A CONTENT ANALYSIS OF FIVE SCHOLARLY JOURNALS: WHAT HAS BEEN WRITTEN ABOUT MEDICAL FAMILY THERAPY?

A DISSERTATION

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

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BY

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DENTON, TEXAS

MAY 2010

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To the Dean of the Graduate School:

I am submitting herewith a dissertation written by Karen Kinman entitled "A Content Analysis of Five Scholarly Journals: What Has Been Written About Medical Family Therapy?" I have examined this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy with a major in Family Therapy.

Linda J. Brock
Linda J. Brock, Ph.D., Major Professor

We have read this dissertation and recommend its acceptance:

Department Chair

Accepted:

Jennifer Martin
Dean of the Graduate School

DEDICATION

To my loving husband and best friend, Buck.

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ABSTRACT

KAREN KINMAN

A CONTENT ANALYSIS OF FIVE SCHOLARLY JOURNALS: WHAT HAS BEEN WRITTEN ABOUT MEDICAL FAMILY THERAPY?

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The family is the context in which diseases are managed and treated. Often, hospitals and medicine are a new culture through which families have to navigate. Medical family therapy is the biopsychosocial treatment, by family psychotherapists, within a family systems framework, of individuals and families who are dealing with medical problems (McDaniel, Hepworth, & Doherty, 1992). A medical family therapist can provide the support patients and families need as they accompany them through their experience.

Medical family therapy is defined in a variety of ways across disciplines in the healthcare field and within the field of family therapy itself. It has been described as psychotherapy, collaborative care, and even as a family therapy model. The purpose of this research project was to ascertain what has been written about medical family therapy in five scholarly journals, *Family Process*; *Families, Systems, & Health*; *Family Practice*; the *Journal of Family Therapy*; and the *Journal of Marital and Family Therapy*, since the phrase medical family therapy was coined in 1984 by McDaniel, Hepworth, & Doherty.

The first part of this research project was a content analysis to determine the frequency of articles with the term medical family therapy published in all five scholarly

journals and which discipline generated those articles. The second part of this inquiry was a qualitative analysis of those articles with the term medical family therapy in its content to determine what is being written about medical family therapy.

There was a total of 5,234 articles, 48 of those (0.92%) contained the term medical family therapy in its content. *Families, Systems, & Health* generated the majority of medical family therapy articles, containing 4.43% of the total of its published articles. *Family Process had 0.*12% of its total of published articles pertaining to medical family therapy, the *Journal of Family Therapy* (.15%), *Journal of Marital and Family Therapy* (.93%), and the journal of *Family Practice* had no articles containing the term medical family therapy. Family therapy and medicine were primary contributors, with the majority of authors contributing some role in academia as well. Five salient themes emerged: Agency and communion, the role of power, collaboration, culture, and knowledge base and competency.

Research in the efficacy of medical family therapy in the treatment of physical illness is extremely rare, with only two randomized control studies noted. Family therapists can have a significant impact in the health and well-being of patients, families, and communities, and their expertise in systems is sorely needed on a more global level in policy making. Research needs to be done by family scientists and family therapists in this area.

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CHAPTER I

INTRODUCTION

Medical family therapy is distinguished from other disciplines by "its constant attention to medical illness and its role in the personal life of the patient and the interpersonal life of the family." (McDaniel, Hepworth, & Doherty, 1992, p. 4). The disciplines of behavioral medicine and consultation-liaison psychiatry traditionally focus on the individual patient, work within a biomedical model, which includes diagnosing and pathologizing behavior, and do not have extensive training in family systems (McDaniel et al., 1992). This chapter will elaborate on the need and development of medical family therapy, its social utility, and integral role in collaboration with the field of medicine.

As acute illnesses have been effectively managed or eradicated by medicine, chronic diseases have become of primary concern today. Chronic illness impacts patients and their families on multiple levels: physical, emotional, mental, social, spiritual, cultural, developmental, and financial. It is in the context and environment of family in which disease develops and treatment often takes place (Doherty & Baird, 1983; Watson & McDaniel, 2000). A family member is often the caregiver, as cost and managed care has shifted care from hospitals or nursing facilities to home (Campbell, 2003; McDaniel & Campbell, 1998), and there is evidence that caregivers suffer more from depression

and anxiety in addition to physical illnesses (Campbell, 2003; Gauthier, Vignola, Calvo, Cavallo, Moglia, Sellitti, et al., 2007).

Increased specialization of physicians, technological advances in biomedicine, and an increase in the exorbitant cost of healthcare have created tremendous burdens on patients and their families (McDaniel et al., 1992). Advances in neonatal medicine have enabled very low birth weight preterm infants on the edge of viability to survive, but not without consequences to parents, families, and communities. Patients and families are confronted with new ethical, legal, and religious dilemmas that can impact them for a lifetime (McDaniel et al., 1992). Risks of intraventricular hemorrhage (bleeding inside the brain), life threatening necrotizing enterocolitis (injury to the bowel), and patent ductous arteriosis (opening in the heart) which may require surgical intervention, are extremely high in premature infants. Parents experience the stresses of unknown long-term outcomes of developmental delays and disabilities in addition to present and future financial stresses. They also experience tremendous loss and grief, such as loss of a perfect newborn baby, loss of dreams, and, initially, the loss of their role as parents. A medical family therapist can provide the support families need as they accompany them through the experience.

Burdens on families are also created by treatment protocols of chemotherapy, radiation, and/or surgical interventions for the diagnosis of cancer (McDaniel et al., 1992). The illness can often be seen as an additional family member, affecting role realignments or activating old family patterns of response to grief, loss, illness, and care giving (Ellenwood & Jenkins, 2007; McDaniel et al., 1992; Rolland, 1994). Similar to

parents who have a premature infant in the neonatal intensive care unit (NICU), families with chronically ill members may be unaware of their own developing symptoms of post traumatic stress related to the onset and course of the illness (Ellenwood & Jenkins, 2007). The medical family therapist sees the family as members who may need care themselves, rather than only as a resource for health care professionals to turn to for help with the patient (McDaniel et al., 1992).

AIDS touches the developmental, social, cultural, spiritual, physical, emotional, and mental well-being of patients and their families, hitting the core of family functioning and its rules surrounding love, sexuality, and trust (McDaniel et al., 1992). Psychosocial services must be provided to a highly vulnerable population who lack resources on multiple levels. Healthcare professionals working with these patients are at greater risk for contracting the virus and even greater risk for burnout (McDaniel et al., 1992). A medical family therapist is necessary to help the staff and medical team in addition to the patients and their families.

Families are also linked to illnesses brought on by lifestyle choices such as addictions and eating disorders - smoking, alcohol, obesity, anorexia, bulimia - which are commonly seen in physicians' offices and hospitals (McDaniel et al., 1992). Due to multidimensional causes and implications, a medical family therapist brings an essential treatment approach by his/her knowledge of families and working systemically within a biopsychosocial framework. A medical family therapist helps to negotiate through the larger healthcare system which includes insurance, the medical team, the hospital, and a

family's own system, while considering the typology of the illness and developmental life stage of the family (McDaniel et al., 1992).

Medical family therapy is not solely the addition of a family therapist to the healthcare team; it brings a new paradigm in which there exist relationships among all involved in treatment (Doherty & Baird, 1983). In addition, knowledge of medications, disease, and medical treatments are essential. For example, diabetes and some blood pressure medications can affect sexual functioning, and thyroid problems can present as depression, forgetfulness, and fatigue.

Illness can elicit a sense of hopelessness and isolation. The goals of medical family therapy are to establish a sense of agency and communion (McDaniel et al., 1992). Medical family therapists help patients and families achieve a sense of autonomy by making their own choices regarding their health and illness (agency), and, to achieve and maintain a sense of connection with the healthcare team, their social networks and the community (communion).

The connection between mind and body, and the influences and perceptions of stressors having significant impact on health, well-being, and illness have been established. Sociocultural, biochemical and cellular levels are affected by the stress response (Haddy & Clover, 2001). There is no separation of the mind from the body. For optimal care in meeting the needs of patients, physicians have to consider the psychosocial realm and family therapists have to consider the biological. McDaniel, Hepworth, and Doherty (1992) stated this eloquently:

> The age of innocence is over. We now know that human life is a seamless cloth spun from biological, psychological, social and cultural threads; that patients come with bodies, as well as minds, feelings, interaction patterns and belief systems, that there are no biological problems without psychosocial implications, and no psychosocial problems without biological implications. (p. 1)

Family Practice Medicine

It was the discipline of medicine, not family therapy, which recognized the need for and embraced this integration of mind-body-spirit (McDaniel et al., 1992, Troost & Filsinger, 1993). In the early 1800s, physicians had close relationships with their patients and families attending to the spiritual, emotional, psychosocial, and physical needs with minimal equipment and surgical techniques (McDaniel et al., 1992). In the early 1900s, the shift towards evidence-based science grew, and with it evolved an increase of specialization in medicine. The prevalence of family physicians or general practitioners (GP) gradually declined. This decline in general practitioners (GP) or family practice physicians, along with the public concern and perception of fragmented, compartmentalized care, led to the development of the discipline of family medicine in 1979 (Dennis, "The History of Family Medicine," p. 8).

In the 1970s, there was also a new paradigm developing within the field of medicine. Engel (1977) challenged the traditional biomedical model, which reduced patients and their diseases to biological and physical processes, and proposed a more comprehensive model which considered the relational aspects of being human. The biopsychosocial model was the integration of general systems theory and biology. It

attempted to understand how psychophysiologic responses impact somatic factors, how communication of symptoms and treatment interventions are impacted by a patient's understanding, and how relationships between the patient and health care providers affect communication and treatment (McDaniel, Hepworth, & Doherty, 1992). The dominant biomedical model continues to be the rubric of medical practice; however, the discipline of family medicine has gone forward in integrating biology and family systems theory.

