be crucial to address the increased behavioral problems that accompany children who are multiply placed, and entered into a cycle of re-placement that only escalates the behavior with subsequent further placements. While there is little prior data regarding age of first placement and its relationship to other clinical variables pertinent to residential youth, Cooper, et al. (1987) found that over half of the youth in her sample of 172 had experienced a removal from their home of origin by their preschool years. Developmentally, these are critical years in the formation of secure attachment. It is theorized that secure attachment serves as the foundation for future adaptive development, for ego functions, social interactions, and adaptive cognitions, all of which are contributory to healthy social integration and adaptation. The small sample size and design of the current investigation may have inhibited the detection of the influence of age of first placement. Perhaps a larger sample, with a longitudinal design would provide sufficient rigor to address this issue.

Cooper, et al. (1987) found that over half of their sample of 172 were removed from their homes during the formative years of 1–3; and that they were most likely to experience a greater number of placements and spent the longest time in foster care. It would seem that these children would be at a heightened risk for developmental disruption given attachment theory that emphasizes the time from age 1-3 as sensitive to the development of successful internal working models. Object relations theory stresses this period of the rapprochement phase of development as significant for the development of object permanence for personality development (Mahler, Pine, & Bergman, 1975). Critical aspects of personality are formulated around the stable and secure relationship to a parent figure. The experience of consistency is
important for the integration of the ego, for future psychic connections, and subsequent development.

Hypothesis Five stated that there would be a significant positive relationship between avoidance coping and the focal stressor. The analysis of the data did not support this hypothesis. Rather, avoidant coping and focal stressor were negatively correlated. These findings were most likely a result of the lack of a relationship between the specific stressful event and coping response style. The results of this hypothesis suggest that residential adolescents have a style of responding to stress that is a product of personality structure, the event at hand, and mood at the time.

The reported focal stressor the residents selected and from which they based their responses on the CRI-Y were not related to the coping responses provided on the remainder of the measure. This finding is consistent with Moos' (1993) finding regarding the focal stressor. Moos found that the severity of the focal stressor was not related to the coping responses. This suggests and supports Moos' research that the CRI-Y provides a measure of general coping strategies, rather than strategies specific to the stressor reported by the test-taker at the time of the testing. This is clinically useful information for those clinicians utilizing this or other measures of coping, to distinguish their utility as a general assessment of coping skills, versus situation specific coping. This hypothesis supports the reliability of the CRI – Y as a means of assessing general coping skills.

Correlational analysis revealed that adolescent females in residential placement a positive correlation between approach and avoidant coping styles. These results suggest that the residually placed female adolescent access both forms of coping when confronted with a stressor. The use of both approach and avoidant strategies were reported by adolescent females in residential care.
It is a positive finding that there is a suggestion here that the adolescent females in residential care demonstrated the ability to access adaptive strategies of coping, rather than predominantly only avoidant strategies when confronted with a stressor. It was interesting to observe one participant’s interaction with another participant when she was apologizing for her explosive behavior in a group. Her behavior reflected the avoidant strategies, while her verbal interactions were quite productive and approach oriented. The presence of adaptive strategies and their identification has the potential for valuable clinical information to be utilized in treatment. It is likely, however, that given the clinical presentation of behavioral problems that are representative of this group, their ego functions inhibit the actual access and/or implementation of these skills when confronted with the actual stress. Individuals with histories of loss and disrupted attachment such as the adolescents in this sample, very often present with difficulties coping due to feeling intensely overwhelmed with stimuli. Numbing behaviors such as depression, withdrawal, dissociation, and avoidance, defiant and disruptive behavior may be observed. While these are forms of coping, they are not adaptive in the sense that they assist the adolescent to use healthy resolutions and when faced with a stressor and to continue on the course of healthy development.

While coping is still a newly emerging source of research with this population, an analysis of the data supported the conclusion that residential adolescent females have compromised coping skills. This area of exploration is crucial since prior research has shown a correlation between maladaptive coping and risk for depression as well as social difficulties. Compromised coping skills have the potential to inhibit healthy development and adaptation. This sample of residentially placed females had maladaptive coping strategies present, but there are also adaptive strategies. The data is consistent with
Singer, et al. (2000) who discovered that the presence of adaptive strategies did not enhance behavior. Similarly, the pathology present in the sample of residential females in this investigation, may also have effected the application of adaptive coping skills.

The supplemental analysis revealed significant information regarding the differences between those residential female adolescents with histories of both physical and sexual abuse versus those with histories of a singular form of abuse or no abuse history. There were several differences between these two groups demonstrated on the scores from the CRI – Y.

