Exploring the relationship between perceived personal well-being and clinical characteristics among youth who have accessed intensive mental health treatment

By

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ABSTRACT

EXPLORING THE RELATIONSHIP BETWEEN PERCEIVED PERSONAL WELL-BEING AND CLINICAL CHARACTERISTICS AMONG YOUTH WHO HAVE ACCESSED INTENSIVE MENTAL HEALTH TREATMENT

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High personal well-being has been found to be associated with many enduring benefits (Diener and Chan, 2011). However, researchers who have explored mental health disorders have often focused on pathology, and personal well-being has been overlooked. This study is part of a larger longitudinal, observational study on the psychosocial outcomes of children and youth who have accessed residential or intensive home-based treatment in five agencies in Ontario, Canada (Preyde et al., 2011). The purpose of this study was to explore the level of perceived personal well-being among a subsample of youth who accessed residential treatment (n=33) and intensive home based treatment (n=30). Youth completed a cross-sectional survey measuring personal well-being at 12-18 months post-discharge. Many youth reported high personal well-being. Demographic and clinical characteristics did not predict participants’ personal well-being scores, suggesting that no clear relationship exists between personal well-being and symptom severity and psychosocial functioning.
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Chapter One: Introduction

Mental health disorders will affect one in five Canadian adults (21.3 percent) throughout their lifetime (CMHA, 2013) and will affect approximately 20% of youth with about 14% in the clinical range (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003; Waddell, Offord, Shepherd, Hua, & McEwan, 2002). Although the exact etiology of mental health disorders is not known, we do know that multiple factors contribute to the onset and maintenance of mental health disorders, including biological, psychological and social factors. Investigators have found that the presence of certain genes can help identify the likelihood of a mental health disorder; thus, particular genotypes may underlie vulnerabilities to the emergence of mental health disorders. However, individuals with the same genes do not necessarily have the same mental health disorder (Cross-Disorder Group of the Psychiatric Genomics Consortium, 2013; Ma, Yang, Romero & Cui, 2011; Millon, Krueger & Simonsen, 2010). In addition, various investigators have provided evidence that environmental factors are particularly influential in the emergence of mental health disorders (Halpern & Figueiras, 2004; Messer & Beidel, 1994; Paananen, Ristikar Merikukka & Gissler, 2013). Examples of environmental factors that may lead to mental health disorders include lack of social capital, family adversity, death or divorce and location of residence. Moreover, researchers have found that the impact of environmental factors in early life may have enduring consequences on mental and physical health trajectories as a result of epigenetic marking of specific genes (McGowan & Szyf, 2010). Therefore, it is believed that the interplay between genetic and environmental factors plays a pivotal role in the etiology of mental health disorders since environmental factors may contribute to mental health disorders and an individual’s genes may influence the susceptibility of these environmental factors (Caspi & Moffit, 2006; Farmer, Eley & McGuffin, 2005; Schwartz & Susser, 2006;
Overall, knowledge is increasing with regard to biological, psychological and environmental factors and their interactions which have been identified as chief contributors to the emergence of mental health disorders.

The high prevalence and the complexity of the etiology of mental health disorders are concerning; furthermore, mental health disorders can have adverse effects in many areas of an individual’s life including social, cognitive and occupational functioning (Meng & Darcy, 2012). Likewise, mental health disorders can be life threatening or lead to acute episodes that may be best treated by residential treatment or intensive home based treatment. Mental health disorders are often chronic and may include severe episodes. Residential treatment may offer patients training and supportive interventions, which have been found to improve the functional status of some individuals experiencing mental health disorders (Bond, Drake & Mueser, 1999; Preyde, Frensch, Cameron, White, Penny, & Lazure, 2011a; Wilcock, 2005). The Ontario Ministry of Children and Youth Services provides funding for various mental health services for children, youth and their families. These programs are delivered through independent agencies, which typically hold membership with Children’s Mental Health Ontario (CMHO). CMHO encompasses more than 85 children’s mental health centres throughout the province. Each centre provides a wide range of services where trained professionals provide support for families and children experiencing mental health problems.

Residential treatment (RT) is one particular service in membership with CMHO, which is delivered in a community setting that provides therapy and skill building for youth experiencing moderate to severe emotional and behavioural disorders. Skill building and strengths based programming may be particularly beneficial for individuals with mental health disorders to promote and encourage future adaptation or coping post discharge (Lyons, Uziel-Miller, Reyes
& Sokol, 2000). Likewise, some youth continue to experience clinical symptoms post-discharge (Preyde, Cameron, Frensch, & Adams, 2011c). Therefore, strengths, resources, and abilities can be used to assist in positive development where strengths may act as protective factors in coping with stressors. However, in conceptualizations of mental health, personal well-being and positive indicators have often been disregarded (Peter, Roberts, & Dengate, 2011). Similarly, investigators have often overlooked positive indicators and strengths among youth with emotional and behavioural disorders. Personal well-being can be defined as an individual’s subjective evaluation of his or her life with specific regard to affective and cognitive states (Diener, 2000). Thus, the acknowledgement of personal well-being may increase understanding with regard to clinical characteristics and may benefit individual’s transition from treatment to the community while encouraging long-term success. Therefore, further attention to personal well-being in addition to psychopathology is warranted.

The purpose of this study was to examine the perceived personal well-being of youth who have accessed residential treatment (RT) and intensive home based treatment (IHB) at post-discharge in relation to clinical characteristics at intake and admission. First, the conceptualization of mental health disorders will be explored with primacy given to developmental psychopathology and the general ecological model. Next, the characteristics of individuals who access residential treatment will be reviewed. Although personal well-being may be related to clinical characteristics, it has yet to be fully explored. Thus, it may be important to acknowledge both psychopathology and positive indicators such as subjective well-being since positive indicators of personal well-being may influence intervention outcomes. The first objective for this study was to explore personal well-being levels in youth who have received residential treatment and intensive home-based treatment. The second objective for this
study was to explore how personal well-being as captured at 12-18 month follow-up is predicted by patients’ demographic and clinical characteristics, namely age, gender, symptom severity and psychosocial functioning as captured at intake and admission respectively.

1.1 Developmental Psychopathology

Developmental psychopathology is a framework concerned with the multifaceted pathways that may precipitate psychological pathology and normal psychological health, while largely attending to normative development and developmental deviations (Sroufe & Rutter, 1984). Moreover, when utilizing the perspective of developmental psychopathology, attention is placed on the emergence and trajectory of disorders, the heterogeneity of presentations with development, the disorder’s antecedents and the disorders relation to nondisordered patterns of behaviour (Sroufe & Rutter, 1984). Thus, Kazdin et al., (1997) suggests that one can view the emergence of mental health disorders as a web, which is non-linear and is bidirectional since this perspective attempts to connect and understand the relationships between antecedents and outcomes.

From this perspective it is believed that complex biological, psychological and environmental interactions occur among individuals, which results in diversity of outcomes and diversity of risk and protective factors (Sameroff, 2000; Tsuang, Bar, Stone & Farone, 2004). Diversity among outcomes and risk and protective factors essentially means that multiple pathways contribute to the emergence of mental health disorders (Millon, Krueger & Simonsen, 2010). Multiple pathways leading to mental health disorders may be understood through the concepts of equifinality and multifinality.
1.2 Equifinality and Multifinality

Influences are changing throughout the process of human development, which uniquely interact and the unique interactions essentially lead to varying outcomes (Kazdin et al., 1997). Similarly, events or experiences affect each person uniquely, in which an event may have large consequences on one individual whereas the same event may have little or no consequences on a different individual due to an individual’s maladaptation or positive adaptation (Cicchetti, 2013; Kazdin et al., 1997). The pathways to either maladaptive or positive adaptive functioning are influenced by a complex interaction of biological, psychological and environmental factors as well as current experiences, active choices and the developmental history of the individuals (Cicchetti & Tucker, 1994). Thus, it is important to recognize the developmental and multiple pathways of mental health disorders. Onset of mental health disorders typically occurs in adolescence or young adulthood but symptoms often begin earlier in childhood. Mental health disorders are characterized by alterations in thinking, mood and/or behaviour and impaired functioning over an extended period of time. Characteristics also vary depending on severity of symptoms (mild to severe) which is contingent upon the type of mental health disorder, the family and the environment (CMHA, 2013).