The Development of Medical Family Therapy

The development of the specialty of family practice in the field of medicine coincided with the increasing popularity of the discipline of family therapy. The field of family therapy was thriving in the middle of the 1970s and 1980s with the opening of new schools and the pioneers in the field to lead them. In the family therapy field, application of family systems to medical problems was exemplified by the works of Minuchin, Baker, Rosman, Liebman, Milman, and Todd (1975) with the psychosomatic family model and research of family interaction processes related to diabetes and asthma. In 1977, John Weakland published, "Family Somatics: A Neglected Edge", bringing the application of family systems theory to health and illness. His stance was a critical one towards the discipline of family therapy, which separated itself from the arena of physical illness, limiting its scope of practice and research. A patient's emotional involvement in the family system is a major component towards the understanding of disease processes (Weakland).

Medical family therapy grew out of the field of family therapy. McDaniel, Hepworth, and Doherty coined the term in 1984, during their involvement in training

medical students and residents introducing a biopsychosocial systemic perspective. Family systems theory began to be used by family and psychiatric nurses in understanding their work with patients and families (Gillis, Highley, Roberts, & Martinson, 1989; McDaniel et al., 1992). The medical family therapist was integrated into the medical team, collaborating with doctors and nurses to address the biopsychosocial aspects of health and illness (McDaniel et al., 1992).

Statement of the Problem

Medical family therapy is defined in a variety of ways across disciplines in the healthcare field and within the field of family therapy itself. It has been described as psychotherapy together with psychology and psychiatry, and psychotherapy in the form of collaborative healthcare, not necessarily involving families. The different definitions, in turn, impact how medical family therapy is perceived and practiced. The use of the term medical family therapy is not found consistently within the literature. This presents a problem with credibility, establishing its legitimacy in the healthcare field, and the process of research. Kuhn (1996) posits the significance of developing a universally shared language within a scientific paradigm, so researchers in that field and across disciplines can work with and understand each other. Underlying principles and assumptions are needed to provide the framework upon which to practice, and guide the direction of research.

Purpose of the Study

The purpose of this study was to ascertain what is being written about medical family therapy in five scholarly journals: *Family Process*; *Journal of Marital and Family*

Therapy; *Journal of Family Therapy*; *Families, Systems, & Health*; and *Family Practice*, since the phrase medical family therapy was coined by McDaniel, Hepworth, and Doherty in 1984 until 2009.

Research Question

The general research question guiding this analysis was the following: What has been written about medical family therapy in selected scholarly journals (*Family Process*; *Journal of Marital and Family Therapy*; *Journal of Family Therapy*; *Families, Systems, & Health*; and *Family Practice*)? This research question provided the framework for the coding and analysis of articles containing the term medical family therapy as the psychotherapy component in healthcare.

Definition of Terms

For the purposes of this study, the following operational definitions apply:

Medical Family Therapy: The biopsychosocial treatment, by family psychotherapists, within a family systems framework, of individuals and families who are dealing with medical problems (McDaniel et al., 1992).

Biopsychosocial Approach: The inclusion of biological, psychological, social, cultural, and developmental factors in healthcare assessment, evaluation, and treatment of families and illness (McDaniel et al., 1992).

Collaboration: Partnership between medical providers and family therapists within a biopsychosocial approach to health and illness (McDaniel et al., 1992).

Assumptions

The following assumptions ground this investigation:

1. There are no biological symptoms without psychosocial issues and no psychosocial problems without physiologic implications (McDaniel et al., 1992).
2. Minimal research exists on the efficacy of medical family therapy in the treatment of families coping with physical illnesses.
3. Medicine and family therapy, working in a collaborative practice, leads to optimal healthcare.
4. All families cope with illness and health-related issues.
5. Family dynamics impact illness and illness impacts family dynamics.
6. Families and their members need support and care in their own right.
7. Families can be a buffer/support or a stressor for patients.
8. Upon diagnosis and treatment, the patient, the family, and the healthcare team becomes a system.
9. Chronic diseases have their own development and time phases (Rolland, 1994).

Delimitations

The delimitations for the purpose of this research study are the following:

1. Only refereed articles published from 1984 until 2009 which contain the term medical family therapy were the focus of this study.

2. Only the selected journals *Family Process; The Journal of Marital and Family Therapy; Families, Systems, & Health; The Journal of Family Therapy;* and *Family Practice* were the sample for this inquiry.

Summary

This chapter discussed the necessity, development, and role of medical family therapy as an integral component in collaboration with medical care. Biomedical advances in diagnosis and treatment interventions create tremendous burdens for patients and families that can impact them for a lifetime. Medical family therapy works within a biopsychosocial systemic framework alongside medicine to attend to patients and their families, in addition to providing support to the medical team. Since there are various interpretations in how medical family therapy is defined, the purpose of this study was to ascertain what is being written about medical family therapy in five scholarly journals since the phrase medical family therapy was coined by McDaniel, Hepworth, and Doherty in 1984 until 2009.

CHAPTER II

LITERATURE REVIEW

This chapter will provide a review of literature on illness and families apart from those articles which will be included in the research sample. The articles obtained from the literature review were generated from the journals included in the study sample. Linville, Hertlein, and Lyness (2007) conducted their own literature review of medical family therapy and acknowledged, along with Campbell (2003), the lack of randomized control studies in medical family therapy, or in the efficacy of family therapy as a treatment intervention for patients and families coping with chronic illness.

History and Development of Medical Family Therapy

In the 1970s, family therapy and family practice medicine were evolving and growing. As Engel (1977) challenged the reductionistic biomedical model for a more comprehensive biopsychosocial paradigm, family systems theory was beginning to be applied to physical illnesses. However, the realization that families affect the course of illness and any exacerbations has been known as early as the 1920s. The Peckham experiment (Ransom, 1983) was a longitudinal study on families in a community health center in London, which demonstrated the recursive relationship of families and health and illness. In 1937, the Macy Project, a longitudinal study of 15 families in the United States, demonstrated the mutual influence of families and health, and elicited the cooperation of public health, medicine and psychiatry at Cornell Medical College, and

social work and nursing at New York Hospital (as cited by McDaniel, Hepworth, & Doherty, 1992).

Curiously, as family therapists were slow to embrace the integration of the biological with psychosocial components in health and illness (McDaniel et al., 1992), many of the pioneers in family therapy, (Carl Whitaker, John Weakland, Salvador Minuchin, Lyman Wynne, and Murray Bowen) did. Whitaker, along with Malone, co-authored a chapter in their book, *The Roots of Psychotherapy* (1953), elaborating on the biological foundations of psychotherapy (as cited in McDaniel et al., 1992). Bowen's theory of the family can be described as an evolutionary theory, with the primitive brain and the more evolved component of the brain playing a role in differentiation, which is the ability to separate feeling from thinking in order to make thoughtful decisions, as opposed to decisions based on emotional reaction.

Later, in the middle to late 1970s, as family systems theories were thriving, Salvador Minuchin, and his colleagues, Rosman, Baker, Liebman, Milman, and Todd (1975) applied structural family therapy to illness, describing the psychosomatic family model. They found family interaction patterns influenced the conditions of diabetes and asthma. Minuchin's structural family theory had also proved effective in treating anorexia nervosa patients and their families (Minuchin, Rosman, & Baker, 1978). Lyman Wynne's work with schizophrenia connected the biological with psychosocial and communication characteristics of the family (McDaniel et al., 1992). Weakland (1977) spurred discussion in the field of family therapy by challenging therapists and researchers to broaden the scope of their discipline to include biology.

An integral step in the growth process of a new scientific paradigm includes the creation of scholarly works and journals which provide a forum for publishing theoretical, scientific, and clinical information to further research (Kuhn, 1996). *Family Systems Medicine* was founded in 1983 by Don Block, Donald Ransom, and Michael Glenn. It was a pioneering journal in its time because it connected scholars across disciplines with its focus on family systems and mental and physical health and illness.

Collaborations with family therapy and family practice medicine began with McDaniel, Hepworth, Doherty, Baird, and Campbell. In 1983, Doherty and family practice physician Macaran Baird co-authored a book for family practice physicians entitled, *Family Therapy and Family Medicine*. They elaborated on how the family system and physical illnesses and/or common complaints seen in the physician's office were integrally connected, and gave the family practice physician insight in how to recognize and approach symptoms of a psychosocial nature, in addition to knowing when to refer for more in-depth therapy.

McDaniel, Hepworth, and Doherty coined the term, medical family therapy, in 1984, during their involvement in training medical students and residents introducing a biopsychosocial systemic perspective. Their book, *Medical Family Therapy: A Biopsychosocial Approach to Families with Health Problems* (1992), is a comprehensive work describing the evolution of medical family therapy within the discipline of family therapy, and the necessity of integrating mind and body in the treatment of disease. John Rolland (1994) expanded this biopsychosocial model by developing his Family Systems-Illness Model, to incorporate the typology of illness. In addition to the family system,

illnesses have characteristics that impact family dynamics; and different diseases present differently in terms of acute and chronic events. The initial diagnosis of an illness (acute phase), its chronic phase (learning to cope), or preterminal/terminal phase each impose developmental and psychosocial demands on the family. The developmental stage of the family and their experience of the illness requires significant consideration as well.

