

**FAMILY PHYSICIANS' PERCEIVED NEED FOR THEIR PATIENTS TO  
RECEIVE FAMILY THERAPY-RELATED CARE**

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Thesis submitted to the Faculty of the  
Virginia Polytechnic and State University  
In partial fulfillment of the requirements for the degree of

**MASTERS OF SCIENCE**  
**in**  
**HUMAN DEVELOPMENT**

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May 14, 2003

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Keywords: Family Physician, Family Therapy, Collaboration, Mixed Methods Study,  
Content Analysis

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**(ABSTRACT)**

The purpose of this study was to explore the extent that family physicians believe their patients could benefit from marriage and family therapy-related care, the extent of their experiences of collaborating with family therapists, and their interest in future collaboration with family therapists. Limitations family physicians face when providing psychosocial care as well roadblocks they face when making mental health referrals and collaborating with family therapist were also explored. Sixty-four percent of the 240 family physicians surveyed responded to the mailed questionnaire. Descriptive statistics are provided for the quantitative analysis, while content analysis was used to evaluate the qualitative data.

Quantitative results revealed that family physicians do detect psychosocial concerns in patient encounters, even when those concerns are not the presenting complaint, but face limitations and roadblocks to adequately addressing these concerns. The most common form of collaboration that the respondents expressed interest in was referring out with collaborative communication continuing with the family therapist, but other forms were also identified.

## ACKNOWLEDGEMENTS

There are so many special people I would like to thank as I think about my journey in creating this thesis. Without them, I would not have become the person I have become, and my thesis would not have fully conveyed what I desired it to encompass.

First of all, I would like to thank my professors who have encouraged me and challenged me to reach higher and stretch further than I dared to think I could. Thank you, Jean Coleman, for encouraging me to embark on this project—the “road less traveled has made all the difference”! Thank you, Eric McCollum, for constantly asking me how my survey was going. Even though I often had to sheepishly admit that I hadn’t gotten started yet, you inspired me to believe that this was possible, and that you believed I was capable of this endeavor. And, Karen Rosen! What an incredible mentor you have been to me as my thesis chairperson and academic advisor! I have grown as a person, researcher, writer, therapist, and persistent traveler in the journey of life. Your tutelage, time, patience, intuitive detection of my procrastination, and encouraging reminders to allow myself to view this project as a process have given me skills to carry with me as I continue my journey. Most importantly, I have come to believe that “I can do this!” Thank you!

To my colleagues and friends—some of you have already traveled this road and some of you are traveling with me as we share the lows and highs of completing this impressive project. Thank you Ellie and Nikki for sharing your organizational ideas, for griping and groaning with me, and for your encouragement and prayers. Thank you, Cindy, for reminding me to break this potentially overwhelming project down into small steps and celebrate each accomplishment. Thank you to all my Virginia Tech professors and colleagues for the encouragement, support, and inspiration you have given me along the way.

Special thanks to those physicians at Bull Run Family Practice who participated in my pilot test. I also want to send a big thank you to my FCC small group. Your encouragement, prayers, secretarial skills, and technical support have been incredible. Wow—I am blessed.

And, Mike, my husband, you have been with me every step of the way. You have been there with your steady encouragement and constant belief in my ability to see this

project through successfully. You have been my sounding board enabling me to process my ideas and “process my process...” You, also, have reminded me to celebrate my every little accomplishment and to take time out to enjoy the roses. I thank God for the gift you are to me and am excited to see what our next step will be together.

I thank my family for their prayers and love throughout this entire journey of graduate student to researcher and professional. And, finally, I cannot close these acknowledgements without thanking God for His grace and strength to accomplish this project and become who I am now. He is undoubtedly able “to do immeasurably more than all [I ] ask or imagine, according to his power that is at work within [me]” (Ephesians 3: 20, NIV).

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## **CHAPTER 1: INTRODUCTION**

### **The Problem and its Setting**

In the 1960's, family practice medicine, a specialty in medicine providing healthcare for the entire family, grew out of the need to restore the dwindling number of "General Practitioners" (Pisacano, 2000). By definition, family practice embraces the "biopsychosocial model of disease," developed by George Engel, which replaced the "biomedical model" of earlier years (AAFP, 2000; Engel, 1980). This biopsychosocial model stresses the importance of the unity of medicine looking at "the whole person in the context of the entire family and social environment" (Chung, 1996, paragraph 4) and throughout the life cycle. Family physicians also claim to incorporate a family systems model as well as a holistic approach to treating individuals and families (Chung, Parks & Novielli, 2000). Consequently, family physicians must also consider the role of advisor, supportive listener, and counselor as part of their responsibility (O'Brien, 2000, paragraph 11).

This is true even when a patient's chief complaint centers around biomedical health concerns (O'Brien, 2000). Jackson and Tisher (1996) report that family physicians are often the first professionals patients turn to in time of stress. They estimate that up to 80% of patient concerns raised in a family physician's office are psychological or stress related. Families have also come to look to the family physician for a supportive and personal relationship that enhances their emotional and physical needs (Ballenger & Alpert, 1989). Likewise, while a patient may visit with a medical concern, further questioning by the family physician will often yield socio/emotional concerns that the patient may have been previously unaware of or hesitant to discuss (Carlat, 1998; Dowrick, 1992; Epperson, 1999; Senior, 1994; Wohlever, 2001).

Since family physicians have a holistic and systemic approach to family medicine, it seems that they would often be the first to detect patients who were experiencing psychosocial problems or stresses in their family environment. While the field of family practice medicine is attempting to equip its practitioners with more family system-focused, counseling skills, managed care is making increasing demands on the physicians' delivery of patient care. HMOs are requiring physicians to see an increasing

number of patients a day, and as a result, placing more and more limitation on the amount of time physicians can give to each patient (Belzer, 1999). Patient visits are being reduced to barely 10 to 15 minutes (McCulloch, Ramesar, & Peterson, 1998), and it is not uncommon for physicians to have double-booked appointments (M. H. Clark, personal communication, April, 2001). Thus, while family physicians maintain that they are attempting to provide holistic care to the patient and family, research shows that they are allowing patients less and less time to fully express their concerns (Marvel, Epstein, Flowers, & Beckman, 1999).

Family physicians continue to look for increasingly comprehensive and therapeutic ways to deliver whole-person, whole-family medical care in the challenging task of addressing the bio-, psycho-, and social- spheres of medicine. There are a number of articles in family practice journals in the last 20 years that address using “family therapy skills” and describe family therapy techniques for the family physician or general practitioner (the United Kingdom and Australian equivalent of a family physician).

It seems that family physicians would find family therapists, mental health professionals also working with families from a systemic, biopsychosocial framework, a good match to provide collaborative services for their patients. Despite this logic, little is known about the family physicians’ perceived need for their patients to receive family therapy-related care and little research has investigated the degree to which family physicians are aware of the field of family therapy. What is missing from the literature is the family physician’s awareness of and experience with the field of family therapy as a helpful resource for providing comprehensive care. Are family physicians, indeed, recognizing psychosocial needs in their patients/patient families? Do family physicians think of family therapy providers as a resource when encountering patients’ psychosocial needs in a medical visit? My study addresses this gap by exploring family physicians’ recognition of psychosocial needs in patient care, awareness of the field of family therapy, and experiences with family therapists as a resource for patient care.

#### Rationale for Study

It seems ironic that while marriage and family therapists address psychosocial issues also from a systemic, biopsychosocial framework, a gap remains between what is known about the coordination of patient care between family physicians and family

therapists. After several searches in a number of professional journal databases including the American Academy of Family Physicians, the National Library of Medicine's PubMed, InfoTrieve of MEDLINE, Infotrac of University Libraries, PsychInfo, Journals@Ovid, CINAHL, NTIS, and Social Abstracts, I found no research investigating family physicians' awareness of marriage and family therapy as a field, their perceived need for their patients to receive family therapy-related care, and their attitude towards family therapists as a potential resource for patient treatment.

This is not to say that collaboration between these two fields has not been put into practice at all. Medical family therapy, treating families struggling with chronic medical illness, has been developing for over 20 years (Doherty, McDaniel, & Hepworth, 1994). Research shows that family therapists have effectively collaborated with medical treatment in areas such as genetic and infertility counseling (Burns, 1999; McDaniel, Hepworth, & Doherty, 1992), cancer treatment (Yeager, et al., 1999), bipolar disorder (Sachs, 2001), childhood asthma and diabetes, cardiovascular and neurological disorders (Campbell & Patterson, 1996), obesity (Campbell & Patterson, 1996; Flodmark, Ohlsson, Ryden, & Sveger, 1993), and anorexia nervosa (Halimi, 1992). Nevertheless, little research has been done by researchers in either field to better understand family physicians' awareness of and experience with family therapy when treating patients with complex psychosocial issues uncovered in a routine medical visit.

It would seem that while family physicians may need to better understand the services offered by family therapists, family therapists must better understand how their field is perceived by family physicians as well as the kind of collaboration family physicians would find helpful. The efforts of family physicians to incorporate elements of family counseling and family systems thinking into their biopsychosocial and medical model despite their growing pressures to increase practice productivity points to the potential for beneficial collaboration between family physicians and family therapists.

While several database searches yielded no research examining family physicians' experience with or attitude towards family therapists as a resource for patient care, the search did yield some studies examining the current and potential types of collaboration between family physicians and family therapists. Hepworth and Jackson (1985) published an in depth paper examining the benefits as well as challenges

experienced by family physicians and family therapists in collaboration. They also delineated three models of collaboration for these professionals: indirect consultation, co-therapy, and limited referral. Nevertheless, there is no feedback from family physicians in this paper regarding their experience and perception of any of these collaborative models.

More recently, Gerdes, Yuen, Wood, and Frey (2001) investigated “the strength of collaborative relationships” (p. 429) between primary care physicians (PCP) and mental health providers (MHP) in general. (PCP generally includes family physicians general internists but also may include ob-gyn and pediatrics.) Through the evaluation of the principal characteristics of both primary care physicians and the healthcare organizations, their study generated variables that would most likely be associated with increased frequency and strength in collaboration between MHPs and PCPs. While not specific to marriage and family therapy, this study provides a model for investigating and evaluating the collaborative relationship between family physicians and family therapists and will be further discussed in chapter II.

Research studies have also investigated attitudes of medical students, internal medicine residents, and practicing PCPs toward psychosocial aspects of patient care (Ashworth, Williamson, & Montano, 1984; Levinson, Kaufman, & Dunn, 1990; Parlow & Rothman, 1974). Other research studies examined PCPs’ treatment and referral practices as well as barriers to effective care when treating patients with depression or other identified psychosocial issues (Fisher & Ransom, 1997; Fosson, Elam, & Broaddus, 1982; McCulloch, Ramesar, & Peterson, 1998; Rogers & Walsh, 1994; Rosenthal, Shiffner, & Panebianco, 1990; Williams Rost, Dietrich, Ciotti, Zyzanski, & Cornell, 1999). While these studies are neither specific to family physicians nor to physicians’ attitudes towards family therapy, they provide a background for my study and evidence for the need of further study in this arena.

Some studies have been published on marriage and family therapists’ training and experience of working within a medical clinic (i.e. Harkness, & Nofziger, 1998; Muchnick, Davis, Getzinger, Rosenburg, & Weiss, 1993; Seaburn, Gawinski, McDaniel, Waxman, & Shields, 1993) and the potential challenges for collaboration between the two fields (McDaniel, & Campbell, 1986). Other articles published by departments of

family medicine staff as well as practicing physicians also call for collaboration between mental health care providers and family physicians in order to maintain a practical biopsychosocial and family systems perspective in family medicine (Medalie, & Cole-Kelly, 1993). Some of these articles were specific to marriage and family therapy rather than the broader spectrum of behavioral science (Dym, & Berman, 1986; Tomson, 1990). While these studies call for integrative, collaborative care, none of them represented a generalizable study of family physicians' actual experiences with family therapists as a resource for patient care. Our field still lacks research focusing specifically on family physicians' awareness of marriage and family therapy as a distinct profession, their perceived need for family therapy providers to work with their patients, and their attitude toward collaboration.

My study, by informing family therapists of family physicians' attitudes about, and experience with, members of their profession, provides a clearer picture about how to work toward a greater understanding of and truer collaboration between the two fields. Furthermore, family physicians have had an opportunity to articulate their needs and consider the implications of collaborating with family therapists.

Moreover, FTs may directly benefit by better understanding the extent to which family physicians are aware of marriage and family therapy as a distinct mental health field embracing common philosophies. Family physicians have been able to clarify the perceived need for their patients to receive family therapy-related care. This study has created an avenue for family physicians to articulate their level of interest in collaboration as well as the limitations they currently face in accessing family therapy-related care for their patients. No study has yet explored these issues from the perspective of the family physician. This study, by bringing in the family physician's self-reported experience and perceptions, offers both fields a clearer look at what is actually happening and where the gaps lie in awareness, communication, and collaboration. As this study promotes dialogue and cooperation between the two fields, I also hope that patients/clients will experience a more continuous form of care.

#### Objectives and Research Questions

The purpose of this study was to investigate family physicians' experience of patient psychosocial needs, awareness of marriage and family therapy as a distinct field,

and perceived need to collaborate with family therapists in order to provide comprehensive, biopsychosocial care to their patients. To do this, I first assessed the extent to which family physicians perceive psychosocial stresses or problems in patients whose chief complaint is biomedical and their confidence in treating these psychosocially stressed patients. Secondly, I investigated the extent to which family physicians think of family therapists as mental health professionals who would complement the care they provide for their patients and the extent that they seek collaboration with family therapists to care for patients with complex psychosocial issues.

The following research questions guided this exploratory study:

- To what extent do family physicians identify psychosocial concerns in patients whether presented as a chief complaint or discovered incidentally?
- What is the extent of family physicians' perceived limitations in their ability to address these psychosocial concerns?
- If these limitations are a factor, to what extent do FPs consider referral?
- To what extent are family physicians aware of the field of family therapy?
- To what extent do family physicians collaborate with family therapists when caring for patients with psychosocial concerns?

#### Theoretical Framework

The theoretical frameworks I used to guide this study include systems theory and phenomenology. The systems theoretical perspective calls for the need to look at interrelationships between systems and within systems. According to Klein and White (1996), systems theory emphasizes that “all parts of the system are interconnected” (p. 155) and can only be understood “by viewing the whole” (p. 156). This theoretical perspective lends itself to an investigation of the interrelationships between the fields of family therapy and family practice. Family therapy and family medicine, as part of the larger system of biopsychosocial health care are potentially interrelated—both by the biopsychosocial, systemic framework upon which they are based and by the individuals for whom they care. While both fields share a similar biopsychosocial framework and family systems approach to family issues, family physicians are most highly skilled in addressing medical issues and family therapists are most highly skilled in addressing

psychosocial issues. The systemic framework enables me to consider the interplay between the two fields and suggest the potential for professional collaboration.

I chose to examine this potential interplay between family physicians and family therapists through a phenomenological theoretical framework. Boss, Dahl, and Kaplan (1996) underscore the goal of phenomenological research to be a “deep, clear, and accurate understanding of the experiences of the participants...” (p. 98). From this lens, I gathered descriptive data representing the experience, perceptions, and attitudes of family physicians towards family therapy-related care (e.g. psychologists, social workers, family therapists). My goal to understand family physicians’ reality concerning the interplay between family practice and family therapy was enhanced by the phenomenology framework. The framework of phenomenology stresses not only the need to seek the understanding of the participants’ reality but also to “observe the `whole”” (Boss, Dahl, and Kaplan; 1996, p. 87). Understanding the experience of family physicians with the field of family therapy as a resource for their patients will support a more thorough knowledge of the interrelationship between these two health care systems. My study has contributed to both fields by adding the family physicians’ perspectives and experiences to the “whole”—the research construct of collaborative health care. And, in keeping with the philosophy of the early phenomenologist, Edmund Husserl, my study also sought to understand the “integrated relation[ship] of various and diverse fields of intellectual inquiry in a cohering and coherent world view”(World Phenomenology Institute, paragraph 2, 2001).

## CHAPTER II: LITERATURE REVIEW

### Introduction

#### Review of Research Questions

This study seeks to answer the following research questions:

(1) Are family physicians (FPs) recognizing psychosocial needs in their patients? What, if any, limitations do they encounter in efforts to adequately manage these patient needs? What are their referral practices and related roadblocks?

(2) Do FPs view family therapists (FTs) as a resource when encountering patient's psychosocial needs during a medical visit? Are they aware of marriage and family therapy (MFT) as a distinct field? What is their current level of interaction with MFT providers? And in what kind of collaboration are they interested? This literature review will summarize the existing research and point out the gaps that remain.

In order to understand FPs' perceived need for collaboration with FTs, it is important to ask about their patient-care experience, how they perceive patient psychosocial needs, how they manage them, and whether or not they are aware of family therapy as a specific mental health care field. To place this study within the context of previous research, this chapter reviews literature on FPs' encounter of patient psychosocial needs during a medical visit, their referral practices to mental healthcare, their awareness of the field of MFT, and their perspectives on collaboration with FTs.

