Development and Testing of FAME: Advancing Care for Families and Their Teens with Mental Disorders

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I have no conflict of interest to declare.
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Agenda

Significance of the problem
Development of FAME
Pilot Testing of FAME
Clinical applications
Questions & answers
Disruptive Behavior Disorders or DBDs (i.e., ODD/CD)
Affects 10% of adolescents 13-18 years
Cost over ¼ trillion dollars to society
Imposes significant toll on families

Academies, 2009; Kilmer et al., 2010; Merikangas, 2010; Oruche et al., 2012
Preliminary work

NEEDS & CHALLENGES OF FAMILY MEMBERS OF ADOLESCENTS WITH DBDS
“STRESS. I will say that out loud. I want you all to hear it again. It is STRESS. It is STRESS.”
Findings: 2 Major Challenges

1. Need to manage the adolescents’ disruptive behaviors
2. Need for frequent interactions with child service providers
Perceived Needs

Intervention modalities

Multiple family groups
Family therapy
Individual therapy
24-hour crisis hotline

Oruche et al., 2014; 2015
Solutions To These Challenges

Managing child’s disruptive behavior
Evidence-based interventions for DBDs

Managing interactions with child service provider
FAmily Management Efficacy (FAME) Intervention
# Evidence-Based Intervention

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Evidence-Based Intervention</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preschool Children (≤ 5 years)</td>
<td>Incredible Years (IY)</td>
<td>↑Parenting skills</td>
</tr>
<tr>
<td></td>
<td>Parent-Child Interaction Therapy (PCIT)</td>
<td>↓disruptive behavior</td>
</tr>
<tr>
<td></td>
<td>Positive Parenting Program (Triple P)</td>
<td>↑Interaction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>↓disruptive behavior</td>
</tr>
<tr>
<td>School-Age Children (5 – 12 years)</td>
<td>Incredible Years</td>
<td>Same as above</td>
</tr>
<tr>
<td></td>
<td>Parent Management Training-Oregon (PMTO)</td>
<td>↑parenting skills</td>
</tr>
<tr>
<td></td>
<td></td>
<td>↓aggression</td>
</tr>
<tr>
<td>Teenage Children (13 – 17 years)</td>
<td>Multisystemic Therapy (MST)</td>
<td>↓criminal acts</td>
</tr>
<tr>
<td></td>
<td>Brief Strategic Family Therapy</td>
<td>↓aggression</td>
</tr>
<tr>
<td></td>
<td></td>
<td>↑family relations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>↑family functioning</td>
</tr>
<tr>
<td></td>
<td></td>
<td>↓disruptive behavior</td>
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</tbody>
</table>

Epstein et al., 2015; SAMHSA, 2011
BUT!!!

Notably even with evidence based interventions, 50 to 68% of children and adolescents still meet diagnostic criteria for DBDs. Many families continue to struggle with challenges of interacting with multiple child service providers.

Epstein et al., 2015
Preliminary work

COLLABORATIVE DEVELOPMENT OF THE FAMILY MANAGEMENT EFFICACY (FAME) INTERVENTION
Collaborative Development of FAME

**Purpose** – develop intervention content and procedures, and identify outcomes

**Design** – using standard protocols

**Sample** – a community advisory board of 6 families and 6 professionals
Collaborative Development of FAME
Conceptual Framework for FAME

Figure 1. Conceptual Framework for FAME

Risk and Protective Factors
- Adolescent Factors (DBD severity, age, gender, education, race/ethnicity)
- Family Member Factors (age, gender, educational level, race/ethnicity, marital status, parent healthcare access)
- Family Factors (socioeconomic status, family network size & structure)
- Child Service System Involvement (mental health; schools; juvenile justice; child welfare)

Proximal Outcome
- Family-Management (self-efficacy in managing interactions within family and with child service system professionals)

FAME
- Network-based, multiple family group intervention components
  - Strengthening family interactions through tailored:
    - Communication Skills
    - Problem Solving Skills
  - Strengthening child service system interactions through tailored:
    - Communication Skills
    - Problem Solving Skills

