PATIENTS WITH PSYCHOSOCIAL ISSUES: THE REFERRAL PRACTICES OF FAMILY PHYSICIANS

A DISSERTATION

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BY

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To the Dean of the Graduate School:

I am submitting herewith a dissertation written by Teresa Masdon entitled "Patients with Psychosocial Issues: The Referral Practices of Family Physicians." 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 Metcalf, Major Professor

We have read this dissertation and recommend its acceptance:

Department Chair

Accepted:

Dean of the Graduate School

DEDICATION

To my loving husband, Scott Masdon,
who encouraged me (with a kick or two) to pursue my dreams.

To my children, Carmelle, David, Nathan, Tamarah, Naomi, and Galen,
who inspired me to never give up.

To my practice partners, Skeeter and Pepper,
who kept me company during the long process.

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ABSTRACT

TERESA A. MASDON

PATIENTS WITH PSYCHOSOCIAL ISSUES: THE REFERRAL PRACTICES OF FAMILY PHYSICIANS

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Over the past twenty years, there is growing concern that primary care physicians worldwide medically treat most psychosocial complaints of their patients with little or no referrals for psychotherapy. This study has contributed to the void in the literature and offers insight as to which mental health professionals are used by family physicians when referring patients with psychosocial issues. A quantitative online survey was designed and made available to the current members of the National Research Network of the American Academy of Family Physicians. The questions inquired as to the participants' familiarity with six mental health providers as well as which of these is most preferred and considered most effective in assisting their patients. These mental health professionals included: counselors, psychiatrists, marriage and family therapists, psychologists, social workers, and psychiatric nurse practioners.

The members who completed the survey ($n = 80$) comprised 37.6% of the total NRN listserv ($N = 213$). The majority of participants who completed this survey were M.D.s (95%) and male (78.8%) with an average of 21.6 years of experience in practice. All of the participants (100%) reported that they prescribe psychotropic medications.

Descriptive statistics found the overall rankings of the different mental health providers. Psychologists ranked highest as a first choice for psychotherapy referral and were seen as most effective in assisting patients as well as being among the most familiar to these physicians. Psychiatrists were noted to be most familiar to these physicians but ranked third as a preferred referral choice and were considered second to last as effective with these patients.

Coming from the perspective of marriage and family therapy, the study found that licensed marriage and family therapists (LMFTs) are mental health professionals who are among the least chosen and the least known to family physicians when referring their patients for psychotherapy. Yet, family physicians consider LMFTs among the top choices of psychotherapists who are highly effective. Since family physicians are the medical specialists most likely to hear first about a person's mental or emotional distress, these findings provide important implications, especially for LMFTs. Recommendations for both practice and further research are presented.

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CHAPTER I

INTRODUCTION

In 2007, antidepressants were the number one medication ordered by U.S. physicians with over 233 million prescriptions written (IMS Health, 2007a). In the same year, Americans spent $13.1 billion dollars on antipsychotics and $11.9 billion dollars on antidepressants (IMS Health, 2007b). The increasing use of psychotropic medications prescribed by physicians to treat psychosocial issues of patients is noted to have first begun in 1988 with the introduction of SSRIs, that is, selective serotonin reuptake inhibitors (Pincus et al., 1998). A number of studies examining the practice trends of primary care physicians point out that during the years since 1988, there has been a marked decline of patients receiving psychotherapy for psychosocial problems (Balestrieri, Paltrinieri, & Bellantuono, 1992; Glied, 1998; Goldberg, 1995; Lecrubier, 2001; Linden et al., 1999; Olfson, Gameroff, Marcus, & Jensen, 2003; Rushton, Clark, & Freed, 2000; Tardieu et al., 2006).

The greatest concern of this trend toward a surge in psychopharmacologic emphasis as well as the sharp decline in psychotherapy referrals is that it is not limited to an adult population or to the field of psychiatry. There has been a considerable rise in family physicians and pediatricians who prescribe psychotropic medications to young children (Olfson et al., 2002; Zito et al., 2002). Studies have found that when humans ingest antipsychotics, antidepressants, and antianxiety drugs, changes take place in the

brain's neurotransmitter function (Fava, 2003; Fava et al., 1994; Fisher, S. & Greenberg, 1997; Hyman & Nestler, 1996). Such changes in the brain resulting from use of psychotropic agents present grave consideration for the vulnerable, developing brain of the young child. This concern is compounded by the fact that there is a virtual lack of clinical research on the consequences of pharmacologic treatment of behavioral disturbances for very young children taking psychotropic medications (Coyle, 2000; Werry, 1993; Wong, Camilleri-Novak, & Stephens, 2003).

What does the future look like for a two year old already started on antipsychotic and antidepressant medications? What will that child be like in the teenage years? Do physicians simply keep increasing his or her drug doses? Practice trends reveal that changes in psychiatric service have currently made psychiatrists unavailable or undesirous of providing psychotherapy (Dial, Bergsten, Haviland, & Pincus, 1998; Eveland et al., 1998; Goldman, 2001; Harpaz-Rotem & Rosenheck, 2006; Penn, 2008). What is behind the fact that the majority of primary care physicians around the world are not referring patients with psychosocial issues for psychotherapy to those mental health specialists outside of medicine?

There are numerous studies demonstrating the effectiveness of psychotherapy in helping people with a range of psychosocial problems (Asen, Berkowitz, Cooklin, & Leff, 1991; Dessaulles, Johnson, & Denton, 2003; Dutra et al., 2008; Fals-Stewart, Yates, & Klostermann, 2005; Huxley, Rendall, & Sederer, 2000; Knekt et al., 2008; MacPhee, Johnson, & Van Der Veer, 1995; Miklowitz et al., 2007; Ritvo & Papilsky,

1999; Shadish, Ragsdale, & Glaser, 1995; Weissman, 1994). Of all the different mental health practioners available, the medical family therapist (LMFT) is uniquely prepared to address the multi-dimensional aspects of human life (McDaniel, Hepworth, & Doherty, 1992). Despite all this evidence, there is furthering decline in the number of physicians referring patients for psychotherapy. A void exists in the literature exploring what influences these referral practices of primary care physicians with their patients presenting with psychosocial and emotional problems. This study explored which mental health practioners family physicians refer their patients to for psychosocial and emotional concerns with particular interest in regards to LMFTs.

Statement of the Problem

In the developed countries around the world, general practioners (GPs) or family practice (FP) physicians are the medical specialists most likely to hear first about a person's mental distress. Over the past thirty years, managed care organizations have identified FPs or GPs as primary care physicians (PCP) to act as gatekeepers in overseeing patients' entire healthcare. The global trend evident in research data shows that PCPs are currently treating most mental disorders or complaints of their patients with little or no referrals to psychotherapy (Balestrieri et al., 1992; Glied, 1998; Goldberg, 1995; Lecrubier, 2001; Linden et al., 1999; Rushton et al., 2000; Tardieu et al., 2006). One study reported (Glied, 1998) that PCPs treat more than 90% of mental issues of their patients. The rising trend reveals that these physicians' predominant treatment of their

patients' psychosocial problems is to write a prescription. This has led to psychotropic medications becoming the number one drug now prescribed in America.

Yet increased psychopharmacotherapy has not lowered the number of depressed persons; in fact, these numbers have steadily been climbing for the past twenty years. The number of unhappy people grows as evidenced in divorce and suicide rates. The U.S. probability of divorce or separation remains between 40-50% for the average couple marrying for the first time, which is among the highest globally (Haskins, McLanahan, & Donahue, 2005; Popenoe, 2007). In 2005, suicide was ranked as the eleventh leading cause of death in the U. S., accounting for 32,637 deaths (McIntosh, 2005). Homicide ranks fifteen. For young people, suicide is the third leading cause of death (National Institutes of Health, 2005). Is medication alone really the answer for the majority of distressed adults and youths?

The growing field of psychoneuroimmunology highlights the connection between stress and increased vulnerability to disease (Fife, Beasley, & Fertig, 1996; Guidi et al., 1998; Kiecolt-Glaser, McGuire, Robles, & Glaser, 2002; Reiche, Morimoto, & Nunes, 2005; Steptoe, Hamer, & Chida, 2007). Among available mental health professionals, medical family therapists are exclusively trained to pay particular attention to the connection between biological, psychological, relational, and emotional processes of human beings (Brucker et al., 2005). Yet in the medical literature there is almost no mention of licensed marriage and family therapists (LMFTs) as a potential choice for referral of patients from medical practioners. Studies have shown that the personal

opinions of physicians play an important role in treatment practices (Glied, 1998). What is the family physician's level of familiarity of the different mental health professionals? There is virtually no information available and a void remains in the literature regarding this topic.

Statement of Purpose

The purpose of this study was to explore which mental health professionals family physicians use for referral of their patients presenting with psychosocial/emotional concerns. Coming from the perspective of marriage and family therapy, this study has provided additional knowledge and guidance to the American Association for Marriage and Family Therapy (AAMFT) in building collaboration with the medical community. Not only can physicians worldwide benefit from a collaborative relationship with medical family therapists and other mental health professionals, but patients and families across the world can experience comprehensive care in addition to psychopharmacotherapy.

Research Questions

Several questions closely related to the following were presented in an online survey:

1. What estimated portion of family physicians' patients present with psychosocial issues?
2. What estimated amount of patients presenting with psychosocial issues are referred for psychotherapy?
3. Which mental health practioners are used when family physicians refer their patients for psychotherapy?

4. How often do these family physicians refer to marriage and family therapists for psychotherapy for patients presenting with psychosocial issues?
5. How does the training of family practice physicians influence their preference choices in making referrals for patients with psychosocial issues?

Definitions

For the purpose of clarification, the following terms have been used throughout the study:

Aminergic Systems: System regulating the characteristics, activation, or secretion of one or more biogenic amines (Coyle, 1997).

Antianxiety Agents: These are the drugs that physicians order to treat symptoms of anxiousness or feelings of uneasiness or apprehension that patients may be experiencing.

Antidepressants: These are the drugs ordered by physicians to treat symptoms of prolonged sadness that may be apparent in their patients.

Antipsychotics: A class of drugs prescribed by physicians to treat mental disorders such as psychosis, schizophrenia, and various states of mania, depression, or paranoia.

Biopsychosocial: Refers to the systemic perspective that considers an interlinking of the biological, psychological, and social processes in an individual or family system (Engel, 1977).

Emotional Problems: These are problems encompassing a person's feelings, behaviors, and thoughts. These represent the subjective perspective of each individual

and are considered to be connected with mood, temperament, personality, and disposition.

Family Medicine: The area of study to prepare a physician for family practice.

Family Practice Physician (FP): A physician who specializes in family medicine by completing a three-year training period in family medicine, known as a residency, in addition to a medical degree. After completion of their residencies, FPs are eligible for board certification, which is required by most hospitals and health plans.

Gatekeeper: Someone who controls access to either someone else or something else.

General Practioner (GP): This is a term frequently used outside of the U.S.A. for physicians who specialize in family medicine. Prior to 1968 when family medicine was recognized as a separate specialty, these were the physicians who trained to treat all ages and both genders for a wide range of illnesses; they are now commonly referred to as family practice (FPs) physicians in the U.S.

Homicide: The act of one person killing another person.

Managed Care Organizations: These are organizations whose primary purpose is to reduce the cost of healthcare, while providing optimal quality of healthcare services. These groups serve as overseers in the management of healthcare services for those people who pay specified fees.

Medical Family Therapy: A family therapy approach that addresses the biomedical along with the emotional, psychological, and relational processes impacting the human species.

Mental Health Providers: These are professionals who treat psychosocial and emotional distress and represent any of the following fields: counseling, psychiatry, marriage and family therapy, psychology, and social work.

Multi-dimensional: This term reflects the variety of dimensions that constitute the qualities exhibited in humans. These dimensions include: mental, emotional, physical, and relational processes.

Neurotransmitter: These are chemicals that are primary in the transmission of signals between a neuron and a cell (Cozolino, 2006).

Pediatrician: A physician who specializes in treating children age 0 to 18 by completing a three-year training period in pediatrics, known as a residency, in addition to a medical degree. After completion of their residencies, pediatricians are eligible for board certification, which is required by most hospitals and health plans.

Physician: This refers to those who have completed medical school as well as residency training to diagnose and treat illness and injuries in humans. Physicians are also known as doctors and medical practioners.

Prescriptions: These are the written directions of physicians for the preparation and use of a drug to treat and remedy unwanted symptoms.

Primary Care Physicians (PCPs): These are medical doctors who treat a wide spectrum of diseases and health problems. In the U.S., these physicians have been recognized by insurance companies and managed care organizations to provide the first contact for anyone with a health concern.

Psychiatrist: These are physicians who have completed a residency in psychiatry. They are trained to treat mental disorders and are one of the mental health providers who may prescribe medications to patients.

Psychoneuroimmunology: The field of scientific study of the interactional process between the neurological, psychological, and immunological systems within the human body (Steptoe et al., 2007).

Psychopharmacotherapy: The specialized use of medications in the treatment of symptoms considered to manifest from behavioral and psychological origins in a human.

Psychosocial: This term refers to the interconnection between psychological, that is mental, and social factors. Problems that occur in one's psychosocial functioning normally include aspects that may be psychological, emotional, or relational in nature.

Psychotherapy: This term refers to the primary treatment venue of mental health professionals assisting their clients with any problems with their life.

Psychotropic: This term refers to the chemical substances that target the central nervous system in the human brain to evoke changes apparent in mood, behavior, and interactional patterns.

Referrals: When one patient is recommended or transferred to the care of another professional.

Stress: A broad term referring to physical, mental, or emotional strain or tension. These can originate with a situation or a response by the body to a stimulus, as in fear or pain.

Suicide: When a person intentionally takes his or her life and dies.

SSRIs or selective serotonin reuptake inhibitors: A fairly recently developed class of antidepressant medication which indirectly increases the extracellular amount of serotonin by inhibiting its reuptake into the following presynaptic cell.

Delimitations of this Study

With regards to the pursuit of any research, investigators need to consider the delimitations inherent to their study (Becker, 1997). By identifying the delimitations of a study, the generalizability of the study's results will have more validity (Babbie, 2004). Since the sample selected resulted from the listserv of current members of the National Research Network (NRN) of the American Academy of Family Physicians (AAFP), these participants have limited this study in similar ways:

1. The sample reflected the population of family physicians across America and did not reflect any other specialty physician group or practice.
2. The family physicians who answered these survey questions may not adequately represent the entire population of family physicians in the nation as there is no

clarity in understanding the thoughts or perspectives of those physicians who did not answer this survey.

Summary

Though in 2007 antidepressants were the number one drug ordered by U.S. physicians with over 233 million prescriptions written (IMS Health, 2007a), depression continues to trouble many Americans (Haskins et al., 2005; McIntosh, 2005; National Institutes of Health, 2005; Popenoe, 2007). Of particular concern is the considerable rise in family physicians and pediatricians who prescribe psychotropic medications to young children (Olfson et al., 2002; Zito et al., 2002). There is evidence that psychotropic drugs can seriously affect the health of the brain in children and adults (Fava, 2003; Fava et al., 1994; Fisher, S. & Greenberg, 1997; Hyman & Nestler, 1996). This concern is compounded by the fact that there is a virtual lack of clinical research on the consequences of pharmacologic treatment of behavioral disturbances for very young children taking psychotropic medications (Coyle, 2000; Werry, 1993; Wong et al., 2003).

Since 1988 when the amount of antidepressant prescriptions began to soar, there has been a marked decline of patients receiving psychotherapy for psychosocial problems (Balestrieri et al., 1992; Glied, 1998; Goldberg, 1995; Lecrubier, 2001; Linden et al., 1999; Olfson et al., 2003; Rushton et al., 2000; Tardieu et al., 2006). Practice trends reveal that changes in psychiatric service have currently made psychiatrists unavailable to provide psychotherapy (Dial et al., 1998; Eveland et al., 1998; Goldman, 2001; Harpaz-Rotem & Rosenheck, 2006; Penn, 2008). And yet numerous studies have demonstrated

the effectiveness of psychotherapy in helping people with a range of psychosocial problems (Asen et al., 1991; Dessaulles et al., 2003; Dutra et al., 2008; Fals-Stewart et al., 2005; Huxley et al., 2000; Knekt et al., 2008; MacPhee et al., 1995; Miklowitz et al., 2007; Ritvo & Papilsky, 1999; Shadish et al., 1995; Weissman, 1994).

Among available mental health professionals, medical family therapists are exclusively trained to pay particular attention to the connection between biological, psychological, relational, and emotional processes of human beings (Brucker et al., 2005). Yet in the medical literature there is almost no mention of licensed marriage and family therapists (LMFTs) as a potential choice for referral of patients from medical practioners. Studies have shown that the personal opinions of physicians play an important role in treatment practices (Glied, 1998). What is the family physician's level of familiarity of the different mental health professionals? A void exists in the literature exploring these referral practices of primary care physicians with their patients presenting with psychosocial and emotional problems. This study has examined which mental health practioners family physicians refer their patients to for psychosocial and emotional concerns with particular interest in regards to LMFTs.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

This literature review examined the trends of psychopharmacotherapy of primary care physicians (PCPs) normally identified as general practioners (GPs), family practice physicians (FPs), or pediatricians. Since psychotropic medications are commonly prescribed to both adults and children, the consequences on human growth and developmental health for this practice pattern have been explored. This review has investigated whether the primary role of physicians' psychopharmacologic treatment has been effective in reducing psychosocial problems in America.

A discussion of the published data as to the possible influences for the progressive decline of psychotherapy will follow. Understanding the evolving changes that have taken place in the medical arena provides a clear foundation in this pursuit of knowledge. In considering the diminished use of psychotherapy within the practice of physicians, the unique expertise of medical family therapists who are commonly LMFTs has been explored as well as their ability to aid patients and their families with biopsychosocial problems. Finally, this review examined the past and potential future of collaboration between mental health professionals, in particular LMFTs, and primary care physicians.

Rising Wave of Human Depression: New Drugs as Preferred Medical Treatment

With the introduction of fluoxetine hydrochloride (Prozac) in 1988, a marked shift has been observed in the pharmacologic practices of physicians across America (Pincus et al., 1998). This medication was the first of a new a class of drugs known as SSRIs (selective serotonin reuptake inhibitors) to treat a person's depression. Olfson and Klerman (1993) reported that between 1980 and 1989, the total number of office visits including a prescription of a psychotropic drug remained fairly stable. Another investigation (Hermann et al., 2002) found a sustained nine year decline in the use of antipsychotic drugs during the 1980s but then a sharp increase during the 1990s. Between 1988 and 1994, the sum of depressed patients seeking aid doubled among all physician groups (Pincus et al., 1998). In that same study, psychiatrists saw the greatest surge in depressed patients in the 1990s from 35.8% to 52.6% of total office visits.

