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Collaborative family health care in an hospital setting: A pilot study on physicians and therapists´ perceptions

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ABSTRACT. Although in recent years, the biopsychosocial approach has been emphasized in the practice of family medicine, how physicians and therapist interact and in particular the role of the family therapist in medical settings has been confusing. This study describes a qualitative study that focused on the understanding of what perceptions influence the collaborative approach or the parameters of family systems medicine, how physicians and therapists perceive their role in the process of collaboration and finally how they characterize the collaborative health care approach. For that purpose, an ethnographic methodology was selected. The domain analysis specified by Spreadleys's DRS model revealed four categories that were important in physicians and therapists' perceptions of the definition of a collaborative approach: 1) collaboration, 2) practice of a family systems medicine, 3) referral, 4) training, and 5) roles. Although in some of these domains family physicians and family therapists differ they seem pretty clear regarding the importance of the biopsychosocial model and interdisciplinary collaboration. Implications for future research and towards the practice and the operationalisation of the collaborative approach are emphasized.

KEYWORDS. Family systems medicine. Collaborative approach. Family practice. Family therapy. Qualitative study.

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RESUMEN. A pesar del énfasis de la perspectiva biopsicosocial en la práctica de la medicina familiar, la forma en que los médicos o terapeutas interactúan y en particular el rol del terapeuta familiar en contextos médicos ha sido confuso. Este trabajo describe un estudio cualitativo que pretende comprender las percepciones que influyen en un abordaje de colaboración o los parámetros de la familia familiar sistémica, la forma en como los médicos y terapeutas perciben su papel y finalmente como caracterizan el abordaje interdisciplinar en el contexto del sistema de salud. Con este objetivo se utilizó una metodología etnográfica. El análisis por dominios especificado según el modelo DRS de Spreadley reveló cuatro categorías en las percepciones que los médicos y terapeutas poseen sobre la definición de un abordaje de colaboración: 1) colaboración, 2) práctica de la medicina familiar sistémica, 3) referencia, 4) entrenamiento, y 5) papeles. Aunque en algunos de los dominios médicos de familia y terapeutas familiares presentan percepciones diferentes, parecen coincidir con respecto a la importancia del modelo biopsicosocial y de colaboración interdisciplinar. Implicaciones para investigaciones futuras y para la operacionalización del abordaje de colaboración son enfantizadas.

PALABRAS CLAVE. Medicina familiar sistémica. Abordaje de colaboración. Medicina familiar. Terapia familiar. Estudio cualitativo.

RESUMO. Embora recentemente a perspective biopsicossocial tenha sido enfatizada na prática da medicina familiar, a forma como os médicos e terapeutas interagem e em particular o papel do terapeuta familiar em contextos médicos tem sido confuso. Este estudo descreve um estudo qualitativo que pretende compreender as percepções que influenciam uma abordagem colaborativa ou os parâmetros da medicina familiar sistémica, a forma como os médicos e terapeutas percebem o seu papel e finalmente como caracterizam a abordagem interdisciplinar no contexto do sistema de saúde. Com este objectivo, foi utilizada uma metodologia etnográfica. A análise por domínios especificada segundo o modelo DRS de Spreadley revelou quatro categorias nas percepções que médicos e terapeutas possuem sobre a definição duma abordagem colaborativa: 1) Colaboração, 2) Pratica da medicina familiar sistémica, 3) referencia, 4) treino, 5) Papeis. Embora em alguns dos domínios médicos de família e terapeutas familiares apresentem percepções diferentes, parecem contudo concordar em relação à importância do modelo biopsicossocial e da colaboração interdisciplinar. Implicações para investigações futuras e para a operacionalização da abordagem colaborativa são enfatizadas.

PALAVRAS CHAVE. Medicina familiar sistémica. Abordagem colaborativa. Medicina familiar. Terapia familiar. Estudo qualitativo.

