

Interventions for Family Members of Adolescents with Disruptive Behavior Disorders

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Abstract

PROBLEM: The family members of adolescents diagnosed with disruptive behavior disorders (DBDs) experience profound stress and burden. Despite the need for empirically supported interventions that address the challenges faced by these family members, few such interventions are available.

METHODS: In this qualitative descriptive study, we conducted in-depth interviews with 15 families of adolescents diagnosed with DBD. We asked the family members to identify what types of mental health services they needed and to describe the “ideal” program that would best address their concerns.

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FINDINGS: Family members identified several intervention modalities that would fit their needs, including multifamily groups, family therapy, individual therapy, and community-based hotlines. They indicated that programs should address the following topics: family communication, conflict resolution, education about DBD, and strategies to improve interactions with child service agencies. CONCLUSIONS: Clinicians should recognize that all family members may need support to manage the stressors associated with caring for or living with adolescents with DBD. When working with families, clinicians should provide information about the etiology and management of DBD, help navigate interactions with child service agencies, and employ strategies to improve family communication and functioning.

Search Terms:

Adolescent, family member, intervention, mental health, need

Interventions for Family Members of Adolescents with Disruptive Behavior Disorders

Disruptive Behavior Disorders (DBD) are mental disorders of childhood that are associated with profound negative effects for the children and their families. DBD include Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) (American Psychiatric Association [APA], 2000; Brown, 2008). According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR[®]), ODD includes a pattern of negativistic, hostile, and defiant behaviors (APA, 2000). This disorder is manifested by loss of temper, arguments with adults, defiance or refusal to comply with adult rules and requests, deliberately annoying people, blaming others for one's mistakes or behaviors, being touchy or easily annoyed by others, being angry and resentful, and/or often being spiteful or vindictive. The DSM-IV-TR[®] indicates that CD includes a repetitive and persistent pattern of behaviors in which the rights of others or major social norms are violated. The disorder is manifested by aggression toward people or animals, destruction of property, deceitfulness or theft, and/or serious violations of rules (APA, 2000).

DBD are the most common causes of child referrals to outpatient clinics and inpatient psychiatric hospitalizations (Merikangas et al., 2011). DBD are associated with significant functional impairments; poor school performance, truancy, and school dropout; disturbed relationships with peers, family, and adults in authority; high rates of drug and alcohol use; and high rates of involvement with the legal system (Heflinger & Humphreys, 2008; Petitsclerc, 2009). DBD often co-occur with Attention Deficit Hyperactivity Disorder (ADHD), depression, anxiety, and learning disorders (Hamilton & Armando, 2008; Heflinger & Humphreys, 2008). In the United States, the lifetime prevalence rates of ODD and CD are 5.5% and 2.2%, respectively

(Merikangas et al., 2010). DBD affects more males than females (APA, 2000; Merikangas, Nakamura, & Kessler, 2009), and the severity of illness worsens as the child ages.

Children who have been diagnosed with a mental illness are typically the focus of research, and few studies have been conducted with their family members. Studies that have included family members often focus on primary caregivers, most often mothers (Kilmer, Cook, Munsell, & Salvador, 2010; Rosenzweig & Kendall, 2008). These studies have shown that primary caregivers often report mild to moderate levels of depression and anxiety and severe levels of stress (Gerkenmeyer et al., 2013; Oruche, Draucker, Al-Khattab, Cravens, Lowry, & Lindsey, 2013). Primary caregivers describe living with and caring for children with mental disorders as overwhelming and unrelenting (Oruche, Gerkenmeyer, Stephan, Wheeler, & Hanna, 2012; Scharer, 2002). The caregivers worry about the children's future, experience guilt for paying less attention to other children in the family, and have little time for relaxation or recreation. The challenges for families of children with mental disorders may be compounded by poverty and other family adversities such as parental drug and alcohol use, incarceration, and interpersonal violence (Oruche et al., 2013; Sydow, Retzlaff, Beher, Haun, & Schweitzer, 2013).