Their performances on the CRI – Y were significantly lower on the sub-scales of Logical Analysis, Positive Reappraisal, Seeking Guidance and Support, and Seeking Alternative Rewards when the girls were reported to be multiply abused. All but the last sub-scale represents Approach coping responses. Logical Analysis and Positive reappraisal are both cognitive efforts to respond to a stress. Logical Analysis is the effort to prepare mentally for a stressor and its consequences. Positive Reappraisal is the effort to construe and restructure a problem in a positive way, while still accepting the reality of the situation. The analysis of the data supported the fact that the experience of multiple forms of abuse affects the residential adolescent female's ability to access these types of positive adaptive cognitive skills. The cumulative impact of the abuses experienced seems to include a level of stress that interferes with accessing or developing these coping skills. Seeking Guidance and Support is another Approach strategy representing behavioral efforts to acquire information, guidance, or support. This strategy is hampered as well and is quite possibly related to the disruption of trust that accompanies abusive experiences. It would seem that interpersonal relationships and the forms of attachment the adolescent female has with significant others, is altered as a result of their
abusive experiences. Seeking Alternative Rewards is classified as an avoidant means of coping, representing behavioral efforts to get involved in substitute activities and create new sources of satisfaction. This data may be related to the adolescent female’s saturation of stress, as was demonstrated on the elevated focal stressor scores, and subsequent difficulty channeling their cognitions or behaviors into more adaptable forms. Additionally, for the multiply abused adolescent females, Cognitive Avoidance, a sub-scale score on the Avoidance Scales was inversely related to the number of out of home placements. That is, as the number of out of home placements increased, Cognitive Avoidance, or the cognitive effort to avoid thinking realistically about a problem, decreased. It appears that the ability to ‘turn off’ or redirect the stress becomes compromised as the adolescent in residential care has had to face abnormal amounts of disruption and multiple forms of abuse. This could be related to the satiation of stress and difficulties inherent in the multiple transitions faced with each re-placement as well as disruptions of trust effected by the abuse. It also could account for the elevated focal stressor and life event stress scores reported by the females who were multiply abused. While these two stress scores were elevated in general for the entire sample, the multiply abused subgroup demonstrated significantly higher scores when compared to their peers who reported a singular form of abuse or no abuse. It is possible that multiple forms of abuse and increased experiences of stress accounts for behavioral problems, or acting out. Coddington (1972) reported that increased scores on the LESA are associated with increased behavioral problems. Generally speaking, the entire sample was experiencing an extraordinarily elevated level of stress, as indicated in the scores on the LESA-A, as well as in the comments made by some of the participants during the meetings with the researcher. One participant made reference to the tremendous stress she felt in
in her life and the inclusion of stress as a variable of interest in the study. She then expressed her subsequent interest in participating. Additionally, the analysis of the data corroborated other findings that multiply abused adolescents were removed from their homes of origin at an earlier age. This finding lends support to the idea that disruptions at an earlier age are related to heightened difficulties with cognitive and affective control. Additionally, these children could be demonstrating increased behavioral problems either as a symptom of abuse not yet disclosed, or as a result of disclosure and reaction to the abuse.

Attachments to caregivers, teachers, peers, sibling-figures and community all become weakened and compromised when disrupted time and time again. Additionally, abuse would seem to create problems with trust, and problems with interpersonal interactions. These two factors have the strong potential to compromise the development and utilization of internal and external coping resources. The familial, social and community environments are three major sources of external support for the typical adolescent. Chronic disruption of these sources due to multiple placements would severely compromise access to external and internal coping skills and resources.

In general, the sample of multiply abused adolescent females did not utilize the Approach forms of coping as effectively as the adolescent females who did not report multiple abuses. Approach coping focuses on problem solving, i.e., using both cognitive and behavioral efforts to master life stressors. Avoidance coping focuses on emotion, or the effort to utilize behaviors and cognitions to avoid thinking about a stressor and its implications, or to try and manage the affect associated with it. Avoidant strategies are not considered the more effective strategies.

On the basis of the data analysis, adolescent females in residential
placements with histories of dual forms of abuse, multiple placements, and elevated stressful life events exhibited inhibited access or development of coping skills which can respond sufficiently to the degree of stress experienced by this group. While these variables need to be incorporated into the clinical picture of every adolescent in residential placement, these data support the review of the histories in particular of adolescent girls in residential care with multiple forms of abuse. It seems to suggest an accumulating effect that multiple abuses may bring to the clinical picture. Additional research addressing this more specifically is needed.

Limitations and Future Research

The inferences gained from this research are limited to the specific adolescent residential female population. Additionally, the sample was acquired from residential programs which housed and schooled their residents. They were all in suburban settings. Consequently, inferences are limited to like environments.