“Multifinality” refers to the notion that diversity of outcomes may result from similar etiological factors (Millon, Krueger & Simonsen, 2010). For example, although two individuals may have very similar developmental pathways, they may have dissimilar outcomes such as one individual presenting with a mental health disorder and one individual may not. In contrast, “equifinality” refers to the notion that mental health disorders emerge from several possible developmental pathways. For example, although two individuals may have the same outcome, such as depression, it does not necessarily mean that their development or etiological factors of
depression are similar. Therefore, these concepts (i.e., equifinality and multifinality) suggest that no clear pathway exists in the emergence of mental health disorders.

1.3 Risk Factors/Protective Factors

Although there are multiple pathways to the emergence of a mental health disorder, it is beneficial to understand the particular factors that may increase or decrease the likelihood of a mental health disorder emerging at different age periods. Increased awareness may allow one to gain a thorough understanding of the development of mental health disorders and also gain information that may be relevant for the prevention and treatment of mental health disorders (Ma, Yang, Romero & Cui, 2011; Sroufe & Rutter, 1984). Risk factor research encompasses both the study of risk and protective factors (Kazdin et al., 1997). A risk factor refers to antecedent conditions which increase the likelihood of adverse outcomes. Protective factors refer to antecedent conditions which decrease the likelihood of adverse outcomes or increase the likelihood of positive outcomes (Kazdin et al., 1997). Examples of risk factors that have been discovered for mental health disorders include maternal stress during pregnancy, maternal substance abuse during pregnancy, low birth weight, birth complications, deprivation of normal parental care during infancy, childhood maltreatment, premature parental loss, exposure to family conflict and violence, stressful life events involving loss or threat, substance abuse, toxic exposures and head injury (Caspi & Moffit, 2006). Similarly, some examples of protective factors for mental health disorders include self-esteem, acceptance by parents, active coping, and peer acceptance (Steinhausen & Winkler Metzke, 2001). However, it is important to recognize that risk and protective factors are conditional not causal, since the manifestation of an outcome is contingent upon the interaction with other factors. Therefore, simple causal models are often limited and do not adequately explain an outcome due to the lack of acknowledgement to
interactions that may occur, which have large consequences on an outcome (Kazdin et al., 1997). Developmental psychopathology is a broad model, which encompasses many models, including the general ecological model.

1.4 The Ecological Systems Theory

The ecological model is a theory of human development across the lifespan which occurs through complex processes of interactions between individuals, objects and symbols in his or her immediate environment (Bronfenbrenner, 1977). In line with developmental psychopathology, in the ecological model the influence of multiple environmental variables at multiple levels of social organization and multiple domains of individual development are connected to human development. This approach may be useful for considering individuals who have accessed residential treatment or intensive home based treatment, since issues are rarely simple.

The ecological model is conceptualized as a set of influential variables, which graduate in size and each variable resides inside the other (Bronfenbrenner, 1994). Firstly, the microsystem is positioned at the core of the ecological model. The microsystem refers to an evolving and developing individual human being’s immediate environment and social context, including the roles, relationships, and engagement in activities. In particular, an example of the microsystem provided by Bronfenbrenner is the family in which the individual interacts. The mesosystem is positioned around the microsystem, which characterizes the associations between two or more settings, such as home and work. Situated around the mesosystem is the exosystem which represents the relationship between two or more settings, one of which has an indirect influence on the developing individual in his or her local environment. Examples of the exosystem suggested by Bronfenbrenner include the neighbourhood and community contexts in which the individual lives. Following the exosystem is the macrosystem; the macrosystem is
encompassing of the micro-, meso-, and exosystems and Bronfenbrenner proposed that examples of this system are lifestyles, opportunities, life course options and the culture or subculture, in which an individual resides within. Lastly, the chronosystem is positioned at the outermost location of the model and refers to how the time period in which one lives may shape the individual as well as the environment. Features of the chronosystem include employment or family structure (Bronfenbrenner, 1994). It is clear that individuals may be influenced by factors at each level of the ecological model. In summary, risk factors for admission to residential treatment and intensive home based treatment may be conceptualized within the context of intrapersonal, interpersonal, and environmental factors in order to understand the complexities of those accessing residential treatment and intensive home based treatment.

Mutual dependence of environment and developing individuals can be characterized as reciprocity. Reciprocity is a process of mutual accommodation by both the environment and developing person as a result of the interaction between the two (Bronfenbrenner, 1977). Thus, human development is the process through which developing and growing individuals acquire an extended, differentiated perception of their environment. As a result of developing extended perceptions, people may accommodate schemas and change their attitudes and behaviour. Therefore, the environment and its complex interaction with individuals play a large part in human development (Bronfenbrenner, 1977; Garbarino, 2009).

1.5 Adolescent Development

As outlined, human development is influenced by various factors including previous development, experiences and contexts, current experiences and contexts, as well as genetic influences. In particular, emotional, social, physical and intellectual development and sexual maturity and identity formation occur throughout adolescence (Steinberg & Sheffield Morris,
2001). Previously, researchers believed that adolescence was a period of stress and dysfunction. For example, it was believed that hormonal changes due to puberty were heightened during adolescence and the likelihood of negative moods increased. However, researchers have discovered that hormone levels only minimally influence change in moods as environmental factors more commonly precipitate change in moods (Brooks-Gunn, Graber & Paikoff, 1994). Adolescents typically engage in more conflicts with parents (Steinberg & Sheffield Morris, 2001) but emotional closeness and positive affect have been found to remain constant (Holmbeck & Hill, 1991; Montemayor, Eberly & Flannery, 1993). Adolescents typically gain a great deal of autonomy and begin to recognize their personal beliefs and standards (Harter, 1990) and closeness and time spent with peer counterparts have been found to increase during this developmental period (Larson & Richards, 1991). Likewise, although mental health disorders or problem behaviour often present themselves during adolescence, it does not necessarily mean that they are related to adolescence since influential factors throughout the life span may have precipitated the emergence of a mental health disorder or problem behaviour (Moffit, 1993; Steinberg & Sheffield Morris, 2001; Zahn-Waxler, Kilmes-Drougan & Slattery, 2000). In addition, some problems that occur in adolescence are temporary and do not persist throughout adulthood (Steinberg & Sheffield Morris, 2001). Therefore, although adolescence has been conceived as a period of emotional turmoil and “storm and stress” (Hall, 1904), it is now recognized that such difficulties are not always prevalent among adolescents (Arnett, 2006; Steinberg & Sheffield Morris, 2001).

Chapter Two

2.1 Background Information/Literature Review

Residential Mental Health Treatment and Intensive Home Based Treatment
The term “residential treatment” is ambiguous since treatment centres often differ in terms of size, services offered, children served and structure (Brady & Caraway, 2002). Nonetheless, a definition that is relatively encompassing suggests that residential treatment centres (RT) are inpatient facilities that serve children with mental health disorders that are not licensed as hospitals and offer mental health treatment (Tuma, 1989). RT settings are 24-hour care settings that can range in terms of structure where some are highly supervised and others are similar to a group home setting. However, in all RT structures, youth remain in care overnight and are in receipt of therapies (Tuma, 1989). At admission, clinicians develop a treatment plan in consultation with the youth and when possible, the youth’s caretakers. Treatment needs are assessed and if youth live in a stable living environment with parents or guardians who are willing to engage in treatment, intensive home-based treatment (IHB) is offered. Similar to RT, IHB provides mental health treatment but is delivered in the youth’s home (Preyde, Frensch, Cameron, Hazineh & Burnham Riosa, 2011b). Youth in both RT and IHB may attend a school that is part of their treatment program or may attend regular school. The intensiveness of treatment provided in RT and IHB is typically less than that provided in inpatient psychiatric units but more intense than that provided in foster care or day treatment (Bates, English & Kouidou-Giles, 1997).