Caregivers of children with DBD are particularly distressed due to the aggressive, defiant, and deceitful nature of their children's behaviors. The caregivers report that they must continually monitor and supervise their children, attempt to prevent them from hurting themselves or others (Cox, 2003; Oruche et al., 2012; Rosenwald & Bronstein, 2008; Schneiderman & Villagrana, 2010), and respond to the unremitting demands of child service agencies that are involved with the family (Oruche et al., 2013).

If the children with DBD are adolescents, family members encounter additional stressors. Adolescents are separating from families and developing their own identities (Rueter &

Conger, 1995). Families of adolescents with DBD report that it becomes more difficult to manage physically aggressive behaviors because of their children's increased size and strength (Oruche et al., 2013). Compared to younger children, adolescents are more likely to be influenced by peer pressure, engage in risky social behaviors, and be involved with the criminal justice system (Merikangas et al., 2010).

The perspectives of family members who are not the primary caregivers of children with mental disorders (i.e., fathers, siblings, and other adult family members) are rarely considered in research, although they experience some of the same stressors identified by primary caregivers (Kilmer, Cook, Taylor, Kane, & Clark, 2008; Oruche et al., 2012; Rosenzweig & Kendall, 2008). Siblings of adolescents with DBD, for example, have been shown to have high rates of anxiety, poor school performance, and adjustment problems (Kilmer et al., 2008; Rosenzweig & Kendall, 2008). Caregivers and mental health experts have argued that there is a need for treatment approaches that include all family members of children with mental health disorders, especially DBD (Kilmer et al., 2010; Rosenzweig & Kendall, 2008; Sydow et al., 2013).

Several evidence-based psychotherapeutic interventions are available for children with DBD, most of which include training for primary caregivers (Johnson & Waller; 2006, U.S. Department of Health and Human Services [USDHHS], 2011). The most widely used programs are Parent Child-Interaction Therapy and Parent Management Training-Oregon, designed for children between the ages of 3 and 12, and the Triple P- Positive Parenting Program, designed for children up to age 16 years (Johnson & Waller; 2006; USDHHS, 2011). These programs are aimed at improving parental management of the children's behaviors and enhancing parent-child relationships (Johnson & Waller, 2006). The four most widely used interventions for adolescents between ages 11 and 18 are Multisystemic Therapy (MST), Functional Family Therapy (FFT),

Multidimensional Treatment Foster Care (MTFC), and Brief Strategic Family Therapy (BSFT) (Radohl, 2011; Sydow et al., 2013; USDHHS, 2011). These programs include components for increasing parental engagement in the adolescents' treatments as well as improving parental management of the adolescents' behaviors (Sydow et al., 2013; USDHHS, 2011). Research on the clinical outcomes of these programs typically focuses on changes in the children's behaviors and family functioning rather than on outcomes related to family members' mental health and quality of life (Sydow et al., 2013).

Despite the challenges faced by family members of adolescents with DBD, few mental health interventions are available that focus primarily on their needs and concerns. To provide foundational information in anticipation of the development of a mental health intervention for family members of adolescents with DBD, our research team is conducting a study (referred to as the primary study) to understand the challenges experienced by family members of adolescents with DBD and their perceived needs for mental health interventions. The challenges have been reported elsewhere (Oruche et al., 2013), and this report (referred to as the current study) focuses on the family members' perceived needs for mental health interventions. We therefore first briefly describe the primary study, titled *The Families of Adolescents with DBD*, to provide a context for the current report. We then describe the families' descriptions of their preferred treatment modalities and the important issues they said should be addressed in a mental health intervention for all family members. We then discuss the implications of the study findings for intervention development and clinical practice.

The Primary Study: The Families of Adolescents with DBD

The primary study was guided by the McCubbin and Patterson's Double ABCX Model of family stress and adaptation (McCubbin & Patterson, 1983). The Model assumes that families

experience transitions and changes (i.e., stressors) including the daily demands of parenting and the serious illness of a child. The stressors result in changes in family boundaries, goals, roles, and patterns of interactions within the family and with their larger community leading to financial, emotional, and social hardships for the entire family. Although, families attempt to manage these hardships with minimal disruption to the family, the demands may exceed their capabilities. Based on this model, we anticipated that caring for an adolescent with a DBD is a demand that would likely exceed the family's capacity to meet that demand and therefore could result in altered family functioning, emotional stress, and the need for outside support.

