Continuing medical education in marital and family therapy: a survey of South Australian psychiatrists

Stephen Allison, Ros Powrie, Colby Pearce, Graham Martin

Objective: South Australian psychiatrists were surveyed to determine their impressions of the usefulness of marital and family therapy (MFT) in the management of serious psychiatric conditions and to ascertain their previous experience with Continuing Medical Education (CME) about family therapy. It was expected that psychiatrists' preferences regarding CME would be related to their clinical experience of the usefulness of MFT.

Method: One hundred and twenty psychiatrists returned a questionnaire about their training, clinical and research interests, with ratings of the usefulness of MFT and CME preferences. This represented 65% of those eligible for the CME programme.

Results: Thirteen percent of the respondents found MFT to be extremely useful and a further 47% found it moderately useful in their current practice. There was evidence of a possible training effect: respondents who had previous CME rated MFT as more useful, especially for mood disorders. Furthermore, the treatment of mood disorders seemed to have a particular relevance in family psychiatry, making a statistically unique contribution to ratings of MFT usefulness in the respondents' total practice. Sixty-nine percent of the respondents requested further CME in family therapy. This represented 45% of all South Australian psychiatrists. Respondents who rated MFT as more useful in practice were significantly more likely to be interested in CME.

Conclusions: There seems to be sufficient interest and clinical experience among psychiatrists for MFT to be included in CME courses. It is recommended that further training focus on major mental disorders, especially mood disorders and schizophrenia.

Australian and New Zealand Journal of Psychiatry 1995; 29:638-644

Child and Adolescent Mental Health Service, Flinders Medical Centre, Bedford Park, South Australia; and Flinders University of South Australia

Stephen Allison FRANZCP, Clinical Lecturer and Senior Psychiatrist

Ros Powrie FRANZCP, Clinical Lecturer and Senior Psychiatrist

Colby Pearce M App Psych, Research Officer

Graham Martin FRANZCP, Senior Clinical Lecturer and Director

Correspond with Dr Allison

Continuing Medical Education (CME) has considerable practical importance in improving the management of serious medical disorders where optimal treatment is advancing beyond established practice [1]. To achieve these potential gains, however, CME programmes need to be pragmatic, applicable to actual medical practice and interesting to the medical practitioners who are the professional learners [2]. Preliminary surveys are used to investigate whether alternative treatment approaches are acceptable in these ways. This is particularly critical with

psychotherapy, where techniques are complex and require lengthy training.

This paper describes a survey of South Australian psychiatrists, investigating their experience and interests in marital and family therapy (MFT) in psychiatric practice. In particular, the survey sought to investigate preferences regarding the inclusion of MFT training in CME activities.

MFT has been a controversial area of psychiatric treatment, sometimes regarded as "a religion with several competing sects led by feuding charismatic prophets" [3,p.381] rather than a scientific pursuit. This situation was partly created by claims of extraordinary results based on individual case reports or uncontrolled studies. Nevertheless, the pragmatic appeal of family participation in treatment has made MFT an integral part of child and adolescent psychiatry. As research has defined the role of family therapy with adult disorders [4,5], MFT has also become more applicable to general psychiatry. Interviews with couples and families can be readily incorporated into assessment and treatment procedures [5].

There is a broad theoretical framework available which has wide acceptance: the biopsychosocial model [6,7]. This model integrates family therapy, as a form of social intervention, with biological and psychological treatments [8]. It is a systems model which describes connections from the molecular to the cellular level, then to the level of complexity of the individual person and finally to the family and society [7], so that therapeutic interventions can be directed at different levels of the system and sequenced in various ways [9]. Within this framework, MFT can be a primary or secondary form of therapy. Sved-Williams *et al* [8] have described biopsychosocial treatment in the context of a strategic family therapy team. In this case, strategic family therapy was the basic modality, and medication changes or psychological treatments were considered when family therapy became "stuck". However family therapy is not usually the primary form of treatment in psychiatric practice. Most psychiatric management relies on a combination of individual psychotherapy and pharmacotherapy, with the occasional use of MFT interventions [10,11]. To be practically relevant, research and training in family psychiatry need to take existing practice into account; there may have been insufficient attention to this in the past.