Prior to accessing RT, youth have typically exhausted all other modes of treatment options and access RT as a last resort (Boyer, Hallion, Hammel & Button, 2009; Frensch & Cameron, 2002; Knorth, Harder, Zandberg & Kendrick, 2008; Landsman, Groza, Tyler & Malone, 2001; Zelechoski et al., 2013). Thus, youth’s needs are often not adequately managed in other settings which may be indicative of the severity of their emotional and behavioural problems (Preyde, et al., 2011b; Zelechoski et al., 2013). Numerous factors play a role when determining if youth
should access residential treatment. For example, the availability of residential treatment programs, the child or youth’s characteristics and the family’s needs are taken into consideration (Bates, English & Kouidou-Giles, 1997). Youth are sometimes referred to residential treatment after they have repeatedly harmed themselves or others, attempted suicide, accessed multiple previous treatment services (Kagan & Spinazzola, 2013) or after they have been stabilized in psychiatric hospitals (Dale, Baker, Anastasio & Purcell, 2007). Thus, the unique needs of each child are assessed at admission to determine if RT and IHB are appropriate treatment options.

Some researchers have suggested that community based care has become the preferred method of treatment for individuals with mental health disorders and residential treatment has become less favourable (Landsman et al., 2001). Brown and Hill (1996) discovered that community based treatment and residential treatment displayed similar efficacy outcomes, however, community based treatment can be provided at a significantly lower cost (Solhkhan, Passman, Lavezzi, Zoffness & Silva, 2007) and funding has been identified as a primary concern with regard to RT (Preyde et al., 2011a). More recently, Preyde et al., (2011a) found statistically and clinically significant differences between youth accessing RT and youth accessing IHB at intake and admission, indicating that very different populations access these programs. Comparisons between youth accessing these two programs cannot provide any meaningful evidence about relative effectiveness of intervention because they are accessed by two different groups of youth. Nonetheless, residential treatment may play a critical role in the treatment of emotional and behavioural disorders since some youths’ improvements in both symptom severity and psychosocial outcomes appeared to be maintained three years post discharge (Preyde et al., 2011a).
RT and IHB are designed to treat youth with moderate to severe emotional and behavioural disorders (EBD) and youth often have more than one disorder (Connor et al., 2004). Common disorders include Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiance Disorder (ODD), Post-traumatic Stress Disorder (PTSD), Obsessive-Compulsive Disorder (OCD), Anxiety, Mood Disorder, Tourette’s syndrome and Reactive Attachment Disorder where ADHD has been found to be the most common disorder among individuals (Connor et al., 2004; Brady & Caraway, 2002; Preyde, et al., 2011a). Girls have been reported to be more likely to have a primary diagnosis of affective and anxiety disorder, whereas, boys were more likely to have a primary diagnosis of a disruptive behaviour disorder (Connor et al., 2004). Behavioural problems that are typical among youth include chaotic behaviour, poor impulse control, aggression (Connor et al., 2004), proneness to harm others, destruction of property, use of physical threats, irritability, anger, learning problems and difficulty with attachment (Connor et al., 2004; Kagan & Spinazzola, 2013; Levin, 2009; Zegers, Schuengel, Van Ijzendoorn & Janssens, 2008). Youth and children in residential treatment are more likely to exhibit high levels of internalizing and externalizing behaviours (Connor et al., 2004; Hussey & Guo, 2002; Levin, 2009; Zegers et al., 2008) and increased use of illicit drugs (Baker et al., 2009; Kagan & Spinazzola, 2013). Overall, adverse behaviours and characteristics have been identified among individuals who have accessed RT which may have taxing effects in various domains of their lives.

After admission to RT or IHB, clinical scores, specifically symptom severity and functioning at admission in various contexts, indicated that youth are often facing significant challenges (Brady & Caraway, 2002; Dale et al., 2007; Preyde et al., 2011b) and many had previously accessed at least one out-of-home placement (Griffith et al., 2009; Landsman, Groza,
Tyler & Malone, 2001). Most individuals in intensive mental health treatment are in receipt of psychotropic medication to treat their symptoms (Dale et al., 2007). In addition to mental health, children and youth who accessed residential treatment have been found to also experience physical illness’ including asthma, obesity, seizure disorders and other neurological conditions (Connor et al., 2004). These findings suggest considerable severity and impairment from mental health disorders among this population.

Many children or youth who have accessed residential treatment have experienced at least one traumatic event at some point in their lifetime (Boyer et al., 2009; Brady & Caraway, 2002; Briggs et al., 2012; Conner et al., 2004; Dale et al., 2007; Greeson et al., 2011; Griffin, Martinovich, Gawron, & Lyons, 2009; Jaycox, Ebener, Damesek, & Becker, 2004; Kagan & Spinazzola, 2013) and Connor et al., (2004) found that female youth experienced an increased prevalence of traumatic exposure. Trauma experienced by this population typically consists of child maltreatment including physical abuse, sexual abuse, emotional abuse, neglect and witnessing violence in both the home and the community (Briggs et al., 2012; Connor et al., 2004; Dale et al., 2007; Greeson et al., 2011; Hussey & Guo, 2002; Kagan & Spinazzola, 2013; Singer 2007). Likewise, trauma has been shown to be a strong predictor of treatment outcomes (Zelechoski, 2013) where individuals who have been exposed to multiple types of trauma are less likely to experience clinical improvement from residential treatment compared to those who have not been exposed to multiple types of trauma (Boyer, Hallion, Hammel & Button, 2009; Zelechoski, 2013). However, Brady and Carraway (2002) found that youth who experienced multiple types of trauma did not display increased symptomatology compared to youth who experienced fewer types of trauma. Trauma also places individuals at an increased risk for additional psychiatric disorders such as, antisocial personality disorder, eating disorders,
dissociative disorders, affective disorders, somatoform disorders, and cardiovascular, metabolic, immunological, and sexual disorders (van derKolk, 2003) in addition to high-risk behaviour (D’Andrea et al., 2012). High-risk behaviours that have been identified among children with a history of trauma include aggression, problems with self-regulation, problems with attention and dissociation (Griffen et al., 2009; Pynoos et al., 1997; van derKolk, 2003). Children who have experienced trauma may present unique challenges (Levin, 2009; Miele & O’Brien, 2010; van der Kolk, 2003; Zelechoski et al., 2013), thus, attention may be warranted to trauma-related symptomology distinct from symptoms of psychiatric disorders to prevent incorrect diagnosis and treatment plans (Miele & O’Brien, 2010; van der Kolk, 2005). Overall, history of trauma may be involved in adversity that can endure (Miele & O’Brien, 2010) but other factors also play a role, such as family relationships and living conditions.

2.2 Support and Living Conditions

In addition to trauma, children and youth who have accessed residential treatment typically have experienced numerous stressors, such as a lack of stability in place of residence and home life (Brady & Caraway, 2002). For example, many youth had accessed prior residential treatment centres (Brady & Carraway 2002; Frensch & Cameron, 2002; Griffith et al., 2009), experienced multiple foster home placements, biological father absent from the home of origin, biological mother experiencing a major mental illness and many youth do not reside with both biological parents (Griffith et al., 2009). In particular, Preyde et al., (2011a) found that 53% of youth who accessed RT were in the care of child welfare services. Among this population there is an increased likelihood that children and youth come from low income households (Griffith et al., 2009; Preyde, et al., 2011a), and families who have experienced alcohol and drug abuse (Connor et al., 2004; Dale et al., 2007; Griffith et al., 2009). Additionally, many children
and youth from this population have experienced family violence, mental illness, and criminal activity (Griffith et al., 2009; Lewis, 1988; Moore & O’Connor, 1991; Quinton & Rutter, 1984). Inappropriate discipline, parental abandonment, parental neglect, parental marital/relationship problems, parental arrest or incarceration, mental health issues of family members, domestic violence, parental abuse, parental unemployment and family isolation were also common factors found among this population (Dale et al., 2007; Griffith et al., 2009). Nickerson et al., (2006) found that many youth are placed in RT to learn how to increase cooperation with family members. Overall, researchers have provided extensive reports on the adverse living conditions or family problems that children and youth may have experienced.