Participants for the primary study were recruited from the child and adolescent program of a publicly funded community mental health center (CMHC) located in a Midwestern city in the U.S. Inclusion criteria for the adolescents with DBD were as follows: (a) 13 to 18 years old, (b) receiving psychotherapy and/or medication management, and (c) diagnosed with ODD or CD by a mental health provider. Three family members were required to participate and had to include the primary caregiver and the adolescent with DBD, and another family member but no more than five members per family. The other family member could be another adult with significant caregiving responsibility for the adolescent with DBD, identified by the primary caregiver, or a sibling over the age of seven. All participants were able to speak and read English and had the expressive capacity to participate in an interview.

Institutional Review Board approval at the investigators' university and institutional approval at the CMHC were obtained to conduct the study. Eligible participants were identified from the clinic's case list of adolescents ages 13 to 18 years who had a diagnosis of ODD and/or CD. The research project coordinator sent a letter from the clinic supervisor that described the study to the parent or primary caregiver of each adolescent. In a few days, the project

coordinator phoned the primary caregiver to determine interest in the study. If the primary caregiver and at least two other family members agreed to participate, the project coordinator conducted a brief screening to determine the family's eligibility and scheduled interviews for those families who met study criteria.

The first author and two or three graduate research assistants met with 15 families. The PI reviewed the study and obtained the appropriate consents for each participant. Eleven families were interviewed in their homes, three were interviewed at the clinic, and one family was interviewed at the University setting. The team first conducted individual semi-structured interviews in which participants were asked to discuss the challenges they experienced caring for or living with an adolescent with DBD and their own needs for mental health services. The questions were open-ended to allow the participants to discuss their challenges and needs from their own perspectives. These interviews lasted from 15 to 30 minutes for children and 45 to 60 minutes for the adolescents and adult family members.

To describe the overall levels of mental health of the participants and the functioning of the families, participants were administered standard self-report questions following completion of the interview. Each participant over 12 years completed the McMaster Family Assessment Device General Functioning Scale (FAD-GF) (Epstein, Baldwin, & Bishop, 1983). The adult caregivers completed the Perceived Stress Scale Inventory (PSSI-10) (Cohen, Kamarck, & Mermelstein, 1983), Patient Health Questionnaire-Depression (PHQ-9) (Kroenke, Spitzer, & Williams, 2001), and the Generalized Anxiety Disorder (GAD-7) (Spitzer, Kroenke, Williams, & Löwe, 2006). All questionnaires are widely used and have well-established psychometric properties (Cohen, 1988; Kroenke & Spitzer, 2002; Miller, Epstein, Bishop, & Keitner, 1985).

Because following the individual interviews we wished to obtain additional information

about what family members of adolescents with DBD desired in terms of mental health services, we conducted a supplemental focus group. Of the 15 primary caregivers in the sample, we selected eight who had provided the richest data during the individual interviews and invited them to participate in the group. All eight agreed to participate, but only three attended the focus group. The group facilitator asked the group to help design an “ideal” intervention that served the needs of all family members of adolescents with DBD. The individual and focus group interviews were digitally recorded, professionally transcribed, de-identified, and uploaded to an encrypted file server.

Current Study: Perceived Needs for Interventions for Family Members of Adolescents with DBD

Data for this study included the transcribed interviews of the 52 participants and the transcript of the focus group that was held with 3 of the primary caregivers who had also participated in an individual interview. As indicated in Table 1, the sample included 15 primary caregivers (14 females and one male, average age 45 years), 10 other adult family members, (six females and four males, average age 37 years), 15 adolescents with DBD (five females and 10 males, average age 15 years), and 12 siblings (four females and eight males, average age 14 years). The racial breakdown of the 52 participants was 61% African American, 16% Caucasian, and 23% biracial (mostly African American/Caucasian). All families had an average annual household income that was less than \$29,000. As indicated in Table 2, the primary caregivers and other adults on average reported mild levels of depression and anxiety and high levels of perceived stress. The primary caregivers, other adult family members, the siblings, and the adolescents with DBD all reported problematic family functioning. Additional demographic and mental health information about the participants is provided in Tables 1 and 2.