#### Family Practice, History and Philosophy

In 1969, the American Medical Association officially recognized family medicine as the 20<sup>th</sup> medical specialty as one committed to a biopsychosocial and systemic approach that encompassed continuous and comprehensive medical care for the individual and the family. This specialty of family medicine grew from the need to restore the dwindling number of "General Practitioners" (Pisacano, 2000) due to increasing specialization and from a disenchantment with the Western reductionist approach to biomedicine (Fischetti, & McCutchan, 2002). In their research on the history of family medicine, Fischetti and McCutchan note that the "U.S. reliance on a narrow biomedical model and its associated problems prompted the early attempts at integration and led to the birth of family practice" (2002, p.116). Family medicine continues to hold biopsychosocial, systemic, whole-person care as the standard for practice (Engel, 1980;

Chung, 1996; Reichel, 1999), incorporating biological, clinical, and behavioral care for all members of the family throughout the life cycle while addressing “each organ system and every disease entity” ([www.aafp.org/about/300\\_c.html](http://www.aafp.org/about/300_c.html)).

Family systems training is an essential component of nearly all family practice residency programs. Holloway (1995) found that nearly 30% of all faculty in family medicine departments were behavioral scientists including “psychologists, marriage and FTs, social workers” (as cited in Fischetti, & McCutchan, 2002, p. 118). Organizations such as the Society for Teachers of Family Medicine are committed to maintaining a family systems approach in the education of new physicians (Fischetti, & McCutchan, 2002; STFM, 2002).

Family medicine literature commonly use a family systems lens for conceptualizing patient issues (e.g. Boyd, 1987; Lapp, 2002; Frank, 1985; Griswold, & Pessar, 2000; Howells, 1970; Novack, Suchman, Clark, Epstein, Najber, & Kaplan, 1997; Nymberg, & Van Noppen, 1994; Rogers & Walsh, 1994; Tomson, 1985) beginning as far back as 1945 in Richardson’s book Patients have families. For example, Merkel (1983) made the argument that treating the individual without the context of the family would be as inappropriate as treating individual cells without the context of the body; and, thus, FPs must investigate ways to integrate the family and family system thinking into their practice of medicine (as cited in Frank, 1985). With this perspective, FPs endeavor to administer holistic care to the family; ideally considering how biological illness can impose stress on the family system or how family stress impacts the biophysical health of individuals.

#### Fit Between Family Medicine (FM) and Marriage and Family Therapy (MFT)

Given FM’s emphasis on family systems and the systemic biopsychosocial model, it seems that MFT would be a logical, and even sought-after, complement to providing comprehensive patient care. Both the fields of family medicine and family therapy recognize this potential match. Family therapists, claiming systemic theory as their foundational principle, are mental health professionals working to provide psychosocial care from a family systems and biopsychosocial framework ([www.aamft.org](http://www.aamft.org)). Although we know little about how commonly FPs and FTs collaborate on routine patient care,

medical family therapy, treating families struggling with chronic medical illness, has been developing for over 20 years (Doherty, McDaniel, & Hepworth, 1994).

Medical family therapy. Research shows that FTs have effectively collaborated with medical treatment in areas such as genetic and infertility counseling (Burns, 1999; McDaniel, Hepworth, & Doherty, 1992), cancer treatment (Yeager, et al., 1999), bipolar disorder (Sachs, 2001), childhood asthma and diabetes, cardiovascular and neurological disorders (Campbell & Patterson, 1996), somaticizing patients (McDaniel, Hepworth, & Doherty, 1995), obesity (Campbell & Patterson, 1996; Flodmark, Ohlsson, Ryden, & Sveger, 1993), and anorexia nervosa (Halmi, 1992). A psychiatrist, John S. Rolland (1994), has proposed a treatment model for medical family therapy in his book Families, Illness, and Health encouraging mental health and other health professionals to fully recognize the biopsychosocial impact illness has on the family.

In addition, FTs have proposed collaboration with FPs as a routine approach to patient care (Dym & Berman, 1986; Harkness & Nofziger, 1998; Hepworth & Jackson, 1985; Seaburn, Gawinski, Harp, McDaniel, Waxman, & Sheilds, 1993; Temperly, 1978). Within this literature there is a broad spectrum of proposed models for collaboration that range from indirect consultation (telephone contact or other informal contact) to a co-therapy model of collaboration (both professionals meeting with patient/client simultaneously) (Dym, & Berman, 1986). Despite the similarities between the philosophical underpinnings of the two fields, the dearth of research suggests little is known about the extent to which FPs and FTs currently work together to provide complementary, comprehensive patient care. Even less is know of the perspective of FPs regarding their perceived need for this collaboration.

### Meaning of Collaboration

There are a variety of models of collaboration between family therapy and family medicine identified in both the family therapy and the family medicine literature. While some scholars suggest physician referral to family therapy with minimal on-going communication represents a moderate form of collaboration (Hepworth & Jackson, 1985), other scholars question whether this can be considered true collaboration (Dym & Berman, 1986). Thus, the mere word *collaboration* is not self-explanatory. In addition,

FTs have suggested “consultations,” but even this lacks clear delineation (Hepworth & Jackson, 1985; Seaburn, Gawinski, Harp, McDaniel, Waxman, & Shields, 1993), on-site physician/therapist meetings (Harkness & Nofzinger, 1998), co-therapy for a one-time appointment (Eshet, Margalit, & Almagor, 1993; Temperley, 1978), and joint practice (Senior, 1994).

If the specific meaning of collaboration is not agreed upon in the family therapy literature, one might question what collaboration means to FPs—or to what extent they are aware of family therapy as a referral resource. Within the medical literature, there is mention of ongoing communication (Searight, Rottnek, & Abby, 2001), referral to family therapy (Bullock & Thompson, 1979; Lang, Marvel, Sanders, Waxman, Beine, Pfaffly, & McCord, 2002; Nymberg & Van Noppen, 1994), “close collaboration with mental health professionals” (Son & Kirchner, 2000, p. 2307), and inviting a psychiatrist to a patient medical visit (Griswold & Pessar, 2000).

One study in an interdisciplinary journal attempts to describe PCPs’ perceptions of collaborative practice with mental health care providers (MHP) (Gerdes, Yuen, & Frey, 2001). Here physicians most often noted the receipt of a written report on the referred out patient as their experience with collaboration. Other reports of perceived collaboration by the PCP were the following: “discuss patient referred,” “phone call or e-mail MHP,” “informal consultations with MHP,” or “regular meetings with MHP” (p.434-435). These were most often reported to be ‘not frequent/never’ in occurrence. With this much variety, it is not surprising that Griswold and Pessar (2000) point out that “informed collaboration depends on an agreed method of communication in a frequency that meets the needs of each physician” (p. 1347). Only Kainz’s research (2002) on physician-psychologist collaboration attempts to cross the gap between fields and obtain directly from PCPs (FPs, general internists, pediatrics, and obstetricians-gynecologists) their perceived need for collaboration and what it might look like. Kainz, a psychologist, tracked the mental health referral practices of physicians in 2 multispecialty clinics and subsequently organized PCP focus groups to gather qualitative information regarding collaboration practices, barriers, and preferences. This qualitative data was then used to construct a survey given to all the physicians at both clinics. From this data, Kainz was able to effectively summarize the barriers to referral and collaboration faced by

physicians in a multispecialty clinic as well as their preferred methods of collaboration. This study is explained in further detail later in the literature review. While it is rare for a mental health professional to examine the perspectives and needs of physicians, even this study is limited in its applicability because of its setting in a multispecialty clinic.

In order to understand the extent of collaboration that is optimal and desired between the FT and the FP, it is important to first understand FPs' perceived need for their patients to receive family therapy related care. Few studies have been done in either field to better understand FPs' awareness of and experience with family therapy as well as desired collaboration when treating patients with complex psychosocial issues uncovered in a routine medical visit.

### Family Physicians' (FP) and their Experience of Patient Psychosocial Concerns

#### Prevalence

Medical literature suggests that FPs frequently encounter patients with psychosocial concerns. Jackson and Tisher (1996) note that up to 80% of patient office visits to their PCP have clinically significant psychosocial underpinnings. Schuman, Kramer, and Mitchell (1989) found that as gatekeepers to specialized care, PCPs (general practitioners, family practitioners, and internists) are the most frequent providers of psychiatric care other than psychiatrists. A 1978 study of all physicians providing mental health care revealed that nearly 80% of the nonpsychiatrist physicians were PCPs. Within this 80%, FPs were the most common psychiatric care providers (Regier, et al, as cited in Schuman, Kramer, & Mitchell, 1989). Thus, PCPs often have a significant role in patient mental health care due to the common physical presentations of underlying mental illness. More recently research presented similar findings with the estimation that PCPs treat between "65 and 85% of mental health problems" (Bray, 1999, as cited in Rabasca, 1999).

#### Recognition of Psychosocial Issues

Many articles in the medical and family therapy literatures call for recognition of psychosocial factors in somatic illnesses (Barsky & Borus, 1999 as cited in Sadovsky, 1999; Kroenke, Spitzer, Williams, Linzer, Hahn, deGruy III, & Brody, 1994; McGrail, Lohman, & Gorman, 2001; O'Brien, 2000). British and Australian general practitioners

(U.S. family practice equivalent) add significantly to this literature by urging physicians to investigate the underlying psychosocial components of the frequent complaints of “heartsink” patients, patients who have frequent and/or vague complaints that are often psychosomatic (Jackson & Tisher, 1996; Mayer, Graham, Schuberth, Launer, Tomson, & Czauderna, 1996; O’Dowd, 1988 as cited in Dowrick, 1992).

Relational stress. Other studies pointing to the probability of psychosocial concerns underlying the presenting complaint suggest that family members are more likely to seek medical care during times of high stress and instability, decreased sense of control, and little or no social support (Ballenger & Alpert, 1998). While these studies link times of high stress and instability to increased vulnerability to illness, Haggerty and co-workers (1975) found that stress related treatment-seeking behaviors increased “even in the absence of illness” (as cited in Ballenger & Alpert, 1998, p. 410). Interestingly, these researchers found that marital distress was directly related to above average use of medical visits for children. Other scholars have also documented the frequency that family members look first to their FP for help in times of stress and family disruptions (Jackson & Tisher, 1996; Searight, Rottnek, & Abby, 2001; Williams, 1988).

Nature of family physician (FP)-patient relationship. Beyond patients presenting physical complaints with significant psychosocial underpinnings, the very nature of the FP-patient relationship opens a door for families to share their stresses and other psychosocial needs (e.g. Lieberman, Stuart, & Robinson, 1996; Rosenthal, Shiffner, and Panebianco, 1990). Ballenger and Alpert (1998) note that families have come to look to the FP for a supportive and personal relationship that enhances their emotional and physical needs. The nature of family practice facilitates such a relationship due to the long-term care for the whole family (Christie-Seely, 1981; Doherty & Baird, 1983). Crouch and McCauley (1985) studied family practice residents’ awareness of patient-family issues as well as patient-expectation of physician awareness of family issues. The researchers found that the patients desired their FP to “be aware of their family problems” as well as to “show some interest in their family and home life” (p. 283).

Literature emphasizes how patient psychosocial concerns that may otherwise have gone unnoticed are often elicited because of the relationship fostered between the patient and the FP. Epperson (1999) articulates the importance of such a trusting, personal,

ongoing relationship with the family in order for family members to feel comfortable sharing psychosocial concerns that patients otherwise would not discuss (i.e. postpartum depression viewed by patient as a self-failing). O'Brien (2000) and Parks and Novielli (2001) underscore the importance of this relationship when providing care for caregivers. Because caregivers are at risk for increased symptoms of stress, anxiety, and depression, FPs are reminded to facilitate discussion of their psychosocial concerns. Other times, FPs are able to use their relationship with the patient as a segue to identifying psychosocial concerns that were not the presenting complaint. Frank (1985) describes experiences such as "recognizing depression in a mother who brought her child in for a mild cold" (p. 146) as examples of the unique FP/patient-family relationship.

### Perceived Ability to Address Psychosocial Concerns

The family medicine literature seems to strongly agree on the importance of a family systems perspective intertwined with a biopsychosocial approach and undeniably identifies the prevalence of psychosocial concerns in a medical visit regardless of the primary complaint. A significant amount of family practice/primary care literature is devoted to discussing family therapy or other counseling techniques for the physician to put into practice.

Medical literature increasingly calls for FPs to add family therapy and general communication skills to their expertise. Articles and books as far back as the 1970s and continuing to the present discuss using family therapy skills during a patient interview (Bader, 1990; Boyd, 1987; Bullock & Thompson, 1979; Christie-Seely, 1981; Czauderna, 1994; Doherty & Baird, 1983; Eshet, Margalit, & Almagor, 1993; Jackson & Tisher, 1996; Lang, Marvel, Sanders, Waxman, Beine, Pfaffly, & McCord, 2002; Tomson & Asen, 1987; William, 1988). These writings emphasize the use of family genograms, family interviewing, identifying a family systems problem rather than blaming an individual, disrupting family triangles, and managing conflict.

Conversely, an equally significant amount of literature suggests a set of limitations that filters the psychosocial care FPs are able to adequately deliver (Christie-Seely, 1981; McCulloch Ramesar, & Peterson, 1998; O'Brien, 2000; Rogers & Walsh, 1994; Rost, Humphrey, Kelleher, Orleans, George, Houpt, & Brodie, 1985; Tomson, &

Asen, 1987; Williams, Rost, Dietrich, Ciotti, Zyzanski, & Cornell, 1999). And, despite the prevalence of literature describing physicians' preparedness to diagnose and treat psychosocial/mental health illnesses, some literature suggests that physicians do not feel adequately prepared.

### Barriers to Exploring Patient Psychosocial Concerns

Some of the literature presents evidence that despite additional training, there are limitations to the quantity and quality of care physicians feel they can deliver to the patient. There are differing opinions on the utility of FPs adding such a broad range of skills to their practice. While all of this literature emphasizes the importance of a family systems perspective and assessment, some question the extent to which FPs should be relied upon to apply these skills (Christie-Seely, 1981; Czauderna, 1994; Rosenthal, Shiffner, & Panebianco, 1990; Tomson & Asen, 1987).

Detection of psychosocial concerns. Some of the research addressing the collaboration of FP and MFT has attempted to evaluate the ability of physicians to detect psychosocial concerns. In Gerdes, Yuen, Wood, and Frey's (2001) research looking for variables indicative of PCP/MHP collaboration, PCPs reported feeling most confident in their ability to treat depression and anxiety. Conversely, these same physicians indicated minimal confidence in their ability to treat "substance abuse, bipolar disorders, violence...child problems, and lifestyle change" (p. 434).

Marvel, Epstein, Flowers, and Beckman (1999) examined the ability of FPs to fully address a patient's total concerns in a medical visit. They found that FPs were likely to redirect patients before hearing their complete agenda—on average, within 23.1 seconds. While this study of 29 board certified FPs suggests that physicians should improve their interviewing skills to more fully and more efficiently elicit each patient's list of concerns, it is not clearly identified whether time or low confidence in their ability to detect psychosocial concerns were factors in this finding.

This is not to say that family medicine literature has not addressed barriers that would limit the detection and treatment of psychosocial problems. Rogers and Walsh (1994) combine personal experience and research to address family systems thinking in family medicine. In their paper, Rogers acknowledges that "receptivity of patients,

availability of consultants and referral sources, insurance coverage, reimbursement, my skill and my time” as well as his own “physical and emotional energy” (p. 192) are major players in his ability to adequately detect and treat patient psychosocial concerns.

Time. Tomson and Asen’s research (1987) found that while FPs were taught to use family therapy skills and reported that these skills very helpful, most identified time as a major restraint in the implementation of these techniques. An AAFP monograph on the diagnosis and management of depression (2000) stated that FPs could use cognitive behavioral therapy in patient treatment, but recognized that comprehensive delivery of this intervention would be difficult due to the major time constraints of a typical office visit (Webb, Dietrich, Katon, & Schwenk, 2000). Orleans, George, Houpt, and Brodie (1985) found that due to time constraints nearly 70% of PCPs feel they cannot treat patient mental health concerns without referral (as cited in Rosenthal, Shiffner, & Panebianco, 1990). Other scholars also identify time as a constraining factor for FPs desiring to provide more comprehensive family therapy to their patients (Doherty & Baird, 1983; Rost, Humphrey, & Kelleher, 1994).

Managed care. Belzer (1999) links the time limitation with the demands of managed care as he calls for FPs to refine their communication skills. He identifies a demand on physicians from HMOs and hospitals to see more and more patients each day as the prime factor in shortened patient visits. Epperson (1999) also acknowledged the pressure from managed care in his article on post partum depression emphasizing that psychosocial issues often get the least amount of attention even from physicians who are generally attuned to these needs. Many other articles in the family medicine literature identify managed care restrictions as a component of the barriers physicians face when attempting to deliver optimal biopsychosocial care (McCulloch, Ramesar, & Peterson, 1998; O’Brien, 2000; Williams, Rost, Dietrich, Ciotti, Zyzanski, & Cornell, 1999)

McCulloch, Ramesar, and Peterson (1998) note that, despite FPs’ responsibility to address patients’ biopsychosocial needs, managed care has increasingly reduced financial and referral resources available for both physicians and patients to address the psychosocial component of care. As an answer to the dilemma of reduced resources, McCulloch, et. al (1998) review Lieberman and Stuart’s 15-minute model for psychosocial assessment in an increasingly shortened patient encounter. While this

model does help a physician facilitate a psychosocial inquiry, and may be useful for detection of psychosocial concerns, it seems limited in its capacity to provide adequate psychosocial care for distressed patients. The question still remains as to whether FPs feel that their skills and techniques combined with environmental and health system limitations are adequate to address patient psychosocial needs.