Selected Applications

Chronic illnesses like diabetes, asthma, and hypertension have physiological changes that can be measured by laboratory values or diagnostic tests such as that which measures pulmonary function. Self-reports of function and improvements in living with illness is also a valid measurement (Campbell, 2003). Although many adults are coping with chronic diseases, like diabetes, there are more studies of children who have chronic illnesses and their family functioning than with adults.

Ochs, Seemann, Franck, Wredenhagen, Verres, and Schweitzer (2005) presented a mixed-method study of 38 children and adolescents, which looked at changes in family interaction patterns and therapy outcomes at a nine month follow-up in a child and family-oriented psychosocial treatment program for pediatric headaches. Treatment consisted of ten child and adolescent group hypnotherapy sessions, three parents' evenings, (which focused on helping parents communicate questions, feelings, and problems regarding their child's headaches, as well as addressing parenting and family issues surrounding the headaches), and three systemic family interviews/ counseling sessions with a therapist. Participants with positive family interaction changes showed a

64% reduction of global headache burden. Only a 17% reduction was noted in families whose interactions remained unchanged or worsened.

The only randomized control trials of family therapy for childhood illnesses are two looking at severe childhood asthma (Campbell, 2003). A total of 55 children were included in these two trials. The objective was to assess the effects of family therapy in addition to medication versus medication alone. One study showed pulmonary function tests and daytime wheeze improved in the family therapy group compared to controls. The other study, (with different measurement of outcome) noted the family therapy group showed improvement in overall clinical assessment and number of impaired days (Yorke & Shuldham, 2005).

Knowledge of specific diseases and their typology and course of illness is a requirement for family therapists to have when working with families in clinical settings, as families cope with illness. These classical works provided the foundation for additional research.

Summary

This chapter presented an overview of the history of literature which provided the foundation for further inquiry in the field of family systems medicine and medical family therapy. The classic works of the pioneers in the field of family therapy with regard to physical health and illness coincided with the growth of family medicine during the same time period. Although more research of family dynamics and illness exists with childhood diseases and conditions, much more needs to be done with adults.

CHAPTER III

METHODOLOGY

This chapter explains the content analysis methodology chosen for this research project. Content analysis is a "research technique for making replicable and valid inferences from texts (or any other meaningful matter) to the contexts of their use" (Krippendorff, 2004, p. 18). Artwork, images, symbols, and other artifacts may be identified or defined as text; however, for the purpose of this project, text was confined to the written word. This methodology stems primarily from the social and behavioral sciences, and follows the rules and standards of scientific research (Neuendorf, 2002).

This research project is a descriptive analysis, identifying and describing articles which contain the term medical family therapy. Constructs, assumptions, properties, and the definition of medical family therapy (from chapter one in this study) focused the researcher on certain concepts and helped derive coding rules and values by the way the concepts were defined (Potter & Donnerstein, 1999, p. 259). Operationalization of this study took the form of classifying, coding, and analyzing the data (Babbie, 2004). Key words, salient themes and/or topics from the articles chosen from the five journals, were recorded.

Sample

The purpose of this study was to ascertain what is being written about medical family therapy in five scholarly journals since the term medical family therapy was

coined by McDaniel, Hepworth, and Doherty in 1984 until 2009. The sample population for this research study included articles in all issues of the five peer-reviewed journals, *Family Process; Families, Systems, & Health; Journal of Marital and Family Therapy; Journal of Family Therapy;* and *Family Practice* published from 1984 to 2009, which included the term medical family therapy in its content. Book reviews, honorariums to any particular scholars, introductions, commentaries and responses, and forwards were excluded in this inquiry.

Family Process was chosen because it is a multidisciplinary international journal that contributes to research, training, and theory of families and family therapy (Kaslow, "About *Family Process*", para. 1). It is indexed in Abstracts of Research in Pastoral Care and Counseling, Abstracts for Social Workers, Care and Counseling, Family Research Database, Index Medicus, Psychological Abstracts, Sage.Publications Family Studies Abstract, Social Work Research Abstracts, Sociological Abstracts, Social Services Abstracts and the International Bibliography of Periodical Literature on the Humanities and Social Services (*Family Process,*"Subscriber information", para. 2). *Family Process* is a significant resource for mental health practitioners regarding research and theory of family systems for clinical practice.

The *Journal of Marital and Family Therapy* is published by the American Association for Marriage and Family Therapy and has over 20,000 subscribers. Current research, theory, and clinical practice in the area of marital and family dynamics are exemplified through peer-reviewed, scholarly works. It is indexed in multiple databases, including: EBSCO, AgeLine Database (AARP), Current Contents/Social & Behavioral

Sciences, Family Index, Index Medicus/MEDLINE (NLM), MEDLINE/PubMed, Proquest Databases, Psychological Abstracts/PsychINFO (APA), SCOPUS (Elsevier), and Social Sciences Index/Abstracts (*Journal of Marital and Family Therapy*, "Journal information"; *Journal of Marital and Family Therapy*, "Aims & scope").

The Journal of Family Therapy was chosen because of its systemic focus and its origins from the United Kingdom. It is published by the Association for Family Therapy and Systemic Practice. Its systemic framework guides the content of the journal when publishing current scholarly works in research, theory, and clinical practice with couples, families, and broader professional networks and groups. Its global perspective is seen in its editorial board which includes leading professionals and academics from around the world (*Journal of Family Therapy*, " Journal information").

Families, Systems, & Health, (originally titled *Family Systems Medicine*), the journal for collaborative healthcare, is published by the American Psychological Association (APA). It is a multidisciplinary journal that publishes scholarly works on research, training and theory with a particular focus on collaborative family healthcare (*Families, Systems, & Health*, "Journal description"). It is indexed on multiple databases including: Academic Search Complete, Alt-HealthWatch, CINAHL, Current Abstracts, Family Studies Abstracts, MEDLINE, PsycINFO, Psychology and Behavioral Sciences Collection, PubMed, SCOPUS, and Sociological Abstracts (*Families, Systems, & Health*, "Abstracting and Indexing Coverage").

The journal of *Family Practice* is a peer-reviewed journal which includes evidence-based research and practice in the discipline of family medicine. PubMed,

MedLine with full text, Academic Search Complete, Psychology and Behavioral Sciences Collection, and Health and Wellness Resource Center are among the databases on which it is indexed (*Family Practice*, "Abstracting and Indexing Coverage").

Population

This sample population for this research study included articles in all issues of the five journals published from 1984 to 2009 which contained the term medical family therapy in its content. Articles were defined and described as theoretical, research, training, or clinical practice.

Data Collection

The researcher retrieved all issues of the four journals published from 1984 to 2009 from Texas Woman's University library. *Family Practice* journal was retrieved on-line from Louisiana Tech University. Each article was read and analyzed by the researcher who kept in mind the primary research question, "What has been written about medical family therapy in selected scholarly journals?" Articles which include the term medical family therapy were read in detail and coded by content.

Categories for Coding

Content analysis is a research methodology which considers the nature of content. Manifest content is that which is easily observable, such as a written word or phrase in a text (Potter & Levine-Donnerstein, 1999). The researcher scanned each issue of the journals selected for this study for content of the term medical family therapy. Those articles which contain the term medical family therapy were then read and evaluated by the researcher.

Latent content is the underlying meaning of text, the depth of the communication (Babbie, 2004). Reading texts, phrases, or paragraphs is a qualitative process as the reader interprets the meaning of the written word. The researcher began the process of categorizing information by selecting key words or phrases which related/described medical family therapy and then documented on the coding sheet (Appendix A). The researcher also made narrative notes about the article and its content.

The Coding Worksheet includes the name of the journal, full citation of the article, a section for narrative notes, and predetermined categories of theory/academia, research, training, and clinical practice. Documentation of author(s') professional credentials and affiliations were also included on the Worksheet.

Treatment of Data

The total numbers of articles from each journal were recorded to provide a baseline in order to obtain percentages and frequencies of the occurrence of medical family therapy journal articles. After reading the article, the researcher documented author and his/her professional affiliation, in addition to key words, and phrases. Data regarding the discipline of the author were presented quantitatively. The primary content themes in the article were presented as qualitative data. Appendix B contains a list of the articles from each of the five journals that met the selection criteria to be included in this study. Appendix A is the Coding Worksheet which provided the structure and guidelines for the presentation of the data. Initially, the researcher addressed each of the categories individually to observe primary content themes which would emerge. However, a strong similarity of content was appearing across each of the categories. To simplify and obtain

more uniform results, the categories were then grouped together in round three of the coding process which illuminated more uniformity among the categories regarding salient themes. Reducing data aids in creating manageable representation units to work with and highlights content which matters (Krippendorf, 2004). Tables were created to represent the results along with a narrative.

Credibility and Trustworthiness

Replication is significant to validity in social science research (Babbie, 2004; Krippendorf, 2004). The researcher has mapped out the purpose and nature of the study along with its methodological procedure in order for others to replicate this research. A content analysis is valid "if the inferences drawn from the available texts withstand the test of independently available evidence, of new observations, of competing theories or interpretations, or of being able to inform successful actions" (Krippendorf, p. 313).

To increase the validity of the coding process, and trustworthiness of the results, two independent coders familiar with the qualitative inquiry process reviewed and coded articles randomly selected independent of the primary researcher. One independent coder who volunteered to assist in this study has an independent practice, is a licensed professional counselor (LPC), had recently obtained a PhD in family therapy, and works in a university setting. The second coder had also recently obtained a PhD in family therapy and is also currently working in a university setting. Neither has a medical background.