Qualitative Descriptive methods as described by Sandelowski (2000) were used to meet the study aims. These methods produce straight-forward and low-inference answers to questions critical to intervention development (Sandelowski, 2000; Sullivan-Bolyai, Bova, & Harper, 2005). For the current study, standard content analytic procedures were used to analyze participants' responses to the following questions: (a) "Do you feel you need/want services to help with your own feelings and concerns? If so, please tell me what you think would be helpful," and (b) "We eventually would like to design a program to help family members who have an adolescent who has behavior problems similar to [adolescent's name]. What would an ideal program include?" These questions were modified according to the participant's age and role in the family. For example, we asked the younger siblings the following questions: (a) "What would you like the doctors/clinic/hospital do to help you?" and (b) "What can they do to help your family?"

Five researchers participated in data analysis so that quality and rigor were ensured by the consideration of multiple perspectives. All analytic decisions were made by mutual consensus. The team included two doctorally-prepared faculty members, one postdoctoral nursing fellow, one nursing doctoral student, and one master's student in public health. Each team member was assigned the individual transcripts of all members of three families and specific components of the focus group transcript to highlight and extract all text units (i.e., relevant words, phrases, or paragraphs) related to the participants' descriptions of their perceived needs for interventions. Each text unit was coded to reflect its content, and categories were created by grouping similar codes together. A case-ordered meta-matrix was used to organize, code, and summarize the data (Miles & Huberman, 1994). The team kept an audit trail to track all decisions regarding the formation of the categories.

Results

The participants shared many views about what they believed would be the characteristics of an optimal mental health intervention for family members of adolescents with DBD. Most data were provided by the primary caregivers and other adults in the families, but a few of the adolescents with DBD and their siblings shared their opinions about mental health interventions. Although some primary caregivers kept returning to the treatment needs of the adolescents with DBD, when queried about an intervention that would be intended to focus on the family members' challenges, most acknowledged the need for an intervention to relieve the stress and burden they experienced. Only one adult participant maintained that interventions for family members were unnecessary. The participants described several modalities of mental health interventions that they thought would be most helpful for family members, and they outlined a variety of issues that should be addressed in the interventions regardless of the modality.

Preferred Intervention Modalities

The participants discussed several treatment modalities that they believed would be best suited to their needs. These modalities included multi-family groups, family therapy, individual therapy, and community-based hotlines.

Many of the adult participants stated that a multi-family group would be an ideal modality because it would allow families with similar issues to learn from and support one another. They indicated that multi-family groups would offer opportunities to gain new knowledge and skills for managing and coping with their adolescents' problem behaviors. The participants suggested that the groups should incorporate both structured educational content and time for socialization. For example, the mother of a 14-year-old boy with CD proposed that

the groups include “normal” social activities such as going to movies or having a potluck supper. When asked how the groups should be structured, the participants indicated that groups should be composed of 10-12 parents from diverse racial/ethnic, demographic, and socioeconomic backgrounds. The participants suggested that the group sessions should last one to two hours. There was some disagreement about how frequently the groups should occur; some participants believed they should be offered as frequently as once a week whereas others thought they should be offered as infrequently as every three months. The participants recommended that the educational portion of the group sessions be led by a counselor, therapist, or other mental health professional. For example, one mother of a 15-year-old boy with ODD indicated that, because the group sessions would bring together parents with a “variety of personalities,” a professional leader would be needed to provide structure for the sessions and ensure the discussion remain on track. The participants differed about where the groups should be held. Though some recommended meeting in members’ homes, most said they would opt for a convenient community location, such as a neighborhood center. Most agreed that the meetings be held away from the mental health center to provide a more relaxed atmosphere.

Some adult participants said that family therapy would also be a helpful treatment modality to address family members’ needs because it would open dialogue among family members. For example, the mother of a 16-year-old girl with ODD described family sessions she had attended: “[They] bring out a lot and it helps.... I was able to open up and say what I say, and hear what [my daughter] had to say...and what I actually thought without being angry and yelling at her.” Two adolescents with ODD, a 14-year-old female and a 15-year-old male, mentioned that family therapy would be helpful for discussing problems and maintaining good

communication in their families. The sibling of a 16-year-old female with ODD agreed that family therapy would be a beneficial treatment modality.