Training. While calling for FPs to be proficient in family systems theory and in family assessment, Christie-Seely (1981) states that unless FPs obtain additional and more specific training, they should not function as FTs. Doherty and Baird (1983) concur that while FPs can increase their proficiency in “primary care counseling,” it is highly unlikely that any FP has had enough training to do regular family therapy. Furthermore, they emphasize that while a few physicians have sought more intensive training in family therapy, the supportive environment needed to consistently grow as a FT (i.e. supervision; MFT colleagues) is rarely available for a busy physician. Furthermore, Cassata and Kirkman-Liff (1981) found little difference between FPs trained in programs emphasizing behavioral science and internal medicine physicians who had not been trained with this emphasis in terms of how they diagnose, treat, or refer their patients (as cited in Fosson, Elam, and Broaddus, 1982).

Fosson, Elam, and Broaddus (1982) conducted a study to discover whether workshop training in family therapy would increase FPs’ skills and use of family systems thinking during a medical visit. Fifty-six FPs were trained in intensive two-hour family therapy workshops and subsequently asked to complete a mailed questionnaire asking about their perceived use of these new skills. Ninety-seven percent of the responders reported an increase in their awareness of the need to work with the family system when dealing with children and/or psychosocial disorders. However, only 39% reported that they frequently used their new therapy skills when addressing family issues. Another significant finding showed that while FPs who had been in practice for more than 10 years were comfortable working with families and applying family therapy concepts to the medical visit, those in practice less than 5 years did not demonstrate this ability. This study postulated that experience in practice might account for the difference in the degree to which therapy skills were used. The study surmises that while a workshop can significantly increase FPs’ awareness of family systems and family therapy skills, there is

a significant gap in transferring this knowledge to practical application. The study did not address any barriers that may have prevented the physicians from fully incorporating these skills into their practice. Furthermore, over twenty years have passed since this study was conducted without replication.

A more recent study identifies barriers PCPs face when detecting and addressing depression (Williams, Rost, Dietrich, Ciotti, Zyzanski, & Cornell, 1999). Physician reported barriers to adequate treatment of depression included patient reluctance (to accept diagnosis, medication or referral to mental health specialist), managed care/HMO restrictions (such as only reimbursing PCPs 60% of their fee schedule for psychiatric diagnoses or creating a “carve out”--completely separating mental health care out of the physicians’ care, reimbursing only specified mental health care providers; AAFP, 2003) and time. Of the PCPs, FPs reported the most confidence in their diagnostic and treatment abilities (attributed to their biopsychosocial approach); yet, all the physicians had relatively low confidence in their ability to use psychotherapy to treat depression. Time, patient reluctance, and reimbursement were also identified as limitations by rural FPs regarding their efforts to provide care for depressed patients (Rost, Humphrey, & Kelleher, 1994).

#### Family Physicians’ (FPs) Referral Practices

Since it appears that FPs face limitations to adequately exploring mental health concerns during a patient encounter, it seems that referral to mental health professionals would be a valid option for FPs addressing patient psychosocial issues. Family medicine literature does indicate that referral out is a common approach. Researchers in one study defined referral as “any instance in which the FP and the patient mutually agreed that the patient would seek the treatment of a psychotherapist” (Rosenthal, Shiffner, Lucas, & DeMaggio, 1991, p. 528).

#### Referral to Mental Health Providers (MHPs)

It is not clear whether family medicine literature distinguishes family therapy providers from other MHPs for referral. In Williams, Rost, Dietrich, Ciotti, Zyzanski, and Cornell’s (1999) research on PCPs management of depression, psychiatrists, psychologists, and social workers were the only MHPs identified as referral options.

When Rosenthal, Shiffner, and Panebianco (1990) explored FPs' and clinical psychologists' perceptions of successful referral, they observed that the lack of a "family orientation" in a psychologist's training could limit the ease of referral between family physicians and psychologists (p. 41). This observation could suggest that FPs look for MHPs with a family or systemic orientation. Nevertheless, other research in the family medicine and interdisciplinary literature regarding PCP/ FP referrals to mental health care makes reference to MHPs or psychotherapists in general rather than demarcating specific professionals within the mental health field (Reust, Thomlinson, & Lattie, 1999; Rosenthal, Shiffner, Lucas, & DeMaggio, 1991; Rost, Humphrey, & Kelleher, 1994).

### Referral to Family Therapy

However, family medicine literature frequently identifies family therapy as a necessary component of treatment for many psychiatric/psychosocial disorders (FP Report, 1999; Griswold & Pessar, 2000; Nymberg & Noppen, 1994; Searight, Rottnek, & Abby, 2001; Son & Kirchner, 2000). Family medicine literature also distinguishes family therapy from other types of interpersonal therapy (Birmaher, 2000; Flodmark, Ohlsson, Ryden, & Sweger, 1993; Halmi, 1998). Searight, Rottnek, and Abby (2001) identify family therapy as the "treatment of choice" (p. 1587) in their article's section on "referral for specialized treatment" (p. 1587). One early article by Bullock and Thompson (1979) and a later one by Lang, Marvel, Sanders, Waxman, Beine, Pfaffly, and McCord (2002) provides guidelines to FPs regarding when to work with the family's psychosocial problems and when to refer to "experienced family therapists" (abstract). There is, nonetheless, no indication that MFT is viewed as a specific specialty or that FPs distinguish Licensed Marriage and Family Therapists (LMFTs) from other MHPs.

The significantly limited number of articles that specifically identify FPs' referral practices to LMFTs may speak to a lack of physician awareness of LMFTs or a lack of therapist availability or affordability. The literature does not clarify this.

### Roadblocks to Mental Health Referral

Like the barriers FPs have when attempting to adequately address their patients mental health or psychosocial concerns, FPs also identify roadblocks they face when referring patients to MHPs. While these roadblocks most often are noted in the context

of general mental health care referral, FPs may face similar roadblocks for the family therapy field as well. Williams, Rost, Dietrich, Ciotti, Zyzanski, and Cornell (1999) surveyed PCPs and found that, in general, the physicians were “dissatisfied with referrals to mental health specialists” (p.65). The researchers did not explore reasons for this dissatisfaction, but speculated that “affordability, limited availability, poor communication, and insurance plans that limit referral options”(p.65) may contribute to PCPs’ unsatisfactory rating of mental healthcare referrals. Patient reluctance was one barrier to referral that PCPs participants did identify in this study.

Patient reluctance as a barrier to mental health care referral was also identified by FPs in a study of FPs’ and psychologists’ beliefs about successful patient referral (Rosenthal, Shifner, & Panebianco, 1990) and in another study regarding PCP referrals to mental health care (Reust, Thomlinson, & Lattie, 1999). Reust, Thomlinson, & Lattie (1999) also reported patient-identified barriers to keeping a mental health appointment. These included financial issues, HMO/managed care limitations, transportation difficulties, lack of motivation/, patient reluctance, poor relationship with physician, or a change in their illness or stress situation. McCulloch, Ramesar, and Peterson (1998) also specified managed care and patient reluctance as a hindrance to mental health care referrals.

In a study of rural FPs caring for depressed patients, Rost, Humphrey, and Kelleher (1994) identify the stigma patients attach to mental health care as a roadblock to physician referral. This study also delineates the unavailability of appropriate MHPs in the rural community, unaffordability of mental health care, significant lag time between referral and appointment availability, and lack of adequate feedback (or none at all) from the MHPs as other barriers to MHP referral. Potential limitations to this study’s generalizability include the small size of the study (N=43) and its focus on rural communities. Moreover, this study focuses on referral to psychologists rather than FTs.

#### Awareness of Marriage and Family Therapy (MFT) as a Specialty Field

##### Recognition of Specialty

In the medical literature on referral there seems to be mixed messages regarding FPs’ awareness of MFT as a distinct mental health care specialty. While much of the FP

literature recommends family therapy as the treatment of choice, there has been little or no research done on FP referral specifically to marriage and family therapists. There has been no research specifically on FP awareness of MFT as a distinct field. However, in 1998, a telephone survey was conducted to examine the general public's (n=1,000) awareness of MFT as a distinct profession (Family Therapy News, Aug/Sept, 2000). This survey revealed that the public was unclear about the role of MFT and most commonly perceived these therapists to only offer marital therapy. This study suggests that the public does not differentiate one MHP from another quoting Janda's 1998 research which makes the same point (see Janda, et al., 1998). Based on this research, the American Association of Marriage and Family Therapy (AAMFT) began special advertising strategies to increase the public's awareness of MFT as a field. One of the aims of the current study is to discover the extent that FPs are aware of MFT as a distinct field. It seems that this is important to discover, especially since surveyed public in this 1998 poll identified their PCP as the second most likely resource for finding a marriage and family therapist (Family Therapy News, Aug/Sept, 1999).

### Gap Between the Two Fields

It may be that FPs do have a higher awareness of MFT as a specific field than the general public due to their training in medical school and/or residency. Nevertheless, research does not specifically address this. An article written in 1983 by FPs does identify family therapy as the "sister field" of family medicine (Candib & Glenn, p. 773) but pointed out an almost paradoxical cut-off between these "sisters" with the observation that historically the "development of each field occurred separately with minimal crossover" (p. 773). In the past, the field of psychiatry, psychology, or social work made an effort to bridge the gap by presenting family therapy ideas while the field of family therapy itself seemed to distance from the medical field. Candib and Glenn noted that Minuchin, a leader in family therapy, and a few others were the exception to this separation as they worked with somaticizing patients and their families.

Kriesel and Rosenthal (1986) propose that while collaboration between family medicine and family therapy seems practical and logical, a widening gap between them has inhibited optimal cooperation. Kriesel and Rosenthal attribute this gap to a

“reductionistic view of the systems model each formally espouse” (abstract). The authors explain that while FPs have been influenced by the practical application of the biomedical model that more exclusively focuses on disease and physiological process, FTs had isolated the family system from the other systems of which it is a part. One might say this process is “different sides of the same coin.” Both Kriesel and Rosenthal (1986) and Candib and Glenn (1983) propose that FPs and FTs should foster flexibility in this professional family health system and work collaboratively towards a common goal of family oriented care. While these scholars offer explanations for a gap between family medicine and family therapy, it is important to note that they were written over 15 years ago. Literature in both fields continues to identify potential collaborative models, while family medicine literature consistently identifies family therapy as an important component of treatment for many disorders. Nevertheless, a gap remains in the understanding of FPs current awareness and utilization of family therapy for their patients.

#### Family Physicians’ (FPs) View of Collaboration with Mental Health Care Providers (MHPs)

The quantity and quality of collaboration FPs perceive they experience with FTs has not yet been studied. However, researchers have addressed this gap by surveying FPs and PCPs regarding their views of successful MHP referrals and/or collaboration. It seems important to note that the words *cooperation*, *coordination*, *collaboration*, and even *referral* can imply similar meaning in the family medicine literature and can be used interchangeably.

When describing a successful referral, FPs consistently report that good communication from MHPs as well as patient follow-up visits after the mental health appointment is optimal (Rosenthal, Shiffner, & Panebianco, 1990; Rost, Humphrey, & Kelleher, 1994). FP literature indicates that regular feedback from MHPs regarding the referred patient is viewed as necessary and customary. It is implied that lack of communication from any other specialist regarding the referred patient would be unthinkable unprofessional (M. Clark, personal communication, February 16, 2003).

Moreover, it seems that while referral out with on-going communication is the most desirable and practical form of collaboration, FPs are frequently reporting

disappointment. While FPs/PCPs report referring to MHPs, they identify the lack of feedback and communication from the MHPs as a primary barrier to collaboration (Kainz, 2002; Rosenthal, Shiffner, & Panebianco, 1990; Rost, Humphrey, & Kelleher, 1994).

A recent survey of PCPs in an integrated healthcare system which reduces problems with separated out mental health care systems, reported on the patient care contact PCPs had with MHPs. Most of the PCPs reported that they received a report on the patient they referred, while almost half reported receiving a phone call or email about the patient they referred. However, discussion of patient after referral, informal consultations, and regular meetings with the MHP were reported to occur “not frequently/never” (Gerdes, Yuen, Wood, & Frey, 2001, p. 435). In this same study, PCPs reported communication with MHPs regarding the patient is most likely to occur when the patient is in crisis. Fifty-three percent reported communication to occur “not frequent/never” “during chronic patient management” (p. 435-36). The majority of PCPs (52.6%) reported receiving contact from MHPs “less than once a month,” yet over a third reported “every other week/once a month” (p. 435). When asked to report their own collaboration level with MHP, 45.7 % identified “periodic communication about shared patients” and 35.8% identified “written, phone, or email communication about initial patient evaluation” (p.435). “Frequent face-to-face communication and coordination of treatment plans,” “regular communication/occasional face-to-face,” and “no communication” combined, were reported by less than 20% of the PCPS (p. 435). Overall, most PCPs reported being “very satisfied” to “satisfied,” while 20.5% reported being “somewhat” to “very dissatisfied” with the PCP/MHP consultation relationship (p. 431). The study also found that having a MHP onsite is linked to increased collaboration. Interestingly, FPs in this study also were linked to increased collaboration, more so than the other PCPs. While this research is helpful to understand the self-reported experience of PCPs’ collaborative experience with MHPs, its generalizability is somewhat limited due to the integrated healthcare organizational structure and a lack of focus on family therapy providers.

While it seems that referral, regular feedback from MHPs, and brief phone call or email consultations are the most common forms of patient care contact between FPs and

MHPs, it may be that these forms of collaboration are limited. Unfortunately, literature has not addressed FPs' patient-care collaboration with FTs specifically.

#### Degree and Type of Collaboration Desired by Family Physicians (FPs)

It is clear that FPs view collaboration as helpful and even necessary in providing optimal care. Family practice literature continues to call for close coordination and communication with the FT or mental health care specialist involved in the patient's care. While FPs have not specifically clarified in literature the ways FTs could be a helpful resource, Kainz's (2002) mixed-method research on collaboration between a multi-specialty physician group (including PCPs) and psychologists provides useful information from physicians regarding their perspective of psychologists and how psychologists could best serve as members of the healthcare team.

In order to best discover what PCPs viewed as "barriers and enhancements to physician-psychologist collaboration" (title), Kainz collected data from physicians in 3 phases at 2 different multispecialty clinics. First, the referral patterns from physicians to psychologists at Clinic A were tracked for 1 year. The PCPs were then divided into lists of high referrers and low referrers. Using these lists, 2 focus groups were formed for Phase 2 of the data collection: "low referrers (7 men and 2 women)" and "high referrers (6 men and 2 women)" (p. 170).

During the focus group, physicians discussed various barriers they experienced when referring patients to psychologists: lag time between referral and appointment, problems in clinic referral system, lack of insurance coverage, poor inter-department communication, the stigma of psychological care, and low physician confidence in differentiating between psychologists and psychiatrists. These physicians also noted factors which facilitated successful referrals. These included the following: existing professional relationship with psychologist, psychologist well-regarded by both the professional and patient community, timely feedback from psychologist (telephone call and/or thorough report), awareness of theoretical approach and personal style of psychologist, ability of physician to directly refer patient to specific psychologist, and a multispecialty clinic which includes psychologists.

From these focus groups, a survey was designed for further clarification and comparison between clinics A and B. The survey was mailed to all the physicians of each multispecialty clinic regardless of their specialty and had a 70% response rate (n=85).

The survey results confirmed and clarified the findings from the focus groups. Participants reported the following characteristics to be most important when deciding to refer their patients to the on-site psychologist: “insurance coverage, summary of treatment (feedback), short-term therapy, and ability to treat children and adolescents” (p. 171). Other significant factors that would influence their decision to send a patient to a particular psychologist were “psychometric testing,” “reputation of psychologist,” “intake report routed to physician,” and “friendly relationship with psychologist” (p. 171). Significant to my study is that 70% of these physicians identified family therapy to be of “Great” or “Moderate” importance “when deciding to send a patient to a psychologist” (p. 173). All of the physicians identified regular feedback to be essential, with the majority describing this feedback to be approximately “one full page,” a brief intake report or “SOAP note [traditional progress note],” or “narrative” in format (p.173). Nevertheless, 21% said that the format of the feedback did not matter as long as they receive something comprehensive.

Kainz (2002) summarizes her research by encouraging psychologists to be active, assertive team players on this health care team. She notes that while psychologists may tend to feel marginalized, especially in a multi-specialty medical clinic, they need to initiate and teach physicians a model of obtainable collaboration. Kainz also emphasizes the importance of understanding the multispecialty clinic format and its significance to her research. Because various medical specialties and psychologists are in the same healthcare network, and often in the same building psychologists have a responsibility to be tuned in to the collaborative relationship. On the other hand, a multispecialty clinic setting can potentially ease some of the barriers faced by physicians and MHPs not in the same healthcare organization or physical setting. Even as this physician-participant research offers a goldmine of implications for MHPs, it is unrealistic to expect that this study could address all barriers and needs of FPs and FTs not linked in a multispecialty network. While this article has addressed the area of collaboration from the experiential

perspective of physicians, much more research must be conducted to address the remaining gap.

