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Study of Brief Single Session Medical Family Therapy with Low-Income Patients

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LOMA LINDA UNIVERSITY
School of Behavioral Health
in conjunction with the
Faculty of Graduate Studies

A Study of Brief Single Session Medical Family Therapy with Low-Income Patients

by

Mayuri L. Pandit

A Dissertation submitted in partial satisfaction of
the requirements for the degree
Doctor of Philosophy in Marital and Family Therapy

September 2013

Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Philosophy.

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ABBREVIATIONS

ANX	Anxiety Symptoms
BSI-18	Brief Symptom Inventory-18
DEP	Depression Symptoms
DM	Decision-Making Skills
E-PAQ	Extended Personal Attributes Questionnaire
FAM	Family Support
FRND	Friend Support
MC	Medical Community Support
MedFT	Medical Family Therapy
MedFTI	Medical Family Therapy Intern
MFT	Marriage and Family Therapy
MFTI	Marriage and Family Therapy Intern
MOMES	MOM Empowerment Scale
PS	Patient Satisfaction with Health Care Provider Scale
RUCS	Revised Unmitigated Communion Scale
SD	Self-Determination
SOMA	Somatization Symptoms
SS	Self-Sufficiency
SSI	Social Support Index
T1	Initial data collection before the visit with the doctor
T2	Data collection after the visit with the doctor
T3	Data collection one week after the visit with the doctor

ABSTRACT OF THE DISSERTATION

A Study of Brief Single Session Medical Family Therapy with Low-Income Patients

by

Mayuri L. Pandit

Doctor of Philosophy, Graduate Program in Marital and Family Therapy
Loma Linda University, September 2013
Dr. Brian Distelberg, Chairperson

Medical Family Therapy (MedFT) has been promoted as beneficial for vulnerable patient populations. However, there is a need for MedFT effectiveness studies with longitudinal randomized control trials. Thus, this pilot study investigated the results of a brief single session of MedFT over a one-week period with low-income primary care patients. Effectiveness in this study was defined as increasing a sense *agency* and *communion* and decreasing *psychological distress*. Results suggested that over time, MedFT may increase some sense of agency for lower-income patients, increase patient satisfaction with care, increase family support for patients with higher education, and decrease depression symptoms for various ethnic groups. Limitations, implications, and future research were also discussed.

CHAPTER ONE

INTRODUCTION

The term *health* has expanded from physical wellbeing to include spiritual, emotional, mental, and social wellbeing in the biopsychosocial framework (McDaniel, Campbell, Hepworth, & Lorenz, 2005; McDaniel, Hepworth, & Doherty, 1992). Medical Family Therapy (MedFT) specifically uses this framework to provide treatment for behavioral, emotional, and relational health while conceptualizing problems as biological, psychological, and social in nature (McDaniel et al., 1992; Willerton, Dankoski, & Martir, 2008). However, to date there are no known empirically validated effectiveness studies with randomized control designs that claim to evaluate MedFT treatment versus no treatment (Linville, Hertlein, & Lyness, 2007).

It is unclear whether MedFT is effective although there is growing evidence that MedFT may be effective. For example, Davey, Duncan, Foster, & Milton (2008), Ragaisis (1996), and Sellers (2000) have promoted the use of MedFT in health care. In addition, the inclusion of behavioral health care in traditional medical models has been advantageous for patients and service providers (Cutler & Everett, 2010; Pignone et al., 2002).

Some patient populations, however, do not receive optimal quality health care services. Health disparity studies have shown that vulnerable patients, such as patients dealing with low socio-economic status (SES) often receive lesser quality health care services (Collins, 2010; U.S. Department of Health and Human Services, 2003). MedFT may aid in addressing this problem as MedFT seeks to increase a sense of patient agency, or empowerment, and communion, or social support (McDaniel et al., 1992). Thus, the current study proposes an examination of the effectiveness of MedFT with low-income patients by evaluating patient agency, communion, and psychological distress after patients engage in integrative behavioral health care services offered by a health care professional team that includes MedFT.

Defining Medical Family Therapy

There are challenges associated with conducting a MedFT effectiveness study, particularly due to unclear consensus regarding what constitutes MedFT (Campbell, 2002; Linville et al., 2007, Tyndall, 2010). There are varying opinions about whether MedFT is a profession in and of itself or an orientation, a way of thinking (Tyndall, 2010). For the purposes of the current study, MedFT will be defined as an orientation, a way of thinking. Because MedFT is not standardized, studying effectiveness can be difficult and defining what it means for MedFT to be effective can be hard to pinpoint.

Even though there has been difficulty reaching a consensus about what MedFT is, there has been some agreement regarding what makes MedFT different from other schools of thought. For example, McDaniel et al. (1992) specifically mentioned the difference between practicing MedFT and Marriage and Marriage and Family Therapy (MFT). “The competent and experienced family therapist is not *de facto* a competent *medical* family therapist. A different knowledge base is needed to work as a psychosocial provider in physical health care settings” (p. x). MedFTs are unique in that they focus on “how to apply family systems approaches in health care settings and how collaboration can be facilitated between therapists, health care providers, and families” (Weiss & Hepworth, 1993, p. 297).

Linville et al. (2007) distinguish MedFT from other fields such as social work and psychology by the fact that medical family therapists “apply the insights of MFT within the medical arena” (p. 86). For instance, medical family therapists not only focus on how the individual patient is coping, but also include the family and social network of the patient in their assessment and treatment. The family is often impacted by a member’s illness, thus the family’s needs and questions should be addressed (McDaniel et al., 1992). Rolland (1994) claimed that when family issues are addressed and improved, individual patient well-being will also improve. Accordingly, MedFT focuses on family as well as individual patient well-being.

Defining Agency and Communion

When defining MedFT, it is also important to define the two goals of MedFT that will be part of the main focus in the current study. These goals include increasing a sense of *agency*, or empowerment and *communion*, or social support (McDaniel et al., 1992). The terms empowerment and social support will be utilized interchangeably with the terms agency and communion in the current study for ease of understanding—since the meaning of agency and communion may not be as well-known or understood.

There are various definitions of empowerment, social support, agency, and communion (Mackrill, 2009). For the purposes of the current study, the term agency will be defined as “a sense of making personal choices in dealing with illness and the health care system” (McDaniel et al., 1992, p. 9). In other words, agency is the sense of being empowered when dealing with illness and the health care system.

The term communion will be defined as a “sense of being cared for, loved, and supported by a community of family members, friends, and professionals” (McDaniel et al., 1992, p. 10). In other words, communion is the sense of being socially supported by not only family and friends but also by professionals such as health care workers.

Effectiveness of Medical Family Therapy

Although randomized control studies that claim to evaluate MedFT effectiveness in increasing a sense of agency and communion have not been done, researchers have recommended and provided a rationale for utilizing MedFT. Specifically, researchers have recommended MedFT for certain populations such as Latinos (Willerton et al., 2008), HIV/AIDS patients and their families (Davey et al., 2008) and diabetes patients and their families (Robinson, Barnacle, Pretorius, & Paulman, 2004). Consequently, additional research is needed to show whether MedFT is effective. Specifically outcome and effectiveness studies examining vulnerable populations and comparing a control group with a treatment group might provide evidence for the benefits of MedFT for vulnerable patient populations.

Sample Population

The current study addresses the question of MedFT effectiveness with low-income patients because of their vulnerability. The following paragraphs will outline specific issues that low-income patient populations struggle with. These issues are discussed in light of the goals of MedFT—to increase agency and communion.

Patients living with low-income often deal with particularly vulnerable issues. Within the health care field there has been quite a bit of research regarding health care disparities, or the connection between SES, gender, and health, specifically the connection between lack of finances and declined level of health (Brown, 2008). For example, the U.S. Department of Health and Human Services (2003) found the following disparities. In regards to patient care, patients dealing with lower SES are less likely to receive optimal care. In regards to preventative medicine, patients dealing with lower SES are less likely to be screened and educated. In regards to patient-health care provider relationships, patients dealing with lower SES report poorer communication. Lastly, in regards to access of health care, patients dealing with lower SES report greater difficulty accessing services and insurance.

Purpose of the Study

The purpose of the current study is to show that MedFT is effective for vulnerable populations, particularly because these populations have experienced a lack of optimal quality health care and support. In this way, MedFT can aid in the fight against health care disparities. In addition, there is a gap in literature regarding the effectiveness of MedFT. Randomized control studies are needed to show that MedFT is effective, particularly because researchers such as Davey et al. (2008), Ragaisis (1996), and Sellers (2000) claim that MedFT benefits clients and patients.

Also, there are some debates in the current literature concerning the possible effectiveness of MedFT. Some studies such as Sellers (2000) have reported that the majority of patients who experience MedFT are satisfied with the results. On the other hand, one author suggested MedFT might not be effective or appropriate for populations outside mainstream U.S. health care industries, i.e. marginalized populations such as low-income patients, due to its focus on the biopsychosocial model which draws its epidemiology from scientific culture and language (Griffith, 1994).

The current study will fill the gap in current literature concerning the question of whether or not MedFT is effective, particularly with marginalized cultures such as low-income patients, a vulnerable population in need.

Aims

The current study proposes two basic aims. First, the study will provide information regarding the effectiveness of MedFT for low-income patients. Second, the study will provide information about MedFTs influence on psychological distress, agency, and communion. Specifically, MedFT will decrease psychological distress, as well as increase a sense of agency and communion.

Hypotheses

The five hypotheses that will guide the exploration of the two aims are:

1. Patients in the treatment group (patients that receive MedFT) will have higher scores on communion in comparison to the control group.
2. Patients in the treatment group (patients that receive MedFT) will have higher scores on agency in comparison to the control group.
3. The treatment group will report improved agency and communion in response to open-ended questions, in comparison to the control group.

4. The treatment group will have lower scores on psychological distress.
5. Patients that receive a "High" dosage of MedFT will report high scores on agency, communion, and low scores on psychological distress. Dosage refers to the amount of MedFT the Medical Family Therapy Intern (MedFTI) felt he or she provided. It's a subjective 1 to 10 scale with 10 being "I provided the most concentrated amount of MedFT in this session".

Summary

To date there are no known empirically validated effectiveness studies with randomized control designs that claim to evaluate MedFT treatment versus no treatment. The current study will focus on the effectiveness of MedFT with low-income patients. Three outcome variables will be examined, agency, communion, and psychological distress. In addition, this study will utilize a longitudinal randomized clinical design with a low-income primary care patient population at a medical clinic that specifically serves low income patients.

CHAPTER TWO

CONCEPTUAL FRAMEWORK

When providing health care services for vulnerable populations, theories that address issues of diversity in gender, SES, and culture would be helpful in alleviating health care disparities by advocating for treatments which empower and support patients. In addition, theories that include family and community views as well as individual views will be helpful in addressing health care disparities from a systemic perspective.

The current study proposes that Medical Family Therapy (MedFT) aids vulnerable populations through increasing patient *agency*, or empowerment, and *communion*, or social support, within medical communities. Accordingly, a Feminist Family Theory (Leslie & Southard, 2009), a sub-theory of Marriage and Family Therapy (MFT), and the Resiliency Model of Family Stress Adjustment, and Adaptation (McCubbin & McCubbin, 1993, 1996) are appropriate guiding frameworks for this hypothesis.

The following paragraphs will first briefly discuss MedFT; discuss main principles of a feminist approach and a resiliency model; delineate points of integration between a feminist approach and a resiliency model; and finally describe the integration between a feminist approach and a resiliency model as related to the purpose and methodology of the current study.

Medical Family Therapy

MedFT is a global approach, an attitude, a grand theory (Burwell, Templeton, Kennedy, & Zak-Hunter, 2008) without a specified theoretical modality regarding the process of change and the onset of physical or mental illness. In other words, MedFT is not a specific model of therapy in itself. For example, various models of family therapy can be utilized within MedFT to create and employ specific interventions (Hodgson, McCammon, & Anderson, 2011; Linville, Hertlein, & Lyness, 2007). In this way MedFT is similar to MFT. McDaniel, Lusterman, and Philpot (2001) wrote that MFT is also more of an attitude than a set of specific techniques. In addition, Linville et al. (2007) claim that MedFT could be considered a subset of MFT because of their shared focus on family structure and systems-oriented thinking.

For the sake of clarity, three delineating factors which outline MedFT will be described in order to distinguish MedFT from any other framework or model of therapy, including MFT. The three factors are as follows: MedFT utilizes a biopsychosocial model of health; has two basic goals for therapy; and relies on family therapy, systems-oriented thinking (McDaniel, Hepworth, & Doherty, 1992).

Biopsychosocial Model

As McDaniel et al. (1992) originally posited, MedFT is a global approach that refers to the biopsychosocial treatment of those who are dealing with medical issues. More recently, Burwell et al. (2008) put it this way, “In addition to collaboration with medical professionals, medical family therapists conceptualize symptoms and issues from a biopsychosocial perspective, acknowledging that all problems include biological, psychological, and social systems levels” (p. 110).

The biopsychosocial model was originally proposed and explored by Engel (1980) in which the person is seen as part of a whole system. This system involves all internal and external environments, from cellular and genetic make-up to the individual's family, society, etc. Before the 1980s, the biomedical model, which focused only on the physical influences and processes of illness, was the main frame from which health care professionals viewed disease. Engel critiqued the biomedical model and said it did not acknowledge the entire system that was part of the patient, only the physical make-up of the body. The biopsychosocial model, on the other hand, focuses on the whole person because it acknowledged and took into consideration the entire system. Thus, Engel claimed that levels of social context impact individuals as much as any physical condition. There has since been a significant amount of literature and research that focused on the link between relationship processes and health outcomes (Fincham & Beach, 2010).

Goals of Medical Family Therapy

Relationship processes directly relate to the two general goals for the proposed outcome of MedFT. These two goals involve aiding the patient and family in increasing their sense of agency and communion (Hertlein, 2003; McDaniel et al., 1992; McDaniel, Harkness, & Epstein, 2001).

Agency

Agency, or empowerment, involves freedom of choice. As McDaniel et al. (1992) define it, "Agency refers to a sense of making personal choices in dealing with illness and the health care system, both of which often contribute to a patient's feelings of passivity and lack of control" (p. 9). MedFT's focus on promoting agency, or empowerment, involves helping the patient and family feel as if they have some control, management skills, and knowledge regarding the illness and the relational, emotional, and physical ramifications of dealing with the illness. As mentioned in Chapter One, agency is the sense of being empowered when dealing with illness and the health care system.

Communion

Communion can be viewed as a sense of social support. As McDaniel et al. (1992) define it, “Communion refers to emotional bonds that are often frayed by illness, disability, and contact with the health care system. It is the sense of being cared for, loved, and supported by a community of family members, friends, and professionals (p. 10). When one has an illness it is common to experience feelings of separation from others. Illness is often associated with negative and frightening connotations such as contamination and death. Thus, as mentioned in Chapter One, communion is the sense of being socially supported by not only family and friends but also by professionals such as health care workers.

Balancing agency and communion, feelings of independence and self-reliance with feelings of closeness and support, is a human goal we all seek. However, those dealing with physical illnesses have an increased need to feel competent and yet cared for because of the often negative emotional, relational, and physical consequences of experiencing illness.

Family Therapy and Systems Thinking

Family therapy also seeks to bring healing within systems, such as families, by utilizing systemic thinking. In fact, some researchers and theorists claim that regardless of which field or school one practices in, whether social work, psychiatry, etc., any type of practitioner working with families should have training in systemic thinking (Willerton, Dankoski, & Martir, 2008). Systemic thinkers believe individuals are embedded within systems and that varying systems interact (Bertalanffy, 1968). For example, families are embedded within larger social networks, i.e. the school the children are enrolled in. Therefore, to understand children's life experiences, their view of school and the interactions in school is explored in addition to their family patterns. In this way, systemic thinkers include the interaction within and among various social systems, i.e. families and schools in their assessment and treatment of individuals and families.

MFT and MedFT are distinguishable from other psychological fields and views by their foundation in family systems models or theories (Hodgson et al., 2011; Linville et al., 2007). Thus, MedFT at its basic core is a systems approach to therapy and shares many MFT principles.

A Feminist Family Therapy Approach

A feminist family therapy approach also utilizes systemic thinking but specifically seeks to bring to light hidden inequalities in gender, class, etc. and create equality through honoring previously silenced voices in marginalized populations (Knudson-Martin & Laughlin, 2005; Leslie & Southard, 2009). This approach comes from the perspective that women and other non-dominant white males are often placed in a one-down position when in unequal relationships (Knudson-Martin & Mahoney, 2009) and that inequalities can be perpetuated by social contexts and cultural expectations

(Almeida, 1998; Cowdery et al., 2009; Maciel, Van Putten, & Knudson-Martin, 2009; Quek & Knudson-Martin, 2006).

The early founders of a feminist approach in family therapy built the platform from which current therapists are challenged to re-examine values and therapeutic processes which may unintentionally perpetuate power differences and silence voices (Goldner, 1985; Hare-Mustin, 1978; Luepnitz, 1988; McGoldrick, Anderson, & Walsh, 1989; Walters, Carter, Papp, & Silverstein, 1988). More recently, Leslie & Southard (2009) have outlined seven principles of a feminist family therapy approach.

> 1. The role of values in therapy needs to be acknowledged and examined. In other words, each therapist holds values and beliefs which he or she needs to be aware of lest these values unintentionally guide therapy.
> 2. Gender must be introduced into therapy and clinical language and techniques that appreciate both women’s and men’s experiences in families need to be used.
> 3. Power inequalities must be addressed in relationships instead of assuming equality.
> 4. Individual choice and responsibility should be incorporated into explanations of family dynamics.
> 5. Diversity should be appreciated in families.
> 6. Individual family members need to be identified as clients. Solely viewing the whole family as a client can sometimes silence individual voices. Therefore, each individual as well as family interaction is considered a client.
> 7. Power inequities between therapist and client should be minimized as much as can be expected. (p. 329-332)

These seven principles are integral to any feminist family therapy approach and thus form an appropriate lens for understanding marginalized populations and families. Specifically, a feminist approach frames symptoms, whether psychological of physical in nature, within larger contexts. Also, this approach attends to the impact of power and social justice issues, seeking to empower marginalized and unheard voices.

In a simplified example, a therapist using a feminist approach will try to understand an openly gay AIDS patient's experience in terms of how his symptoms and diagnosis impact his view of himself in relation to others, his status in society, his ability to be heard and acknowledged within his family and social network, etc. Some of the goals of therapeutic interaction may be to equalize power differences between the patient and other adults in his life, by helping him voice his thoughts and feelings, as well as to empower him to feel he has the right to speak and be heard, especially within his family.

A Resiliency Model of Family Stress, Adjustment, and Adaptation

A resiliency model also addresses families, specifically how families handle stress and crisis (McCubbin & McCubbin, 1993, 1996). Families in which one or more members are dealing with illnesses are especially impacted from an emotional, physical, and relational standpoint (Fekete, Stephens, Mickelson, & Druley, 2007; Saba, 1999). A resiliency model incorporates a theme of resiliency in family functioning as shown in the five principles of a resiliency model of family stress, adjustment, and adaptation.

1. Families experience stress and hardship as a predictable aspect of family life over the life cycle.

> 2. Families also possess strengths and develop competencies to protect and assist in the recovery from both expected and unexpected non-normative stressors and strains and to foster the family's recovery following a family crisis.
> 3. Families benefit from and contribute to a network of relationships in the community, particularly during periods of family stress and crisis.
> 4. Families will search for and establish a view that will give the family meaning, purpose, and shared perspective so the family can move forward as a group.
> 5. Families faced with major stressors and crises seek to restore order, balance, and harmony even in the midst of great upheaval. (McCubbin, Balling, Possin, Frierdich, & Bryne, 2002, p. 104)

Thus, families are able to cope and adapt through relations with the community as well as within the family system.

A resiliency model also includes two phases, the adjustment phase and adaptation phase after experiencing a stressful life event (McCubbin et al., 2002). In the adjustment phase families cope with stressors by relying on their established patterns and resources with only minor changes being made. For example, when one family member gets diagnosed with diabetes, the rest of the family adjusts in a minor way to the stressor, i.e. buying more fruits and vegetables and not eating as much junk food.

If this reliance is not adequate to manage the situation, the family moves into the adaptation phase whereby the family experiences a state of disorganization and is in need of change (McCubbin et al., 2002). Thus, if the family is buying more fruits and vegetables but the family member is still experiencing symptoms, i.e. fainting because of lack of insulin, the family may not know what to do and may feel frustrated and helpless. The adaptation phase requires additional strengths and capabilities such as acquiring new or activating old social support resources at the individual, family, and community level (McCubbin et al., 2002). Consequently, the family may reach out to others such as family or friends who have dealt or are dealing with diabetes, their doctor, and a support group within the community to get help with how to cope with the adjustments necessary. In this way, the family adapts through connections within family members, friends, and the community.

The positive outcome of family adaptation in this model is when individual family members are functioning well and the family has a sense of cohesion and balance in operating as well as in relationship to the community (McCubbin et al., 2002). To conclude the example, as a result of the connections between and within the family and others, the family knows how to operate and adjust to diabetes and can balance being self-sufficient with reaching out for addition help within the community if needed.

Integration of a Feminist Approach and a Resiliency Model

Points of Agreement

Upon exploration of current literature, a feminist approach and a resiliency model have not been formally integrated as one theoretical framework. However, the concepts of feminism and resiliency have been utilized together as viewpoints from which Dickerson (1995), Hill and Thomas (2002), Ramsey and Blieszner (2000), and Walsh (2006, 2012) explain women’s experiences coping with societal adversity and challenges.

Froma Walsh (2006, 2012) in particular has utilized feminist-informed perspectives in her theory regarding family resiliency. Regarding health care, Prouty Lyness (2007) and Rogers-Clark (2002) claimed that resiliency can be a feminist-informed construction that appropriately applies to women and families dealing with cancer. They stated that a feminist-informed construction of resiliency incorporates issues of power and marginalization into what it means to be resilient for these women. Also, the women can decide what resiliency means for them. In addition, social support is seen as part of resiliency. Therefore, families have internal strengths which guide them through crises but social support is essential for resiliency, as outlined in the principles of a resiliency model.

For example, an African American single mother on welfare may often experience racism and stigmatization, e.g. some may view her as lazy and unintelligent. Based on a feminist-informed construction of resiliency, this woman is seen as resilient and strong, especially since she may deal with these extremely oppressive experiences frequently but still continue to bear the burden of responsibility for her children. Moreover, her utilization of welfare is not seen as lacking resiliency but as part of her ability to reach out to others for social and financial resources and thereby adapt.

The principles of a feminist approach and a resiliency model can thus be integrated. For example, the conclusion that social support is essential for the resiliency of vulnerable and marginalized populations ties into feminist and resiliency principle number three. Accordingly, when health care providers can assess for power inequalities and then provide social support, the patient and family are more likely to feel understood, empowered, and connected. In this way, resiliency is viewed within a systemic and social context, rather than just an individually developed strength (Seccombe, 2002).