2.3 Post Discharge

Some investigators have found that residential treatment programs generally improved individual’s outcomes from admission to discharge (Boyer et al., 2009; Briggs et al., 2012; Knorth et al., 2008; Preyde et al., 2011b). Additionally, researchers found that fewer youth displayed high levels of impairment with respect to levels of anxiety, depression, moodiness, fear, worry, irritability, tenseness, panic and anhedonia at discharge (Preyde et al., 2011b). In particular, Hoagwood and Cunningham (1992) found that short lengths of stay have been associated with increased positive outcomes. However, some individuals, specifically those who have been found to have substance abuse problems, tend to try running away from residential treatment which may be problematic for youth (Connor et al., 2004; Dale et al., 2007; Hoagwood & Cunningham, 1992). Nonetheless, after reviewing 110 studies, Knorth et al., (2008) suggested that individuals who access RT typically improve in their psychosocial functioning.

Often times, the goal of residential treatment is to stabilize individuals and focus exclusively on progress within treatment (i.e. admission to discharge) (Thompson et al., 2012)
and emphasis is not placed on transitioning into the community due to the urgent needs of individuals (Zelechoski et al., 2013). Moreover, residential treatment often commences the treatment process but it is expected that treatment will be continued in a less costly community setting soon after discharge from RT (Leichtman & Leichtman, 2006). Thus, even when individuals do make progress in residential treatment, the gains may not be sustained after discharge for some youth (Bond, Drake & Mueser, 1999; Griffith et al., 2009; Leichtman & Leichtman, 2001; Preyde et al., 2011b; Thompson et al., 2012). However, Preyde, et al., (2011a) found that some youth retained the improvements they had made in treatment at three year follow up.

However, in addition to the transient discharge process, some youth return to a hostile living environment which may perpetuate their mental illness (Leichtman & Leichtman, 2006). Post treatment adaptation is highly correlated with the post discharge environment (Knorth et al., 2008). In particular, family involvement and support during treatment have been closely related to treatment progress and successful adaptation in the community after discharge (Frensch & Cameron, 2002). Additionally, community-based programs following discharge may be critical for maintenance of positive treatment outcomes (Frensch & Cameron, 2002; Hoagwood and Cunningham, 1992). Likewise, individualized care plans are needed considering that individual differences exist (Connor et al., 2004) and an individual’s satisfaction with their discharge plan has been found to be correlated with lower levels of depression (Brady & Caraway, 2002). Thus, a smoother transition from treatment to the community may be established through support and individualized community based treatment programs post discharge.
Chapter Three

3.1 Strengths and Subjective Well-being

Researchers have recently recognized the value of promoting individual strengths and mental health by means of increasing the subjective well-being of individuals (Diener, 2000; Laursen, 2003; Peter, Roberts, & Dengate, 2011). Strength–based treatments for youth accessing RT has resulted in improved outcomes and may be pivotal for long-term success (Lyons et al., 2000). Fortunately, most residential treatment centres include a strength-based framework because strengths can be developed or increased (Kagan & Spinazzola, 2013; Lyons et al., 2000). Treatment programs that provide individuals with coping strategies, emotional regulation or build on strengths and skills may allow for a smoother transition from treatment to life outside of treatment because youth may be able to recognize and utilize positive strengths when faced with adversity in the future. Similarly, the likelihood of engaging in high risk behaviour may be reduced. Therefore, although individuals may continue to experience clinical symptoms, it is possible that they may leave treatment with better life trajectories (Preyde et al., 2011b).

Some individuals in residential treatment were found to have a sense of humour, ability to enjoy positive life experiences, and many identify having a strong relationship with a sibling (Lyons, et al., 2000). Additionally, some individuals who have accessed RT have mentioned that their life experiences have allowed them to become stronger individuals (Brady & Caraway 2002) and many indicated that they had positive hopes and aspirations about their future family life and reported relatively little conflict and/or significant improvement in the level of conflict between themselves and other family members (Preyde et al., 2011c). Others stated that they felt confident overcoming future challenges or obstacles that they may encounter and were content with their lives post-treatment, which is considered an indicator of good health (Preyde et al.,
Therefore, positive indicators among this population are evident and recognition of these positive indicators may be valuable in terms of sustaining the improvements made in treatment (Briggs et al., 2012; Dale et al., 2007; Leichtman & Leichtman, 2006).

Investigators have found that many youth often continue to experience clinical problems after discharge from residential treatment or intensive home based treatment and given the significant amount of adversity that these individuals have encountered, they are at increased risk for negative life trajectories (Preyde et al., 2011c). In addition, there has been a strong focus on pathology and deficits within the literature of individuals accessing residential treatment and positive indicators of individual’s subjective well-being with regard to mental health have been often overlooked or unexplored (Griffin et al., 200; Peter, Roberts, & Dengate, 2011). However, focusing only on deficits may be limiting in our understanding because many children and adolescents with severe psychopathology also have significant strengths or identify positive personal well-being. An individual’s subjective well-being is his or her perceptions and evaluations of his or her own life with regard to affective states and psychological and social functioning (Diener, 2000; Keyes, 2002). That is, a person could have a serious illness, and still have a positive sense of subjective well-being. Subjective well-being, perceived well-being, self-rated quality of life have been used interchangeably throughout the literature and is considered the scientific term for happiness (Lyubomirsky, King & Diener, 2005).

High personal well-being scores have been found to be associated with many desirable and enduring consequences. However, youth who access intensive mental health treatment are typically experiencing a multitude of stressors and challenges in their lives. Thus, it is important to explore the association between personal well-being and clinical characteristics in order to begin to develop a comprehensive view of youth’s mental health and well-being. In addition, this
exploration may permit increased understanding with regard to the practical utility of strengths-based treatments which focus on increasing youth's personal well-being.

3.1 Study Purpose

The purpose of this study was to explore the level of perceived positive personal well-being in youth who accessed intensive mental health treatment (i.e., RT and IHB). A second purpose was to explore how personal well-being as captured at 12-18 month follow-up is predicted by demographic characteristics (i.e. age and gender) and clinical characteristics (i.e., symptom severity and psychosocial functioning) as captured at intake and admission respectively.

3.2 Objective and Hypothesis

The objective for this study was to explore demographic characteristics, specifically age and gender, and clinical characteristics, specifically symptom severity and psychosocial functioning, in relation to overall personal well-being as defined by Cummins and Lau (2005) in youth who accessed RT and IHB. It was hypothesized that better clinical scores at intake and admission would predict a higher score of personal well-being at 12-18 month follow up.

3.4 Design and Data Collection

This study is a part of a larger longitudinal, observational study on the psychosocial outcomes of children and youth who have accessed residential or intensive home-based treatment in five agencies in Ontario, Canada (Preyde et al., 2011). Three of these mental health agencies serve children aged 5 to 12 years upon admission and their families, and two of the mental health agencies serve adolescents aged 12-18 years upon admission and their families. In the original study, the research included administering standardized scales to caregivers and gleaning clinical
information from youths’ files. Staff from each of the five agencies contacted families or caregivers of youth who had been discharged from RT or IHB within the past 12-18 months to ask if they would provide contact information to researchers to learn about the study. The contact information of families who were interested was given to researchers and researchers obtained informed consent from participants. If youth were not in the care of the family, a caseworker or foster parent was the respondent for the study. Similarly, for this part of the study, staff made the initial contact with youth 12 years old or older and researchers obtained informed consent and conducted a semi-structured interview. The present study included a subsample of youth who accessed RT (n=33) and IHB (n=30) and were contacted 12-18 months post-discharge. Youth’s clinical data were also gleaned from agency files. Researchers received ethics approval from Wilfred Laurier University and the five mental health agencies.