An orientation and brief training session for the independent coders was conducted prior to participation. The primary researcher summarized the purpose,

rationale and use of the Coding Worksheet for this research project. The research question which guided this study was given to the rater along with the definitions and Coding Worksheet.

A total of eighteen out of the forty eight articles were independently coded. One independent coder read and analyzed ten articles, and the other coder read and analyzed eight articles, each identifying key concepts and primary content themes which emerged. One Coding Worksheet was completed for each article. The coders then met with the researcher and discussed the results. Each coder was in agreement with key concepts and emerging themes and did not have additional recommendations or changes to the process or the Coding Worksheet.

Summary

This chapter elaborated on the methodology of the content analysis research which was implemented for this project. This sample population for this research study included articles in all issues of the five peer-reviewed journals, *Family Process; Families, Systems, & Health; Journal of Marital and Family Therapy; Journal of Family Therapy;* and *Family Practice* published from 1984 to 2009, which included the term medical family therapy in its content. Keeping in mind the research question, "What has been written about medical family therapy in selected scholarly journals?" the researcher read and analyzed each of the articles, selecting key words and phrases. Categories for coding showed emerging themes and topics. Data were documented on a coding sheet.

Two independent coders familiar to qualitative analysis reviewed and analyzed randomly selected articles for key concepts and primary content themes to contribute to the trustworthiness of the process. Each coder was in agreement with key concepts and emerging themes and had no additional recommendations or changes to the methodology.

CHAPTER IV

RESULTS

This research project is a descriptive analysis for the purpose of ascertaining what has been written about medical family therapy in five scholarly journals since the term medical family therapy was coined by McDaniel, Hepworth, and Doherty in 1984 until 2009. The sample population for this research study included articles in all issues of five peer-reviewed journals: *Family Process; Families, Systems, & Health; Journal of Marital and Family Therapy; Journal of Family Therapy;* and *Family Practice* which included the term medical family therapy in its content. This chapter will discuss the results of the study in two parts: The manifest content of the inquiry expressed quantitatively, and the latent content of the inquiry which is the qualitative component of the study.

The manifest content, that which is visibly observable, is expressed quantitatively. The number of articles from each journal was recorded to provide a baseline in order to obtain percentages and frequencies of the occurrence of medical family therapy journal articles within the twenty-five year time period (see Table 1). The total number of articles in the *Journal of Marital and Family Therapy* observed from its table of contents was 860, eight (.93%) of which included the term medical family therapy in its content or title. The *Journal of Family Therapy* contained one article (.15%) with medical family therapy in its content out of the 664 articles published. *Family Process* also published one article (.12%) within the time period (1984 until the end of 2009) among the 836 total

number of published articles. *Families, Systems, & Health* (known as *Family Systems Medicine* when initially created) published the majority of the medical family therapy articles in this inquiry which totaled 38 (4.43%) out of the 858 articles written. The medical journal, *Family Practice*, did not have any articles with the term medical family therapy in its content, out of a total of 2025 articles; however, the term biopsychosocial appeared in the titles of articles from the table of contents. Biopsychosocial does appear in the definition of medical family therapy in Chapter I of this study, which was a key term found throughout the articles taken for the qualitative component of this study.

Table 1
Number of Medical Family Therapy Articles Published From 1984 until 2009

Journal	Total Number of Articles	Total Number of Medical Family Therapy Articles	Percentages
Families, Systems, & Health	858	38	4.43%
Family Process	836	1	0.12%
Journal of Family Therapy	664	1	0.15%
Journal of Marital and Family Therapy	860	8	0.93%
Family Practice	2025	0	0
Total	5234	48	0.92%

In addition, the researcher compiled a list of the disciplines contributing the published articles. Family therapy generated 31 authors, and 19 authors were from family medicine. Two authors, in addition to being physicians, were family therapists.

Contributing disciplines of authors are seen in Table II. A majority of the authors participated both in academia as well as clinical practice. Out of the total 48 articles, 21 were under the category of clinical practice, 13 were categorized as research articles, 9 articles were descriptive of the training of medical family therapists, and the remaining 5 the researcher categorized as theoretical.

Table 2
Discipline of Authors Publishing Medical Family Therapy Articles from the Five Journals

Healthcare Discipline	Number of Authors Publishing Medical Family Therapy Articles
Family Therapy	31
Pediatric Medicine	3
Family Medicine	19
Psychiatry AND Family Medicine	6
Psychiatry	4
Behavioral Pediatrician AND Family Therapy	2
Physician Assistant	2
Psychology/Other Psychotherapy	11
Behavioral Sciences	4
Nursing	5
Social Work	2
Osteopathic Medicine	1
Child Development and Family Relations	8

Table 2 cont

Table 2 (continued)
Discipline of Authors Publishing Medical Family Therapy Articles from the Five Journals

MBA	1
Family Social Sciences	3
Applied and Professional Studies	1
Center for the Study of Addiction and Recovery	1
Lifespan Family Healthcare	1

Qualitative Content Analysis

Each article was read and analyzed by the researcher who kept in mind the primary research question, "What has been written about medical family therapy in selected scholarly journals?" Articles which included the term medical family therapy were read in detail and coded by content under the predetermined categories of theory, research, clinical practice and training. The following five primary themes emerged after the third round of the coding process, which appeared across each of the broader categories: Agency and communion; the role of power; knowledge base and competency; collaboration; and culture.

Agency and Communion

The goals of medical family therapy are to establish a sense of agency and communion (McDaniel, Hepworth, & Doherty, 1992). Agency refers to helping patients and families achieve a sense of control and autonomy by making their own choices regarding managing their own health and illness, and, communion refers to achieving

and maintaining a sense of connection with the healthcare team, their social networks and the community, as illness can elicit a sense of helplessness and isolation. The theme of establishing a sense of control and developing meaningful relationships and connections with the physician, the rest of the healthcare team and family, friends and the outside community was prevalent throughout the literature. Agency and communion are necessary and significant components to establishing patient and family-centered care. Listening to patients and families is a necessary and significant component to establishing agency and communion. Deeper connections and relationships with the physician and healthcare team promotes improved compliance to treatment, which is important since the family is the context within which diagnosis, treatment and management of health and illness occurs (Doherty & Baird, 1983).

Giving up the control of managing and coping with illness to the patient and family requires trust and respect for patients' and families' wisdom and expertise. Trust and respect come with deeper connections with patient, family, and healthcare team which develops through improved communication and dialogue within the family, between the patient/family and healthcare providers.

Although many of the families with chronic illness are healthy functioning families, they may need assistance with learning effective coping skills. In order to manage chronic illness effectively, patients and families need to increase their knowledge of the diagnosis, which is often done with psychoeducation. An additional strategy to help families cope more effectively focuses on "putting illness in its place", maintaining a sense of family unity and identity without the illness becoming the identifying factor in

the family, which is often the case. "Putting illness in its place" incorporates the attention to progress in individual development in addition to the progress of the family unit and its development and life stages. The medical family therapist helps creates illness narratives and hope, and connection by shared meaning (Sellers, 2000; Harrington, Kimball, & Bean, 2009). The medical staff, along with the therapist and patient, become learners and teachers for each other. The act of listening, without judgment, to the experiences and narratives and meanings patients and families hold is essential. This can also facilitate the personal and professional growth of each of the healthcare team members.

Establishing communion connects patients and families to community resources and organizations for information and/or support, increases the staff's understanding of the patient's individual experience and establishes a better relationship with the healthcare system (Anderson, Huff, & Hodgson, 2008). There is a continued assessment and reevaluation of how the impact of the healthcare system is affecting the patient, family and course of illness (Leahy, Galbreath, Powell, & Shinn, 1994).

Davey, Duncan, Foster, and Milton (2008) reported on a case in an AIDS pediatric and adolescent clinic's transition from traditional to integrative care with medical and family therapy providers. Long-term medical and psychosocial support is required for HIV patients and their families. Improving communication and "putting illness in its place" is exemplified in the case of GB, a twelve-year-old Latino boy who was HIV+, and living with his grandmother. GB was diagnosed at infancy, born to a known HIV+ mother with severe mental health issues and drug addiction.

GB's grandmother insisted the healthcare team refer to her as "mother" because, "I'm the only mother he has known." Grandmother often admitted that she went back on her word regarding punishments and consequences, because she feels bad that he is HIV+ and his mother abandoned him. Grandmother tended to give GB double messages about being too sick and infantile to be punished, but not too old to do chores around the house. The family therapist respectfully challenged the parenting style of the grandmother, encouraging her to use a clearer and more direct style of communication about expectations and rules in her home. Team members then modeled clear and direct communication with the grandmother in their interactions. (Davey et al., p. 353)

"The staff, by seeing progress through concrete results, was able to focus less on family chaos during medical visits.... The staff was also able to see concrete evidence of improved medication adherence" (Davey et al., p. 354).