A significant limitation of this study is the small sample size and lack of power inherent in the design of the study. While efforts were made to secure a more substantial sample size of 72 and power approaching .7, access to the facilities and parental consent provided hurdles preventing this goal. In association to difficulties with access to facilities was the staff turnover that contributed to the process of sorting through ‘red tape’ associated with acquiring access to the programs. During the time frame from the initial contact with one of the programs until the time of testing there were a total of four directors with whom the researcher had to interact and explain the study and seek approval for access. Another program actually closed down in the midst of the researcher’s efforts to gain access. Also, on a state level, in contacting the Division of Youth and Family Services, directors and requirements for the
department in charge of research changed on two occasions. This required the submission of the proposal of the study on two different occasions spaced approximately six months apart with many months of waiting for approval in between in each submission. The challenge of a substantial sample size is consistent with professional studies cited in the literature. It is also consistent with the experience of professional researchers who have had experience in studying the residential adolescent population. Robert Lyman, PhD, Professor/Practitioner, University of Alabama, and Steven Elson, PhD, Chair of research/Continuing Education, The American Association of Residential Treatment Centers, corroborated this researcher's experience of difficulty accessing this population (personal communications, February, 2000). Organizations such as the American Association of Residential Treatment Facilities, The New Jersey Organization for Residential Treatment Facilities, The New Jersey Division of Youth and Family Services, and the Institute of Training and Research for Deveroux Deerhaven; as well as multitudes of individual facilities in various states throughout the Northeast were contacted by this researcher. While the interest in the research was consistently positive, permission for access was not. The inaccessibility experienced by this researcher, as experienced by professional researchers, is a factor contributing to the limitations of this research. An additional factor that challenged the collection of a more substantial sample was the ratio of female to male beds in the residential facilities. By far, there were more male beds in male/female facilities as well as a larger number of male only programs. In fact, the singular female only and largest residential facility in New Jersey was closed in August 2000 making this issue a very local one. Pazaratz (1999) provided a qualitative discussion of a specific residential
facility in order to illuminate more specific issues related to residential programs that impact upon programmatic changes. A highlighted issue in his article was the tendency for male beds to be more cost-efficient and therefore influencing program development. He cites a specific program's elimination of female beds since 1990 in order to function more cost efficiently.

Any future research regarding this population would benefit from an organized and collaborative effort of associations for residential programs to establish a branch addressing research efforts. This was not found on either a state or national level by this researcher.

Future research should incorporate multiple measures on the variables providing additional information aside from that based on self-report and data collection from files. Also, time series repeated measures, cross-sectional and longitudinal designs would gather data beyond that of the relationship and move toward more specific information about descriptors of diagnostic information, as well as effective interventions. For example, the introduction of a problem-solving, or resiliency training program to a group of residential adolescent females, with a pre and post-test could result in valuable information. Longitudinal investigations could specifically address developmental issues such as the sequelae of impaired attachment organizations, early childhood maltreatment, placements history, and coping.

Future directions for research would be the differentiation of multiple abuses versus singular forms of abuse and the influence on variables such as coping and depression. There are multitudes of variables surrounding the abuse experiences that may have had an influence on the results. Severity of abuse, time frame of the abuse and age at which it occurred, identity and relationship to the perpetrator, response to disclosure by significant others, subsequent therapeutic experiences, are but some of the factors that should be incorporated
into future research. This information may expand understanding of the effects the various forms of abuse have on coping, resiliency, depression, and stressful life events. The idea that there is a cumulative effect when multiple abuses are experienced could help clinicians identify particularly vulnerable children and provide more specific treatment plans to meet their needs.

Emerging research on resilience and coping could address both adaptive and maladaptive strategies that appear to become activated in response to stress. Future research might include such variables as degree of impulsivity, treatment experiences, level of intelligence, ego resilience and ego control, psychopathology, and poor interpersonal relationships in order to develop a more complete assessment of adolescent functioning.

Attachment theory identifies critical periods of development for the disruption or loss of an attachment figure. Eighteen months to 3 years are identified as vulnerable to the future formation of severe personality disorders, ego damage, and depression. Ages 3 years to 6 years are vulnerable to personality disorders and depression, and anxiety as well. Research looking at adults who were in residential placements as youngsters with histories of losses/disruptions to attachment figures due to foster placements would lend valuable insight into the long-term ramifications on development. It has been demonstrated in past research that addressing behavioral changes or social skills changes alone does not result in consistent, reliable long term reductions in problem behaviors (Moore, Moretti, & Holland, 1998).

Moore et al. stresses the need for the incorporation of attachment related issues into the very core of treatment in residential facilities. Given the research documenting the value of attachment organization in mitigating the impact of earlier adverse experiences on future development, it would seem that this direction for future research would be valuable.
There is a continued need for the development of the sophistication that the treatment residential care offers to youth and their families. Residential care often continues to be considered a 'last resort' treatment option. At the point of entry into the residential treatment system, the youth bring a myriad of complex issues and needs to be addressed. Continued research to assist in the understanding of these issues and needs is important for effective intervention.
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Appendices
Appendix A

CRI-Youth Form
CRI-YOUTH FORM

Item Booklet

Rudolf H. Moos, Ph.D.