## Summary

### Not Known

From the literature it is clear that collaboration between family physicians and FT is valued and discussed in both fields. The literature also recognizes the natural compatibility FPs and FTs have for collaboration based on their underlying philosophical tenets of systems and biopsychosocial and even spiritual care of the family. Family practice training programs and current practice literature continue to emphasize psychosocial care for the patient. Research has also shown that patients often bring their psychosocial concerns to their FPs, but that, although FPs are trained to address these concerns, they often face barriers to fully addressing these non-medical concerns. In recognition of this, family practice literature continues both to educate physicians on brief psychosocial care and knowing when to refer to FTs or other MHPs.

Research has shown that PCPs are referring patients to MHPs and desiring some form of collaboration. Family physicians and psychologists have examined factors that promote referral and/or collaboration. While the specialty of medical family therapy has developed to help families struggling with chronic illness, while family medicine has strived to address patient psychosocial needs in literature and practice, and while specific collaborative models have been developed for whole-person care, very little data identifies the extent and form of collaboration that is actually occurring.

Nevertheless, while it seems that FPs are aware of MFT as a resource, there have been no studies that focus specifically on the referral and/or collaborative relationship between FPs and FTs. The extent of FP/FT collaboration that is truly happening as well as FPs perception of patient-need for family therapy are still unanswered questions. While models of collaboration have been proposed and tested, the literature in the field has not examined the experience of the FP. Furthermore, despite evidence that FP literature often upholds family therapy as a treatment of choice, it is still unclear whether or not FPs identify FTs as distinct licensed mental health specialists that share their biopsychosocial, systemic philosophical approach to family wellness. Research must

focus on these gaps to better facilitate the collaboration that both fields seem to describe as helpful for effective patient care.

### CHAPTER III: METHODS AND RATIONALE

For this study, I used an exploratory survey design to investigate family physician-family therapist collaboration from family physicians' perspective. I described family physicians' knowledge and use of family systems in the context of family medicine, awareness of the field of family therapy, their current experience of collaborative practices with marriage and family therapists, and their preferred form of collaboration with family therapists for comprehensive care of their patients. While the questions were primarily close-ended, open-ended questions were also used to enrich the quantitative data. A national random sample was chosen because it promises to provide findings that can be generalized to practicing family physicians in the United States.

#### Participants and Selection Process

Two hundred forty board certified, practicing family physicians in the United States were randomly selected for this study from the American Academy of Family Physicians (AAFP) directory. The sample was consistent with the regional distribution of the population (Table 1). A sample of 240 was chosen based on the financial and time resources available to the researcher and the population size of FPs throughout the US and US territories ( $N \approx 53,000$ ). According to Rea and Parker (1997), who discuss the determination of sample sizes based on population in depth, populations of 100,000 or less can be considered small populations. Based on their calculations of probability, it is possible to get a confidence interval of about  $\pm 6\%$  with a sample and population size similar to this research (see pp. 116-121). Thus, the researcher can be reasonably confident that this study's sample size of 240 from a population of nearly 53,000 can yield at least a 95% level of confidence with a  $\pm 6\%$  margin of error.

In addition, the expected response rate of my population was carefully considered. In Williams' et al. (1999) study the overall physician response rate was 58.3% ( $n=1350$ ). A much smaller study of PCP ( $n=43$ ) by Rost, Humphrey, and Kelleher (1994) confirms a response rate of 86%. Another study of similar size ( $n=23$ ) reports a response rate of 49%--all of whom were family physicians (Rosenthal, Shiffner, Lucas, & DeMaggio, 1991). Based on the response rates of these studies, it was predicted that a randomly

selected number of 240 would provide a sample of about 120 participants, which should be enough to provide valuable descriptive information for my exploratory study.

### Procedures

After reviewing the literature and brainstorming with medical professionals and family therapists, a survey questionnaire was developed to assess participants' demographics, their perceived need for their patients to receive family therapy-related care, their view of their ability to deal with their patients' complex psychosocial issues, the extent of their awareness of family therapists as a resource, the extent and experience of collaboration with family therapists, and roadblocks they may have encountered in the process (see Appendix A). The questionnaire was pilot tested with 5 family physicians as well as reviewed by the research committee. This enabled me to revise the questions included in this instrument and to determine the length of time required to complete the questionnaire. I was also able to obtain helpful information for increasing my response rate from a sometimes elusive population.

Before collection of data, consent to conduct the study was granted from the Institutional Review Board (IRB). Next, two hundred forty family physicians were randomly selected from the American Academy of Family Physicians' (AAFP) membership directory by the research department of the AAFP. Participants were randomly selected on these criteria: (a) active members of AAFP (completed a three-year FP residency training and engaged in practice of family medicine. Family physicians engaged in full-time teaching, administration, or the practice of emergency medicine also qualify for active membership but were not used in this study); (b) graduated from a US medical school; (c) completed their residency after 1969 (the year family practice was established as an official medical specialty); (d) located within a US zip code; and (e) involved in direct patient care (rather than only administration, only teaching, or only research). Retired or in-training family physicians as well as family physicians spending most of their time in administrative medicine or research would bias the results, thus, they were excluded (Williams, et al., 1999). Subsequently, the self-administered questionnaire was sent out to these participants via the U.S. Postal Service. This mailing included an introductory letter describing the research, assuring complete

confidentiality if they chose to participate accompanied by a brightly colored post-it note™ with a brief handwritten message from the researcher (see Appendix B). A self-addressed stamped envelope was included, but participants were also given the option to return the survey via fax. Each survey was numbered to enable a follow-up mailing to the non-respondents and lettered to identify the census region of the participant. To protect participants' confidentiality, I kept the list of participants as well as the returned surveys under lock and key. The list of participants was destroyed upon completion of my study.

During the first wave of surveys, 104 surveys were returned. After four weeks the same material was re-mailed to encourage the non-responding family physicians to participate (including all of the original material with a slightly different post-it™ note message). Forty-nine surveys were returned in this second wave. After eliminating 16 surveys based on failure to meet qualifications, I entered the data into SPSS and conducted a descriptive statistical analysis. The answers to the open-ended questions and qualitative responses were cross-coded to increase reliability and then analyzed using content analysis. Content analysis is a mixed-method of qualitative data analysis that uses both quantitative and qualitative procedures to identify categorical themes in the data and describe the frequency and numerical patterns of those themes (Newfield, Sells, Smith, Newfield, & Newfield, (1996). Lastly, I reported my results.

### Instruments

As discussed earlier, in the process of constructing a preliminary questionnaire for this survey research, I met with health professionals for a brainstorming session. This questionnaire (Appendix A) was primarily composed of closed-ended questions. An open-ended question at the end of each section allowed for additional input by the respondents. The questionnaire was divided into five basic sections. Section 1 gathered basic demographic information. Section 2 focused on family physicians' experience with psychosocial needs in family medicine and the limitations to adequately exploring them. Section 3 dealt largely with family physicians' current referral practices for mental health (psychosocial) concerns. Section 4 assessed the extent to which family physicians are aware of the field of family therapy. Section 5 explored family physicians' current

professional collaboration with family therapy providers as well as preferred mode of collaboration for the future. The last component of the questionnaire included a qualitative question inviting family physicians to briefly describe how family therapists could be a more helpful resource as they care for patients with complex psychosocial issues.

### Analysis

Data from this survey research was analyzed using a variety of descriptive statistical methods. Data was analyzed to describe the profiles of participants (e.g. mean age, mean years in private practice as well as a range of both), frequencies, and distributions of values (how did these physicians respond in an overall picture). Graphical depictions of the descriptive results are also included in the report.

## CHAPTER IV: RESULTS

This chapter contains the results of a nation-wide survey of family physicians. To obtain these data, 240 family physicians were randomly selected from the American Academy of Family Physicians' (AAFP) mailing list by the research department of the AAFP. This random selection was obtained using a designated order form available on the AAFP website ([www.aafp.org](http://www.aafp.org)). Participants were randomly selected based on these criteria: (a) an active membership in AAFP; (b) graduation from a US medical school; (c) completion of residency after 1969; (d) located in a US zip code; and (e) involvement in direct patient care. Of the 240 surveyed, 153 (64%) returned a completed questionnaire. Of those respondents, 16 were disqualified from this analysis for the following reasons: (a) Emergency medicine full-time (N=12); (b) Occupational medicine full-time (N=2); (c) Geriatric medicine only (N=1); and (d) No longer in clinical practice (N=1). Consequently, there were a total of 137 usable returns (57%).

### Demographics

On average, the physicians had been in practice for 12 years with a range from 1 – 30 years of practice. Of the 137 respondents, 66% were male and 34% were female. Their ages ranged from 30 to 64 with an average age of 46. There was no statistically significant gender difference in age or in years of practice.

The four major census regions of the US as well as US territories and military were represented in the sample. Fifteen percent (N=21) of the physicians practice in the Northeast, 35% (N=48) practice in the South, 27% (N=29) practice in the Midwest, 21% (N=29) practice in the West, and 2% (N=2) practice in a US territory/APO addresses (i.e. Puerto Rico and deployed military physicians). Based on the AAFP census of their members (2002), the sample appears representative of the regional distribution of family physicians throughout the United States (see Table 1). Ninety-two percent of the physicians spent 50% or more of their professional time in direct patient care; 98% were board certified in family practice medicine; and 95% of the physicians were trained in a residency program that had a non-MD mental health professional on staff.

Table 1  
Demographics

Variable	%* of respondents	% of random sample	% of 2002 National AAFP Census <sup>^*</sup>
<b>REGION</b>			
Northeast	15	13	15
South	35	33	33
Midwest	27	33	28
West	21	20	21
US Territory/APO	2	2	3
<b>GENDER</b>			
Male	66	65 <sup>+</sup>	71 <sup>++</sup>
Female	34	35 <sup>+</sup>	29 <sup>++</sup>
≥ 50% of time in Direct. Pt. Care	92	--	--
FP Board Certified	98 <sup>**</sup>	--	--
Non MD MHP trained	95 <sup>***</sup>	--	--

Note. \* all rounded to the nearest whole %; N=137 unless otherwise indicated

<sup>^\*</sup> Membership (US, US Territories, and Military). American Academy of Family Physicians, 2003.

<sup>+</sup> This is an approximation based on first and middle name as well as known respondents.

Unable to confidently determine 7 from the original sample. <sup>++</sup> Active AAFP members (this percentage includes 138 Canadian members and 350 foreign members that were not part of my sampled population). <sup>\*\*</sup> N=136; <sup>\*\*\*</sup>N=134

### Psychosocial Concerns in Patient Care

#### Research Question 1:

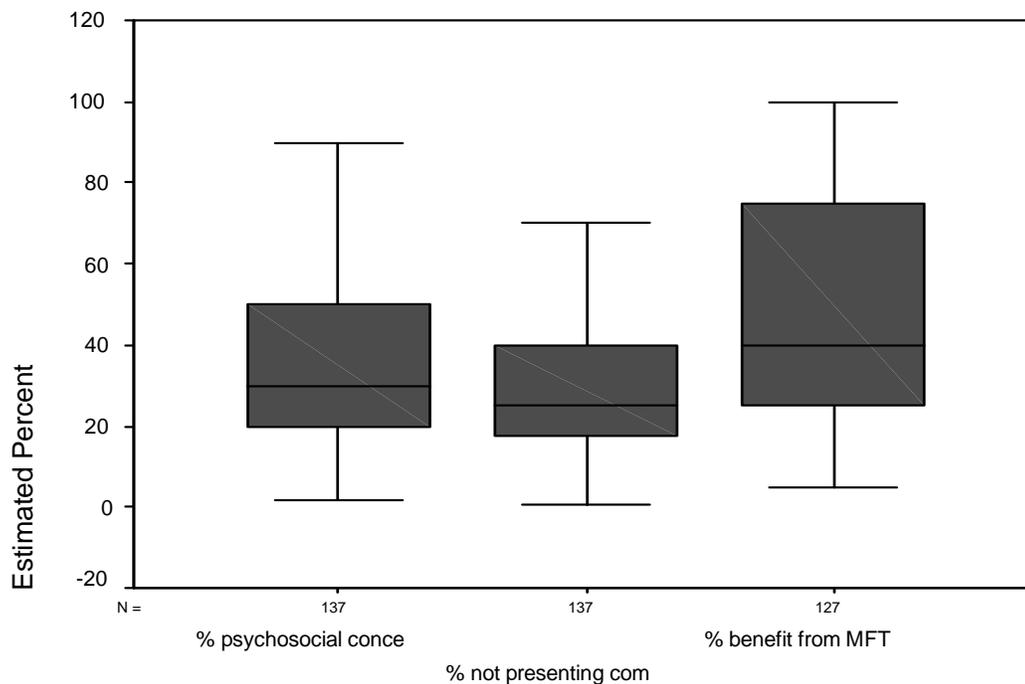
*To what extent do family physicians identify psychosocial concerns in patients whether presented as a chief complaint or discovered incidentally?*

Four survey questions were designed to address this research question (see Appendix A). For the first question, when asked to estimate the percent of patient

encounters in which they detected significant psychosocial concerns, the average estimate was 38% (mode=30%, range 2% to 100%; Figure 1).

For the second question, when asked to estimate the percent of patient encounters that ultimately involved psychosocial concerns even though these concerns were not the presenting complaint, the average estimate was 30% (mode=30%; range 0.5% to 100%).

For the third question, when asked to estimate the percentage of their patients with identified psychosocial concerns that the physicians felt could benefit from marital and/or family counseling, the average response was 48% (mode=30%; range 5% to 100%). Almost 25% of these physicians responded with an estimate of 75% or more. One participant emphasized her response with the additional comment of “so many!” referring to the number of patients with identified psychosocial concerns who could benefit from marital and/or family counseling.



**Figure 1.** This represents the mean and range of the percent estimated by the respondents regarding the percent of psychosocial concerns detected in patient care ( $\underline{M}$ =38%, range 2%-100%), percent of psychosocial concerns when NOT the presenting complaint ( $\underline{M}$ =30%, range=0.5%-100%), and percent that could potentially benefit from MFT ( $\underline{M}$ =48%, range=5%-100%).

On the fourth question, 84% of the respondents thought a patient’s presenting medical complaint could be related to or exacerbated by family/marital/relational stress “almost all the time” or “frequently”. None of the respondents chose “hardly ever” for this question (Figure 2).

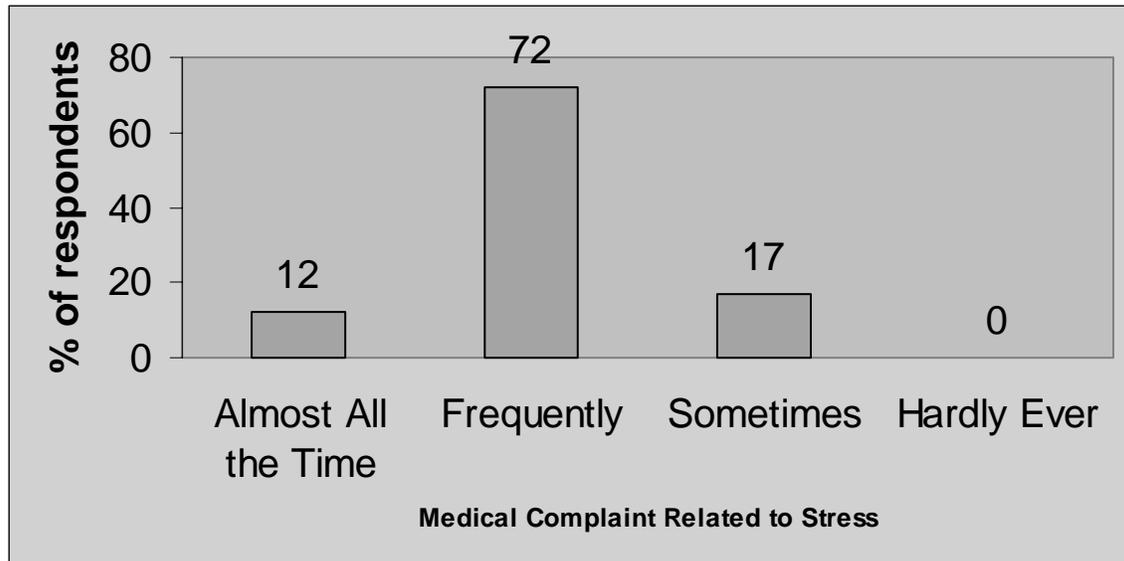


Figure 2. Physicians’ belief regarding the extent a patient’s presenting medical complaint could be related to or exacerbated by family/marital/relational stress.

Research Question 2:

*What is the extent of family physicians’ perceived limitations in their ability to address these psychosocial concerns?*

One primary survey question was designed to address this research question. When asked about limitations they face to adequately exploring patient psychosocial concerns in an average appointment, 95% of the respondents identified time and, thus, time was the most frequently identified limitation in this question (Figure 3). Six of these respondents added up to 9 additional check marks on this line to emphasize the extent they felt time to be a limitation. Reimbursement (59%) and patient reluctance (57%) were the next most commonly identified limitations. The physicians also identified HMO restrictions (20%), Training (20%), Experience (15%), and Interest (10%) as

limitations to adequately exploring psychosocial needs. Only 2 physicians indicated that they did not encounter limitations (“None”=2%).

