Moving Beyond Behavioral *(only)* Screening and Assessment: The Case for Relational Screeners, Assessments, and Outcomes in Integrated Care

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Disclosures

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

Conference Resources

Slides and handouts shared by our conference presenters are available on the CFHA website at https://www.cfha.net/page/Resources_2019 and on the conference mobile app.

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Learning Objectives

At the conclusion of this session, the participant will be able to:

- Identify evidence-based relational screeners for use in integrated care settings.
- Discern which combinations of behavioral and relational measures are appropriate for research and clinical evaluation in diverse healthcare settings and populations.
- Discuss the utilization of assessments for research, and clinical care to distinguish areas of concern for targeted treatment of patients and family members.

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Agenda

- Overview
  - Behavioral health assessments
  - Relational assessments
- Use of relational assessments as screeners and outcomes
- Review of the utility and evidence for behavioral and relational assessments in health care
- Assessment exemplar
- Practice-based relational assessment activity
  - Discuss how relational assessments can fit with attendees own clinical and/or research sites/settings

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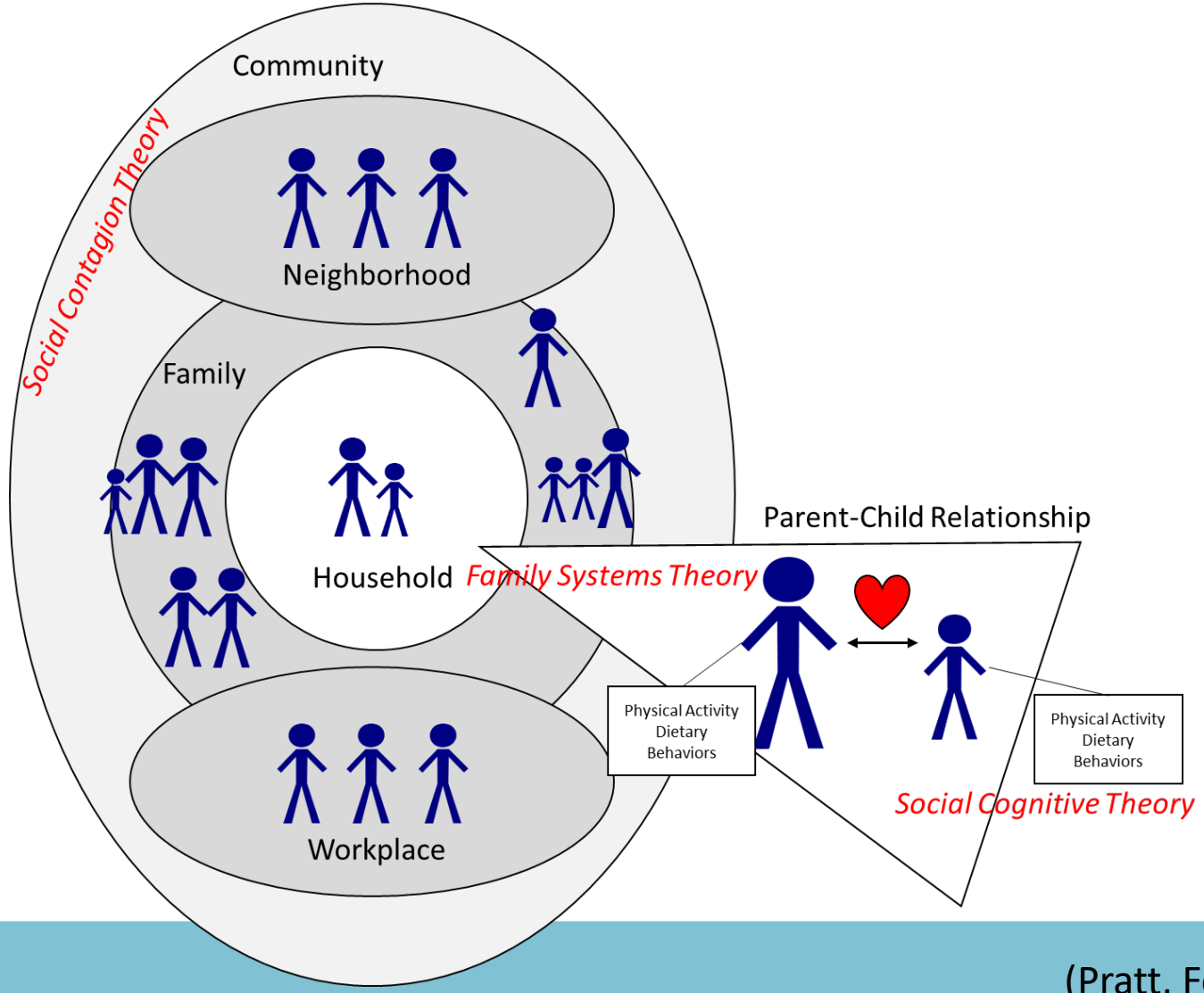
Foundations