Listening to the patient's experience of and beliefs and meanings around the illness is a component to establishing agency and communion. Latz and Baird (1994) documented dialogue between the therapist and a forty-five-year old woman continuing cardiac rehabilitation:

> At the first session, Mary greeted me saying, "Where were you when I needed you?" My response was, "I don't know, but I'm here now and ready to listen." Mary began to describe her biomedical experiences and spoke about how she made sense of her life over the last three years. She told me she had undergone bypass surgery a year ago. It had taken her

> doctors almost three years from her first complaint of exhaustion to their recommendation for surgery. I asked, "How do you think this happened?" Mary replied, "I don't know, but my symptoms of possible heart problems began when I was forty-two years old and I began feeling tired all the time". Mary had explained away her exhaustion as part of everyday life with two teenage (14 and 17) sons. She also worked outside the home. Her husband lived and worked 250 miles away because he was unable to find a local job. (Latz & Baird, p. 205)
>
> Mary has a serious disease (ischemic heart disease) that is difficult to diagnose early and has complicated medical and surgical treatment. At this point, she remains angry and frustrated and does need a way to process her experience and associated feelings. The therapist is immediately helpful by just listening, but would be even more helpful by inviting the primary care physician and the patient's family members to join this important family discussion. (p. 206)

"Her anger toward her physician can be addressed most helpfully with the physician present. If the therapist had invited the physician and family members, everyone would be able to offer perspectives on this difficult experience." (p. 206) "Mary and her family, however, did not agree with the physician that her condition was a major health problem. I asked, "How did you and your family decide that your condition wasn't serious?" She stated, "Everyone knows that young women don't have heart problems." (p. 207)

Another illustration of the process of agency and communion is from the article by Radomsky (1996) in which she describes experiences in the doctor-patient partnership.

> In the following story about Karen, I see the healing process as not just a matter of my determining the correct patient label by the usual diagnostic approach and then applying the right treatment. Rather, I see a balance between being with Karen in a way that allows her space to value her own perspective about the healing journey and my need to act in a way that is respectful of this process. (p. 498)

"Paradoxically however, I've noticed that when I'm more willing to take the risk of being with my patients and being respectful of my patients' healing process, I'm less exhausted." (p. 502).

Munshower (2004) describes how he coordinated group visits for his diabetic patients and an additional family member to address issues surrounding the care and management of diabetes, and time management for the physician to meet the needs of his patients.

> Guest speakers over the course of the year included a dietitian, an exercise therapist, a nephrologist, an opthalmologist, a vascular surgeon, a podiatrist, and a dermatological nurse practitioner. They each generally spoke for about a half hour and also gave out educational materials, which the patients stored in binders. . . . The dialogues were lively. As the group members became more knowledgeable about their disease, they asked

> more informed questions and offered more incisive observations. They learned to kid with each other about their respective situations. . . . I expected that the patients' increased knowledge of diabetes would change their relationship with their disease. In my mind, education is the road to empowerment. I watched many of my patients gradually get their arms around their disease like they never had before. I saw many of them follow through on getting tests and making lifestyle changes that we had discussed forever but that they had not been ready to undertake . . . . I also had not anticipated how strong the influence of the patients would be on each other - stronger than the medical information provided. (p. 499)

A component of agency is helping families cope more effectively. This is exemplified in an excerpt from the article by Muchnick, Davis, Getzinger, Rosenberg, and Weiss (1993): "Putting illness in its place helped patients to take better control of their lives. It also helped the doctor to focus time, energy, and resources, on medical care of the patients." (p. 175)

Knishkowy & Herman (1998) documents a case study of a patient named Ruth who presented with multiple physical and psychosocial symptoms:

> Regardless of scientific justification, prescribing antibiotics is often influenced by "clinical information of a nonphysical nature.". . . For family doctors, prescribing a drug that makes little scientific sense, as with Ruth, may be a means of preserving the physician-patient relationship so that more rational therapies, such as empathy, may be brought to bear. Such decisions may also have

broader implications when considering the "family as a unit"(Ramsey & Lewis, 1990). (p. 327)

Communion is establishing connections with family, friends, and community. Harkness & Nofziger (1998) demonstrate this in an excerpt from their article: ". . . [He] also supported our ideas on referring Mr. Smith to a dual diagnosis program for more intensive outpatient care." (p. 447).

The Role of Power

Power as a theme, permeated multiple levels of each of the categories. It was found in relationships, within and between the patient and family, the physician, and other healthcare providers, and with the medical family therapist as the leader of the collaborative process taking a "one down position". Power issues were seen beyond the healthcare setting in the political and economic levels, the hierarchy in medicine, and through the hospital/healthcare system and insurance industry/Health Maintenance Organization (HMO) which dictate services patients can receive and the time physicians can spend with their patients. Medical family therapy is aware of and addresses power at each of these levels in addition to being mindful of the power illness has over the family. The following are examples of the role of power embedded in the process of providing health care.

Bell, Wright, and Watson (1992) interpreted the term medical family therapy as one which creates distance between other healthcare disciplines.

> The term "medical family therapy" can imply that the medical narrative is more significant than other narratives (p. 35). Medicine has a rich tradition of

> power, influence, and hierarchical prestige, which can hinder its curiosity about knowledge generated by other disciplines. . . . another example of physician myopia was evidenced at a 1990 conference called a "Symposium on the Family in Primary Health Care." Although professionals from a variety of disciplines were invited, the focus of the entire conference was on strategies to improve family medicine's practice and research with families . . . By family therapy not making a border crossing to other lands such as family nursing, social work, sociology, and anthropology, family therapists are left with a skewed and limited view of other disciplines' knowledge and clinical competency in working with families with physical health problems. (p. 36)

Grauf-Grounds & Sellers (2006) elaborated on creating internships and special jobs for medical family therapists: "We strategically solicited physicians, nurses, and clinical decision makers who might welcome the help provided from a psychotherapist who could be placed within their medical site." (p. 232) The article elaborated further showing the underlying role of power in the healthcare system:

> . . . Some of the enthusiastic physicians we met with were part of a clinic that was housed inside a larger organizational structure. This factor meant the decision-making power no longer resided with the attending physicians but rather with a medical director over several clinics or with another administrator. Generally the larger the medical organization and the more complex its structure, the longer it took to launch a site. (p. 236)

Leahy, Galbreath, Powell, and Shinn (1994): ". . . Add to this the fact that mental health is the only service to which a patient can self-refer, while also being the only benefit with significant co-payments and limits associated with visits there, and you begin to see some of the complexities involved in a collaborative effort." (p. 438)

The University of San Diego's marriage and family therapy training program, and a family medicine residency based in a large health maintenance organization, Sharp Healthcare, are integrating care in order to practice within a collaborative framework (Patterson, Bischoff, Scherger, & Grauf-Grounds, 1996). . . . These therapists will have less autonomy than therapists in the past because utilization review and federal clinical practice guidelines will affect treatment planning (Sanderson, 1995). (p. 8)

Lareau & Nelson (1994) focused on prevalence and feasibility of a physician/counselor liaison practice. "In Great Britain, whether the physician pays the counselor or whether the counselor bills for services, the physician is ultimately responsible for the patient" (p. 38). The role and status of the physician is paramount in the healthcare system in addition to the public perceptions contributing to this status.

"The intern [medical family therapist] discovered that some interventions were most effective when delivered by the physician and members of her natural support system" (Gawinski, Edwards, & Speice, 1999, p. 477). In this same article, the authors then elaborated on part of the training/orientation to the medical setting:

> The family therapy intern joins the new physicians during an intense week of orientation. This experience allows the intern to establish relationships with

physicians outside the work environment and helps to diminish the hierarchy problems that commonly exist in medical settings. (p. 479)

Linville, Hertlein, and Lyness (2007) commented in their literature review of medical family therapy: "Many times, the focus seems to be on how psychotherapists can better collaborate with physicians and there seems to be less of a focus on how physicians can better collaborate with therapists" (p. 94).

The literature describes the physician and/or nurse practitioner being the ones to initiate referrals to the medical family therapist in addition to the physician setting the tone for patient-therapist relationships. Aspects of agency and communion (improved patient/family relationships and deeper connections with the physician) impact how power influences the process of treating and managing patient needs and is exemplified through the following excerpts:

". . . The medical providers initiate the collaborative care approach during a patient's routine medical visit" (Phelps, Howell, Hill, Seemann, Lamson, Hodgson, et al., 2009, p. 134).

Reust, Thomlinson, and Lattie (1999): ". . . However, to state the obvious, none of these benefits can accrue to patients or healthcare systems if patients do not show up for their behavioral health appointments after the referral by the physician" (p. 400).

Regarding the referral process, clusters of behavior and language emerged.

> . . . (1) physician extolling positive qualities of the mental health facility, e.g., "we have a cooperative relationship," or, "we have an excellent facility here onsite,", (2) physician preparation and exploration of mental health perceptions

with patient, e.g., encouraging patient, checking affective responses to the idea of the referral, normalizing mental health referrals.... (Reust et al., p. 405)

> . . . Therapists believed that when the referral to psychotherapy is initiated by a trusted, respected physician, the patients' respect for that physician transfers to the therapist. . . . Therapists also believed that patients' positive relationship with their physician - and the patients' perception of the referral as a prescription - enhanced the benefits of psychotherapy. Finally, therapists believed that physician referrals increased client attendance rates. (Todahl, Linville, Smith, Barnes, & Miller, 2006, p. 52)

> . . . I was often present during the physician's consultations with the patient, and I decided that the best way to become part of the system initially was to take a "one-down" stance in the triad . . . Due to the different routines of the two supervising physicians, the methods of integration into the system were very different. With one doctor I was a part of the initial examination/interview process.... (Muchnick, Davis, Getzinger, Rosenberg, & Weiss, 1993, p. 275)

Knowledge Base and Competency

McDaniel, Hepworth, and Doherty (1992) dispelled the notion that it is not enough to place a family therapist in a medical/healthcare setting and call it medical family therapy. Although knowledge and competency was explained in detail with articles descriptive of the training process of medical family therapist interns, this theme emerged in the other categories as well. The eight sites across the country providing postgraduate courses, doctoral programs, inservice programs, clinical site training and/or

fellowships in medical family therapy are University of Rochester, Loma Linda University, Seattle Pacific University, Wake Forest University, University of Minnesota, University of Chicago, and East Carolina University. Nova University has also an established Family Systems Health Care Clinical Specialist degree to meet the need for training family therapists to work collaboratively with medicine as part of a family-focused healthcare team (Muchnick et al., 1993).