Three other points of integration between a feminist approach and a resiliency model are as follows:

1. Based on feminist principle six and resiliency principle three, a feminist approach and a resiliency model call for a broader, systemic look at individuals and families in addition to valuing individual contributions to interactions and patterns.
2. Based on feminist principles two and five and resiliency principles two, four, and five, a feminist approach and a resiliency model are strength-based in that diversity and adaptation are considered strengths.
3. A feminist approach and a resiliency model advocate for medical patients to receive community and family support as well as empowerment and a voice within medical settings.
    a. Based on feminist principles one, four, and seven, from a position of social power and social context, a feminist approach seeks to equalize the relationship between patient, family, and provider.
    b. Based on resiliency principles one and three, from a position of coping with stress, which is a normal part of human life, a resiliency model seeks to create connection and support between patient, family, and provider.

Theoretical Concepts, Communion, and Agency

A feminist approach and a resiliency model are appropriate guiding theories for the current study because of their focus on community and social support as well as individual responsibilities, strengths, and empowerment. Based on these theories, the current study uses social support, or *communion*, and empowerment, or *agency,* as important outcomes of therapy. The following will outline how the theoretical concepts relate and give rise to the current study's focus on agency and communion.

Communion

Specifically, communion from a resiliency lens calls for families and individuals to reach out and connect to others in order to alleviate stressors such as dealing with physical illnesses (McCubbin et al., 2002; McDaniel, et al., 1992). In essence, communion informs resiliency and is a healing agent. Thus, a resiliency model's goal coincides with MedFT's goal of fostering communion within and around families. Also, a resiliency model's goal fits well with the current study's hypothesis that MedFT aids vulnerable populations through increasing patient communion within medical communities. In addition, one purpose of the current study, which is to examine the effectiveness of MedFT with vulnerable populations by evaluating patient communion, flows easily out of resiliency principles.

From a feminist lens, communion is also seen as important but those who hold power such as health care providers must be aware of their influence. For example, the patient must perceive an act as supportive in order to classify a health care provider's behavior as supportive, regardless of the health care provider's intention to offer support. Thus, power imbalances are attended to and equalized through attention to diversity of views and opinions. Consequently, a feminist spotlight on marginalization influences the current study's methodology. For example, through a few open-ended questions and a number of self-report measurements, patients are given a chance to voice their own opinions regarding what they identify as socially supportive.

In summary, an integration of a feminist approach and a resiliency model gives rise to the current study's hypothesis, purpose, methodology, and measurements regarding communion. With only one perspective, the direction concerning the creation of the current study, particularly concerning communion, would have been lacking. Thus, when integrating a feminist approach and a resiliency model, communion is seen as essential to patient and family well-being when the power balances are attended to and communion is viewed as supportive from the patients' perspective.

Agency

From a feminist lens, agency is also important to patient and family well-being (Knudson-Martin & Mahoney, 2009; World Health Organization, n.d.). Agency is the general goal of many therapeutic approaches and is present through marginalized voices being heard. A strong social justice component is part of a feminist approach which raises issues such as health care disparities and power imbalances between patient and provider. If a feminist approach is applied in the health care industry, patients and health care professionals will be expected to communicate on a more equal level. Patients would therefore feel free to ask questions and get the care they need. Also, health care professionals would be aware and conscious of social influences which may block patients' access to health care and information. Thus, from a feminist perspective, patient agency is essential to receiving quality health care and is the goal of many approaches.

Feminist goals coincide with MedFT's goal of fostering agency within patients and families. In fact, some founders of MedFT have specifically attended to issues of gender and social context within MedFT (McDaniel & Cole-Kelly, 2003; McDaniel & Hepworth, 2003). Also, feminist goals fit well with the current study's hypothesis that MedFT aids vulnerable populations through increasing patient agency within medical communities. In addition, one purpose of the current study, which is to examine the effectiveness of MedFT with vulnerable populations by evaluating patient agency, flows easily out of feminist principles.

From a resiliency lens, the importance of agency is not expressly mentioned but is alluded to in the discussion of the adaptation and adjustment phases of family coping. When families have a hard time coping with a stressor such as a physical illness in the adaptation phase, families need social support resources which then empower them to cope and adapt (McCubbin et al., 2002; McDaniel, et al., 1992). Therefore, a resiliency approach views agency and communion as two sides of the same coin.

When integrating a feminist approach and a resiliency model's perspective on agency, a feminist approach would add that communion which is seen as supportive by patients and families and which decreases power imbalances is a part of agency. This integrated concept of agency fits well with MedFT's goal of not only increasing communion but also increasing agency since the two constructs coincide with each other.

Theoretical Influence on Study Design

The integration of a feminist approach and a resiliency model's perspectives on communion and agency also fit well with the current study's hypothesis that MedFT aids vulnerable populations through increasing patient agency and communion within medical communities. In addition, the purpose of the current study, which is to examine the effectiveness of MedFT with vulnerable populations by evaluating patient agency and communion, flows easily out of the integration of feminist and resiliency principles. Lastly, the integration of a feminist approach and a resiliency model influence the current study's focus on both agency and communion as outcome variables in this effectiveness study of MedFT. One variable without the other would produce an incomplete picture of whether or not MedFT is effective in meeting its goal to increase both constructs (McDaniel et al., 1992).

In summary, the integration of a feminist approach and a resiliency model give rise to the current study's hypotheses, purpose, and methodology. In addition, the integration of a feminist approach and a resiliency model add a systemic lens to the constructs communion and agency, which is well-suited to MedFT's views on communion and agency. Thus, the integration of a feminist approach and a resiliency model is an appropriate viewpoint for an analysis of MedFT effectiveness.

CHAPTER THREE

REVIEW OF LITERATURE

Medical Family Therapy (MedFT) relies on the biopsychosocial model of health, incorporates a systemic lens, and has two main goals, to increase a sense of *agency*, synonymous with empowerment, and *communion*, synonymous with social support (McDaniel, Hepworth, & Doherty, 1992). Also, as mentioned in Chapter Two, MedFT has been considered a subset of Marriage and Family Therapy (MFT) because of their shared focus on family structure and systems-oriented thinking (Linville, Hertlein, & Lyness, 2007). Although MedFT has been discussed within the family therapy field, MedFT often integrates with other fields such as the medical field to provide care. It is important, therefore, to examine other professional views of MedFT.

Thoughts on Medical Family Therapy Outside Family Therapy Field

The nursing field encourages MedFT's to take a broader view. Although MedFT has its roots in family therapy and medicine, the nursing field encourages MedFT's to widen their gaze and discover other field's contributions to the understanding of families and illness (Bell, Wright, & Watson, 1992). Bell et al. (1992) suggest MedFT's utilize theory and research from nursing, social work, anthropology, etc. literature and perspectives, not just the traditional physician's perspective. They claim the nursing field has been dealing with issues of illness, families, and patients for years and MedFT is not a new idea. However, even though the idea of incorporating families in patient care is not new, MedFT provides a unique framework from which theory and clinical practice can intersect and create a process of helping patients, families, and professionals navigate health care from a systemic perspective.

The psychological and theological field reported positive interest in MedFT. In the *Journal of Psychology and Theology,* Hunter (1993) reviewed the original McDaniel's et al. (1992) book introducing MedFT and said it was well-received. The author encouraged family therapists to continue working within the field of health psychology.

The field of pediatric medicine has also attempted to integrate MedFT. Wirtberg (2005), in *Acta Paediatrica,* introduced MedFT to pediatric medicine. Wirtberg recommended MedFT be combined with attachment theory, salutogenic theory, or interactional theory but did not describe said theories or discuss how these theories could be used in the services of MedFT.

The idea of MedFT appears to be well-received by other fields of study, further evidence that the effectiveness of MedFT needs to be evaluated. In theory MedFT seems sound and valuable, yet without evidence demonstrating the effectiveness of MedFT, we cannot know whether MedFT is actually helpful by meeting the goals it claims to meet.

Feminism and Thoughts on Medical Family Therapy

MedFT goals coincide with other perspectives and thoughts. In particular, as mentioned in Chapter Two, feminist literature has long been fighting the war against oppression and discrimination against marginalized members of society's health needs, specifically the health of women and those dealing with low SES. Defining illness and health for women and bringing female issues to the forefront of medicine has paved the way for other marginalized populations to receive recognition for not being provided the health care services they need (Munch, 2006).

Feminist-informed MedFT, also called Feminist Medical Family Therapy, highlights the influence of power and gender on the treatment and management of illnesses (Burwell, Templeton, Kennedy, & Zak-Hunter, 2008). A feminist focus has been part of the foundation of MedFT. In fact, when Pratt (2003) interviewed one of the founders of MedFT, Susan McDaniel, McDaniel noted, “We organized medical family therapy around two major goals: agency and communion, terms that come out of the psychology and theology literature. So, I think those were appealing to Jeri Hepworth, Bill Doherty, and I in part because it is easy to translate agency and communion into feminist kind of ideology and feminist theory” (p. 144). McDaniel went on to add that more equal and respectful partnerships between physicians and patients are also feminist goals within MedFT. These feminist goals apply not only to women but to other vulnerable and diverse populations, such as low income individuals and families.

According to Burwell et al. (2008), Hertlein (2003), and Knudson-Martin (2003), a feminist perspective is congruent with MedFT in that feminist family therapists are systemic thinkers, focusing on interactions among biological, emotional, relational, and social factors. Also, the core of MedFT seems to emphasize bringing services to the underprivileged and overlooked. Therefore the focus on low SES patients in a MedFT effectiveness study seems natural. If MedFT is to be effective at all, it should be effective with these vulnerable populations.

The following section thus outlines current literature that support the possible effectiveness of MedFT. In addition, *agency,* or empowerment, and *communion*, or social support, are discussed as outcome variables for the sake of clarification since they may be more novel ideas to the reader.

Evidence for Effectiveness

Some studies have provided support for the effectiveness of MedFT (Phelps et al., 2009; Sellers, 2000; Yeager et al., 1999). One study which recommended MedFT for diabetes management with patients in integrative care settings described the process of collaboration with professionals and patients. However the study only outlined what possible issues were discussed, not the effectiveness of MedFT (Phelps et al., 2009).

Yeager et al. (1999) looked at the process of becoming a MedFT. MFT trainees worked with families dealing with physical illnesses and gathered a knowledge base of the mind-body interaction in a systemic way. Students reported that they felt they had helped patients and their families and reported that the patients felt the students had helped as well. However in this paper, the focus was on creating experiences for the students, and did not address how well or effectively they conducted MedFT.

Sellers (2000) reported on a model of integrative health care in outpatient medical oncology. In Sellers’ study, after a needs-assessment which concluded that additional support was necessary, a MedFT was asked to join the medical treatment team. The results of the study reported on health care professionals’ as well as patients’ satisfaction with MedFT integration. The current study was helpful in suggesting that MedFT can increase patient satisfaction with care. However, the effectiveness of MedFT was not evaluated in terms of comparing treatment and control groups. A randomized controlled methodology was not employed. Nevertheless, supportive results were reported:

> “Ninety percent of the patients polled (n = 35) indicated that they experienced a significant reduction in emotional suffering due to their work with the Medical Family Therapist. Ninety one percent reported being significantly assisted to employ personal and community resources (friends, faith, courage, hope, humor, family, etc.). Seventy three percent of respondents indicated significant benefit in their ability to sustain hope as well as gain clarity and a plan regarding concerns created in the cancer experience”. (Sellers, p. 19-33)

In regards to cost-effectiveness studies, Crane has provided a few studies examining family therapy and suggesting that MFTs reduce the overall cost of health services. For example, the inclusion of MFTs in health care services decreased utilization and amount of money put into providing health care (Law & Crane, 2000; Law, Crane, & Berg, 2003). However, there has been some debate surrounding the issue of whether MFT versus other individual psychotherapy is more cost-effective. Crane, Wood, Law, and Schaalje (2004) found that any form of psychotherapy is helpful when it comes to lowering utilization of medical care. More recently, Crane and Payne (2011) published a study reporting that family therapy is more cost-effective than any other therapy, individual or otherwise. Nonetheless, Sellers (2000) noted that until reimbursement companies include a more integrated way of payment, the issue of including any psychotherapy in medical care will be undecided in regards to cost-effectiveness. Nevertheless, Crane’s studies provide evidence for the idea that if family therapy can be cost-effective, perhaps MedFT can also be cost-effective since MedFT specifically focuses on improving patients’ behavioral health and health care.

Evidence for Effectiveness outside the Family Therapy Field

The family therapy field has advocated for the use of MedFT. However, the nursing field has also recommended MedFT as a possible intervention. In fact, Ragaisis

(1996) provided a rationale for Psychiatric Consultation-Liaison Nurse (PCLN)’s use of MedFT. Ragaisis outlined how a PCLN could use MedFT principles, such as including families in treatment planning, in a helpful manner. Other fields such as psycho-oncology (Northouse, Kershaw, Mood, & Schafenacker, 2005) and pediatric psychology (Kazak et al., 2005) have utilized family interventions but did not claim to be conducting or studying MedFT. For example, Northouse et al. (2005) compared treatment and control groups of patients with advanced breast cancer and their families. The treatment group consisted of patients and families who participated in family-based interventions. The control group consisted of patients and families who received standard care alone. Family-based interventions consisted of home visits to the family led by a nurse who implemented the FOCUS program. The FOCUS program was designed to provide patients and families with mostly standardized information and support and involved discussing topics such as family involvement, coping effectiveness, and symptom management (Northouse et al., 2005). Findings revealed that the treatment group reported less hopelessness and less negative assessment of the illness than the control group. It is important to note that the study did not claim to be an effectiveness study regarding MedFT goals and outcomes.

Agency and Communion as Outcome Variables

Depending on the topic of an effectiveness study, outcome variables vary. In the current study outlined in this paper, agency, communion, and psychological distress are the identified outcome variables. Rather than only individual biological measures such as reduction of pain or decrease in psychological distress symptoms, agency and communion are chosen as outcome variables for two reasons. First, MedFT claims that its ultimate outcome is to increase a sense of agency and communion within patients. Therefore, it is valid to assume that MedFT is effective if it meets the goal it sets out to meet. Second, the current study will include vulnerable patient populations who are known to experience health care disparities (Munch, 2006; U.S. Department of Health and Human Services, 2003). Increasing a sense of agency and communion will address and help eradicate the social injustice issue of unequal quality health care by providing these populations with a voice through agency, and support through communion (World Health Organization, n.d.).

It is important to note, however, the current study also hypothesizes that the treatment group will have lower scores on psychological distress symptoms in comparison to the control group. Decreasing psychological distress is defined as lower scores on somatization, depression, and anxiety symptoms (Galdón et al., 2008). Thus, MedFT will be evaluated for effectiveness in increasing a sense of agency and communion as well as decreasing psychological distress.

History of Agency and Communion

The terms agency and communion, as outlined by the founders of MedFT (McDaniel et al., 1992) and defined earlier in this chapter, have not always related to families dealing with illness. The various arenas of social psychology (Locke & Nekich, 2000), sex roles (Hirokawa & Dohi, 2007), humanistic psychology (Mackrill, 2009), personality research (Shih-Ming, Li-Chung, Chin-Sheng, & Ciou-Jhen, 2007), medicine (Karnilowicz, 2011), and nutrition (Dube et al., 2007) have also examined these terms.

These different arenas find their definition of agency and communion from Bakan (1966). Bakan proposed the idea that agency and communion are two fundamental dimensions of human existence:

> Agency manifests itself in self-protection, self-assertion, and self-expansion; communion manifests itself in the sense of being at one with other organisms. Agency manifests itself in the formation of separations; communion in the lack of separations. Agency manifests itself in isolation, alienation, and aloneness; communion in contact, openness, and union. (pp. 14-15)

As McDaniel, Lusterman, and Philpot (2001) put it, we all seek to be self-sufficient as well as have significant connections.

Agency and communion have not only been identified as dimensions of existence but also as personality indicators (Shih-Ming et al., 2007). In fact, there are various ways in which agency can be referred to. For example, Mackrill's (2009) review of the existing literature illustrated that client agency is often defined many ways: a process of making therapy work, a personality type or diagnostic criteria, an active or passive participation in therapy, a way of dealing with and overcoming life's struggles, and an active mover and shaker of one's circumstances. The term communion does not appear to have been explored as extensively as the term agency and seems to mainly refer to connecting with others in relationship (Shih-Ming et al., 2007).

Definition of Agency and Communion

It is important to note that agency in the current study is relatively consistent with various existing definitions. Agency and empowerment have often been used interchangeably and, as mentioned earlier, will continue to be used interchangeably in the current study. In fact with a definition similar to McDaniel et al. (1992), patient empowerment has been defined as a feeling that one is in control of one's own health (Rohrer, Wilshusen, Adamson, & Merry, 2008). Thus, agency in the current study is defined as “a sense of making personal choices in dealing with illness and the health care system” (McDaniel et al., 1992, p. 9). Communion, on the other hand, does not seem to be defined as extensively in current literature. Therefore, for the purposes of the current study and based on the definition used by McDaniel et al., communion will be synonymous with social support. Communion will be defined as a “sense of being cared for, loved, and supported by a community of family members, friends, and professionals” (McDaniel et al., 1992, p. 10).

Agency and Communion in Literature

Depending on the context, a sense of agency and communion may differ. In the context of personality traits, Diehl, Owen, and Youngblade (2004), among others, found consistent gender and age differences regarding agency and communion (Voci & Cramer, 2009; Ward, Thorn, Clements, Dixon, & Sanford, 2006). Diehl et al. (2004) found that young and middle-aged adults, as opposed to older adults, tended to have an increased sense of agency. Also, men, as opposed to women, tended to have an increased sense of agency. In addition, Diehl et al. (2004) found that older adults tended to have an increased sense of communion, as opposed to young adults; and women tended to have an increased sense of communion, as opposed to men.

In fact, agency has commonly been linked with stereotypical masculine traits such as dominance and independence, and communion has commonly been linked with stereotypical feminine traits such as extraversion and sociability (Leaper, 1987; Trudeau, Danoff-Burg, Revenson, & Paget, 2003; Voci & Cramer, 2009). Bakan (1966) noted that we can be socialized to enact these characteristics based on our sex role. Thus, women are socialized to be in relationship with others and men are socialized to be independent from others.

Agency and communion also have general positive influences. Hirokawa and Dohi (2007) found that these two characteristics are positively associated with social-support and self-esteem for men and women.

Agency and communion have also been associated with health outcomes and well-being (Karnilowicz, 2011; Trudeau et al., 2003; Welzel & Inglehart, 2010). Voci and Cramer (2009) researched the influence of agency and communion on the psychological adjustment and quality of life (QOL), for women dealing with irritable bowel syndrome. They found that agency was positively related to all dimensions of psychological adjustment and QOL, meaning that as a sense of agency increased, psychological adjustment and quality of life increased in a positive way. They also found that a lack of agency had a negative influence such as an increase in food avoidance. Communion was not found to be associated with adjustment or QOL. Also, Trudeau et al. (2003) researched agency, communion, and rheumatoid arthritis and found that agency was associated with better health outcomes. There were no significant associations with communion. Welzel and Inglehard (2010) went on to argue that based on empirical evidence, not only was agency linked to well-being in western societies but also across cultures. In fact, one study concluded that the better the perception of empowerment, the better the score in satisfaction with QOL (Liu, Tai, Hung, Hsieh, & Wang, 2010).

In addition, Dube et al. (2007) looked into the influence of agency and communion on meal intake as represented by the interaction between patient and provider. They found that increased agency and communion influenced an increase in positive health care behaviors such as higher energy protein intake.

As noted above, studies evaluating the influence of communion on physical illness did not produce significant results. However, social support has been positively related to QOL and negatively related to depression (Beeble, Bybee, Sullivan, & Adams, 2009).

Perceived social support was also influential regardless of level of stress for parenting and child-well-being (McConnell, Breitkreuz, & Savage, 2011). McConnel et al.'s (2011) results are particularly relevant to the current study since those dealing with low-income are often stressed. Thus, level of stress will not influence patients' perceived social support and does not necessarily need to be taken into account when examining patients' perceived social support.

In a similar study, social support buffered the impact of ecological risks, such as living with a low-income and mothers' symptoms of psychological distress, thereby influencing parenting behaviors (Prelow, Weaver, Bowman, & Swenson, 2010).

In fact, another study found that family social support was either a complete or partial mediator in the relationship between different major sources of income and depression (Chou, Chi, & Chow, 2004). Social support clearly aids in well-being, regardless of level of stress, financial income, or ecological risks.

Social support also aids in medical compliance. One study found that emotional social support, not the size of social networks, influences medical compliance and cancer screenings (Honda & Kagawa-Singer, 2006). Another found that social support bears the highest correlation with medical compliance (DiMatteo, 2004). Thus, social support, or the current study's definition of communion, is integral for well-being as well as medical compliance.

Unmitigated Agency and Communion

When discussing communion and agency in literature, authors often identify whether they are referring to unmitigated or mitigated agency and communion. Unmitigated agency involves extreme independence with a lack of connection with others (Buss, 1990; Helgeson, 1994), e.g. a husband making decisions based solely on his needs and wants without taking his wife's needs and wants into consideration. Unmitigated communion involves a connection with others that leaves no room for autonomous thinking or choice (Buss, 1990; Helgeson, 1994), e.g. a husband neglecting his own psychological and physical well-being to focus on his wife's needs and wants.

It is important to note the difference between agency and communion and unmitigated agency and unmitigated communion because unmitigated agency and communion are linked to negative health outcomes (Trudeau et al., 2003; Voci & Cramer, 2009), psychological distress (Hirokawa & Dohi, 2007), and negative well-being (Helgeson, 1993). It is also important to note the difference between mitigated and unmitigated characteristics because if this distinction is not made, research studies might unintentionally include confounding variables. For example, suppose a study examines the relationship between a sense of agency and a sense of well-being. The researcher utilized an instrument which measured agency but did not take into account unmitigated agency. The results of the study would have questionable usefulness, especially since well-being is positively related to agency and negatively related to unmitigated agency. Thus, the results may produce a skewed and confusing picture of the relationship between agency and well-being.

Indirect and Interacting Variables

In any research study, it is necessary to focus and differentiate the variables being studied in order to produce results which are as accurate as possible. It is also necessary to examine the relationship between variables so that interacting and indirect variables are taken into consideration (Baron & Kenny, 1986).

Indirect Variables

Upon researching moderating and mediating variables in connection to agency and communion, there were no studies which clearly used the terms mediating and moderating variables when associated with agency or communion as an outcome or a dependant variable.

Several mediating variables have been identified regarding social support. One study found that empowerment can mediate the relationship between perception of support from provider and symptom relief (Bann, Sirois, & Walsh, 2010). Thus, empowerment and social support must be clearly differentiated and accounted for when examining symptom relief.

