Family Therapy in Family Practice: A Solution to Psychosocial Problems?

Abe R. Fosson, MD, Carol L. Elam, MA, and David A. Broaddus, MSW
Lexington, Kentucky

The family physician can make advances toward helping parents and children with emotional or behavioral problems quickly and effectively in an office setting by gaining competence in family therapy. After learning to recognize several clinical presentations of families with behavioral and emotional problems, the physician can implement an abridged version of family therapy. This study suggests that a two-hour workshop on family therapy can increase physician awareness of the need to interact with dysfunctional families who present a child as the symptom bearer. The results also demonstrate that the actual clinical application of the therapeutic method may vary with physician's years in practice.

The family practice movement began with the commitment of placing the family into the center of medical care delivery.[1] A comprehensive approach was promised and, still envisioned by the American Academy of Family Physicians and the American Board of Family Practice, is reflected by their policy statement, "the family physician is educated and trained to develop and bring to bear in practice unique attitudes and skills which qualify him or her to provide continuing comprehensive health maintenance and medical care to the entire family regardless of sex, age or type of problem, be it biological, behavioral or social."[2] These highly desirable goals have been difficult to attain. Concern for the conspicuous absence of the family in the clinical practice of family medicine and in postgraduate training programs has been raised.[1] As a result, in family practice as in other medical specialties, the individual has remained the significant or exclusive focus of attention while the family is virtually ignored. In similar fashion the incorporation of behavioral science into the clinical application of family medicine has been difficult.[3,4] Although family medicine has enthusiastically welcomed behavioral scientists into their midst and verbally acknowledged the importance of physicians' sensitivity to patients' emotional responses, this area is frequently neglected in practice.[4]

The findings of Cassata and Kirkman-Liff's recent survey[5] are particularly disturbing. The practice style of graduates from a family practice training program emphasizing behavioral science

From the Departments of Pediatrics and Behavioral Science, the Division of Educational Development, and the Department of Social Work, University Hospital, University of Kentucky. Requests for reprints should be addressed to Dr. Abe Fosson, Department of Pediatrics and Department of Behavioral Science, College of Medicine, University of Kentucky, Lexington, KY 40536.

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were compared with practice habits of physicians trained in programs without this emphasis. Both groups estimated that 30 to 36 percent of their patients had psychological or behavioral problems as their fundamental diagnosis, but only 2 to 4 percent of their patient encounters were for counseling or resulted in a psychological referral.[5] This is essentially the same low level (3 percent of visits) of therapy for emotional problems provided by internists.[6] Given the low volume of behavioral medicine activity and the high level of need, continuing medical education programs designed to redress this discordance have been recommended.[5]

The counseling process that seems most relevant and adaptable to clinical medicine is family therapy. In family therapy the origin and persistence of psychophysiologic disorders, poor adjustment to physical disease, emotional disturbance, and conduct disorders are attributed to recurring dysfunctional patterns of interaction.[7] These sequences of interaction can be recognized in the physician's office when two or more family members are present. The dysfunctional interaction can be changed by instructing the family members to carry out simple tasks that are organized around the concerns of the family and structured to break up the dysfunctional sequence. If the tasks are properly designed and the family members sufficiently motivated by the physician, the presenting symptom is often eliminated in a few weeks.[8] On the basis of clinical impressions, family therapy is the response of choice for most adjustment problems of children and adolescents.[9]

In a continuing education seminar sponsored by the University of Kentucky Department of Family Practice, family physicians were instructed in psychological intervention through the use of family therapy. This study attempted to measure the impact of this educational effort on the attitudes and clinical activity of family physicians who elected the workshop when it was offered as a component of a general continuing medical education program.

The goals of this study were to (1) demonstrate that a two-hour workshop can increase the participating physician's awareness of the need to interact with families presenting a child with a psychosocial problem and (2) demonstrate that as a result of the workshop the participants will increase their clinical activity with dysfunctional families in their respective practices.