Introduction

The importance of the relationship between family factors and health and illness has been documented in the literature (Doherty and Campbell, 1988; Henao and Grose, 1985; McDaniel, Campbell, and Seaburn, 1990; Ramsey, 1989; Turk and Kerns, 1985). Contemporary Medicine has been criticized for conceptualizing disease exclusively in somatic parameters. This view has been described as emphasizing reductionism by not

taking in consideration the behavioral, psychological and social factors in the identification of disease (Engel, 1977; McDaniel, Hepworth and Doherty, 1992), and mind-body dualism by separating the mental from the somatic aspects of disease (Engel, 1977, 1980). The development of a new collaborative field between family therapists and medical providers has slowly being developed. Family Systems Medicine, as a field, was coined in 1983 with the publication of the journal "Family Systems Medicine". The new territory was characterized by an alliance between medicine, family therapy, and systems thinking (Bloch, 1983). The changes in medical and mental health practice, the establishment of family medicine and family therapy, and the epistemological shift from linear to systemic thinking created the conditions that culminated in the end of the schism between the medical and mental health field. The biopsychosocial approach places illness within a larger framework involving multiple systems. In that model, to understand an illness, the health care provider attends to the biological factors, the person, the family, the patient-provider relationship, and the social context (Campbell, McDaniel, and Seaburn, 1990). As a result, Family Systems Medicine emphasizes the importance of the systemic paradigm in Medicine or the use of the biopsychosocial model (Engel, 1977). Medical family therapy in particular, refers to the specific contribution of family therapy to the practice of biopsychosocial medicine. It emphasizes collaboration between family physicians and family therapists and focuses on medical illness and its role in the personal life of the patient and the interpersonal life of the family (McDaniel *et al.*, 1992). Although, in recent years family therapy practitioners have been working in physical health environments, this process has been confusing as to the proper role of the family therapist in such settings (Bloch, 1992). Also, in the practice of biopsychosocial medicine or family systems medicine, the distinction between the role of the medical family therapist and other mental health professionals in medical settings has not been clearly defined in the literature.

Although several models of collaboration between mental health providers and medical providers have been discussed in the literature (Crane, 1986; Dymn and Berman, 1986; Hepworth, Gavazzi, Adlin, and Miller, 1988), how those involved in the practice of Family Systems Medicine or collaborative family health care experience and understand this collaborative approach to health care is still in its formative stages (Pereira, Barbosa, Sousa, Santiago, and Lima 2002; Pereira and Smith, 2003). With the increased attention on health care reform and an emphasis on interdisciplinary in health care delivery (Glenn, 1987), it is important to understand what perceptions influence the collaborative approach, how physicians and therapists perceive their role in the process, and how they characterize Family Systems Medicine or collaborative family health care. This lack of congruence between theory, research and practice has resulted in part from research designs that are either qualitative or quantitative (Liddle, 1991). Research is needed to generate theory that guides the practice of Family Systems Medicine as an interdisciplinary approach and informs how the biopsychosocial model guides the collaboration between family therapists and other health professionals.

The purpose of this qualitative study (Montero and León, 2002) was to attempt to clarify the field of family systems medicine or collaborative family health care. Since the goal was to generate information regarding the new field of practice, a qualitative mode of analysis that employed an ethnographic methodology was selected. This

methodology allowed to uncover physicians and therapists' perceptions, regarding family systems medicine, by creating theoretical concepts inductively from participants' detailed descriptions that later could be assessed as hypothesis and propositions using a quantitative methodology. In qualitative research, research questions are derived inductively in the process of the study. There is an iterative development of questions over time as the analysis of content of each interview leads to further questions. In this study the research question was "*What are therapists and physicians perceptions of Family Systems Medicine or collaborative family health care?*An ethnographic methodology that adapts the framework associated with Spradley's (1979) Developmental Research Sequence (DRS) Model was used in this study. In a domain analysis, statements are broken in three parts: a) the main concept called the covert term, b) the other terms that describe the main concept called the included terms, and c) the relationship between the covert and included terms called the semantic relationship (Spradley, 1979). The current paper followed the guidelines proposed by Bobenrieth (2002).

Method

Sample

Ten physicians and two therapists were interviewed over a six months period concerning their perceptions of a Family Systems Medicine's approach in their work. Informants were selected using an opportunistic sampling strategy. A purposive sample fitted the goals of the study since the purpose was not generalization to a population but the description of meanings of therapists and physicians regarding the practice of Family Systems Medicine. The aim was to generate assertions that lead to theory development (Yin, 1989). Physicians were second and third year residents in the Family Practice Residency Program at the Tallahassee Memorial who collaborated with a family therapist' intern and a psychologist who worked in the same practice with them. The psychologist had training in family therapy and the family therapist was a PhD. Collaboration between these two types of informants happened on the basis of referral and they would discuss treatment plans together. Sometimes they both would see the patient together. Because of these characteristics, we believed that they were good informants regarding a collaborative family health care' approach.

Site

The site included a family practice residency in a general hospital. Being a hospital based service; the residency received mostly low-income patients. Black and Hispanic minorities were well represented.