Atienza, Collins, and King (2001) found that a sense of control over the situation partially mediates the relationship between perceived support and stress-induced negative mood changes. Thus, if a patient feels he or she has control over what is happening in the medical arena, his or her perception of social support may vary. However, a sense of control can also be accounted for by measuring empowerment.

Social support relates to depression only through its relationship with coping. Therefore, coping styles mediate the relationship between social support and depression (Bigatti, Wagner, Lydon-Lam, Steiner, & Miller, 2011). For example, if a patient typically copes with depression by reaching out to others for support, his or her social support scores may differ from another patient who typically copes by withdrawing into himself or herself. However, the issue of coping styles as a mediator relates to the current study in terms of patients' self-report of their need for communion or agency and is taken into account when examining mitigated and unmitigated agency and communion.

Interacting Variables

Additional factors could contribute to the outcome of the effectiveness study. Although there are no clearly delineated moderators in the literature, several influential and possibly co-varying factors were listed when agency and communion were outcomes or dependant variables. These should be taken into consideration.

Inter-personal and power motives could be considered moderators when examining the relationship between a treatment and agency and communion (Locke & Nekich, 2000; Saragovi, Aubé, Koestner, & Zuroff, 2002). In other words, depending on whom one is talking to, what the social situation presents, etc. the individual will have different motivations to act in an autonomous or integrative way. For example, if a patient is talking to another patient out in a park, he or she might exhibit more autonomous characteristics, i.e. stating opinions, because of the more egalitarian relationship and relaxed setting. However, if a patient is talking to a physician in an examination room, he or she may not feel as motivated to exhibit autonomous characteristics, i.e. stating opinions, because of the difference in status and power between patients and physicians and the more formal setting.

Unfortunately, there have not been studies done concerning the influence of patient-provider status and power on the patient’s sense of agency and communion. Wojciszke, Abele, and Baryla (2009) did find, though, that depending on one’s focus, liking versus respecting someone, levels of communion and agency varied respectively. Thus, patient satisfaction with the patient-provider relationship will account for motives.

Depending on the level of self-esteem or self-criticism a patient already has or develops, the outcome on agency and communion could be different (Locke & Nekich, 2000; Saragovi et al., 2002). If patients do not believe they have the right to speak up or create connections with others because of a lack of self-worth, their level of agency might be varied from another patient’s level, especially if the other patient had higher self-esteem to begin with. However, patients’ views of whether they should connect or separate from others can be accounted for by measuring unmitigated agency and communion.

The level of satisfaction and connection, or therapeutic alliance as it is called in the field of psychotherapy, which one has with another provider influences agency and communion. Smith et al. (2009) found that couples who had been married reported a varied sense of agency and communion. When the results were controlled for relationship satisfaction, the sense of agency and communion varied. Helgeson (1993) found that relationship distress also influences the sense of agency and communion. Consequently, a patient's self-report of agency or communion might not differ solely because of MedFT. It may also vary depending on the patient's satisfaction with the relationship and level of relationship distress or connection with his or her provider.

Levels of agency and communion could also differ depending on individual differences in disposition or personality (Sheldon & Cooper, 2008). Sheldon and Cooper reported that those who were more agency-focused were motivated by achievement. Those who were communion-focused were motivated by intimacy. Thus, depending on whether a patient feels comfortable and motivated with agency and communion may not depend solely on MedFT but could be moderated by personality and perceived goal of interaction between patient and provider.

Along the same vein of thought, Helgeson (1994) characterized agency and communion as masculine and feminine, respectively. As mentioned earlier, agency has commonly been linked with stereotypical masculine traits such as dominance and independence, and communion has commonly been linked with stereotypical feminine traits such as extraversion and sociability (Leaper, 1987; Trudeau et al., 2003; Voci & Cramer, 2009). Therefore, depending on one's gender or gendered role preference, one will be higher or lower in his or her sense of agency or communion. Gender scripts also preclude valence, or the attractiveness of behaving in a certain way. Therefore, valence could also be a moderating variable (Abele, Uchronski, Suitner, & Wojciszke, 2008; Suitner & Maass, 2008). Depending on whether a patient feels he or she should be portraying more masculine or feminine roles, the level of agency and communion will differ. Thus, MedFT may not be the sole contributor for increased levels of agency or communion in patients. In the next section, agency and communion will be discussed in terms of how they relate to low income medical patients.

Stress, Agency, and Communion and Low-Income Patients

Low income medical patients provide a similar, but often unique understanding of agency and communion. First it is important to note that low-income medical patients report high stress (Cashman, Savageau, Lemay, & Ferguson, 2004; Fabrega, Moore, & Strawn, 1969). Scarinci, Ames, and Brantley (1999) found that low-income medical patients, on average, experience 15 chronic stressors, i.e. was disturbed while trying to sleep; not enough money for basics such as food and clothing; not enough money for fun or recreation; ran out of pocket money; was disturbed while trying to sleep; interrupted while talking.

In addition, Scarinci et al. (1999) found that eight of the ten items that were reported as the most frequent chronic stressors were also rated as the most stressful, i.e. had household chores (shopping, cooking, etc.); ran out of pocket money; not enough money for fun or recreation; was disturbed while trying to sleep; had problems paying bills; interrupted while relaxing; not enough money for basics (food, clothing, etc.); forgot something.

Female patients dealing with low income also experience high stress (World Health Organization, n.d.). In fact, Scarinci et al. (1999) stated that women in their sample reported dealing with more stressful events than men.

Stress influences agency, or empowerment (Holdsworth & Cartwright, 2003). For example, Holdsworth and Cartwright found that individuals who were highly stressed also reported feeling less empowered. Therefore, low-income medical patients, as opposed to mid-income or high-income patients may have a lower baseline of empowerment due to high stress.

Social support does not appear to be influenced by stress (Cropley & Steptoe, 2005; Durden, Hill, & Angel, 2004). However, low-income patients, or those who experience high stress, do report that social support greatly buffers the effects of stress (Cropley & Steptoe, 2005). In particular, Durden et al. (2004) found that for female low-income patients, the positive association between stress and depression was incrementally diminished with increasing levels of social support.

Still, marginalized populations such as low-income patients and female low-income patients often feel powerless as well as stressed when it comes to having a voice in society (Hardy, 2011). Therefore, these patients may focus more on fitting in and respecting authority and power rather than advocating for themselves. Consequently, a low-income patient’s level of agency may tend to be lower than mainstream population scores since he or she may not prize having a voice as highly as fitting into society.

As a result, it is important that instruments and surveys used to measure agency and communion are appropriate for this population. Also, since the buffering effects of social support and empowerment can be very useful in increasing the well-being of vulnerable patient populations, it is quite appropriate to evaluate the effectiveness of MedFT with these variables and this population.

CHAPTER FOUR

METHODS

There are various research methods to choose from when conducting research within the scientific field. The current study will utilize a longitudinal randomized clinical design. The following will describe the research design, the rationale for this particular research design, the sampling procedures, and the analytic strategy to be used.

Longitudinal Randomized Clinical Design

When examining the effectiveness and efficaciousness of a treatment or product, randomized clinical outcome study methodologies are often used. Yet, effective and efficacious are not synonymous. Effectiveness studies use real-world clinicians and patients, as well as patients who have multiple diagnoses or needs. However, efficacious studies utilize a controlled experimental research trial with specific artificial settings (Adult Mental Health Division, 2004).

Pinsof and Wynne (2000) and Addison, Sandberg, Corby, Robila, and Platt, (2002) reported that the problem with these efficacy studies is that there is slim resemblance to actual therapy. For example, when therapy is conducted in real-life settings, therapists often do not adhere to strict methods. In addition, clients bring in more complex issues than just one psychiatric disorder. These issues seem to be more of a problem as researchers attempt to improve randomized trials. The research study becomes even less like real-life settings. This leaves the academic field in a bind since one will not know the cause of an event or change unless one rules out other variables.

However, ruling out other variables creates a setting that does not reflect actual clinical practice.

Addison et al. (2002), based on Pinsof and Wynne's (2000) ideas surrounding efficacy and effectiveness, claimed that another perspective might be helpful. Perhaps by focusing more on effectiveness studies instead of efficacy studies, more integrated and practical methods could arise. In addition, Sprenkle and Piercy (2005) discussed a recently occurring trend in Marriage and Family Therapy (MFT) research: *pluralism*. This trend involves accepting alternative ways of conducting research, whether qualitative or quantitative, as valid.

In summary, a randomized clinical design utilizing an outcome survey method, an alternative and practical way of conducting effectiveness research, is a good fit for the current study. Outcome survey methods involve self-reports through surveys gathered from participants regarding their opinion of the product and result of treatment, therapy, etc. (Addison et al., 2002). Thus, effectiveness in the current study is defined as improvement reported by any member of the system, health care or family when seen by a Medical Family Therapist.

Strengths and Limitations of Research Design

This method is appropriate specifically for a population consisting of low income patients. For example, Pinsof and Wynne (2000) say that self-report measures for therapists and clients are less expensive and less time consuming. From experience working with low income populations in medicine, Cashman, Savageau, Lemay, and Ferguson (2004) noted that patients are often pressed for time, money, and transportation.

Therefore, a simple self-report measure such as a paper-pencil survey that can be administered during a medical visit or a telephone survey is a more appropriate method than perhaps interviewing or requesting patients to participate in laboratory settings, which can occur in quasi-experimental, qualitative, and case study research designs. In fact, Addison et al. (2002) expressed surprise that these simple surveys, which are relatively easy to administer, are not used more frequently to establish clinical outcomes. In addition, adding a few open-ended questions at the end of the surveys will provide a means for anecdotal evidence relating to the quantitative results of the study (Nelson & Allred, 2005). Thus, the current study gives patients a chance to explain their experience of agency and communion using their own words.

The longitudinal design, involving three time periods: time one-the initial data collection; time two-right after the doctor's visit; and time three-one week after the doctor's visit, also honors the patients' experience by providing additional opportunities for patients to add to their account of their experiences. Additional information regarding the sampling procedure is outlined below. Mullins, Junling, Cooke, Blatt, and Baquet (2004) examined the strengths and weaknesses of utilizing a longitudinal versus cross-sectional design. They found some advantages of a longitudinal design such as the fact that it follows patients over time, provides a more complete picture of a patient, and can include a large patient population.

There are also limitations to a longitudinal design. For example, Mullins et al. (2004) found that longitudinal designs call for more data, take a longer time to complete, are relatively more costly to implement, and include problems of attrition at follow-up. However, it is important to note that even though the longitudinal aspect of the research design does require more time, in the current study patients are not required to come back into the doctor’s office to take the survey and a time commitment of only one week later will be required. Also, the survey will be administered over the phone, reducing money and transportation issues. In addition, even though longitudinal designs can be costly and include possible loss of participants at follow-up, a chance at a more complete picture of a patient is worth the risk of losing participants at follow-up for the purpose of the current study.

There are also limitations with utilizing an outcome survey method. For example, self-report, as opposed to observational data, can lack reliability and validity since participants may answer questions depending on their possibly skewed view of their own functioning (Brouwer et al., 2005). However, since the purpose of the current study is to examine the effectiveness of Medical Family Therapy (MedFT) with vulnerable populations by evaluating patient agency and communion, it is important that patients are allowed to voice their own views. It is anticipated that additional possible research studies, such as observational evaluations of patient agency and communion, will emerge from the current study.

Therefore in summary, a randomized clinical design utilizing an outcome survey method will be implemented when researching the hypotheses outlined in the current study with a population of low-income medical patients. The particulars of the method including the randomized sampling process, measures and assessments, and analytic strategy are outlined below.

Sample

As mentioned earlier, the populations in the current study are medical patients dealing with low-income issues. The sample will consist of general medical patients receiving primary care from a medical clinic specifically assisting low-income individuals in southern California.

All participants who are willing to participate will be included. Since, as mentioned above, patients dealing with low-income often face issues of making time for non-necessary actions, only those who have the time and inclination will be asked if they are willing to participate.

Inclusion criteria will be as follows: All primary care patients that come to see the primary care doctor on the day of recruitment will be included in this study. All patients that are at least 18 years old will be included in this study. All patients that understand, speak, read, and write English will be included in this study.

Exclusion criteria will be as follows: Patients will be excluded if they do not understand, speak, read, and write English. Patients will be excluded if they are unable to comprehend and sign the informed consent for themselves due to any mental/cognitive impairment (and thus require legal guardianship). Patients will be excluded if they are minors. Patients will excluded if they do not finish filling out surveys at all three time points. Patients will be excluded if they no longer wish to participate in the study at any time. If a patient is delegated to the control group but during the study process starts to have a crisis (i.e. anxiety attack) and needs to be seen by the Medical Family Therapist immediately, then he or she will be excluded from the study. Patients will be excluded if the doctors' need to see them before they have finished filling out the first survey.

An a priori power analysis was conducted to determine a target sample size. Based on a power calculation for β = .95 with a priori effect size = .2, the current study requires a sample size of 94. Therefore, I will oversample by 40% to account for attrition and sample 150 participants, 75 will be assigned to the treatment group and 75 to the control group.

Sampling Procedure

Nelson and Allred (2005) as well as Fowler (2009) claim it is important to know why potential participants may not respond or participate when conducting surveys. For example, based on working with low income medical populations, patients sometimes do not keep their appointments. Also, as mentioned above, the U.S. Department of Health and Human Services (2003) found the following disparities in regards to preventative medicine: patients dealing with lower SES are less likely to be screened and educated. In regards to patient-health care provider relationships, patients dealing with lower SES report poorer communication. These issues often lead to a lack of medical compliance in this population. Therefore, mailing out another set of instructions for the entire population or even a randomly chosen sample of patients to follow in a survey, with no incentive, will most probably lead to a large number of non-respondents.

The sampling procedure most likely to produce an adequate number of participants involves asking patients whether they would be interested in participating when they come in to see the doctor and are waiting in the waiting room to be taken to the exam room. In this way, patients have the time and are also asked to refuse or assent to a live person with a face and feelings, providing some sort of incentive to participate.

Another incentive to participate that will be included in the current study is a chance to receive a gift through a drawing for a $100 gift certificate to WalMart. Participants will be eligible after they have completed all surveys in this longitudinal study.

Participants will be randomly chosen in that every other participant that checks in to see a primary care doctor, meets the inclusion criteria, and agrees to participate will be delegated to the treatment group. The participants not delegated to the treatment group will be delegated to the control group. For example, participant one will be part of the treatment group, participant two will be part of the control group, participants three will be part of the treatment group, participant four will be part of the control group, etc. The participants who are delegated to the control group will be informed that they have the option of receiving MedFT care after the study.

Since patient flow at the clinic consists of patients often waiting for longer periods of time in the waiting room, there is ample opportunity for researchers to identify and recruit patients. Also, it is important to note that the researcher that recruits participants will not be the Medical Family Therapist providing the therapeutic treatment to the participants.

The researcher who is recruiting participants will approach a participant after he or she has checked-in to see a primary care doctor in the waiting room and will say: “Hello. I am researcher from Loma Linda University conducting a study about patient experiences. Would you like to know more about being a part of this study?” If yes, then: “This study would involve taking a survey about your experiences here at this clinic. You would take a survey before seeing the doctor while you are waiting in the waiting room, after seeing the doctor while you are waiting for your prescriptions, and through a phone call one week later. Each survey should take about 20 minutes. If you would like to be a part of this study and after taking all three surveys, you will be eligible for a $100 Wal-Mart gift card drawing. Please feel free to let me know if you would not like to be a part of this study. Do you have any questions? Would you like a minute to yourself to think about this?"

If they say they would not like to participate, the researcher will thank them for their time and wish them a good day. If they say they would like to participate, the researcher will hand them the first survey packet which includes the informed consent and would say: "Please look the informed consent over and let me know if you have any questions at all. You can choose to discontinue being a part of the study at any time and I will be available for any questions throughout the doctor's visit. Also, please remember that we are looking for your first response to these questions. Do not feel like you have to spend too much time thinking about your answer."

If the researcher who recruits patients in the waiting room delegates the participants to the treatment group, he or she will notify the Medical Family Therapist who is waiting near the exam rooms that the patients will need to receive treatment. If the researcher delegates the participants to the control group, he or she will notify the therapist that the patients will not be eligible to receive treatment until after the follow-up a week later.

After the participants in the treatment group fill out the necessary information, the therapist will enter the session. After the doctor's visit, both the treatment and control group participants will be handed the surveys again. One week later, the researcher will call and administer the surveys to both groups a third time over the phone.

Medical Family Therapists Utilized in the Study

It is important to note that the three Medical Family Therapists, also known as Medical Family Therapy Interns (MedFTI), utilized in the current study, including this author, have completed class work from Loma Linda University in a concentration program for MedFT. Classes include *Social Context of Health, Health and Illness in Families, Family Therapy and Medicine, and Special Projects in Families, Systems, and Health.* In addition, all three MedFTIs are currently working in the clinic and are required to work as a MedFTI for a minimum of 10 hours a week. One MedFTI has worked at since October 2010, another since August 2011, and the third since May 2012. All MedFTIs have been informed of the current study and have agreed to participate in providing therapeutic treatment as well as administering the survey when this author is the therapist providing treatment for the required 10 hours a week.

It is also important to note that the clinic has been notified of this research study proposal and is willing to allow access to the patient population pending Institutional Review Board approval.

Medical Family Therapy Interventions

Since MedFTIs at this clinic usually spend varied amounts of time with patients and utilize several MedFT and MFT interventions, fidelity of treatment will need to be assured. To create treatment fidelity, all MedFTIs will fill out a check-list after seeing each participant assigned to the treatment group. The check-list will include the following questions and statements:

1. Approximately how much time did you spend with the patient(s)?

2. Please check all the Medical Family Therapy interventions that were used in this session.
3. Please circle a number to indicate the overall “amount” of typical MedFT interventions and processes you felt you provided for this patient(s). A score of 10 indicates that you provided the most concentrated amount of MedFT in this session.

Regarding MedFT interventions that will be utilized by the MedFTIs, there are several integral and specific interventions outlined in McDaniel, Hepworth, and Doherty (1992). They include soliciting the illness story; increasing a sense of agency in the patient; maintaining communication; recognizing the biological dimensions; respecting defenses, removing blame, and accepting unacceptable feelings; attending to developmental issues; and leaving the door open for future contact.

All MedFTs will be required to utilize the first three interventions: soliciting the illness story; increasing a sense of agency in the patient; and maintaining communication, as they are described in McDaniel et al. (1992). These three interventions will be utilized for every patient because they directly relate to the goals of increasing a sense of agency and communion and are foundational aspects of conducting MedFT. The other four interventions will be listed as optional interventions.

The question regarding the overall “amount” of typical MedFT interventions and processes provided pertains to the “dose” of MedFT given to the participant. Since as mentioned earlier, time spent with patients vary, the dose will assist in assessing for differing scores on research variables and effectiveness at differing levels of therapy.

Measures

The demographic sheet that the participants initially fill out will include questions regarding the following factors: gender, age, ethnicity, current monthly income, completed level of education, physical and psychological diagnosis if applicable, number of previous visits with MedFTI (labeled Family Health Consultant at the clinic), and number of visits to the doctor yearly (see Appendix). These factors will provide information about SES and severity of illness, possible influential factors when considering agency and communion.

Regarding the outcome variables, agency and communion, there are various instruments that measure these concepts. The Extended Personal Attributes Questionnaire (E-PAQ) measures agency, communion, and unmitigated agency (Trudeau, Danoff-Burg, Revenson, & Paget, 2003). The Revised Unmitigated Communion Scale (RUCS) has been identified as an adequate measure for unmitigated communion (Voci & Cramer, 2009). The E-PAQ and the RUCS are the most widely used and accepted assessment of agency and communion (Trudeau et al.). However, these instruments measure agency and communion in the context of personality traits and so will be utilized to rule out possible co-varying variables. Also, it is important to note that the measures described above have not been tested on various cultures and SES levels (Shih-Ming, Li-Chung, Chin-Sheng, & Ciou-Jhen, 2007). The populations tested with these assessments have mostly consisted of the western dominant culture, e.g. Caucasian, middle SES.

Measures pertaining to diverse, low SES populations will be utilized to examine outcome variables in the current study, i.e. the MOM Empowerment Scale (MOMES), the Social Support Index (SSI), the Patient Satisfaction with Health Care Provider Scale

(PS), and the Brief Symptom Inventory-18 (BSI-18). These measures are discussed in more detail below.

Measuring Agency

MOM Empowerment Scale (MOMES)

The MOMES (Kovach, Becker, & Worley, 2004), an appropriate empowerment measure for diverse, low-income populations, was originally designed to measure the before and after relationship between empowerment in pregnant, high health risk patients and their participation in a specific program. However, Kovach et al. (2004) asserted that this scale may be used in other treatment evaluations. Items are on a 5-point Likert scale, e.g. from *not very confident* to *extremely confident*, with items such as "Define your own needs" and "Decide what to do based on your needs" (see Appendix B). Empowerment in the MOMES consists of three dimensions: self-sufficiency, (SS), self-determination (SD), and decision-making skills (DM).

The MOMES was developed and tested with a sample of 244 women from African American and Latina backgrounds as well as Caucasians (Kovach et al., 2004). A large percentage of this sample was low-income in that they were receiving welfare benefits. The MOMES is scored by summing up item scores on each subscale and dividing subscale scores by three for an overall empowerment score. Higher scores reflect a sense of greater patient empowerment. Also, the internal consistency is adequate with alphas of .87 for SS, .83 for SD, and .77 for DM (Kovach et al.). The MOMES is reported to be very sensitive to change following interventions. Lastly, this author created a few open-ended questions that will be included with the MOMES to evaluate patient empowerment.

Measuring Communion

Social Support Index (SSI)

The SSI (McCubbin, Patterson, & Glynn, 1996) is a 17-item survey based on a 5-point Likert scale designed to measure the degree to which families find support in their communities. This focus is particularly important for the current study since social support in medical communities is the variable being measured. Therefore, SSI measures the patient's perceived social support within their community, i.e. medical, family, and friendship.

McCubbin et al. (1996) reported that the SSI has been used with thousands of families from diverse ethnic backgrounds and SES's. The scoring for the SSI consists of summing all items after reverse scoring to ensure the same, positive directionality. An example of an item is, "I have friends who let me know they value who I am and what I can do" with answers ranging from *strongly disagree* to *strongly agree*. Higher scores reflect an increased sense of social support.

The internal consistency for the SSI is adequate with an across-sample alpha of .82. The test-retest correlation reports adequate stability with .83 (McCubbin et al., 1996). Also, the concurrent validity is adequate as correlated with criterion of family well-being. Lastly, this author created a few open-ended questions that will be included with the SSI to evaluate patient social support.

It is important to note that the SSI was re-worded by this author to reflect assessment of the medical community and not just the community in general. The re-worded SSI was handed out to potential patients (*n* = 10) and feedback was requested regarding ease of understanding.