The rising trend in pharmacotherapy has not been limited to the treatment of depression. A recent study examined the treatment options for anxiety disorders (Olfson, Marcus, Wan, & Geissler, 2004). The authors collected data between 1987 and 1999 from two leading national medical surveys. Outpatient treatment of anxiety disorders rose from 0.43 per 100 persons in 1987 to 0.83 per 100 persons in 1999. It is interesting to note that of these subjects, antidepressant use increased from 18.3% to 44.9% while the use of benzodiazepines as well as psychotherapy experienced a decline. A similar decline in the use of psychotherapy to treat patients with attention deficit hyperactivity disorder (ADHD) was observed in another study (Olfson et al., 2003). From 1987 to 1997, these

researchers found that for a sample of children presenting with ADHD, there was a significant decrease in psychotherapy along with an increase in the number of stimulant prescriptions given.

Following the inception of SSRIs, of greatest concern has been the considerable surge in the number of family physicians and pediatricians who prescribe psychotropic medications to young children (Olfson et al., 2002; Zito et al., 2002). In the study by Zito and colleagues, 1% to 1.5% of all children age 2 to 4 years old enrolled in either a Medicaid program or a managed care organization received stimulants, antidepressants, or antipsychotic drugs. These authors noted that psychopharmacologic treatment in this age group sharply rose during the 1990s. In an earlier study done (Zito et al., 2000) data confirmed that psychotropic medications for preschoolers increased dramatically between 1991 and 1995. Around the same time, evidence revealed that a large majority of prescriptions written for psychotropic drugs for children were provided by family practioners or pediatricians (Goodwin, Gould, Blanco, & Olfson, 2001).

In an analysis of Michigan Medicaid claims in the late 1990s, researchers identified 223 children who were age three or younger who had been diagnosed with ADHD. Nearly 60% of these children received psychotropic medications while almost half of these were prescribed two or more psychotropic drugs (Rappley et al., 1999). With a focus on the use of psychotropic medications by children and adolescents within six Independent Practice Association health plans, Shatin and Drinkard (2002) noted an increase of SSRIs prescribed from 7.9 to 12.8 per 1000. In a more recent study examining

the use of psychotropic medications for 277 adolescents under treatment for alcohol use disorders, antidepressant use increased significantly from 18% to 55% from 1991 to 2000 (Clark, Wood, Cornelius, Bukstein, & Martin, 2003).

Yet these trends are not limited to the United States. Adams (1991) investigated the prescribing patterns of general practioners (GPs) and child psychiatrists in Great Britain. She used a questionnaire to look at a three month period of a sample of practice trends for 100 GPs and 28 child psychiatrists. She found that 73% of the GPs and 46% of the psychiatrists reported prescribing hypnotics to preschool children. About 72% of both groups reported prescribing psychotropic medication for children under the age of 18 during the months explored. In a study conducted in Germany, the prescribing practices of GPs, pediatricians, and psychiatrists were compared (Trott et al., 1995). These investigators found all three groups documented prescribing psychotropic medications every month with an average of 20.4% of these prescriptions written for 2 to 5 years old. In Turkey, researchers found that SSRIs are among the most common medications prescribed within a child and adolescent psychiatric outpatient clinic (n = 822) with 54.2% of depressed children under this treatment (Aras, Varol Tas, & Unlu, 2007). Data collected in Australia (Efron et al., 2003) of a sample of 435 pediatricians and 187 child showed that 72% of these practioners (n = 622) frequently prescribe a combination of psychotropic medications for children who present with various psychosocial issues.

A Hard Pill to Swallow

There is growing apprehension of this world-wide trend of increased use of psychotropic medications in medical treatment practices. Studies have found that when humans ingest antipsychotics, antidepressants, and antianxiety drugs, changes take place in the brain's neurotransmitter function (Fava, 2003; Fava et al., 1994; Fisher, S. & Greenberg, 1997; Hyman & Nestler, 1996). The concern of these investigators is that the use of these drugs may result in physical changes creating chronic mental illness and the need for ongoing medication. Such changes in the brain resulting from use of psychotropic agents present grave consideration for the vulnerable, developing brain of the young child. Studies of laboratory animals have shown that the aminergic systems, which comprise the main target action of these psychotropic medications, play an important role in neurogenesis, axonal outgrowth, synaptogenesis, and neuron migration (Coyle, 1997).

Other studies reveal the persistent effect in young rats that these drugs have on a growing brain. One study (Mazer et al., 1997) involving the depletion of serotonin in the postnatal rat resulted in long-term decrease in cortical synaptic density manifesting as special learning and memory deficits in adulthood. A prior study demonstrated prolonged abnormality in dopamine receptor function with altered levels of dopamine and norepinephrine in perinatal rats given an antipsychotic agent (Rosengarten & Friedhoff, 1979). These animal studies suggest the detrimental effects that psychotropic medications can have on a developing brain and provide important implications to guide the

prescription practice of physicians. But of added interest is the virtual lack of clinical research on the consequences of pharmacologic treatment of behavioral disturbances for very young children taking psychotropic medications.

In a article written on the medical practices of psychopharmacotherapy in children (Werry, 1993), the author reported on the results of current empirical tests. He stated that, with the exception of medications for early onset adult psychiatric disorders, there was little evidence that any available psychotropic drugs were beneficial in the long term treatment of psychosocial issues in children. In more recent findings (Wong et al., 2003), researchers point out that the number of psychotropic prescriptions for both adults and children has significantly increased though the majority of these medications are not licensed for children and adolescents due to the lack of clinical studies.

There seems to be general consensus among medical practioners that psychotropic medications are of little proven value in treating distressed infants and preschoolers (Coyle, 2000). This has been documented in well designed double-blind studies of preschool children diagnosed with sleep disturbances (Richman, 1985) as well as aggressive behavior (Shaw, Keenan, & Vondra, 1994) where the children received psychotropic medications for a brief period of time. Authors in both studies suggested a decrease in isolated symptoms for these children. Yet, they stated that the changes were either temporary or accompanied by so many side effects that the medications were discontinued in virtually all cases as soon as the drug trial was completed.

Despite the evidence presented in these drug studies of animals and children, the number of prescriptions for antidepressants and antipsychotics continues to soar. In 2007, antidepressants were the number one medication ordered by U.S. physicians with over 233 million prescriptions written (IMS Health, 2007a). In the same year, Americans spent $13.1 billion dollars on antipsychotics and $11.9 billion dollars on antidepressants (IMS Health, 2007b). These figures underline that the current medical trend toward increased psychopharmacotherapy has not lowered the number of depressed persons; in fact, these numbers have steadily been mounting for the past twenty years. The number of unhappy people climbs as evidenced in divorce and suicide rates. The U.S. probability of divorce or separation remains between 40-50% for the average couple marrying for the first time, which is among the highest globally (Haskins et al., 2005; Popenoe, 2007). In 2005, suicide was ranked as the eleventh leading cause of death in the U.S., accounting for 32,637 deaths (McIntosh, 2005). Homicide ranks fifteen. For young people, suicide is the third leading cause of death (National Institutes of Health, 2005). Is medication alone really the answer for the majority of distressed adults and youths?

What does the future look like for a two year old already started on antipsychotic and antidepressant meds? What will that child be like in the teenage years? Do physicians keep simply adding drugs to his or her daily routine? Dr. John Harrington at Eastern Virginia Medical School's Division of General Pediatrics poses a similar question (Harrington, 2008). He asks whether physicians will keep increasing the medication doses as children get older to help with psychosocial and behavioral problems.

He suggests that behavioral interventions that are aimed at bringing psychosocial changes may have taken a back seat in the medical community. Is that true? What has contributed to such a shift in medical practice? How did we end up here?

Physicians Evolving Role as Lone Rangers

In the developed countries around the world, general practioners (GPs) or family practice (FP) physicians are the medical specialists most likely to hear first about a person's mental distress. In the U.S., family medicine was recognized as a separate medical specialty in 1968 as a result of the fragmentation of patient care (Sholevar & Sahar, 2003). Over the past thirty years, managed care organizations have identified FPs or GPs as primary care physicians (PCP) to act as gatekeepers in overseeing patients' entire healthcare. The global trend evident in research data shows that PCPs are currently treating most mental disorders or complaints of their patients with little or no referrals to psychotherapy (Balestrieri et al., 1992; Glied, 1998; Goldberg, 1995; Lecrubier, 2001; Linden et al., 1999; Rushton et al., 2000; Tardieu et al., 2006). One study reported (Glied, 1998) that PCPs treat more than 90% of mental issues of their patients. As previously discussed, primary care physicians' predominant treatment of psychosocial problems of their patients is psychopharmacotherapy. In two studies (Mechanic, 1990; Rogers, Wells, Meredith, Sturm, & Burnam, 1993) PCPs did not treat identified mental distress but in all these cases, physicians were not likely to refer these patients for psychotherapy. Why not?

Two studies reveal a trend among some GPs who are attempting to provide psychotherapy themselves for their patients. Trent (1990) observed that more GPs in Canada are seeking to gain additional psychotherapy skills in assisting their patients. In the Canadian medical system it is reported that referrals to psychiatrists are delayed over a long period of time due to the specialist's overburdened case loads. In a more recent study (Huibers, Beurskens, Bleijenberg, & Van Schayck, 2007) investigators suggested that since there is a large number of patients presenting to GPs with psychosocial issues, then it may be beneficial for GPs to acquire the tools necessary to help these patients. Using a mixed methods study, they found that GPs who utilized verbal problem-solving treatment protocol correlated with reduced depressive symptoms in patients diagnosed with major depression. Of course, the authors mentioned that typically a physician's practice is pressed by time constraints and psychotherapy is understood to be defined as a time-intensive process (Olfson, Marcus, & Pincus, 1999).

A qualitative study of 11 Danish GPs who frequently offered psychotherapy in their practice, revealed that these practioners were self-taught with no formal training in psychotherapy (Davidsen, 2008). How is it that GPs who are under tight time constraints in their practice and have not had formal psychotherapy training would consider attempting to offer such service to their patients? What has led to this current trend? Historically, GPs have used psychiatrists as consultants for referrals of patients with psychosocial disorders. Yet, the literature indicates that this is no longer the practice of PCPs.

Current findings suggest that primary care pediatricians predominantly use psychiatrists and psychologists as referral sources with a significant increase recently in the use of social workers for their patients with behavioral issues (Williams, Klinepeter, Palmes, Pulley, & Meschan Foy, 2007). This one study was solitary among those explored in this literature review in even mentioning family therapy as a referral choice, which was noted to be 2% of the total referrals of these pediatricians. The vast majority of medical data did not separately identify family therapy as a consideration for referral of patients with psychosocial issues. A small number of articles in the medical literature defined psychotherapy but consistently equated it with psychology and psychiatrists with these specific practice preferences (Kovacs & Lohr, 1995). By and large, the preferred consultant for PCPs was psychiatrists and psychologists. Yet, over and over again in the literature, researchers report that in the U.S. there seems to be a shortage of child psychiatrists and unavailability of psychiatrists in general (Dial et al., 1998; Eveland et al., 1998; Goldman, 2001; Harpaz-Rotem & Rosenheck, 2006; Penn, 2008). How can this be?

The psychiatric world since its inception in the early 1900s has undergone its own evolutionary process. In the plenary address given to the California Psychiatric Association in 1990, Dr. Wallerstein commented on the altered direction within psychiatry (Wallerstein, 1991). He lamented that psychotherapy had once been "the dominant vehicle of psychiatric care" but "is rapidly becoming an endangered species within psychiatry" (p. 421). He mentioned the growing popularity of

psychopharmacology as well as brief therapy as likely determinants in bringing about this change. Dr. Wallerstein reported that various educational systems currently require as little as 200 hours (2 ½%) of psychotherapy training out of the 8,000 hours comprising the 4 year residency program of psychiatrists. In a letter to the editor of the Journal of the American Medical Association (JAMA), Staudenmeier and Jacoby (1998) commented that these training changes in psychiatric residencies has resulted in specialists who are more comfortable in prescribing drugs than providing psychotherapy to patients. The literature supports this perspective as revealed in the reports of practice trends of psychiatrists.

Within the past decade, researchers observed that among psychiatrists there has been an increase in the number of psychotropic medications prescribed as well as a decline in psychotherapy (Gabbard & Kay, 2001; Mojtabai & Olfson, 2008; Olfson et al., 1999; Tanielian, Marcus, Suarez, & Pincus, 2001). From data collected from a cross-sectional National Ambulatory Medical Care Survey (1996 through 2005), Mojtabai and Olfson (2008) maintained that the percentage of patient visits with psychiatrists including psychotherapy decreased from 44.4% in 1996 to 28.9% in 2004. For the preceding decade (1985 to 1995) data collected from the same national survey (Olfson et al., 1999) showed that psychiatric visits that were less than or equal to 10 minutes made up the largest portion of total visits and there was a significant increase of these from 1985 (2.9%) to 1995 (12.1%). In examining practice trends for psychiatrists from 1988 to 1998, researchers found that in 1998 psychotropic medications were given to more than

80% of patients and in 1988 this figure was 40% (Tanielian et al., 2001). The literature discusses several explanations for this trend in psychiatric care.

The most recent exploration into psychiatric practice trends (Mojtabai & Olfson, 2008) offered various reasons for the decline of psychotherapy with patients. The authors implied that a primary influence has been the ongoing expansion of managed care plus the changes in reimbursement resulting from the introduction of the Federal Mental Health Parity Act of 1996. This speculation concurs with the findings of other researchers (Coyle, 2000; Detre & McDonald, 1997; Olfson et al., 1999; Peota, 2006). Mojtabai and Olfson's report included the growing increase of psychiatrists who specialize in pharmacologic treatments and a continued decline of psychiatrists who offer psychotherapy (2008). They explained that aggressive marketing of newer psychotropic agents has significantly contributed to diminished psychotherapy. The authors also suggested greater public awareness of mental health disorders as well as increased openness to pharmacologic treatment has added to the popularity of medication usage.

Another study cited changes in financial reimbursement as a dominating influence in the swell of psychopharmacotherapy (Silver, 2003). The researchers discovered that third-party reimbursement for one 45 to 50 minute outpatient psychotherapy session of psychiatrists is about 41% less than the reimbursement for three 15 minute medication management visits. There is expressed concern of the ethical ramifications of psychiatrists providing treatment based on the expected payment of managed care organizations (Kahan, 2000). Plus there are those who feel the current focus of

psychiatry, which is more pharmacotherapy than psychotherapy, is looking more like the world of GPs. The boundaries between these two medical fields seems to be somewhat fading.

In comparison analyses between the practices of GPs and psychiatrists, researchers point out that there are few differences in prescribing patterns. Harpaz-Rotem and Rosenheck (2006) contended that for a sample of depressed children, GPs increased use of psychotropic treatment and decreased use of psychotherapy was not significantly different than that of psychiatrists. When comparing the management of panic disorder between PCPs and psychiatrists, another study found greater similarity in pharmacologic treatment practices (Blanco et al., 2004). The decreased use of psychotherapy was even evident between PCPs and psychiatrists treating patients with mood or anxiety disorders (Mojtabai, 1999).

An expanse of research has demonstrated the effectiveness of psychotherapy in helping people with a range of psychosocial problems (Asen et al., 1991; Dare, Eisler, Russell, Treasure, & Dodge, 2001; Dessaulles et al., 2003; Dutra et al., 2008; Fals-Stewart et al., 2005; Furukawa, Watanabe, & Churchill, 2006; Guthrie et al., 1999; Huxley et al., 2000; Knekt et al., 2008; Lust, Ryan-Haddad, Coover, & Snell, 2007; MacPhee et al., 1995; Miklowitz et al., 2007; Ritvo & Papilsky, 1999; Shadish et al., 1995; Simon, Ludman, Bauer, Unutzer, & Operskalski, 2006; Weissman, 1994). What is behind the fact that the majority of physicians do not refer their patients for psychotherapy? There are a number of identified mental health professionals outside of

the medical field who have the expertise to remedy psychosocial issues along with empirical data supporting their efficacy. These include family therapists, counselors, social workers, and psychologists.

Could it be that, generally speaking, physicians do not esteem the qualifications of these mental health professionals? Within an article discussing the evolutionary changes resulting from managed care systems, the authors referred to those practioners outside the medical arena as "lower-level professionals" (Detre & McDonald, 1997, p. 202). Though the specific identity of these providers remains unclear, the authors presented their opinion that the preferred professional to intervene in these "complex clinical tasks" is the physician (p. 202). Is this opinion shared by many in the medical community?

The personal opinions of physicians have been shown to impact their treatment practices. In a study assessing the effect of practice characteristics of physicians on the diagnosis and treatment of mental health illness, practice style and specialty were identified as important factors (Glied, 1998). Practice style is understood to reflect the personal preferences of a physician. The author found a stronger relationship with this personal characteristic with the mental health treatments used for patients with psychosocial difficulties. In a prior examination of the impact of patient feedback to medical providers, it was found that a physician's level of interest and concern correlated highly with the likelihood of a mental health diagnosis (Shapiro et al., 1987). What part does training and experience play on the personal preferences and opinions of physicians in the treatment of psychosocial problems?

In this literature review, the only study found to partially address the influence of physician training on the knowledge of psychosocial treatment was conducted by Elkins and Wall (1996). These investigators sought to assess the training levels and knowledge of Texas physicians with regards to hypnosis. The sample consisted of both physicians with a wide range of accumulated experience and resident physicians still in training. Results showed that 79% of the experienced physicians and 67% of the residents had no prior education in hypnosis. How much of physicians' training includes familiarity of the different mental health professionals? There is virtually no other information available and a void remains in the literature regarding this topic.

Medical Family Therapy: Powerful Resource in Biopsychosocial Issues

Of the various mental health professionals available to assist medical patients and their families with psychosocial issues, the medical family therapist specializes in taking a biopsychosocial approach. Medical family therapy is a subspecialty within the profession of licensed marriage and family therapists (LMFTs). Coined in 1992, the term *medical family therapy* is a recently formed concept known as the "biopsychosocial treatment of individuals and families who are dealing with medical problems" (McDaniel et al., 1992). Medical family therapy is distinguished from other types of psychotherapy in that family therapists pay "mindful attention to the systemic and reciprocal influences among the illness, the individual, the family, and the medical system (including insurance providers) to help clients achieve their particular goals for therapy" (Brucker et al., 2005, p. 132).

These goals might include help with lifestyle changes, greater ability to handle a medical regimen of chronic illness or disability, and more effective communication with physicians and family members (Campbell, McDaniel, & Seaburn, 1992). For the medical family therapist, the systemic impact of illness is thoroughly explored as well as ongoing significant relationships. Doherty, McDaniel, and Hepworth (1994) assert that "the fundamental tenet of medical family therapy is that all human problems are biopsychosocial systems problems" (p. 34). More than ever, families are becoming aware that problems on the physical level are connected to every other aspect of the individual and the family.