Two adult participants said they would appreciate individual therapy to help them express their feelings, cope with stress, or manage their children's behavior. Two other adult participants suggested implementing a 24-hour hotline that they could call when they needed to vent their frustrations or obtain information. The mother of an 18-year-old male with ODD said that a hotline would provide someone to listen to her concerns, even if the hot-line responder could not offer advice.

Issues to Be Addressed

Most of the adult participants and a few of the child and adolescent participants identified important issues that should be addressed in a mental health intervention for family members regardless of modality. These issues included managing the adolescents' disruptive behaviors, family communication and conflict resolution, education about the disorders, strategies to manage the adolescents' care and service use, the personal issues and feelings of family members, and positive outcomes experienced by families.

Most of the adults indicated that interventions should help them manage the adolescents' disruptive behaviors, which would then reduce the stress and burden experienced by the family. The adults wished for help in developing strategies to provide structure for the adolescents, defuse escalating situations, and handle outbursts. One mother of a 15-year-old boy diagnosed with ODD said, "So I think that topics [on behavior management] are great 'So tonight, we're going to talk about technique.' You always hear that with ODD, trying different techniques..."

Several adults also mentioned that interventions should be aimed at helping families

communicate better or deal more successfully with conflicts. For some adults, this was limited to helping them find better ways to communicate with the adolescents, but for others it included helping the family as a whole communicate more effectively. One mother of a 13-year-old boy diagnosed with ODD, when asked what would help her family, stated, “If we can just have more [time] where we can talk, actually talk-talk instead of look at each other and go crazy. So we all can understand how each person is feeling, what pisses them off or gets them upset....” The need for help with managing sibling conflict was mentioned by some of the adults, and a few indicated that interventions need to address communication issues that arise in instances of divorce, step-parenting, and blended families. Two of the siblings mentioned that improved communication might help their families. One brother of a 14-year-old boy diagnosed with ODD indicated that his family needed help to “communicate without yelling.”

Several adults indicated that interventions should provide education about DBD. One step-father of a 13-year-old boy diagnosed with CD regretted his lack of understanding of his son’s disorder. He said, “Like I say, sometimes I feel that I don’t even know what is going on with the boy. Here I am thinking that he was just being rebellious but there was something there and I am under the same roof with him.” Some adults were interested in learning more about the etiology of the adolescents’ disorders, including the role of genetics and environment, and receiving information about the medications being prescribed for the adolescents. Several wished for better understanding about recovery from DBD. Two of the adults stressed that learning about the disorder and treatment was more important than “discussing feelings.”

Several of the adults stated that they believed mental health interventions for family members should provide assistance with managing the mental health care and social services the adolescents were receiving. The adults desired help with finding appropriate services,

negotiating the mental health system, and managing conflicts with providers. The participants in the focus group, for example, suggested that counselors attend group meetings to hear caregivers' frustrations and ideas and to answer their questions.

A few of the adult participants indicated that they wished to discuss their own feelings and problems and would welcome interventions that addressed the personal stress they experience. One father of a 15-year-old boy diagnosed with ODD talked about how he had attended a helpful group session that taught caregivers different ways of "de-stressing." One mother of a 15-year-old boy diagnosed with ODD indicated that she thought parents should receive counseling and life skills training when they were young adults, before their children begin to experience behavioral problems.

Several adults, and one adolescent, indicated that interventions should focus on positive activities and outcomes. Some mentioned that there is a need to focus on what is going well in the family and that interventions should include activities focused on recovery and well-being. The focus group members agreed that bringing in caregivers who could share success stories as "guest speakers" would be helpful.

Discussion

The current study was the first of its kind to obtain ideas from multiple family members of adolescents with DBD about how mental health services might best address their stress and burden. The self-report surveys indicated that while the adult participants reported, on average, mild levels of depression and anxiety, as is consistent with prior studies (Gerkenmeyer et al., 2013), most notably they reported high levels of perceived stress. This finding was supported by the participants' narratives in which they emphasized that any intervention that we might develop for family members should address the severe and persistent stress they experience

living with or caring for a child with DBD. In addition, the finding from the self-report survey and the interviews that both the adults and children experienced problematic family functioning underscores the need for a family-focused intervention.