Patient Satisfaction with Health Care Provider Scale (PS)

Since patient satisfaction has been an outcome variable for studies related to the benefits of MedFT (Sellers, 2000; Yeager et al., 1999), patient satisfaction will also be considered a measure of communion in the current study for replication purposes. The Patient Satisfaction with Health Care Provider Scale (PS) was designed to measure patient satisfaction with health care providers from primary care settings (Marsh, 1999, see Appendix). The PS has adequate internal consistency with a total scale Cronbach's alpha of .93 (Marsh, 1999).

Measuring Psychological Distress

Brief Symptom Inventory-18 (BSI-18)

The third and final outcome variable in this current study, psychological distress will be measured by the BSI-18 (Galdón et al., 2008). The BSI-18 is frequently used with women and cancer-survivors to assess psychological distress within three dimensions: somatization, depression, and anxiety. The internal consistency of the BSI-18 is adequate with a Cronbach's alpha of .82. Items include, “thoughts of ending your life” and “spells of terror or panic” and are rated on a 5-point Likert scale ranging from *not at all* to *always*. Higher scores reflect increased psychological distress. Also, the BSI-18 has been sampled with diverse populations.

Measuring Interacting and Indirect Variables

Patient Satisfaction with Health Care Provider Scale (PS)

Varied instruments are also considered when ruling out mediating and moderating variables. Regarding relationship factors and patient motives, the Patient Satisfaction with Health Care Provider Scale (PS) will also be used as a covariate. This scale will give additional information regarding the relationship the patient has with the provider, ruling out relationship factors and patient motives when interacting with health care providers as co-varying variables.

E-PAQ and RUCS

In terms of assessing for personality factors, i.e. sex roles, self-esteem, and coping styles, the E-PAQ and the RUCS not only measure agency and communion, they also measure unmitigated agency and communion. These terms can be referred to as extreme masculine and feminine orientations. The scores will shed light on the patient's adherence to gender scripts and personality type.

The E-PAQ (Spence, Helmreich, & Holahan, 1979) had adequate internal consistency with Cronbach's alphas between .75 and .79 (Ghaed & Gallo, 2006), and included items such as "Not at all arrogant" to "Very arrogant". Participants marked how much they felt the statements described them based on a five-point scale. The RUCS includes nine items on a five-point Likert scale (Fritz, & Helgeson, 1998). Sample items include: ‘‘I often worry about others’ problems’’. Internal consistency reliability was adequate with a Cronbach’s alpha of .66 (Ghaed & Gallo, 2006).

Analytic Strategy

The measures and assessments used greatly influence the analytic strategy of a study. Each quantitative measurement in the current study such as the MOMES, SSI, etc. provide continuous variables, or variables that do not fall in categories and can contain values in between observed values (Gravetter & Wallnau, 2009). In addition, the current study is investigating group differences. Meaning quantitatively, the control group will report significantly different scores than the treatment group. Also, there is one independent variable (IV) with two categories, treatment group and control group, and three dependent variables (DV)s, agency, communion, and psychological distress identified in this study.

Consequently, analytic strategies such as a repeated measures MANOVA, and a multivariate analysis of covariance, or MANCOVA are considered appropriate (Mertler & Vannatta, 2010). As Mertler and Vannatta report, a MANOVA is employed to simultaneously study two or more related DV’s while controlling for the correlations among the DV’s. A MANCOVA, however, explores group differences among several DV’s while also controlling for covariate(s) that may influence the DV’s. In this way, the researcher can analyze whether the treatment group and control group scores on agency and communion are truly different, accounting for MedFT, and also whether co-varying variables are influencing whether or not the groups are significantly different.

Regarding demographic variables, demographic variables will be analyzed for means and percentages. Regarding the timed sequence in which data are collected three times, repeated measures MANOVA will be used to determine whether scores changed over time. Time one-the initial data collection, time two-after the doctor's visit, and time three-one week later, can be compared for the treatment group as well as the control group. Then the amount of score changes for treatment group and control group can be viewed and contrasted.

Regarding the open-ended questions, themed grouping of participants' words regarding their experience with their health care providers in relation to agency and communion will be conducted. For example, possible sentences discussing not wanting to take up too much of the provider's time can be grouped and categorized as time influences on agency and communion. Thus, the hypotheses of the current study based on specific measurements are as follows.

1. Treatment and control groups will be significantly different per the repeated measures MANOVA regarding overall scores on the MOMES, SSI, PS, and BSI-18 at Time 2 and Time 3.
2. Covariates measured by E-PAQ, RUCS, and PS will not co-vary significantly with scores from MOMES, SSI, and BSI-18 per MANCOVA and covariates measured by E-PAQ and RUCS will not co-vary significantly with scores from PS.
3. Treatment group will have higher mean scores on MOMES than control group.
4. Treatment group will have higher mean scores on SSI than control group.
5. Treatment group will have higher mean scores on PS than control group.

6. Treatment group will have lower mean scores on BSI-18 than control group.
7. Treatment group will report improved agency, communion, and psychological distress in self-report anecdotal data than control group.

In addition, the five hypotheses outline in Chapter One will be tested as follows.

1. The treatment group, patients that receive MedFT, will have higher scores on agency in comparison to the control group, or patients that receive care as usual without MedFT, as tested by a repeated measure MANOVA.
2. The treatment group, after receiving MedFT, will have higher scores on communion in comparison to the control group, as tested by a repeated measure MANOVA.
3. The treatment group, after receiving MedFT, will report improved agency and communion in self-report anecdotal qualitative data in comparison to the control group, as concluded by categorical grouping of qualitative data.
4. The treatment group, after receiving MedFT, will have lower scores on psychological distress, meaning somatization, depression, and anxiety symptoms, in comparison to the control group, as tested by a repeated measure MANOVA.
5. The treatment group participants who had higher "doses" of MedFT will have higher scores on agency and communion, and lower scores on psychological distress, as tested by a Linear Regression.

In summary, first the demographic variables will be analyzed with percentages of each demographic variable outlined and means for each continuous variables provided. Then a MANOVA will be utilized to analyze group difference with two independent variables, treatment versus control group and time, and three dependent variables, agency, communion, and psychological distress. After that, a MANCOVA will be utilized to assess for co-variations with the personality factors of communion, agency, and relationship with provider. If the MANOVA shows group differences and the MANCOVA is able to account for co-variance and still show group differences, then the Linear Regression will be the final model that pin points what was the reason for the group difference, based on the MANOVA's Ad Hoc test and will test for differences in scores based on MedFT “dosage”.

Limitations

As with every research study, there are limitations that arise pertaining to the method and definitions used. First, the sample may not represent the population due to the sampling procedure. Second, gaining data by self-report can be problematic in terms of bias on the participants’ part.

MedFT is rooted in systemic thinking, or general systems theory (GST) (Bertalanffy, 1968). Expounding on GST is beyond the scope of this paper. For a simplified and applicable version as pertaining to family therapy, see Sprenkle and Blow (2004). Nevertheless, because MedFT is rooted in GST, research conducted on MedFT effectiveness must take a GST view into consideration. For example, from a systemic perspective the therapist impacts therapy as much as the client does. There is no one cause for one behavior. Each interaction is reciprocal, a two-way street (Sprenkle & Blow, 2004). Therefore the treatment becomes individualized and unique; a problem when trying to figure out what the therapist is doing that influences change (Pinsof & Wynne, 2000). Actually, the question should be: What are the therapist and client(s) doing together? The challenge when answering this question is that the answer can change from moment to moment, case to case.

Also, this reciprocal way of viewing relationships is a problem for researchers because when asking only one member of the system to express their experience, such as the patient, the researcher only gets a one-sided glimpse of what is really occurring (Copeland & White, 1991). For this reason, family therapists often include as many significant individuals as possible in therapy (Sprenkle & Blow, 2004). Family therapists and MedFTs seek to understand the whole picture. However, the researcher often does not have the monetary luxury or the statistical analysis tools necessary when asking more than one or two significant individuals related to the patient to answer questions and participate in the study (Copeland & White, 1991). For these reasons, conducting research with a GST framework is a challenge.

Thus, according to GST this current study is limited in that it only asks the patient's perspective and not the health care providers', families', etc. In addition, any MedFT effectiveness study must deal with the issue of non-uniformity. There is no one way to conduct MedFT due to its lack of standardized interventions. Therefore each therapist might do some things differently. The results from this possible study should be viewed with these limitations in mind.

Implications

The purpose of the current study is to investigate the hypothesis that MedFT is effective with vulnerable populations in terms of increasing a sense of agency and communion and decreasing psychological distress. It is anticipated that the results of the current study will provide additional information in three areas of scholarly research: biopsychosocial model of health care, behavioral integration in health care, and health disparities in health care.

Since MedFT is based on a biopsychosocial model, the effectiveness of MedFT will lend further evidence that this model is an important adjunct to quality health care. In this day and age of health care industries and patients as consumers, researchers are continually asking for quality health care. Perhaps the current study will add to the growing body of literature by supporting the claim that a more holistic perspective is beneficial (World Health Organization, 1998, World Health Organization, n.d.). In this way, the current study may also create evidence for the inclusion of MedFT in health care. Also, the current study may have implications for further research. MedFT practitioners can take the next step and begin identifying practices which are more effective than others.

In addition, the current study may place a spotlight on health care disparities in that the effectiveness of MedFT with vulnerable populations can be seen as a way to combat health disparities. Also, additional studies concerning interventions that battle health care disparities can spring from the current study.

CHAPTER FIVE

PUBLISHABLE PAPER

A STUDY OF BRIEF SINGLE SESSION MEDICAL FAMILY THERAPY WITH LOW-INCOME PATIENTS

A Study of Brief Single Session Medical Family Therapy with Low-Income Patients

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Abstract

Medical Family Therapy (MedFT) has been promoted as beneficial for vulnerable patient populations. However, there is a need for MedFT effectiveness studies with longitudinal randomized control trials. Thus, this pilot study investigated the results of a brief single session of MedFT over a one-week period with low-income primary care patients. Effectiveness in this study was defined as increasing a sense *agency* and *communion* and decreasing *psychological distress*. Results suggested that over time, MedFT may increase some sense of agency for lower-income patients, increase patient satisfaction with care, increase family support for patients with higher education, and decrease depression symptoms for various ethnic groups. Limitations, implications, and future research were also discussed.

Keywords: Medical Family Therapy, effectiveness, low-income patients, agency, communion, psychological distress

A Study of Brief Single Session Medical Family Therapy with Low-Income Patients

Someone to tell it to is one of the fundamental needs of human beings. ~Miles Franklin.

Medical Family Therapy (MedFT) focuses on enhancing relationships among patients, families, and health care professionals (McDaniel, Hepworth, & Doherty, 1992). In particular, MedFT uses a biopsychosocial framework to provide systemic behavioral health treatment (McDaniel, Campbell, Hepworth, & Lorenz, 2005; McDaniel & Hepworth, 2000; Mendenhall, Pratt, Phelps, & Baird, 2012; Willerton, Dankoski, & Martir, 2008). Various researchers and clinicians have promoted the use of MedFT in health care (Davey, Duncan, Foster, & Milton, 2008; Hughes, Hertlein, & Hagey, 2011; Ragaisis, 1996; Sellers, 2000). However, there is a need for MedFT effectiveness studies with longitudinal randomized control designs (Linville, Hertlein, & Lyness, 2007; Mendenhall et al., 2012). MedFT has not been established as an empirically validated treatment, although there is evidence for effectiveness with various populations (Cutler & Everett, 2010; Pignone et al., 2002; Ragaisis, 1996; Sellers, 2000), including vulnerable populations, i.e. HIV/AIDS patients (Davey et al., 2008).

Low-income patients are a particularly vulnerable population because they often receive poorer quality of care and report lower satisfaction with care (Collins, 2010; DeVoe, Wallace, Pandhi, Solotaroff, & Fryer, 2008; Jensen, King, Guntzviller, & Davis, 2010; U.S. Department of Health and Human Services, 2003). MedFT may aid in addressing this health disparity as MedFT goals include increasing a sense of patient agency or empowerment and communion or social support (McDaniel et al., 1992). Thus, the purpose of this study is to examine the effectiveness of MedFT with low-income patients. Effectiveness in this study is defined as increased agency and communion and decreased psychological distress.

Conceptual Framework

This study is conceptualized and viewed from an integration of Feminist Medical Family Therapy (FMFT) and the Resiliency Model of Family Stress, Adjustment, and Adaptation (RM) lens. FMFT stems from a feminist approach combined with systemic thinking and MedFT influences (Burwell, Templeton, Kennedy, & Zak-Hunter, 2008; Prouty Lyness, 2003). It highlights the influence of societal power and gender socialization on the treatment and management of illnesses (Burwell et al., 2008; McDaniel & Cole-Kelly, 2003; McDaniel & Hepworth, 2003; Prouty Lyness, 2003). RM is a strengths-based approach that addresses resilient ways individuals and families handle stress and crisis, such as when one or more members are dealing with illnesses (Fekete, Stephens, Mickelson, & Druley, 2007; McCubbin & McCubbin, 1993, 1996; Saba, 1999). RM stresses the idea that people adjust and adapt through connections with the community as well as within the family system (McCubbin & McCubbin, 1993, 1996).

Medical Family Therapy Effectiveness

A conceptual framework and previous literature on the benefits of MedFT provided the foundation for this study. Numerous studies within as well as outside of the family therapy field have provided support for the effectiveness of MedFT (Campbell, 2003; Crane & Christenson, 2012; Kazak et al., 2005; Northouse, Kershaw, Mood, &

Schafenacker, 2005; Phelps et al., 2009; Ragaisis, 1996; Sellers, 2000; Tyndall, Hodgson, Lamson, White, & Knight, 2012a; Yeager et al., 1999). Tyndall et al. (2012a), in particular, have provided a concise literature review of evidence for MedFT. They conclude that health care professionals, as well as patients report increased satisfaction with health care services when MedFT is involved (Hodgson, McCammon, Marlowe, & Anderson, 2012; Sellers, 2000; Yeager et al., 1999). In addition, Northouse et al. (2005) found patients and families reported less hopelessness and less negative reactions to the presence of illness when family interventions were utilized.

Agency, Communion, and Psychological Distress

Significant outcomes thought to be associated directly with MedFT are agency and communion (McDaniel et al., 1992). Thus this study examined the two outcomes of MedFT, increasing a sense of patient agency and communion (McDaniel et al., 1992). There are various definitions of agency and communion (Mackrill, 2009). However, MedFT founders defined agency as “a sense of making personal choices in dealing with illness and the health care system” (McDaniel et al., 1992, p. 9). Communion involved a “sense of being cared for, loved, and supported by a community of family members, friends, and professionals” (McDaniel et al., 1992, p. 10). In other words, agency is the sense of being empowered when dealing with illness and the health care system. Communion is the sense of being socially supported not only by family and friends but also by the medical community. Accordingly, patient satisfaction with care is an important aspect of feeling supported by the medical community.

The third outcome variable in this study, psychological distress, is defined as symptoms of somatization, depression, and anxiety (Galdón et al., 2008). Somatization is defined as "discomfort produced by the perception of [physical symptoms]" such as nausea and pain. Depression symptoms include "symptoms commonly related to depression, such as apathy, sadness, and thoughts of suicide". Anxiety symptoms include "feelings of fear, general nervousness, and even panic" (Galdón et al., 2008, p. 534).

Research Questions

There are five research questions that guided the exploration of agency, communion, and psychological distress. These are: 1. Do participants in the treatment group have increased scores on agency in comparison to the control group? 2. Do participants in the treatment group have increased scores on communion in comparison to the control group? 3. Do participants in the treatment group have decreased scores on psychological distress in comparison to the control group? 4. Does the "dose" of MedFT correlate with agency, communion, and psychological distress scores? 5. Do participants in the treatment group report improved agency and communion in response to open-ended questions when compared to the control group?

Method

This study utilized a longitudinal randomized clinical trial design with an outcome survey method. The longitudinal design involved three time periods: Time one (T1)—the initial data collection right before the visit with the doctor; Time two (T2)—right after the visit with the doctor; and Time three (T3)—one week after the visit with the doctor. Outcome survey methods consisted of self-reports gathered through surveys. Randomization was accomplished by systematically assigning participants to the treatment group or the control group, e.g. participant one was assigned to the treatment group, participant two was assigned to the control group, etc.

Defining Medical Family Therapy

MedFT has been practiced in various settings with various targeted populations (Tyndall, Hodgson, Lamson, White, & Knight, 2012b). In fact, there are challenges associated with researching MedFT effectiveness, particularly because there is no clear consensus regarding what constitutes MedFT (Campbell, 2002; Linville et al., 2007, Mendenhall et al. 2012; Tyndall et al., 2012a,b). There are varying opinions about whether MedFT is a profession with a specific model or an orientation, a way of thinking (Tyndall et al., 2012b). For example, MedFT has been viewed as a sub-specialty within Marriage and Family Therapy (MFT) (Mendenhall et al., 2012). Others promote the idea that many clinicians and not only those in the field of behavioral health can and are practicing MedFT (Bischoff, Springer, Felix, & Hollist, 2011, a perspective the founders of MedFT strongly encourage (Jacobs, 2012). In this study, MedFT is defined as family therapists working from a MedFT knowledge base in a medical setting (cf. Fox, Hodgson, & Lamson, 2012).

Medical Family Therapy On-Site

Family therapists, called Medical Family Therapy Interns (MedFTI) worked in the primary care unit of a Federally Qualified Health Center (FQHC) where this study was conducted. This community health center focused on serving the uninsured, low-income patient population in part of southern California. The primary care unit typically provided care for adults dealing with chronic and comorbid conditions such as hyperlipidemia, hypertension, diabetes, asthma, etc. (cf. Ostbye et al., 2005; Tinetti, Fried, & Boyd, 2012). MedFTIs were on-site, meaning available to consult on a face-to-face basis whenever primary care physicians needed them. In addition, the amount of time spent with patients was flexible, anywhere between 5-60 minutes. Also, the practice of MedFT at this clinic was very similar to the practice of MedFT cited in Marlowe, Hodgson, Lamson, White, & Irons (2012). The MedFTIs regularly interacted with new and returned patients regardless of their diagnoses. They introduced MedFTI, elicited the illness story, provided interventions, and relayed pertinent information to the primary care doctor. It is important to note that the MedFTIs working in this clinic had completed master's level and doctorate level class work from a university that included 11 of the 12 courses recommended in Tyndall et al. (2012b) for MedFT academic training.

Procedure

The data in this study was collected on a primary care unit at a community medical clinic that specifically focused on serving underserved populations, such as individuals dealing with low-income and MedFT. Before joining the study and filling out the instruments, participants were randomly assigned to the treatment or control group. Every other participant in the waiting room that checked-in to see a primary care doctor and agreed to participate through the informed consent procedure was assigned to either the treatment or control group. If the researcher assigned the participant to the treatment group, he or she notified the MedFTI that the patient needed to receive treatment. If the researcher assigned the participant to the control group, he or she notified the MedFT that the patient was not eligible to receive treatment until after the follow-up a week later. Before and after the doctor's visit, both the treatment and control group participants were handed the same surveys regarding agency, communion, and psychological distress. One week later, a researcher called and administered the third survey over the phone to any participant that completed the first and second surveys.

Treatment Dose

To establish some fidelity of treatment, the MedFTI filled out a check-list after treating each participant assigned to the treatment group. The check-list included questions about how much time the MedFT spent with a patient, what interventions were used, and the "dose" of MedFT. Dosage refers to the amount of MedFT the MedFTI felt was provided. It's a subjective 1 to 10 scale with 10 being "I provided the most concentrated amount of MedFT in this session".

Regarding MedFT interventions that were utilized, there are several integral and specific interventions outlined in McDaniel et al. (1992). These interventions are all family focused in that they acknowledge family influence on individual health (McDaniel et al., 2005). They include soliciting the illness story; increasing a sense of agency in the patient; maintaining communication; recognizing the biological dimensions; respecting defenses, removing blame, and accepting unacceptable feelings; attending to developmental issues; and leaving the door open for future contact. Definitions and examples of these interventions are provided in Hughes et al. (2011), McDaniel et al. (1992), and Mendenhall et al. (2012).

The MedFTI was required to utilize the first three interventions. These interventions included: 1. soliciting the illness story, 2. increasing a sense of agency in the patient, and 3. maintaining communication. These three interventions were required because they are foundational aspects of conducting MedFT (Bischoff et al., 2011). The other four interventions were listed as optional interventions and were utilized more often than not, depending on timing and need.

Measuring Outcome Variables

Demographic data and outcome data were measured with specific questions and instruments. Agency, social support, and psychological distress scores were measured by the MOM Empowerment Scale (MOMES), the Social Support Index (SSI), the Patient Satisfaction with Health Care Provider Scale (PS), and the Brief Symptom Inventory-18 (BSI-18), respectively.

Measuring Agency

The MOM Empowerment Scale (MOMES) is an appropriate empowerment measure for diverse, low-income populations (Kovach, Becker, & Worley, 2004). It consists of 21 items on a 5-point Likert scale, e.g. from not very confident to extremely confident, with items such as “Define your own needs” and “Decide what to do based on your needs”. The MOMES has three sub-scales: self-sufficiency, (SS), self-determination (SD), and decision-making skills (DM). The internal consistency is adequate with alphas of .87 for SS, .83 for SD, and .77 for DM (Kovach et al., 2004). Two open-ended questions regarding a sense of empowerment were also asked in order to gather anecdotal data.

Measuring Communion

The Social Support Index (SSI) (McCubbin, Patterson, & Glynn, 1996) is a 17-item survey based on a 5-point Likert scale. It is designed to measure individual's perceived social support within their community. McCubbin et al. (1996) reported that the SSI has been used with thousands of families from diverse backgrounds. An example of an item is, "I have friends who let me know they value who I am and what I can do" with answers ranging from strongly disagree to strongly agree. The internal consistency for the SSI is adequate with an across-sample alpha of .82. The test-retest correlation reports adequate stability with .83 (McCubbin et al., 1996). Also, the concurrent validity is adequate as correlated with criterion of family well-being. It is important to note that the SSI was re-worded by this author to reflect assessment of the medical community and not just the community in general. The re-worded SSI was handed out to potential patients (n = 10) and feedback was requested regarding ease of understanding. Thus, scores within SSI include medical community support (MC), family support (FAM), and friend support (FRND).

In addition, the Patient Satisfaction with Health Care Provider Scale (PS) is an 18-item survey based on a 5-point Likert scale designed to measure patient satisfaction with health care providers from primary care settings (Marsh, 1999). Thus the PS also measured patients' sense of support through statements such as "My health care provider always does his or her best to keep me from worrying” and “My health care provider always treats me with respect.” The PS has adequate internal consistency with a total scale Cronbach's alpha of .93 (Marsh, 1999). Two open-ended questions regarding a sense of social support were also asked in order to gather anecdotal data.