Not only are physical symptoms intertwined with emotional and relational problems, the growing field of psychoneuroimmunology highlights the connection between stress and increased vulnerability to disease (Fife et al., 1996; Guidi et al., 1998; Kiecolt-Glaser et al., 2002; Reiche et al., 2005; Steptoe et al., 2007). It is generally accepted if one is unhappy, one is stressed. An abundance of studies have reported the biological effects of an unhappy marriage (Amato, 2000; Coyne et al., 2001; Kiecolt-Glaser et al., 1997; Kiecolt-Glaser et al., 1993; Kiecolt-Glaser et al., 1996; Marcenes & Sheiham, 1996; Mayne, O'Leary, McCrady, Contrada, & Labouvie, 1997; Wickrama et al., 2001; Zautra et al., 1998). In four of these studies, married partners who are dissatisfied with the marriage are more prone to have an impaired ability to fight disease (Kiecolt-Glaser et al., 1997; Kiecolt-Glaser et al., 1993; Kiecolt-Glaser et al., 1996; Mayne et al., 1997).

Of the remaining data, marriages with greater partner conflict are associated with a lower survival rate of patients having congestive heart failure (Coyne et al., 2001), an increase in rheumatoid arthritis (Zautra et al., 1998), early onset hypertension (Wickrama et al., 2001), and even greater incidence of periodontal disease (Marcenes & Sheiham, 1996). Yet apparently not having close connections with others can also be harmful. There is evidence that the lack of social support can be as dangerous to a person's health as smoking cigarettes (House, Landis, & Umberson, 1988). One study found that widowers have significantly reduced immune system function as compared to those who are married (Kiecolt-Glaser et al., 1987).

According to research, even children can experience stress when there is parental discord. Preschool children who were from families with greater conflict had higher levels of an identified stress hormone in their blood despite the fact that they did not necessarily witness the interactional conflict (Gottman & Katz, 1989). In a 2003 report, between 3.3 and 10 million children are exposed to domestic violence annually (Centers for Disease Control and Prevention, 2003). Approximately half of all children living today are expected to reside without one parent by the age of fifteen (Smeeding, Moynihan, & Rainwater, 2004). For many Americans, the home can be the center for stress and sorrow in life.

As Arthur Schopenhauer, a German philosopher, observed near the end of the nineteenth century, "almost all of our sorrows spring out of our relations with other people" (Schopenhauer, 1890, p. 72). In the 1980s and early 1990s, a substantial amount

of research was published exploring the relationships between family factors and health (Aronson, 1996; Campbell, 1986; L. Fisher, Ransom, Terry, Lipkin, & Weiss, 1992; Turk & Kerns, 1985). These research endeavors resulted in a greater recognition of the importance of family's dynamics in all aspects of healthcare. It became evident that the exclusively biological focus of medical science was limited to explain the complex, chronic diseases that are more common to families today (Doherty & Campbell, 1988). In addition, the biomedical model has been restricted in successfully assisting individuals in making healthy life style modifications.

Indeed, as presented by the Surgeon General's Report on Health Promotion and Disease Prevention, seven of the ten leading causes of death in the United States could be substantially reduced by improving just five habits. These are diet, smoking cessation, exercise, moderate alcohol intake, and correct use of antihypertensive medications (Doherty & Campbell, 1988). As with these habits, nearly half of all causes of morbidity and mortality in the United States are linked to behavioral and social factors. However the medical model's theoretical perspective limits itself primarily to biological processes.

Family psychologist, Dr. Susan McDaniel, potently observed "that every theory evolves in a particular context that is a fertile, determining environment for its development" (McDaniel, Harkness, & Epstein, 2001, p. 375). Such seems to be the case for George Engel, who in 1977 published a theory that was a foundational step towards a shift in perspective on medical illness. Engel, an internist, proposed that a fully comprehensive and scientific model of medicine involves the simultaneous consideration

of biological, psychological, and social issues (Engel, 1977, 1980). Dr. Engel insisted that all medical issues have psychological components and all psychosocial issues have biological features.

Based on the biopsychosocial systems theory developed from Engel's model, medical family therapy emerged to address the behavioral and social factors affecting health (McDaniel et al., 1992; Watson & McDaniel, 2005). Over the past two decades, a growing body of literature confirms the need for collaboration between mental healthcare professionals and medical healthcare professionals to provide optimal patient care (Blount & Bayona, 1994; McDaniel et al., 1992; Rolland, 1994; Seaburn, Lorenz, Gunn, Gawinski, & Mauksch, 2003; Turk & Kerns, 1985). What sets medical family therapy apart is the routine collaboration with medical professionals as well as working with and seeing illness as part of the system (McDaniel et al., 1992).

Collaboration is a primary aspect of medical family therapy and these specialists have an understanding of the medical system which facilitates a multidisciplinary team approach with physicians and other healthcare providers (Ruddy & McDaniel, 2003). Sometimes these collaborations take place across settings, such as in private practice, a medical clinic, or perhaps within the same institutional setting. To successfully integrate illness into the therapy, the family therapist has a working knowledge of diseases and their influence on individuals and families (Doherty et al., 1994). Medical family therapists are uniquely prepared to address the multi-dimensional aspects of human life and a powerful resource for healthcare practioners.

Benefits of Collaboration: Steps for the Cure

There is speculation that the limited reimbursement from Medicaid programs for the evaluation of behavioral and psychosocial issues in children and adults has made a significant effect on medical practice trends. Coyle (2000) believes that the multidisciplinary approach that was common in years gone by has mostly ceased to exist. Historically, such an approach of utilizing a collaborative approach of psychiatric and medical expertise is known to have been common practice in the twentieth century. It is recorded that the addition of behavioral and family system specialists began working alongside medical practioners during the 1950s to help bring successful resolution to difficult cases (Clayton & Pitts, 1965; Minuchin et al., 1975; Minuchin, Rosman, & Baker, 1978). Brook and Temperley (1976) remarked that it took time for a mutually satisfactory collaborative relationship to develop between these professionals and even though most physicians seemed reluctant, many expressed appreciation for the benefits to their patients.

If collaboration is not resurrected as a standard practice, then what will the future look like? As previously discussed, the continued trend for physicians globally is the rising use of psychotropic medications in treating psychosocial issues of their patients with little or no psychotherapy. Behr (1998) speculated that this trend is attributable to the fact that these drugs are new and novel which has sparked greater enthusiasm among physicians to write prescriptions. He compared this increase of psychopharmacotherapy to what happened in America when electroconvulsive therapy (ECT) was first discovered

and utilized. The frequent use of ECT in medical practice aroused the interest of the National Institutes of Health (NIH) who stepped in to instigate change. The NIH statement (National Institutes of Health, 1985) on ECT reads as follows: "As often occurs with new therapies, ECT was used for a variety of disorders, frequently in high doses and for long periods. Many of these efforts proved ineffective, and some even harmful" (p. 1). Behr (1998) mentioned the dilemma faced by physicians who choose to limit their prescription practice of psychotropic medications. He argues that "if we do not prescribe psychotropic drugs, the family will then go to one of our colleagues, who will be seen as more knowledgeable because he or she will prescribe the newest and most untested medications?" (p. 901).

However Behr emphasizes that without a change, others may step in with regulations to prohibit and control this widening practice of pharmacotherapy as happened to the practice of ECT in the United States. Actually, in March 2000, a White House Conference met following published research data to consider legislation to regulate the practice of prescribing psychotropic drugs to children (Stubbe & Martin, 2000). Will government control solve this growing concern? Are there other options available to help people with their psychosocial problems?

In all the discussions found in medical journals in this literature review, authors mentioned only depressive and anxious symptoms requiring the physical need for pharmacologic treatment. Yet what part do relationships play in a person's depression or anxiety? In a Gallup poll taken at the turn of the 21st century, Americans cited family

decline for the first time in 50 years as one of the most serious problems facing our nation ("What's the problem?," 1999). The general public can see the serious role that relationships play in a human's life, but this does not seem as apparent among the practice patterns of American physicians.

In a survey conducted a decade ago, an amazing 99% of Americans rated loving family relationships as extremely important (Bennett, Petts, & Blumenthal, 1999). More recently, a public poll revealed 93% of Americans consider the pursuit of a happy marriage one of their most important life goals (Mason, Carnochan, & Fine, 2004). The underlying reason behind this desire may be the evidence that married couples live longer with better health and reduced emotional problems than unmarried couples appropriately matched (Nock, 2005; Ooms, 1998). Despite the rise in divorce rates, a satisfying marriage has been found to enhance personal happiness. A study involving 17 nations substantiated that in 16 out of 17 countries, marriage was found to further happiness more than cohabitation (Stack & Eshleman, 1998). Despite all the broken dreams, people still want a happily-ever-after and this pursuit appears to touch every aspect of human existence.

Not only do married partners benefit from a stable relationship but there are many advantages for their children. Research has shown that children flourish best—mentally, physically, socially, financially—when their biological parents have a solid marriage with minimal conflict (Amato, 2000; Glenn, 1996; McLanahan & Sandefur, 1994). Regardless of income or race, most Americans agree that the ideal environment for children to grow

and develop is when their two parents have a satisfying marriage (Ooms & Wilson, 2004). Can medications alone help with these relational goals? The literature provides evidence that a collaborative approach of a multidisciplinary team results in greater benefits for patients with psychosocial problems (Peota, 2006).

A recent study of mental health services for a sample of children and adolescents showed that those seen by both a mental health specialist and medical provider displayed greater retention rates (Harpaz-Rotem, Leslie, & Rosenheck, 2004). These new users of mental health services made a greater number of visits when seen by a PCP as well as a mental health practioners. Another investigation compared the efficacy of pharmacotherapy and psychotherapy alone or in combination for patients with major depression (Keller et al., 2000). The researchers randomly assigned 681 adults with major depressive disorder to a 12 week treatment regime using nefazodone, a cognitive behavioral-analysis system of psychotherapy (CBT) (16 to 20 sessions), or a combination of both. Of the 519 subjects who completed the study, the rate of satisfactory response for the drug protocol only or the CBT only was around 54%. For the patients who undertook psychotherapy along with the medication, the satisfactory rate was 85%. Tyrer, Ferguson, and Wadsworth (1990) tested a collaborative model of healthcare delivery for patients seen in primary care clinics throughout Nottingham, UK. Over the initial eight year period that the clinic began, the number of new and referred patients climbed from 1% to 18%. Over the same period, inpatient admissions significantly declined as compared with the rest of England.

American practioners speculate that there are advantages in combining psychotherapy and pharmacotherapy in the treatment of psychosocial problems (Gabbard & Kay, 2001). In view of the trend of using pharmacotherapy alone, researchers demonstrated that collaborative care models using both non-physician mental health practioners and PCPs offer the most hope in increasing the availability of effective mental health care (Harpaz-Rotem & Rosenheck, 2006). The benefits of collaboration utterly outnumber the reasons to do nothing new and provide comprehensive steps for the cure of human depression and other psychosocial problems.

Summary

Antidepressants stand alone as the number one drug ordered by U.S. physicians with over 233 million prescriptions written (IMS Health, 2007a). The rising trend is found to begin in 1988 with the introduction of SSRIs. Yet this trend toward increased psychopharmacotherapy has not lowered the number of depressed persons; in fact, these numbers have steadily been climbing for the past twenty years. Of particular concern is the considerable rise in family physicians and pediatricians who prescribe psychotropic medications to young children (Olfson et al., 2002; Zito et al., 2002).

Studies have found that when humans ingest antipsychotics, antidepressants, and antianxiety drugs, changes take place in the brain's neurotransmitter function (Fava, 2003; Fava et al., 1994; Fisher, S. & Greenberg, 1997; Hyman & Nestler, 1996). Such changes in the brain carry serious implications for the vulnerable, developing brain of the young child. This concern is compounded by the fact that there is a virtual lack of clinical

research on the consequences of pharmacologic treatment of behavioral disturbances for very young children taking psychotropic medications (Coyle, 2000; Werry, 1993; Wong et al., 2003).

From 1988 to the present, there has been a marked decline of patients receiving psychotherapy for psychosocial problems (Balestrieri et al., 1992; Glied, 1998; Goldberg, 1995; Lecrubier, 2001; Linden et al., 1999; Olfson et al., 2003; Rushton et al., 2000; Tardieu et al., 2006). Practice trends reveal that changes in psychiatric service have currently made psychiatrists unavailable to provide psychotherapy (Dial et al., 1998; Eveland et al., 1998; Goldman, 2001; Harpaz-Rotem & Rosenheck, 2006; Penn, 2008). And yet numerous studies have demonstrated the effectiveness of psychotherapy in helping people with a range of psychosocial problems (Asen et al., 1991; Dessaulles et al., 2003; Dutra et al., 2008; Fals-Stewart et al., 2005; Huxley et al., 2000; Knekt et al., 2008; MacPhee et al., 1995; Miklowitz et al., 2007; Ritvo & Papilsky, 1999; Shadish et al., 1995; Weissman, 1994). Despite all this evidence, there is furthering decline in the number of physicians referring patients for psychotherapy.

Among available mental health professionals, medical family therapists who are commonly LMFTs are exclusively trained to pay particular attention to the connection between biological, psychological, relational, and emotional processes of human beings (Brucker et al., 2005). Yet in the medical literature there is almost no mention of these marriage and family therapists as a potential choice for referral of patients from medical practioners. Studies have shown that the personal opinions of physicians play an

important role in treatment practices (Glied, 1998). How does training and experience influence the personal preferences and opinions of physicians in the treatment of psychosocial problems? What is the family physician's level of familiarity of the different mental health professionals? A void exists in the literature exploring what influences these referral practices of primary care physicians with their patients presenting with psychosocial and emotional problems.

CHAPTER III

METHODOLOGY

This was a predominantly quantitative study with qualitative features to explore which mental health professionals family physicians use for referral of their patients presenting with psychosocial/emotional concerns. There is a rising trend in the number of prescriptions written for psychotropic medications among primary care physicians (PCPs) and psychiatrists (Olfson et al., 2004; Pincus et al., 1998). This increase in psychopharmacotherapy has included young children (Zito et al., 2000, 2002). At the same time, there is a growing decline of patients receiving psychotherapy for psychosocial issues (Balestrieri et al., 1992; Glied, 1998; Goldberg, 1995; Lecrubier, 2001; Linden et al., 1999; Olfson et al., 2003; Rushton et al., 2000; Tardieu et al., 2006). Yet there are numerous studies demonstrating the effectiveness of psychotherapy in helping people with a range of psychosocial problems (Asen et al., 1991; Dessaulles et al., 2003; Dutra et al., 2008; Fals-Stewart et al., 2005; Huxley et al., 2000; Knekt et al., 2008; MacPhee et al., 1995; Miklowitz et al., 2007; Ritvo & Papilsky, 1999; Shadish et al., 1995; Weissman, 1994). Medical family therapy is a subspecialty within the profession of licensed marriage and family therapists (LMFTs).

Of all the different mental health practioners available, the medical family therapist is a specialist within the field of marriage and family therapy who is uniquely prepared to address the multi-dimensional aspects of human life (McDaniel et al., 1992).

Despite all the evidence, there is furthering decline in the number of physicians referring patients for psychotherapy. A void exists in the literature exploring what influences these referral practices of primary care physicians with their patients presenting with psychosocial and emotional problems. The data from this inquiry will guide psychotherapists and physicians in considering the comprehensive benefits of collaboration in addition to psychopharmacotherapy for patients with psychosocial problems.

In quantitative study, clear and precise research questions guide the investigator (Chen, 1990). The focus is on numerical representation of meanings obtained through closed-ended questions through selected instruments (Sprenkle & Moon, 1996). Anderson and Goolishian (1988) described the human species as made up of "language-generating, meaning-generating systems" (p. 377). In a quantitative study that chooses a survey as the instrument, Mertens (1998) explained the importance of designing questions that will encourage the chosen sample to complete the entire survey. Ideally, questions need to be precise and arranged in an organized fashion for the best possible response from those surveyed. Questions that are difficult or sensitive in nature need to be located near the end of the survey to foster minimum abandonment of participants (Whitley, 1996).

There were several key considerations in formulating the survey used in this study. The overall research questions determined the goals of this project as well as the focus (Mertens, 1998). Next, the sample was chosen using the listserv of the National

Research Network (NRN). A survey was then designed by the author with the assistance from committee members. To help establish content validity, the author had two expert physicians review the survey and offer feedback. Of course, instruments that have replicated tests offer the researcher assurance for a higher degree of validity (Healey, 1999). One reviewer was Sheryl Wright, M.D., a pediatric intensivist with 19 years medical experience and the second reviewer was Rosa L. Mercado, M.D., who is Director of Employee Health Services at Los Angeles Unified School District with 28 years of medical experience. Their feedback reduced the number of questions on the survey and contributed to the verbiage used.

Braud and Anderson (1998) recommended that the investigator take an inquisitive approach and develop questions that build connection with the participants using language suited best for the population chosen. The author then sought feedback from Thomas V. Stewart who is the Research Administrator of the National Research Network at the American Academy of Family Physicians. Mr. Stewart's advice further reduced the number of questions used in the final survey. From the initial survey, a total of nine questions with a possibility of 24 answers were removed from the final survey used. Most of these discarded questions addressed research question number five. The revised survey did not include any questions to address number five so this question will not be included in any of the analysis.

Participants

Subjects included 213 primary care clinician members of the current available listserv of the National Research Network (NRN) representing 48 US states and four Canadian provinces. The NRN is a voluntary research association of primary care physicians who participate in studies in order to improve the phenomenon of primary care practice. The NRN is a subgroup of the American Academy of Family Physicians (AAFP). The AAFP is one of the largest national medical organizations representing more than 94,000 family physicians, family medicine residents, and medical students nationwide. Founded in 1947, its mission has been to preserve and promote the science and art of family medicine and to ensure high-quality, cost-effective health care for patients of all ages.

In both qualitative and quantitative studies, when the researcher requires access to a certain group for a study, access may be gained through the assistance of a gatekeeper. A gatekeeper is defined as someone who is in a position of having access to the group and can assist the researcher in connecting with the selected population (Creswell, 1998). The senior program coordinator at NRN, Ms. Mindy Spano, served as a gatekeeper and mediated with the NRN listserv within the constraints of the following inclusion and exclusion criterion:

1. The inclusion criteria included any current member of NRN who is a primary care physician (PCP) or a family practice (FP) physician or a general practioner (GP) currently practicing medicine.

2. The exclusion criteria included any member of NRN who is a medical student.

Instrumentation

The instrument for this study was an online survey designed with closed-ended questions with the intent of finding out specifics regarding practice trends of these physicians (Appendix A). The demographic portion of the survey consisted of five questions where the first inquiry was whether the physician is a Doctor of Medicine (M.D.) or a Doctor of Osteopathic Medicine (D.O.). Gender, how many years in practice, as well as state of practice and state of residency, were also included in these demographic questions. Questions regarding the physician's professional practice were grouped together and consisted of seven different items with a possibility of 21 selected answers. These two sections were spaced on two short separate computer screen pages. The goal was to keep the survey brief so as to minimize possible survey abandonment. The third page included one optional open-ended question. The physicians who reviewed this survey took between two to four minutes to complete its entirety.