Our findings resonate with those of other researchers who call for interventions designed to improve the quality of life of family members as well as to enhance their capacity to care for the adolescents with DBD (Kilmer et al., 2010; Rosenzweig & Kendall, 2008). Consistent with prior research on the problems experienced by family members of children with mental health disorders (Ha, Hong, Seltzer, & Greenberg, 2008; Nelson, 2002; Oruche et al., 2013; Oruche et al., 2012; Rosenzweig & Kendall, 2008), the participants in this study recommended that interventions should tackle a wide variety of issues that contribute to the challenges they experience in their daily lives.

Some of the needs the participants identified have been well addressed in the child mental health literature. For example, discussions of parental management strategies for problem behaviors are already incorporated in many interventions for DBD (Johnson & Waller, 2006; Sydow et al., 2013; USDHHS, 2011). However, some of the needs identified by the participants, such as the desire to interact with other families with similar challenges and the need for help managing interactions with child service agencies, have not been widely discussed.

Because the participants believed that interactions with other families of adolescents with DBD should be the basis of mental health interventions that address their daily challenges, the recommendation that a multi-family group would be the optimal treatment modality was our strongest finding. Although few studies have examined the efficacy of multi-family groups, a recent study revealed that a 16-week multiple family group intervention for children 7 to 11 years old diagnosed with DBD led to fewer oppositional behaviors and less parenting stress

(McKay et al., 2011). Our participants recommended that a multi-family group should include socialization and networking opportunities as well as a structured, psychoeducational component led by professionals. The research group's next goal is to develop and test an evidence-based intervention for families and their adolescents with DBD to improve their mental health and family functioning. By basing the intervention on the needs expressed by family members in this study, we intend to develop an intervention that is acceptable to the targeted population and therefore decrease the problem of non-adherence, which is often a treatment dilemma with this population (Greener, Joe, Simpson, Rowan-Szal, & Lehman, 2007; McKay, Hoagwood, Murray, & Fernandez, 2004). In addition, by including multiple families in a group and focusing on improving existing relationships with child service agencies, we intend to develop an intervention that is cost effective and can be offered in public mental health agencies.

The study also has several implications for psychiatric nurses and other mental health clinicians in everyday practice. First, clinicians should recognize that all family members may need support to deal with the stressors of caring for or living with adolescents with DBD. A family assessment should include discussions of the challenges experienced not just by the primary caregiver but by other family members as well. Younger siblings in particular may have trouble articulating their needs and concerns.

Second, addressing the families' needs for information as identified by our participants should be a primary component of all treatment approaches for families of adolescents with DBD. Clinicians might design educational programs or strategies that provide information about the etiology, best treatment practices, and management of DBD. Such initiatives can be supplemented by available educational resources to help family members better understand the disorder. For example, the American Academy of Child and Adolescent Psychiatry (AACAP)

provides a number of on-line resources for families of children with ODD and CD (AACAP, 2009, 2013).

Third, clinicians should determine the nature of the interactions families are having with child service agencies, identify areas of tension or burden, and develop strategies to strengthen ties between the families and the agencies. Clinicians can assist family members with issues such as deciding when to call the police if their adolescents' behaviors become out of control, managing numerous calls from the schools, resolving conflicts with treatment providers, and determining how to obtain needed social services. Clinicians might also intervene at the systems level to address problematic interactions with the child service agencies. For example, clinicians might arrange for meetings for groups of parents and school officials to determine how to lessen the burden of frequent or urgent "calls" from the schools while ensuring that parents are informed of and involved in decisions about the management of the adolescents' behaviors in school.

Finally, some of the needs expressed by the participants can be addressed by standard clinical practices. For example, clinicians may employ family therapy techniques to improve family communication and functioning, and stress reduction strategies to reduce the negative outcomes of persistent strain resulting from living with and caring for adolescents with DBD.