Directions:
On the accompanying answer sheet, please fill in your name, today's date, and your sex, age, grade in school, and ethnic group. Please mark all your answers on the answer sheet. Do not write in this booklet.
Part 1

This booklet contains questions about how you deal with important problems that come up in your life. Please think about the most important problem or stressful situation you have experienced in the last 12 months (for example, a problem with your parents, a problem at school, a serious illness or accident, or the death of a family member or a friend). Briefly describe the problem in the space provided in Part 1 of the answer sheet. If you have not experienced a major problem, list a minor problem that you have had to deal with. Then answer each of the 10 questions about the problem or situation (listed below and again on the answer sheet) by circling the appropriate response:

Circle "DN" if your response is DEFINITELY NO.
Circle "MN" if your response is MAINLY NO.
Circle "MY" if your response is MAINLY YES.
Circle "DY" if your response is DEFINITELY YES.

1. Have you ever faced a problem like this before?
2. Did you know this problem was going to happen to you?
3. Did you have enough time to get ready to deal with the problem?
4. When this problem happened, did you think about how it might harm you?
5. When this problem happened, did you think of it as a challenge?
6. Was this problem caused by something you did?
7. Was this problem caused by something someone else did?
8. Did anything good come out of dealing with this problem?
9. Has this problem or situation been worked out?
10. If the problem has been worked out, did it turn out all right for you?
Part 2
Read each item carefully and indicate how often you took that action to deal with the problem you described in Part 1. Circle the appropriate response on the answer sheet:

Circle "N" if your response is NO, Not at all.
Circle "O" if your response is YES, Once or Twice.
Circle "S" if your response is YES, Sometimes.
Circle "F" if your response is YES, Fairly often.

There are 48 items in Part 2. Remember to mark all your answers on the answer sheet. Please answer each question as accurately as you can. All your answers are strictly confidential. If you do not wish to answer a question, please circle the number of that question on the answer sheet to indicate that you have decided to skip it. If an item does not apply to you, please write NA (Not Applicable) in the box to the right of the number for that item. If you wish to change an answer, make an X through your first answer and circle the new answer. Note that answers are numbered across in rows on Part 2 of the answer sheet.

1. Did you think of different ways to deal with the problem?
2. Did you tell yourself things to make yourself feel better?
3. Did you talk with a parent or other family member about the problem?
4. Did you decide on one way to deal with the problem and do it?
5. Did you try to forget the whole thing?
6. Did you feel that time would make a difference—that the only thing to do was wait?
7. Did you get involved in new activities?
8. Did you take it out on other people when you felt angry or sad?
9. Did you try to step back from the problem and think about it?
10. Did you tell yourself that things could be worse?
11. Did you talk with a friend about the problem?
12. Did you know what had to be done and try hard to make things work?
13. Did you try not to think about the problem?
14. Did you realize that you had no control over the problem?
15. Did you try to make new friends?
16. Did you take a chance and do something risky?
17. Did you go over in your mind what you would say or do?
18. Did you try to see the good side of the situation?
19. Did you talk with an adult like a teacher, coach, counselor, clergyman, or doctor?
20. Did you decide what you wanted and try to get it?
21. Did you daydream or imagine things being better than they were?
22. Did you think that the outcome would be decided by fate?
23. Did you begin to read more often for enjoyment?
24. Did you yell or shout to let off steam?
25. Did you think about how things might turn out?
26. Did you keep thinking about how you were better off than other people with the same problems?
27. Did you look for help from other kids or groups with the same type of problem?
28. Did you try at least two different ways to solve the problem?
29. Did you put off thinking about the situation, even though you knew you would have to at some point?
30. Did you accept the problem because nothing could be done to change it?
31. Did you begin to spend more time in fun activities, like sports, parties, and going shopping?
32. Did you cry to let your feelings out?
33. Did you try to make sense out of why this problem happened to you?
34. Did you try to tell yourself that things would get better?
35. Did you ask a friend to help you solve the problem?
36. Did you try to do more things on your own?
37. Did you wish the problem would go away or somehow be over with?
38. Did you expect the worst possible outcome?
39. Did you try to keep busy with school or other things to help you cope?
40. Did you do something that you didn't think would work, but at least you were doing something?
41. Did you think about the new hardships that would be placed on you?
42. Did you think about how this situation could change your life for the better?
43. Did you ask for sympathy and understanding from someone?
44. Did you take things a day at a time, one step at a time?
45. Did you try to deny how serious the problem really was?
46. Did you lose hope that things would ever be the same?
47. Did you find new ways to enjoy life?
48. Did you listen to music as a way to cope?
Appendix B

MACI – Millon Adolescent Clinical Inventory
DIRECTIONS:

1. Print your identification number in the spaces. Then find the circle below each space that has the same number and blacken it. In a similar way, complete the Birth Date and Test Date boxes.

2. Blacken the circle for either male or female. Blacken the circle that shows your current school grade. In the same way, blacken the two circles that best describe your problems. Your counselor will complete the information in the shaded section.

3. Use a soft black lead pencil only, and fill in the circles with a heavy, dark mark.

4. If you want to change an answer, erase it carefully and then fill in your new choice.

5. Do not make any marks outside the circles.

Which two of the following trouble you the most?