The training site at University of Rochester Department of Family Medicine for family therapy doctoral students utilizes an interdisciplinary collaborative team approach. The themes of the internship experience encompass immersion into a multidisciplinary healthcare setting, exposure to diversity of patient population, the redefinition of own understanding of systems, sharing, exploring the self as therapist and the development of a cohort of trainees (Gawinski, Edward, & Speice, 1999). The internship experience highlights the salient themes of collaboration, culture, importance of knowledge within the medical arena, and awareness of power and medical hierarchy. Similar to the other medical family therapy sites, the University of Rochester integrates knowledge in the use of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) reference text, psychopharmacotherapy, psychoeducation treatment and family therapy. An expanded awareness of the integral role the larger social systems play in the lives of families is introduced through the diversity of the population and the complex psychosocial issues which present in this busy urban setting.

University centers for medical family therapy provide training in psychosocial curriculum which incorporates a biospychosocial model with systems theory (Harkness &

Nofziger, 1998). In an outpatient oncology clinic, familiarization and education on medical protocols and radiation medicine, treatment effects, equipment, diagnoses, and language is a prerequisite (Yeager, Auyang, Brown, Dickinson, Goldstein, Jaffe, et al., 1999). Seattle Pacific University offers a training certificate in medical family therapy. Like the other sites, core requirements for the outpatient clinic include physiology, knowledge of medical issues and of the medical profession regarding collaboration and use of common language. Therapists' beliefs of spirituality and health are also explored, as interns will be confronted with issues concerning pain and suffering, life and death (Grauf-Grounds & Sellers, 2006).

Building awareness and a knowledge base in the culture of medicine, diagnoses, protocols, collaboration, pharmacology, biology/physiology, family systems and illness/health existed in all the curriculums. Specialized training at the Chicago Center for Family Health practices a family centered collaborative model of healthcare which includes the family systems approach, developmental and family life cycle, a resilience framework, and knowledge regarding the typology of illnesses (Rolland's family systems-illness model). At this site, a social justice and advocacy orientation are more evolved and organized (Rolland & Walsh, 2005).

The training sites differed in how medical family therapy was implemented, as each clinic adapted this integration of medicine and psychotherapy to meet unique needs. A biopsychosocial approach integrating medical family therapist interns into a medical practice/clinic evolved due to multiple factors: A general acceptance across disciplines of a biopsychosocial systemic paradigm to guide practice, physician frustrations with

limited time and/or expertise in treating patients with multiple complex psychosocial issues (Muchnick et al., 1993), and the creativity of healthcare providers and instructors in expanding the sites for medical family therapy interns. Many training sites were affiliated with university programs, and the universities and programs were known to medical practices within the community. Clinics with medical family therapy interns were also more cost effective than hiring a licensed medical family therapist. The following examples are from the theme of knowledge base and competency:

". . . One of the important tasks for family systems health care educators is to prepare graduates for collaboration with health care professionals. . ." (Muchnick et al., 1993, p. 271). ". . . It was necessary to enter the doctor's worldview in order to build a bridge between the two cultures. . .We knew that the cultural exchange had occurred when we began to hear the doctors' talk reflect family therapy language" (p. 276).

> . . . Educated together, physicians and therapist can achieve a level of comfort and understanding about each other's field that does not occur in traditional training programs. . . . When I first arrived at the Family Medicine Center, I spent considerable time learning how to read medical charts and becoming familiar with common diagnoses. (Harkness & Nofziger, 1998, p. 443)

Rolland and Walsh (2005) elaborated within their article workshops to increase knowledge base and competency, encouraging supervisors of medical family therapist interns to take advantage of these offerings as well as other healthcare disciplines. Examples of these workshops are as follows:

. . . In 2003, CCFH (Chicago Center for Family Health) began offering a new certificate format in a series of monthly workshops:

- . . . Families, Illness, & Disability: An Integrative Approach. Provides overview and clinical application of Rolland's Family Systems Illness Model
- . . . Parental Illness or Disability: Meeting the Challenges of Childrearing. Addresses issues with children and adolescents (e.g., separation/dependency); separating illness from person; honoring strengths; building community of care; including extended kin
- . . . Aging, Chronic Illness, and Caregiving. Addresses key challenges: Sons and daughters, couples, diverse cultural expectations challenges with dementia, and balancing eldercare with other life cycle demands
- . . . Living and Loving Beyond Loss. Examines legacies of complicated or traumatic loss; applies Walsh's Family Resilience Framework to foster healing and adaptation. . . (p. 296)

Recommendations to supervisors of medical family therapy interns mirror those for the interns themselves:

> Shadow a physician. An effective way to get quickly immersed in medical culture is to shadow a physician in an outpatient or inpatient setting. . . Visit the medical setting. Visiting the medical setting where

> students are placed is important at the beginning of an internship and throughout a trainee's internship. A supervisor could visit the setting for a number of reasons, including live or case report supervision and to attend lectures on a variety of topics. . . Read the foundational medical family therapy texts and journals. The Appendix provides a list of key books and journals devoted to the practice of family therapy in medical settings. Attend multidisciplinary conferences. The Collaborative Family Healthcare Association (CFHA), The Society of Teachers of Family Medicine (STFM), and Society of Behavioral Medicine (SBM) organize conferences focused on families in health care and multidisciplinary treatment in medical settings... Have access to resources on pharmacology. (Edwards & Patterson, 2006, p. 41)

Culture

A biopsychosocial approach to care is often implemented because of the high incidence of comorbidity seen in the physician's office, the diversity of culture and increased complex psychosocial needs of the patient. Culture is not only attended to with families in family therapy, but within the healthcare system, the clinic/office environment and the process of clinical practice, including meanings of time, physical space, language, paradigm, and patient motivation (Edwards & Patterson, 2006). Specific diseases, when treatment and management is ongoing for long periods of time, are enveloped in their own culture. In addition, how illness is diagnosed, treated and managed is influenced by the social and political zeitgeist.

The following is an excerpt from an article Davey and colleagues (2008) had written citing a 2003 article from Mitrani, Prado, Feaster, Robinson-Batista, & Szapocznik:

". . . Additionally, there has been a profound effect on low-income African American and Latino families who tend to be disproportionately affected by HIV/AIDS in the United States, highlighting the need for both family centered and culturally sensitive approaches" (p. 350).

> . . . The second modification used to increase collaboration was a change to include a different community agency with a history of providing family therapy with more focus on culturally sensitive care, including in-home family services, allowing for closer collaboration between staff and agency workers and the use of culturally sensitive systemic therapeutic models. (Davey et al., p. 352)
>
> ... A unique strength of our program is the population we are able to reach. Our patients include primarily African American and Hispanic populations in eastern North Carolina whose income ranges from zero to $30,000 dollars annually... Having bilingual providers on our team was also critical, insofar as it facilitated the building of rapport, collecting accurate data, and conducting effective therapy. (Davey, et al., p. 137)
>
> ... Depending on the amount of experience a physician has with Latinos, with somatization, or with integrated care, such symptoms may or may not indicate to the physician that there is a psychological component

> involved. The best approach for somatization (regardless of a patient's ethnicity) is an integrated biopsychosocial approach, yet many physicians misinterpret symptoms and try to use a purely biomedical framework (McDaniel et al., 1992, cited in Willerton, Dankoski, & Martir, 2008).

"Having a culturally competent medical family therapist on the treatment team could increase the likelihood that such symptoms be recognized as involving an emotional basis" (Willerton et al., p. 201).

> . . . There are four main reasons why the presence of medical family therapists in medical settings could increase and improve mental health care for Latinos: (a) their physical presence integrated into a medical practice would reduce access and availability barriers for Latino patients; (b) family therapists, because of their family systems approach, may be most culturally congruent for working with Latinos and their families. . . . (Willerton et al., 2008, p. 203)

Culture in clinical practice is illustrated in the following excerpt: ". . . The interns collaborated in the day-to-day work of biomedical professionals and promoted a cultural exchange between the perspectives of systemic therapy and biomedicine." (Muchnick et al., 1993, p. 272)

". . . We came from various back-grounds, but we learned the medical culture by working in it." (Yeager et al., 1999, p. 428) ". . . Radiation treatment represents a whole new world for them, and a whole new language." (Yeager, et al., 1999, p. 429)

" . . . It is critical that medical family therapists develop a fine-tuned understanding of how medical culture differs from psychotherapeutic culture and how to navigate with ease, compassion, and savvy within a medical setting with all medically trained personnel" (Grauf-Grounds & Sellers, 2006, p. 231).

Diseases have their own unique characteristics and accompanying meanings held by society, families, and individuals.

> ... Typically framed as a function of ethnic, racial, or religious characteristics, culture contextualizes family dynamics and the associated interactions between therapists and family member. We suggest that culture may transcend ethnicity and race and that other sociodemographic groupings can also be included in its discussion and definition. (Harrington, Kimball, & Bean, 2009, p. 16)

"... most families who experience the diagnosis of a child with cancer become participating members in the 'culture of childhood cancer.' As such, they become part of a cultural group with its own unique terminology, traditional practices, rites of passage, and individual-and family-focused demands." (Harrington et al., 2009, p. 16)

Collaboration

Collaboration is the partnership between medical providers and family therapists within a biopsychosocial approach to health and illness (McDaniel et al., 1992). Collaboration is found throughout the categories, with slight variations in how it is practiced and adapted to a particular medical setting. Collaboration relates to integrating the biological and psychosocial for more effective, holistic, quality care (Davey et al.,

2008; Gellerstedt & Mauksch, 1993; Fogarty, 1996; Navon, 2005; Ruddy, Farley, Nymberg, & Hayden, 1994) and the role of the medical family therapist in practice with medicine and other healthcare disciplines. Medical family therapy is often defined as collaborative care. One of its underlying premises is that there is no separation between the biological and psychosocial levels. "All human problems are biopsychosocial systems problems" (Doherty, McDaniel, & Hepworth, 1994, p. 34). Medical family therapy brings a biopsychosocial systems perspective to treatment and management of illness that is unavailable in any established area of psychotherapy (Doherty et al., 1994). It is attentive to the recursive relationship between families and illness (Yeager et al., 1999).