The study findings should be interpreted in the context of several limitations. All participants were from one large, publicly funded urban CMHC. The needs for intervention identified by the sample may therefore be particularly salient for families of adolescents served by this agency in this community. The study should be replicated in diverse settings to determine if the needs expressed by our sample were common across geographical locales (e.g., urban vs. rural) and study sites (e.g., public vs. private funding). In addition, only three participants

attended the focus group. Additional focus groups would be needed to further explicate the ideal characteristics of an intervention for family members of adolescents with DBD. A larger sample would allow researchers to determine if the “ideal” intervention described by family members differs according to demographic factors (e.g., ethnicity, age of adolescent) or clinical presentation of the adolescents (e.g., ODD vs. CD). In addition, focus groups with practitioners and other service providers would be needed prior to the development of an intervention for family members of adolescents with DBD. These professionals could provide input into the content of the intervention, the preferred delivery mode, and outcomes to target.

The experiences of the participants were consistent with the tenets of the Double ABCX Model of Family Stress and Adaptation (McCubbin & Patterson, 1983). The families clearly indicated that the demands of caring for or living with an adolescent with DBD overwhelmed their resources and they needed outside support to manage their challenges. Our team’s next step is to begin development of an empirically supported mental health intervention for these families. The findings also suggest, however, that psychiatric nurses and other clinicians can clearly address some of the needs expressed by the family members in the context of everyday clinical practice.

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Table 1

Demographic descriptions of the participants

Variable	Primary Caregiver	Other Adult Family Members	Siblings	Adolescent with DBD
Number of participants	15	10	12	15
Gender				
Male	1	4	8	10
Female	14	6	4	5
Race				
African American	9	8	6	8
Caucasian	5	1	2	3
Other (biracial)	1	1	4	4
Married/Partnered				
Yes	4	n/a	n/a	n/a
No*	11			
Education (grade)				
<High school grad	1	6	n/a	n/a
High school grad	7	2		
Some College	6	2		
2 year college degree	1	0		
Employed				
Yes	4	8	n/a	n/a
No **	11	2		
Income		n/a	n/a	n/a
≤\$10,000	5			
\$ 10,000-\$19,999	4			
\$ 20,000-\$29,000	6			
Age				
Mean(SD)	45(10)	37(17)	14(3)	15(2)

Note. * Separated, divorced, or widowed; **Unemployed, homemaker, or retired.

Table 2

Clinical descriptions of the participants

Variable	Primary Caregiver	Other Adult Family Members	Siblings	Adolescent with DBD
Number of participants	15	10	12	15
Number of participants diagnosed with each mental disorder ^a				
ODD	0	0	6	12
CD	0	0	2	2
ODD & CD	0	0	0	1
ADHD	0	0	9	9
PTSD	0	0	0	2
Depression	4	0	2	4
Mood Disorder	0	1	0	2
Substance Abuse	0	0	0	1
Age at the time of diagnosis				
Before age 10	n/a	n/a	8	8
After Age 10	n/a	n/a	4	7
Number of participants taking a psychiatric medication				
Yes	5	1	n/a	9
No	10	9	n/a	6
Mean scores (standard deviation)				
Family Functioning (FAD-GF) ^b	2.66 (0.66)	2.20 (0.4)	2.16 (0.33)	2.42 (0.62)
Stress (PSSI-10) ^c	23.47 (5.74)	20.17 (8.67)	n/a	n/a
Depression (PHQ-9) ^d	8.20 (5.07)	12.77 (8.04)	n/a	n/a
Anxiety (GAD-7) ^e	9.93 (5.12)	9.87 (6.31)	n/a	n/a

Note. ^a Primary caregiver, other adult, siblings by self-report; adolescents with DBD according to clinic records. The diagnoses of the adolescents was the current diagnoses at the time of referral to the study ADHD = Attention Deficit Hyperactivity Disorder, PTSD = Post Traumatic Stress Disorder.

^b FAD-GF: range is 1- 4; scores of 2 or more indicate problematic family functioning. ^c PSSI: range is 0-34; mean score for normative sample is 13.02 (6.35). ^d PHQ-9: range is 0-27, scores of 5-9 = mild depression, scores of 10-14 = moderate depression, scores of 15-19 = moderately severe depression, and scores ≥ 20 = severe depression. ^e For GAD-7: range is 0- 21; scores of 5-9 = mild anxiety, scores of 10-14 = moderate anxiety; scores of 15-19 = moderately severe anxiety, and scores ≥ 20 = severe anxiety.