The questions were compiled and administered through www.psychdata.com. Psychdata is a web presence using state-of-the-art technology combining centralized database architecture with strict security policies and procedures. Their services meet and exceed industry standards for Internet security as well as IRB policy for the protection of research participants. The survey link was sent via email addresses to the sample three separate times about two weeks apart. The email began with an introductory note from Wilson D. Pace, M.D., FAAFP, who is the Director of NRN followed by a cover letter

from the author and her faculty advisor (Appendix B). The participants were given two different links to connect to the survey in order to provide optimal access to the site.

Treatment of Data

A quantitative study allows the researcher to collect numerical values and input these figures into statistical programs that provide multiple analyses. Psychdata read all of the participant's data files and merged their responses into a single data file that easily interfaced with the analytic software, Statistical Package for the Social Sciences (SPSS for Windows, version 16.0). Descriptive statistics were gathered from the data. An overall frequency count was run and results were tabulated and comparisons made. Tables and figures of these results will follow in chapter 4.

Participants' free-form text answers in response to the optional question were treated differently from the quantitative data described above. First, the short answers were imported into a common word processing package, Microsoft Word. Thematic content analysis was then used to review each participant's response, searching for discrete units of meaning. The meaning units were grouped and labeled as concrete themes. The total number of answers was 37 and the majority fell into seven main identified themes that were coded by the author. These results were reviewed and verified by a second researcher.

Each participant who sent the author an email address requesting the results of this study was sent the web address (URL) to a web page presenting the research findings. These results included the overall descriptive statistics (e.g., means, standard

deviations, frequencies, percentages) and a brief narrative interpretation of those statistics.

Delimitations

The minimum sample size planned for this pilot study was 50 participants. There was no maximum sample size enforced. The original plan was to offer the online survey to physicians for two full months. Unforeseen delays in launching the survey limited the time that participants had access due to the author's deadline perimeters. The survey began on January 5, 2009, and was closed on February 24, 2009.

Ethical Considerations

The greatest concern with working with this sample of participants was to make certain that there was no possibility of harm. Answering the questions of this short survey on the Psychdata link posed no threat or harm to participants. The only identified possible concern was that the participants may be inconvenienced in the time it took to complete the survey. In designing the survey, measures were taken to minimize this possibility and keep completion to less than 5 minutes. Since no personal demographic information was collected on these physicians, such as name, address, or phone number, further discomfort was minimized.

Another ethical concern was the potential for the loss of confidentiality. Confidentiality was protected to the extent allowed by law. No names were collected on the survey and personal information was limited to gender, degree, years in practice and the state where the physician currently provides service. Since the researcher worked

through the gatekeeper at NRN, no other personal identifying information was collected. Participation was completely voluntary and the subject's responses were kept anonymous through a coding of their answers.

Summary

In this predominantly quantitative study with qualitative features, the purpose was to investigate which mental health professionals family physicians use for referral of their patients presenting with psychosocial/emotional concerns with particular interest in regards to LMFTs. The participants were selected from a current available listserv of the National Research Network (NRN) within the American Academy of Family Physicians (AAFP). The data was tabulated from the answers to an online survey accessible through Psychdata. To help promote the content validity of the findings, the researcher used expert reviewers in designing the survey. A gatekeeper adhered to inclusion and exclusion criterion. The closed ended questions resulted in data that was numerically coded for analysis. The statistical software program, SPSS, was used to examine descriptive frequencies and comparisons made. Participants' free-form text answers in response to the optional question were analyzed and grouped into separate categories according to themes. Ethical concerns guided the study along with protective measures.

CHAPTER IV

RESULTS

This chapter will first discuss the demographic characteristics found within this sample of subjects in this study. Descriptive statistics were used in the data analysis with overall frequency counts calculated. Except for the last research question, each of the original research questions will then be addressed along with the appropriate findings. Additional questions from the survey that found useful information but did not address the original research questions will be individually discussed. Finally, an analysis of the subjects' answers to the optional open-ended question will complete the findings portion of this study.

Demographic Findings

At the close of the survey, 80 (37.6%) of the 213 total members of the NRN had completed the survey. The demographic profiles of the family physicians included 76 (95%) Doctors of Medicine (M.D.s) and 4 (5%) Doctors of Osteopathic Medicine (D.O.s) as seen in Table 1. The gender difference between subjects revealed 17 (21.2%) were female and 63 (78.8%) were male (Table 2).

Table 1

Degree of Survey Participants

	f	%
M.D.	76	95
D.O.	4	5

Table 2

Gender of Survey Participants

	f	%
Female	17	21.2
Male	63	78.8

Further demographics showed that that the mean number of years in practice among these family physicians was 21.6 years ($M = 21.55$, $SD = 8.99$). There were nine (11.1%) who reported 0 to 10 years experience, 28 (35.1%) who reported 11 to 20 years experience, 29 (36.3%) who reported 21 to 30 years experience, and 14 (17.5%) who reported 31 to 45 years experience (Table 3 and Figure 1). All together, 33 US states and three Canadian provinces were represented as the locations where these family physicians currently practice medicine (Figure 2). The Canadian provinces were British Columbia, New Brunswick, and Ontario and were not included in Figure 2.

Table 3

Years in Practice of Survey Participants

	f	%
0 to 10 years	9	11.1
11 to 20 years	28	35.1
21 to 30 years	29	36.3
31 to 45 years	14	17.5

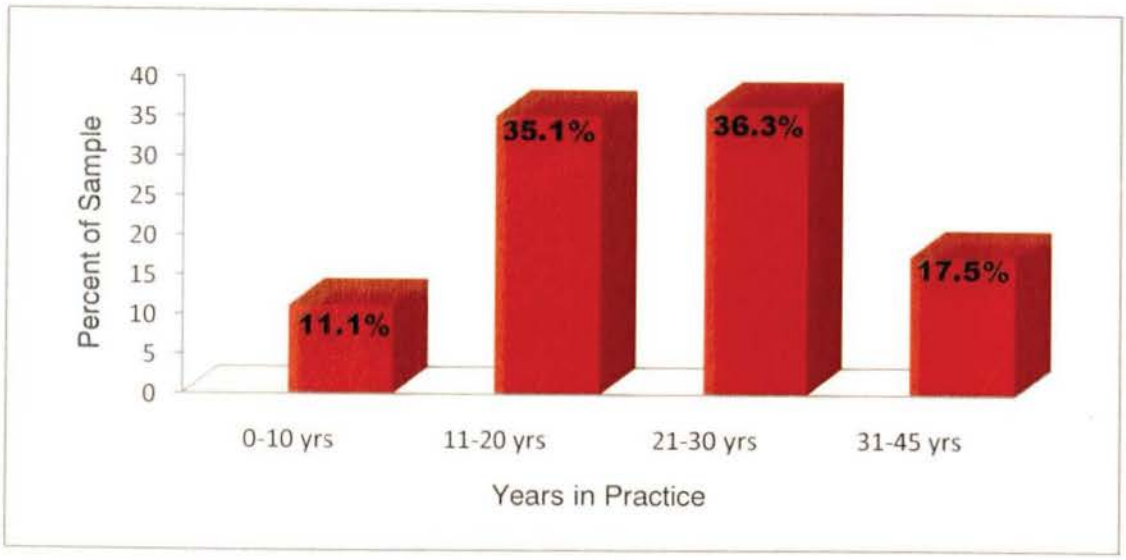

Figure 1. Years in practice of survey participants.

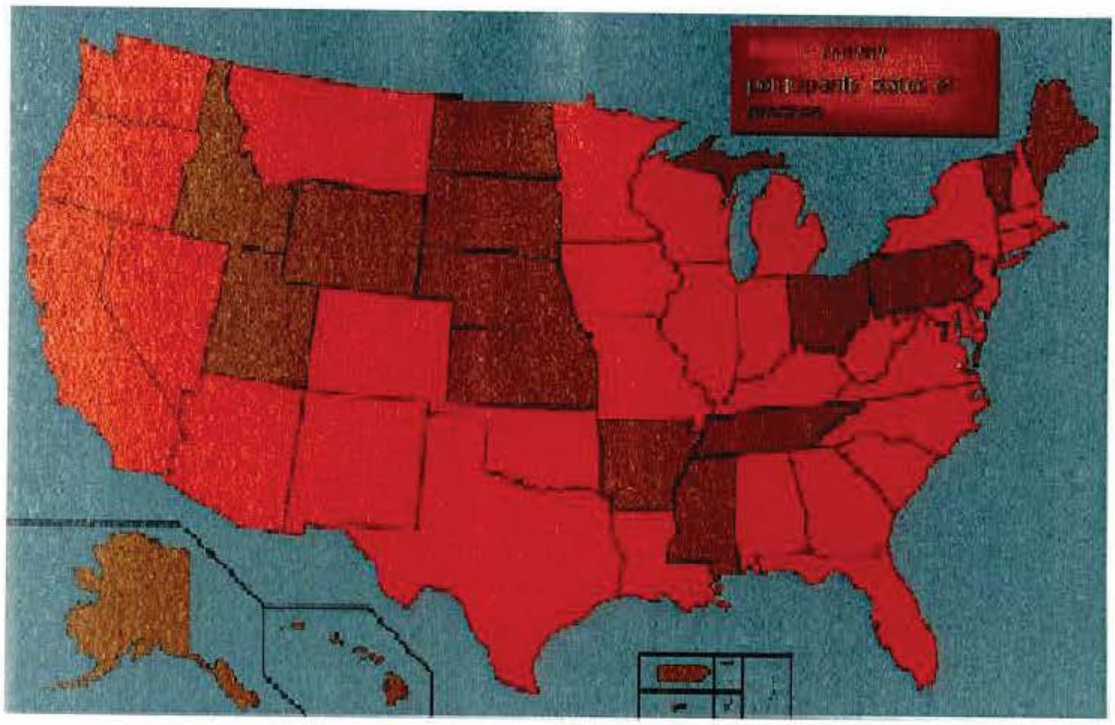

Figure 2. U.S. states of practice of survey participants.

Research Questions

Originally, five research questions were formed to guide the design and analysis of this study. As stated previously in chapter three, the fifth research question will not be considered in this analysis. During the review of the initial survey, a total of nine questions with a possibility of 24 answers were removed from the final survey used. Most of these discarded questions addressed research question number five. The revised survey did not include any questions to address number five so this question will not be included in any of the analysis.

1. What estimated portion of family physicians's patients present with psychosocial issues?

The participants were given choices from a drop down menu of percentages in multiples of five to estimate how many of their patients present with psychosocial issues. From Table 4, it is apparent that 83.7% of the participants reported that up to 50% of their patients present with psychosocial issues. Virtually all of the participants (100%) stated that they prescribe psychotropic medications.

Table 4

Estimated Percentage of Patients Presenting with Psychosocial Issues

Percentages	*f*	%
5%	0	0
10%	6	7.5
15%	9	11.2
20%	7	8.8
25%	13	16.2
30%	11	13.8
35%	3	3.8
40%	9	11.2
45%	0	0
50%	9	11.2
55%	0	0
60%	2	2.5
65%	2	2.5
70%	5	6.2
75%	1	1.2
80%	2	2.5
85%	0	0
90%	0	0
95%	1	1.2

2. What estimated amount of patients presenting with psychosocial issues are referred for psychotherapy?

As in the preceding question, the participants were given choices from a drop down menu of percentages in multiples of five to estimate how many of their patients presenting with psychosocial issues are then referred for psychotherapy. A majority of family physicians (77.5%) state that up to 25% of these patients are referred for psychotherapy with a large portion of physicians (37.5%) referring only up to 5% of their patients (Table 5). Figure 3 shows a comparison between the estimated percentage of patients presenting with psychosocial issues and those patients with psychosocial issues who are referred for psychotherapy.

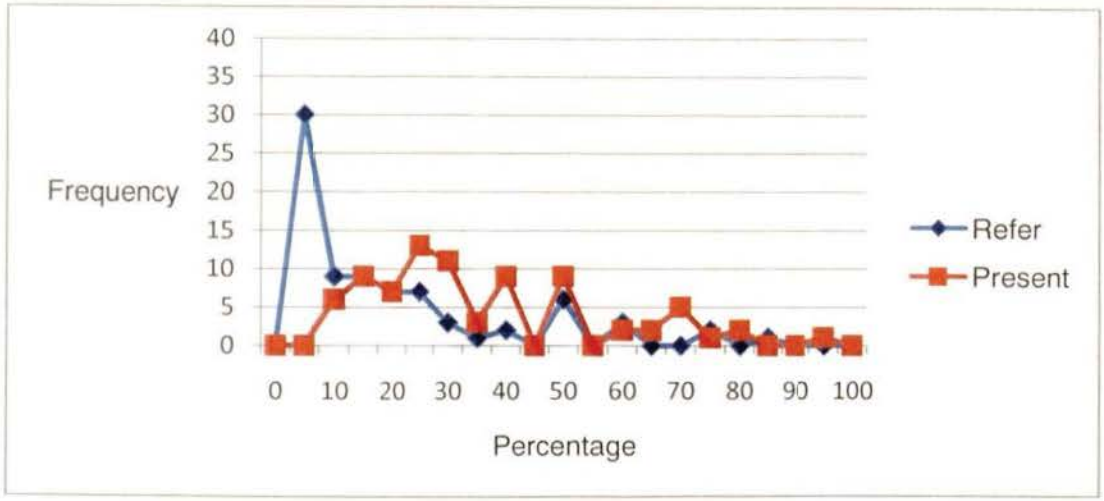

Figure 3. Estimated percentage of patients presenting with psychosocial issues versus estimated percentage of patients referred for psychotherapy.

Table 5

Estimated Percentage of Patients Referred for Psychotherapy

Percentages	*f*	%
5%	30	37.5
10%	9	11.2
15%	9	11.2
20%	7	8.8
25%	7	8.8
30%	3	3.8
35%	1	1.2
40%	2	2.5
45%	0	0
50%	6	7.5
55%	0	0
60%	3	3.8
65%	0	0
70%	0	0
75%	2	2.5
80%	0	0
85%	1	1.2
90%	0	0
95%	0	0

3. Which mental health practioners are used when family physicians refer their patients for psychotherapy?

For this question, the participants were asked to rank the top three (with 1 representing their first choice) preferences of mental health professionals used for referral of their patients with psychosocial issues. The frequency results of the ranking for each of the six possible mental health professionals of these family physicians' preferences has been detailed in Table 6. The figures that follow (Figures 4 to 6) present the separate choices made by family physcians as ranked by first, second and third. Overall, the participants' first choice was a psychologist, second a counselor, third a psychiatrist, fourth a social worker, fifth a marriage and family therapist, and last a psychiatric nurse practioner.

Table 6

Preferred Choice of Mental Health Professionals for Psychosocial Referrals

	First Choice		Second Choice		Third Choice	
	f	%	*f*	%	*f*	%
Psychologist	31	43.7	16	22.2	13	18
Counselor	18	25.4	13	18	18	25
Psychiatrist	12	16.9	19	26.4	14	19.4
Social Worker	9	12.7	14	19.4	11	15.3
Marriage & Family Therapist	1	1.4	10	1.4	12	16.7
Psychiatric Nurse Practioner	1	1.4	0	0	4	5.6

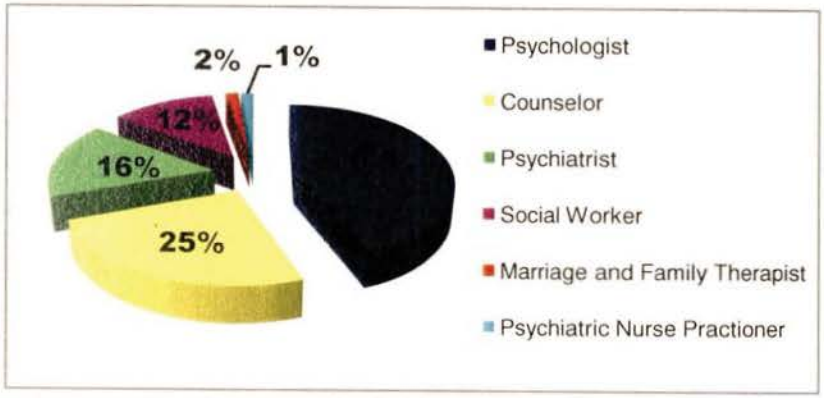

Figure 4. Family physician's first choice for psychosocial referrals.

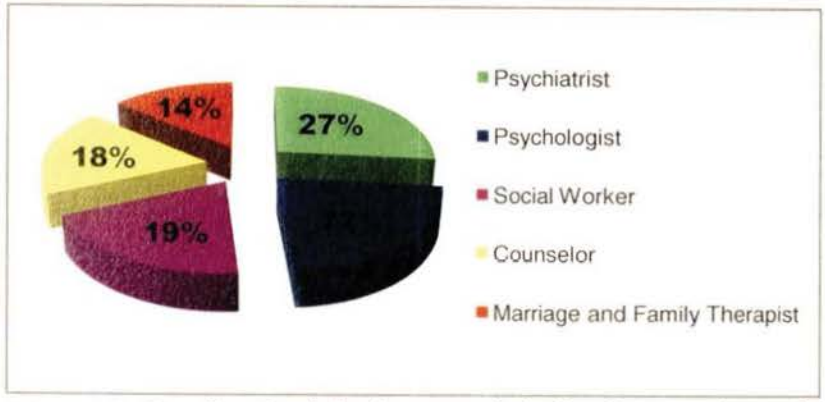

Figure 5. Family physician's second choice for psychosocial referrals.

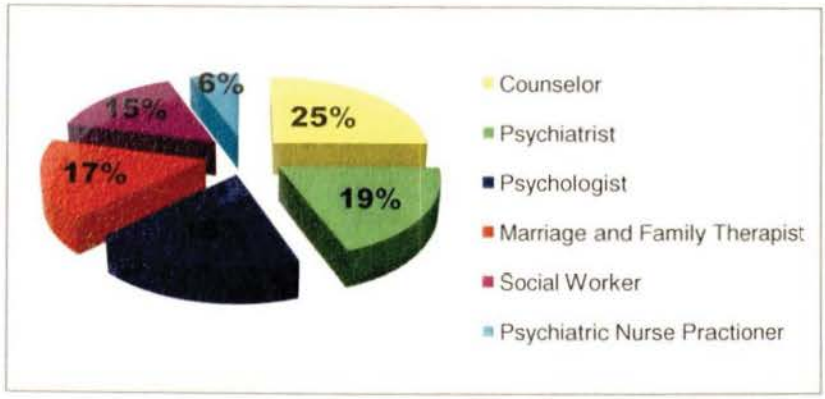

Figure 6. Family physician's third choice for psychosocial referrals.

4. How often do these family physicians refer to marriage and family therapists for psychotherapy for patients presenting with psychosocial issues?

The previous findings offer an answer for this question as well. Family physicians reported that marriage and family therapists were rarely considered (1.4%) as a first choice of referral for patients presenting with psychosocial issues. For the participants' second choice, marriage and family therapists were the last choice (14%) though these second choices were more evenly dispersed among five of the mental health professionals with no selections made for psychiatric nurse practioner. With regards to family physicians' third choice for psychosocial issues, marriage and family therapists ranked fourth (17%).