1st
- Body/Looks
- Career Goals
- Court Problems
- Drugs/Alcohol
- Family Life
- Fear/Apatathy
- Lack of Confidence
- Lack of Friends
- Lonely/Depressed
- Moody/Unstable
- Restless/Bored
- Schoolwork
- Sexual Feelings
- Sick/Tired
- Other

2nd

CURRENT SCHOOL GRADE

Junior or Senior High School
College
Not Attending

TEST DATE
MONTH
DAY
YEAR

COUNSELOR DIRECTIONS:

Please mark your rating and provide information about your relationships, interests, and goals.

GENDER
- Male
- Female

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1. I would much rather follow someone than be the leader.
2. I'm pretty sure I know who I am and what I want in life.
3. I don't need to have close friendships like other kids do.
4. I often neglect doing things others expect of me.
5. I do my very best not to hurt people's feelings.
6. I can depend on my parents to understand me.
7. Some people think of me as a bit condescending.
8. I would never use drugs, no matter what.
9. I always try to do what is proper.
10. I like the way I look.

11. Although I go on setting binges, I hate the weight I gain.
12. Nothing much that happens seems to make me either happy or sad.
13. I seem to have a problem getting along with other teenagers.
14. I feel pretty shy telling people about how I was abused as a child.
15. I've never done anything for which I could have been arrested.
16. I think everyone would be better off if I were dead.
17. Sometimes, when I'm away from home, I begin to feel tense and anxious.
18. I usually act quickly without thinking.
19. I guess I'm a complainer who expects the worst to happen.
20. It is not unusual to feel lonely and unwelcome.

21. Punishment never stopped me from doing whatever I wanted.
22. Drinking seems to have been a problem for several members of my family.
23. I like to follow instructions and do what others expect of me.
24. I seem to fit in right away with any group of new kids I meet.
25. So little of what I have done has been appreciated by others.
26. I hate the fact that I don't have the looks or brains I wish I had.
27. I like it at home.
28. I sometimes scare other kids to get them to do what I want.
29. Although people tell me I'm thin, I still feel overweight.

30. When I have a few drinks I feel more sure of myself.
31. Most people are better looking than I am.
32. I often fear I'm going to panic or faint when I'm in a crowd.
33. I sometimes force myself to vomit after eating a lot.
34. I often feel as if I'm floating around, sort of lost in life.
35. Most other teenagers don't seem to like me.
36. When I have a choice, I prefer to do things alone.
37. Becoming involved in other people's problems is a waste of time.
38. I often feel that others do not want to be friendly to me.
39. I don't care much what other kids think of me.
40. I used to get so stoned that I did not know what I was doing.
41. I don't mind telling people something they won't like hearing.
42. I see myself as falling far short of what I'd like to be.
43. Things in my life just go from bad to worse.
44. As soon as I get the impulse to do something, I act on it.
45. I've never been called a juvenile delinquent.
46. I'm often my own worst enemy.
47. Very few things or activities seem to give me pleasure.
48. I always think of dying, even when people say I'm overweight.
49. I find it hard to feel sorry for people who are always worried about things.
50. It is good to have a routine for doing most things.

51. I don't think I have as much interest in sex as others my age.
52. I don't see anything wrong with doing others to get what I want.
53. I would rather be almost anywhere but home.
54. Sometimes I get so upset that I want to hurt myself seriously.
55. I don't think I was sexually molested when I was a young child.
56. I am a dramatic and showy sort of person.

57. I can hold my beer or liquor better than most of my friends.
58. Parents and teachers are too hard on kids who don't follow rules.
59. I like to flirt a lot.
60. To see someone suffering doesn't bother me.
61. I don't seem to have much feeling for others.
62. Enjoy thinking about sex.
63. I worry a great deal about being left alone.
64. I often feel sad and unloved.
65. I'm supposed to be thin, but I feel my thighs and backside are much too big.
66. I often observe it when others put me down.
67. People put pressure on me to do more than I can.
68. I think I have a good body.
69. I feel left out of things socially.
70. I make friends easily.

71. I'm a somewhat unsteady and anxious person.
72. I hate to think about some of the ways I was abused as a child.
73. I'm not different from lots of kids who steal things now and then.
74. I prefer to act first and think about it later.
75. I've gone through periods when I smoked pot several times a week.
76. Too many rules get in the way of my doing what I want.
77. When things get boring, I like to stir up some excitement.
78. I will sometimes do something I know is wrong to make someone unhappy.
79. I spend a lot of time worrying about my future.
80. I often feel I'm not worthy of the nice things in my life.