Distal Outcomes
- Family Health (perceived stress, quality of life)
- Family Functioning (communication, problem solving, adaptability/cohesion, perceived life difficulty)

Pescosolido et al., 1998; Oruche et al., 2014
Table 1: FAME Protocol

<table>
<thead>
<tr>
<th>Frequency/Session #</th>
<th>Conceptual framework focus area Session structure/proposed content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1 Session 1</td>
<td>Managing Stress: Letting It All Out</td>
</tr>
<tr>
<td>Week 2 Session 2</td>
<td>Strengthening Family Interactions through Communication &amp; Problem Solving</td>
</tr>
<tr>
<td>Week 3 Session 3</td>
<td>Strengthening Child Service System Interactions: Mental Health (Counselors, Nurses &amp; Doctors)</td>
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<tr>
<td>Week 4 Session 4</td>
<td>Strengthening Child Service System Interactions: School</td>
</tr>
<tr>
<td>Week 5 Session 5</td>
<td>Strengthening Child Service System Interactions: Juvenile Justice (Police, Probation, &amp; Child Welfare)</td>
</tr>
<tr>
<td>Week 6 Session 8</td>
<td>Make a Family/Social Support Plan: Pulling It All Together</td>
</tr>
</tbody>
</table>
Good Communication Skills

GOOD COMMUNICATION SKILLS
Good communication helps you to solve real life problems! It is important for you to learn good communication skills, which are made up of both verbal and non-verbal communication.

Did you know???
55% of your communication is through body language, 38% of your communication is through the tone of voice or volume and only 7% of your communication is through words.

Your body language (facial expression, the way you sit, use your hands, tilt your head, roll your eyes) and the tone and volume of your voice can communicate a great deal more to another person than the words you speak.

Increase your positive communication by:

- Making direct eye contact
- Speaking with a clear, warm tone of voice
- Smiling
- Leaning forward
- Nodding occasionally

Other suggestions for effective communication:

- Using encouraging signs like (“oh?” “Mmm hmm”)
- Restating the other’s points in your own words
Steps to Solving Real Life Problems

1. Identify the problem
2. Select a realistic goal
3. Brainstorm or think of possible solutions
4. Write down the ups and downs of each solution
5. Pick the best solution

Nezu, Nezu, & D’Zurilla (2013)
Session 5 Tip Sheet

TIPS ON INTERACTING EFFECTIVELY WITH THE POLICE ABOUT YOUR CHILD

- **Plan Ahead**
  - Have a crisis plan!

- **Call your Network**
  - Identify 2-3 family members or friends that you can call to help your child calm down.

- **Call the Crisis Intervention Police**
  - Call the police if your child is still out of control and you are worried for his/her safety. Ask for Crisis Intervention Police - specialized officers who are trained to work with children who have mental disorders.

- **Know their role**
  - The officers are there to help you defuse the situation. Think of them as partners, not enemies.

- **Stay Calm**
  - Try your best to stay calm. Speak to everyone on the scene calmly without yelling. Do not make any aggressive actions toward the officers. Remember, they are there to help you NOT blame or arrest you.

Help the Police to Help You: Ideas for Communicating with the Police
Pilot Study 2-phase 2

TESTING OF THE FAMILY MANAGEMENT EFFICACY (FAME) INTERVENTION
FAME Intervention

FAME is designed to strengthen family members’ perceived *self-efficacy* to manage interactions both within the family and with child service system professionals to reduce family member *stress*, and to improve *quality of life* and *family functioning*.
Testing of FAME

**Purpose** – evaluate feasibility, acceptability and effects on outcomes (stress, QOL, & family functioning)

**Design** – 2 groups experimental design (FAME vs. Usual treatment)

**Sample** – 24 pairs of parents and support person (n= 48 individuals) or families of adolescents 12-18 years with DBD.
Testing of FAME: Study Schema

Figure 2. Study schema

Consent
Baseline T1 Measures
Random Assignment

FAME Session 1
FAME Session 2
FAME Session 3
FAME Session 4
FAME Session 5
FAME Session 6

Time 2 Measures (post-intervention)
Time 3 Measures (2 months post-intervention)
Qualitative Interview