Measuring Psychological Distress

The third and final outcome variable in this current study, psychological distress was measured by the Brief Symptom Inventory-18 (BSI-18) (Galdón et al., 2008). The BSI-18 has been sampled with diverse populations and includes three dimensions: somatization (SOMA), depression (DEP), and anxiety (ANX) symptoms. The internal consistency of the BSI-18 is adequate with a Cronbach's alpha of .82. Items include, “feeling blue” and “spells of terror or panic” and are rated on a 5-point Likert scale ranging from not at all to always.

Data Analysis

After completing data collection, data were entered into SPSS and analyzed. Data were screened to ensure that the assumptions of univariate statistics were fulfilled (Tabachnick & Fidell, 2011). Through this screening it was noted that the overall MOMES empowerments score and BSI-18 anxiety, depression, and somatization symptoms scores were skewed and therefore transformed to meet univariate normality assumptions.

Four processes were used to test the five research questions. First, two-way repeated measures ANOVAs were used to test whether the treatment provided differences in agency, communion, and psychological distress scores over three time points (T1, T2, T3). Second, multi-way repeated measures ANOVAs were used to test whether the difference from the treatment changed in the presence of the control variables (such as gender, age, ethnicity, SES, education, employment status, and annual income). Due to the limited sample size, demographics were grouped to maintain adequate power in analyses. Third, to address research question four, MedFT dose was analyzed utilizing a correlation, examining the relationship between dose and outcome scores. Fourth, to address research question five regarding the open-ended questions, participants' answers were reviewed utilizing a general inductive approach (Thomas, 2006) in relationship to the findings from the above steps.

Results

Of the 112 participants that were enrolled in the study, 68 (60.7%) completed T1 and T2 surveys with 36 in the treatment group and 32 in the control group. In addition, 42 participants completed all three time point measurements with 21 in the treatment group and 21 in the control group. A Pearson's chi-square test for categorical variables and *t*-test for continuous variables found that all demographic variables, except income, were not significantly different between groups. Refer to Table 1 for demographic percentages and test results.

Table 1

Grouped sample characteristics

	Treatment (n = 21)	n	Control (n = 21)	n	χ^2
			Individual Identification Characteristics		
Gender					.000
Male	33.3%	7	33.3%	7	
Female	66.7%	14	66.7%	14	
Age					.382
Younger than 45 years	52.4%	11	42.9%	9	
Older than 45 years	47.6%	10	57.1%	12	
Ethnic Classification					.286
Hispanic/Latino	44.4%	8	52.6%	10	
Black/African American	22.2%	4	21.1%	4	
Caucasian/White	33.3%	6	26.3%	5	
			Socio-Economic Status Characteristics		
Education Completed					1.714
Before high school	23.8%	5	42.9%	9	
After high school	76.2%	16	57.1%	12	
Employment Status					.008
Employed	25.0%	5	23.8%	6	
Unemployed	75.0%	15	76.2%	16	
Annual Income					*5.068
Less than $10,000	25.0%	5	61.1%	11	
Greater than $10,000	75.0%	15	38.9%	7	
	M(SD)		M(SD)		*t*
Previous visits with MedFT	.67 (1.30)		.17 (.39)		-1.274
Annual doctor's visits	2.53 (1.67)		3.07 (1.49)		.971
Number of physical illness diagnoses	2.00 (1.92)		1.33 (1.14)		-1.284
Number of mental illness diagnoses	.33 (.77)		.26 (.45)		-.341

*$p < .05$

Of the 42 participants, a large majority were women (n = 28) and were unemployed (n = 31). Most participants identified as Hispanic (n = 18) and completed some education after high school (n = 28). In addition, the age range was 18-69. Since the mean and median age was very close to 45 and the sample size was limited, age was grouped into older and younger than 45 to analyze group differences. After removing three outliers ($\geq$10) for number of previous visits with the MedFTI, the mean number of previous visits with the MedFTI at any time and number of mental illness diagnoses was less than one. Outliers were determined by eliminating numbers more than double the largest number without outliers.

The following numerical results for agency, communion, and psychological distress are displayed in the tables and figures below. The first table presents the repeated measures ANOVA results for outcome variables after controlling for individual identification sample characteristics. The second table presents the repeated measures ANOVA results results for outcome variables after controlling for SES sample characteristics. The subsequent table and figures show interaction effects and then anecdotal results.

Agency

Research question one: Do participants in the treatment group have increased scores on agency in comparison to the control group?

A two-way repeated measures ANOVA of changes in overall MOMES empowerment scores was conducted first, followed by an examination of the subscales within the MOMES. For the overall MOMES score from T1 to T3 there was a significant

Time effect, $F(2, 80) = 8.410$, $p < .001$, $\eta^2 = .174$; but not a TimeXGroup interaction effect, $F(2, 80) = .173$, $p = .841$. In addition, a repeated measures ANOVA of changes in overall MOMES empowerment scores from T1 to T3 after controlling for grouped demographic variables did not reveal TimeXGroup interaction effects (See Table 2, 3). Thus overall empowerment scores did improve, but not due specifically to the treatment, rather, as noted by the time effect, all participants reported an increase in empowerment between T1 and T2, $F(1, 40) = 4.147$, $p < .001$, $\eta^2 = .094$, and between T2 and T3, $F(1, 40) = 6.972$, $p < .05$, $\eta^2 = .148$.

When examining MOMES subscales, self-determination (SD), $F(2, 60) = 4.033$, $p < .05$, $\eta^2 = .119$, and decision-making skills (DM), $F(2, 56) = 3.175$, $p < .05$, $\eta^2 = .102$, scores had a significant interaction with the treatment group and annual income. All participants had increased SD and DM scores between T1 and T3, with a TimeXGroupXAnnual Income significant improvement for SD scores between T2 and T3, $F(1, 30) = 8.954$, $p < .01$, $\eta^2 = .230$ and a TimeXGroupXAnnual Income significant improvement for DM scores between T2 and T3, $F(1, 28) = 7.371$, $p < .05$, $\eta^2 = .208$. Thus, participants in the treatment group who reported the lowest annual income also reported the most increase in SD and DM scores (See Figure 1, 2).

Table 2

Adjusted means and standard deviations with individual identification sample characteristics

	Empowerment	Self-Sufficiency (SS)	Self-Determination (SD)	Decision-Making Skills (DM)	Social support	Medical Community Support (MC)	Family Support (FAM)	Friend Support (FRND)	Patient Satisfaction (PS)
Treatment									
T1	3.08(.21)	34.78(1.86)	11.68(.40)	27.53(.80)	64.66(1.78)	20.53(1.02)	21.69(1.02)	19.01(.73)	62.24(2.63)
T2	2.97(.20)	35.10(1.86)	11.82(.54)	28.67(.79)	61.38(2.45)	22.29(.93)	20.85(.93)	18.09(.76)	65.22(1.96)
T3	2.76(.17)	34.66(1.74)	12.63(.38)	29.15(.65)	62.56(2.50)	22.30(.72)	21.52(1.11)	19.39(.55)	64.84(2.08)
Control									
T1	2.77(.20)	38.00(1.78)	12.32(.36)	27.89(.72)	61.17(1.73)	23.23(.97)	22.86(1.02)	19.37(.74)	68.04(2.52)
T2	2.61(.19)	38.41(1.78)	12.63(.49)	29.14(.70)	65.61(2.38)	24.23(.89)	22.62(.93)	19.52(.76)	67.51(1.88)
T3	2.45(.16)	38.12(1.66)	12.90(.34)	29.24(.58)	65.96(2.43)	24.50(.69)	21.92(1.11)	19.84(.55)	68.96(1.99)
$\boldsymbol{F}_{\text{within}}$	3.067	.042	2.312	3.110	.214	*4.167	.235	1.787	.726
$\boldsymbol{F}_{\text{interaction}}$	.055	.034	.307	.041	2.895	.850	1.158	.449	.714

	Psychological Distress	Anxiety Symptoms (ANX)	Depression Symptoms (DEP)	Somatization Symptoms (SOMA)
Treatment				
T1	13.45(1.96)	1.51(.31)	1.73(.29)	2.17(.23)
T2	10.02(2.63)	1.14(.36)	1.58(.29)	1.65(.35)
T3	5.93(1.63)	.79(.29)	1.02(.33)	1.50(.29)
Control				
T1	8.74(1.82)	1.15(.29)	1.36(.26)	1.57(.22)
T2	8.75(2.46)	1.08(.34)	1.50(.26)	1.48(.34)
T3	5.17(1.52)	.88(.27)	.989(.30)	1.41(.28)
$\boldsymbol{F}_{\text{within}}$	*17.828	*4.675	*15.104	*4.485
$\boldsymbol{F}_{\text{interaction}}$	1.543	.538	2.205	.617

*$p < .05$

Table 3

Adjusted means and standard deviations with socio-economic status sample characteristics

	Empowerment	Self-Sufficiency (SS)	Self-Determination (SD)	Decision-Making Skills (DM)	Social support	Medical Community Support (MC)	Family Support (FAM)	Friend Support (FRND)	Patient Satisfaction (PS)
Treatment									
T1	3.10(.22)	35.84(2.03)	11.15(.42)	27.96(.96)	63.73(1.33)	21.10(1.13)	21.90(1.16)	19.13(.81)	63.54(2.90)
T2	2.84(.21)	36.69(2.07)	11.89(.55)	28.52(.77)	59.90(2.46)	22.83(.85)	20.25(1.04)	18.35(.87)	67.66(2.44)
T3	2.59(.17)	36.26(1.85)	12.71(.34)	29.98(.67)	58.43(2.87)	22.43(1.02)	20.40(1.24)	18.99(.59)	65.05(2.93)
Control									
T1	2.72(.23)	39.51(2.14)	12.46(.44)	28.05(.95)	60.78(1.29)	23.93(1.19)	22.59(1.26)	19.79(.86)	71.51(3.05)
T2	2.31(.22)	40.52(2.18)	13.23(.58)	30.30(.76)	66.46(2.38)	25.03(.89)	22.91(1.12)	20.45(.92)	71.01(2.57)
T3	2.36(.18)	38.16(1.95)	13.10(.35)	29.73(.67)	65.21(2.78)	25.13(1.08)	22.17(1.34)	19.80(.63)	71.54(3.09)
$\boldsymbol{F}_{\text{within}}$	*8.390	1.626	*6.511	*5.758	.318	2.727	.847	.149	.535
$\boldsymbol{F}_{\text{interaction}}$	.729	1.224	.106	.509	*12.443	1.171	1.939	1.406	.629

	Psychological Distress	Anxiety Symptoms (ANX)	Depression Symptoms (DEP)	Somatization Symptoms (SOMA)
Treatment				
T1	15.03(2.86)	1.68(.34)	1.73(.36)	2.23(.34)
T2	13.46(2.92)	1.44(.32)	1.76(.37)	2.05(.40)
T3	9.60(1.81)	1.44(.23)	.93(.34)	1.53(.40)
Control				
T1	6.34(2.68)	.86(.34)	1.31(.37)	1.25(.33)
T2	5.15(2.74)	.47(.32)	1.32(.37)	1.06(.39)
T3	3.95(1.70)	.52(.23)	1.04(.35)	.89(.39)
$\boldsymbol{F}_{\text{within}}$	2.149	1.442	*4.490	3.105
$\boldsymbol{F}_{\text{interaction}}$	.074	.062	.122	.537

*$p < .05$

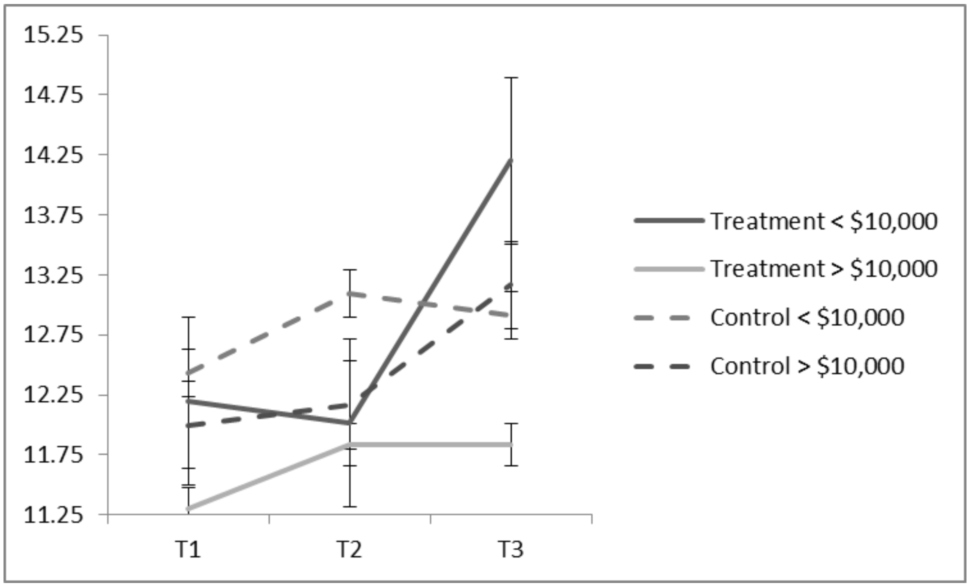

Figure 1. Self-determination means and standard errors for groupXannual income

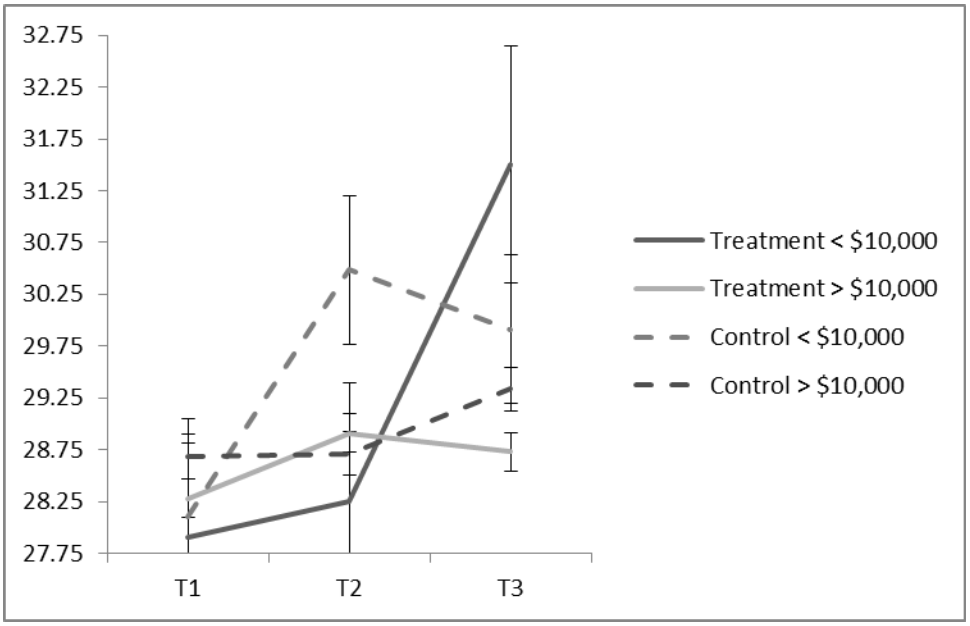

Figure 2. Decision-making skills means and standard errors for groupXannual income

Communion

Research question two: Do participants in the treatment group have increased scores on communion in comparison to the control group?

A two-way repeated measures ANOVA of changes in overall SSI social support scores from T1 to T3 did not reveal a Time effect, $F(2, 72) = .241$, $p = .787$; but did reveal a TimeXGroup interaction effect, $F(2, 72) = 4.172$, $p < .05$, $\eta^2 = .104$, with a significant decrease between T1 and T2, $F(1, 36) = 5.535$, $p < .05$, $\eta^2 = .133$. In addition, a repeated measures ANOVA of changes in overall SSI social support scores from T1 to T3 after controlling for SES demographic characteristics variables showed a TimeXGroup interaction effect, $F(2, 42) = 12.443$, $p < .001$, $\eta^2 = .372$, with a significant decrease between T1 and T2, $F(1, 21) = 14.357$, $p < .01$, $\eta^2 = .406$. Thus overall social support scores initially decreased for the treatment group.

When examining SSI subscales, family support (FAM) scores had a significant interaction with the treatment group and education, $F(2, 72) = 7.989$, $p < .05$, $\eta^2 = .182$, with a significant effect for FAM scores between T2 and T3, $F(1, 36) = 7.375$, $p < .05$, $\eta^2 = .170$. In other words, control group FAM scores remained relatively stable between T1 and T3. Treatment group FAM scores, however, decreased for participants who reported lower educational levels but initially decreased and then increased for participants who reported higher education levels (See Figure 3). It is possible that the decreased FAM scores for participants who reported lower educational levels may have been due to participants being faced with their lack of family support as well as their possible lack of resources and skills to increase family support. Whereas participants with higher education, when faced with their lack of family support between T1 and T2, may possess resources and skills to increase some family support between T2 and T3.

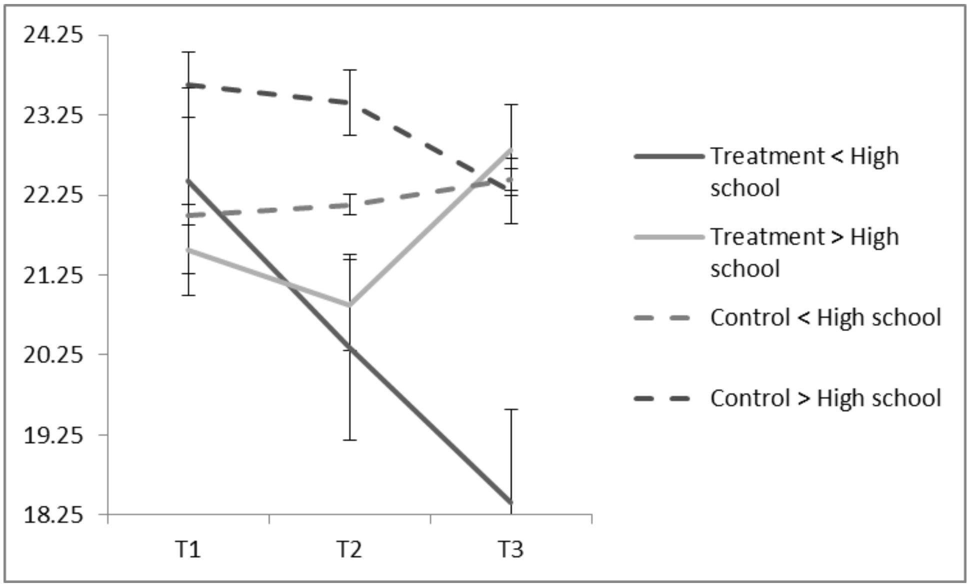

Figure 3. Family support means and standard errors for groupXeducation level

Regarding patient satisfaction as a measure of communion, a two-way repeated measures ANOVA of changes in patient satisfaction scores from T1 to T3 did not reveal a Time effect, $F(2, 80) = 3.002$, $p = .055$; nor a TimeXGroup interaction effect, $F(2, 80) = 1.257$, $p = .290$. However, changes in patient satisfaction scores from T1 to T2 (n = 68) did show a Time effect, $F(1, 64) = 12.818$, $p < .05$, $\eta^2 = .167$; and a TimeXGroup interaction effect, $F(1, 64) = 5.193$, $p < .05$, $\eta^2 = .075$, with treatment group scores increasing more (T1M = 60.77, SD = 9.74, T2M = 65.86, SD = 7.69) than control group scores (T1M = 68.30, SD = 8.75, T2M = 69.43, SD = 7.64). A repeated measures ANOVA of changes in patient satisfaction scores from T1, T2, and T3 after controlling for grouped demographic variables did not reveal TimeXGroup interaction effects. Thus patient satisfaction scores initially increased for the treatment group. This was a promising finding since low-income patients usually report lower satisfaction with patient care (Collins, 2010; DeVoe et al., 2008; Jensen et al., 2010; U.S. Department of Health and Human Services, 2003)

These significant results suggest that MedFT may have an initial effect of increasing patient satisfaction with care but decreasing a sense of social support and then over time and with participants who report higher education, increasing a sense of family support.

Psychological Distress

Research question three: Do participants in the treatment group have decreased scores on psychological distress in comparison to the control group?

A two-way repeated measures ANOVA of changes in overall BSI-18 psychological distress scores from T1 to T3 revealed a Time effect, $F(2, 66) = 8.793$, $p < .001$, $\eta^2 = .210$; but not a TimeXGroup interaction effect, $F(2, 66) = .883$, $p = .419$. In addition, a repeated measures ANOVA of changes in overall BSI-18 psychological distress scores from T1 to T3 after controlling for grouped demographic variables did not reveal TimeXGroup interaction effects. Thus overall psychological distress scores did improve, but not due specifically to the treatment, rather, as noted by the time effect, all participants reported a decrease in distress between T2 and T3, $F(1, 33) = 8.541$, $p < .01$, $\eta^2 = .206$.

When examining BSI-18 subscales, depression symptoms (DEP) scores had a significant interaction with the treatment group and ethnicity, $F(2, 58) = 3.712$, $p < .01$,

$\eta^2 = .204$, with a significant TimeXGroupXEthnicity improvement for DEP scores between T2 and T3, $F(1, 29) = 5.217$, $p < .05$, $\eta^2 = .265$. Thus, even though an LSD post hoc test did not find differences between ethnic groups alone, depression symptoms did decrease more for ethnic groups within the treatment group than ethnic groups within the control group. Participants in the treatment group who identified as African American reported the most decrease in depression symptoms (See Figure 4). These significant results suggest that MedFT may decrease depression symptoms for various ethnicities over time, particularly African American participants. However, this result should be taken in context. Depression symptoms can vary by ethnicity (Halbreich et al., 2007). For example, the Latino population often cites somatization symptoms when referring to what western culture would call depression (Guarnaccia, Angel, & Worobey, 1989; Halbreich et al., 2007). Thus even though African American treatment group participants reported the most decrease in depression symptoms, one cannot conclude that African Americans benefit the most from MedFT in terms of decreasing depression.