- Practice and Discipline
  - Family science
  - Medical family therapy
  - Behavioral health
  - Integrated care

- Theoretical Models
  - Health behavior theories (TTM/MI, SCT, HBM)
  - Systemic theories (Brief models- SFT, F-CBT, BST)

Theoretical Framework



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(Pratt, Ferriby, Noria, Skelton, Taylor, & Needleman, 2018)

Rationale for Screeners

- Universal behavioral health screening in pediatric primary care
  - Patients responded well to behavioral health screenings
  - Portrayed as:
    1. universal
    2. confidential
    3. optimizing patient concerns

- Parent and child behavioral health screeners in routine well-child visits increased referrals to family therapy services

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(Stein et al., 2008; Wissow et al., 2013; Jonovich et al., 2014)

Behavioral Assessment – Health Care

- General Behavioral Questionnaires
  - Pediatric Symptom Checklist (Jellinek, Murphy, Robinson, Feins, Lamb, & Fenton, 1988)
  - Child Behavior Checklist (Achenbach & Ruffle, 2000)
  - Patient Health Questionnaire (Spitzer, Kroenke, & Williams, 1999)

- Disorder/Condition Specific
  - PHQ-9 (Depression; Spitzer, Kroenke, Williams, 1999)
  - GAD-7(Anxiety; Spitzer, Kroenke, Williams, 1999)
  - Eating Disorder Examination (Eating Disorders; Luce & Crowther, 1999)
  - DSM structured clinical interview (All Disorders; DSM 5)

Behavioral Assessment – Depression Example

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
add columns:		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:**				

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- **Not difficult at all** _____
- **Somewhat difficult** _____
- **Very difficult** _____
- **Extremely difficult** _____

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at *http://www.pfizer.com*. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.

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Feeling bad about yourself __or that you are a failure or have let yourself or your family down

Trouble concentrating on things, such as reading the newspaper or watching television

Thoughts that you would be better off dead, or of hurting yourself

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Overview of Relational Assessments

1. General Family Functioning
   - Family Assessment Device General Function Scale (Epstein et al., 1983)
2. Romantic-relationship Functioning
   - Relationship Structures Questionnaire (Fraley et al., 2011)
3. Condition-specific (i.e., weight management)
   - Social Support and Eating Habits Survey (Sallis et al., 1987)
   - Social Support for Exercise Survey (Sallis et al., 1987)
4. Dyadic Assessment for Relational Congruence
   - Child Behavior Checklist & Youth Self- Report (Achenbach System of Empirically Based Assessment)
   - PedQL4.0 Parent and Child Proxy (Varni, Burwinkle, Seid, & Skarr, 2003)

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Review of Relational Assessments

Family Systems Theory (FST) views the family as a complex, interacting system, and provides a framework for understanding family functioning as an open, ongoing, goal-seeking, self-regulating social system, with basic assumptions:

1. Elements of a system are interconnected.
2. Systems are best viewed as a whole.
3. Environment interacts with the system in a feedback loop.