Research concerning the integration of family therapy into the treatment of major mental disorders is most advanced with respect to schizophrenia [5]. Meta-analysis of the available randomised controlled trials has shown that the addition of family psychoeducation and behavioural therapy to a standard management regime reduces the risk of relapse with increasing efficacy over time [12]. Family support probably needs to be prolonged, since the benefits are not maintained after the cessation of therapy [13]. Sustained family contact may help reinforce previous strategies and act as a non-specific social support [14]. Effectiveness is reduced when withdrawals and drop-outs are taken into account [12]. For over a decade, quality assurance guidelines in Australia have recommended family psychoeducational and behavioural intervention as potentially useful adjuncts to the standard treatment of schizophrenia [15]. Practising psychiatrists surveyed by the Quality Assurance Project [15] also indicated that MFT had a role in the management of schizophrenia in clinical practice, a finding consistent with the research results.

In the light of this research, MFT training might be expected to achieve the best results by concentrating on the management of schizophrenia. However, there are preliminary studies with other psychiatric disorders: these outline the indications and contraindications for MFT with affective disorders, drug and alcohol abuse, anxiety and eating disorders [4,5]. With time, these results may also influence the content of training programmes aimed at integrating MFT into general psychiatric practice.

Currently there is little published information about the training Australian psychiatrists have in MFT and their clinical experience of its effectiveness. It is probable that MFT is not widely used outside of child psychiatry. In a representative sample of Australian psychiatrists taken from the Quality Assurance Project, Andrews and Hadzi-Pavlovic [11] found that family, marital and conjoint therapy accounted for 3% of all primary treatments, with a smaller proportion of patients receiving family therapy as a secondary form of treatment. There was concern that these findings indicated that "Australian psychiatry is ignoring the interpersonal world both of the child and the depressed adult" [16,p.243].

However, practitioners may be more aware of the benefits of MFT than this low utilisation suggests. In the current survey, psychiatrists were asked to rate their clinical impressions of the usefulness of MFT rather than the proportion of cases for which they used family intervention. To highlight this distinction be-

tween use and usefulness with another clinical example: electroconvulsive therapy may be used infrequently in a particular setting and still be viewed as extremely useful for a particular group of patients.

The use of a particular treatment method may be increased by CME, provided that practitioners are interested and generally positive about its clinical usefulness [17]. In this survey perceptions of MFT usefulness were expected to be related to preferences regarding further training in family psychiatry within CME activities organised by the South Australian Branch of the Royal Australian and New Zealand College of Psychiatrists.

The survey inquired about the respondents' impressions of MFT usefulness in their total practice and in treating a range of common presenting problems. The aim was to determine which of these common disorders were most closely related to the total practice ratings of usefulness and to CME preference. It may be that practitioners are most interested in learning more about treating disorders which respond best to MFT in a clinical situation rather than those disorders which have been the focus of published research, namely the schizophrenic disorders. To be effective, CME programmes need to balance these domains: the pragmatic findings of psychiatric practice and the research findings of controlled outcome trials.

Method

Sample

The questionnaire was mailed to all 185 members of the South Australian Branch of the Royal Australian and New Zealand College of Psychiatrists. A freepost envelope was included; respondents were encouraged to return the survey, even if only partly completed. A second mailing was sent to non-respondents from a code held by a clerical officer. In all, 131 members returned the survey: this represented 71% of the membership. Of these, 11 returned blank questionnaires, explaining that they were retired or had no clinical practice in the areas presented (e.g. conditions specific to the psychiatry of old age were not included), leaving 120 replies which were used in the analysis. This amounted to 65% of the total membership.

From the sample of 120 respondents, 33 (27%) were female and 87 (73%) were male. The average age was 46.4 years (SD = 10.0). The majority of respondents were in general psychiatric practice (80.4%), with smaller groups mainly practising in the subspecialty areas of psychoanalytically-oriented psychotherapy (9.8%) or child and adolescent psychiatry (9.8%). Eighty four percent were in full-time practice. Most respondents were in private practice (60%), while 40% worked mainly in the public sector.

Psychiatrists were asked to rate their clinical impressions of the usefulness of MFT with a range of child and adult conditions for which family interventions have been described: 106 respondents had treatment experience with all the adult disorders listed and 86 had experience with the entire list of childhood and adult disorders.