Data collection

Interview procedures. Each informant was interviewed at least twice. After the first interview, a domain analysis was conducted and a second interview followed allowing the researcher to verify domains and expand on earlier ones. Interviews lasted on average 30 minutes and sometimes more. Open-ended questions and structured questions were used. First interviews included only open-ended questions to elicit as

much information as possible. Structured questions were asked in the following interviews with the same informant and later included in the first interview with other informants. In this process research questions emerged in an iterative fashion as new ideas from all the informants were generated.

Table 1 shows the first iterative development of questions for therapists; Table 2 shows the same procedure for physicians and Table 3 describes the second iterative development for therapists and physicians.

TABLE 1. Original and first iteration therapists´ questions.

Original questions-therapists	*First iteration-therapists*
1. What is it like for you to be a family systems practitioner? 2. Tell me about the processa client goes through from the time he/she steps in to the time he/she steps out, in the place you work? 3. What is your role as family therapist? 4. Is there anything about the approach to family systems in medicine that I did not ask you that you think I should know because of its importance?	1. Tell me about your interest in a Family Systems approach in your work? 2. Could you describe the steps that a client goes through from the moment they check in till they receive treatment in the place you work? 3. What is your role as a family therapist? 4. Tell me about some of your beliefs concerning this interdisciplinary approach? 5. What are the characteristics of a family systems approach in a medical setting? 6. What is important about the culture of medicine for a therapist who wants to work in a medical setting?

TABLE 2. Original and first iteration physicians´ questions.

Original questions-physicians	First iterative-physicians
1. Could you describe for me a typical day of work for you? 2. Tell me about the process a patient goes through, from the moment he/she steps in the Family Practice till he/she leaves? 3. What is your role as a physician? 4. Is there any comments you would like to comment concerning a family systems approach in medicine?	1. What is it like for you to work in a Family Practice that incorporates a family systems approach? 2. How and when do you make a decision to refer patients to therapy? 3. What is you role as a physician? 4. What are some of the benefits/hindrances for the patient and the professionals of having physicians and therapists working together? 5. Tell me about the relationship between physicians and therapists when they are working within a family systems medicine approach?

TABLE 3. Second iteration questions for therapists and physicians.

Second iteration-therapists	Second iteration-physicians
1. Tell me about your interest in family systems medicine? 2. Could you tell me how the interface between therapists and physicians takes place? 3. Other therapists told me that there is a relationship between emphasis on health and on the patient's family system and how often they show up at the emergency care. What do you think? 4. What is your role as a family therapist? 5. What are the characteristics of a family systems approach in Medicine? 6. What type of training has been more helpful to you in being a medical family therapist?	1. Describe to me all the ways a physician can work in a team with therapists? 2. How and When do you refer a patient for therapy? 3. Tell me about your assumptions concerning the use of a family systems approach in medicine? 4. Could you tell me which patients benefit more from a family systems approach?

The transcribed text of each ethnographic interview was subjected to a domain analysis as specified by Spreadley's DRS model (1979). A domain is defined as an informant expressed relationship between two terms: a cover term (main concept being talked about) and the included terms (other terms used to describe the main concept). The covert term and the included terms are paired together through a semantic relationship (relationship between the included terms and a covert term). Each domain identified in the ethnographic interviews was grouped in a box diagram. A taxonomic and componential analysis that located similarities and differences across each domain was performed and all related domains were collapsed into several core categories. As a result, a category system emerged based on patterns across domains. For example, a physician stated "I believe that a big part of why physicians have a hard time collaborating with therapists ["doing" Collaborative Health Care] is not because of the therapist but because of the issues at hand, those are issues that they have not dealt with in their own lives and I think that is why they feel intimidated by therapists". Using a domain analysis, "not dealing with those issues in their own lives", "feeling intimidated by therapists" are all included terms that causes (semantic relationship of cause-effect) physicians to have a hard time dealing with therapists and, as a result, creates a challenge in the practice of Collaborative Health Care. The emerging domain for this group of sentences was called "Challenges to the practice of Collaborative Health Care" (subscale). The two included terms were introduced in item (23) of the questionnaire: "Physicians feel intimidated by therapists because patient's psychosocial concerns have not been addressed by physicians in their own lives. The emerging core category that included the domain (subscale) "Challenges to the practice of Collaborative Health Care", and another similar domain "Definition of Collaborative Health Care" constitute scale B in the questionnaire

and were called "Practice of Collaborative Health Care". The same taxonomic process was used to identify all the other core categories or scales in the questionnaire.