Family Functioning Assessments

- Family Environment Scale (Moos and Moos, 1994)
- Family Adaptability and Cohesion Scale (FACES IV; Olson, Gorral, Tiesel, 1985)
- Family Assessment Device (Epstein, Baldwin, & Bishop, 1983)

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(Pratt & Skelton, 2018)

Evidence for Relational Assessments

- Alderfer and colleagues (2008) identified 19 family measures relevant to pediatric psychology

- The Society of Pediatric Psychology task force rated the McMaster Family Assessment Device (FAD) as a well-established self-report measure due to its consistent test re-test reliability and internal consistency

- The brief version of the McMaster Family Assessment Device, the General Functioning subscale, has utility for integrated care settings to quickly identify families with impaired functioning

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(Alderfer et al., 2008; Mansfield, Keitner, & Dealy, 2015)

Review of Relational Assessments

The McMaster Model of Family Functioning is based on Family Systems Theory

Assessments:

1. McMaster Structured Interview of Family Functioning (Clinical Interview)
2. McMaster Clinical Rating Scale and Mealtime Interaction Coding System (Observational)
3. McMaster Family Assessment Device; General Functioning Subscale (Self-report)

- **Focuses on the following six dimensions of family life**
    1. Communication
    2. Problem solving
    3. Roles
    4. Affective involvement
    5. Affective responsiveness
    6. Behavior control

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(Miller, Ryan, Keitner, Bishop, & Epstein, 2000)

Family Assessment Device

- **Family Assessment Device General Functioning Scale** (Epstein et al., 1983)
  - >12 years old ideal
  - Score of ≥ 2 indicates impaired family functioning

Question	Strongly Agree	Agree	Disagree	Strongly Disagree
1. Planning family activities is difficult because we misunderstand each other.	4	3	2	1
2. In times of crisis we can turn to each other for support.	1	2	3	4
3. We cannot talk to each other about the sadness we feel.	4	3	2	1
4. Individuals are accepted for what they are.	1	2	3	4
5. We avoid discussing our fears and concerns.	4	3	2	1
6. We can express feelings to each other.	1	2	3	4
7. There are lots of bad feelings in the family.	4	3	2	1
8. We feel accepted for what we are.	1	2	3	4
9. Making decisions is a problem for our family.	4	3	2	1
10. We are able to make decisions about how to solve problems.	1	2	3	4
11. We don't get along well together.	4	3	2	1
12. We confide in each other.	1	2	3	4

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Outcomes for Family Functioning

- Higher family functioning was associated with: (Berge, Wall, Larson, Loth, 2013)
  - Lower BMI in adolescents
  - Higher healthful dietary intake (i.e., fruit and vegetables, breakfast, family meals)
  - Less sedentary behavior (i.e., screen time)
  - More physical activity (only for boys)

- Halliday et al. (2014) systematic review
  - 12/17 studies identified reported significant associations between family functioning and child overweight/obesity
  - Poor family functioning was associated with increased risk of overweight and obesity
  - Authors recommend standardized family functioning measures

- Family functioning mediated the relationship between child chronic health symptoms and child anxiety and depressive symptoms (Ferro & Boyle, 2015)

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(Berge, Wall, Larson, Loth, 2013)

Outcomes for Family Functioning (our work)

- Among bariatric surgery patients (N=224):
  - ~45% of patients reported impaired family functioning
  - Patients who perceived their child to be overweight/obese reported ↓ family functioning, ↓ family exercise participation, and ↑ discouragement for eating habit change
  - Single parents more often perceived their children to be overweight/obese, and had ↓ family functioning, and ↓ support for changing eating habits and family exercise participation
  - Patients with impaired family functioning reported ↓ support for changing eating habits and family exercise participation

- Among adult weight management patients (N=203):
  - ~25% patients reported impaired family functioning
  - Parents with ↓ family functioning ↑ restrictive feeding practices

- In pediatric primary care, parents/caregivers (N=329):
  - ~13% of parents reported impaired family functioning
  - Caregivers who reported impaired family functioning reported that their child had a higher weight status
  - Caregivers with impaired family functioning and in two-parent families, with at least a Bachelor's degree, and ≥ the federal poverty level were more likely to report their child had a higher weight status

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(Pratt et al., 2019; Pratt et al., 2019; Pratt et al., 2018; VanFossen et al., 2018)

Suggested Algorithm for use of FST Screener

Family Assessment

Family Clinical Characteristics

Family Structure: Living arrangements (one or more homes), parenting dynamic (co-parent, single parent, etc.), # of youth and adults in home, child care arrangements
Demographics: Ethnicity/race, religion, SES, food insecurity, neighborhood safety, life events
Readiness to Change: Youth, parent(s), and family members' readiness to change