Questionnaire

For the purposes of this survey, the definition of MFT was derived from the Medicare Benefit Schedule term of "family group psychotherapy" [18] because it provided a brief general description of family group meetings with different sized groups. Some examples of family therapy technique were given - notably the psychoeducational, behavioural and systemic approaches - but since there is a paucity of research comparing these different approaches, the definition was kept atheoretical and specified only some form of family group sessions. Family group psychotherapy included group sizes of two or more related individuals, and hence couples therapy lay within the broad definition. (The terms family therapy and MFT are used interchangeably in this paper.)

The survey instrument was a 24-item self-report questionnaire developed by the authors to assess the perceived usefulness of MFT in the psychiatrist's own practice, and their experience of the usefulness of MFT as a modality of treatment with five psychiatric conditions in adults (anxiety disorders, mood disorders, schizophrenia, eating disorders and alcohol or substance abuse) and two groups of child and adolescent disorders (conduct disorders and emotional disorders). The 5-point MFT usefulness rating scale asked the psychiatrist how useful MFT was as a treatment modality when used appropriately as an adjunct to psychiatric treatment: the anchor points were "not at all useful" (1) to "extremely useful" (5). The direction of the 1 to 5 rating scales was alternated to encourage separate consideration of each item and reduce global responses. The survey also inquired about: previous specific training in MFT; referral of patients to medical or non-medical colleagues for MFT; information

about particular interests in the MFT field; and preferences concerning an increased component of MFT in the existing CME programme. Respondents were asked to give reasons for their preference regarding CME in family therapy. The covering letter sought the range of views among the college membership and gave the assurance that individuals would not be identified in collating the data. From the data in this survey, measures of central tendency indicated that parametric analysis was appropriate for the ratings. The analysis was performed using the Statistical Package for the Social Sciences for Macintosh. Copies of the questionnaire are available from the authors.

Results

1. Preferences regarding continuing education in MFT

Eighty three (69%) of the respondents wanted specific family therapy topics to be included in the CME programme while the remaining 37 (31%) did not want specific training. Comparisons were made according to CME preference using a series of t-tests. There were significant differences in the respondents' ratings of the usefulness of MFT in overall psychiatric practice (Table 1) and for each of the childhood and adult disorders considered. Respondents requesting more continuing education in MFT found family group psychotherapy to be significantly more useful in their overall practice ($t=3.4$, $df=116$, $p<0.001$) and for treating a range of psychiatric presentations (all disorders, $p<0.05$).

A discriminant function analysis with stepwise inclusion of variables (excluding overall practice usefulness) was performed to identify the best determinants of CME preference. Ratings of MFT usefulness with drug and alcohol abuse, childhood emotional disorders, childhood conduct disorders, mood disorders and schizophrenia (their order of entry) gave the maximum separation between the groups ($F(5,78)=6.0$, $p<0.001$); only anxiety disorders and eating disorders failed to remain significant in the step-wise analysis. These five items discriminated CME preference with 94% sensitivity and 46% specificity.

Respondents were also asked whether they had particular interests in the field of family therapy. Those who cited specific research, teaching and/or clinical or theoretical interests in family therapy were more likely to indicate a preference for continuing education in MFT (Chi square=18.9, $df=1$, $p<0.0001$).

2. Previous training in MFT

Forty four (38%) of the respondents had previous specific training in MFT. In comparing the "trained" and "untrained" groups, respondents with previous training found MFT to be significantly more useful in their own psychiatric practice ($t=3.6$, $df=115$, $p=0.001$). In further comparisons of the ratings of MFT usefulness for particular psychiatric presentations, the only significant difference between the groups was in their ratings of mood disorders, where respondents with previous training found MFT to be significantly more useful ($t=2.3$, $df=110$, $p<0.05$). In particular, the "trained" and "untrained" groups did not differ significantly in their experience of MFT usefulness with schizophrenia.

Comparisons were made to determine whether psychiatrists without specific training in MFT were more frequent referrers of patients to colleagues (medical or non-medical) when they felt that MFT was indicated. In the complete sample, 59 respondents (49%) referred frequently or some of the time, and 61 (51%) referred rarely or never. There was no statistical difference in the reported frequency of referral between the groups with and without training.

We also investigated whether previous MFT training influenced preferences about further education in MFT. Comparison showed that respondents with previous training were not significantly more likely to request ongoing training through the CME programme.