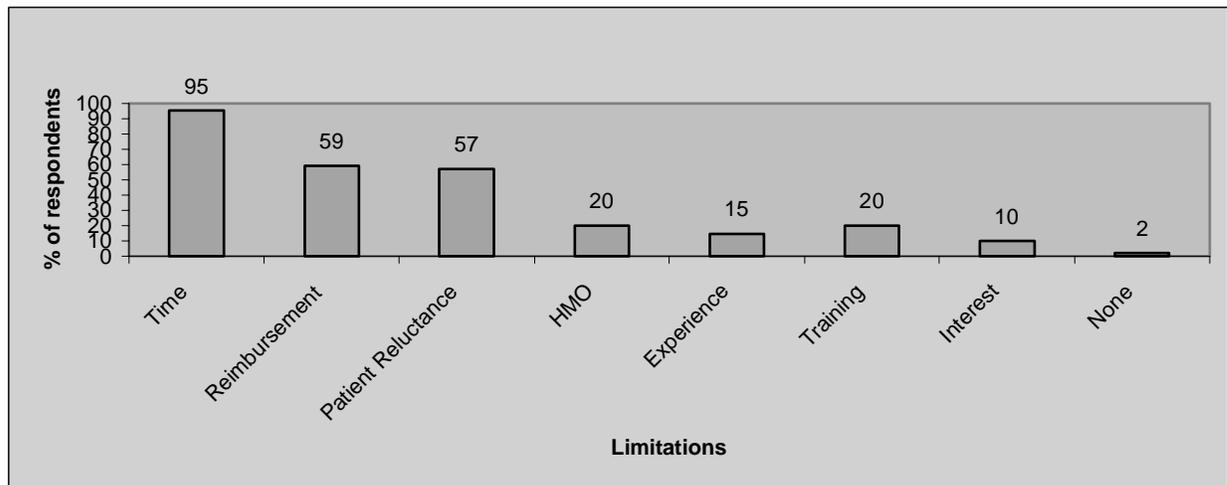


Figure 3. Limitations to adequately exploring psychosocial concerns of patients in an average appointment. Participants were asked to check all that apply. One participant indicated Reimbursement/HMO Restrictions were N/A.

Nine respondents offered further comment in the open-ended component of the “Limitations” question labeled *other* (Figure 4). Using content analysis, a new category of limitations emerged with 55% of physicians who responded to the open-ended question indicating a lack of referral sources as a major limitation to adequately exploring psychosocial concerns of individuals/families in an average appointment. One respondent put it succinctly by writing that he had “difficulty in obtaining appropriate assistance/resources once psychosocial concerns have been identified.”

Patient-related variables were mentioned by 2 respondents (22%) while managed care-related variables was mentioned once (11%) and no limitations was mentioned once (11%). Patient-related responses included the following statements: “Lack of patient interest/insight” and “Native American culture and small town (everybody is somebody’s family).” A respondent indicating managed care as a limitation stated “HMO has separated mental health coverage.” Only one respondent felt there were no limitations stating “If I don’t have time...I schedule a follow-up visit.”

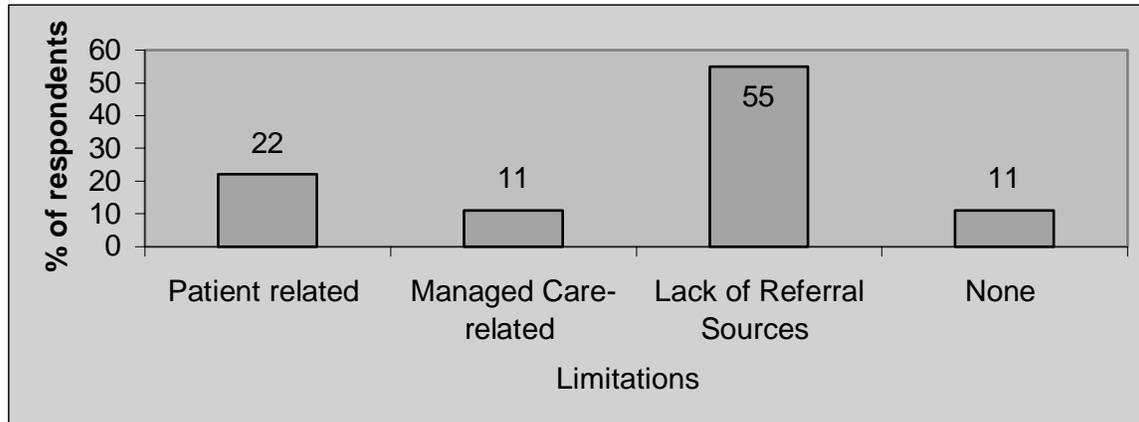


Figure 4. Qualitative responses pertaining to limitations to exploring psychosocial concerns of patients. There were nine respondents.

### Referral Practices

#### Research Question 3:

*If limitations are a factor, do family physicians seek referral to enhance their patients' care? Are there limitations to referral?*

Three survey questions were designed to address this research question. First, physicians were asked to estimate what percent of their patients they refer for mental health services. On average, respondents estimated that they refer 12% of their patients for mental health services (Mode 10%, range 0% to 90%; Figure 5). However, when asked to estimate the percentage of their patients whom they referred specifically for couples and/or family therapy-related care (MFT), the average response was 5% (Mode 5%, range 0 to 30%). Only 10 of the respondents estimated their MFT referrals to be 20% or higher.

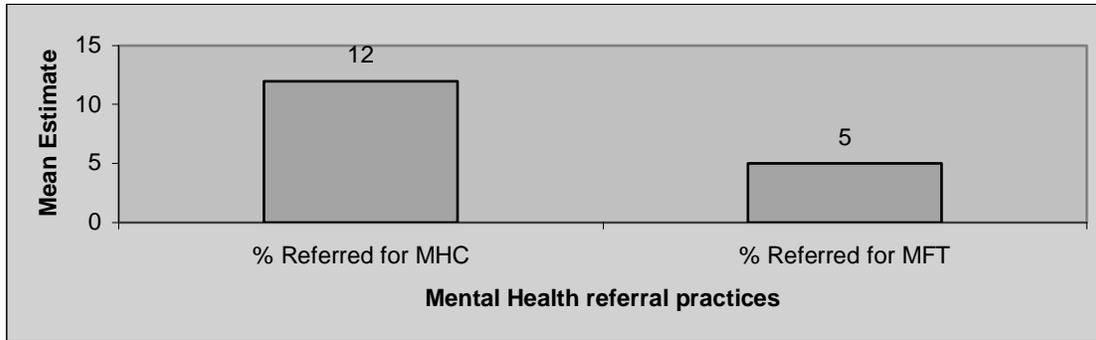


Figure 5. Physicians were asked to estimate the percent of patients they referred for mental health services in general as well as the percent of patients they referred specifically for marriage and family therapy-related care

Roadblocks to MFT referral. Physicians were also asked to identify roadblocks they encountered when referring patients for marriage and family therapy. Eighty-five percent checked “Patient Reluctance” as a roadblock to referring patients to MFT while 65% of the respondents indicated HMO/Insurance as a roadblock to MFT referral (Figure 6). Forty percent of the respondents indicated that the unavailability of appropriate therapists was a roadblock while 33% indicated that their lack of awareness of appropriate therapists was a roadblock. Thirty four percent of the respondents indicated time as a roadblock to referral, and only 4% indicated that they believed MFT was not helpful.

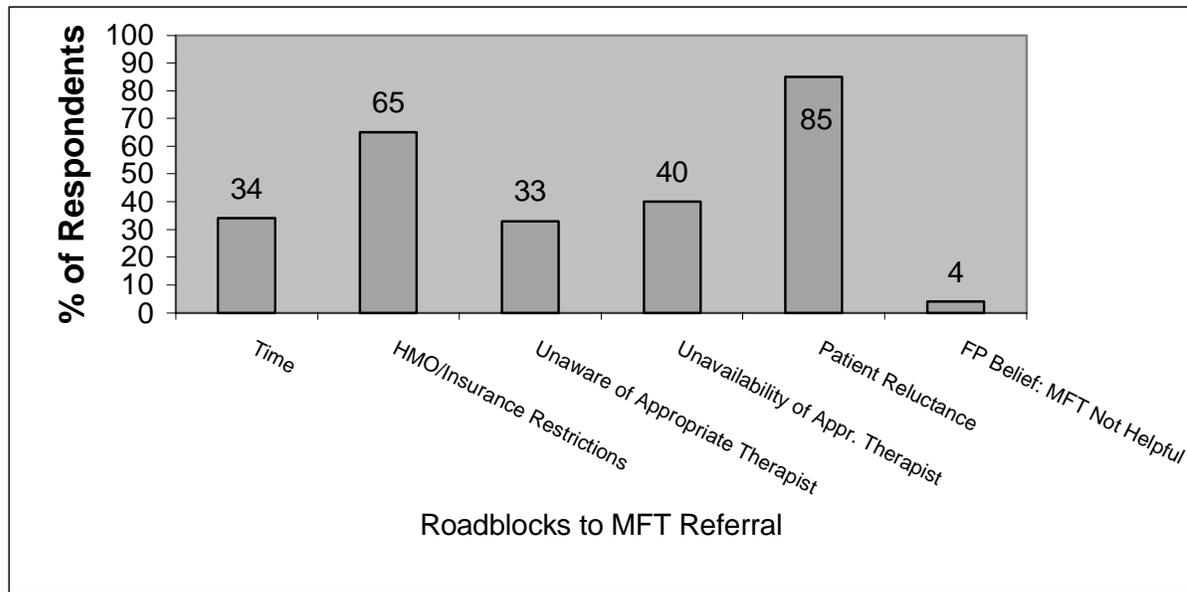


Figure 6. Roadblocks encountered by FPs when referring patients for marriage and family therapy-related care. (N=136).

Twenty-four participants (18% of the total respondents) responded to the component of this question marked *other* (Figure 7). A content analysis of these responses indicated five categories: Managed Care/Affordability, Patient-related variables, Lack of referral resources, Lack of therapist cultural diversity, and Physician-related variables.

Managed Care/Affordability was the most often cited roadblock to referring patients for marriage and family therapy (N=11; 46%). Many of these physicians described the difficulty of identifying therapists who accepted their patients' insurance plans. Physicians reported that many of their patients simply did not have mental health coverage at all. Responses such as this were common: "...limited or no insurance coverage for mental health services." Others identified the lack of insurance coverage specific to marriage and family therapy-related care: "Patients are typically sent for individual counseling since this is covered by insurance while couples/family counseling is not!" The cost of therapy for patients who did not have mental health insurance was another factor that made referral difficult for these physicians.

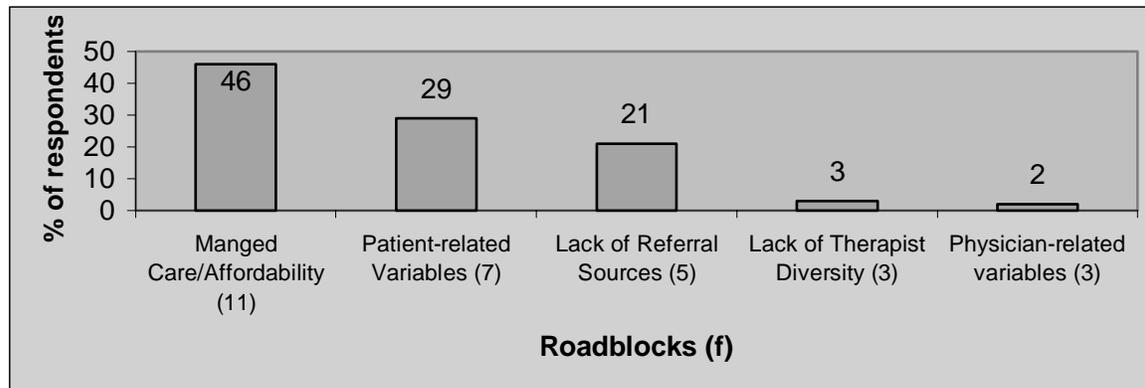


Figure 7. Qualitative response regarding physician encountered roadblocks when referring patients for marriage and family therapy-related care. (N=24; some participants gave more than one response).

Patient-related variables (N=7; 29%) emerged as another prominent theme not distinct in the quantitative component. “Patient reluctance,” “spouse reluctance,” and patient concern about “mental health privacy” are examples of patient-related variables.

On the other hand, 5 of the 24 participants (21%) responding to the open-ended question reported that a lack of referral sources inhibited their ability to refer patients for marriage and therapy-related care. Some identified a lack of therapists in the area: “No or very few resources for this population [uninsured, undocumented]” and “Patients must leave town [to find therapist]”. Some referred to the difficulty of finding therapy specialists, such as “...pediatric/adolescent counselors.” One described the challenge of identifying an effective therapist: “Inability to determine which therapists are effective, and which are quacks.”

Three respondents (3%) identified lack of therapist cultural diversity as a roadblock when referring patients for marriage and therapy-related care. One physician stated: “All our therapists are Caucasian—most patients are not!” Two responses (8%) were placed in the category labeled physician-related variables. One stated that he was able to provide couples therapy in his practice, while another thought that patients who initiated their own counseling rather than being referred were “statistically more successful” (Figure 7).

## Awareness of Marriage and Family Therapy

### Research Question 4:

*To what extent are family physicians aware of the field of family therapy?*

Two survey questions were designed to address this research question. Eighty-three percent of the participants reported that they were aware that Marriage and Family Therapists are mental health professionals “trained in psychotherapy and family systems, and licensed to diagnose and treat mental and emotional disorders within the context of marriage, couples, and family systems”(AAFMT, 2002; Figure 8). However, 64% reported that prior to this survey they did not recognize the initials “LMFT” as credentials for a Licensed Marriage and Family Therapist (Figure 9).

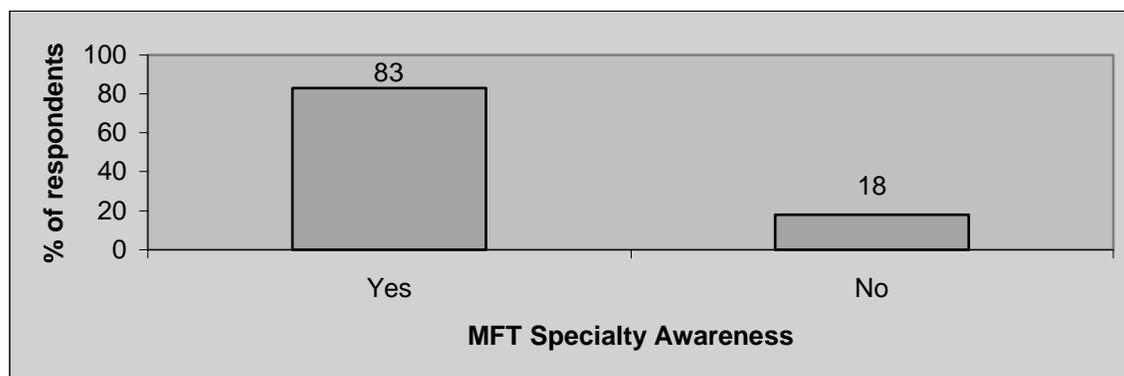
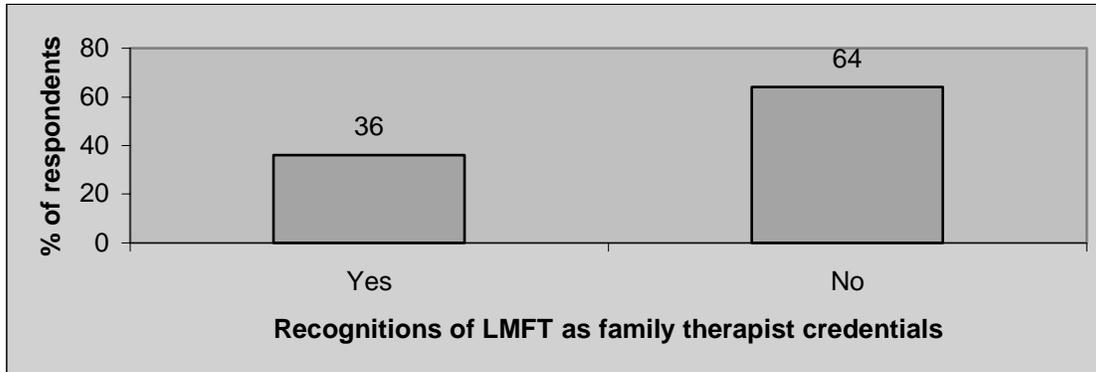


Figure 8. FP awareness of Marriage and Family Therapists (LMFTs) as mental health professionals “trained in psychotherapy and family systems, and licensed to diagnose and treat mental and emotional disorders within the context of marriage, couples, and family systems” (aamft.org). (N=137; values rounded to nearest percent).

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**Figure 9.** Physician recognition of the initials “LMFT” as credentials for a Licensed Marriage and Family Therapist (N=137).