Usual Care
Time 2 Measures (post-intervention)
Time 3 Measures (2 months post-intervention)
Inclusion & Exclusion Criteria

**Child** (AA, 12-18 years; diagnosed with ODD and/or CD by professional)

**Caregiver** (AA, ≥ 21 years; score of 5 on 1-10 scale for stress, biological or non-biological)

**Kin/fictive kin** (≥ 21 years; identified by caregiver)

No diagnosis of schizophrenia or bipolar disorder; homeless or incarcerated
Measures

1. Stress: *Perceived Stress Scale (PSS)*

2. Quality of Life: *Pediatric Quality of Life Family Impact Module (PedsQL)*

3. Family functioning: *PedsQL*

4. Self- efficacy : *General Self Efficacy Scale (GSE)*
Statistical Analysis

Demographic variables: Chi-square, Fisher’s exact tests & Wilcoxon rank sum test

Outcome variables: Linear regression models
Sample Description

Child (n= 15; mean age = 15.5 years; 6 males, 9 females)

Caregiver (n= 15; mean age = 47.1 years; 1 male, 14 females)

Kin/fictive kin (n= 15; mean age = 45.5 years; 2 males, 13 females). Relationship with caregivers include 1 spouse, 5 mothers, 6 friends, 1 sibling, 1 other
Sample Description

14 of 15 families had household income $\leq $40,000

Noted differences between groups in age of child and relationship of kin to caregiver
Results - Feasibility & Acceptability

<table>
<thead>
<tr>
<th>Feasibility &amp; Acceptability Measures</th>
<th>Threshold</th>
<th>Achieved</th>
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</thead>
<tbody>
<tr>
<td>Number eligible</td>
<td></td>
<td>365</td>
</tr>
<tr>
<td>Eligible caregiver/kin dyads consented</td>
<td>75%</td>
<td>21 dyads</td>
</tr>
<tr>
<td>Number of sessions completed</td>
<td>75%</td>
<td>5.5 sessions</td>
</tr>
<tr>
<td>Planned measures completed at Time 1 (baseline)</td>
<td>60%</td>
<td>21 dyads</td>
</tr>
<tr>
<td>Planned measures completed at Time 2 (6 weeks)</td>
<td>60%</td>
<td>12 dyads</td>
</tr>
<tr>
<td>Planned measures completed at Time 3 (18 weeks)</td>
<td>60%</td>
<td>10 dyads</td>
</tr>
</tbody>
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Result: Effect of FAME Intervention on Outcomes

Data collection Time 2 (week 6 adjusted for baseline)
FAME n = 8; Usual Care n = 7

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Effect Size</th>
<th>Cronbach’s Alpha</th>
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<tbody>
<tr>
<td>²PSS</td>
<td>-0.56³</td>
<td>0.78</td>
</tr>
<tr>
<td>¹PedSQL HRQL</td>
<td>0.95</td>
<td>0.82</td>
</tr>
<tr>
<td>¹PedSQL family function</td>
<td>-0.55³</td>
<td>0.86</td>
</tr>
<tr>
<td>²General Self Efficacy</td>
<td>0.34</td>
<td>0.85</td>
</tr>
</tbody>
</table>

1. Caregiver only (n = 15)
2. Dyad (n = 13 caregiver/kin or fictive kin dyad)
3. Negative (-) sign means the score was greater in the control group
Results: Acceptability & Satisfaction

All participants LIKED FAME intervention

FAME will be applicable to other racial/ethnic group not just AA
Conclusion

We had good effect sizes in favor of intervention for the following except Family Functioning:

- **Reduced Stress** with a medium effect size
- **Improved Quality of Life** with a large effect size
- **Increased General Self-Efficacy** with a small to medium effect size
So What?

PRACTICE IMPLICATIONS
What You Can Do About Challenges

Engage families’ in discussion about effective responses to specific types of disruptive behaviors

Inquire about distress stemming from the families’ interactions with child service providers
What You Can Do About Family Needs

Provide information about ODD and/or CD

American Academy of Child & Adolescent Psychiatry


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Appreciations
Questions
References