3. Perceived usefulness of MFT in psychiatric practice

Fifteen respondents (13%) found MFT to be extremely useful in their own practice and a further 56 (47%) found MFT moderately useful. The remaining 48 respondents (40%) found MFT to be rarely or not at all useful in their practice. Ratings of MFT usefulness were influenced by the type of psychiatric practice involved. There were significant differences between the subspecialties of child psychiatry (mean=4.3, SD=0.65), general psychiatry (mean=3.1, SD=1.18) and psychoanalytically-oriented psychotherapy (mean=1.5, SD=0.7) ($F(2,109)=17.0$, $p<0.0001$).

Table 1. Mean ratings of the usefulness of MFT in psychiatric practice grouped by Respondent variables

Gender		
Male	3.0 (1.3)	df=118, p=n/s
Female	3.2 (1.2)	
Sector		
Public	3.5 (1.2)	df=101, p<0.01
Private	2.8 (1.6)	
Subspecialty		
General	3.1 (1.2)	df(2,109), p<0.0001
Child	4.3 (0.7)	
Psychotherapy	1.5 (0.7)	
Previous MFT training		
Yes	3.6 (1.2)	df=116, p<0.001
No	2.8 (1.2)	
CME preference		
Yes	3.3 (1.3)	df=116, p<0.001
No	2.5 (1.6)	

Standard deviations shown in parentheses. The p-values indicate the statistical significance of differences between the groups

In a comparison of public sector psychiatrists (mean=3.5, SD=1.1) and private sector psychiatrists (mean=2.8, SD=1.2), public sector psychiatrists perceived MFT to be significantly more useful as a modality of treatment (t=2.9, df=101, p<0.01).

As expected, there were significant correlations (r) between MFT usefulness for common adult presentations and usefulness in the respondent's total practice (n=105, mood disorders r=0.63, anxiety disorders r=0.53, drug and alcohol abuse r=0.51, schizophrenia r=0.42 and eating disorders r=0.35, all significant p<0.001). However, usefulness with childhood disorders was not significantly correlated with practice usefulness. This is probably because only a small proportion of the respondents were child psychiatrists (9.85%). In a multiple regression analysis, usefulness ratings for the adult disorders offered statistically significant prediction of the total practice usefulness (R-squared=0.40, F(5,99)=15.1, p<0.0001), with mood disorders making a statistically unique contribution (t=3.2, p<0.01).

Discussion

The concept that psychiatric practice could be based on the family has been controversial [3,4,16]. Studies seem to suggest that family therapy has remained a minority activity. For instance, Andrews and Hadzi-Pavlovic [11] found that family group psychotherapy accounted for only 3% of primary treatment. The current survey provides more information on the current status of MFT within Australian psychiatry. Respondents had remarkably positive impressions of the usefulness of MFT and a majority were in favour of more CME activities to increase their skills. These two aspects were closely related: those who found MFT to be useful in practice were more interested in CME. This suggests that a pragmatic appreciation of the usefulness of MFT is important and that the field may be ready to move beyond its religious stage [3]. This move will be enhanced by recent publications addressing the empirical status of family therapy [4,5,12].

As was expected, the respondent's type of practice related to whether MFT was useful. Usefulness seemed to be influenced by a combination of factors, including previous training, subspecialty and the sector in which the respondent worked (public or private).

Respondents who had previous family therapy training found MFT to be significantly more useful in their overall practice. A combination of practice demands, professional interests and the benefits of training could explain respondents' different experiences of MFT: for instance, subspecialty training emphasises the development of different skills to meet the needs of selected patient groups. The significantly different ratings of MFT usefulness by psychotherapists, general psychiatrists and child psychiatrists are consistent with the expected usefulness of MFT in these sub-specialties. Psychotherapy is analytically orientated and individually based, while child psychiatry emphasises the contribution of the wider system and more frequently involves the family in treatment. The more numerous general psychiatrists are probably more eclectic and their impressions of MFT usefulness fell between those of the smaller subspecialties.

MFT was also found to be more useful in the public than in the private sector. This effect was not related to differences in training, subspecialty or length of practice as measured in this study. The effect may be more related to the facilities and teamwork in public practice. Special facilities such as larger consulting

rooms, one-way screens and video equipment are more often available in the public sector. Equally, it may also be that multidisciplinary teams encourage the practice of MFT by psychiatrists when family therapy is part of a unit's culture.