Addressing Other Survey Questions

Additional data from the survey questions provided meaningful information. The results to these questions will be discussed separately.

1. Using the scale provided, how has your medical training and professional experience contributed to your familiarity with each of the following mental health professionals?

The drop down list offered the choices of "greatly," "moderately," "small amount," "very little," or "not at all" to describe how their medical training and professional experience contributed to the familiarity of each of the six mental health professionals. The frequency results for each of the six possible mental health professionals were ranked using the mean and standard deviation (Table 7). The order

that resulted showed that of greatest familiarity was the psychiatrist ($M = 4.59$, $SD = 0.68$), second was psychologist ($M = 4.11$, $SD = 0.89$), third was social worker ($M = 3.90$, $SD = 1.04$), fourth was counselor ($M = 3.11$, $SD = 1.46$), fifth was marriage and family therapist ($M = 2.90$, $SD = 1.24$), and last was psychiatric nurse practioner ($M = 2.25$, $SD = 1.35$).

Table 7

Family Physicians' Overall Rank of Greatest to Least Familiarity of Mental Health Professionals

Greatest Familiarity	*M*	*SD*
Psychiatrist	4.59	0.68
Psychologist	4.11	0.89
Social Worker	3.90	1.04
Counselor	3.11	1.46
Marriage and Family Therapist	2.90	1.24
Psychiatric Nurse Practioner	2.25	1.35

Table 8 and Figure 7 specifically report the frequencies and percentage of family physicians with regards to the psychotherapists whom they are most familiar. Marriage and family therapists were next to the lowest (7%) of mental health professionals familiar to these physicians.

Table 8

Psychotherapists of Greatest Familiarity to Family Physicians

Most Familiar	*f*	%
Psychiatrist	49	37.7
Psychologist	29	22.3
Social Worker	22	17.0
Counselor	15	11.5
Marriage and Family Therapist	9	6.9
Psychiatric Nurse Practioner	6	4.6

Figure 7. Psychotherapists of greatest familiarity to family physicians.

Table 9 and Figure 8 identify the frequencies and percentage of family physicians with regards to the psychotherapists whom they are least familiar. In this ranking, marriage and family therapists ranked the highest (34%) of mental health professionals not known to these physicians.

Table 9

Psychotherapists of Least Familiarity to Family Physicians

Least Familiar	*f*	%
Marriage and Family Therapist	23	33.8
Psychiatric Nurse Practioner	21	30.9
Counselor	13	19.1
Social Worker	5	7.4
Psychologist	4	5.9
Psychiatrist	2	2.9

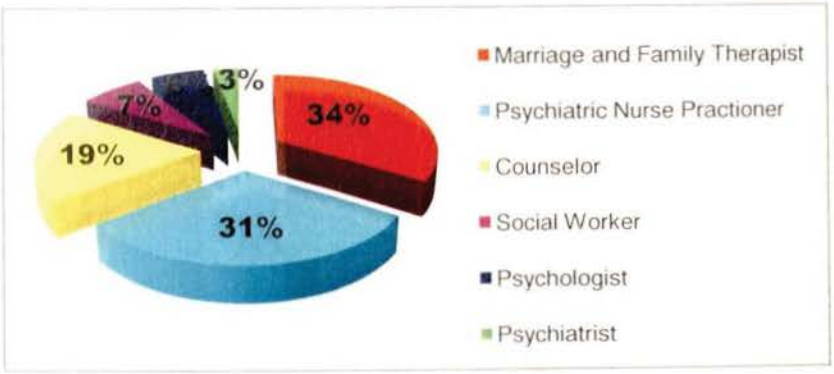

Figure 8. Psychotherapists of least familiarity to family physicians.

2. How do you see the effectiveness of the following mental health professionals in assisting your patients with psychosocial issues?

The drop down list offered the choices of "greatly," "moderately," "small amount," "very little," or "not at all" to describe how these physicians perceive the effectiveness of each of the six mental health professionals. The frequency results for each answer were rank ordered using the mean and standard deviation (Table 10). The rank order that resulted showed the order of perceived effectiveness, beginning with the greatest which was the psychologist ($M = 4.40$, $SD = 0.76$), second was marriage and family therapist ($M = 4.15$, $SD = 0.82$), third was counselor ($M = 4.14$, $SD = 0.85$), fourth was social worker ($M = 4.11$, $SD = 0.88$), fifth was psychiatrist ($M = 3.77$, $SD = 1.12$), and last was psychiatric nurse practioner ($M = 3.45$, $SD = 1.22$).

Table 10

Family Physicians' Overall Rank of Greatest to Least Effective Mental Health Professionals

Most Effective	*M*	*SD*
Psychologist	4.40	.76
Marriage and Family Therapist	4.15	.82
Counselor	4.14	.85
Social Worker	4.11	.88
Psychiatrist	3.77	1.12
Psychiatric Nurse Practioner	3.45	1.22

Table 11 and Figure 9 report the frequencies and percentage of family physicians with regards to the psychotherapists who are considered the most effective for their patients with psychosocial issues. In this ranking, marriage and family therapists tied for second (17.1%) along with counselors (17.1%) and social workers (17.1%). Table 12 and Figure 10 report the frequencies and percentage of family physicians with regards to the psychotherapists who are considered moderately effective in assisting their patients with psychosocial issues. In this ranking, the marriage and family therapist ranked highest (18.9%) which was close to the social worker (18.3%).

Table 11

Psychotherapists Considered Most Effective by Family Physicians

Most Effective	*f*	%
Psychologist	38	26.0
Marriage and Family Therapist	25	17.1
Counselor	25	17.1
Social Worker	25	17.1
Psychiatrist	21	14.4
Psychiatric Nurse Practioner	12	8.2

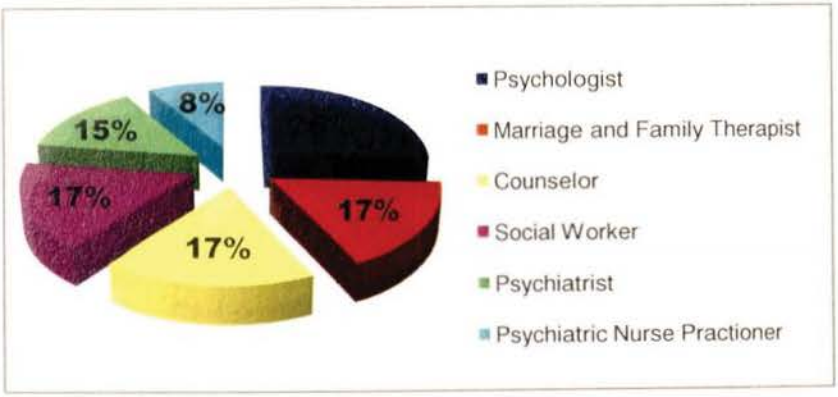

Figure 9. Psychotherapists considered most effective by family physicians.

Table 12

Psychotherapists Considered Moderately Effective by Family Physicians

Moderately Effective	*f*	%
Marriage and Family Therapist	36	18.9
Social Worker	35	18.3
Counselor	33	17.3
Psychiatrist	31	16.2
Psychologist	29	15.2
Psychiatric Nurse Practioner	27	14.1

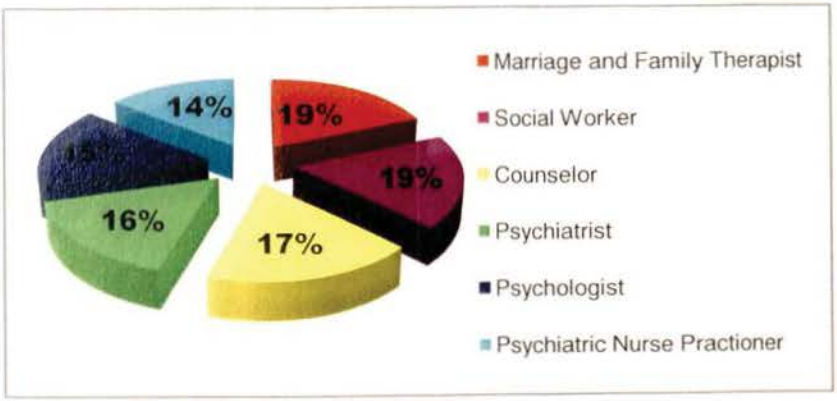

Figure 10. Psychotherapists considered moderately effective by family physicians.

3. In your opinion, rank the top three choices below (with 1 representing the best and 3 representing the worst) to designate the best source for a family practice physician to gain knowledge of the expertise of mental health providers?

With this question, the participants were given 12 different choices of possible ways to learn more about a mental health provider. The rank order that resulted listed the subjects' preferred methods of finding out about mental health providers starting with their first choice being personal contact, second was residency, third was colleagues, fourth was workshops, fifth was medical schools, sixth was professional organizations, seventh was word of mouth, eighth was journals, ninth was books, tenth was radio, eleventh was television (TV), and last was the internet (Table 13).

Table 13

Preferred Source for Information of Mental Health Professionals

	First Choice		Second Choice		Third Choice	
	f	%	*f*	%	*f*	%
Personal Contact	32	42.1	15	18.3	9	11.4
Residency	22	28.9	12	14.6	8	10.2
Colleagues	5	6.7	18	22	18	22.8
Workshops	7	9.2	9	11	14	17.7
Medical Schools	4	5.3	11	13.4	5	6.3
Professional Organizations	1	1.3	6	7.3	6	7.6
Word of Mouth	2	2.6	4	4.9	7	8.9
Journals	3	3.9	4	4.9	3	3.8
Books	0	0	2	2.4	2	2.5
Radio	0	0	1	1.2	2	2.5
TV	0	0	0	0	3	3.8
Internet	0	0	0	0	2	2.5

Optional Research Question

The optional research question for this study was presented on the third (final) page of the online survey. The question read as follows: Is there anything else you would like to mention or any comments you may have? Of the total number of completed surveys ($n = 80$), there were 37 answers submitted for this optional question.

The participants' free-form text answers in response to the optional question were all relatively brief and coded into seven main identified themes and four minor themes that did not provide meaningful data to this study such as one participant suggesting a book for the author to read. The seven main themes found were: (a) Lack of Availability or Choices, (b) Regarding Psychiatrists, (c) Collaboration Is the Answer, (d) Difficulty with Items on Survey, (e) Variability of Choice, (f) Meatball Therapy, and (g) Feedback from Patients. Supporting quotations for each of the themes are presented to provide examples.

Lack of Availability or Choices

Eighteen of the participants who left comments mentioned inadequate access to mental health professionals in their areas or their limited choice of mental health providers based on the patient's insurance or pay source. This theme was expressed in the following examples:

> Most choices on mental health professionals are based on availability [*sic*], unfortunately [*sic*] not necessarily on talent (#12, female M.D.).

> Mine is a rural practice. Our resources for consultation regarding psychosocial problems are woefully inadequate (#14, male M.D.).

> My use of a particular mental health professional is largely determined by their availability (LP vs. SW vs. MFC vs. psychologist) [*sic*]. Psychiatrists are used more for medication management or uncertain diagnosis (#24, male M.D.).

Most referrals are influenced by the patient [*sic*] insurance status, availability of professionals and how soon the patients can be seen. Lot [*sic*] of time we use resources which may not be the first choice but we do not have options (#27, male M.D.).

Biggest problem: lack of parity for mental health insurance coverage & finding [*sic*] good MH professional who takes insurance (#30, female M.D.).

Managed care often carves out psychological benefits, so the primary care physician is bypassed. Getting appointments with psychiatrists and psychologists in my community is very difficult (#34, male M.D.).

I am a bit concerned about how these questions will help you at all. I make my decisions based on the quality of the individual MH provider, not their background. I have seen no correlation between the various counselor/LPC/SW/Psychol [*sic*] to believe there is any real difference in outcomes due to their training. It is not an issue of training. It is a question of how effective (or not) these persons are. The overall quality of counselors seems to have deteriorated or at least not improved (#54, female M.D.).

Psychiatrists are generally too medication oriented. Other therapists are too expensive as they are not covered by medical insurance. Psychiatric Nurse Practioners are not found in my community (#62, male, M.D.).

You didn't ask whether there even are any of these categories of mental health workers in my area. The choices available to patients also depend heavily on their insurance, or lack of it. The resources for adults also differ greatly from the resources available to children and adolescents (#63, male M.D.).

The big issue in my practice is a terrible lack in our region of all sorts of mental health providers, particularly ones [*sic*] can take on patients with poor means of paying (#69, male M.D.).

Regarding Psychiatrists

Eight of the participants left comments pertaining to their knowledge or experience with psychiatrists. This theme can be observed in the following examples:

In the past we have used psychiatry frequently but honestly our area no longer has easy access to psychiatrists any more (#33, male M.D.).

Patients tell me that psychiatrists are uninterested in psychodynamics and very focused on control of psychiatric symptoms with medicines. The publically

funded mental health sector is over stretched (county mental health center for example) (#50, male M.D.).

Psychiatrist [*sic*] do not do any counciling [*sic*] in our area of the country. I go with who has helped my patients in the past and recommendation [*sic*] from colleagues (#51, female M.D.).

In our system we have very little access to psychiatrists or psychologists so we have to use counselors quite a bit. Some are good, same [*sic*] are fair and some...well they leave a lot to be desired. I do quite a bit of counseling/active listening and really like the transactional analysis approach in philosophical terms... [*sic*] but only use it tangentially in clinical practice. We are involved in the creation of the medical home model in our system and our use of teams, [*sic*] I think, [*sic*] and our patient's identity in relating to being a part of their team is critical in their overall health and their ability to come to terms with their mental illness. Getting involved is empowering and therapeutic for most of the patients and gives them a sense of control and responsibility (#68, male M.D.).

Since 1978 I have worked in the same rural FQHC [*sic*] which has been a state leader in developing the collaborative care model. We use LICSW [*sic*] and LPC [*sic*] in primary care sites and 4 school based clinics. We also have Psychiatrist

[*sic*] and Psych FNP [*sic*] who come for 1-2 sessions per week for complex med [*sic*] management. In this region, a psychiatrist who does psychotherapy is virtually non-existent. 40-50 patients per day [*sic*], 5 minute visits, lots of meds [*sic*], highly influenced by drug reps [*sic*] i.e[*sic*] always the latest SSRI, SNRI, [*sic*] atypical antipsychotic (#75, male M.D.).

Collaboration Is the Answer

Seven of the family physicians who left comments in the open text area mentioned the benefits of collaboration between mental health and medical practioners. This theme can be seen in the following examples:

Collaborative arrangements where there is improved access to any mentaol [*sic*] health professional greatly enhance the delivery of services and can address the multitude of other issues frequently involved in the delivery of quality care patients (#44, male M.D.).

Working in collaborative practice with therapists and psychologists during the past three years has been a great aid in patient management and expediting consultations (#48, male M.D.).

There needs to be more structured joint education between FPs and mental health providers (#59, male M.D.).

Difficulty with Items on Survey

There were six comments added to the optional question that centered on how participants felt some degree of difficulty in the items on this survey. A few stated having trouble estimating as well as in ranking different mental health providers. Other participants explained that the wording in questions was not clear. This theme was expressed in the following examples:

> It is difficult to precisely estimate the prevalence of psychosocial issues or to give the relative value of different types of profesional [*sic*] in general terms (#01, male M.D.).

> I"ve [*sic*] had some difficulty understanding exactly what some of the wording in the questions is getting at. For example, "psychosocial issues" could mean innumerable things to a clinician, so that % [*sic*] could range from 10% to 80% to me. Presumably you meant "patients who need professional counseling" (#64, male M.D.).

Variability of Choice

Five comments offered by the participants were related to the various considerations that play into the choices that family physicians make when selecting a mental health professional for their patients. This theme was evident in the following examples:

> The choice of which type of therapist depends on the particular issue (#02, female M.D.).

> Different psychosocial issues affect to [*sic*] which professional I refer (#40, male M.D.).

> Almost all mental health care in this country is focused on the persistently and severely mentally ill. The majority of patients with mental health problems do not fall into this category. Also, most mental health treatment is focused on problem activation, not resource activation. Finally, the traditional 50 minute hour is not useful to improve the mental health of a population (#49, male M.D.).

Meatball Therapy

Three comments submitted by participants offered how these family physicians themselves provide some type of psychotherapy to their patients. The following examples demonstrate this theme:

> Therapy can be quite helpful. Most of my patients have some sort of psych [*sic*] overlay, not all of them of a severity that warrants a trip to a therapist [*sic*] I do some "meatball therapy" in my office every day (#05, male D.O.).

> I prefer to use drug therapy and counseling to treat mental illness. Unfortunately, there are either not enough specialists around to refer patients to or they don't

accept Medicare or Medicaid patients so we end up doing a lot of the psychotherapy part of the puzzle in our offices if time permits or not at all (#09, male M.D.).

Feedback from Patients

Two of the comments written in this free-form text section pointed out that feedback from patients guides these family physicians in selecting a mental health professional for psychosocial referrals. An example follows:

> The number one reason I would form opinions about the effectiveness of psychotherapists is feedback from my patients, which was not an option (#22, male M.D.).

Summary

For this quantitative study, the sample included 80 of the 213 members of the National Research Network (NRN) that is a subgroup of the American Academy of Family Physicians (AAFP). Descriptive statistics guided the data analysis with overall frequency counts tabulated. This chapter has presented the results of this analysis in light of 4 of the original research questions designed for this study. The results of additional questions found in the survey that provided meaningful information but did not address the original research questions were presented. Finally, the participants' answers to the optional open-ended question were coded and reported.

CHAPTER V

CONCLUSIONS, DISCUSSION, LIMITATIONS, IMPLICATIONS, AND RECOMMENDATIONS

The purpose of this study was to explore which mental health professionals family physicians use for referral of their patients presenting with psychosocial/emotional concerns with particular interest in regards to LMFTs. An online survey was designed and the link to the site was sent via email to the current members of the National Research Network (NRN) of the American Academy of Family Physicians (AAFP). The members who completed the survey ($n = 80$) comprised 37.6% of the total listserv ($N = 213$). Four research questions were answered in the responses from the survey.

There were three additional questions and one optional open-ended question found in the survey that provided meaningful data but did not address the research questions. There were 37 free-form answers in response to the optional question and these were read a minimum of four times and coded by the author into seven major themes and verified by a second researcher. This chapter includes conclusions of this study as well as a discussion of the findings along with implications identified. Limitations of this research endeavor are presented, and recommendations for future studies are offered.

Conclusions

The majority of participants who completed this survey were M.D.s (95%) and male (78.8%) with 21.6 years of experience in practice ($M = 21.55$). Though the sample represented 33 different US states and three Canadian provinces, the small percentage cannot be considered as an adequate representation of the entire states and Canadian provinces comprising family physicians.

All of the participants (100%) reported that they prescribe psychotropic medications to their patients. A majority of family physicians (83.7%) estimated that up to 50% of their patients present with psychosocial issues. A majority of these subjects (77.5%) estimated that up to 25% of these patients are referred for psychotherapy with a large portion of these family physicians (37.5%) referring only up to 5% of their patients.