Methods

From February through June 1980, 56 persons participated in one of three "Psychosocial Evaluation of Kids" workshops held in conjunction with the Family Medicine Review meeting in Lexington, Kentucky. These workshops lasted two hours and included presentations by a physician and a social worker. A four-page handout detailing the therapeutic process was distributed at the beginning of the educational exercise. Concepts illustrated in the handout were reinforced by a one-hour slide presentation covering diagnostic categories, intervention strategies, and therapist-client communication styles. The workshop leaders enriched the presentation by citing cases, stimulating audience participation, and modeling effective therapist-to-client communication.

Following a discussion regarding this approach to family therapy training, the groups participated in exercises that involved formulating diagnoses and proposing intervention strategies for families presented by videotape. The selected tapes were recordings of the first five minutes of the initial interview with an actual family in a clinical setting. The cases were selected to illustrate the clinical application of the information provided during the didactic presentation. By stimulating group discussion, the tapes provided an opportunity to reinforce the participants' learning through immediate feedback.

After the first workshop presentation, 5 of the 18 participants were randomly selected for interviews. These physicians were asked questions using the grounded theory technique[10] to determine those significant concerns regarding use of the family therapy method that should be reflected in a survey instrument. Major concepts generated from the concerns expressed by the participants combined with items derived from the authors' experience and pertinent literature were used to develop a 20-item survey. The final survey instrument included questions addressing the topics of (1) session presentation, (2) attitudes toward family therapy, (3) utilization of the psychosocial evaluation system, (4) constraints in conducting therapy sessions in the office, and (5) desire for follow-up sessions. The Likert-scaled survey was supplemented by open-ended questions regarding the respondents' perceptions of this approach to family therapy and demographic data on their practices.

Table 1. Attitudinal and Satisfaction Ratings of Psychosocial Method (n=35)

Item	Rating (%)			
	Strongly Agree	Agree	Disagree	Strongly Disagree
Session reinforced need to interact with families who present child with psychosocial problem	54.3	42.8	2.9	0
Am better able to recognize family interaction problems	25.7	62.9	11.4	0
Am more aware of the impact of family interaction on health and behavior of children	34.4	54.3	11.4	0
Content of the session is a realistic approach to dealing with family therapy in my office practice	27.3	60.6	9.1	3.0
Believe families who present a child with a psychosocial problem could benefit from this treatment approach	20.6	76.5	2.9	0

Results

Two months after attending the session, 35 of the original 56 participants (63 percent) responded to the survey questionnaire. The sample size was adversely affected by 12 physicians leaving incomplete or incorrect forwarding addresses and by nonrespondents who did not reply to a second mailing or to telephone contacts.

Of the 35 physicians responding to the survey instrument, 34 characterized their practice as strictly family practice and 1 as obstetrics/gynecology. Nearly 40 percent of the physicians came from rural practices, with the remaining 60 percent coming from urban practices. Forty percent of the physicians had practiced less than 10 years, and 60 percent had practiced from 12 to 29 years. Over one half (19) of the physicians were in solo practices, 11 were in group practices, and 5 were in multispecialty clinics, military service, or Veterans Administration hospitals.

The 36 respondents were generally satisfied with the family systems approach to psychosocial problems. Table 1 shows the ratings of items pertinent to attitudinal impact and level of satisfaction with this method. Ninety-seven percent of the respondents felt that the session heightened their awareness of the need to interact with the family system when dealing with children and felt that children with psychosocial disorders could benefit from this approach. Although the form and open-ended comments reflected satisfaction with the approach, a parallel high-frequency rating in the utilization of the method was not distinguished from the survey results. Fifty-one percent of the respondents had tried this intervention, but only 39 percent of those responding frequently used the therapy when working with family problems. Concerning the degree of interaction with families, 11 percent indicated a significant increase, 55 percent a slight increase, 31 percent no change, and 3 percent a slight decrease. Table 2 illustrates utilization frequencies.