81. I sort of feel sad when I see someone who's lonely.
82. I eat little in front of others; then I stuff myself in private.
83. My family is always yelling and fighting.
84. I sometimes feel very unhappy with who I am.
85. I don't seem to enjoy being with people.
86. I have talents that other kids wish they had.
87. I'm very uncomfortable with people unless I'm sure they really like me.
88. Killing myself may be the easiest way of solving my problems.
89. Sometimes I get confused or upset when people are nice to me.
90. Dressing really seems to help me when I'm feeling down.
91. I rarely look forward to anything with much pleasure.
92. I'm very good at making up excuses to get out of trouble.
93. It is very important that children learn to obey their elders.
94. Box is enjoyable.
95. No one really cares if I live or die.
96. We should respect our elders and not think we know better.
97. I sometimes get pleasure by hurting someone physically.
98. I often feel lousy after something good has happened to me.
99. I don't think people see me as an attractive person.
100. I'm a loner and I don't mind it.
101. Almost anything I try comes easy to me.
102. There are times when I feel that I'm a much younger person than I actually am.
103. I like being the center of attention.
104. If I want to do something, I just do it without thinking of what might happen.
105. I'm terribly afraid that no matter how thin I get, I will start to gain weight if I eat.
106. I won't get close to people because I'm afraid they may make fun of me.
107. More and more often I have thought of ending my life.
108. I sometimes put myself down just to make someone else feel better.
109. I get very frightened when I think of being all alone in the world.
110. Good things just don't last.
111. I've had a few run-ins with the law.
112. I'd like to trade bodies with someone else.
113. There are many times when I wish I were much younger again.
114. I have not seen a car in the last ten years.
115. Other people's age seem more sure than I am of who they are and what they want.
116. Thinking about sex confuses me much of the time.
117. I do what I want without worrying about its affect on others.
118. Lots of things that look good today will turn out bad later.
119. Others' age never seem to call me to get together with them.
120. There have been times when I could not get through the day without some pain.
121. I make my life worse than it has to be.
122. I prefer being told what to do rather than having to decide for myself.
123. I have tried to commit suicide in the past.
124. I go on eating binges a couple of times a week.
125. Lately, this thing seems to depress me.
126. I saw across the Atlantic 30 times last year.
127. There are times I wish I were someone else.
128. I don't mind pushing people around to show my power.
129. I'm ashamed of some terrible things adults did to me when I was young.
130. I try to make everything I do as perfect as possible.
131. I am pleased with the way my body has developed.
132. I often get frightened when I think of the things I have to do.
133. Lately, I feel jumpily and nervous almost all the time.
134. I used to try hard drugs to see what effect they'd have.
135. I can charm people into giving me almost anything I want.
136. Many other kids get breaks I don't get.
137. People old things to me sexually when I was too young to understand.
138. I often keep setting to the point that I feel sick.
139. I will make fun of someone in a group just to put them down.
140. I don't like being the person I've become.
Appendix C

Life Event Scale
# LIFE EVENT SCALE — ADOLESCENTS (Age 12 and over)

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<tr>
<th>NAME:</th>
<th>DATE:</th>
<th>AGE:</th>
<th>SEX:</th>
<th>RACE:</th>
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If any of the events listed below occurred in the PAST 12 MONTHS, write the weight in the correct column on the right.

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<td>The death of a friend</td>
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<td>Divorce of your parents</td>
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<td>Marital separation of your parents</td>
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<td>The death of a grandparent</td>
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<td>Hospitalization of a parent</td>
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<td>Birth of a child</td>
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<td>Hospitalization</td>
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<td>Loss of a job by your father or mother</td>
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<td>Major increase in your parents' income</td>
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<td>Major decrease in your parents' income</td>
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<td>Going for the first time</td>
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<td>Going through a divorce</td>
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<td>Breaking up with a boyfriend/girlfriend</td>
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<td>Being told to break up with a boyfriend/girlfriend</td>
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<td>Start of a new problem between you and your parents</td>
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<td>End of a problem between you and your parents</td>
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<td>Getting your first permanent job</td>
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<td>Deciding to leave home</td>
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<td>Being sent away from home</td>
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<td>Being hospitalized for illness or injury</td>
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<td>Being involved with alcohol</td>
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<td>Stopping the use of drugs</td>
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<td>Finding an adult who really respects you</td>
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<td>Getting pregnant or fathering a pregnancy</td>
<td>Boys 81, Girls 88</td>
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<td>Outstanding personal achievement (special prize)</td>
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Other events (describe and check column)