3.5 Setting

Children who accessed RT resided in the treatment centre five days a week and often joined their families on weekends, if possible, or remained at the treatment centre. Trained professionals typically developed an individualized treatment plan for each youth. Some youth attended an on-site school for youth whereas other youth attended a community school. Youth were in receipt of individual counseling for their mental health disorder and family counseling was provided to families who were willing. The average length of stay in RT for this specific population was 7.8 months (Preyde et al., 2011). Some youth accessed intensive home based treatment (IHB). IHB was initially developed to overcome the barrier of long-waiting lists for residential services, but it is now considered one main type of treatment to be used in developing an individualized treatment plan. However, in order to access IHB, the youth’s family must be willing to host the intervention in their home. Typically the family of origin hosts this
intervention, but adoptive or foster families may also provide accommodations for the program where a mental health care provider delivers the intervention in the youth’s home (Preyde et al., 2011c). It should be acknowledged that intensive home based treatment is comparable to residential treatment. The average length of stay in intensive home based treatment for this specific population was 5.25 months (Preyde et al., 2011). A strength based approach was employed in both settings, which is used to capitalize on the strengths of the youth (Preyde et al., 2011).

3.6 Measures

Clinical data are comprised of standardized scales of symptom severity captured by the Brief Child and Family Phone Interview (3rd version; BCFPI) at intake and psychosocial functioning captured by the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 2000) at admission. Both scales are mandated for use with all patients in Ontario and can be used for a variety of secondary functions such as research, service planning, and comparative analyses.

The BCFPI (Cunningham, Boyle, Hong, Pettingill & Bohaychuk, 2009) is a computer-assisted, clinical intake process that is administered to the parents or caregivers of children or youth and takes approximately a half an hour to complete (BCFPI, 2014). The intake personnel first records a narrative overview of basic concerns mentioned by parents or caretakers. Next, the parent or caregiver is asked standardized questions (BCFPI, 2014). In particular, the BCFPI is an interview tool that captures symptom severity relating to three externalizing disorders (i.e. Attention deficit hyperactivity disorder, oppositional defiant disorder, and conduct disorder) and three internalizing disorders (i.e. separating anxiety disorder, general mood, and self harm) (Cunningham et al., 2009). The BCFPI has been found to demonstrate acceptable internal
consistency reliability with Cronbach’s Alpha values being above .75 on all subscales with the exception of the conduct subscale which is .68 (Cook et al., 2013; Cunningham et al., 2009). Additionally, strong correlations were discovered between BCFPI and the Conners’ Parent Rating Scale, indicating high concurrent validity (Cook et al., 2013; Cunningham et al., 2009).

The CAFAS (Hodges, 2000) is the gold standard tool to assess the degree of functional impairment in children and youth with emotional, behavioural, or substance use problems. The CAFAS takes approximately 10 minutes to complete by a clinician with input from the youth and potentially other sources. Based on the response from the participant, the clinical interviewer rates the client’s functioning on eight scales; School/Work, Home, Community, Behaviour Towards Others, Moods/Emotions, Self-Harmful Behaviour, Substance Use, and Thinking. The CAFAS has been found to demonstrate reliability and predictive validity (Hodges & Wong, 1996) and is the best option to measure functioning in youth with mental health disorders (Bates, 2001). The CAFAS can be used for both research and in clinical settings to assess clinical progress or outcome. For the purpose of this study, the composite scores of the BCFPI and CAFAS will be used to determine youth’s symptom severity and psychosocial functioning where higher scores on both scales indicate increased impairment compared to lower scores.

Youths’ perceptions of the quality of their lives were captured with The Personal Well-Being Index-School Children (PWI-SC; Cummins & Lau, 2004), which was used as an interview guide at 12-18 month post-discharge. Instead of satisfaction the colloquial term of happiness was substituted for increased understanding among youth. The domains include school, work, learning, family, people you live with, where you are living, friends, doing things with people outside of your home, money/things you own, future, healthy, life as a whole. Participants rated
their happiness on each of these mentioned domains on a scale from zero to 10, where zero indicates very sad and 10 indicates very happy and total scores were presented as a mean overall happiness score. The PWI-SC has been found to demonstrate high inter-item reliability with Cronbach’s Alpha being .82 (Tomyn & Cummins, 2011).

3.7 Data Analysis

Demographic information is presented with descriptive statistics. An independent samples t-test was conducted to explore the difference between overall personal well-being among youth who accessed RT and overall personal well-being among youth who accessed IHB and the assumption of homogeneity was met (p=.598). To explore the relationship between demographic and clinical characteristics and personal well-being, a hierarchical multiple regression was conducted. According to Cohen (1992), a sample size of at least 38 is required for a multiple regression analysis with four independent variables with a large effect size, a statistical of power of .80 and an alpha level at .05. The independent variables were participant’s age, sex, symptom severity (captured by the BCFPI at intake) and psychosocial functioning (captured by the CAFAS at admission). The dependent variable was the mean score of participant’s overall happiness as captured by the PWI-SC at 12-18 month post-discharge. Given that we were not able to predict PWI based on intake and admission scores, a subsequent analysis (i.e. Pearson correlation) was performed to explore the relationship between personal well-being at 12-18 month post-discharge and symptom severity at three year post-discharge.
Chapter Four

4.1 Results

The sample consisted of 63 youth of whom 33 (52.4%) accessed IHB and 30 (47.5%) accessed residential treatment. Their mean age was 14.61 (SD=1.82) and the majority (43; 68%) were male. Many youth were attending school (53; 85.5%) with most attending full time (51; 94.4%) (Table 1). The mean total CAFAS score was 98.30 (SD 38.72), the mean total BCFPI score was 78.83 (SD 11.56) and the mean personal well-being score was 7.49 (SD 1.39). Both the CAFAS and BCFPI scores of this population were beyond the clinical range.

Table 1

Youth Characteristics

<table>
<thead>
<tr>
<th></th>
<th>RT</th>
<th>IHB</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=30</td>
<td>n=33</td>
<td>N=63</td>
</tr>
<tr>
<td>Age in years, mean (SD)</td>
<td>14.7 (1.87)</td>
<td>14.55 (1.80)</td>
<td>14.61 (1.82)</td>
</tr>
<tr>
<td>Male, n (%)</td>
<td>20 (67.6%)</td>
<td>23 (69.7%)</td>
<td>43 (68.3%)</td>
</tr>
<tr>
<td>Female, n (%)</td>
<td>10 (33.3%)</td>
<td>10 (30.3%)</td>
<td>20 (31.7%)</td>
</tr>
<tr>
<td>Born in Canada, n (%)</td>
<td>29 (96.7%)</td>
<td>33 (100%)</td>
<td>62 (98.4%)</td>
</tr>
<tr>
<td>Attending School, n (%)</td>
<td>25 (96.2%)</td>
<td>28 (84.8%)</td>
<td>53 (85.5%)</td>
</tr>
<tr>
<td>Employed, n (%)</td>
<td>4 (13.3%)</td>
<td>7 (21.2%)</td>
<td>11 (17.5%)</td>
</tr>
<tr>
<td>Trouble with the law, n (%)</td>
<td>14 (46.7%)</td>
<td>6 (18.8%)</td>
<td>20 (32.3%)</td>
</tr>
<tr>
<td>CAFAS, mean (SD)</td>
<td>109.26 (31.98)</td>
<td>81.25 (33.77)</td>
<td>98.30 (38.72)</td>
</tr>
<tr>
<td>BCFPI, mean (SD)</td>
<td>78.44 (10.23)</td>
<td>80.91 (12.12)</td>
<td>78.83 (11.56)</td>
</tr>
<tr>
<td>PWI, mean (SD)</td>
<td>7.36 (1.32)</td>
<td>7.62 (1.45)</td>
<td>7.49 (1.39)</td>
</tr>
</tbody>
</table>
There was no statistically significant difference in the BCFPI total score between youth who accessed RT (mean 78.44, SD=10.23) and those who accessed IHB (mean 80.91, SD=12.12); $t(50)=0.721, p=0.442$. There was a statistical difference in the CAFAS total score between youth who accessed RT (mean 112.88, SD=36.42) and those who accessed IHB (mean 85.49, SD=36.22); $t(57)=-3.252, p=0.002$. There was no statistically significant difference in total happiness scores between youth who accessed RT (mean 7.35, SD=1.32) and youth who accessed IHB (mean 7.61, SD=1.45); $t(61)=0.729, p=0.469$. Thus, the entire sample was included in the subsequent analyses. The highest rated domain of personal well-being was “happiness with friends”, with a mean score of 8.8 (SD 1.38), followed by “happiness with doing things with people outside your home” with a mean score of 8.1 (SD 2.16). The lowest rated domain of personal well-being was “happiness with people with whom you live”, with a mean score of 5.57 (SD 2.17) (See Table 2).