Overall, the top four choices of mental health professionals used by these family physicians when referring patients for psychotherapy (beginning with first choice) were psychologists, counselors, psychiatrists, and social workers. Psychiatric nurse practioners (AAPN) were the least chosen and in the optional question, several family physicians mentioned that AAPNs were not ever considered as a referral option. Marriage and family therapists were rarely considered (1.4%) as a first choice of referral for patients presenting with psychosocial issues. As a second choice, marriage and family therapists ranked last though these choices were more evenly dispersed among five of the mental health professionals. With regards to family physicians' third choice for psychosocial referral, marriage and family therapists ranked fourth.

In examining family physicians' familiarity of the six mental health professionals listed, psychiatrists were shown to be the most familiar ($M = 4.59$, $SD = 0.68$), second were psychologists ($M = 4.11$, $SD = 0.89$), third were social workers ($M = 3.90$, $SD = 1.04$) and fourth were counselors ($M = 3.11$, $SD = 1.46$). Marriage and family therapists ranked second to last ($M = 2.90$, $SD = 1.24$) and psychiatric nurse practioners were found to be the least familiar to this sample of family physicians. When participants were asked to rank psychotherapists according to their least familiarity, marriage and family therapists ranked the highest (34%) of mental health professionals by these subjects.

Family physicians ranked the six mental health professionals listed according to effectiveness in assisting their patients with psychosocial issues. In this ranking, marriage and family therapists tied for second (17%) along with counselors (17%) and social workers (17%). Psychologists were selected more often as the most effective in helping with psychosocial problems. Participants then ranked psychotherapists according to those considered moderately effective in assisting referred patients. In this ranking, marriage and family therapists ranked highest (18.9%) which was close to social workers (18.3%).

Family physicians reported that the top four choices (beginning with the first) of sources where a physician could best gain knowledge of the expertise of mental health providers were: personal contact, residency, colleagues, and workshops. The internet was considered the worst choice in learning about psychotherapists. Thirty seven answers were submitted for the optional question of the total number of completed surveys ($n = 80$). Seven main themes were identified and the number of responses for each theme.

Eighteen of the participants who offered comments mentioned inadequate availability of mental health professionals in their areas or their limited choice of mental health providers due to insurance coverage. Eight of the family physicians reported their knowledge or experience with psychiatrists. Seven participants discussed the importance of collaboration between family physicians and mental health providers. Six subjects remarked about the difficulty in clearly understanding and being able to answer the survey questions. Five of the participants noted the various considerations that play into selecting a mental health professional for their patients. Three family physicians added that they themselves offer their patients psychotherapy. And finally, two comments indicated that a patient's referral choice for psychotherapy depends on feedback from patients.

Discussion

Globally, modern human society appears to be evolving with greater incidence of depression and mental distress as evidenced by climbing divorce and suicide rates (Haskins et al., 2005; McIntosh, 2005; National Institutes of Health, 2005; Popenoe, 2007). Since 1988 with the inception of SSRIs, there is growing apprehension of the practice trends of physicians in treating psychosocial issues. In the past twenty years, data reveals physicians worldwide are more likely to prescribe psychotropic medications for their patients presenting with mental or emotional problems without referring these patients for psychotherapy (Balestrieri et al., 1992; Glied, 1998; Goldberg, 1995; Lecrubier, 2001; Linden et al., 1999; Rushton et al., 2000; Tardieu et al., 2006). Such

practice is not limited to an adult population or to the field of psychiatry and prompts serious implications for the increased use of psychotropic medications among young children (Olfson et al., 2002; Zito et al., 2002). There is evidence that ingestion of psychotropic medications brings about changes in the brain's neurotransmitter function, which causes concern especially for the developing brains of children (Fava, 2003; Fava et al., 1994; Fisher, S. & Greenberg, 1997; Hyman & Nestler, 1996).

The increased dependence solely on the use of psychotropic medications is surprising with the vast data supporting the effectiveness of psychotherapy in aiding people with a range of mental health issues (Asen et al., 1991; Dessaulles et al., 2003; Dutra et al., 2008; Fals-Stewart et al., 2005; Huxley et al., 2000; Knekt et al., 2008; MacPhee et al., 1995; Miklowitz et al., 2007; Ritvo & Papilsky, 1999; Shadish et al., 1995; Weissman, 1994). Throughout the literature, there is no information exploring the referral practices of family physicians with patients presenting with mental health problems.

This study has attempted to contribute to the void found in the literature and offer some insight as to what influences the referral practices of family physicians with their patients who present with psychosocial issues. The fact that all of the US and Canadian participants in this study prescribe psychotropic medications reinforces how in the developed countries around the world, family physicians are the medical specialists most likely to hear first about a person's mental distress (Glied, 1998). In this study, a large majority of family physicians estimated that up to half their patients present with

psychosocial problems while the majority report only referring up to 5% of their patients for psychotherapy. These results concur with the global trend evident in research that primary care physicians medically treat most mental disorders or complaints of their patients with little or no referrals to psychotherapy. The current study made no attempt to differentiate between patients who are adults and those who are children. The results of this study demonstrate that steps toward behavioral interventions aimed at bringing about psychosocial changes may overall have taken a back seat in the medical community (Harrington, 2008).

Within this sample population, this study found that psychologists ranked highest as a first choice for psychotherapy referral as well as being among the most familiar to these family physicians. Psychiatrists were noted to be most familiar to this sample population though psychiatrists ranked third as a preferred referral choice. This finding correlates with the medical literature reviewed which more frequently mentioned psychologists when discussing psychotherapy and treated psychiatry as synonymous with the mental health field. Counselors were found to rank second as a primary referral choice though this group of professionals ranked fourth as greatly familiar to family physicians. This data differed slightly from the literature for in one study of primary care physicians (PCPs), these PCPs reportedly used psychologists and psychiatrists as preferred referral sources with a significant increase recently in the use of social workers rather than counselors (Williams et al., 2007). The difference may be related to that sample population which included PCPs and pediatricians. Conversely, in this current

study, social workers were found to rank fourth as a primary referral choice for their patients with mental/emotional distress but social workers ranked third in being familiar to these participants.

Only one study from the medical literature reviewed mentioned licensed marriage and family therapists (LMFTS) as a referral choice with psychosocial problems (Williams et al., 2007). In that study, LMFTs were least preferred (2%) as a primary choice for referral of patients presenting with psychosocial problems. This current study supports these previous findings as marriage and family therapists ranked second to last (1.4%) as a primary choice for psychotherapy referrals.

It is interesting to note that LMFTs were considered the next to the last choice of the practioners offering psychotherapy and were also the least familiar to these family physicians. The absence of marriage and family therapy mentioned in medical research emphasizes these two findings. Of course, perhaps LMFTs are not used for psychosocial referrals since they are the least known among family physicians. Further investigation is needed to examine specifically how a family physician is trained regarding the different mental health providers, especially marriage and family therapists. This would correlate with the findings of Elkins and Wall (1996) who observed that the education and training of a physician influences their familiarity of psychosocial treatment approaches.

Of particular interest was that among these family physicians, licensed marriage and family therapists (LMFTs) were equally rated as greatly effective (number two) along with counselors and social workers in assisting their patients with psychosocial

problems. Yet the participants ranked LMFTs as their first choice as moderately effective in assisting their patients with psychosocial distress. There is nothing in the literature that helps to explain this result. The answers provided to the optional open-ended question offer some further insight.

The most frequent comment made by participants in the free-form text area was that mental health professionals were chosen based on their availability and/or these physicians had a lack of choices as medical coverage determined the referral choice for psychosocial issues. What was meant by availability was not clearly explained in most of the comments submitted. Since psychologists and psychiatrists were specifically identified in some answers as being unavailable, could it mean that all of these other vague comments of availability were referring to only psychologists and psychiatrists who were noted to be the top two referral choices of FPs?

Does availability relate to the physician, or the patient, or both and how? Is this referring to the psychotherapist residing (or not) in the community where the physician works or perhaps whether the mental health professional is included as a provider with the patients' insurance companies? Or does availability mean finding a mental health professional who is qualified to address the pressing issue? Is this availability reflecting a list that the family physician uses when making referral choices and if so, how do these physicians decide on who their regular choices are? Who or what is actually determining availability? Unfortunately, these answers stir up more questions rather than providing clarity.

The second most frequent comment provided by these participants in the optional question section reflected their knowledge of or relationship with psychiatrists. Most of these statements offered that psychiatrists do not provide psychotherapy any longer and seem more focused on medication administration. As previously noted, research indicates that among psychiatrists there has been an increase in the number of psychotropic medications prescribed as well as a decline in psychotherapy (Gabbard & Kay, 2001; Mojtabai & Olfson, 2008; Olfson et al., 1999; Tanielian et al., 2001). Some stated that it was difficult for their patients to get appointments with psychiatrists and psychologists. These remarks support the research of psychiatric practice trends reporting that psychiatrists have become unavailable or undesirous of providing psychotherapy (Dial et al., 1998; Eveland et al., 1998; Goldman, 2001; Harpaz-Rotem & Rosenheck, 2006; Penn, 2008). These comments also support Dr. Wallersteins's remarks that psychotherapy seems to be disappearing within the practice of psychiatrists (Wallerstein, 1991).

Several participants discussed the benefits to their patients when physicians work collaboratively with mental health practioners. Most described this as working together in proximity such as at primary care sites and clinics. This finding concurs with the research demonstrating that collaborative care models using mental health professionals along with primary care physicians increase the effectiveness of overall healthcare delivery (Gabbard & Kay, 2001; Harpaz-Rotem et al., 2004; Harpaz-Rotem & Rosenheck, 2006; Keller et al., 2000; Peota, 2006; Tyrer et al., 1990).

Participants stated having some difficulty with understanding words used in the survey such as "psychosocial" as there could be a range of psychosocial problems in a patient's life, but perhaps these people are simply having a bad day versus actually needing professional therapy. It seems apparent that these physicians may use different standards when determining whether a patient needs psychotropic medications or referral to psychotherapy. What these standards are is unclear and needs further investigation. As previously stated, research shows that antidepressants were the number one medication ordered by physicians in 2007 with Americans spending even more money on antipsychotics in the same year (IMS Health, 2007a, 2007b). Clearly the current findings reveal that family physicians do not necessarily believe every person on a psychotropic medication needs to be referred for psychotherapy.

A few family physicians reported that they themselves render an unspecified amount of psychotherapy to their patients. This finding correlates with earlier studies showing how some GPs are attempting to provide psychotherapy for their patients with psychosocial issues (Huibers et al., 2007; Trent, 1990). Considering the number of participants reporting the "unavailability" of mental health professionals, these family physicians who offer psychotherapy are filling a need that seems to exist. Yet without formal psychotherapy training and pressing time constraints, can these physicians take the place of mental health professionals? Are these physicians devoting fifty minutes to their patients with psychosocial needs?

This finding conflicts with the comment made by one participant that most mental health treatment is ineffective within the time constraints of fifty minutes as the focus is on the problem and not the resources. This comment might suggest that this participant is not completely informed with regards to solution-focused family therapy which focuses only on a patient's strengths and viable solutions and not on the problem. Again, are most family physicians similarly uninformed? Overall, none of the physicians' comments reflected a lack of respect or esteem for mental health professionals as found in the literature (Detre & McDonald, 1997). The major complaint was the lack of availability which may reflect a lack of awareness of all the mental health professionals who are prepared to address the needs of their patients with psychosocial problems.

No known prior research offers any suggestions to the best ways that family physicians can gain more knowledge of the expertise of mental health professionals. In this study, the participants selected personal contact as the preferred method of learning more of a psychotherapist. If a physician has never made contact with specific psychotherapists, such as marriage and family therapists, then how would the physician have any knowledge to refer his/her patients? How would prior contact with mental health professionals (or the lack thereof) influence referral choices? Have any of these family physicians sought psychotherapy for themselves or their families? The participants rated residency as a second choice for an avenue to learn about a mental health professional. What is taught in residency regarding the different mental health

providers and which of these psychotherapists are likely to work alongside family physicians during their residencies?

These family physicians selected their colleagues as a third possible choice in gaining knowledge about psychotherapists. Workshops were considered the fourth choice in ways to obtain further education about different mental health professionals. The internet was seen as the worst choice in learning about psychotherapists and this is curious since the internet is commonly referred to as the gateway to information. Is it that family physicians currently have a lack of credible sources via the internet that offer helpful information of mental health providers? Or is it that these family physicians are unlikely to use the internet in gaining such information?

Limitations

There are several limitations that must be considered with this study. The sample resulted from the listserv of current members of the National Research Network (NRN) of the American Academy of Family Physicians (AAFP). The NRN is a voluntary research subgroup of the AAFP of primary care physicians interested in participating in studies in order to improve the phenomenon of primary care practice. Because of this relatively narrow sampling frame, the generalizability of the findings is reduced. With a return rate of 37.6%, the results obtained do not necessarily reflect the population of family physicians across America. Because the sample included only family physicians, the results do not reflect any other physician group or practice. Furthermore, the family physicians who answered these survey questions may not adequately represent the entire

population as there is no clarity in understanding the thought or perspectives of those physicians who did not answer the survey.

This study is also limited due to the instrument used. Though the survey was reviewed during its design by experienced physicians, there is no assurance of validity. The study relied upon self-reported data in which the participants depended upon their memory to estimate the number of patients that present with psychosocial issues as well as the number of these patients referred for psychotherapy. It would have been interesting to relate the preferred psychotherapists used for referral to the physicians' familiarity of these mental health professionals. Unfortunately, the exploration of this relationship went beyond the perimeters of this study but would be worth investigating in future studies. The comments posted in the optional question section suggest that the wording used in the survey was not completely clear and the ranking measures may not adequately reflect the practice of these family physicians.

As with any study, the degree of candidness and honesty that a participant applied when filling out the survey lays beyond the researcher's control. It was hoped that the anonymity facilitated by the online administration of the survey might have contributed to participants' comfort and authenticity. It is unknown how forthright these participants were and subsequently how this impacted the results. Any generalizations made from the results of this study need to be regarded cautiously.

Implications

The results of this research provide important implications for licensed marriage and family therapists (LMFTs). Family physicians (FPs) are the medical specialists most likely to hear first about a person's mental or emotional distress. Family physicians estimate that up to half their patients present with psychosocial issues but the majority of these medical practioners refer only up to 5% of their patients for psychotherapy.

This research revealed that licensed marriage and family therapists (LMFTs) are mental health professionals who are among the least chosen and the least known to family physicians when referring their patients for psychotherapy. Yet, family physicians consider LMFTs as moderately effective in assisting patients with mental and emotional distress and among the top choices of psychotherapists who are highly effective. This suggests that family physicians associate value to the work of LMFTs which may be more related to the name, that is, marriage and family therapy, rather than having an experiential knowledge of LMFTs.

From the results of this study, family physicians have acknowledged a void in optimal mental health services to their patients. Family physicians voiced that mental health professionals were unavailable for referrals of their patients with psychosocial problems. This observation may reflect their lack of familiarity with marriage and family therapists and other psychotherapists as well as the growing trend that psychiatrists infrequently provide psychotherapy.

Whatever the reason, some family physicians have attempted to fill this void by providing psychotherapy themselves to their patients while the majority of FPs have become more comfortable in treating psychosocial problems by prescribing more and more psychotropic medications. This represents serious implications for the future of our species as medications bring about changes that may be lasting in human neurotransmission function. The consequence of doing nothing differently could likely result in further government regulations over the practice of prescribing psychotropic medications, especially with regards to young children.

Family physicians suggested that a collaborative model of care would be an efficacious option in maximizing the delivery of healthcare. Participants emphasized the benefits to their patients when mental health professionals work collaboratively with primary care physicians. Collaboration has long been an integral element for those working in the medical field, but has generally not been accepted as a practice by the majority of family therapists and other psychotherapists. Among mental health professionals, medical family therapists are uniquely prepared to work collaboratively with physicians by paying attention to the connection between biological, psychological, relational, and emotional processes of humans. Including the consideration of biological issues assists the family therapist to adhere to a true systems approach.

Something else worth noting is that many of the participants involved in this research believe that personal contact is the best way for a family physician to gain knowledge about mental health professionals. Licensed Marriage and family therapists

who desire to help fill this void in meeting the needs of family physicians and their patients need to pursue training in health and disease processes as well as finding opportunities to make personal contact with these physicians. Working alongside family physicians during their residencies would increase the LMFT's contact with these medical practioners and would result in family physicians' familiarity of marriage and family therapists.

Recommendations

Licensed marriage and family therapists (LMFTs) are virtually unknown to family physicians and it makes complete sense that this may be why family physicians rarely consider LMFTs as a referral choice for their patients with psychosocial problems. This suggests insight into the difficulty for LMFTs in becoming eligible providers of mental health services recognized by all insurance groups and that is that the medical community is not well acquainted with the field of marriage and family therapy. Perhaps a more advantageous first step might be for LMFTs to take measures in making themselves more familiar to family physicians as well as to other physician groups. The following are suggestions in increasing family physicians' familiarity and referral use of LMFTs:

1. The national organization, American Association of Marriage and Family Therapy (AAMFT) to require additional training in the curriculum of graduate family therapy programs that will prepare students to collaborate with physicians and be comfortable addressing health and illness issues.

2. AAMFT to set up a collaborative relationship with family practice residency sites across the nation with area family therapy programs. Develop practicum sites which allow these family therapy interns to train alongside family practice residents in the medical community.
3. AAMFT to reexamine their current marketing practices and to develop a task force to explore and suggest effective marketing strategies to the medical community. This should include connecting with family practice residencies across the nation, especially the teachers of family medicine. This exploration needs to take into consideration how the internet can be used practically as a method of connecting family physicians (and other physician groups) to the appropriate mental health professional.
4. AAMFT to offer guidance and suggestions in assisting licensed marriage and family therapists (LMFTs) to make personal connections with the family physicians in their localities.

There is a lack of research exploring the referral practices of physicians with their patients who present with mental health issues. Wide opportunity exists for further study using either the rich meaningful methods of qualitative research or the broad deductions of quantitative pursuits. This topic is worth further investigation since data reveals the trend among medical practioners toward a sharp decline in psychotherapy referrals along with a surge in psychopharmacologic emphasis. What might possibly be the benefit of these physicians not referring their patients for psychotherapy?

1. Replicate the study to include a larger, preferably random sample as well as different physician groups for comparative analysis. A longitudinal form of this research that includes periodic retesting could measure possible correlations between different factors over time. Are all physician groups similarly uninformed about LMFTs? Find out whether these physicians have a working knowledge of LMFTs or merely acquainted with the name of the field. What, if any, personal experience do different physician groups have with psychotherapists and which ones? Within the study, differentiate the treatment practices of physicians with their adult patients versus their pediatric patients.
2. Specifically examine the training of family physicians possibly via questions posed to the teachers of family medicine and compare training across the nation. What is taught to family practice residents regarding the different mental health professionals, particularly marriage and family therapists? What are family practice residents taught regarding family therapy, specifically with all the different models and the overall approach to make change happen in people's lives? Are family physicians trained to have a preference for medication as the primary solution to mental distress without the need for psychotherapy? Are family practice residents trained to do psychotherapy themselves and how? Which psychotherapists are likely to work alongside family practice residents during their training?