A collaborative practice aids physicians in their role, decreasing stress (Harrington, Kimball, & Bean, 2009) and increasing job satisfaction (Sellers, 2000) is cost effective (Weiner & Lorenz, 1994), and provides a comprehensive biopsychosocial approach. Collaboration challenges time management (Sellers, 2000).

A side effect of having medical family therapists and physicians working side by side expands care to be more comprehensive; it broadens the view of problems presenting symptoms in context (Leahy, Galbreath, Powell, & Shinn, 1994). The working alliance between physician and family therapist influences each other's treatment of the patient (Ruddy et al., 1994; Fogarty, 1996). A therapist-patient-family relationship contributes to knowledge and resources of the collaborative healthcare team (Doherty et al., 1994).

Muchnick and colleagues (1993) noted that collaboration helps physicians by addressing:

- frequent utilizers of healthcare
- time constraints of physician to meet psychosocial needs of patients and families
- patient/family's emotional responses to diagnosis/illness
- limitations of MD expertise
- complex issues, vague complaints, somaticizing families
- conservation of resources for all levels: patient, family, staff, financial, and administrative (Rolland & Walsh, 2005).

". . . In therapy, Sara disclosed that one of the men who had sexually abused her used the guise of 'playing doctor.' This made medical visits extremely anxiety provoking, and made it difficult for Sara to trust Dr. Farley." (Ruddy et al., 1994, p. 329) "Had her medical and psychological treatment been performed separately, it is unlikely that her physician would have realized the possible consequences and meaning of certain medical procedures for Sara..." (Ruddy et al., 1994, p. 337).

Prest, Fitzgibbons, and Krier (1996) documented a case of an eighteen-year-old boy who had been injured in a motor vehicle accident resulting in massive brain injuries. Mary was his mother.

Dr. Fitzgibbons reported that Mary had been visiting the clinic regularly, presenting "everything from a broken thumb to gastritis." In

addition to her grief over her son and uncertainty regarding the future, during these visits Mary reported that she and her husband Jack disagreed about their son's prognosis and care....(Prest et al., 1996, p. 387)

> . . . Dr. Fitzgibbons also expressed her concern for Mary's well-being, pointing out the number of symptoms she was dealing with that seemed related to stress and anxiety. I (medical family therapist) joined the discussion by asking them to reflect on their roles within the family. I asked them about their perceptions of how these previously functional roles had become problematic during this family crisis. All family members agreed that Mary was bearing a disproportionate burden.... (Prest et al., 1996, p. 391)

"... Medical family therapists, among other psychosocial providers, are often called upon to provide consultation to health care systems" (Seaburn, 1994, p. 183). "The CEO contacted me at the time of a young patient's death, which had greatly affected all the staff, because she was concerned about the impact of such deaths on the Center's staff and medical professionals" (Seaburn, 1994, p. 184).

". . . Despite the demands of a busy practice, the physicians manage to stay true to the biopsychosocial model. Two of the five physicians have postgraduate training in family therapy and maintain small family therapy practices" (Ruddy et al., 1994, p. 327).

> . . . The physician reported that having a family therapist in the office was a great help with a constant problem - the lack of time... Seeing many patients with serious life-threatening illness didn't leave much time

for conversation with family members about problems they were facing in managing the disease. (Muchnick et al., 1993, p. 273)

". . . her intent is to act as the bridge between medical and mental health disciplines by shifting the team's focus to a comprehensive, biopsychosocial perspective." (McDaniel, Hepworth, & Doherty, 1992, cited in Phelps, Howell, Hill, Seemann, Lamson, Hodgson, et al., 2009, p. 135.) ". . . Medical family therapists work to foster an environment of encouragement where patients can begin to explore their choices while applying recommendations from the collaborative team." (Phelps et al., 2009, p. 136)

"...Specifically, a MedFT [medical family therapist] may be an ideal fit given their extensive training for integrated care work in medical contexts and skills at maneuvering the systemic, contextual, and cultural barriers common when mental health services are merged with a traditionally biomedical clinic" (Phelps et al., 2009, p. 138).

Summary

This chapter discussed the results of this content analysis which contained both quantitative and qualitative components. It was a descriptive analysis for the purpose of ascertaining what has been written about medical family therapy in five scholarly journals from 1984, when the term was first created by McDaniel, Hepworth, and Doherty, until 2009. The qualitative component included all articles containing the term medical family therapy in all issues of the five peer-reviewed journals, *Family Process; Families, Systems, & Health; Journal of Marital and Family Therapy; Journal of Family Therapy;* and *Family Practice,* were read in full and then reread and coded for emerging key concepts and themes. The quantitative component expressed the total number of

articles in the twenty-five year time period with the total number of articles containing the term medical family therapy in its content, in addition to what discipline was prevalent in publishing trends, and which category (clinical practice, theory, research, or training) the articles described.

Families, Systems, & Health contained the majority of articles with a prevalence of 4.43%. The disciplines of family therapy and family medicine generated the most articles regarding medical family therapy. The themes which emerged as a result of the coding process were: Agency and communion, the role of power, knowledge base/competency, culture, and collaboration. The themes emerged across each category (clinical practice, theory, research, and training), were intertwined, and had mutual influence over each other. The articles demonstrated how a comprehensive, holistic, biopsychosocial approach with a systemic lens impacts complex family and healthcare dynamics.

CHAPTER V

DISCUSSIONS, LIMITATIONS, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS FOR FUTURE RESEARCH

Discussions

This chapter discusses the findings within the present day context and healthcare environment, and the need for more comprehensive and systemic thinking. Findings are then related to present implications for family therapists, in general, and recommendations for research. Limitations of this inquiry are also discussed.

The biomedical model is limited in its sole focus on disease and biological processes, and the inability to address the complex psychosocial issues and family dynamics which influence the course and processes of health and illness. The uniqueness of medical family therapy lies in its biopsychosocial and systemic approach to intervention with patients and families coping with medical illness. It is a change in paradigm in how medicine is practiced and disease occurs. All diseases have been demonstrated to be biopsychosocial in nature which can be influenced by biomedical and psychosocial processes (Campbell & Patterson, 1995).

Campbell (2003) stated, research affirming the efficacy of family therapy in the treatment of physical illness is in its infancy. Research exists regarding how the perceptions of stress can affect the body, contributing to illness, and the recursive relationship between the influence of family dynamics and health and illness (Kannai,

2009), but research focusing on the efficacy of (medical) family therapy in the treatment of chronic illness is rare. There were only two randomized, control studies which showed a significant decreased utilization of healthcare with family therapy intervention compared to individual psychotherapy (Law & Crane, 2000; Law, Crane, & Berge, 2003). There have been no other randomized control studies demonstrating the efficacy of medical family therapy in the treatment of medical illness.

Although studies with families and their influence on health and illness date back to the 1920s, there has been stagnation in research in this area. This could possibly be due to the Depression and World War II, among other global events, in addition to the growth in specialized medicine and direction toward fragmented or compartmentalized care. Correlating with fragmentation is an individualistic and reductionistic lens through which conditions are addressed. The specialty of family medicine, created in the late 1970s at the time when the discipline of family therapy was flourishing, recognized the need to return to a more comprehensive biopsychosocial approach.

Limitations

Only refereed articles published from 1984 until 2009 which contained the term medical family therapy were analyzed from the journals *Family Process*; *Families, Systems, & Health*; *Family Practice*; *Journal of Family Therapy*; and *Journal of Marital and Family Therapy*. The researcher looked at all the issues in each of the journals within the twenty-five year time period. A majority of the counts obtained were from viewing the Table of Contents from the hard copies of the journals; however, four years of *Families, Systems, & Health*, and two issues from the *Journal of Marital and Family*

Therapy were missing and were obtained and viewed on-line from the Texas Woman's Library site. The entire contents for the medical journal *Family Practice* was obtained and viewed on-line through Louisiana Tech University Library access.

Reviewing the materials on-line may influence results, as there may be differences in reading and processing materials electronically from viewing a book in hand. The view of the Table of Contents in *Families, Systems, & Health* may have appeared more compartmentalized in the physical books holding the journal volumes. One example of this was an article written by McDaniel (1992) which was originally included for qualitative review. Upon printing out the article, and obtaining a physical copy of the journal issue, the article was discovered to be under the commentary section, which was excluded from the focus of this study.

This inquiry is also limited in its exclusion of nursing, social work, and other healthcare professions which work and contribute significantly to the health and well-being of families. The number of articles generated in this study is by no means exhaustive of articles containing medical family therapy in its content. The *Journal of Family Therapy* was chosen related to its European (UK) origin and systemic perspective, as chronic illness is a global concern. The researcher came across an article on medical family therapy (describing a case study of a mother with Chron's Disease and her son) in the *American Journal of Family Therapy*, which was not a journal included in this study.