Table 2

*Participant’s perceived happiness*

<table>
<thead>
<tr>
<th>PWI Domains M (SD)</th>
<th>RT n=30</th>
<th>IHB n=33</th>
<th>Total Mean</th>
<th>Test Statistic</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>School</td>
<td>6.4 (2.41)</td>
<td>6.71 (2.60)</td>
<td>6.59 (2.49)</td>
<td>0.41</td>
<td>0.68</td>
</tr>
<tr>
<td>Work</td>
<td>8.85 (1.94)</td>
<td>7.36 (3.47)</td>
<td>8.07 (2.88)</td>
<td>-1.19</td>
<td>0.25</td>
</tr>
<tr>
<td>Learning</td>
<td>7.18 (2.43)</td>
<td>7.20 (2.17)</td>
<td>7.19 (2.28)</td>
<td>0.03</td>
<td>0.98</td>
</tr>
<tr>
<td>Family</td>
<td>7.75 (1.90)</td>
<td>7.41 (2.23)</td>
<td>7.56 (2.08)</td>
<td>-0.64</td>
<td>0.53</td>
</tr>
<tr>
<td>People you live with</td>
<td>5.25 (2.18)</td>
<td>7.5 (0.71)</td>
<td>5.57 (2.17)</td>
<td>1.41</td>
<td>0.19</td>
</tr>
<tr>
<td>Where you are living</td>
<td>5.70 (2.72)</td>
<td>7.83 (2.70)</td>
<td>6.8 (2.89)</td>
<td>3.10</td>
<td>0.00*</td>
</tr>
<tr>
<td></td>
<td>1st group</td>
<td>2nd group</td>
<td>3rd group</td>
<td>4th group</td>
<td>p-value</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>-----------</td>
<td>-----------</td>
<td>-----------</td>
<td>-----------</td>
<td>---------</td>
</tr>
<tr>
<td>How safe where you are living</td>
<td>7.75 (2.87)</td>
<td>8.00 (2.60)</td>
<td>7.88 (2.71)</td>
<td>0.36</td>
<td>0.72</td>
</tr>
<tr>
<td>Friends</td>
<td>8.77 (2.87)</td>
<td>8.82 (1.31)</td>
<td>8.8 (1.38)</td>
<td>0.15</td>
<td>0.88</td>
</tr>
<tr>
<td>Doing things with people outside your home</td>
<td>8.05 (2.26)</td>
<td>8.21 (2.10)</td>
<td>8.14 (2.16)</td>
<td>0.29</td>
<td>0.77</td>
</tr>
<tr>
<td>Money/Things you own</td>
<td>6.95 (3.36)</td>
<td>7.80 (1.94)</td>
<td>7.4 (2.73)</td>
<td>1.25</td>
<td>0.22</td>
</tr>
<tr>
<td>Future</td>
<td>8.12 (1.82)</td>
<td>7.23 (1.92)</td>
<td>7.65 (1.91)</td>
<td>-1.89</td>
<td>0.06</td>
</tr>
<tr>
<td>Healthy</td>
<td>7.56 (2.33)</td>
<td>7.14 (2.47)</td>
<td>7.34 (2.4)</td>
<td>-0.71</td>
<td>0.48</td>
</tr>
<tr>
<td>Life as a whole</td>
<td>7.05 (2.32)</td>
<td>7.67 (1.94)</td>
<td>7.37 (2.14)</td>
<td>1.15</td>
<td>0.26</td>
</tr>
<tr>
<td>Overall Happiness</td>
<td>7.36 (1.32)</td>
<td>7.62 (1.45)</td>
<td>7.49 (1.39)</td>
<td>0.729</td>
<td>0.468</td>
</tr>
</tbody>
</table>

*Significantly different between groups at 0.05 however with Bronferroni correction, p would have to be equal to or less than 0.0038

Some youth had missing clinical data, thus, only participants with no missing data were included in the multiple regression (n=51). The required assumptions were checked. The assumption of collinearity was met (Sex, Tolerance=.996, VIF=1.004; Age, Tolerance=.993, VIF=1.007; BCFPI score, Tolerance=0.969, VIF=1.032; CAFAS score, Tolerance=0.975, VIF=1.026). The Durbin-Watson test indicated that the assumption of independent errors was met with a value of 2.058. A histogram and a P-P plot of standardized residuals was produced with SPSS and indicated that the data met the assumption of normally distributed errors.
Additionally, a scatterplot of standardized residuals was produced on SPSS and indicated that the data met the assumptions of homogeneity of variance and linearity.
In order to control for age and sex, these variables were entered into the model in the first stage and symptom severity (BCFPI score) and psychosocial functioning (CAFAS score) were entered into the model in the second stage. The results of this analysis revealed that 6.4% of the variance was explained by age and sex ($R^2=.064$, $F(2,48)=1.642$, $p=.204$). With the addition of symptom severity (BCFPI score) and psychosocial functioning (CAFAS score) in the second model, there was an increase of 6.1%, thus, 12.5% of the variance was explained ($R^2=.125$, $F(2,46)=1.639$, $p=.181$). Moreover, the analysis revealed that sex ($\beta=.420$, $t(50)=1.617$, $p=.113$), age ($\beta=-.145$, $t(50)=-1.050$, $p=.299$), symptom severity ($\beta=.096$, $t(50)=.684$, $p=.497$) and psychosocial functioning ($\beta=-.213$, $t(50)=-1.525$, $p=.134$) did not significantly predict personal well-being scores (See table 3). Since there was no relationship between demographic and clinical scores captured prior to treatment and youths’ perception of well-being at 12-18 month follow-up, subsequent analyses were conducted.

A second hierarchical multiple regression was conducted and the type of treatment was controlled. The assumption of collinearity was met (Treatment, Tolerance=.851, VIF=1.175; BCFPI score, Tolerance=0.970, VIF=1.030; CAFAS score, Tolerance=0.846, VIF=1.182). The Durbin-Watson test indicated that the assumption of independent errors was met with a value of 2.235. A histogram and a P-P plot of standardized residuals was produced with SPSS and indicated that the data met the assumption of normally distributed errors. Additionally, a scatterplot of standardized residuals was produced on SPSS and indicated that the data met the assumptions of homogeneity of variance and linearity.