Does the Family Organize around Weight-related Behaviors that Lead to Obesity?	YES	NO
Home Environment		
Does the family participate in shopping and food prep together?		X
Does the family eat fast-food?	X	
Does the family participate in family meals?		X
Does the family engage in fun physical activity or active play?		X
Are there rules for screen time use?		X
Are weight and size talked about instead of health in the family?	X	
Family Functioning		
Is the FAD score > the clinical cutoffs for healthy functioning?	X	
Family History		
Is there a history of obesity in the family?	X	
Past attempts/success with weight management?		X

If NO

Family-based Behavioral Approach

- *Self-Monitoring*
- *Goal Setting*
- *Problem solving*
  - Barriers
  - Support
- *Behavioral Contracting*
- *Relapse Prevention*

If YES

Family Systems Theory-Informed Approach

FST Concepts	Not Health-specific	Health-specific
Structure	Appropriate household structure between adults and youth	Adults provide structure for health eating and PA
Rules	Rules are established and understood within home and family	Rules for eating and engaging in PA in and outside of the home
Communication	Effective communication between members	Communication is about health, not weight, shape, or size
Behavioral Control	Established consequences for breaking rules	Implementation and reinforcement of health goals
Responsiveness	How responsive are family members to one another	How supportive family members are with health behavior goals
Involvement	How involved family members are with one another	How involved family members are in health behavior goals
Strengths	General strengths for youth and family (i.e., school, caring, etc.)	Prior successes related to weight management or health
Barriers to Change	Other pressing priorities in family	Family or household barriers to making health changes

Evaluation

Are Improvements seen for the youth and family?

- If ***YES***, continue as is.
- If ***NO*** using **Family-based Behavioral**, consider re-assessing family functioning and implementing FST-informed approach.
- If ***NO*** using **FST-informed** approach, consider re-assessing readiness to change and barriers, and referring out (or in-house) for additional family services, like family therapy, for families with extenuating circumstances (i.e., divorce, loss).

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(Pratt & Skelton, 2018)

Adult weight management patients' perceptions of family dynamics and weight status

Keeley J. Pratt, Megan Ferriby, Callie L. Brown, Sabrena Noria, Bradley Needleman, Joseph A. Skelton

First published: 24 June 2019 | https://doi.org/10.1111/cob.12326 | Cited by: 1

SECTIONS PDF TOOLS SHARE

The **purpose** of this study was to describe the dynamics between adult WMP patients and their children (restrictive feeding, pressure to eat) and romantic partners (romantic relationship anxiety and avoidance), the broader family environment (family functioning), and perceptions of both their children's and partners' weight status

Sample: Patients (N=203) who resided with a child (2-18 years-old) and partner from two US University-based outpatient WMPs

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Research Questions

1. Does family functioning mediate the effect between parent-child and romantic relationship dynamics and perceived child and parent weight status, respectively?

2. Does perceived child and partner weight status moderate the relationship between family functioning and parent-child and romantic relationship dynamics, respectively?

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Results

	Partner Weight Status			
	M(SD)	M(SD)	t(df)	p
	Under/Healthy Weight (n=84)	Overweight/ Obese (n=117)		
FAD	1.59(.41)	1.72(.56)	-1.89(198.82)	.060
Anxious	1.63(1.21)	1.86(1.39)	-1.21(199)	.227
Avoidant	1.75(.98)	2.24(1.47)	-2.84(197.81)	.005
Restriction	2.76(1.12)	3.22(.96)	-3.03(160.99)	.003
Pressure	2.16(.95)	2.07(.96)	.69(199)	.485

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Results

	Child Weight Status			
	M(SD)	M(SD)	t(df)	p
	Under/Healthy Weight (n=157)	Overweight/ Obese (n=46)		
FAD	1.65(.47)	1.72(.61)	-.89(201)	.374
Anxious	1.83(1.38)	1.56(1.04)	1.37(94.90)	.174
Avoidant	2.02(1.29)	2.13(1.35)	-.53(201)	.598
Restriction	2.88(1.06)	3.52(.85)	-4.23(90.05)	.000
Pressure	2.23(.93)	1.67(.87)	3.65(201)	.000

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Results

	Child Weight Status			
	M(SD)	M(SD)	t(df)	p
	Under/Healthy Weight (n=157)	Overweight/ Obese (n=46)		
FAD	1.65(.47)	1.72(.61)	-.89(201)	.374
Anxious	1.83(1.38)	1.56(1.04)	1.37(94.90)	.174
Avoidant	2.02(1.29)	2.13(1.35)	-.53(201)	.598
Restriction	2.88(1.06)	3.52(.85)	-4.23(90.05)	.000
Pressure	2.23(.93)	1.67(.87)	3.65(201)	.000