Results

As a result of the domain analysis the following categories with respective subdomains emerged:

- A. Collaboration: 1) Characteristics of Physician and Therapist Collaboration, 2) Benefits of Physician and Therapist Collaboration, 3) Rational for Physician and Therapist Collaboration, 4) Limitations of Physician and Therapist Collaboration.
- B. Practice of Family Systems Medicine: 1) Definition of FSM, 2) Challenges to the practice of FSM.
- C. Referral: 1) Rational for referral, 2) Expectations after referral.
- D. Training: 1) Characteristics of Therapist's Training, 2) Characteristics of Physicians' training.
- E. Roles: 1) Characteristics of Physician's role, 2) Characteristics of Therapist's role 3) Characteristics of other Mental Health Professional's Role.

Tables 4, 5, 6 7, and 8 describe each domain with their respective subdomains.

TABLE 4. A-Collaboration.

Therapists	*Physicians*
Collaboration between family physicians and family therapists results in a treatment plan that includes medical and psychosocial components (A-1).	One of the benefits of collaboration between physicians and family therapists is improvement in patient compliance (A-2).
Collaboration between family physicians and family therapists increases the quality of care and decreases health care costs (A-2).	Collaboration between family therapists and family physicians works best with patients who have a problem that is not strictly medical (A-2).
Collaboration with physicians increases therapists' understanding of the biomedical aspects of disease. (A-2).	Patients see their physicians less often when the cause of the problem is psychosocial and they have a therapist (A-2).
Collaboration with family therapists helps physicians understand concretely how families work (A-3).	Collaboration between family therapists and family physicians strengthens the bond between physician-patient and therapist patient (A-2).
When physicians and family therapists work together closely in the same setting, patients are more comfortable in seeking therapy or accepting therapy referrals (A-3).	Collaboration between family physicians and family therapists is particularly helpful for patients with physical symptoms that are stress-related (A-2).
In the practice of Family Systems Medicine the physician is in charge and the therapist is the outside member (A-4).	Collaboration between family therapists and family physicians makes practice more interesting (A-3).
The difference in salaries between family physicians and family therapists creates conflict in the collaborative relationship (A-4).	Collaboration between physicians and family therapists requires too much time to be implemented into an HMO (A-4).

In this domain therapists and physicians describe family systems medicine as improving compliance, decreasing health care costs, helping therapists understand the biochemical aspects of disease, and helping physicians understand the psychosocial issues involved in the patient's disease. However, power issues are also acknowledged in particular by therapists.

TABLE 5. B-Practice of FSM.

Therapists	*Physicians*
Family Therapists need to follow the DSM-IV regardless of their epistemological beliefs (B-1).	FSM is too vague to be included into family physician's daily practice (B-1).
FSM is the application of behavioral medicine expanded to the family level (B-1).	The focus of FSM is on prevention (B-1).
FSM is an area of specialization within family therapy (B-1).	Sharing information with patients about their diagnoses and prognoses requires physicians to be trained in counseling (B-2).
Physicians do not know enough about family systems to understand the psychosocial aspects of illness (B-2).	Patients with complicated physical problems make the family systems medicine approach impractical (B-2).
In the practice of medical family therapy, patient's access to charts, that include personal notes of therapists can create ethical problems (B-2)	Physicians feel intimidated by therapists because patient's psychosocial concerns have not been addressed by physicians in their own lives (B-2).
In order to be accepted by the "medical culture", family therapists need to help physicians identify a need that family therapy can meet (B-2).	Practicing Family Systems Medicine is like learning a new skill or procedure that requires practice (B-2).
Dependence on the medical provider for reimbursement of therapy services for Medicare or Medicaid patients limits the practice of family systems medicine (B-2).	There are no financial rewards for physicians to discuss patients' condition with therapists (B-2).
In order for Family Systems Medicine to become main- streamed, psychosocial issues should be included in physicians' assessment (B-2).	
If Family Systems Medicine is to prosper, it needs to develop a strong empirical base regarding the effects of collaboration (B-2).	
In order for Family Systems Medicine to survive, health care delivery has to become interdisciplinary (B-2).	

In this domain, issues regarding the definition of the field are emphasized by both therapists and physicians. Informants appeared confused regarding the focus of the field. Both sides acknowledge the need for strong empirical base on the effects of collaboration and an integration of both psychosocial and biochemical aspects in patients' assessment. Finally, physicians perceive the family systems medicine approach as difficult to implement in a hospital setting.