3. Explore what family physicians mean when they explain that psychotherapists are not available. Could it be that these family physicians are actually describing only their first choice of mental health practioners, that is, psychiatrists and psychologists, and not other psychotherapists such as LMFTs? Could this comment of family physicians represent their limited awareness of all mental health professionals who are qualified to address the needs of patients with psychosocial problems? What is meant by availability? Does this relate to the physician or the patient or both and how?
4. Examine what factors into the determination of family physicians when deciding to refer patients for psychotherapy? What elements are involved? Do patients or physicians initiate this step?
5. Investigate where the field of psychiatry is heading. If psychiatrists as a whole no longer desire to provide psychotherapy, what changes exist in their training and how does this affect their role in mental health care?

Summary

This chapter contained a discussion of the meaningful results of an online survey sent to family physicians in light of research questions. Limitations of the study along with implications for marriage and family therapists were identified. Recommendations for future research as well as for the practice of family therapy were proposed.

The results of this research suggest that marriage and family therapists are mental health professionals who are among the least chosen and the least known to family physicians

when referring their patients for psychotherapy. Yet family physicians consider LMFTs among the top choices of psychotherapists who are highly effective in assisting patients with mental and emotional distress. This study contributes knowledge of the referral practices of family physicians with their patients who present with psychosocial problems. Further research is still needed in this area.

REFERENCES

Adams, S. (1991). Prescribing of psychotropic drugs to children and adolescents. *BMJ: British Medical Journal, 302*(6770), 217.

Amato, P. (2000). The consequences of divorce for adults and children. *Journal of Marriage and Family, 62*(4), 1269-1287.

Anderson, H., & Goolishian, H. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. *Family Process, 27*, 371-393.

Aras, S., Varol Tas, F., & Unlu, G. (2007). Medication prescribing practices in a child and adolescent psychiatry outpatient clinic. *Child: Care, Health and Development, 33*(4), 482-490.

Aronson, J. (1996). *Inside managed care: Family therapy in a changing environment.* New York: Brunner/Mazel.

Asen, K., Berkowitz, R., Cooklin, A., & Leff, J. (1991). Family therapy outcome research: A trial for families, therapists, and researchers. *Family Process, 30*(1), 3-20.

Babbie, E. (2004). *The practice of social research*. Belmont, CA: Wadsworth/Thomson Learning.

Balestrieri, M., Paltrinieri, E., & Bellantuono, C. (1992). Who prescribes antidepressant drugs? A survey of a sample of pharmacies in Verona, Italy. *Human Psychopharmacology: Clinical and Experimental, 7*(3), 193-198.

Becker, H. (1997). *Tricks of the trade: How to think about your research while you're doing it.* Chicago: University of Chicago.

Behr, R. (1998). Overzealous prescribing of medications. *Journal of the American Academy of Child and Adolescent Psychiatry, 37*(9), 900-901.

Bennett, Petts, & Blumenthal. (1999, April). *Adult attitudes towards sexual problems: National survey of American adults aged 25 and older.* Paper presented at the conference on Gender and Human Sexuality: A Continuing Medical Education Conference, Washington, DC.

Blanco, C., Goodwin, R. D., Liebowitz, M. R., Schmidt, A. B., Lewis-Fernandez, R., & Olfson, M. (2004). Use of psychotropic medications for patients with office visits who receive a diagnosis of panic disorder. *Medical Care, 42*(12), 1242-1246.

Blount, A., & Bayona, J. (1994). Toward a system of integrated primary care. *Family Systems Medicine, 12*, 171-182.

Braud, W., & Anderson, R. (1998). *Transpersonal research methods for the social sciences: Honoring human experience.* Thousand Oaks, CA: Sage.

Brook, A., & Temperley, J. (1976). The contribution of a psychotherapist to general practice. *The Journal of the Royal College of General Practitioners, 26*(163), 86-94.

Brucker, P. S., Faulkner, R. A., Baptist, J., Grames, H., Beckham, L. G., Walsh, S., et al. (2005). The internship training experience in medical family therapy of doctoral-level marriage and family therapy students. *American Journal of Family Therapy, 33*(2), 131-147.

Campbell, T. (1986). Family's impact on health: A critical review and annotated bibliography. *Family Systems Medicine, 4*, 135-328.

Campbell, T., McDaniel, S. H., & Seaburn, D. B. (1992). Family systems medicine: New opportunities for psychologists. In T. Akamatsu & M. Stephens (Eds.), *Family health psychology* (pp. 193-215). Washington, DC: Hemisphere.

Centers for Disease Control and Prevention. (2003). *Costs of intimate partner violence against women in the United States*. Retrieved May 22, 2008, from http://purl.access.gpo.gov/GPO/LPS58078

Chen, H. (1990). *Theory-driven evaluations*. Newbury Park, CA: Sage.

Clark, D. B., Wood, D. S., Cornelius, J. R., Bukstein, O. G., & Martin, C. S. (2003). Clinical practices in the pharmacological treatment of comorbid psychopathology in adolescents with alcohol use disorders. *Journal of Substance Abuse Treatment, 25*(4), 293-295.

Clayton, P., & Pitts, F. (1965). Affect disorder. IV. Mania. *Comprehensive Psychiatry, 6*(5), 313-322.

Coyle, J. T. (1997). Biochemical development of the brain: Neurotransmitters and child psychiatry. In C. Popper (Ed.), *Psychiatric pharmacosciences of children and adolescents* (pp. 3-25). Washington, DC: American Psychiatric Press.

Coyle, J. T. (2000). Psychotropic drug use in very young children. *JAMA: The Journal of the American Medical Association, 283*(8), 1059-1060.

Coyne, J., Rohrbaugh, M., Shoham, V., Sonnega, J., Nicklas, J., & Cranford, J. (2001). Prognostic importance of marital quality for survival of congestive heart failure. *American Journal of Cardiology, 88*(5), 526-529.

Cozolino, L. (2006). *The neuroscience of human relationships*. New York: W. W. Norton & Company.

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks: Sage.

Dare, C., Eisler, I., Russell, G., Treasure, J., & Dodge, L. (2001). Psychological therapies for adults with anorexia nervosa: Randomized controlled trial of out-patient treatments. *The British Journal of Psychiatry: The Journal of Mental Science, 178*, 216-221.

Davidsen, A. (2008). Experiences of carrying out talking therapy in general practice: A qualitative interview study. *Patient Education and Counseling, 72*(2), 268-275.

Dessaulles, A., Johnson, S. M., & Denton, W. H. (2003). Emotion-focused therapy for couples in the treatment of depression: A pilot study. *American Journal of Family Therapy, 31*(5), 345-353.

Detre, T., & McDonald, M. C. (1997). Managed care and the future of psychiatry. *Archives of General Psychiatry, 54*(3), 201-204.

Dial, T. H., Bergsten, C., Haviland, M. G., & Pincus, H. A. (1998). Psychiatrist and nonphysician mental health provider staffing levels in health maintenance. *American Journal of Psychiatry, 155*(3), 405.

Doherty, W. J., & Campbell, T. L. (1988). *Families and health*. Beverly Hills, CA: Sage.

Doherty, W. J., McDaniel, S. H., & Hepworth, J. (1994). Medical family therapy: An emerging arena for family therapy. *Journal of Family Therapy, 16*, 31-46.

Dutra, L., Stathopoulou, G., Basden, S. L., Leyro, T. M., Powers, M. B., & Otto, M. W. (2008). A meta-analytic review of psychosocial interventions for substance use disorders. *The American Journal of Psychiatry, 165*(2), 179-187.

Efron, D., Hiscock, H., Sewell, J. R., Cranswick, N. E., Vance, A., Tyl, Y., et al. (2003). Prescribing of psychotropic medications for children by Australian pediatricians and child psychiatrists. *Pediatrics, 111*(2), 372-375.

Elkins, G. R., & Wall, V. J. (1996). Medical referrals for hypnotherapy: opinions of physicians, residents, family practice outpatients, and psychiatry outpatients. *The American Journal of Clinical Hypnosis, 38*(4), 254-262.

Engel, G. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196*, 129-136.

Engel, G. (1980). The clinical application of the Biopsychosocial Model. *American Journal of Psychiatry, 137*, 535-544.

Eveland, A. P., Dever, G. E., Schafer, E., Sprinkel, C., Davis, S., & Rumpf, M. (1998). Analysis of health service areas: another piece of the psychiatric workforce puzzle. *Psychiatric Services 49*(7), 956-960.

Fals-Stewart, W., Yates, B. T., & Klostermann, K. (2005). Assessing the costs, benefits, cost-benefit ratio, and cost-effectiveness of marital and family treatments: Why we should and how we can? *Journal of Family Psychology, 19*(1), 28-39.

Fava, G. (2003). Can long-term treatment with antidepressant drugs worsen the course of depression? *Journal of Clinical Psychiatry, 64*(2), 123-133.

Fava, G., Grandi, S., Belluardo, P., Savron, G., Raffi, A., Conti, S., et al. (1994). Benzodiazepines and anxiety sensitivity in panic disorder. *Progress in Neuro-Psychopharmacology and Biological Psychiatry, 18*(7), 1163-1168.

Fife, A., Beasley, P. J., & Fertig, D. L. (1996). Psychoneuroimmunology and cancer: Historical perspectives and current research. *Advances in Neuroimmunology, 6*(2), 179-190.

Fisher, L., Ransom, D. C., Terry, H. E., Lipkin, M., & Weiss, R. (1992). The California family health project: 1. Introduction and a description of adult health. *Family Process, 31*, 231-250.

Fisher, S., & Greenberg, R. P. (1997). *From placebo to panacea: Putting psychiatric drugs to the test*. New York: John Wiley & Sons.

Furukawa, T. A., Watanabe, N., & Churchill, R. (2006). Psychotherapy plus antidepressant for panic disorder with or without agoraphobia: Systematic review. *The British Journal of Psychiatry: The Journal of Mental Science, 188*, 305-312.

Gabbard, G. O., & Kay, J. (2001). The fate of integrated treatment: Whatever happened to the biopsychosocial psychiatrist? *American Journal of Psychiatry, 158*(12), 1956.

Glenn. (1996). Values, attitudes, and the state of American marriage. In D. Popenoe, J. Elshtain, & D. Blankenhorn (Eds.), *Promises to keep: Decline and renewal of marriage in America* (pp. 15-33). Lanham, MD: Rowman & Littlefield.

Glied, S. (1998). Too little time? The recognition and treatment of mental health problems in primary care. *Health Services Research, 33*, 891-910.

Goldberg, D. (1995). Epidemiology of mental disorders in primary care settings. *Epidemiologic Reviews, 17*(1), 182-190.

Goldman, W. (2001). Economic grand rounds: Is there a shortage of psychiatrists? *Psychiatric Services 52*(12), 1587-1589.

Goodwin, R., Gould, M. S., Blanco, C., & Olfson, M. (2001). Prescription of psychotropic medications to youths in office-based practice. *Psychiatric Services 52*(8), 1081-1087.

Gottman, J., & Katz, L. (1989). Effects of marital discord on young children's peer interaction and health. *Developmental Psychology, 25*, 373-381.

Guidi, L., Tricerri, A., Frasca, D., Vangeli, M., Errani, A. R., & Bartoloni, C. (1998). Psychoneuroimmunology and aging. *Gerontology, 44*(5), 247-261.

Guthrie, E., Moorey, J., Margison, F., Barker, H., Palmer, S., McGrath, G., et al. (1999). Cost-effectiveness of brief psychodynamic-interpersonal therapy in high utilizers of psychiatric services. *Archives of General Psychiatry, 56*(6), 519-526.

Harpaz-Rotem, L. D., & Rosenheck, R. A. (2004). Treatment retention among children entering a new episode of mental health care. *Psychiatric Services 55*(9), 1022-1028.

Harpaz-Rotem, L. D., & Rosenheck, R. A. (2006). Prescribing practices of psychiatrists and primary care physicians caring for children with mental illness. *Child: Care, Health and Development, 32*(2), 225-237.

Harrington, J. W. (2008). Are we overmedicating our children? *Pediatrics, 122*(1), 211.

Haskins, R., McLanahan, S., & Donahue, E. (2005). *The decline in marriage: What to do*. Washington, DC: The Future of Children.

Healey, J. (1999). *Statistics: A tool for social research*. Belmont, CA: Wadsworth.

Hermann, R. C., Yang, D., Ettner, S. L., Marcus, S. C., Yoon, C., & Abraham, M. (2002). Prescription of antipsychotic drugs by office-based physicians in the United States, 1989-1997. *Psychiatric Services 53*(4), 425-430.

House, J., Landis, K., & Umberson, D. (1988). Social relationships and health. *Science, 241*(4865), 540-545.

Huibers, M. J., Beurskens, A. J., Bleijenberg, G., & Van Schayck, C. P. (2007). Psychosocial interventions by general practitioners. *The Cochrane Library, 3*(4), 1-23.

Huxley, N. A., Rendall, M., & Sederer, L. (2000). Psychosocial treatments in schizophrenia: A review of the past 20 years. *The Journal of Nervous and Mental Disease, 188*(4), 187-201.

Hyman, S., & Nestler, E. (1996). Initiation and adaptation: A paradigm for understanding psychotropic drug action. *American Journal of Psychiatry, 153*(2), 151-162.

IMS Health. (2007a). 2007 top therapeutic classes by U.S. dispensed prescriptions. *IMS National Sales Perspectives*. Retrieved May 24, 2008, from http://imshealth.com/vgn/images/portal/CIT_40000873/39/59/834330292007%20Top%20Therapeutic%20Classes%20by%20RXs.pdf

IMS Health. (2007b). 2007 top therapeutic classes by U.S. sales. *IMS National Sales Perspectives*. Retrieved May 24, 2008, from http://imshealth.com/vgn/images/portal/CIT_40000873/39/60/834330392007%20Top%20Therapeutic%20Classes%20by%20Sales.pdf

Kahan, J. (2000). Trends in office-based practice under managed care. *The American Journal of Psychiatry, 157*(3), 484-485.

Keller, M. B., McCullough, J. P., Klein, D. N., Arnow, B., Dunner, D. L., Gelenberg, A. J., et al. (2000). A comparison of nefazodone, the cognitive behavioral-analysis system of psychotherapy, and their combination for the treatment of chronic depression. *New England Journal of Medicine, 342*(20), 1462-1470.

Kiecolt-Glaser, Fisher, L., Ogrock, P., Stout, J., Speicher, C., & Glaser, R. (1987). Marital quality, marital disruption, and immune function. *Psychosomatic Medicine, 49*(1), 13-34.

Kiecolt-Glaser, Glaser, R., Cacioppo, J., MacCallum, R., Snydersmith, M., C, K., et al. (1997). Marital conflict in older adults: Endocrinological and immunological correlates. *Psychosomatic Medicine, 59*(4), 339-349.

Kiecolt-Glaser, Malarkey, W., Chee, M., Newton, T., Cacioppo, J., Mao, H., et al. (1993). Negative behavior during marital conflict is associated with immunological down-regulation. *Psychosomatic Medicine, 55*(5), 395-409.

Kiecolt-Glaser, McGuire, L., Robles, T. F., & Glaser, R. (2002). Psychoneuroimmunology: Psychological influences on immune function and health. *Journal of Consulting and Clinical Psychology, 70*(3), 537-547.

Kiecolt-Glaser, Newton, T., Cacioppo, J., MacCallum, R., Glaser, R., & Malarkey, W. (1996). Marital conflict and endocrine function: Are men really more physiologically affected than women? *Journal of Consulting and Clinical Psychology, 64*(2), 324-332.

Knekt, P., Lindfors, O., Laaksonen, M. A., Raitasalo, R., Haaramo, P., & Jarvikoski, A. (2008). Effectiveness of short-term and long-term psychotherapy on work ability and functional capacity: A randomized clinical trial on depressive and anxiety disorders. *Journal of Affective Disorders, 107*(1-3), 95-106.

Kovacs, M., & Lohr, W. D. (1995). Research on psychotherapy with children and adolescents: An overview of evolving trends and current issues. *Journal of Abnormal Child Psychology, 23*(1), 11-30.

Lecrubier, Y. (2001). Prescribing patterns for depression and anxiety worldwide. *The Journal of Clinical Psychiatry, 62* (13), 31.

Linden, M., Lecrubier, Y., Bellantuono, C., Benkert, O., Kisely, S., & Simon, G. (1999). The prescribing of psychotropic drugs by primary care physicians: An international collaborative study. *Journal of Clinical Psychopharmacology, 19*(2), 132-140.

Lust, E., Ryan-Haddad, A., Coover, K., & Snell, J. (2007). Measuring clinical outcomes of animal-assisted therapy: Impact on resident medication usage. *The Consultant Pharmacist: The Journal of the American Society of Consultant Pharmacists, 22*(7), 580-585.

MacPhee, D. C., Johnson, S. M., & Van Der Veer, M. M. (1995). Low sexual desire in women: The effects of marital therapy. *Journal of Sex & Marital Therapy, 2*, 159-182.

Marcenes, W., & Sheiham, A. (1996). The relationship between marital quality and oral health status. *Psychology and Health, 11*(3), 357-369.

Mason, M., Carnochan, S., & Fine, M. (2004). Family law for changing families in the new millennium. In M. Coleman & L. Ganong (Eds.), *Handbook of contemporary families: Considering the past, contemplating the future* (pp. 432-450). Thousand Oaks, CA: Sage.

Mayne, T., O'Leary, A., McCrady, B., Contrada, R., & Labouvie, E. (1997). The differential effects of acute marital distress on emotional, physiological and immune functions in maritally distressed men and women. *Psychology and Health, 12*, 277-288.

Mazer, C., Muneyyirci, J., Taheny, K., Raio, N., Borella, A., & Whitaker-Azmitia, P. (1997). Serotonin depletion during synaptogenesis leads to decreased synaptic density and learning deficits in the adult rat: A possible model of neurodevelopmental disorders with cognitive deficits. *Brain Research, 760*(1-2), 68-73.

McDaniel, S. H., Harkness, J. L., & Epstein, R. M. (2001). Differentiation before death: Medical family therapy for a woman with end-stage Crohn's disease and her son. In S. H. McDaniel & D. Lusterman (Eds.), *Casebook for integrating family therapy: An ecosystemic approach* (pp. 323-336). Washington, DC: American Psychological Association.

McDaniel, S. H., Hepworth, J., & Doherty, W. J. (1992). *Medical family therapy: A biopsychosocial approach to families with health problems*. New York: Basic Books.

McIntosh, J. L. (2005). U.S.A. suicide: 2005 Official final data. Retrieved May 24, 2008, from http://www.suicidology.org/associations/1045/files/2005datapgs.pdf

McLanahan, S., & Sandefur, G. (1994). *Why we care about single parenthood: Growing up with a single parent. What hurts, what helps.* Cambridge, MA: Harvard University Press.