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Mediation Results

- Family functioning was not a mediator between romantic relationship dynamics and perceived partner weight status or parent-child dynamics and perceived child weight status
- Significant pathways in red

Pathway	B	SE	p
SO Weight Status			
Avoidance	0.19	0.10	.064
Anxiety	-0.06	0.09	.513
Restrictive	0.29	0.09	.002
Pressure	-0.17	0.10	.089
FAD	0.11	0.22	.613
Child Weight Status			
Avoidance	0.01	0.12	.940
Anxiety	0.05	0.11	.668
Restrictive	-0.07	0.11	.510
Pressure	-0.06	0.13	.647
FAD	0.18	0.26	.493
FAD			
Avoidance	0.15	0.03	.000
Anxiety	0.07	0.02	.002
Restrictive	0.03	0.03	.276
Pressure	0.03	0.04	.425

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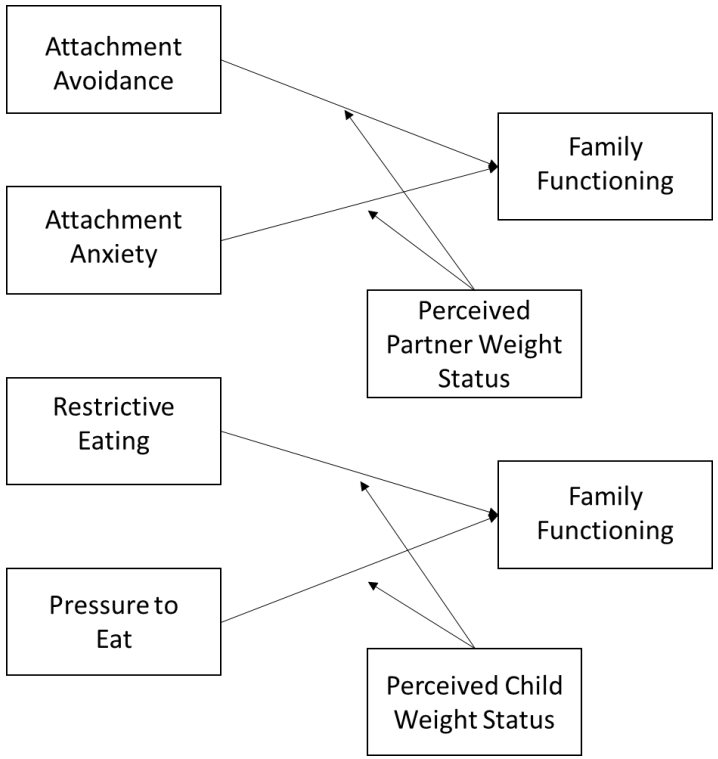
Moderation Results

- If patients perceived children to have an overweight/obese weight status, higher restrictive feeding practices (B = .21, SE = .08, p = .01) was associated with more impaired family functioning, with the model explaining 4% of the variance in family functioning
- If patients perceived romantic partners to have an overweight/obese weight status, both higher avoidance (B = .17, SE = .04, $p < .001$) and anxiety (B = .10, SE = .04, $p < .01$) were associated with more impaired family functioning, with the model explaining 41% of the variance in family functioning.
- No Signiant results for children or partners perceived to be a healthy weight status



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EXEMPLAR

Family Functioning in Pediatric Primary Care

- Van Fossen, Pratt, Murray, & Skelton, 2018. *Clinical Pediatrics.*
- Pratt, Van Fossen, Berge, Murray, & Skelton, 2019. *Clinical Obesity*.