Type of treatment was entered into the model in the first stage and symptom severity (BCFPI score) and psychosocial functioning (CAFAS score) were entered into the model in the second stage. The results of this analysis revealed that 0% of the variance was explained by
treatment ($R^2=.000$, $F(1,49)=0.23$, $p=.879$). With the addition of symptom severity (BCFPI score) and psychosocial functioning (CAFAS score) in the second model, there was an increase of 6.1%, thus, 6.1% of the variance was explained ($R^2=0.061$, $F(3,47)=1.009$, $p=3.97$) by type of treatment and clinical characteristics. Moreover, the analysis revealed that treatment ($\beta=.079$, $t(50) = .513$, $p=.611$), symptom severity ($\beta=-.230$, $t(50) = -1.495$, $p=.142$) and psychosocial functioning ($\beta=-.101$, $t(50) = .707$, $p=.483$) did not significantly predict personal well-being scores (See table 4).

Next, a Pearson correlation coefficient was performed to explore if there was a relationship between personal well-being and CAFAS scores captured at three years post-discharge. A correlation analysis revealed that there was no significant relationship between personal well-being scores (7.493, 1.39) and youth’s symptom severity score at three year post discharge (70.04, 11.55), $r(63)=-0.051$, $p=.721$.

Table 3

<table>
<thead>
<tr>
<th></th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$B$</td>
<td>Std Error</td>
</tr>
<tr>
<td>Constant</td>
<td>8.67</td>
<td>2.358</td>
</tr>
<tr>
<td>Gender</td>
<td>0.67</td>
<td>0.42</td>
</tr>
<tr>
<td>Age</td>
<td>-0.11</td>
<td>0.112</td>
</tr>
<tr>
<td>Symptom Severity</td>
<td>(BCFPI)</td>
<td>0.01</td>
</tr>
</tbody>
</table>
Psychosocial Functioning (CAFAS) -0.00 0.006 -0.213 -1.525 0.134

*Note.* Dependent variable: Personal Well-Being Score

Table 4

*Coefficients Variables Resulting from second Multiple Regression Analysis*

<table>
<thead>
<tr>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Std Error</td>
</tr>
<tr>
<td>---</td>
<td>----</td>
</tr>
<tr>
<td>Constant</td>
<td>7.368</td>
</tr>
<tr>
<td>Treatment</td>
<td>0.225</td>
</tr>
<tr>
<td>Symptom Severity (BCFPI)</td>
<td>0.013</td>
</tr>
<tr>
<td>Psychosocial Functioning (CAFAS)</td>
<td>-0.009</td>
</tr>
</tbody>
</table>

*Note.* Dependent variable: Personal Well-Being Score

4.2 Discussion

The primary finding of this study was the high proportion of youth (88.9%) who indicated that they were experiencing happiness in their lives as many reported an overall personal well-being score of six or above (M=7.49, SD=1.39). Despite the symptoms of mental health disorders and often the adverse experiences of youth who have accessed intensive mental health treatment, it appears that happiness levels may not be negatively impacted among
adolescents with emotional and/or behavioural disorders. This finding supports previous research which suggests that positive emotions can in fact co-exist with stress or challenges (Diener & Diener, 1995). In addition, these findings are consistent with the notion that positive mental health and mental health disorders should not be conceived as two ends of one spectrum, as they are separate entities (Diener, 2009; Hatch, Harvey, & Maughan, 2010; Keyes, 2002). In particular, a large portion of youth (82%) who rated their overall personal well-being above six attended school full time. This finding can be connected to previous research by Currie et al., (2012) who indicated that school environments may function as a support network for youth and may contribute to youth’s well-being. However, it should also be acknowledged that youth with emotional and behavioural disorders may have great difficulty in the school setting with particular regard to academic achievement (Nelson, Benner, Lane, & Smith, 2004), inappropriate behaviour and social skills (Landrum, Tankersley & Kauffman, 2003). Overall, although adverse consequences are typically characteristic of mental health disorders (Meng & Darcy, 2012), this study provides promising findings which indicate that positive factors seem to exist and can be recognized by youth despite the presence of a mental health disorder.

High personal well-being may not only be conceived as an outcome since many enduring consequences have been found to be related high personal well-being scores. Moreover, various benefits stemming from high personal well-being include better health and longevity, rewarding relationships with others, increased success in work, stronger immune systems, and higher incomes compared to less happy counterparts (Diener & Chan, 2011; Lyumbomirsky, King, & Diener, 2005). Additionally, high SWB has been found to ameliorate negative outcomes, including psychological disorders (Park, 2004). Thus, youth with negative life experiences, which have been typically featured among youth who have accessed residential treatment, can in
fact experience happiness despite stressful life circumstances and the experience of a mental health disorder. In addition, these youth may also experience the accompanying benefits that high personal well-being seems to offer and high personal well-being may be useful in combating the symptoms of a mental health disorder.

Complete mental health can be referred to the absence of illness and the presence of positive factors, such as life satisfaction (Keyes, 2002). Although many youth in this sample may indicate high personal well-being, we do know that they may not have complete mental health as they have accessed intensive mental health treatment, indicating they do not have an absence of illness. However, less than a complete state of wellness may prove valuable, as researchers have found that a lack of negative feelings may have adverse consequences (Oishi, Diener, & Lucas, 2009). For example, negative emotions may act as a constructive catalyst, whereby individuals are motivated to overcome challenges in their life and negative emotions prompt individual human beings to better themselves. Thus, a balance between negative and positive moods may be the ideal level of happiness, but it should be acknowledged that the ideal level of happiness may vary across individuals.

Another notable finding from the present study is the similarity of happiness levels between youth who accessed RT compared to youth who accessed IHB. Previous researchers have indicated that very different populations access RT in comparison to those who access IHB in terms of psychosocial functioning and living arrangements (Preyde et al., 2011a). However, the results of this study indicate that happiness levels between both groups are not dissimilar with the exception of “happiness with where you are living”. This discrepancy between groups may be attributed to the fact that the youth who were accessing IHB may have been more likely to have a stable home environment in comparison to youth who accessed RT. Additionally,
youths’ total CAFAS scores were clinically and significantly different, yet their overall mean happiness levels remained similar. Therefore, it should be noted that individual happiness levels tend to be stable over time and changes in happiness levels are minimally affected and if so, only temporarily (Lyubomirsky et al., 2005). Genes are found to account for 80% of individual happiness levels (Nes, Roysamb, Tambs, Harris, & Reichborn-Kjennerud, 2006) and numerous researchers have indicated that personality largely contributes to happiness levels (DeNeve & Cooper, 1998; Pavot, Diener & Fujita, 1990; Steel, Schmidt & Shultz, 2008). Nonetheless, despite the differences between psychosocial functioning and living arrangements in baseline characteristics between both populations, happiness levels may be largely contingent upon individual personalities. In contrast, some researchers have suggested that living conditions may have influences on happiness levels indicating that happiness is in fact not a trait (Veenhoven, 1994). Therefore, happiness levels may be conceived, similar to psychopathology, as being largely influenced by the complex interaction among numerous factors, including genetic and environmental contributions.

4. 3 Highest rated domains: Happiness with friends

Another meaningful finding of this study may be the high degree of happiness participants indicated with their friends. It has been well documented that adolescents heavily value friendships, and peers play important roles during this developmental stage. Satisfaction with peers becomes particularly important as children mature (Park, 2004) and a significant amount of adolescents’ time is occupied with friends (Steinberg & Sheffield Morris, 2001). Peer relations are imperative at this developmental stage as friends assist adolescents in their identity formation, social skills development and establishment of autonomy (Currie et al., 2012). Likewise, good relationships with others may serve as a protective factor against poor health
(Currie et al., 2012; Olsson, McGee, Nada-Raja & Williams, 2013). Happiness has been associated with creating and maintaining relationships with others (Chu, Saucier, & Hafner, 2010; Diener, 2000; Shaw & Taplin, 2007) and sadness has been found to be associated with losing good relationships (Shaw & Taplin, 2007). In general, people tend to be happier when they are in the presence of other people (Pavot, Diener & Fujita, 1990; Ryff, 1989).