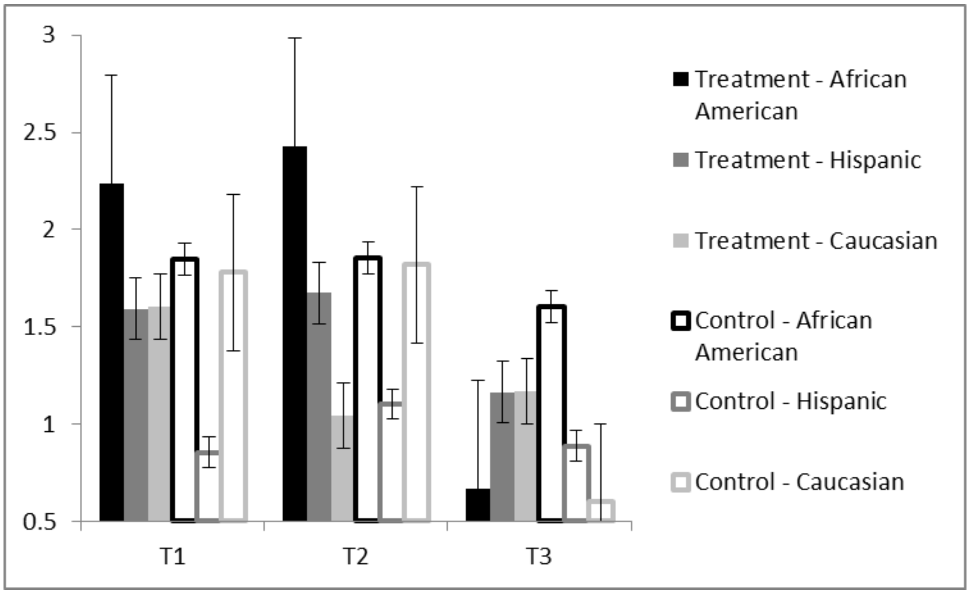

Figure 4. Depression symptom means and standard errors for groupXethnicity

Medical Family Therapy Dose

Research question four: Does the "dose" of MedFT correlate with agency, communion, and psychological distress scores?

The average time the MedFTI spent with participants in the treatment group was 22 minutes (M = 21.81; SD = 1.75). The average dose of MedFT that was given to the participants in the treatment group was 7 out of 10 (M = 6.97; SD = .353). A correlation analysis found that the time spent with the patient had a significant relationship with the MedFT dose, $R^2 = .391$, $R^2_{adj} = .373$, $F(1, 34) = 21.861$, $p = < .001$. In addition, at T2 the MedFT dose had a significant relationship with medical community support (MC) scores, $R^2 = .154$, $R^2_{adj} = .129$, $F(1, 34) = 6.202$, $p = < .05$, and family support (FAM) scores, $R^2 = .152$, $R^2_{adj} = .128$, $F(1, 34) = 6.2116$, $p = < .05$. Therefore, the dose does correlate with communion, meaning medical community and family support, but does not correlate with agency or psychological distress scores.

Anecdotal Evidence

Research question five: Do participants in the treatment group report improved agency and communion in response to open-ended questions when compared to the control group?

Participants were asked to answer three questions regarding whether they felt supported, cared for, and understood by their health care professionals, referring to experiences of communion. Participants were also asked to answer two questions regarding whether they felt encouraged to speak up with their health care professionals, referring to experiences of agency.

Both treatment and control groups referenced their relationship with their doctor when answered the questions. Both also highly praised their doctors when they discussed feeling supported and encouraged (See Table 4).

Table 4

Anecdotal data summary at T2

Agency		
Did you feel encouraged by your healthcare professionals to speak up about your health and health care? If yes, how were you encouraged?		
	Treatment (n = 17)	Control (n = 19)
“Yes”	94.1%	100%
“No”	5.9%	
Did you feel you were encouraged to speak up about anything? If yes, how were you encouraged?		
	Treatment (n = 17)	Control (n = 19)
“Yes”	94.1%	94.7%
“No”	5.9%	5.3%
Communion		
Did you feel supported and cared for by your health care professionals? If yes, how so?		
	Treatment (n = 17)	Control (n = 20)
“Yes”	100%	100%
“No”		
Did you feel connected with and understood by your health care professionals? If yes, how so?		
	Treatment (n = 17)	Control (n = 20)
“Yes”	100%	95.5%
“No”		5.0%
Did you feel that your health care professionals encouraged you to have good relationships with your friends and family?		
	Treatment (n = 16)	Control (n = 17)
“Yes”	68.8%	58.8%
“No”	25.0%	35.3%

Communion

In answer to the question of how participants knew they felt supported, connected, understood, and encouraged by their health care professionals—“listened” was listed the most frequently for both groups. Other ways were when the doctor explained things, asked questions, gave recommendations and advice, and calmed fears about test results and physical symptoms by telling participants there was nothing wrong.

It was interesting to note that for the control group, interactions appeared to focus only on participants' physical health. The treatment group also reported that focusing on physical health was helpful but added that listening to emotional worries was beneficial. For example, one participant in the treatment group wrote, "I feel like I can open up emotionally." Another wrote, "Talked about something that was heavy on my heart". In addition, the control group mainly referred to their relationship and interaction with the doctor when answering the questions. The treatment group would say, "They helped…" or "They listened…" suggesting that the treatment group saw their health care professionals as a team with the MedFTI included, rather than only their doctor providing care. Thus, anecdotal evidence supported the quantitative results suggesting that the treatment group may have felt more supported by their physician and medical community, particularly regarding improving relationships with family and friends.

Agency

In answer to the question of how participants knew they felt encouraged to speak up by their health care professionals—"asked questions" was listed the most frequently for both groups. Other ways were when the doctor listened, explained things, and appeared knowledgeable.

Both groups did not appear to write in many answers except for "Yes" or "No" and when they did write in answers, they wrote about the doctor's ability to diagnose and treat. For example, in answer to question one, one participant in the control group wrote, "Very informative". Another participant in the treatment group said, "Yes she knew for sure [that the] allergic reaction was [the] cause of [the] rash".

The control group still mainly referred to their relationship and interaction with the doctor when answering the questions. The participants in the treatment group, on the other hand, said, "Yes, *they* were very attentive" and "Yes, by the *kind person I saw before the doctor* [the MedFTI]". These comments suggest that the treatment group saw their health care professionals as a team. In conclusion, however, anecdotal evidence regarding a sense of agency was minimal and seemed to suggest that the treatment group initially did not feel more empowered than the control group. Nevertheless, some perceptions within the treatment group seem to have shifted.

Discussion

The purpose of this study was to investigate MedFT effectiveness with low-income primary care patients in terms of increasing a sense of agency and communion and decreasing psychological distress. The results suggest that MedFT may increase a sense of some agency specifically for those with lower income when income is taken into consideration. Also, MedFT may initially increase satisfaction with care but decrease a sense of social support. Over time and with participants who report higher levels of education, MedFT may increase a sense of family support. In addition, the results suggest that over time MedFT may decrease depression symptoms for ethnic groups. Therefore over time, MedFT does seem to be effective in increasing some sense of agency for lower-income patients, increasing family support for patients with higher education, and decreasing depression symptoms for various ethnic groups.

The findings in this study are consistent with current literature reporting increases in patients' satisfaction when MedFT is included (Hodgson et al., 2012; Sellers, 2000; Yeager et al., 1999). The results are also consistent with current literature about patients feeling supported by their health care professionals when they listen and explain things (Jensen, King, Guntzviller, & Davis, 2010).

In addition, the increase in patient satisfaction scores for the treatment group is an encouraging finding, especially since low income patients usually report lower satisfaction with patient care which may contribute to health care disparities (Collins, 2010; DeVoe et al., 2008; Jensen et al., 2010; U.S. Department of Health and Human Services, 2003). For example, Jensen et al. (2010) note that "A primary concern of the medical community is that dissatisfied low-income patients may disregard health advice or reject the healthcare system as a whole, widening healthcare disparities" (p. 30).

The initial decrease in participants' sense of social support, or communion, was also an interesting finding. However, viewed from a systemic lens, the preliminary drop before rise in scores may be explained by MedFT intentionally shifting homeostasis, the status quo of patterns of functioning (Bertalanffy, 1968; Downing, 2012; Warren, Franklin, & Streeter, 1998). For example, Orthner, Jones-Sanpei, and Williamson (2003, 2004) found that low-income families often report lower levels of family strengths such as social support. Thus, when the MedFTI assessed for strengths such as social support, participants may have been faced with their lack of support, their status quo of functioning alone, and were encouraged to seek support and function differently, through reaching out to others. In particular, it is possible that those with higher educational levels may have had an easier time finding ways to gain support than those with lower educational levels who may not know how to get the information and help they need. This perspective is consistent with the MedFTI's experience in the study. Participants in the treatment group would often express a lack of support and a desire for connection to others.

Regarding anecdotal data for agency, it did not seem like participants knew how to answer questions about expressing their opinions to their health care professionals. Perhaps participants interpreted the questions to mean, "If the doctors are not doing a good job, can you tell them that?", and participants were quickly noting that their doctor does do a good job and they do not have anything to complain or "speak up" about. For example, during the course of collecting data the researcher was made aware that a few participants refused to participant because they thought answering questions about their physician and the care they received might make their doctor "look bad". Perhaps participants did not want to be disloyal by even entertaining the question of whether or not the health care services were helpful. Nevertheless when examining the empowerment subscale that specifically pertained to empowerment with health care professionals, the decision-making skills subscale, the mean scores increased more for the treatment group than the control group. Also, anecdotal data suggested that the encounter with the MedFT did help participants in the treatment group feel like more health care professionals cared. The increased empowerment with health care professionals and the increased sense of being cared for suggest that MedFT may have improved patients' sense of agency and communion.

Limitations

The limited nature of the treatment, i.e. brief time spent with patients and only one MedFTI performing MedFT, with the small sample size and analysis of one encounter with a MedFTI are limitations of this study, even though one therapeutic encounter can be very beneficial (Talmon, 1990). It is also important to note that any MedFT effectiveness study at this point must deal with the issue of non-uniformity. There is no one way to conduct MedFT due to its lack of standardized parameters. Hodgson et al. (2012) noted that the personality of the therapist matters when they examined patient views of MedFT. Therefore the MedFTI in this study may have conducted MedFT differently from others, influencing participants' reponses.

In addition, this was an effectiveness study conducted within a regularly functioning clinic, not an efficacy study in which variables were isolated, therefore variables other than MedFT may have accounted for scores on agency, communion, and psychological distress. In addition, accessing data through self-report can be problematic in terms of bias on the participants' part. Also, the results are limited in that data were gathered from the patients' perspective, not their families', friends', health care providers', etc. Furthermore for all significant results, effects were small possibly due to the small sample size but provided some evidence and information regarding the effect of MedFT on agency, communion, and psychological distress scores. Thus, even though the results from this study should be viewed with these limitations in mind, there are implications that can be discussed.

Implications

In their article, Edwards, Patterson, Vakili, and Scherger (2012) discussed the health care movement within the United States. They listed a number of skills that behavioral health providers will need to learn in order to be a part of the wave of integration and increased quality of health care services. Medical Family Therapists are ideally suited to be a part of these integrated services due to their skill and knowledge base. Thus, this is an ideal time for MedFT effectiveness studies to be conducted. Edwards et al. note, "There is a great need and opportunity for family therapists to play a leadership role in the future of healthcare delivery" (p. 226). With effectiveness studies like this study suggesting that patients, especially low-income patients, benefit from MedFT, the MedFT framework can begin to create an empirical basis for utilization.

In addition, just as Marlowe et al. (2012) noted that there is a gap in literature regarding models of integrated care with primary care physicians and behavioral health for diverse populations and issues, there is a gap in literature regarding the effectiveness of MedFT for diverse populations and issues. This study fills that gap and creates evidence for the inclusion of MedFT in many areas of health care.

Future Research

This pilot study is a launching pad for other studies on MedFT effectiveness, which are needed. Tyndall et al. (2012a,b) and Crane and Christenson (2012) called for more MedFT effectiveness and efficacy research. Also, since there has been a call for MedFT to also streamline definitions, interventions, and competencies (Bischoff et al., 2011; Mendenhall et al., 2012; Tyndall et al., 2012a,b), future research should standardize MedFT treatment and desired MedFT outcomes. Standardization can help future MedFT effectiveness studies examine clearly identified outcome variables.

In addition, Mendenhall et al. (2012) suggested utilizing different methodological styles of research that will produce nuanced and varied pictures of MedFT effectiveness. Thus, this study can provide a basis for additional MedFT effectiveness with increased samples sizes, research designs, and perspectives, i.e. patients' families, health care providers, etc. For example, studies that incorporate a qualitative methodology and a longer period of MedFT treatment can help create a clearer picture of the benefits and impact of MedFT on agency for low-income patients.

The social context surrounding vulnerable patient populations, such as low-income patients and women, and their experience of being in a submissive one-down position to those who they perceive to be in power, such as the physician, has been researched and discussed (Candib, 2003; Fiscella, Goodwin, & Stange, 2002; McDaniel & Cole-Kelly, 2003; Prouty Lyness, 2003; Willems, De Maesschalck, Deveugele, Derese, & De Maeseneer, 2005). Thus entrenched power imbalances that influence patient-provider relational dynamics (Candib, 2003; McDaniel & Cole-Kelly, 2003; Prouty Lyness, 2003) usually do not shift smoothly or easily due to set relational patterns and expectations (Bertalanffy, 1968; Downing, 2012; Warren et al., 1998). In fact, the 2012 Blue Shield of California Foundation survey of low-income patients in California found that a large percentage of their participants, 39%, said they would rather leave decision-making primarily up to their health care professionals instead of having a say in their treatment and care (Blue Shield of California Foundation, 2012).

Since the results in this study suggested that MedFT may improve a sense of agency for lower-income patients, it would be beneficial to conduct additional MedFT effectiveness studies examining whether MedFT does improve agency and how MedFT may unbalance the homeostatic relational patterns between low-income patient populations and health care professionals such as physicians, in order to increase patients' sense of agency. Thus, studies focused on MedFT outcomes and which specific MedFT interventions produce an improvement in agency and communion for low-income patients as well as care-givers and family members can be beneficial for implementing evidence-based behavioral health treatment for stressed patients and their close social networks.

MedFT has been suggested as a beneficial treatment for patients, family members, and health care professionals. Arguable, vulnerable populations such as low-income patients stand to gain more through MedFT's focus on increasing a sense of agency and communion. Thus, additional MedFT effectiveness studies can assist clinicians in providing effective, quality health care to populations in need.

CHAPTER SIX

DISCUSSION OF CHANGES MADE FROM ORIGINAL PROPOSAL

There were five changes made to the proposal due to unforeseen circumstances. In the following paragraphs, barriers to research with low-income patients and their health care workers are first discussed so that changes made to the original proposal are put in context. Then the five changes are outlined.

Barriers to Research

Overburdened health care employees and overburdened patients seem to be two of the main barriers to conducting research focusing on low-income patients. Health care employees caring for low-income patients, such as physicians and administrative staff in community health centers, often deal with an overwhelming number of patient needs (National Association of Community Health Centers, 2008; Ventres, & Gordon, 1990; Willems, De Maesschalck, Deveugele, Derese, & De Maeseneer, 2005). In addition, these health care employees, although dedicated to serving the underserved, are often overworked and underpaid (National Association of Community Health Centers, 2008). During my experience working and trying to conduct a research study in a community health center, I encountered the monumental amount of stress and work the employees dealt with. Thus conducting research is usually not a priority in this setting since time may be taken away from patient care when research is involved. Consequently, overburdened employees may be a common barrier that researchers may face when conducting a research study with low-income patients.

Low-income patients must also deal with stress, especially associated with financial difficulties that permeate every facet of their lives, i.e. lack of time, food, sleep, transportation, etc. (Cashman, Savageau, Lemay, & Ferguson, 2004; Fabrega, Moore, & Strawn, 1969; Mishra, Gioia, Chilaress, Barnet, & Webster, 2011; Scarinci, Ames, & Brantley, 1999). Thus participating in a research study is the least of their worries. For example, there were a number of participants in the current study who had their children with them. One mother said she had no one to watch her child and could not afford day care so she brings her baby to her appointments. Needless to say, she did not end up finishing the survey because her baby needed attention and she did not have the time to finish the survey before the doctor came in to see her. These factors associated with being overburdened and stressed have a significant influence on patient recruitment and participation in research studies (Molyneux et al., 2009) and are consequently significant barriers to research.

Based on the context surrounding community health centers such as the site where participants were recruited for this study, there were five changes made to the original proposal. The first three changes involved recruitment and the last two changes involved the analysis process.

Changes in Recruitment

First, instead of three Medical Family Therapy Interns (MedFTI) participating in the study, only one MedFTI was available and had site permission to provide MedFT services to the patients at the clinic, this author. Three other colleagues did help with recruitment but were unable to get permission from the community health center to provide MedFT. Although this presented a relatively large limitation in this study, after careful consideration, the study proceeded with only one MedFTI instead of aborting the entire study since results could still be helpful in understanding the influence of MedFT as performed by one MedFTI.

Second, since the clinic was going through several changes related to patient care, a time limit was put on the recruitment process; impeding the ability to enroll additional participants and leaving a smaller than anticipated sample size to analyze. Even though a smaller sample size also limits the results of this study, beneficial results can still be found and future research directions can be discovered. Thus, analyses continued and results were written.

Third, since participants were hard to reach and then keep on the phone for the one-week later follow-up phone call, the open-ended questions were omitted and a 20 minute limit was placed on the call so as to increase participation. The open-ended questions at the one-week follow-up would have provided valuable insight regarding patients' views of agency and communion. However, the dilemma between increasing sample size or increasing amount of data was resolved by increasing the sample size since the research design of this study is primarily quantitative and thus sample size directly influences findings.

Changes in Analysis

Fourth, due to the smaller sample size, factorial ANOVAs and ANCOVAs were utilized to examine group differences instead of MANOVAs and MANCOVAs. Utilizing MANOVAs would have provided a more nuanced picture of the effect of MedFT, however results would not have been applicable in any way since a very limited number of participants would have fit into different groups to be analyzed. Thus comparing two or three participants with each other would not have produced appropriate or significant results.

Fifth and last, the covariate variables—patient satisfaction with health care providers and the personality indicators for agency, communion, unmitigated agency, and unmitigated communion—did not significantly co-vary with outcome variables. In fact only a few covariates met the assumptions needed to conduct the analysis necessary. Thus, they were not mentioned in the publishable paper. This was done to reduce the readers' confusion and provide concise results.

CONSOLIDATED REFERENCES

Abele, A. E., Uchronski, M., Suitner, C., & Wojciszke, B. (2008). Towards an operationalization of the fundamental dimensions of agency and communion: Trait content ratings in five countries considering valence and frequency of word occurrence. *European Journal of Social Psychology, 38*(7), 1202-1217.

Addison, S. M., Sandberg, J. G., Corby, J., Robila, M., & Platt, J. J. (2002). Alternative methodologies in research literature review: Links between clinical work and MFT effectiveness. *The American Journal of Family Therapy, 30*, pp. 339.

Adult Mental Health Division. (2004). *Effectiveness vs efficacy*. Retrieved from http://www.amhd.org/cebp/concept3.html

Almeida, R. (Ed.). (1998). *Transforming gender and race*. New York: Haworth.

Atienza, A. A., Collins, R., & King, A. C. (2001). The mediating effects of situational control on social support and mood following a stressor: A prospective study of dementia caregivers in their natural environments. *The Journals of Gerontology: Series B: Psychological Sciences and Social Sciences, 56B*(3), S129-S139.

Bakan, D. (1966). *The duality of human existence: Isolation and communion in Western man*. Chicago: Rand McNally.

Bann, C. M., Sirois, F. M., & Walsh, E. G. (2010). Provider support in complementary and alternative medicine: Exploring the role of patient empowerment. *Journal of Alternative & Complementary Medicine, 16*(7), 745-752.

Baron, R. M., & Kenny, D. A. (1986). The moderator–mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology, 51*(6), 1173-1182.

Beeble, M. L., Bybee, D., Sullivan, C. M., & Adams, A. E. (2009). Main, mediating, and moderating effects of social support on the well-being of survivors of intimate partner violence across 2 years. *Journal of Consulting and Clinical Psychology, 77*(4), 718-729.

Bell, J. M., Wright, L. M., & Watson, W. L. (1992). The medical map is not the territory: or, "Medical family therapy?"—watch your language. *Family Systems Medicine, 10*(1), 35-39.

Bertalanffy, L. von. (1968). *General systems theory: Foundations, development, applications* (Rev. Ed.). New York: Braziller.

Bigatti, S., Wagner, C., Lydon-Lam, J., Steiner, J., & Miller, K. (2011). Depression in husbands of breast cancer patients: relationships to coping and social support. *Supportive Care in Cancer*, *19*(4), 455-466.

Bischoff, R. J., Springer, P. R., Felix, D. S., & Hollist, C. S. (2011). Finding the heart of medical family therapy: A content analysis of medical family therapy casebook articles. *Families, Systems, & Health*, *29*(3), 184-196.

Blue Shield of California Foundation. (2012). *Empowerment and engagement among low--income Californians: Enhancing patient--centered care*. Langer Research Associates.

Brouwer, S., Dijkstra, P. U., Stewart, R. E., Göeken, L. N. H., Groothoff, J. W., & Geertzen, J. H. B. (2005). Comparing self-report, clinical examination and functional testing in the assessment of work-related limitations in patients with chronic low back pain. *Disability & Rehabilitation*, *27*(17), 999-1005.

Brown, P. (2008). *Perspectives in medical sociology* (4th ed.). Long Grove, IL: Waveland Press, Inc.

Burwell, S. R., Templeton, B., Kennedy, K. S., & Zak-Hunter, L. (2008). Feminist-informed Medical Family Therapy principles and techniques across biopsychosocial systems levels for younger women with breast cancer and their partners. *Journal of Feminist Family Therapy*, *20*(2), 99-125.

Buss, D. M. (1990). Unmitigated agency and unmitigated communion: An analysis of the negative components of masculinity and femininity. *Sex Roles*, *22*(9/10), 555-568.

Campbell, T. L. (2002). Physical disorders. In D. H. Sprenkle (Ed.). *Effectiveness research in marriage and family therapy* (pp. 311-337). Alexandria, VA US: American Association for Marriage and Family Therapy.

Campbell, T. L. (2003). The effectiveness of family interventions for physical disorders. *Journal of Marital and Family Therapy*, *29*(2), 263-281.

Candib, L. M. (2003). A venn diagram: Feminism, family therapy, and family medicine. In T.J. Goodrich & L. Silverstein (Eds.) *Feminist Family Therapy*. Washington, D.C.: American Psychological Association Publications, pp 253-265.

Cashman, S. B., Savageau, J. A., Lemay, C. A., & Ferguson, W. (2004). Patient health status and appointment keeping in an urban community health center. *Journal of Health Care for the Poor and Underserved*, *15*(3), 474-488.

Chou, K. L., Chi, I., & Chow, N. W. (2004). Sources of income and depression in elderly Hong Kong Chinese: Mediating and moderating effects of social support and financial strain. *Aging & Mental Health*, *8*(3), 212-221.

Collins, B. A. S. (2010). *Health care quality and disparities in women: Selected findings from the 2010 National Health care Quality and Disparities Reports.* U.S. Department of Health and Human Services Agency for Health care Research and Quality. Retrieved from: http://www.ahrq.gov/qual/nhqrwomen/nhqrwomen.htm

Copeland, A. P., & White, K. M. (1991). Studying families. *Applied Social Research Methods Series, 27*. Newbury Park, CA: Sage Publications, Inc.