### Collaboration with Family Therapists

#### Current Experience with Collaboration

##### Research Question 5:

*To what extent do family physicians collaborate with family therapists when caring for patients with psychosocial needs?*

Five survey questions were designed to address this research questions. For the first question, when asked if they had ever consulted with a mental health professional regarding a patient case, 100% of the respondents reported that they had (Table 2). In the second questions 47% indicated they had consulted a Licensed Marriage and Family Therapist (LMFT) regarding a patient, while in the third question 53% indicated they either had not or were not sure if they had consulted with an LMFT (Table 2).

Table 2

#### FP Consultations with MHP and LMFT

Variable	%
Consult with MHP	100
Consult with LMFT	
Yes	47
Not sure	32
No	21

Note. N=137.

Current FP Collaboration with FT. This multi-component question contained several examples of patient-care contact with a licensed marriage and family therapist (LMFT) or comparable professional and invited respondents to check as many that applied. When asked which statements best described their patient-care contact with a LMFT or comparable professional in their community, 49% checked infrequent reports from therapist on patient referred (Figure 10). Forty-three percent identified a phone call or email with a family therapist, 40% percent reported an informal consultation with a family therapist, 19% reported that they regularly receive reports, while only 3% reported regular meetings with a family therapist. Twenty percent indicated that they had no patient-care contact with family therapists in their community.

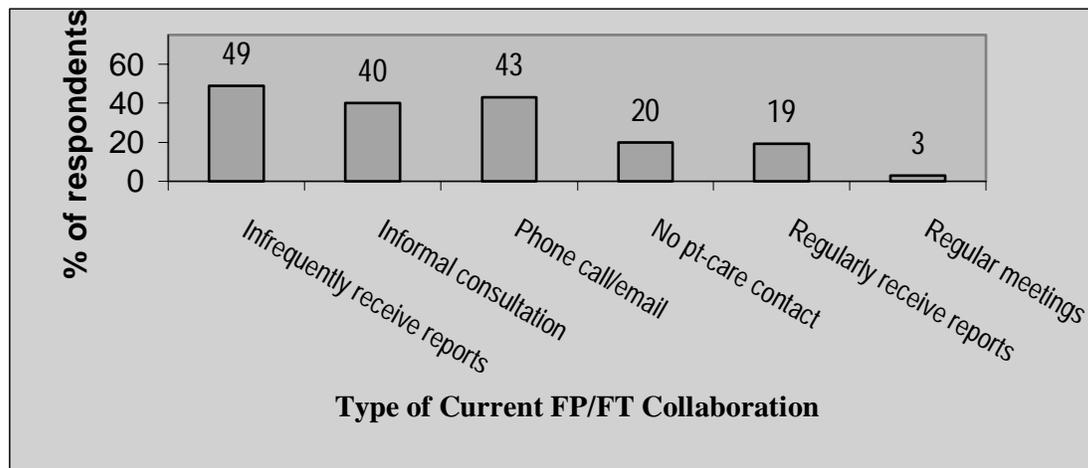


Figure 10. This figure describes the frequency of each type of LMFT patient-care contact identified by the participants. Participants were asked to check all that applied. N=137.

The participants could also choose the option indicated *other* and write in their own comments. A content analysis of these responses (N=14) revealed two themes: minimal feedback and no feedback (Table 3). Four responses were placed in a miscellaneous category. Of the 14 participants (10%) who responded to this portion of the question, nine (64%) reported that they received minimal feedback from therapists regarding the patient referred (Table 3.). One physician wrote “I have referred five families and have never received a consult note.” Another stated that he “must call the therapist” to get any feedback. Four of these 14 participants (29%) described no collaborative contact due to a lack of therapists in their area.

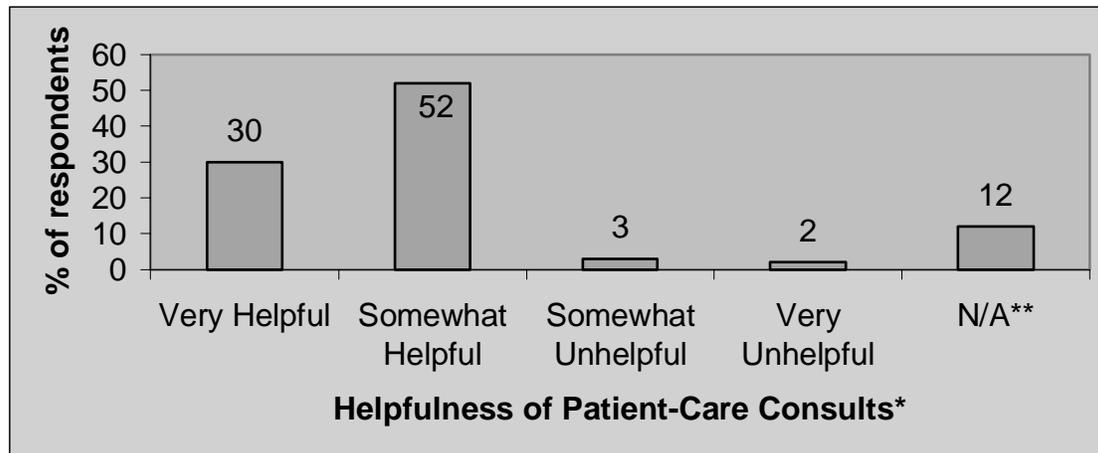
Table 3

Experience with Collaboration—Qualitative Responses

Experience	<i>f</i>	%	Examples
None	4	29	“Therapists not in community” (4)
Little or no feedback from therapist	9	64	“[therapists] never send follow-up letters” (4) “I must call therapist to get feedback.” “Mental health notifies me if a pt follows up, but no other info, exchanged”
Miscellaneous	4	29	“Formal consultation and referral for management” “I was the supervisor for a family therapist” “Not in current practice, but where I came from we had LMFTs interning with us”

Note. Participants often made more than one comment. N=14

Helpfulness of current collaboration. Physicians were also asked to rate the degree of helpfulness they experienced in these family therapist patient consults (Figure 11). Eighty-two percent of the physicians responding to this question (N=134) indicated that the consults were either “Very helpful” or “Somewhat helpful”. Six physicians (5%) indicated that the consults had been either “Somewhat unhelpful” or “Very unhelpful”. Sixteen (12%) respondents indicated that the question did not apply. Four of the respondents added remarks in the margin of their survey emphasizing the lack of feedback from therapists.



**Figure 11.** Based on their experiences, participants reported on the helpfulness of family therapy patient-care contact consults. \*N=134 \*\*These participants indicated that they had not received feedback from therapists or did not have any pt-care contact with FTs.

Interest in Collaboration with Family Therapists (FT). For the final question in this section of the questionnaire, physicians were asked to describe their interest in collaborating with an LMFT or comparable mental health professional when identifying psychosocial needs with their patients. They were invited to do this by choosing as many options from the list that applied and/or filling in the blank next to *other*. Eighty-four percent of the respondents indicated that they would “prefer to refer out with collaborative communication continuing between themselves and the therapist (Figure 12). Twenty-one respondents (15%) indicated that they would be interested in inviting a family therapy provider to a patient’s appointment to discuss psychosocial concerns while 15 respondents (11%) indicated they would be interested in meeting regularly with a marriage and family therapy provider regarding complex patients.

Two respondents (2%) preferred to provide care without collaboration, while 7 (5%) indicated interest in referring patients out without collaboration. Thus, only 7% of family physicians responding to this survey indicated they were not interested in collaborating with family therapists.

Due to an error, only 38 physicians (28% of total valid responses) received the option “I need a brief consultation to decide” (regarding collaboration need) on their survey. Of the 38 physicians receiving this choice, 8 (21%) chose this option.

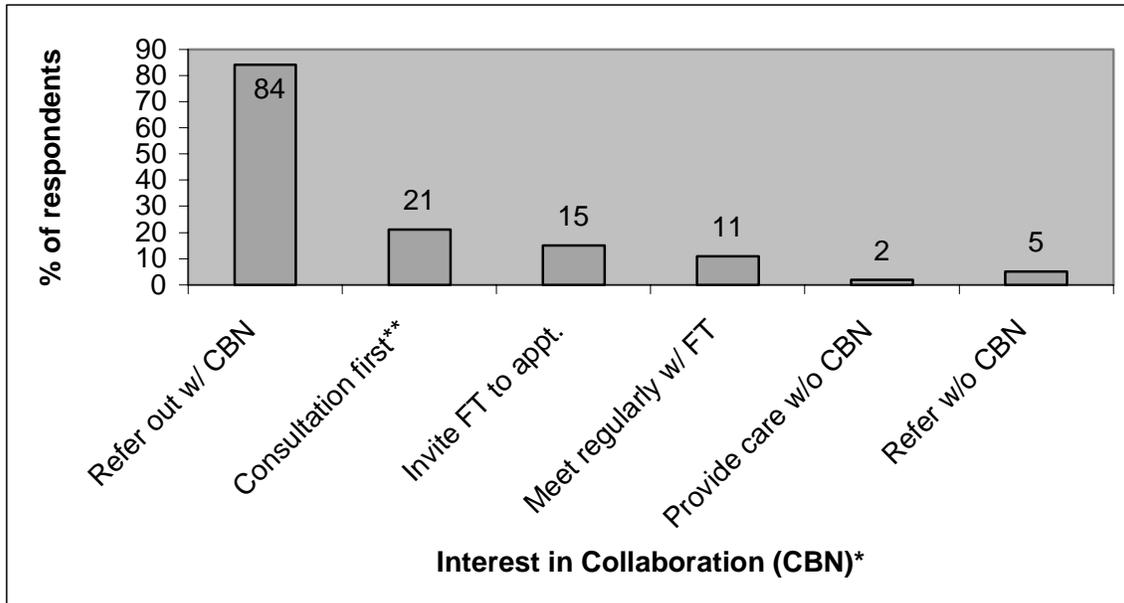


Figure 12. Participants’ interest in select forms of collaboration (CBN) with Family Therapists. \*Participants asked to check all that applied. \*\*N=38 for this variable because 99 participants did not receive this choice on their survey. N=137 for all other variables in this table.

Using a content analysis procedure to analyze the qualitative responses accompanying this question (N=7), two categories emerged—preferred forms of collaboration and physician experienced barriers (Table 4). Within the category of preferred forms of collaboration, two respondents indicated they were interested in inviting a family therapist to a medical appointment but felt they were limited by time, two respondents reported satisfaction with the current form of collaboration (i.e. mental health record included in medical record), and two respondents indicated an interest in receiving feedback from therapists whether in email form, conference calling, or progress note. All four of the comments identifying barriers to collaboration referred to time.

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Table 4

Interest in Collaboration (CBN) with Family Therapists

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Interest	<i>f</i>	%	Example
Preferred Forms of CBN	6	86	“...interest is there [inviting family therapy provider to med. appt.]”(2) “Email or perhaps conference calling with LMFT and pts when appropriate” “Would prefer updates/progress reports regarding patients referred out for therapy”
Barriers	4	57	“No time...”(4) “...less by insurances (especially reimbursement if capitated).”

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Note. N=7. Often 1 participant made more than one comment.

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What Would Make FTs a More Helpful Resource?

A final open-ended question was added to the survey in order to enhance the data obtained. This question also allowed for final comments and suggestions: Please take a moment to briefly describe what would make marriage and family therapy providers a more helpful resource for you as a family physician when treating patients with complex psychosocial issues OR if you don't consult with a marriage and family therapist, why not? Sixty-five percent of all participants (N=89) responded to this question, and a content analysis produced six primary themes: (1) Ideal Collaborative Practices, (2) Barriers to Referral, (3) MFT Specialty Awareness, (4) Let Us Know Who You Are, (5) Barriers to Collaboration, and (6) FP Attitudes Towards MFT. Table 4 represents these findings.

Ideal collaborative practices. Fifty-four physicians (61% of the 89 respondents) described collaborative practices that would make family therapists a more helpful resource (Table 4). These included “Proximity” (10%--“I wish I had a family therapist in my office”); “Ease of Referral” (15%--“Be available to my patients within 2 weeks of the request,” “Ones that would work out payment with indigent patients”); “Collaborative Communication” (21%--“More communication after [patient] evaluation” “Regular feedback”); “Topical/Specialty Information” (11%--“Suggestions on what I can do to help further the therapeutic goals...” “a specialist who could incorporate issues related to aging...”); and “Religious/Faith-Based” (3%--“Faith-based, a plus!” “I would like to work with a Christian marriage and family therapist”).

Barriers to referral. Thirty-three responses fell into the next most common theme: “physicians-faced barriers to MFT referral” (37%; Table 5). Within this category, sub-themes of “Patient Reluctance” (N=4; “Primary obstacle is patient resistance”); “Managed Care” (N=7; “Many patients don’t have mental health coverage”); “Don’t Know the Therapist” (N=2; “...hard to refer when don’t know therapist”); and “Availability” (N=19; “Therapists not available in my rural area”) were identified through content analysis. Examples of Patient Reluctance are “Difficulty convincing patients that therapy can help them and sometimes even that there is a problem” and “Primary obstacle is patient resistance.” Managed Care roadblocks were reflecting in statements such as “I do use other therapists when driven by insurance,” “many patients don’t have mental health coverage/can’t afford,” and “Have no idea how to identify therapists appropriate to patient insurance...” Two physicians made known their challenge of referring patients to therapy when they “haven’t met or [don’t] know the LMFT”. Two subcategories emerged in the theme of Availability. Five of the 19 respondents indicating Availability as a barrier to MFT referral reported a rural or small town limiting the resources available (e.g. “Therapists are not readily available in my rural area.”). The other subcategory referred to the lack of marriage and family therapists (e.g. “If one were more readily available, this would be an excellent resource” and “The only limiting factor for utilizing one is availability”). Only 1 of the responses indicated that they encountered no barriers to referral (see Table 5).

MFT specialty awareness. Fifteen responses fell into the “MFT Specialty Awareness” theme. Twelve respondents (13%) described either being completely unaware of MFT as a distinct field or being unclear on the professional role of an FT (“I didn’t know there was a family/marriage therapy specialist.”). Many asked for more information about family therapists and what types of services they provide. Some indicated that they had not differentiated between the various MHPs that they worked with (whether they be social workers, psychologists, family therapists, etc.). Only 3 respondents (3%) reported an awareness of MFT, a consequence of personal contact with therapists (“I’m married to a family therapist;” Table 5).

Let us know who you are. Fourteen responses (16%) fell into the “let us know who you are” theme by indicating that they were either unaware of any family therapists in the community or had had no professional contact with any of them (Table 5). Seven of the 14 respondents in this theme indicated that they are more likely to work with therapists they had met and suggested that meeting face to face or being personally introduced to the family therapists in the community would be helpful.

Barriers to Collaboration. Thirteen responses fell into the “Another Barriers to Collaboration (CBN)” theme (15%). Time (n=3; “Unfortunately we seem to have less time to [collaborate]”); Managed Care (n=4; “HMO...typically listed an 800# to call...made communication very difficult between the anonymous therapist and I”); Lack of Therapist Feedback (n=2; “Helpful to get reports back from therapists, but it often doesn’t happen—”); and Interest (n=4; “I like to refer but don’t necessarily feel I need to receive reports”) were subcategories of this common theme (Table 5).

Family Physician Attitudes. Twelve responses fell into the “FP Attitudes” regarding marriage and family therapy theme (13%). Seven responses in this theme had positive overtones (8% --“They are already a helpful resource for me—I can’t think of any way to improve this presently”). Two responses suggested an uncertain or even negative mind-set towards marriage and family therapy (2%-- “...most of the MFT people only have a Master’s...for more complex cases, I might choose [a] psychiatry or doctoral psychology background”). Three others made reference to the importance of a philosophical fit (3%--“I would be much more favorable to LMFTs if their professional

organization made some public declaration that the institution of marriage and family have an absolute value as the foundational piece of a civilized society”).

Table 5

Response to Final Open-ended Question: Increasing FT Helpfulness

Qualitative Variable	<i>f</i>	%	Example
1. Ideal Collaborative Practices	54	61	
Proximity	9	10	“Have their practice locally” “.. I wish I had a family therapist in my office.” “If I were in private practice, I would have a full time therapist on staff to see pts.”
	<i>f</i>	%	Example
Qualitative Variable			
Ease of Referral	13	15	“Be available to pt. Within 2 weeks of the request”(3) “Better HMO/Insurance coverage...” (7) “...ones that would work out payment...”(3)
Collaborative Communication	19	21	“Follow up/consult letters would be great”(19) “Specific resource list identifying FT’s area of interest” “I prefer to let the therapist discover what the issues are...I have found it useful to fill in the therapist after the first visit...”
Topical/Specialty information	10	11	“Suggestions on what I can do to help further the therapeutic goals...” “Suggestions to help patients (especially men) overcome stigma associated with undergoing counseling” “Great need for parenting skill education”
Religious affiliations	3	3	“Faith-based, a plus”

*(table continues)*

Table 5 (continued)

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2. Barriers to referral	33	37	Example
Patient Reluctance	4	4	“Primary obstacle is patient resistance”
Managed Care	7	8	“Have no idea how to identify therapists appropriate to patient insurance ...” “The main roadblock is reimbursement. Pts. cannot/will not pay 80% or more of the cost of counseling.” (5)
Don’t know therapist	2	2	“It’s hard referring someone when you haven’t met or [don’t] know the LMFT”
Availability	19	21	“Therapists are not readily available in my rural area” “The only limiting factor for utilizing one is availability”
No barriers	1	1	“No problem with referrals in this town”
3. MFT Specialty Awareness	15	17	
Unaware/Unclear of field	9	10	“I didn’t know there was a family/marriage therapy specialist.” “Becoming more familiar with available local mental training/certification(s) would be helpful.”
No differentiation b/n MHP	3	3	“Really we don’t know about training or experience of each staff.”
Personal awareness	3	3	“I’m married to a family therapist.”