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EXEMPLAR

Article

Family Functioning in Pediatric Primary Care Patients

Clinical Pediatrics
2018, Vol. 57(13) 1549–1557
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DOI: 10.1177/0009922818793347
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Catherine A. Van Fossen, MS[1], Keeley J. Pratt, PhD[1,2], Robert Murray, MD[3], and Joseph A. Skelton, MD[4,5]

Purpose: To pilot a brief family functioning screener, using the General functioning subscale of the Family Assessment Device in pediatric primary care practices among a sample of diverse caregivers of pediatric patients aged 2 to 18 years

- Sample of 400 families in pediatric primary care
- Study identified 13% of families with clinically impaired family functioning

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EXEMPLAR

Reliability

- Internal Consistency α=.9

Validity

- Model: χ^2 (54) =226.71, p=.000
- Root Mean Square Error of Approximation= .09
- Comparative Fit Index =.91

Range 12-32

Mean 16.8

Standard Deviation 4.73

- **Impaired Family Functioning** (Clinical Cut Off ≥2.00)
  - 46 families (12.6% of sample)

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EXEMPLAR

Results: Confirmatory Factor Analysis

Item	β	B	SE	R^2
1. Planning family activities is difficult because we misunderstand each other.	1.00	.64	-	.41
2. In times of crisis we can turn to each other for support.	.77	.58	.08	.34
3. We cannot talk to each other about the sadness we feel.	1.13	.71	.09	.51
4. Individuals are accepted for what they are.	.75	.51	.08	.26
5. We avoid discussing our fears and concerns.	1.08	.70	.09	.48
6. We can express feelings to each other.	1.02	.69	.09	.48
7. There are lots of bad feelings in the family.	.98	.73	.08	.53
8. We feel accepted for what we are.	1.02	.68	.09	.46
9. Making decisions is a problem for our family.	1.09	.71	.09	.50
10. We are able to make decisions about how to solve problems.	.98	.55	.10	.30
11. We don't get along well together.	1.03	.76	.08	.58
12. We confide in each other.	1.13	.70	.10	.49

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EXEMPLAR

Results: Demographic Differences

Child age: Caregivers who reported clinically significant impairment had older children (M=8.96, SD=4.46) compared to caregivers who reported lower impairment (M=7.57, SD=5.02; t(355)=-1.94, p=.05).

Income: Family annual income was marginally correlated with the FAD_GF total score (r(358)=-.09, p<.09).

No significant differences by- Child race/ethnicity, gender, child diagnosis, child education, caregiver race/ethnicity, relationship status, employment, and child insurance type

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EXEMPLAR

clinicalobesity
WORLD OBESITY

ORIGINAL RESEARCH ARTICLE

Youth weight status and family functioning in paediatric primary care

Keeley J. Pratt, Catherine A. Van Fossen, Jerica M. Berge, Robert Murray, Joseph A. Skelton

First published: 21 May 2019 | https://doi.org/10.1111/cob.12314

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EXEMPLAR

- We examined the associations between family functioning and youth overweight and obesity in the same sample of primary care pediatric patients (N=329)
  - Parent-reported child height and weight to calculate weight status was included
- We hypothesized that caregivers of youth with an overweight/obese weight status will report more impaired family functioning
- Caregivers who reported impaired family functioning based on the clinical cutoff score also reported that their child had a higher weight status
- Caregivers with impaired family functioning and who identified as being in two-parent families, with at least a Bachelor's degree, and were at or above the federal poverty level reported that their child was higher weight status

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Practice Based Relational Assessment Activity

Divide into groups

Discuss how to integrate the Family Assessment Device General Functioning Scale with a screener appropriate for your population/setting

- It may be psychosocial (e.g., child behavioral symptoms; Pediatric Symptom Checklist)

OR

- Focused on specific health behaviors or outcomes (e.g., physical activity; Social Support for Exercise)

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Behavioral Assessment – Health Care

- General Questionnaires - Psychosocial
  - Pediatric Symptom Checklist (Jellinek, Murphy, Robinson, Feins, Lamb, & Fenton, 1988)
  - Child Behavior Checklist (Achenbach & Ruffle, 2000)
  - Patient Health Questionnaire (Spitzer, Kroenke, & Williams, 1999)

- Disorder specific
  - PHQ-9 (Depression; Spitzer, Kroenke, Williams, 1999)
  - GAD-7(Anxiety; Spitzer, Kroenke, Williams, 1999)
  - Eating Disorder Examination (Eating Disorders; Luce & Crowther, 1999)
  - DSM structured clinical interview (All Disorders; DSM 5)

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Learning Assessment

- A learning assessment is required for CE credit.
- A question and answer period will be conducted at the end of this presentation.

Session Survey

Use the CFHA mobile app to complete the survey/evaluation for this session.

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