Mechanic, D. (1990). Treating mental illness: Generalist versus specialist. *Health Affairs 9*(4), 61-75.

Mertens, D. M. (1998). *Research methods in education and psychology*. Thousand Oaks, CA: Sage.

Miklowitz, D. J., Otto, M. W., Frank, E., Reilly-Harrington, N. A., Wisniewski, S. R., Kogan, J. N., et al. (2007). Psychosocial treatments for bipolar depression: A 1-year randomized trial from the systematic treatment enhancement program. *Archives of General Psychiatry, 64*(4), 419-426.

Minuchin, S., Baker, L., Rosman, B. L., Liebman, R., Milman, L., & Todd, T. C. (1975). A conceptual model of psychosomatic illness in children. *Archives of General Psychiatry, 32*, 1031-1038.

Minuchin, S., Rosman, B. L., & Baker, L. (1978). *Psychosomatic families: Anorexia nervosa in context*. Oxford, England: Harvard University Press.

Mojtabai, R. (1999). Datapoints: Prescription patterns for mood and anxiety disorders in a community sample. *Psychiatric Services 50*(12), 1557-1557.

Mojtabai, R., & Olfson, M. (2008). National trends in psychotherapy by office-based psychiatrists. *Archives of General Psychiatry, 65*(8), 962-970.

National Institutes of Health. (1985). Electroconvulsive therapy: National Institutes of Health Consensus Development Conference statement. *Journal of ECT, 5*(11), 1-23. Retrieved October 20, 2008, from http://consensus.nih.gov/1985/1985ElectroconvulsiveTherapy051html.htm

National Institutes of Health. (2005). Suicide in the U.S.: Statistics and prevention. Retrieved May 22, 2008, from http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention.shtml#children

Nock, S. (2005). Marriage as a public issue. *The Future of Children, 15*(2), 13-32.

Olfson, M., Gameroff, M. J., Marcus, S. C., & Jensen, P. S. (2003). National trends in the treatment of attention deficit hyperactivity disorder. *The American Journal of Psychiatry, 160*(6), 1071-1077.

Olfson, M., & Klerman, G. (1993). Trends in the prescription of psychotropic medications: The role of physician specialty. *Medical Care, 31*(6), 559-564.

Olfson, M., Marcus, S. C., Druss, B., Elinson, L., Tanielian, T., & Pincus, H. A. (2002). National trends in the outpatient treatment of depression. *JAMA: Journal of the American Medical Association, 287*(2), 203.

Olfson, M., Marcus, S. C., & Pincus, H. A. (1999). Trends in office-based psychiatric practice. *The American Journal of Psychiatry, 156*(3), 451-457.

Olfson, M., Marcus, S. C., Wan, G. J., & Geissler, E. C. (2004). National trends in the outpatient treatment of anxiety disorders. *The Journal of Clinical Psychiatry, 65*(9), 1166-1173.

Ooms, T. (1998). *Towards more perfect unions: Putting marriage on the public agenda.* Washington, DC: Family Impact Seminar.

Ooms, T., & Wilson, P. (2004). The challenges of offering relationship and marriage education to low-income populations. *Family Relations, 53*(5), 440-447.

Penn, J. V. (2008). Psychotropic medications in incarcerated juveniles: Overprescribed or underprescribed? *Archives of Pediatrics and Adolescent Medicine, 162*(3), 281-283.

Peota, C. (2006). Big push. *Minnesota Medicine, 89*(1), 15-16.

Pincus, H. A., Tanielian, T. L., Marcus, S. C., Olfson, Zarin, D. A., Thompson, J., et al. (1998). Prescribing trends in psychotropic medications: Primary care, psychiatry, and other medical specialties. *JAMA: The Journal of the American Medical Association, 279*(7), 526-531.

Popenoe, D. (2007). The state of our unions: The social health of marriage in America: The future of marriage in America. *National Marriage Project.* Retrieved May 24, 2008, from http://marriage.rutgers.edu/Publications/SOOU/TEXTSOOU2007.htm

Rappley, M. D., Mullan, P. B., Alvarez, F. J., Eneli, I., Wang, J., & Gardiner, J. (1999). Diagnosis of attention-deficit/hyperactivity disorder and use of psychotropic medication in very young children. *Archives of Pediatrics & Adolescent Medicine, 153*(10), 1039-1045.

Reiche, E. M. V., Morimoto, H. K., & Nunes, S. M. V. (2005). Stress and depression-induced immune dysfunction: Implications for the development and progression of cancer. *International Review of Psychiatry, 17*(6), 515-527.

Richman, N. (1985). A double-blind drug trial of treatment in young children with waking problems. *Journal of Child Psychology & Psychiatry & Allied Disciplines, 26*(4), 591-598.

Ritvo, R. Z., & Papilsky, S. B. (1999). Effectiveness of psychotherapy. *Current Opinion in Pediatrics, 11*(4), 323-327.

Rogers, W. H., Wells, K. B., Meredith, L. S., Sturm, R., & Burnam, M. A. (1993). Outcomes for adult outpatients with depression under prepaid or fee-for-service financing. *Archives of General Psychiatry, 50*(7), 517-525.

Rolland, J. S. (1994). *Families, illness, & disability: An integrative treatment*. New York: Basic Books.

Rosengarten, H., & Friedhoff, A. (1979). Enduring changes in dopamine receptor cells of pups from drug administration to pregnant and nursing rats. *Science, 203*(4385), 1133-1135.

Ruddy, N. B., & McDaniel, S. H. (2003). Medical family therapy. In T. Sexton & G. Weeks (Eds.), *Handbook of family therapy: The science and practice of working with families and couples* (pp. 365-379). New York: Brunner-Routledge.

Rushton, J. L., Clark, S. J., & Freed, G. L. (2000). Pediatrician and family physician prescription of selective serotonin reuptake inhibitors. *Pediatrics, 105*(6), E82-E82.

Schopenhauer, A. (1890). *Counsels and maxims*. London: Swan Sonnenschein.

Seaburn, D. B., Lorenz, A. D., Gunn, W. B., Gawinski, B. A., & Mauksch, L. B. (2003). *Models of collaboration: A guide for mental health professionals working with health care practitioners* (2nd ed.). New York: Basic Books.

Shadish, W. R., Jr., Ragsdale, K., & Glaser, R. R. (1995). The efficacy and effectiveness of marital and family therapy: A perspective from meta-analysis. *Journal of Marital and Family Therapy, 21*, 345-360.

Shapiro, S., German, P. S., Skinner, E. A., VonKorff, M., Turner, R. W., Klein, L. E., et al. (1987). An experiment to change detection and management of mental morbidity in primary care. *Medical Care, 25*(4), 327-339.

Shatin, D., & Drinkard, C. R. (2002). Ambulatory use of psychotropics by employer-insured children and adolescents in a national managed care organization. *Ambulatory Pediatrics: The Official Journal of the Ambulatory Pediatric Association, 2*(2), 111-119.

Shaw, D. S., Keenan, K., & Vondra, J. I. (1994). Developmental precursors of externalizing behavior: Ages 1 to 3. *Developmental Psychology, 30*(3), 355-364.

Sholevar, G. P., & Sahar, C. (2003). Medical family therapy. In G. P. Sholevar (Ed.), *Textbook of family and couples therapy* (pp. 747-767). Washington, DC: American Psychiatric Publishing.

Silver, C. B. (2003). A survey of clinicians' views about change in psychoanalytic practice and theoretical orientation. *Psychoanalytic Review, 90*(2), 192-224.

Simon, G. E., Ludman, E. J., Bauer, M. S., Unutzer, J., & Operskalski, B. (2006). Long-term effectiveness and cost of a systematic care program for bipolar disorder. *Archives of General Psychiatry, 63*(5), 500-508.

Smeeding, T., Moynihan, D., & Rainwater, L. (2004). The challenge of family system changes for research and policy. In D. Moynihan, T. Smeeding & L. Rainwater (Eds.), *The future of the family* (pp. 1-22). New York: Russell Sage Foundation.

Sprenkle, D. H., & Moon, S. M. (1996). *Research methods in family therapy.* New York: The Guilford Press.

Stack, S., & Eshleman, J. (1998). Marital status and happiness: A 17-nation study. *Journal of Marriage and Family, 60*(2), 527-536.

Staudenmeier, J. J., & Jacoby, I. (1998). Trends in prescribing psychotropic medications. *JAMA: The Journal of the American Medical Association, 280*(2), 133.

Steptoe, A., Hamer, M., & Chida, Y. (2007). The effects of acute psychological stress on circulating inflammatory factors in humans: A review and meta-analysis. *Brain, Behavior, and Immunity, 21*(7), 901-912.

Stubbe, D. E., & Martin, A. (2000). The use of psychotropic medications in young children: The facts, the controversy, and the practice. *Connecticut Medicine, 64*(6), 329-333.

Tanielian, T. L., Marcus, S. C., Suarez, A. P., & Pincus, H. A. (2001). Datapoints: Trends in psychiatric practice, 1988-1998: II. Caseload and treatment characteristics. *Psychiatric Services 52*(7), 880-880.

Tardieu, S., Bottero, A., Blin, P., Bohbot, M., Goni, S., Gerard, A., et al. (2006). Roles and practices of general practitioners and psychiatrists in management of depression in the community. *BMC Family Practice, 7*, 5-15.

Trent, B. (1990). GP psychotherapy: Its popularity is growing among patients and MDs. *CMAJ: Canadian Medical Association Journal 143*(4), 320-323.

Trott, G., Badura, F., Wirth, S., Friese, H., Hollmann-Wehren, B., & Warnke, A. (1995). Self-assessment of prescribing behavior of psychotropic drugs for children and adolescence: Results of a survey of established physicians. *Psychiatrische Praxis, 22*(6), 235-239.

Turk, D. C., & Kerns, R. D. (1985). *Health, illness, and families: A life-span perspective.* New York: John Wiley.

Tyrer, P., Ferguson, B., & Wadsworth, J. (1990). Liaison psychiatry in general practice: The comprehensive collaborative model. *Acta Psychiatrica Scandinavica, 81*(4), 359-363.

Wallerstein, R. S. (1991). The future of psychotherapy. *Bulletin of the Menninger Clinic, 55*(4), 421-443.

Watson, H., & McDaniel, S. H. (2005). Managing emotional reactivity in couples facing illness: Smoothing out the emotional roller coaster. In M. Harway (Ed.), *Handbook of couples therapy* (pp. 253-271). New York: John Wiley & Sons.

Weissman, M. M. (1994). Psychotherapy in the maintenance treatment of depression. *The British Journal of Psychiatry, 3*(26), 42-50.

Werry, J. (1993). Long-term drug use in psychiatric disorders in children: Facts, controversies and the future. *Acta Paedopsychiatrica, 56*(2), 113-118.

What's the problem? (1999, August 1). *New York Times,* p. 4.

Whitley, B. E. (1996). *Principles of research in behavioral science*. Mountain View, CA: Mayfield.

Wickrama, K. A., Lorenz, F., Wallace, L. E., Peiris, L., Conger, R. D., & Huhr Jr., G. (2001). Family influence on physical health during the middle years: The case of onset of hypertension. *Journal of Marriage and Family, 63*(2), 527-539.

Williams, J., Klinepeter, K., Palmes, G., Pulley, A., & Meschan Foy, J. (2007). Behavioral health practices in the midst of black box warnings and mental health reform. *Clinical Pediatrics, 46*(5), 424-430.

Wong, I. C. K., Camilleri-Novak, D., & Stephens, P. (2003). Rise in psychotropic drug prescribing in children in the UK: An urgent public health issue. *Drug Safety: An International Journal of Medical Toxicology and Drug Experience, 26*(15), 1117-1118.

Zautra, A., Hoffman, J., Matt, K., Yocum, D., Potter, P., Castro, W., et al. (1998). An examination of individual differences in the relationship between interpersonal stress and disease activity among women with rheumatoid arthritis. *Arthritis Care and Research, 11*(4), 271-279.

Zito, J., Safer, D. J., DosReis, S., Gardner, J. F., Boles, M., & Lynch, F. (2000). Trends in the prescribing of psychotropic medications to preschoolers. *JAMA: The Journal of the American Medical Association, 283*(8), 1025-1030.

Zito, J., Safer, D. J., DosReis, S., Gardner, J. F., Soeken, K., Boles, M., et al. (2002). Rising prevalence of antidepressants among US youths. *Pediatrics, 109*(5), 721.

APPENDIX A

Online Survey

As stated in the cover letter on the previous page, your completion and successful submission of the following anonymous questionnaire will constitute your informed consent to act as a participant in this research study.

Demographics

1. M.D.:_____ D.O.:_____

2. Female: _____ Male: _____

3. How many years have you been in practice? _____

4. What state did you complete your residency training? _____

5. In which state do you currently practice? _____

Professional Practice

1. Do you prescribe psychotropic medications? _____

3. What estimated percentage of your patients present with issues involving psychosocial aspects? _____

4. What estimated percentage of your patients with psychosocial issues do you refer for psychotherapy? _____

5. Of the following mental health providers, rank the top three (with 1 representing your first choice) to designate your preference of choice for psychosocial referrals:

_____Counselor, as in Licensed Professional Counselor (LPC)
_____Psychiatrist
_____Marriage & Family Therapist, Licensed Marriage & Family Therapist (LMFT)
_____Psychologist
_____Social Worker
_____Psychiatric Nurse Practitioner, Advanced Practice Psychiatric Nurses (APPN)

6. Using the scale provided, how has your medical training and professional experience contributed to your familiarity with each of the following mental health professionals?

A. **Counselor** (LPC)

_____	_____	_____	_____	_____
not at all	very little	small amount	moderately	greatly

B. **Psychiatrist**

_____	_____	_____	_____	_____
not at all	very little	small amount	moderately	greatly

C. **Marriage and Family Therapist** (LMFT)

not at all	very little	small amount	moderately	greatly

D. **Psychologist**

not at all	very little	small amount	moderately	greatly

E. **Social Worker**

not at all	very little	small amount	moderately	greatly

F. **Psychiatric Nurse Practitioner** (APPN)

not at all	very little	small amount	moderately	greatly

7. How do you see the effectiveness of the following mental health professionals in assisting your patients with psychosocial issues?

A. **Counselors** (LPC) can benefit patients with psychosocial problems:

not at all	very little	small amount	moderately	greatly

B. **Psychiatrists** can benefit patients with psychosocial problems:

not at all	very little	small amount	moderately	greatly

C. **Marriage and Family Therapists** (LMFT) can benefit patients with psychosocial problems:

not at all	very little	small amount	moderately	greatly

D. **Psychologists** can benefit patients with psychosocial problems:

not at all	very little	small amount	moderately	greatly

E. **Social Workers** can benefit patients with psychosocial problems:

not at all	very little	small amount	moderately	greatly

F. **Psychiatric Nurse Practitioner** (APPN) can benefit patients with psychosocial problems:

not at all	very little	small amount	moderately	greatly

8. In your opinion, rate the top three choices below (with 1 representing the best and 3 representing the worst) to designate the best source for a family practice physician to gain knowledge of the expertise of mental health providers?

_____Medical school
_____ Radio
_____Colleagues
_____Workshops or conferences
_____Journal articles
_____Professional organizations
_____Residency training
_____Internet
_____Word of mouth
_____Television
_____Personal contact with a mental health professional
_____Books

9. Optional question: Is there anything else you would like to mention or any comments you may have?

APPENDIX B

Introductory Note and Cover Letter

Dear NRN member,

Currently the AAFP National Research Network is working on a long term research agenda in collaborative mental health care. Below is some preliminary work that will assist Ms. Masdon with her PhD, in additional to the NRN, in its long term work on improving mental health care. We encourage you to take a few minutes to review the information below and complete the survey if it is of interest to you.

Thank you,

Wilson Pace, M.D. - AAFP NRN Director

Recent data of practice trends reveals that the number of psychotropic medications prescribed by family physicians continues to increase yet there is a corresponding marked decline of patients receiving psychotherapy for psychosocial problems. There is a void in the literature explaining what may be contributing to the referral practices of family practioners.

You are invited to participate in an initial investigation exploring a few general considerations influencing collaboration of mental health professionals and family physicians. This pilot study will help to guide future studies examining specific factors in the mental health referral practices of family practioners.

TITLE OF STUDY: Patients with psychosocial issues: The referral practices of family physicians

LINK TO SURVEY: To access the survey, either click on https://www.psychdata.com/s.asp?SID=126890 or www.psychdata.com/s.asp?SID=126890. If unable to use these links, then go to www.psychdata.com and in the box next to "Go to survey #" type in 126890.

PURPOSE: The purpose of this pilot study is to explore which mental health professionals family physicians use for referral of their patients presenting with psychosocial/emotional concerns. This study seeks to identify the factors influencing the personal preferences and opinions of family practioners in the treatment of psychosocial problems. This research is being conducted by Ms. Teresa Masdon, M.S. as part of the requirement for a Doctor of Philosophy degree in Family Therapy at Texas Woman's University in Denton, Texas.

PARTICIPATION: Your participation in this pilot study is completely voluntary and anonymous. You are free to withdraw from this study at any time without penalty. If you choose to participate in this online survey, you will need 3 to 5 minutes of your time to respond to the entire survey. The online survey is two pages long followed by a final optional question.

BENEFITS: A potential benefit of your participation in this research is the opportunity to contribute to a greater understanding of the factors influencing family physicians' referrals of patients presenting with psychosocial problems. Another benefit is that you can elect to receive a summary of this study's results. You may request a copy of the outcome by contacting the investigator at g_masdon@mail.twu.edu.

POTENTIAL RISKS/CONFIDENTIALITY: The risk of loss of confidentiality will be protected to the extent that is allowed by law; however, there is potential risk of loss of confidentiality through all transactions. Your identity will be completely anonymous as the survey is designed so that absolutely no identifiable information (including names, email addresses or phone numbers) will be requested or attached to the survey when it is submitted. All information in the pilot study will be destroyed within 30 days of completion of the study following presentation in the investigator's dissertation. Only the researcher will have access to information collected during the study and all downloaded data will be kept locked in the investigator's office.

QUESTIONS: The researchers will try to prevent any problems that could happen because of this study. You should let the researchers know at once if there is a problem and assistance will be offered. However, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this study. Additionally, the Investigator or Research Advisor would be pleased to respond to any questions you may have concerning the research study; contact information is located below. If you have any questions about your rights as a participant in this research or the way the study has been conducted, you may contact the Texas Woman's University Office of Research and Sponsored Programs at 940-898-3378 or via email at IRB@twu.edu.

Investigator: Teresa A. Masdon, R.N., M.S., g_masdon@mail.twu.edu

Advisor: Linda Metcalf, Ph.D., 940-898-2685, lmetcalf@mail.twu.edu

INFORMED CONSENT: Your completion and successful submission of the following anonymous questionnaire will constitute your informed consent to act as a participant in this study.