*(table continues)*

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Table 5 (continued)

4. Let Us Know Who You Are	14	16	Example “Probably meeting face to face [would be helpful]” “My biggest barrier in referring patients is mainly due to not knowing any of the therapists in the area.”
5. Barriers to Collaboration (CBN)	13	15	Example
Time	3	3	“Time constraint is major roadblock in CBN with LMFTs”
Managed Care	4	4	“...HMO...typically listed an 800 # to call. This made communication very difficult between the anonymous therapist and I.”
6. FP Attitudes	12	13	Example
Positive	7	8	“I am a true believer in working with family therapists. I think they are great!”
Negative/Uncertain	2	2	“Uncertain of evidence supporting efficacy”
Desire Philosophical fit	3	3	“Knowing the general tenor of their counsel—e.g. divorce is a poor long-term solution to many problems in marriage.”

Note. N=89. Participants often gave more than one response.

While a few of these participants did indicate a lack of interest in collaborating, nearly 30% of all valid survey responses contained a request for a summary of the final results.

## CHAPTER V: DISCUSSION

The purpose of this research was to explore family physicians' current perceptions and experience of collaboration with family therapists (FTs). To accomplish this, a questionnaire was developed to explore the following areas: the extent of psychosocial concerns in patient care perceived by family physicians as well as the limitations they face in addressing these concerns; their mental health referral practices and the barriers to marriage and family therapy (MFT) referral; their awareness of the specific field of MFT; and their current experience and/or interest in collaboration with FTs. To add richness to this data, an open-ended question was included. Here participants commented further on their experience with or interest in collaborating with FTs. Phenomenological theory guided this study as the researcher focused on gaining insight on the participants' experiences with the goal of building an interdisciplinary bridge between the field of family medicine and family therapy.

Two hundred forty randomly selected FPs received this nation-wide survey via the US postal service. After two mailings, 153 (64%) returned a completed survey, and 137 of these responses (57%) met the research criteria for inclusion in this study. Data were analyzed using both quantitative and qualitative methods. For the quantitative analysis, a variety of descriptive statistical methods were employed. Qualitative data were analyzed using a content analysis method. While the quantitative and qualitative data were presented in the previous chapter, this chapter will summarize the study's findings, discuss the study's potential limitations, describe the clinical implications for FTs, and present implications for future research.

### Summary of Findings

#### Primary Themes

Four major themes emerge in this study and enhance our understanding of FPs' views of collaboration with FTs: (1) Many family physicians (FPs) do encounter psychosocial concerns in patient encounters but face limitations to their adequate exploration; (2) There is a considerable gap between the percent of patients FPs identified as potentially needing MFT and the percent of patients actually referred to MFT; (3) FPs have limited ability to identify FTs in the community; and (4) Collaboration with FTs is desired by FPs but is limited in its occurrence.

### Detection of Psychosocial Concerns

It appears that most FPs are attuned to patient psychosocial concerns and are thinking systemically. On average, the participants estimated that nearly 40% of their patient encounters involved psychosocial concerns. On average, respondents estimated that 30% of these patient encounters that ultimately involved psychosocial concerns were not the initial reason for the medical visit. Furthermore, more than 80% of the respondents estimated that a patient's presenting medical complaint could be related to or exacerbated by family/marital/relational stress almost all the time or frequently. It is interesting to note the discrepancy between participants' estimate of patient encounters involving psychosocial concerns (40%) and the high estimate that their patients' presenting medical complaint could be related to relational stress (80%, almost all the time or frequently). This may mean that FPs suspect a greater occurrence of patient psychosocial concerns than they feel they can confidently report. This discrepancy identified here could be further explored in future research.

On average, respondents estimated that 48% of their patients would benefit from MFT, and 25% of these respondents estimated that 75% or more of their patients with psychosocial concerns could benefit from MFT. Based on these responses it seems that FPs are encountering patient psychosocial concerns in their medical practice and believe in the value of MFT. This is congruent with the literature that emphasizes the biopsychosocial, systemic approach of family medicine and the significant nature of the FP-patient relationship that makes room for the discovery of patient psychosocial concerns (AAFP, 2003; Ballenger & Alpert, 1998; Epperson, 1999; Jackson & Tisher, 1996). As Jackson and Tisher (1996) and Ballenger and Alpert (1998) suggest, it seems that the unique relationship of FPs with their patients increase the likelihood that patients will turn to their FPs with psychosocial concerns. This is not to say that FPs are the sole referral agents to mental health care. While this study focused on FPs, other PCPs as well as oncologists and obstetrician/gynecologists are also known for their long-term relationship and supportive role with their patients.

### Limitations to Addressing Psychosocial Concerns

However, despite the nature of the FP/patient relationship, FPs reported barriers to addressing the psychosocial concerns. Based on the literature, it is not surprising that 98% of the respondents identified one or more limitations that inhibit them from adequately exploring psychosocial concerns of patients in an average appointment. Time, reimbursement, HMO restrictions, patient reluctance, experience, training, and interest were all identified by the respondents as problematic limitations to providing ideal psychosocial care for their patients. These limitations were also cited in several studies (Belzar, 1999; Christie-Seely, 1981; McCulloch, Ramesar, & Peterson, 1998; Rosenthal, Shiffner, & Panebianco, 1990; Rogers & Walsh, 1994; Tomson & Asen, 1987; Williams, Rost, Dietrich, Ciotti, Zyzanski, & Cornell, 1999). The two limitations most often cited in this study were time and reimbursement. As Tomson and Asen (1987) suggested, physicians identify time as a primary limitation to incorporating MFT skills into their patient care. Likewise, the AAFP (2003) position paper on FP delivered mental health care emphasizes that physicians are often reimbursed only partially or not at all for providing mental health care). Patient reluctance, also common in the literature, was a close third while a lack of referral sources was emphasized in the qualitative responses in the current study. Rogers and Walsh (1994) validate these findings also identifying patient reluctance and lack of referral sources, as well as managed care, time, and skill as deterrents to exploring patient psychosocial concerns.

### Referral Practices

Since FPs are detecting mental health needs in their practice but are limited by several factors to adequately explore these needs, it seems likely that they would seek referral to address these patient needs. While family medicine literature does recommend referral for family therapy, this study identifies a wide gap between the detected need for MFT services (48%) and the estimated percent respondents actually refer to MFTs (5%). Surprisingly, respondents report that they refer only 12% of their patients to MHPs and only 5% of their patients specifically for marriage and family therapy-related care. The roadblocks to referral identified in both the quantitative and qualitative data are congruent with of the roadblocks identified in the literature. Williams, Rost, Dietrich, Ciotti,

Zyzanski, and Cornell (1999) reported that cost, lack of referral resources, inadequate feedback from MHPs, and managed care place limitations on MFT referral. Personal communication with physicians added additional emphasis to the roadblock of HMO/managed care (M. Perez, September, 2002). The most frequently identified roadblocks in the current study are patient reluctance, HMO/Insurance restrictions, and Unaware/ Unavailability of appropriate therapist. The qualitative responses add another layer to therapist factors suggesting that a lack of appropriate therapists in particularly rural areas is a roadblock to MFT referral. Similarly, in their study on rural physicians' referral practices, Rost, Humphrey, and Kelleher (1994) identified that rural physicians face difficulties when referring patients to mental health specialists. One conclusion of their study was that there is a limited number of mental health providers in rural areas (Rost, Humphrey, & Kelleher, 1994). In the current study, a few respondents more specifically identified a lack of FT cultural diversity when working in areas more densely populated with non-majority patients. Likewise, MFT educators and other leaders in the field acknowledge the growing diversity in the United States and the importance of increasing the "cultural competence" of the field's professionals (Hastings, 2002). It would be interesting to discover if those physicians who are unaware of appropriate MFT referral resources find it more difficult to reduce patient reluctance to MFT.

#### Awareness of the Field

This study suggest that while FPs are aware that there are professionals trained specifically to treat psychosocial concerns from a family systems perspective, there is limited awareness of how to identify these professionals. Sixty-four percent of FPs did not recognize "LMFT" as credentials for licensed marriage and family therapists prior to this study and over 50% reported that they either had not or were not sure if they had interacted with an LMFT for a patient-care consult. Researchers in neither fields have examined FPs referrals to LMFTs which may explain the limited awareness of MFT and LMFTs in this study. The findings of the current study may also suggest that FPs need to be better informed of the nature and availability of family therapy for their patients. Interestingly, 33% of qualitative responses in the final questions of this survey indicate that FPs would like to be better informed. Respondents indicate they would like FTs to

introduce themselves, reporting that it is hard to refer to therapists they have not met, and ask for more information about the field. It may be that FTs need to respond to one participant's appeal: "Let us know you're out there."

### Current Family Physician/Family Therapist Collaboration

Certainly literature in both fields is calling for collaboration between FPs and FTs to provide comprehensive, systemic care for the patient families (Candib, 1983; Dym & Berman, 1986; Harkness & Nofzinger, 1998; Rabasca, 1999). Kriesel and Rosenthal (1986) present a model to encourage and facilitate collaboration between FPs and FTs. Candib (1983) discusses an apparent rift between the field of family medicine and MFT and suggests that collaboration could enhance patient care while reducing their number of office visits. McDaniel and Campbell (1986) discuss the "cultural" and attitudinal barriers to FP/ FT collaboration with the hope of promoting further discussion and effort towards effective collaboration. However, I have found no studies that discuss the actual extent and type of collaboration between FPs and FTs except those that were conducted in collaborative training programs such as the family medicine residency program at the University of Rochester (Harkness and Nofziger, 1998; Seaburn, Gawinski, Harp, McDaniel, Waxman, & Shields, 1993) and the family systems health care program at Nova University in Florida (Muchnick, Davis, Getzinger, Rosenberg, & Weiss, 1993).

Despite the call for collaboration in the literature, less than 50% of the participants in this study identified collaborating with a FT. Furthermore, less than 50% of the participants in this study identified any one form of collaboration that they currently experience. The most frequently identified form of collaboration was infrequent reports (49%) obtained from FTs. The participants' qualitative responses were congruent with these findings. Sixty-four percent of the participants stated that they received little or no feedback from FTs after they referred a patient. Similarly, the literature focusing on FP referral to MHPs is congruent with this finding often linking FP dissatisfaction with the referral process to the lack of feedback or communication from the MHP (Kainz, 2002; Kushner, Diamond, Beasley, Mundt, Plane, & Robbins, 2001; Rost, Humphrey, & Kelleher, 1994; Williams, Rost, Dietrich, Ciotti, Zyzanski, & Cornell, 1999). Kainz's study (2002) shows that 83% of the surveyed PCPs indicated that a "summary of

treatment routed to the physician” (p. 173) would be of “great” or “moderate” importance when deciding to refer to a particular psychologist.

Nevertheless, 82% of the participants in the current study indicated that the patient-consults they had with FTs were either very or somewhat helpful. Several, however, wrote in the margins that they could not respond to this since they never received feedback from FTs. Kainz (2002) proposes in her study with PCPs and psychologists, that the psychologist take a more assertive, active role in the initiation of collaboration. The data gained in this study may give FTs a clearer picture of the first steps they can take towards effective collaboration.

### Interest in Collaboration.

Despite the lack of feedback, most participants in this study indicated an interest for some form of collaboration. The most commonly indicated mode of collaboration was referral out with continuing collaborative communication (84%). Some participants also were interested in a more intensive form of collaboration (meeting regularly with an FT or inviting an FT to a medical appointment; 26%), but often noted that time was a limiting factor. It seems that while there are many roadblocks to FP/FT collaboration, the interest and need is there, according to respondents.

### Suggestions for Collaborative Practices

Nearly two-thirds (65%) of the participants responded to the optional, open-ended question at the end of the questionnaire, often with more than one comment. Their responses were rich with implications for FTs and future collaborative practice. They gave 54 practical suggestions for ideal collaborative practices corresponding with and adding depth to the literature on FP/MHP collaboration. The most frequently occurring suggestion for improved collaboration with FTs was more communication. This is in agreement with the literature which identifies the lack of communication from MHPs as a major barrier to referral and/or collaboration (Kainz, 2002; Rost, Humphrey, & Kelleher, 1994). Personal communication with physicians has also reinforced these findings.

Participants also offered suggestions for easing the referral process. Lag time between referral to mental health and the scheduled appointment was one limiting factor noted by Reust, Thomlinson, and Lattie (1999) in their study examining patient follow-

thru on mental health referrals. Participants in the current study made this same observation. For example, one physician stated that it would be helpful if the FT could “be available to my patients within two weeks of the request.” Other participants indicated that if FTs could adjust their fees for patients with minimal financial resources or increase their third party coverage, often reducing patient reluctance, more of their patients could benefit from the FTs services. One participant reported that when a patient’s insurance will not pay for family counseling, they refer for individual counseling. Likewise, literature frequently identified patient reluctance, cost, and managed care as barriers to referral and collaboration (Williams, Rost, Dietrich, Ciotti, Zyzanski, & Cornell, 1999). In Reust, Thomlinson, and Lattie’s (1999) qualitative research, the primary reason identified by clients for not keeping mental health appointments was financial concern. Certainly, the MFT profession faces challenges in the world of private and public managed care, and it is not uncommon for FTs to choose a fee-for-service payment schedule. Perhaps greater discussion could be generated in the MFT field considering creative and flexible options in order to provide care for clients with minimal financial resources. One initial idea would be for MFT training programs with sliding scale fees to make the area physicians aware of their services and desire to collaborate.

Participants also wrote that it would be helpful if FTs would offer information on specific psychosocial issue. Most commonly, participants identified a need for information on how to reduce patient reluctance to MFT as well as information on the specific services offered by the local FTs. It seems that FTs could use this suggestion as an opportunity to introduce themselves to the local FPs especially those whose patients they are already counseling. At this time, FTs could communicate their desire to collaborate and include their business card, rolodex insert, and brochure describing their areas of specialty. A brief fact sheet for FPs on reducing patient reluctance to mental health referral could also be advantageous for both the FP and the FT, and even the patient. Other fact sheets may also be helpful addressing common patient psychosocial concerns faced by the FP. Rabasca also (1999) reports how several FTs built their practice by initiating this type of collaboration with area PCPs. Many participants also desired to have an on-staff or on-site FT to collaborate with. Yet, if FTs can initiate

collaboration in these ways, other barriers identified by FPs, such as a lack of proximity and an unawareness of FTs who offer faith-based counseling, may be lessened.

Some respondents reported that they would like to collaborate, but cited several barriers congruent with overall survey responses and current literature. Lack of availability was the most frequently occurring barrier to referral, and many noted that their rural community lacked MFT referral resources. As mentioned before, Rost, Humphrey, and Kelleher's (1994) study also made this observation. Another common request was for FTs to make themselves known to the FPs so that they would be able to identify them for referral and feel comfortable referring to them. One respondent in the current study wrote that it is "hard to refer to someone I don't know." A recent study by Kainz (2002) on physician-psychologist collaboration also reports FPs' preference to have a friendly relationship with the psychologist before referring patients. FTs should also consider the implications this research has for collaboration with other healthcare specialists such as nurses, oncologists, and obstetricians/gynecologists who may also encounter frequent patient psychosocial concerns.

Finally, one physician suggested that the more important work of FTs is to move towards "helping the system [family healthcare] work as a unit." Perhaps this would repair the gap between the two fields identified by Candib and Glenn (1983) and Kriesel and Rosenthal (1986). Like this respondent, these researchers suggest that both fields have something to offer the other and may need to rethink their biases that inhibit collaboration.

#### Limitations

While this study has produced valuable data, it is important to be mindful of the potential limitations when interpreting results. Although a survey research design is an appropriate method to explore the opinions and practices of a sample, this design carries its own limitations. The potential ease of the survey research method is both a strength and a weakness. While a large amount of data can be gathered in a relatively short amount of time, Nelson (1996) notes that each step must be carefully guarded against carelessness and lack of attention to error that would confound the results. Furthermore, survey research can be "... difficult to replicate..." due to the uncontrolled processes of the respondents (Nelson, p. 462). Also, the more structured form of a survey may limit

the respondents' ability to share their experience. Also, the validity and reliability of the instrument used in this study is unknown. Since this is an exploratory study, and based on a collective account of many respondents, it is important that the report remains focused on the descriptive results rather than attempting to interpret meaning. Advantageously, however, the qualitative components of the survey added depth and definition to the quantitative results,

Moreover, while the size of my sample is sufficient enough to produce a confidence interval of about  $\pm 6\%$  (Rea & Parker, 1997), it is still a relatively small sample compared to a population of over 53,000 FPs. Thus, readers should consider the margin of error when interpreting results.