* R. Dean Coddington, M.D. 1981
Appendix D

Excerpt of Title 9 of the New Jersey Statutes
9:6-8.21.c. "Abused or neglected child" means a child less than 18 years of age whose parent or guardian, as herein defined, (1) inflicts or allows to be inflicted upon such child physical injury by other than accidental means which causes or creates a substantial risk of death, or serious or protracted disfigurement, or protracted impairment of physical or emotional health or protracted loss or impairment of the function of any bodily organ; (2) creates or allows to be created a substantial or ongoing risk of physical injury to such child by other than accidental means which would be likely to cause death or serious or protracted disfigurement, or protracted loss or impairment of the function of any bodily organ; (3) commits or allows to be committed an act of sexual abuse against the child; (4) or a child whose physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as the result of the failure of his parent or guardian, as herein defined, to exercise a minimum degree of care (a) in supplying the child with adequate food, clothing, shelter, education, medical or surgical care though financially able to do so or though offered financial or other reasonable means to do so, or (b) in providing the child with proper supervision or guardianship, by unreasonably inflicting or allowing to be inflicted harm, or substantial risk thereof, including the infliction of excessive corporal punishment; or by any other acts of a similarly serious nature requiring the aid of the court; (5) or a child who has been willfully abandoned by his parent or guardian, as herein defined; (6) or a child upon whom excessive physical restraint has been used under circumstances which do not indicate that the child's behavior is harmful to himself, others, or property; or (7) or a child who is in an institution and (a) has been placed there inappropriately for a continued period of time with the knowledge that the placement has resulted or may continue to result in harm to the child's mental or physical well-being or (b) who has been willfully isolated from ordinary social contact under circumstances which indicate emotional or social deprivation.

A child shall not be considered abused or neglected pursuant to paragraph (7) of subsection c. of this section if the acts or omissions described therein occur in a day school as defined in this section.

No child who in good faith is under treatment by spiritual means alone through prayer in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof shall for this reason alone be considered to be abused or neglected.
Appendix E

Consent Form
Dear Parent or Guardian,

My name is Mary Hebert. I am a doctoral student conducting a study through (insert name of facility). I would appreciate any consideration you can give to allowing your child to be a part of this study. Your child will also be asked if they would like to participate and will be given a consent form. The purpose of the study is to better the understanding of how adolescents in residential treatment think and behave in response to stress and how it affects their mood and how they cope. The purpose of this research is to use this information to help residents prepare for leaving the program so that they feel better able to respond to stress and troubles as they come up in their life.

This information may help mental health professionals and all staff in residential facilities respond more effectively to the teenagers in these programs and help to prepare them for their eventual discharge from treatment.

Each resident will be asked to respond to three questionnaires taking an estimated 50 minutes or less to complete. There are no right or wrong answers to these forms, rather, they are designed to see how the respondent thinks and behaves in response to stress and how they would describe their general mood. The three questionnaires to be used include the Life Events Questionnaire, The Millon Adolescent Clinical Inventory, and The Coping Response Inventory. The first measures will be used to assess stressful life events in the past 12 months. The Life Events Questionnaire lists stressors commonly experienced by teenagers. They will be asked to mark those that they have experienced in the past year. The Millon Inventory is a questionnaire asking teenagers to respond true or false of questions designed to assess their thoughts and feelings. The Coping Inventory asks the teenager to respond to questions about how they coped with a recent problem on a scale ranging from not at all to fairly often. Only assigned numbers will be placed on the questionnaires that the residents complete, not their names. This will maintain confidentiality of their answers and any information acquired from their file. Information from the resident’s file will be provided by the staff in an anonymous fashion. Information will include a yes or no as to whether the resident has experienced any history of physical or sexual abuse, the number of places they have lived over the years, and when they first lived away from home. Again, this information will be provided without the resident’s names attached to the information, using only an assigned number rather than their names.

The results of the study will be provided to the program in group form without any information related to the identity of the residents who participated.

You have the right to refuse to have your child participate in this study. Their on-going treatment will in no way be affected by this choice. If you are willing to allow your child to participate, please sign below and return this form as
promptly as possible. Thank you very much for your cooperation.

*Should you have any further questions about this research please feel free to contact (insert contact person at facility).*

This project has been reviewed and approved by the Seton Hall University Institutional Review Board for Human Subjects Research. The IRB believes that the research procedures adequately safeguard the participant’s privacy, welfare, civil liberties, and rights. The Chairperson of the IRB may be reached through the Office of Grants and Research Services. The telephone number of the Office is (973) 275-2974.

I have read the material above, and any questions I asked have been answered to my satisfaction. I agree to allow my child to participate in this activity, realizing that I may withdraw without prejudice at any time.

I hereby attest that I am the ____Parent or ____Legal Guardian of ____________________________, and that I agree to the above statement in its entirety.

Signature: ____________________________________________________________

Date: _______________________________________________________________
Appendix F

Statement of Solicitation to Residents
Hello. My name is Mary Hebert. I am a doctoral student at Seton Hall University doing some research on teenagers in residential treatment programs. The (insert name of facility) has agreed to allow me to ask you if you would like to participate in this study. Your participation is completely voluntary however and you have every right not to participate or to withdraw from participation at any time. Not participating or withdrawing will in no way affect your treatment at (insert name of facility). Should you be willing to participate and agree to sign the assent form, permission for your participation will then be asked of your parent or guardian. They will be sent a consent form to sign.