Cowdery, R. S., Scarborough, N., Knudson-Martin, C., Seshadri, G., Lewis, M. E., & Mahoney, A. R. (2009). Gendered power in cultural contexts: Part II. Middle class African American heterosexual couples with young children. *Family Process, 48*(1), 25-39.

Crane, D. D., & Christenson, J. (2012). A summary report of the cost-effectiveness of the profession and practice of marriage and family therapy. *Contemporary Family Therapy: An International Journal, 34*(2), 204-216.

Crane, D. R., & Payne, S. H. (2011). Individual versus family psychotherapy in managed care: comparing the costs of treatment by the mental health professions. *Journal of Marital & Family Therapy, 37*(3), 273-289.

Crane, D. R., Wood, N. D., Law, D. D., & Schaalje, B. (2004). The Relationship between therapist characteristics and decreased medical utilization: An exploratory study. *Contemporary Family Therapy: An International Journal, 26*(1), 61-69.

Cropley, M., & Steptoe, A. (2005). Social support, life events and physical symptoms: a prospective study of chronic and recent life stress in men and women. *Psychology, Health & Medicine, 10*(4), 317-325.

Cutler, D. M., & Everett, W. (2010). Thinking outside the pillbox: Medication adherence as a priority for health care reform. *The New England Journal of Medicine, 363,* 1553-1555.

Davey, M. P., Duncan, T. M., Foster, J., & Milton, K. (2008). Keeping the family in focus at an HIV/AIDS pediatric clinic. *Families, Systems, & Health, 26*(3), 350-355.

DeVoe, J. E., Wallace, L. S., Pandhi, N., Solotaroff, R., Fryer, G. E. (2008). Comprehending care in a medical home: A usual source of care and patient perceptions about healthcare communication. *The Journal of the American Board of Family Medicine, 21*, 441–450.

Dickerson, B. J. (1995). *African American single mothers: Understanding their lives and families.* Thousand Oaks, CA US: Sage Publications, Inc.

Diehl, M., Owen, S. K., & Youngblade, L. M. (2004). Agency and communion attributes in adults' spontaneous self-representations. *International Journal of Behavioral Development*, *28*(1), 1-15.

DiMatteo, M. R. (2004). Social support and patient adherence to medical treatment: A meta-analysis. *Health Psychology, 23*(2), 207-218.

Downing, R. (2012). Family medicine's waltz with systems. *Bulletin of Science, Technology & Society, 32*(4), 269-272.

Dubé, L., Paquet, C., Ma, Z., McKenzie, D. S. A., Kergoat, M. J., & Ferland, G. (2007). Nutritional implications of patient–provider interactions in hospital settings: Evidence from a within-subject assessment of mealtime exchanges and food intake in elderly patients. *European Journal of Clinical Nutrition, 61*(5), 664-672.

Durden, E., Hill, T., & Angel, R. (2004). Demands, supports, and depression among low-income women with children. *Conference Papers -- American Sociological Association*, 1-21.

Edwards, T., Patterson, J., Vakili, S., & Scherger, J. (2012). Healthcare policy in the United States: A primer for medical family therapists. *Contemporary Family Therapy: An International Journal*, *34*(2), 217-227.

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

Fabrega, H., Jr., Moore, R. J., & Strawn, J. R. (1969). Low income medical problem patients: Some medical and behavioral features. *Journal of Health and Social Behavior, 10*(4), 334-343.

Fekete, E. M., Stephens, M. A. P., Mickelson, K. D., & Druley, J. A. (2007). Couples' support provision during illness: The role of perceived emotional responsiveness. *Families, Systems, & Health, 25*(2), 204-217.

Fincham, F. D., & Beach, S. R. H. (2010). Marriage in the new millennium: A decade in review. *Journal of Marriage & Family, 72*(3), 630-649.

Fiscella, K., Goodwin, M., & Stange, K.C. (2002). Does patient education level affect office visits to family physicians? *Journal of the National Medical Association, 56*, 157-165.

Fritz, H. L., & Helgeson, V. S. (1998). Distinctions of unmitigated communion from communion: Self-neglect and overinvolvement with others. *Journal of Personality and Social Psychology, 75*(1), 121-140.

Fowler, F. J. Jr. (2009). *Survey research methods* (4th ed.). Thousand Oaks, CA: Sage Publications, Inc.

Fox, M., Hodgson, J., & Lamson, A. (2012). Integration: Opportunities and challenges for family therapists in primary care. *Contemporary Family Therapy: An International Journal, 34*(2), 228-243.

Galdón, M. J., Durá, E., Andreu, Y., Ferrando, M., Murgui, S., Pérez, S. et al. (2008). Psychometric properties of the Brief Symptom Inventory-18 in a Spanish breast cancer sample. *Journal of Psychosomatic Research, 65*(6), 533-539.

Ghaed, S. G. & Gallo, L. C. (2006). Distinctions among agency, communion, and unmitigated agency and communion according to the interpersonal circumplex, five-factor model, and social-emotional correlates. *Journal of Personality Assessment, 86*(1), 77-88.

Goldner, V. (1985). Feminism and family therapy. *Family Process, 24*, 31–47.

Gravetter, F. J., & Wallnau, L. B. (2009). *Statistics for the behavioral sciences* (8th ed.). Belmont, CA: Wadsworth.

Griffith, J. L. (1994). Review of "Medical Family Therapy". *Family Systems Medicine, 12*(1), 87-89.

Guarnaccia, P.J., Angel, R., & Worobey, J.L. (1989). The factor structure of the CES-D in the Hispanic Health and Nutrition Survey: The influence of ethnicity, gender, and language. *Social Science and Medicine, 29*(1), 85–94.

Halbreich, U., Alarcon, R. D., Calil, H., Douki, S., Gaszner, P., Jadresic, E., Jasovic-Gasic, M., Kadri, N., Kerr-Correa, F., Patel, V., Sarache, X., Trivedi, J. K. (2007). Culturally-sensitive complaints of depressions and anxieties in women. *Journal of Affective Disorders, 102*(1–3), 159-176.

Hardy, K. (2011, February). *The Invisible wounds of oppression: Healing our clients, healing ourselves.* Workshop presented at Alliant International University, Irvine, CA.

Hare-Mustin, R. (1978). A feminist approach to family therapy. *Family Process, 17,* 181–194.

Helgeson, V. S. (1993). Implications of agency and communion for patient and spouse adjustment to a first coronary event. *Journal of Personality and Social Psychology, 64*(5), 807-816.

Helgeson, V. S. (1994). Relation of agency and communion to well-being: Evidence and potential explanations. *Psychological Bulletin, 116*(3), 412-428.

Hertlein, K. M. (2003). Reflecting on feminist suggestions and the practice of Medical Family Therapy: One therapist's personal framework. *Journal of Feminist Family Therapy, 15*(2/3), 127-136.

Hill, M. R., & Thomas, V. (2002). Racial and gender identity development for Black and White women in interracial partner relationships. *Journal of Couple & Relationship Therapy, 1*(4), 1-35.

Hirokawa, K., & Dohi, I. (2007). Agency and communion related to mental health in Japanese young adults. *Sex Roles, 56*(7/8), 517-524.

Hodgson, J. L., McCammon, S. L., & Anderson, R. J. (2011). A conceptual and empirical basis for including Medical Family Therapy services in cancer care settings. *American Journal of Family Therapy, 39*(4), 348-359.

Hodgson, J. L., McCammon, S. L., Marlowe, D. P., & Anderson, R. J. (2012). Medical family therapy in cancer care: Patient and family experiences. *American Journal of Family Therapy, 40*(3), 258-266.

Holdsworth, L., & Cartwright, S. (2003). Empowerment, stress and satisfaction: An exploratory study of a call centre. *Leadership & Organization Development Journal, 24*(3), 131-140.

Honda, K., & Kagawa-Singer, M. (2006). Cognitive mediators linking social support networks to colorectal cancer screening adherence. *Journal of Behavioral Medicine, 29*(5), 449-460.

Hughes, A., Hertlein, K. M., & Hagey, D. W. (2011). A MedFT-informed sex therapy for treating sexual problems associated with chronic illness. *Journal of Family Psychotherapy, 22*(2), 114-127.

Hunter, W. F. (1993). Medical Family Therapy: A biopychosocial approach to families with health problems. *Journal of Psychology & Theology, 21*(3), 262-263.

Jacobs, B. J. (2012). “Here’s how we’re seeing it”: An interview with Susan H. McDaniel, PhD, Jeri Hepworth, PhD and William J. Doherty, PhD. *Contemporary Family Therapy: An International Journal, 34*(2), 147-155.

Jensen, J. D., King, A. J., Guntzviller, L. M., & Davis, L. A. (2010). Patient–provider communication and low-income adults: Age, race, literacy, and optimism predict communication satisfaction. *Patient Education & Counseling, 79*(1), 30-35.

Karnilowicz, W. (2011) Identity and psychological ownership in chronic illness and disease state. *European Journal of Cancer Care, 20,* 276–282.

Kazak, A. E., Simms, S., Aldefer, M. A., Rourke, M. T., Crump, T., McClure, K., Reilly, A. (2005). Feasibility and preliminary outcomes from a pilot study of a brief psychological intervention for families of children newly diagnosed with cancer. *Journal of Pediatric Psychology, 30*(8), 644–655.

Knudson-Martin, C. (2003). Gender and biology: A recursive framework for clinical practice. *Journal of Feminist Family Therapy, 15*, 1-21.

Knudson-Martin, C., & Laughlin, M. J. (2005). Gender and sexual orientation in family therapy: Toward a post-gender approach. *Family Relations*, *54*, 101-115.

Knudson-Martin, C., & Mahoney, A. R. (2009). *Couples, gender, and power: Creating change in intimate relationships*. New York: Springer.

Kovach, A. C., Becker, J., & Worley, H. (2004). The impact of community health workers on the self-determination, self-sufficiency, and decision-making ability of low-income women and mothers of young children. *Journal of Community Psychology*, *32*(3), 343-356.

Law, D. D., & Crane, D. R. (2000). The influence of marital and family interventions on professional health care services in a health maintenance organization. *Journal of Marital and Family Therapy*, *26*, 281–291.

Law, D. D., Crane, D. R., & Berge, J. M. (2003). The influence of individual, marital, and family therapy on high utilizers of health care. *Journal of Marital and Family Therapy*, *23*(3), 353–363.

Leaper, C. (1987). Agency, communion, and gender as predictors of communication style and being liked in adult male-female dyads. *Sex Roles, 16*(3/4), 137-149.

Leslie, L. A. & Southard, A. L. (2009). Thirty years of feminist family therapy: Moving into the mainstream. In S. A. Lloyd, A. L. Few, & K. R. Allen (Eds.). *Handbook of feminist family studies* (pp. 328-339). Los Angeles: Sage Publications.

Linville, D., Hertlein, K. M., & Lyness, A. M. P. (2007). Medical family therapy: Reflecting on the necessity of integrative health care research. *Families, Systems, & Health, 25*(1), 85-97.

Liu, M., Tai, Y., Hung, W., Hsieh, M., & Wang, R. (2010). Relationships between emotional distress, empowerment perception and self-care behavior and quality of life in patients with type 2 diabetes [Chinese]. *Journal of Nursing, 57*(2), 49-60.

Locke, K. D., & Nekich, J. C. (2000). Agency and communion in naturalistic social comparison. *Personality and Social Psychology Bulletin, 26*(7), 864-874.

Luepnitz, D. (1988). *The family interpreted: Feminist theory in clinical practice*. New York: Basic Books.

Maciel, J. A., Van Putten, Z., & Knudson-Martin, C. (2009). Gendered power in cultural contexts: Part I. Immigrant couples. *Family Process, 48*(1), 9-23.

Mackrill, T. (2009). Constructing client agency in psychotherapy research. *Journal of Humanistic Psychology, 49*(2), 193-206.

Marlowe, D., Hodgson, J., Lamson, A., White, M., & Irons, T. (2012). Medical family therapy in a primary care setting: A framework for integration. *Contemporary Family Therapy: An International Journal, 34*(2), 244-258.

Marsh, G. W. (1999). Measuring patient satisfaction outcomes across provider disciplines. *Journal of Nursing Measurement, 7*(1), 47-62.

McConnell, D., Breitkreuz, R., & Savage, A. (2011). From financial hardship to child difficulties: Main and moderating effects of perceived social support. *Child: Care, Health & Development, 37*(5), 679-691.

McCubbin, M., Balling, K., Possin, P., Frierdich, S., & Bryne, B. (2002). Family resiliency in childhood cancer. *Family Relations, 51*(2), 103-111.

McCubbin, M.A. & McCubbin, H.I. (1993). Family coping with health crisis: The resiliency model of family stress, adjustment and adaptation. In C. Danielson, B. Bissell Hamel, & P. Winstead-Fry (Eds.), *Families, Health, and Illness* (pp. 3-63). St. Louis, MO: Mosby.

McCubbin, M.A. & McCubbin, H.I. (1996). Resiliency in families: A conceptual model of family adjustment and adaptation in response to stress and crisis. In H. I. McCubbin, A. I. Thompson, & M. A. McCubbin (Eds.), *Family Assessment: Resiliency, Coping and Adaption. Inventories for Research and Practice* (pp. 1-64). Madison: University of Wisconsin System.

McCubbin, H. I., Patterson, J., & Glynn, T. (1996). Social Support Index (SSI). In H. I. McCubbin, A. I. Thompson, & M. A. McCubbin (Eds.), *Family Assessment: Resiliency, Coping and Adaption. Inventories for Research and Practice* (pp. 357-389). Madison: University of Wisconsin System.

McDaniel, S. H., Campbell, T. L., Hepworth, J, & Lorenz, A. (2005). *Family-oriented primary care.* (2nd ed.). New York, NY: Springer Science + Business Media, LLC.

McDaniel, S.H., & Cole-Kelly, K. (2003). Gender, couples, and illness: A feminist analysis of medical family therapy. In T.J. Goodrich & L. Silverstein (Eds.) *Feminist Family Therapy*. Washington, D.C.: American Psychological Association Publications, pp 267-280.

McDaniel, S. H., Harkness, J. L., & Epstein, R. M. (2001). Medical Family Therapy for a woman with end-stage Crohn's Disease and her son. *American Journal of Family Therapy, 29*(5), 375-395.

McDaniel, S. H., & Hepworth, J. (2000). Medical Family Therapy; A biopsychosocial approach to behavioral interventions in health care settings. *Clinician's Research Digest, 23*, 1-2.

McDaniel, S.H. & Hepworth, J. (2003). Family psychology in primary care: Managing issues of power and dependency through collaboration. In: R. Frank, S.H. McDaniel. J. Bray, M. Heldring (Eds.), *Primary Care Psychology*. Washington, DC: American Psychological Association Publications.

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

McDaniel, S. H., Lusterman, D.D., & Philpot, C. L. (2001). Introduction to integrative ecosystemic family therapy. In S. H. McDaniel, D. D. Lusterman & C. L. Philpot (Eds.), *Casebook for integrating family therapy: An ecosystemic approach.* (pp. 3-17): American Psychological Association.

McGoldrick, M., Anderson, C., & Walsh, F. (Eds.). (1989). *Women in families: A framework for family therapy.* New York: Norton.

Mendenhall, T., Pratt, K., Phelps, K., & Baird, M. (2012). Advancing medical family therapy through research: A consideration of qualitative, quantitative, and mixed-methods designs. *Contemporary Family Therapy: An International Journal, 34*(2), 187-203.

Mertler, C. A., & Vannatta, R. A. (2010). *Advanced and multivariate statistical methods* (4th ed.). Pyrczak Publishing.

Mishra, S. I., Gioia, D., Chilaress, S., Barnet, B., & Webster, R. L. (2011). Adherence to medication regimens among low-income patients with multiple comorbid chronic conditions. *Health & Social Work, 36*(4), 249-258.

Molyneux, C., Goudge, J., Russell, S., Chuma, J., Gumede, T., & Gilson, L. (2009). Conducting health-related social science research in low income settings: Ethical dilemmas faced in Kenya and South Africa. *Journal of International Development*, *21*(2), 309-326.

Mullins, C. D., Junling, W., Cooke, J. L., Blatt, L., & Baquet, C. R. (2004). Longitudinal versus cross-sectional methodology for estimating the economic burden of breast cancer: A pilot study. *PharmacoEconomics, 22*(5), 285-291.

Munch, S. (2006). The women's health movement: Making policy, 1970-1995. *Social Work in Health Care, 43*(1), 17-32.

National Association of Community Health Centers. (2008). Access transformed: Building a primary care workforce for the 21st century. From the *ACCESS for All America Report Series*. With the Robert Graham Center and George Washington University School of Public Health and Health Services.

Nelson, T. S., & Allred, D. D. (2005). Survey research in marriage and family therapy. In Sprenkle, D. H., & Piercy, F. P (Eds.), *Research methods in family therapy.* (2nd ed., pp. 211-237): New York, NY: Guilford Press.

Northouse, L., Kershaw, T., Mood, D., & Schafenacker, A. (2005). Effects of a family intervention on the quality of life of women with recurrent breast cancer and their family caregivers. *Psycho-oncology, 14*, 478–491.

Orthner, D., Jones-Sanpei, H., & Williamson, S. (2003). Family strengths and income in households with children. *Journal of Family Social Work, 7*(2), 5-23.

Orthner, D., Jones-Sanpei, H., & Williamson, S. (2004). The resilience and strengths of low-income families. *Family Relations, 53*, 159-167.

Ostbye, T., Yarnall, K., Krause, K., Pollak, K., Gradison, M., & Michener, J. (2005). Is there time for management of patients with chronic diseases in primary care? *Annals of Family Medicine, 3*(3), 209-214.

Phelps, K. W., Howell, C. D., Hill, S. G., Seemann, T. S., Lamson, A. L., Hodgson, J. L. et al. (2009). A integrative care model for patients with Type-2 diabetes. *Families, Systems, & Health, 27*(2), 131-140.

Pignone, M. P., Gaynes, B. N., Rushton, J. L., Burchell, C.M., Orleans, C. T., Mulrow, C. D., & Lohr, K. N. (2002). Screening for depression in adults: A summary of the evidence for the U.S. preventive services task force. *Annals of Internal Medicine,136,*765-776.

Pinsof, W. M., & Wynne, L. C. (2000). Toward progress research: Closing the gap between family therapy practice and research. *Journal of Marital & Family Therapy, 26*(1), 1-8.

Pratt, D. M. (2003). Interview with Dr. Susan H. McDaniel: Medical Family Therapy and feminism. *Journal of Feminist Family Therapy, 15*(2/3), 137-147.

Prelow, H. M., Weaver, S. R., Bowman, M. A., & Swenson, R. R. (2010). Predictors of parenting among economically disadvantaged Latina mothers: Mediating and moderating factors. *Journal of Community Psychology, 38*(7), 858-873.

Prouty Lyness, A. M. (2003). *Feminist Perspectives in Medical Family Therapy* (Ed.). New York: Haworth Press.

Prouty Lyness, A. M. (2007). Inviting resiliency to join the family's journey with cancer. In D. Linville & K. M. Hertlein (Eds.), *The therapist's notebook for family health care: Homework, handouts, and activities for individuals, couples, and families coping with illness, loss, and disability.* (pp. 167-173). New York, NY US: Haworth Press.

Quek, K. M.-T., & Knudson-Martin, C. (2006). A push toward equality: Processes among dual- career newlywed couples in collectivist culture. *Journal of Marriage & Family, 68*(1), 56-69.

Ragaisis, K. M. (1996). The psychiatric consultation-liaison nurse and medical family therapy. *Clinical Nurse Specialist: The Journal for Advanced Nursing Practice, 10*(1), 50-56.

Ramsey, J. L., & Blieszner, R. (2000). Community, affect, and family relations: A cross-cultural study of spiritual resiliency in eight old women. *Journal of Religious Gerontology, 11*(1), 39-64.

Robinson, W. D., Barnacle, R. E., Pretorius, R., & Paulman, A. (2004). Collaboration in action. *Families, Systems & Health: The Journal of Integrative Family Health care*, *22*(4), 490-496.

Rogers-Clark, C. (2002). Living with breast cancer: the influence of rurality on women's suffering and resilience. A postmodern feminist inquiry. *Australian Journal of Advanced Nursing, 20*(2), 34-39.

Rohrer, J. E., Wilshusen, L., Adamson, S. C., & Merry, S. (2008). Patient-centredness, self-rated health, and patient empowerment: Should providers spend more time communicating with their patients? *Journal of Evaluation in Clinical Practice, 14*(4), 548-551.

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

Saba, G. W. (1999). Commentary—daily experiences of relationships and illness: Reflecting on our focus. *Families, Systems, & Health, 17*(3), 287-293.

Saragovi, C., Aubé, J., Koestner, R., & Zuroff, D. (2002). Traits, motives, and depressive styles as reflections of agency and communion. *Personality and Social Psychology Bulletin, 28*(5), 563-577.

Scarinci, I. C., Ames, S. C., & Brantley, P. J. (1999). Chronic minor stressors and major life events experienced by low-income patients attending primary care clinics: A longitudinal examination. *Journal of Behavioral Medicine, 22*(2), 143-156.

Seccombe, K. (2002). "Beating the odds" versus "changing the odds": Poverty, resilience, and family policy. *Journal of Marriage & Family, 64*(2), 384-394.

Sellers, T. S. (2000). A model of integrative health care in outpatient medical oncology. *Families, Systems, and Health*, *18*(1), 19–33.

Sheldon, K. M., & Cooper, M. L. (2008). Goal striving within agentic and communal roles: Separate but functionally similar pathways to enhanced well-being. *Journal of Personality, 76*(3), 415-448.

Shih-Ming, L. I., Li-Chung, T., Chin-Sheng, W. U., & Ciou-Jhen, C. (2007). Development of the agency and communion scale. *Social Behavior & Personality: An International Journal, 35*(10), 1373-1378.

Smith, T. W., Berg, C. A., Florsheim, P., Uchino, B. N., Pearce, G., Hawkins, M. et al. (2009). Conflict and collaboration in middle-aged and older couples: Age differences in agency and communion during marital interaction. *Psychology and Aging, 24*(2), 259-273.

Spence, J. T., Helmreich, R. L., & Holahan, C. C. (1979). Negative and positive components of psychological masculinity and femininity and their relationships to neurotic and acting-out behaviors. *Journal of Personality and Social Psychology, 37,* 1631-1644.

Sprenkle, D. H., & Blow, A. J. (2004). Common factors and our sacred models. *Journal of Marital and Family Therapy, 30*(2), 113-129.

Sprenkle, D. H., & Piercy, F. P. (2005). Pluralism, diversity, and sophistication in family therapy research. In Sprenkle, D. H., & Piercy, F. P (Eds.), *Research methods in family therapy.* (2nd ed., pp. 3-18): New York, NY: Guilford Press.