Lastly, this study's response rate (64%) is remarkable for an often elusive population (Maheux, LeGault, & Lambert, 1989; VanGeest, Wynia, Cummins, & Wilson, 2001). In a carefully designed study of the response rates of FPs, Everett, Price, Bedell, and Telljohann (1997) mailed out 300 surveys to FPs with a monetary incentive (experimental group) and 300 surveys without a monetary incentive (control group). While the methods of their study and survey design were quite comparable to this research design, they received a 63% response rate from the experimental group (with monetary incentive) and a 45% response rate from the control group (no incentive). Nevertheless, consideration must be given to the potential non-respondent bias (Everett, Price, Bedell, & Telljohann, 1997; Maheux, LeGault, & Lambert; 1989; Nelson, 1996). Whether nonresponders differ in some systematic way from responders is unknown. For example, participants with a greater interest in the research topic may have been more likely to respond, thus creating a response selection bias. However, since this population tends to have much lower response rates than most populations, and this survey generated a remarkably high response rate for the population, it may be inferred that there is a considerable interest in the research topic, thus adding emphasis to the study's findings. However, it should be noted that the demographics of the respondents appear to be comparable to those of the population.

Another limitation important to note is the lack of national uniformity for FT credentialing. Not all states use "LMFT" to designate a licensed marriage and family therapist, and four states currently do not recognize FTs as official mental health care

providers. While the questionnaire in this research asked about FPs' collaboration with "LMFTs or other comparable professionals," it is not clear how this lack of national uniformity affected the participants' responses.

#### Implications for Clinical Practice and Clinical Training

This study offers significant implications for clinical practice and clinical training. The qualitative responses from participants are an invaluable component to this research. Many suggestions were offered to FTs in order to make marriage and family therapy providers a more helpful resource. FTs can learn from this input that they need to increase the awareness of FPs in their community on the field of MFT as well as the specific services that they are able to offer to both the FP and the patient. Family therapists can also learn that FPs desire to collaborate, but that they need to be proactive in introducing themselves, learning the medical culture of collaboration, and working on creative and flexible approaches for enhancing the ease of referral. For example, as part of the larger medical healthcare system culture, specialists routinely send progress notes to the referring physician. FTs need to consider themselves as part of this system and consistently return brief feedback to the referring physician. Due to confidentiality constraints, this may mean learning to obtain a release from the client for the referring physician during the intake session. This would also be a good opportunity to explain the concept of collaboration to the client. If the client declines to release information, the FT could send a brief note acknowledging and thanking the FP for the referral.

Perhaps this study's findings will also facilitate the FTs to consider their own potential biases that might get in the way of successful FP/FT collaboration. As McDaniel (1990) illustrates, stereotypes that both FPs and FTs have of each other based on professional culture differences often inhibit effective communication and collaboration. After a lively vignette of an over-stereotyped FP to FT referral, McDaniel concludes that "Recognizing and appreciating our differences can facilitate collaboration and reduce miscommunications..."(p. 4; 1990). Another example occurred at an MFT training clinic in which a trainee hesitated to call a client's physician, but then described being very surprised at the physician's family systems insight and strong advocacy of family therapy for the patient.

There are similar implications for clinical training. The field of MFT should look for ways to bridge the gap between these two compatible fields. This could occur in training programs, professional associations, professional journals, and community interactions. It may be that MFT training programs could add a component of collaboration training in their curriculum. William Doherty (March 22, 2003, personal communication) stated that professionals most often collaborate with whom they train or know personally. For example, I became interested in the potential collaboration between FPs and FTs due to my personal and professional experience with FPs. Being married to a FP has provided me a unique opportunity to gain a better understanding of the nature of family medicine and to interact on a frequent basis with other FPs. It was through these conversations that I began to consider research and practice that would bridge an apparent gap between the two fields.

However, not all FTs are in this unique position. A collaborative component should begin at the earliest point possible in MFT training. If MFT training programs offer more tools for their graduates to interact with health professionals from other disciplines, it is likely to carry over into their professional work. Furthermore, the MFT field itself should look for opportunities to interact with the field of family medicine. For example, AAMFT could offer a workshop at an AAFP conference or invite an FP to present at an MFT conference. FTs could publish in family medicine journals more frequently and could also offer brief workshops or grand rounds to the FPs in their community.

Finally, FTs and MFT administrators should learn an effective marketing approach to managed care corporations. It is important to recognize that many barriers identified in this study will remain until there is significant policy change in the healthcare system. However, as FTs learn to bridge the gap with FPs, it is possible that FTs and FPs will also learn to work together to promote collaborative marketing and advocate for effective policy change.

#### Future Research

More research is needed to increase our field's awareness of the current collaboration occurring between FPs and FTs. Successful collaboration between FPs and FTs should be further examined to better understand what variables and characteristics

increase the likelihood of successful collaboration. It also may be interesting to discover what biases MFT trainees and trainers currently have about FPs and their interest in collaboration. For example: What beliefs do FTs trainees have about FPs interest in collaboration? Or What characteristics of FTs contribute to their likeliness to initiate collaboration with FPs? Another member of the collaborative triad, the patient, could also offer opinions and experiences regarding the helpfulness of collaboration. Moreover, the patient's perspective of the risks/benefits of their FP and FT working together may also be an integral component to the current literature.

This study also identified several barriers to MFT referral and collaboration. Research investigating ways to increase FPs ability to reduce patient reluctance, as well FPs' experience and understanding of patient reluctance, may be useful. Concepts in family therapy such as stages of change, motivational interviewing, and effectively linking a physical complaint with a systemic/relational issue can be taught to FPs and subsequently examined for their efficacy in decreasing of patient reluctance. Research should also be conducted to discover variables and characteristics associated with effective MFT referrals. It is possible that the more successful FPs feel about making MFT, the more often they will make them. Additionally, research should be done to learn what methods of advertising and networking is most useful in increasing FPs awareness of the MFT field and practitioners. It would be valuable to learn more about FPs' understanding of the MFT field and what FTs are trained to do. Finally, research should also continue in the area of cost-effectiveness for family therapy as a component of preventative healthcare. Health management corporations must be convinced by outcome-based research that MFT is a cost-effective way of providing healthcare, ideally reducing the managed care roadblock FPs face when referring to FTs.

Despite the barriers and limitations identified in this study, the findings suggest that FPs feel that many of their patients could benefit from MFT and are interested in collaboration with FTs. It is the hope of the researcher that this study will continue to generate interdisciplinary discussion that bridges the gap between FPs and FTs, helps these professionals work more closely together, and ultimately promotes more continuous, effective care for the patient/client.

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## APPENDIX A: COVER LETTER

7054 Haycock Road  
Falls Church, VA 22043

A. B. ABCD, MD

2222 Franklin Ave.

Motown, NH 33331-3211

*Last patient of the morning. Complaint: stomach pain. You ask if there is anything going on in her life that might be producing stress. She nods, tears forming. Says that, recently divorced, she has been trying to play both parenting roles for her two teenage children as well as work overtime in hopes of making a little extra money....  
My study explores how family physicians deal with situations like this.*

Dear Dr. ABCD:

As a graduate student in Marriage and Family Therapy, I invite you to participate in a national study conducted as part of my Master's thesis research at Virginia Tech's Northern Virginia Center. Attached you will find a questionnaire examining the extent of psychosocial care you find yourself providing for your patients, the limitations you encounter to adequately provide this care, and your awareness of family therapy as a resource for providing mental health care from a biopsychosocial perspective. The goal of this study is to facilitate the collaboration between family physicians and family therapists. It is my hope that patients will benefit from this study as both family physicians and mental health professionals work together to provide them with integrated, whole-person care.

So, please don't throw this out! Since the validity of the results depends on obtaining a high rate of response, your participation is crucial to the success of my survey. Your answers will be kept in strict confidence and your identity will not be revealed at any time. The number on the survey is to assist me in making follow-up mailing. There are no anticipated risks or compromising situations for you as a participant. *This research has been approved by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic Institute and State University and by the American Academy of Family Physicians' Division of Research and Information Services.* By your returning this questionnaire you are indicating that you consent to participate in this study.

A summary of my findings will be available to you, upon your request, at the conclusion of this research. If you have any questions about this research, please contact me at (703) 426-9664 or my research supervisor, Dr. Karen Rosen, at (703) 538-8461.

Pre-test participants found that it took them **under 5 minutes** to complete this survey. I am looking forward to receiving your response within two weeks. Please accept my great appreciation for your participation in my thesis research.

Sincerely,

Rebecca E. Clark

Graduate Student Researcher

Virginia Tech, Northern Virginia Center

APPENDIX B: QUESTIONNAIRE

Perceived Need of Family Physicians for Their Patients to Receive Family Therapy-Related Care.

Please check ✓ an answer for each question

I. Demographics.

Age: \_\_\_\_\_
Sex: M \_\_\_\_\_ F \_\_\_\_\_
Years of Practice: \_\_\_\_\_
Is at least 50% of your professional time spent in direct patient care? Y \_\_\_\_\_ N \_\_\_\_\_
Board Certified in Family Practice: Y \_\_\_\_\_ N \_\_\_\_\_
Your residency staff included non-MD mental health professional(s) Y \_\_\_\_\_ N \_\_\_\_\_

II. Psychosocial Needs in Patient Care

Please estimate the percentage of patient encounters in which you detect significant psychosocial concerns. \_\_\_\_\_%

Please estimate the % of patient encounters that ultimately involved psychosocial concerns although those concerns were not the presenting complaint \_\_\_\_\_%

How often do you think a patient's presenting medical complaint could be related to or exacerbated by family/marital/relational stress?

Almost all the time \_\_\_\_\_
Frequently \_\_\_\_\_
Sometimes \_\_\_\_\_
Hardly Ever \_\_\_\_\_

Please estimate the % of your patients with identified psychosocial concerns that you feel could benefit from marital and/or family counseling \_\_\_\_\_%

What are the LIMITATIONS you encounter to adequately exploring psychosocial concerns of individuals/families in an average appointment (Please ✓ as many that apply).

Time \_\_\_\_\_
Reimbursement \_\_\_\_\_
HMO Restrictions \_\_\_\_\_
Patient Reluctance \_\_\_\_\_
Experience \_\_\_\_\_
Training \_\_\_\_\_
Interest \_\_\_\_\_
None \_\_\_\_\_
Other (please specify) \_\_\_\_\_

III. REFERRAL for Mental Health Care

Please estimate the percentage of your patients whom you REFER for mental health services \_\_\_\_\_%
Please estimate the percentage of your patients whom you refer specifically for couples &/or family counseling \_\_\_\_\_%
Roadblocks encountered when REFERRING patients for marriage and family therapy-related care (✓ check as many that apply).

Time \_\_\_\_\_
Managed Care/ Insurance Restrictions \_\_\_\_\_
Unaware of appropriate therapists in community \_\_\_\_\_
Unavailability of appropriate therapists in community \_\_\_\_\_
Patient Reluctance \_\_\_\_\_
Don't feel this type of therapy is helpful \_\_\_\_\_
Other (please specify) \_\_\_\_\_

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**I.V. Awareness of Marriage and Family Therapy**

Among the many mental health professionals, are you aware that Marriage and Family Therapists (LMFTs) are mental health professionals “trained in psychotherapy and family systems, and licensed to diagnose and treat mental and emotional disorders within the context of marriage, couples, and family systems”(aamft.org)? Yes \_\_\_\_\_ No \_\_\_\_\_

Previous to receiving this survey did you recognize the initials “LMFT” as credentials for a Licensed Marriage and Family Therapist? Yes \_\_\_\_\_ No \_\_\_\_\_

**V. Attitude Towards Collaboration**

Have you ever consulted with a mental health professional regarding a patient case?  
Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever consulted a Licensed Marriage and Family Therapist (LMFT) regarding a patient/family? Yes \_\_\_\_\_ No \_\_\_\_\_  
Not Sure \_\_\_\_\_

Which best describes your patient-care contact with a marriage and family therapist or comparable professional in your community?  Check as many that apply.

Informal consultation with family therapist \_\_\_\_\_  
Phone call or e-mail family therapist \_\_\_\_\_  
Regular meetings with family therapist \_\_\_\_\_  
Regularly receive report on patient/family referred \_\_\_\_\_  
Infrequently receive report on patient/family referred \_\_\_\_\_  
No patient-care contact with family therapist in my community \_\_\_\_\_  
Other (please specify) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Based on your experience, how helpful have these patient-care consults been, in general?  
Very helpful \_\_\_\_\_  
Somewhat helpful \_\_\_\_\_  
Somewhat unhelpful \_\_\_\_\_  
Very unhelpful \_\_\_\_\_  
Not applicable \_\_\_\_\_

What best describes your interest in collaborating with an LMFT or comparable mental health professional when identifying psychosocial needs with your patients?  Check as many that apply

I need a consultation to decide \_\_\_\_\_  
I prefer to refer out with collaborative communication continuing between myself and marriage/family therapy provider \_\_\_\_\_  
I would be interested in meeting regularly with a marriage and family therapy provider regarding complex patients \_\_\_\_\_  
I would be interested in inviting a family therapy provider to a patient’s (s’) medical appointment to discuss psychosocial concerns \_\_\_\_\_  
I prefer to provide care w/o collaboration \_\_\_\_\_  
I prefer to refer out w/o collaboration \_\_\_\_\_  
Other (please specify) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please take a moment to briefly describe what would make marriage and family therapy providers a more helpful resource for you as a family physician when treating patients with complex psychosocial issues OR if you don’t consult with a marriage and family therapist, why not? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(cont. on back)

Please check this box if you would like a summary of the results. **THANK YOU!!!**  
**Please return survey in enclosed envelope OR FAX both pages to Rebecca Clark at (703) 538 – 8465**

## VITA

### **Rebecca E. Clark**

8514 Durham Ct.  
N. Springfield, VA 22151  
703.426.9664  
[reclark@vt.edu](mailto:reclark@vt.edu)

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### **EDUCATION**

**M.S., Human Development, 2003**  
Special Option in Marriage and Family Therapy  
Virginia Polytechnic Institute and State University  
Falls Church, Virginia

**B.A., Family Studies, 1998**  
Messiah College  
Grantham, Pennsylvania

### **CLINICAL EXPERIENCE**

**Family Therapist Intern** (May 2002-May 2003)  
*Inova Kellar Center* Fairfax, VA

***Intensive Family Therapy and Outpatient***  
Conducted ten-week crisis intervention therapy for adolescents and their families;  
Provided outpatient systemic therapy for couples, individuals of all ages, and families;  
Developed custom treatment plans, documented all forms of case management;  
participated in individual and team supervision; collaborated with other clinicians and  
physicians; participated in co-therapy with licensed professional. Received AAMFT  
approved supervision with Susan Ward, LPC, LMFT and Kelly McCracken, LPC,  
LMFT.

***Day Treatment Programs***  
Co-facilitated group therapy in adolescent day treatment program; documented each  
session for patients.

**Family Therapist Intern** (May 2001-May 2003)  
*Center for Family Services* Falls Church, VA

***Virginia Tech***  
Provided systemic outpatient therapy to individuals, couples, and families, developed  
case treatment plans, documented all forms of case management; coordinated therapeutic  
services; participated in co-therapy with other interns; observed/teamed with other's  
cases. Collected over 500 client contact hours and have received over 350 hours of  
supervision. Received live supervision from AAMFT approved clinical members.

**Family Therapist Intern/Group Co-Facilitator** (Spring/Summer 2001)  
*Franconia Youth Alcohol and Drug Services* Alexandria, VA

Co-facilitated multi-family groups for adolescents involved in substance abuse and their parents; participated in individual and family progress meetings as an intern; participated in individual and team post-group supervision; received AAMFT supervision from Dr. Eric McCollum, Virginia Tech.

**Family Support Specialist** (1999-2000)  
*Woodfords Family Services* Portland, ME

Provided in-home family support for youth with PDD and MR; developed and implemented long term goals and daily objectives as part of a team of social workers; worked one-on-one with youth in manner focused on building trust and creating a positive bond in order to progress in goals of daily living, social interaction, and personal care; documented case management.

**Teacher—5<sup>th</sup> grade** (1998-1999)  
*International School* Tegucigalpa, Honduras

Developed/taught curriculum for 54 students in bilingual Christian school; provided appropriate classroom structure as well as academic, social, and spiritual instruction. Participated in parent-teacher meetings in English and Spanish.

**Guidance Counselor—Junior High**

Gathered/recorded intake information in English and Spanish. Provided counseling for 7<sup>th</sup> thru 9<sup>th</sup> grade students in English.

## Volunteer Experience

**Red Cross Disaster Relief Training** 1999-2000  
*Portland Chapter of the Red Cross* Portland, ME

Completed emergency disaster relief training; served as emergency shelter volunteer; served as member of international social service committee.

**Emergency Relief Volunteer** (Fall 1998)  
*Hurricane Mitch relief work* Tegucigalpa, Honduras, Central America

Served as volunteer relief worker with several emergency service organizations (packing medicine, clothing, food; delivering food).]

## Professional Memberships

**Student Member**

American Association of Marriage and Family Therapy (2000-present)

Collaborative Family Healthcare Association (2001-present)

National Council on Family Relationships (1998-present)

**Certified Family Life Educator** (1998-present)