TABLE 6. C-Referral.

Therapists	*Physicians*
Physicians refer patients to therapy after they have found nothing medically wrong with the patient (C-1).	There is always the chance of patients feeling abandoned by their physicians when they are referred to therapists (C-2). When patients are referred to therapists, they should at least provide a summary of the session to the referring professional (C-2).

In this domain, therapists describe physicians as ruling out medical problems before referring patients to therapy. On the other hand, physicians seem more concerned with the fear that patients may feel abandoned and the need to know what is going on with their patients after referral.

TABLE 7. D-Training.

Therapists	*Physicians*
Family Therapists' training in Biomedicine is very limited (D-1). Family therapists feel intimidated when they go on rounds with family physicians and have to relate to the biochemical aspects of disease (D-1).	Family therapists do not know enough about common diseases to truly collaborate with physicians (D-1). Physicians' training in Family Systems Medicine is primarily informal (D-2).

In this domain, therapists describe the training in biomedicine limited, and physicians describe the training in family systems informal making the practice of family systems medicine difficult.

TABLE 8. E-Roles.

Therapists	*Physicians*
Physicians only get involved in patient's psychotherapy when the patient is not improving medically (E-1). When physicians and therapists collaborate, the physician addresses the patient disease and the therapist addresses the psychosocial impact of the illness on the patient and family (E-1). When patients have emotional concerns, physicians first screen for medical causes and only when they find no apparent medical cause, they refer patients to therapy (E-1). Family therapists are mental health professionals who are better qualified to practice the biopsychosocial model (E-2). Family Systems Medicine can be practiced by any medical provider and any non-medical mental health professional as long as there is collaboration between both parties (E-3).	There is no difference between a family health psychologist and a medical family therapist in terms of how they practice Family Systems Medicine (E-3). In the practice of Family Systems Medicine, the contribution of the medical family therapist is distinct from the contribution of the medical social worker (E-3).

Interestingly enough in this domain, therapists do not agree. Some express that family therapists are the best qualified professionals to practice family systems medicine and others believe, as long as there is collaboration between medical providers and non-medical providers, that can be called family systems medicine or collaborative family health care. Therapists also reinforce the idea of a division of tasks in the practice of the biopsychosocial model i.e., they take care of the psychological issues of the patient while physicians deal with the biomedical aspects. Finally, physicians speak to the distinction between family health psychology and medical social work in the practice of family systems medicine.

Discussion and implications

This study attempted to understand the parameters of family systems medicine or collaborative family health care. The ethnographic analysis revealed five domains: collaboration, practice, referral, training and roles of professionals involved. In several instances physicians and therapists differ in their perceptions. It is understandable that

for this sample that physicians first ruled out biomedical problems before referring patients to therapy, since they are students and do not have much experience and as a result cannot take risks. Also the fact that they believe that collaboration is limited in a hospital setting may also have to do with the fact of being still in training and having to fulfill many requirements leaving them with little time to converse with therapists. Family physicians and family therapists although differing in their perceptions seem very clear regarding the key concepts of this new approach: the emphasis on the patient in context or the use of the biopsychosocial model and interdisciplinary collaboration. Collaboration in particular, is seen as beneficial for all the parts involved. An interesting finding was the discrimination among the disciplines of family health psychology and medical social work. In this regard, physicians were not clear in how therapists with different backgrounds can contribute differently to the practice of collaborative family health care or family systems medicine.

Implications for future research

An ethnographic methodology proved very useful in generating information regarding the therapists and physicians' perceptions of family systems medicine. However, ethnography research has limitations. Qualitative designs have been accused of being non-replicable and not subject to disconfirmation (Cavell and Snyder, 1991); misleading, irrelevant and stereotyped (Weirsma, 1988). Wynne (1988) argued that in the initial stages of development of a new field, emphasis should be given to discovery-oriented research and hypothesis-generating research rather that confirmatory research. We would like to acknowledge the fact that informants in this study were resident and therapy trainees who work collaboratively. However, their views may be different than physicians and therapists who have been working longer and are not students. Thus, the theoretical concepts generated inductively from this study are now able to be subjected to theory confirmation research. Future research using a quantitative design can decide how much of these findings are generalizable to the population of those who endorse a collaborative family health care or are family systems medicine' practitioners and also include patients and managed care' voices in this debate.

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