The survey also sought to determine whether clinical impressions of the usefulness of MFT were related to the treatment of common psychiatric disorders. Thus respondents were asked to rate the usefulness of MFT in their total practice and for the management of a group of psychiatric conditions for which family treatments have been described. These ratings of the usefulness of family therapy for common conditions explained 40% of total usefulness in current practice. This suggests that family therapy has a specific role in the treatment of serious disorders seen in psychiatric practice, as well as being a general treatment for relationship problems.

In further analysis, MFT with mood disorders had a particular importance in clinical practice. Ratings of MFT usefulness with mood disorders made a statistically unique contribution to the ratings of usefulness in the respondents' total practice. This contrasts with the focus of empirical research, which has been mostly concerned with relapse prevention in schizophrenia [12]. Given the large number of presentations with depression, this result is not entirely surprising. Marital interventions have a particular role with moderately depressed women where there is marital disharmony [19]. The survey results suggests that the need for family involvement in the treatment of mood disorders is recognised; this may provide a clinically relevant focus for CME in family therapy. CME activities could build on this appreciation by outlining methods for engaging spouses and families in therapy [20] and describing recent developments in practice [19].

A majority of the respondents were interested in further CME in the general area of MFT. Positive responses came from 69% of the respondents (representing 45% of the complete membership of the South Australian Branch). If respondents found MFT to be more useful in practice, they were significantly more likely to be interested in further training. In fact, MFT usefulness was a sensitive indicator of CME interest, suggesting that most psychiatrists who would attend CME activities concerning family therapy would find MFT useful in practice and would be relatively experienced family practitioners seeking to update their skills and knowledge. Correspondingly few practitioners who did not find MFT useful in patient management would be likely to be interested in these CME sessions.

At present, the CME training available for psychiatrists may not focus adequately on the treatment of specific psychiatric disorders. MFT training in academic programmes or courses organised by private family therapy practices are often not directed towards the management of specific psychiatric disorders. They also do not usually deal with the realities of psychiatric practice, which has an eclectic approach based on individual psychotherapy and pharmacotherapy. While nonspecific factors are important in family psychotherapy [21], training programmes in family psychiatry need to suit practice conditions and focus on specific programmes which influence the course of psychiatric disorders.

The survey results suggest that training programmes could be better targeted. As mentioned earlier, respondents who had sought out specific family therapy training rated MFT as more useful in their total practice, however training was not believed to increase the usefulness of MFT with most of the specific psychiatric conditions. The exception was mood disorders, where respondents with previous CME found MFT significantly more useful. MFT for depression seems to have a special significance in family psychiatry, and previous training may have conferred a significant benefit. However training did not increase the usefulness of MFT with other conditions: in particular, with schizophrenia. This was surprising in that family behavioural and psychoeducational packages are comprehensive, potentially improving therapist competence and delaying patient relapse [12-14]. By the time of the survey, established quality assurance guidelines recommending MFT for schizophrenia [15] were expected to have increased its acceptance in MFT training programmes. However, it may be that MFT training so far has been insufficient and that the available programmes do not adequately teach family intervention with schizophrenia.

These conclusions are limited by the study design. The current survey was cross-sectional; more detailed investigations are required to clarify the benefits of MFT training on practitioner competence and patient management. There are considerable difficulties in developing training programmes which produce demonstrable practice changes and impact upon patient outcomes [22]. Counselling and clinical management skills are particularly complex; current evidence indicates that combined approaches using a

variety of educational media, role play and workplace-based feedback are more likely to be effective [22]. The development of family therapy skills probably requires a range of educational techniques. Video feedback in training groups is one technique which can have a significant impact on practitioners' interviewing skills [23] and could provide a basis for advanced training groups in family therapy [24].