Four variables from the open-ended questions were analyzed against the 20-item questionnaire:

Table 2. Utilization Ratings of Psychosocial Method (n = 35)

Item	Rating (%)			
	Strongly Agree	Agree	Disagree	Strongly Disagree
Had previously utilized form of this method	6.1	30.3	51.3	12.1
Time constraints prohibit my use of the method	12.1	45.5	39.4	3.0
Lack of family cooperation has affected use of method	9.4	28.1	62.5	0
Seldom see families in my office who present child with psychosocial problems	5.9	26.4	61.8	5.9
Understand the concepts, but have difficulty applying this method	42.4	54.6	3.0	0
Frequently use method when working with family problems	3.0	36.3	54.6	6.1

(1) physicians whose interaction with families had increased since attending the session, (2) physicians with more than ten years' experience, (3) physicians in solo practice, and (4) physicians from rural settings. Using Kendall's tau C test of significance ($P \leq 0.05$), no significant difference was found between rural and urban physicians in their perception of the value of the method and its applications. The physician in solo practice was found to be more likely to have utilized a form of this method while working with family problems. This response may be important, given the potential ease of referral for family counseling or social work in many group practices and clinic settings.

The physicians who had been in practice for more than 10 years correlated significantly ($P \leq 0.05$) with several items dealing with the session content and their use of the method. These physicians felt the sessions provided adequate practice and enabled them to better suggest directives to their patients. These physicians felt comfortable with families, had little difficulty in applying the concepts, and frequently used the method. They would also attend a follow-up session. The same correlations existed for physicians who had been in practice more than 5 years but fewer than 10. The physicians in practice less than five years were unable to assimilate the skills from the session and remained uncomfortable in dealing with family problems.

Several factors correlated significantly with physicians who noted an increased level of interaction with dysfunctional families. These physicians believed they had learned the skills and concepts and were afforded adequate practice during the session. They would attend a follow-up session on devising treatment plans and practicing the technique if it were offered. Further, these physicians felt the family systems method was a realistic approach for treating dysfunctional families and that families who present a child with a psychosocial problem would benefit from this treatment. This group of family physicians described themselves as better able to recognize family problems and more aware of the impact of interactional patterns on personal health. Additionally, the physicians who reported frequently using the method when working with families who had problems also noted they felt better able to discuss psychosocial problems with family members.

Discussion

The two-hour workshop format is feasible and appears to meet a need of the family physician for training in family therapy that has not previously been readily available.[11-13] In addition, the workshop approach provides a good context for the translation of family therapy to medical terms and concepts and the modification of technique necessary to facilitate clinical application in medical practice.

The goal of increasing the participating physician's awareness of the need to interact with families presenting a child with a psychosocial problem seemed to have been accomplished. The results indicate that over 90 percent of the physicians developed increased awareness. This sensitivity was translated into increased interaction with families by 66 percent of the participants.

The second goal, increasing the physician clinical activity with dysfunctional families, was only partially attained. Nearly all participants (97 percent) believed they understood the concepts but have difficulty applying the method. Eighty-nine percent agreed they were better able to recognize family interactional problems (ie, make a diagnosis). The complete process of clinical activity can be conceptualized to consist of five phases: (1) change in physician attitude (ie, increased awareness), (2) provision of clinical method for data collection, (3) differentiation of families into diagnostic categories, (4) formulation of a plan of action from principles of management, and (5) motivation of family members to implement the therapeutic plan. The last two phases of the process, the clinical intervention steps, remained difficult for most participants. Accordingly, only one half of the physicians reported having tried this method of family counseling, and only 39 percent reported they frequently used the method when working with family problems.

The physician with more than five years in practice may have been an important subgroup. They reported greatest success in adapting this method to their office practices. Their successful assimilation and application of the therapeutic process to the physicians' patient populations were probably related to repeated exposures to dysfunctional families in their individual practices. This experiential preparation could have greatly facilitated the educational process.

Although the two-hour workshop appears to meet the goal of increasing physician awareness of the need to interact with families, for physicians of all levels of experience, it fails to increase the rate of family therapy interventions. Most participants feel they would benefit from further training in family therapy, especially if task formulation and family member motivation were emphasized. The educational approach to future family therapy workshops should be differentiated according to the participating physician's experience. Those physicians in practice for less than five years would probably benefit from information defining the importance and frequency of these problems in family practice and supervised active practice under simulated clinical conditions should be provided. Future workshops could also include family therapy strategies for psychosocial problems of adults and geriatric patients.

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