Given that many youth who access intensive mental health treatments are in custody of child welfare, friends may serve as an essential support role in the lives of these youth. In particular, adolescents without close family ties may be more likely to be influenced by peer counterparts (Gauze, Bukowski, Aquan-Assee & Sippola, 1996). Thus, developmental age and developmental norms regarding social development should be considered when planning the therapeutic treatment process (Park, 2004) and facilities should provide flexible visiting schedules to enable and encourage support from peers and family for patients (Pinquart & Fröhlich, 2009). For these reasons, it may be valuable to consider treatment processes from the perspective of family systems theory, as we do know that mental health disorders are hosted in a contextual environment and are influenced by contextual factors. However, it should also be recognized that peers may influence adolescents in negative ways such as, drug and alcohol use, cigarette smoking and delinquency (Urberg, Degirmencioglu & Pilgrim, 1997).

4.4 Happiness with doing things outside of the home

Rated second highest, was the happiness participants indicated with doing things outside of their home. This finding corroborates previous research as structured extra-curricular activities have been found to be associated with increased positive development and higher overall satisfaction with life (Gilman, 2001). Given that some youth who have accessed residential treatment have often experienced hostile or unstable environments (Leichtman &
Leichtman, 2006), positive activities outside of the home, such as leisure activities, may act as opportunities for adolescents to develop relationships with adults and peers, promote new skills, and foster positive relationships with others. Likewise, positive minor life events that occur on a day-to-day basis have been found to largely contribute to subjective well-being among youth (McCullough, Huebner, & Laughlin, 2000). Thus, attention may be placed on the importance of creating or discovering opportunities to experience positive minor life events in the treatment process. Even more encouraging is that engagement in leisure activities has been related to increased management of major life stressors and transitions (Trenberth & Dewe, 2002). Therefore, consistent engagement in the community or activities outside of the home may be particularly valuable to include in the treatment process and post discharge plans to enable sustainable and enduring positive satisfaction among youth.

4.5 Clinical Characteristics and Personal Well-being

In this exploration, it was found that demographic, treatment type, and clinical characteristics did not predict the participants’ personal well-being scores, suggesting that no clear relationship exists between personal well-being and symptom severity and psychosocial functioning. These findings again support the idea that positive well-being and mental health disorders should be considered as distinct and exclusive entities (Huppert & Whittington, 2003; Keyes, 2006). These findings somewhat contrast those of Suldo and Hueber (2004), who did in fact find a relationship where low life satisfaction predicted the occurrence of externalizing problems and high life satisfaction acted as a buffer against the perception of stressful life events. Likewise, Hatch, Harvey and Maughan (2010) found that oppositional or aggressive behaviour in childhood, police contact and truancy in adolescence, and negative social environments (i.e. poor material conditions, poor relationship with parents, contact with services, parental divorce or
separation at age seven, and poor relationships with siblings) increased the likelihood of poor well-being and mental health disorders later in life. Although no clear relationship was found between clinical characteristics predicting personal well-being in the present study, we can conclude that individuals who have accessed intensive mental health treatment for their mental health disorders can experience happiness in many domains of their life. Thus, this finding supports the notion that personal well-being and mental health disorders demonstrated a degree of independence from each other with this sample.

Chapter Five

5.1 Strengths and Limitations

A major strength of this study was the examination of both clinical characteristics and perceived personal well-being among an adolescent population who accessed intensive mental health treatment. As mentioned, positive factors have often been overlooked among the literature, specifically among populations with mental health disorders. As mental health disorders can have adverse consequences, this exploration provided an increased understanding of the characteristics of youth who access intensive mental health treatment with regard to well-being.

Limitations of this study should also be acknowledged. First, the method of recruitment posed challenges in obtaining follow-up data as agency staff initially contacted participants to gain permission to provide researchers with youths’ contact information. However, by the time the contact information was received by the researchers some was no longer valid. Likewise, only youth who were interested in participating were included in this study. Findings of this study may not be generalizable to youth accessing other mental health systems as it was a relatively small sample size and all of the youth were living in Ontario, Canada. Another
limitation was the cross-sectional nature of this study as happiness was only captured at one time point.

5.2 Implications for Research

In the future, investigators may consider exploring personal well-being over an extended period of time in addition to mental health disorders. As mentioned, researchers have indicated that happiness has been largely contingent upon personality types, yet happiness has been also found to exist despite the absence of a happy predisposition (Lyubomirsky, King & Diener, 2005). Therefore, a longitudinal study could be conducted in the future to explore happiness levels throughout treatment and post-discharge which may shed light on the query of happiness being a trait or a state. Similar research could also discover the bidirectional relationship between happiness and mental health disorders. Also, as many benefits accompany high personal well-being scores, future research could explore if the benefits remain for this at-risk population in addition to the exploration of the accuracy of self-perceptions.

5.3 Implications for Practice

When connecting these findings to practical terms, it is recognized that mental health disorders are often chronic and lifelong conditions. These findings allow us to recognize that youth can experience and identify happiness in their lives, despite their mental health disorder. Likewise, it has been discovered that strategic interventions may foster increased happiness levels for individual human beings (Norrish & Vella-Brodrick, 2007; Sin & Lyubomirsky, 2009), including those experiencing mental health disorders (Boiler et al., 2013; Fava, et al., 2005; Lyubomirsky & Layous, 2013). Positive feelings, including happiness, can have enduring positive consequences whereby individual human beings tend to implicitly think and behave in a positive manner. By doing so, it is believed that strong physical and psychological resources
will be created that can be accessed throughout the lives of individuals (Fredrickson, 2001). Thus, it is clear that positive well-being acts a resource for youth that can positively influence their daily life.

Similarly, with the resilience framework individuals are viewed as active agents who can influence their life circumstances through effective use of resources, despite having experienced adversity (Luthar & Cicchetti, 2000). Positive interpretation and adjustment to life events may be equally as important as the occurrence of positive life events (MacLeod & Moore, 2000). Therefore, incorporating interventions in the treatment process that are focused on positive adjustment and improving happiness levels among youth with mental health disorders may prove useful. From a resilience framework, mental health disorders may act as the vulnerability factor, which may adversely influence health outcomes. Whereas, personal well-being interventions may act as a protective factor since they may have the potential to modify the effects of risk in a positive direction. For example, it has been shown that both temporary positive affect and long-term well-being were associated with many desirable characteristics including, sociability and activity (Diener & Seligman, 2002), prosocial behaviour (Lucas, 2001; Thoits & Hewitt, 2001), less likely to engage in unhealthy behaviour (Pettit, Kline, Gencoz, Gencoz, & Joiner, 2001), more likely to engage in healthy behaviour (Lox, Burns, Treasure, & Wasley, 1999), high immune functioning (Gil, et al., 2004) and good coping skills (Maruta, Colligan, Malinchoc, & Offord, 2000). Happiness was also found to predict productive work, satisfying relationships, and superior mental and physical health and longevity (Lyubomirsky, King & Diener, 2005). Likewise, interventions that aim to increase personal well-being may be executed in an economically feasible manner whereby various professionals, within and outside of the medical field, can administer the respective interventions which may result in increased accessibility for
those in need (Cloninger, 2006; Shaw & Taplin, 2007). Therefore, interventions that aim to increase happiness levels may have long lasting consequences for youth, specifically those who experiencing mental health disorders.

5.4 Conclusion

Evidently, individuals accessing RT or IHB treatment may experience numerous stressors and have experienced adversity in their lives. However, in this study, promising results were revealed; that is, these youth indicated high levels of perceived personal well-being. Moreover, the promotion of mental health by means of strengthening and enhancing subjective wellbeing of children and youth is perhaps equally important as treating mental health disorders (Peter, Roberts & Dengate, 2011). In addition, in order to function optimally, individuals may need positive mental health (Keyes, 2002) and it is believed that many adverse trajectories may be ameliorated with high long term personal well-being and temporary positive affect. Overall, the findings from this study support the notion that well-being and psychopathology have a degree of independence from each other.
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