In conclusion, MFT is a suitable area for continuing education in that family therapy can be useful for serious psychiatric disorders, interests a considerable proportion of practitioners and has the potential to be used more frequently in psychiatric practice. South Australian psychiatrists generally found that family group psychotherapy was a useful adjunct to psychiatric treatment, although a considerable minority found it to be rarely or not at all useful in their own practice. As expected, practitioners' experience of the usefulness of MFT offered significant prediction of their preference for continuing education in the area. Falloon *et al* have described family care as "the greatest natural resource for the clinical management of all health problems" [4,p.ix]. With reductions in inpatient services, the "therapeutic milieu" for serious mental illness becomes the family, household or hostel. Further training in family therapy is one response to the changing demands of current practice: especially for mood disorders, which have a particular relevance in family psychiatry, and for schizophrenia, where MFT research is most advanced.

References

1. Laxdal OE. Needs assessment in continuing medical education: a practical guide. Journal of Medical Education 1982; 57:827-834.
2. Harden RM, Laidlaw JM. Effective continuing education: the CRISIS criteria. Medical Education 1992; 26:408-422.
3. Werry JS. Family therapy - professional endeavour or successful religion? Journal of Family Therapy 1989; 11:377-382.
4. Falloon IRH, Laporta M, Fadden G, Graham-Hole V. Managing stress in families. Cognitive and behavioural strategies for enhancing coping skills. London: Routledge, 1993.
5. Bloch S, Hafner J, Harari E, Szmuckler GI. The family in clinical psychiatry. Oxford: Oxford University Press, 1994.
6. Engel GL. The need for a new medical model: a challenge for biomedicine. Science 1977: 196;129-136.
7. Engel GL. The clinical application of the biopsychosocial model. American Journal of Psychiatry 1980: 137;535-544.
8. Sved-Williams AE, Burnett P, Hawker F. When strategic approaches get stuck - maps out of the mire. Australian and New Zealand Journal of Family Therapy 1991; 12:9-16.
9. Lazarus A. Casebook of multimodal therapy. New York: Guilford, 1985.
10. Andrews G, Hickie C. The people seen by Sydney psychiatrists. Australian and New Zealand Journal of Psychiatry 1986; 20:492-495.
11. Andrews G, Hadzi-Pavlovic D. The work of Australian psychiatrists, circa 1986. Australian and New Zealand Journal of Psychiatry 1988; 22:153-165.
12. Mari JDJ, Streiner DL. An overview of family interventions and relapse on schizophrenia: meta-analysis of research findings. Psychological Medicine 1994; 24:565-578.
13. Hogarty GE, Anderson CM, Reiss DJ, Kornblith SJ, Greenwald DP, Ulrich RF, Carter M. Family psychoeducation, social skills training, and maintenance chemotherapy in the aftercare treatment of schizophrenia. Archives of General Psychiatry 1991; 48:340-347.
14. Kavanagh DJ. Recent developments in expressed emotion and schizophrenia. British Journal of Psychiatry 1992; 160:601-620.
15. Quality Assurance Project. Treatment outlines for the management of schizophrenia. Australian and New Zealand Journal of Psychiatry 1984; 18:19-38.
16. Quadrio C. Re-medicalisation and regression in psychiatry. Australian and New Zealand Journal of Psychiatry 1988; 22:242-245.
17. Wright JM. Continuing medical education in psychiatry. Australian and New Zealand Journal of Psychiatry 1991; 25:111-118.
18. Commonwealth Department of Health, Housing, Local Government and Community Services. Medicare benefits schedule book. Canberra: Australian Government Publishing Service, 1993.
19. Jacobson NS, Dobson K, Fruzzetti A, Schamling KB, Salusky S. Marital therapy as a treatment for depression. Journal of Consulting and Clinical Psychology 1991; 59:547-557.
20. Hafner J. Spouse-aided therapy in psychiatry: an introduction. Australian and New Zealand Journal of Psychiatry 1981; 15:329-337.
21. Martin G, Allison S. Therapeutic alliance - a view constructed by a family therapy team. Australian and New Zealand Journal of Family Therapy 1993; 14:205-214.
22. Davis DA, Thompson MA, Oxman AD, Haynes. Evidence for the effectiveness of CME. A review of 50 randomized controlled trials. Journal of the American Medical Association 1992; 268:1111-1117.
23. Gask L, Goldberg D, Lesser AL, Millar T. Improving the psychiatric skills of the general practice trainee: an evaluation of a group training course. Medical Education 1988; 22:132-148.
24. Botelho RJ, McDaniel SH, Jones JE. A family systems Balint group: a case report from a CME course. Family Systems Medicine 1990; 8:265-271.