If you do choose to participate, it will take about an hour of your time. You will be asked to fill out three questionnaires regarding how you cope and feel when you are faced with stress in your life. The questionnaires are called The Coping Response Inventory, The Life Events Scale, and The Millon Adolescent Clinical Inventory. The Coping Response Inventory is a questionnaire about how you respond to stressors in your life. The questions on the Coping Inventory are to be answered by circling an answer on a scale ranging from not at all to fairly often. The Life Events Scale lists stressors commonly experienced by teenagers. You will be asked to mark which ones you have had in the past year. The Millon Adolescent Clinical Inventory is a questionnaire about your thoughts and feelings. The questions on this form are to be answered true or false.

Your answers will be completely confidential. Only a code number will be placed on your questionnaires, not your name. The results of my study will be provided to (insert name of facility) in group form without any information regarding the names of the people who participated. The purpose of the study is to improve how to help teenagers deal with stress as it comes up not only at (insert name of facility) but when you leave the program as well. Your counselors will be made aware that this study is taking place. While they will not be told who chooses to be a part of the study, it is your choice to let them know if you would like to talk with them about the study and your feelings and thoughts about it. If you would like my help in letting them know, I can help arrange you to do that.

When you finish the questionnaires you will receive a gift certificate to a local restaurant to enjoy when you are on pass from the program.

If you are interested in participating I would ask that you now read the assent form and ask any questions you have before signing it. Once your questions are answered to your satisfaction, and should you decide to participate, then you can go ahead and sign your name and today’s date.
Appendix G

Assent Form
Dear Resident,

My name is Mary Hebert. I am a doctoral student doing a research study. I am hoping that this study will help to better the understanding of how girls in residential/group care think and behave about stress. It will also help to understand how they feel and cope with problems. The purpose of my research is to use this information to help girls to get ready for leaving the program so that they feel better able to deal with stress and troubles as they come up in their life.

The purpose of this form is to explain the study to you. Should you agree to be a part of the study, your parent or legal guardian will be sent a similar form for their permission to allow you to participate.

The three questionnaires that will be given do not have right or wrong answers and will take about 50 minutes or less to finish. The first questionnaire is the Life Events questionnaire. It lists problems that teenagers commonly have. You will be asked to mark those you have had in the past 12 months. The second questionnaire is the Coping Response Inventory. It has questions about how you acted or felt when faced with something that has been stressful for you. You will be asked to circle answers ranging from not at all to fairly often. The last questionnaire is the Millon Adolescent Clinical Inventory. It is made up of questions about your thoughts and feelings. You will be asked to answer these true or false.

You do not have to be a part of this study and refusal to do so will in no way affect your treatment at the program. If you do agree to be a part of the study please know that your answers and information reviewed from your file will be kept confidential. The staff at (insert name of facility) will provide three pieces of information from your file without your name being attached to the information so that your privacy is secure. Information from your records will include whether you have ever experienced physical or sexual abuse, how old you were when you first lived away from home, and the number of places you have lived over the years. No other details about this information will be provided from your file. Your names will not be used on the questionnaires or in connection with the file information given. Only code numbers rather than your name. While (insert name of facility) will get the group results, they will not receive any individual results.

The staff at (insert name of facility) know that this study is taking place. Should you wish to let your counselor know that you chose to be a part of it, they will be available to help you with any questions, thoughts, or feelings that may come up about participating. If you would like my help in letting your counselor know that you participated and would like to talk with them about it, with your permission, I am available to help you do that.
I have read this entire form, or it has been read to me and I understand it completely. All my questions about this form and about this study have been answered to my satisfaction. I understand that by signing this form I agree to be a part of this study. I also know that I may withdraw at any time. Should I agree to be a part of this study I understand that my parent or guardian will be sent a consent form asking for their permission to let me participate.

Any questions that may come up about this study can be directed (insert appropriate contact at facility)

This project has been reviewed and approved by the Seton Hall University Institutional Review Board for Human Subjects Research. The IRB believes that the research procedures adequately safeguard the participant's privacy, welfare, civil liberties, and rights. The Chairperson of the IRB may be reached through the Office of Grants and Research Services. The telephone number of the Office is (973) 275-2974.

Name (Please Print): _____________________________________________

Signature: __________________________ Date: ______________

Witness: ___________________________ Date: ______________
Appendix H

Debriefing Summary
I want to thank you for your time and willingness to participate in this study. The questionnaires that you have just filled out will help me to understand stressors that you have experienced in the last year, ways in which you tended to cope when faced with them, and how you felt emotionally. As explained to you before filling out these questionnaires, your answers will be kept confidential. However, please note that if any of the questions upset you in any way I encourage you to see your counselor. If you would like my help in arranging to meet with your counselor please let me know.

The counselors on staff are available to discuss your feelings and thoughts now or at any time you may wish to do so. Your individual counselor has been made aware that this study is taking place at (insert name of facility), and is available to discuss it with you should you wish to let them know you participated and wish to speak with them about it.

The information from this study will be used to gain a better understanding of how girls in residential care who have had similar experiences feel and respond to stress. The purpose of the study is to use this information to help teenagers in residential care prepare to eventually leave and adjust to a new environment.

Thank you once again for your help. Your participation has been greatly appreciated.

Mary L. Hebert, MA