The five scholarly journals selected are well respected, widely circulated, and are a quality sample within the field of family therapy. *Families, Systems, & Health*, which

generated the majority of articles, had created a section for submission of articles to the journal titled Medical Family Therapy Casebook. This was done after the book *Medical Family Therapy* was published in 1992, by McDaniel, Hepworth, and Doherty. McDaniel was/is a contributing editor of the journal. Mindful of the limitations, the benefits of a comprehensive biopsychosocial approach were apparent in the literature. There still needs to be more research done regarding medical family therapy's efficacy in the treatment of physical illnesses, and an agreement among multiple disciplines for a common language to be used for guiding research.

Conclusions

In ascertaining what has been written about medical family therapy, this inquiry focused on five scholarly journals relevant to family therapy and healthcare. A content analysis was done revealing that the use of the term medical family therapy is not a universally shared or accepted phrase, and is defined and practiced in various ways, from group intervention without any psychotherapist mentioned (Munshower, 2004), to a family therapy model (Kowal & Johnson, 2003), to, more accurately, a biopsychosocial systemic framework within which any psychotherapeutic interventions can be applied.

The term biopsychosocial was prevalent throughout the literature. Even though *Family Practice* had no articles with the term medical family therapy, articles containing the term biopsychosocial did appear. It was just not the focus of this inquiry to evaluate those articles. In addition to the fields of family therapy and medicine, there were other healthcare fields generating articles and contributing to a much needed expanded view of health and illness. This is encouraging.

The five themes generated from the qualitative analysis were prevalent across each of the categories and exhibited a mutual, intertwining, and recursive relationship with each other. A sense of agency and communion are established by attending to power and cultural issues within the healthcare system, and often the broader social, political, and economic systems, in addition to the family system. To be an advocate for patients and families requires a knowledge base and competency in family systems, culture, medicine and diseases. Successful collaboration of family therapy with medicine and other healthcare disciplines requires knowledge and competency, awareness of power structure (and perhaps, intervention toward obtaining less imbalance of power) and culture of the clinical site. Deeper connections with patients and families is transforming to a system. Letting go of control to families and entering in a partnership with them transforms the power structure, and changes the culture of the environment. The literature suggests that including relational work in all levels of complex multiple systems of healthcare is necessary for optimal, cost effective, and quality care.

Practicing from the premise that there are no biological problems without psychosocial significance and no psychosocial issues without biological effects, incorporation of a systemic and biopsychosocial approach is pragmatic. The literature emphasizes the need to normalize and make collaborative care standard. Some of the benefits discussed included improving relationships, increasing job satisfaction, decreasing burnout, improving compliance to treatment, decreasing hospitalizations, providing continuity of care, team building, decreased use of psychotropic medications,

decreased utilization of healthcare/office visits/phone calls, helping healthcare providers with time management and proving cost effectiveness.

Interestingly, these five themes relate to the current status of family therapy in the treatment of physical illness and in the medical environment: Economic and political trends supportive of compartmentalized medical care, reimbursement issues, stigma associated with mental health care and mental illness (Lareau & Nelson, 1994), and the different culture and structural differences in the fields of medicine and family therapy (Clark, Linville, & Rosen, 2009) disciplines may be problematic. Once more, the themes of power and culture emerge in the broader context towards achieving a collaborative effort. Humans are social beings and exist in relationships. Who is more qualified than family therapists to take a position as one of the primary healthcare provider resources?

Implications

The benefits of pursuing research in utilizing a biopsychosocial systems framework is supported by the literature. I believe we are at a crossroad. Collaboration does not mean combining two disciplines with similar lenses, like medicine and individual psychotherapy, but expanding the view of how illness and health manifests within a person to a relational perspective. Family therapists, and other systemic thinkers, can impact the way health and illness is viewed, treated, and managed, and can steer practice and research towards a more effective model.

Family therapists practicing outside the primary care setting, should be mindful of the physical health of their clients, in addition to any medications they are taking, and should establish communication with their clients' primary care physician as necessary.

Their interventions can effect medical management and treatment. Collaboration with medical family therapists and their expertise on families and systems provides an expanded lens in which to view and treat illness.

McDaniel (1992) states that the economic cost of establishing a collaborative practice are not as influential as resisting a shift to a new paradigm and sharing power. Engel (1977) confronts his colleagues as to whether comfort in professional identity and status stunts progress towards improving the human condition. There is a problem with accepting medical family therapists by other psychosocial providers (Grauf-Grounds & Sellers, 2006). There is also a mistrust of physicians on the part of therapists who may have an anti-medical belief system (Gawinski et al., 1999).

I believe the differences in the culture, structure and focus of family therapy and medicine is what makes the integration and collaboration comprehensive and effective. The differences in perspectives broadens the view of presenting problems or symptoms in context (Leahy, Galbreath, Powell, & Shinn, 1994). Physicians and medical family therapists can work on the same goal for the patient with different tools (Clark, Linville, & Rosen, 2009).

Managed care, patient reluctance, unavailability of therapists in rural communities (on-site collaboration much more utilized), financial issues, lack of adequate feedback to physician by therapists, lack of understanding what an LMFT is, and the stigma attached to mental health care also provide obstacles to collaborative process (Clark et al., 2009). Training sites for medical family therapy interns are also difficult to find.

Health and healing within a family context is encouraged and supported, or discouraged and prevented, by the larger political and socioeconomic systems in our communities (Rolland & Walsh, 2005). In the wake of heated healthcare reform debates, family therapists, systemic thinkers, need to play a more active political role. Integrative care - mental health services WITH medical treatment - should be standardized care. Behavioral sciences are given a low priority in sciences (Weiner & Lorenz, 1994). There are disadvantages to change. Family therapists and systemic thinkers can provide a broader lens to view the complex health problems and solutions in context. Family therapists have an important role in the treatment of physical illnesses. Medical family therapy provides the framework within which to practice and to collaborate with other healthcare disciplines.

Recommendations for Future Research

Research on family therapy as an intervention for the treatment of physical diseases is at the point where research on families and schizophrenia was thirty years ago, and most of the research on family interventions was not conducted by family researchers or based on family science (Campbell, 2003,).

Campbell's (2003) review of evidence of family intervention and its impact on physical health and illness expand on the particular areas for research in the family science field which is pertinent to the practice of medical family therapy: Observational research on families and health to identify family variables and specific family processes which influence health and illness needs to be done. This will facilitate evidence-based practices in family therapy. Randomized control trials with marriage and family therapy

need to be based upon family theories and family science. Measured outcomes can be brought to insurance companies and can increase recognition, credibility, and support by healthcare providers for family therapists in medical settings.

Intervention studies should measure multiple outcomes within broader family systems including individual patient, family members' physical and emotional health, quality of dyadic relationships within a family system, and overall healthcare costs (Campbell, 2003). Interventions attentive to gender and diversity is an additional area in healthcare in which research is lacking. Future studies should include all different types of families in structure, culture, and ethnicity. Most current studies are conducted with White middle class families (Campbell, 2003, p. 276). Family therapy is attentive to these issues.

Research comparing traditional medical practices and those with medical family therapists need to be done measuring cost effectiveness, utilization of healthcare, job satisfaction, rate of hospitalizations, and patient compliance. Outcome studies across a variety of chronic illnesses comparing medical family therapy intervention to controls need to be done. Studies comparing family therapy treatment to medication alone are also lacking.

Studies within an action-oriented framework can be beneficial in demonstrating medical family therapy's social utility. Many chronic diseases are attributed to lifestyle, and family histories are connected to predisposition of disease. Obesity has become a focus for United States' first lady, Michele Obama, as it has been associated with chronic diseases of diabetes, heart disease, and cancer. Family therapy should assert their position

as the most qualified resource on families AND systemic theories, and conduct, among other types of research, longitudinal studies. Although family therapists take a "one down position" within a collaborative practice, the discipline of family therapy should not be quiet. Family therapy needs to educate the public and the medical profession regarding our knowledge and expertise, and we need research to support this position. Family therapists can have a significant impact in the health and well-being of patients, families, and communities, and their expertise in systems is sorely needed on a more global level in policy making.

> The age of innocence is over. We now know that human life is a seamless cloth spun from biological, psychological, social and cultural threads; that patients come with bodies, as well as minds, feelings, interaction patterns and belief systems, that there are no biological problems without psychosocial implications, and no psychosocial problems without biological implications.
>
> (McDaniel, Hepworth, & Doherty, 1992, p. 1)

The distinction between physical and mental disorders is an artificial and culturally determined one (Campbell & Patterson, 1995). Family therapists and physicians should be equal partners in helping patients and families coping with chronic illness. The goals and tenets of medical family therapy provide a foundation for a new and different way of healthcare delivery.

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APPENDIX A

Coding Worksheet

CODING WORKSHEET

Name of Journal _____

Article Citation _____

_____

_____

Author(s) _____

Professional Affiliations: _____

_____

Discipline:

Medicine (specialty)_____ Family Therapy _____ Nursing(specialty) _____

Social Work _____ Education _____ Other _____

Categories for Coding:

Theory _____ Training _____ Clinical Practice _____

Research _____ Academia _____

Other _____

Key Words and/or phrases and emergent themes or topics:

_____

_____

_____

Narrative Notes _____

_____

APPENDIX B

Articles for Qualitative Analysis

ARTICLES FOR QUALITATIVE ANALYSIS

Families, Systems, & Health

Anderson, R. J., Huff, N. L., & Hodgson, J. L. (2008). Medical family therapy in an inpatient psychiatric setting: A qualitative study. *Families, Systems, & Health, 26*, 164-180.

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