Suitner, C., & Maass, A. (2008). The role of valence in the perception of agency and communion. *European Journal of Social Psychology, 38*(7), 1073-1082.

Tabachnick, B. G. & Fidell, L. S. (2011). Using multivariate statistics. (5th ed.). Boston: Allyn and Bacon.

Talmon, M. (1990). *Single Session Therapy: Maximizing the Effect of the First (and Often Only) Therapeutic Encounter*. San Francisco, CA: Jossey-Bass

Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation*, *27*, 237-246.

Tinetti, M., Fried, T., & Boyd, C. (2012). Designing health care for the most common chronic condition-multimorbidity. *Journal of the American Medical Association, 307*(23), 2493-2494.

Trudeau, K. J., Dannoff-Burg, S., Revenson, T. A., & Paget, S. A. (2003). Agency and communion in people with rheumatoid arthritis. *Sex Roles, 49*(7/8), 303-311.

Tyndall, L. (2010). *Medical family therapy: Conceptual clarification and consensus of an emerging profession*. (Unpublished doctoral dissertation). East Carolina University, Greenville, NC.

Tyndall, L., Hodgson, J., Lamson, A., White, M., & Knight, S. (2012a). Medical family therapy: A theoretical and empirical review. *Contemporary Family Therapy: An International Journal, 34*(2), 156-170.

Tyndall, L., Hodgson, J., Lamson, A., White, M., & Knight, S. (2012b). medical family therapy: charting a course in competencies. *Contemporary Family Therapy: An International Journal, 34*(2), 171-186.

U.S. Department of Health and Human Services. (2003). *National Health Disparities Report 2003 Summary*. Retrieved from http://www.ahrq.gov/qual/nhdr03/nhdrsum03.htm

Ventres, W., & Gordon, P. (1990). Communication strategies in caring for the underserved. *Journal of Health Care for the Poor and Underserved, 1*, 305-314.

Voci, S. C., & Cramer, K. M. (2009). Gender-related traits, quality of life, and psychological adjustment among women with irritable bowel syndrome. *Quality of Life Research*, *18*(9), 1169-1176.

Walsh, F. (2006). *Strengthening family resilience*. (2nd Ed.). Guilford Press, NY, NY.

Walsh, F. (2012). The new normal: Diversity and complexity in 21st–century families. In F. Walsh (Ed.) *Normal Family Processes: Growing Diversity and Complexity* (4th ed.). Guilford Press, NY.

Walters, M., Carter, B., Papp, P., & Silverstein, I. (Eds.). (1988). *The invisible web: Gender patterns in family relationships*. New York: Guilford Press.

Ward, L. C., Thorn, B. E., Clements, K. L., Dixon, K. E., & Sanford, S. D. (2006). Measurement of agency, communion, and emotional vulnerability with the Personal Attributes Questionnaire. *Journal of Personality Assessment*, *86*(2), 206-216.

Warren, K., Franklin, C., & Streeter, C. (1998). New directions in systems theory: Chaos and complexity. *Social Work*, *43*(4), 357-372.

Weiss, M., & Hepworth, J. (1993). Medical family therapy casebook: A case for solutions. *Family Systems Medicine*, *11*(3), 297-302.

Welzel, C., & Inglehart, R. (2010). Agency, values, and well-being: A human development model. *Social Indicators Research*, *97*(1), 43-63.

Willerton, E., Dankoski, M. E., & Martir, J. F. (2008). Medical family therapy: A model for addressing mental health disparities among Latinos. *Families, Systems, & Health*, *26*(2), 196-206.

Willems, S., De Maesschalck, S., Deveugele, M., Derese, A., & De Maeseneer, J. (2005). Socio-economic status of the patient and doctor-patient communication: Does it make a difference? *Patient Education & Counseling*, *56*, 139-146.

Wirtberg, I. (2005). Introduction to Medical Family Therapy. *Acta Paediatrica*, *94*, 45-46.

Wojciszke, B., Abele, A. E., & Baryla, W. (2009). Two dimensions of interpersonal attitudes: Liking depends on communion, respect depends on agency. European Journal of Social Psychology, 39(6), 973-990.

World Health Organization (1998). *World Health Report: Life in the 21st century, a vision for all*. Retrieved from http://www.who.int/whr/1998/en/whr98_en.pdf

World Health Organization: Department of Mental Health and Substance Dependence (n.d.). *Gender disparities in mental health*. Retrieved from http://www.who.int/mental_health/media/en/242.pdf

Yeager, B., Auyang, M., Brown, D. L., Dickinson, P., Goldstein, J. A., Jaffe, N., & Workman, G. (1999). MFT student training in medical family therapy: A integrative hospital project with radiation oncology. *Families, Systems, & Health*, *17*(4), 427–436.

APPENDIX A

INFORMED CONSENT

LOMA LINDA UNIVERSITY

School of Behavioral Health

INFORMED CONSENT

TITLE:	EFFECTIVENESS OF MEDICAL FAMILY THERAPY WITH VULNERABLE PATIENT POPULATIONS
PRINCIPAL INVESTIGATOR:	Brian J. Distelberg, PhD 113 Griggs Hall Loma Linda University Loma Linda CA, 92350 Office: (909)558-4547 x47019

1. WHY IS THIS STUDY BEING DONE?

The purpose of this study is to examine and understand patients' views of their social and physical experiences depending on whether or not they have participated in Medical Family Therapy. This study is being conducted by a Doctoral student in Marriage and Family Therapy from the Department of Counseling and Family Sciences at Loma Linda University, under the supervision of the faculty of the department. The results of this study will be contributed to the doctoral student's dissertation project.

Medical Family Therapy (MedFT) is a type of counseling which tries to help patients, their families, and medical professionals understand and support each other. Previous studies have suggested that patients can benefit physically as well as socially when they receive quality medical care with MedFT. Therefore, this study seeks to explore whether MedFT is helpful and also how the field of healthcare can better benefit patients.

You are invited to participate in this research study because your experience is important and may help other patients receive quality care. In addition, you are invited to be in this study because you are a primary care patient at SACHS today, which may or may not include a visit with a Medical Family Therapist.

2. HOW MANY PEOPLE WILL TAKE PART IN THIS STUDY?

Approximately 150 patients will participate in this study. Patients will be assigned by the investigator to either a treatment group, in which you will be visited by the Medical Family Therapist in addition to receiving standard care as usual, or the treatment as usual group, in which you will NOT be visited by the Medical Family Therapist but WILL receive standard care as usual. The chances of being in one of the two groups are 50/50, meaning every other patient will be assigned to either the treatment group or the treatment as usual group.

3. HOW LONG WILL THE STUDY GO ON?

Your participation in this study will last one week. You will take a survey before seeing the doctor today, another survey after seeing the doctor today, and a third and last survey over the phone one week after today. Each survey is five pages and should take 20 minutes to complete.

In addition, if you are assigned to the treatment group, there is a chance that the length of time you spend at SACHS will be longer due to the time it takes to complete the second survey after your doctor’s visit and if you desire more time to talk to the Medical Family Therapist.

4. HOW WILL I BE INVOLVED?

You must meet the following requirements to be in the study:

Inclusion Requirements

You can participate in this study if you are at least 18 years of age and understand, speak, read, and write English.

Exclusion Requirements

You will not be able to participate in this study if you cannot comprehend and sign the informed consent for yourself. If you are dealing with a severe emergency and need immediate attention, you will not be able to participate in this study. In addition, if the speed and quality of care you receive are going to be negatively impacted, you will not be able to participate in this study. Also, you will not be able to participate in this study if you are unable to finish filling out the surveys or choose not to finish filling out the surveys.

If you meet the screening requirements and you choose to take part in the study, then the following procedures will take place: It is important to note that you may or may not get a visit from the MedFT during your doctor’s visit. However, whether or not the MedFT visits with you, you will be asked to fill out a survey before seeing the doctor today, after seeing the doctor today, and over the telephone one week from today. In addition, your

MedFT will not be the same person as the investigator asking you to fill out surveys and calling you for the final survey.

After you have completed all the surveys, you will be eligible to receive a $100 Wal-Mart gift card in a drawing. For example, your name will be placed in one box. After everyone has finished participating in the study, the investigator will pull out one name from the box of names and that person will get the gift card.

Participation in this study involves the following:

- Before seeing the doctor, the investigator will hand you the first survey
- The survey will first ask you about your gender, income, education, etc. Then it will ask you about your social and physical experiences. Your experiences at the doctor's office and in your community will also be explored. Please read each question carefully but <u>do not spend too much time answering each question</u>. Answer according to your first impression.
- After completing the first survey, give it back to the investigator, who will be checking in on you from time to time.
- You are then free to visit with the doctor and anyone else during your visit.
- After your doctor's visit, you will be asked to fill out a second survey. The first and second surveys include similar questions. In addition, you will be asked to write down when you are available to be called for a telephone appointment so that your last survey questions can be answered. Also, you will be asked to fill out your name and information so you can be contacted if you win the $100 Wal-Mart gift card.
- One week from today, you will be called for a telephone appointment and you will again be asked questions regarding your social and physical experiences.

5. WHAT ARE THE REASONABLY FORESEEABLE RISKS OR DISCOMFORTS I MIGHT HAVE?

There are no risks of physical harm associated with participation in this study. However, participation in this research study may involve invasion of privacy. Therefore, every effort will be made to protect the confidentiality and anonymity of the information you have given.

There may also be some psychological discomfort. Some of the questions may cause embarrassment or anxiety or may be upsetting or make you uncomfortable. If you do not wish to answer a question, you can skip it and go to the next question. If you do not wish to participate you can stop. If you find yourself needing more support, on-site counselors are available for you.

6. WILL THERE BE ANY BENEFIT TO ME OR OTHERS?

Although you will not benefit directly from this study, the scientific information we learn from the study may benefit individuals in the future by improving the quality of health care.

7. WHAT ARE MY RIGHTS AS A SUBJECT?

Participation in this study is voluntary. Your decision whether or not to participate or withdraw at any time from the study will not affect your ongoing relationship with your healthcare professionals and will not involve any penalty or loss of benefits to which you are otherwise entitled.

8. WHAT HAPPENS IF I WANT TO STOP TAKING PART IN THIS STUDY?

You are free to withdraw from this study at any time. If you decide to withdraw from this study you should notify the investigator immediately. The investigator may also end your participation in this study if you do not follow instructions, miss scheduled visits, or if your safety and welfare are at risk.

9. WHAT OTHER CHOICES DO I HAVE?

If you are assigned to the control group but need to meet with the Medical Family Therapist, please inform the investigator and you will be able to meet with the therapist. However, you will no longer be able to participate in this study at that time.

In addition, if you choose not to be a part of this study, you will still have the option of meeting with the Medical Family Therapist depending on his or her availability.

10. HOW WILL INFORMATION ABOUT ME BE KEPT CONFIDENTIAL?

Efforts will be made to keep your personal information confidential by 1) removing your name from information stored in the hard and electronic copies; 2) limiting access to information linking your name with your surveys; and 3) limiting access to research data and information to only investigators.

The three surveys you fill out will be labeled with a number. Your name will not be listed on any of the pages in the surveys. The pages that do ask for your name and contact information will be placed in a separate place to limit anyone from linking your name with your survey answers.

It is important to note that this study information is separate and distinct from your medical records. None of the surveys you fill out will be in your medical chart and none of your medical staff will have access to your survey answers.

The results of this study will be included in a investigator's [Mayuri Pandit] doctoral dissertation project and may also be included in manuscripts submitted to professional journals for publication. However, you will not be identified by name in any publications describing the results of this study.

Your rights regarding permission to use your health information are described on the attached “Authorization for Use of Protected Health Information” form.

11. WHAT COSTS ARE INVOLVED?

There is no cost to you for participating in this study.

12. WILL I BE PAID TO PARTICIPATE IN THIS STUDY?

You will not be paid to participate in this research study. However, you will be eligible to win a $100 Wal-Mart gift card through a drawing at the end of this study.

13. WHO DO I CALL IF I HAVE QUESTIONS?

Please call Mayuri (Mia) Pandit at (909) 382 7135 if you have any questions. You may also call (909) 558 4647 or e-mail patientrelations@llu.edu for information and assistance with complaints or concerns about your rights in this study as they are an impartial third party.

14. SUBJECT’S STATEMENT OF CONSENT

- I have read the contents of the consent form given by the investigator.
- My questions concerning this study have been answered to my satisfaction.
- Signing this consent document does not waive my rights nor does it release the investigators, institution or sponsors from their responsibilities.
- I may call Mayuri (Mia) Pandit at (909) 382 7135 or Brian Distelberg, PhD at (909) 558 4547 x47019 if I have additional questions or concerns during routine office hours.
- I hereby give voluntary consent to participate in this study.

I understand I will be given a copy of this consent form after signing it.

Signature of Subject	Printed Name of Subject
Date	

15. INVESTIGATOR'S STATEMENT

I have reviewed the contents of this consent form with the person signing above. I have explained potential risks and benefits of the study.

Signature of Investigator	Printed Name of Investigator

Date

APPENDIX B

PATIENT PACKET 1 (T1)

Patient Packet 1

Patient Numerical Identifier (To be filled out by the researcher only):______

**Please check one box for each question or write in your answer to indicate your current status:*

What is your sex?
☐ Male
☐ Female

What is your age? _________

What is your marital status?
☐ Now married
☐ Widowed
☐ Divorced
☐ Separated
☐ Never married

What is the highest degree or level of school you have completed?
☐ No school
☐ Elementary school
☐ Some high school, but did not finish
☐ Completed high school
☐ Some college, but did not finish
☐ Completed college
☐ Some graduate work , but did not finish
☐ Completed graduate work

How would you describe your current employment status?
☐ Employed
☐ Unemployed / Looking for work
☐ Student
☐ Homemaker
☐ Retired
☐ Unable to work

What is your annual household income?
☐ Less than $10,000
☐ $10,000 to $19,999
☐ $20,000 to $29,999
☐ $30,000 to $39,999
☐ $40,000 to $49,999
☐ $50,000 to $59,999
☐ $60,000 to $69,999
☐ $70,000 to $79,999
☐ $80,000 to $89,999
☐ $90,000 to $99,999
☐ $100,000 or more

How would you classify yourself?
☐ Asian/Pacific Islander
☐ Black/African American
☐ Caucasian/White
☐ Hispanic/Latino
☐ Indigenous or Aboriginal
☐ Multiracial
☐ Would rather not say
☐ Other:___________________

Number of previous visits with Family Health Consultant (*e.g. Counselor*):_______________

Number of visits to the doctor every year:___________________

Please list your medical diagnoses (e.g. *Diabetes*):
1.______________________________
2.______________________________
3.______________________________
4.______________________________
5.______________________________
☐ NONE

Please list your mental illness diagnoses (e.g. *Bi-Polar Disorder*):
1.______________________________
2.______________________________
3.______________________________
4.______________________________
5.______________________________
☐ NONE

*P*lease circle your first response to each statement regarding **your previous experiences at your doctor's office***

1. I was willing to listen to different opinions.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
2. I could get information from community resources.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
3. I could get information from my doctor or nurse.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
4. I could understand the information I received from my doctor or nurse.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
5. I could make choices based on the information I received.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
6. I could take responsibility for the decisions I made.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
7. Decisions about my life were:	Very hard to make	Somewhat hard to make	Neither hard nor easy	Somewhat easy to make	Very easy to make
8. I was comfortable with most of my decisions.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
9. I was able to set goals for myself.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
10. I was able to follow through on the goals I set.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
11. I would describe my ability to take care of my needs as:	Unable to meet my needs	Meet a few of my needs	Meet some of my needs	Meet most of my needs	Meet all of my needs

How confident are you that you can:

12. Define your own needs?	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident
13. Decide what to do based on your needs?	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident
14. Act on the decisions you made based on your needs?	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident
15. Take care of your needs on a daily basis?	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident
16. Get family and friends to help you with things you need? (such as household chores and	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident
17. Get help with daily tasks from outside resources? (any group other than family and	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident
18. Get emotional support from family and friends? (such as listening or talking over	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident
19. Talk about personal problems with your health care professionals?	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident
20. Do the daily tasks and activities necessary to take care of yourself and your family?	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident

*_Please write in your answer._

Have you felt encouraged by your healthcare professionals to speak up about <u>your health and health care</u> at your previous doctor's visit? If yes, how were you encouraged?

Have you felt you were encouraged to speak up about <u>anything</u> at your previous doctor's visit by your healthcare professionals? If yes, how were you encouraged?

Please circle your first response to each statement regarding* ***your previous experiences with your family, friends, and medical community* *(doctors, nurses, etc. who have been providing health care).*

1. If I had a critical problem, even people I do not know in this medical community would be willing to	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
2. I feel good about myself when I sacrifice and give time and energy to members of my family.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
3. The things I do for members of my family and they do for me make me feel part of my family.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
4. People here know they can get help from the medical community if they are in need.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
5. I have friends who let me know they value who I am and what I can do.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
6. People can depend on each other in this medical community.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
7. Members of my family seldom listen to my problems or concerns, I usually feel criticized.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
8. My friends are a part of my everyday activities.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
9. There are times when my family members do things that make my other family members unhappy.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
10. I need to be very careful how much I do for my friends because they take advantage of me.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
11. Coming to this medical community gives me a secure feeling.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
12. The members of my family make an effort to show their love and affection for me.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
13. There is a feeling in this medical community that people should not get too friendly with each other.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
14. This is not a very good medical community to bring children to.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
15. I feel secure that I am as important to my friends as they are to me.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
16. I have some very close friends outside the family who I know really care for me and love me.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
17. Member(s) of my family do not seem to understand me; I feel taken for granted.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree

**Please write in your answer.*

Have you felt supported and cared for by your healthcare professionals? If yes, how so?

Have you felt connected with and understood by your healthcare professionals? If yes, how so?

Have you felt that your healthcare professionals encouraged you to have good relationships with your friends and family?

Please circle the answer that best describes how you felt during the* ***past 7 days**.*

1. Faintness or dizziness	Not at all	Occasionally	Seldom	Frequently	Always
2. Feeling no interest in things	Not at all	Occasionally	Seldom	Frequently	Always
3. Nervousness or shakiness inside	Not at all	Occasionally	Seldom	Frequently	Always
4. Pain on heart or chest	Not at all	Occasionally	Seldom	Frequently	Always
5. Feeling lonely	Not at all	Occasionally	Seldom	Frequently	Always
6. Feeling tense or keyed up	Not at all	Occasionally	Seldom	Frequently	Always
7. Nausea or upset stomach	Not at all	Occasionally	Seldom	Frequently	Always
8. Feeling blue	Not at all	Occasionally	Seldom	Frequently	Always
9. Suddenly scared for no reason	Not at all	Occasionally	Seldom	Frequently	Always
10. Trouble getting one's breath	Not at all	Occasionally	Seldom	Frequently	Always
11. Feeling worthless	Not at all	Occasionally	Seldom	Frequently	Always
12. Spells of terror or panic	Not at all	Occasionally	Seldom	Frequently	Always
13. Numbness or tingling in parts of one's body	Not at all	Occasionally	Seldom	Frequently	Always
14. Feeling hopeless about the future	Not at all	Occasionally	Seldom	Frequently	Always
15. Feeling so restless that one could not sit still	Not at all	Occasionally	Seldom	Frequently	Always
16. Feeling weak in parts of one's body	Not at all	Occasionally	Seldom	Frequently	Always
17. Thoughts of ending one's life	Not at all	Occasionally	Seldom	Frequently	Always
18. Feeling fearful	Not at all	Occasionally	Seldom	Frequently	Always

Please circle your first response to each statement. Think of the people close to you—**friends and/or family****—in responding to each statement.*

1. I *always* place the needs of others above my own.	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree
2. I never find myself getting overly involved in others' problems.	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree
3. For me to be happy, I need others to be happy.	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree
4. I worry about how other people get along without me when I am not there.	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree
5. I have *no* trouble getting to sleep at night when other people are upset.	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree
6. It is impossible for me to satisfy my own needs when they interfere with the needs of	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree
7. I can't say no when someone asks me for help.	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree
8. Even when exhausted, I will always help other people.	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree
9. I often worry about others' problems.	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree

Please circle your first response to each statement regarding* *<u>your previous experiences with your doctor(s).</u>***

1. If I have a health care question, I can reach my health care provider without any problems.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
2. My health care provider always does his or her best to keep me from worrying.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
3. My health care provider always treats me with respect.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
4. Sometimes my health care provider makes me feel foolish.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
5. My health care provider causes me to worry a lot because he or she doesn't explain medical	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
6. My health care provider respects my feelings.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
7. My health care provider hardly ever explains my medical problems to me.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
8. My health care provider is not as thorough as he or she should be.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
9. My health care provider encouragers me to get a yearly exam.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
10. My health care provider is very careful to check everything when examining me.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
11. My health care provider asks what foods I eat and explains why certain foods are best.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
12. My health care provider ignores medical problems I've had in the past when I seek care for new problems.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
13. My health care provider doesn't explain about ways to avoid illness or injury.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
14. I'm very satisfied with the care I receive from my health care provider.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
15. The care I receive from my health care provider is just about perfect.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
16. My health care provider could give better care.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
17. There are things about the care I receive from my health care provider which could be better.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
18. The type of health care I need is available from my health care provider.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree

***<u>The items below inquire about what kind of person you think you are</u>**. Each item consists of a PAIR of characteristics, with the numbers 1-5 in between. For example:

Not at all artistic *1 2 3 4 [✓ 5]* **Very artistic**

Each pair describes contradictory characteristics - that is, you cannot be both at the same time, such as very artistic and not at all artistic. The numbers form a scale between the two extremes. ***<u>Please choose a number which describes where YOU fall on the scale</u>***. For example, if you think that you have no artistic ability, you would choose 1. If you think that you are pretty good, you might choose 5. If you are only medium, you might choose 3, and so forth.

Not at all arrogant	*1*	*2*	*3*	*4*	*5*	**Very arrogant**
Not at all independent	*1*	*2*	*3*	*4*	*5*	**Very independent**
Not at all emotional	*1*	*2*	*3*	*4*	*5*	**Very emotional**
Looks out for self	*1*	*2*	*3*	*4*	*5*	**Looks out for others**
Very passive	*1*	*2*	*3*	*4*	*5*	**Very active**
Not at all egotistical	*1*	*2*	*3*	*4*	*5*	**Very egotistical**
Difficult to devote self completely to others	*1*	*2*	*3*	*4*	*5*	**Easy to devote self completely to others**
Very rough	*1*	*2*	*3*	*4*	*5*	**Very gentle**
Not at all helpful to others	*1*	*2*	*3*	*4*	*5*	**Very helpful to others**
Not at all boastful	*1*	*2*	*3*	*4*	*5*	**Very boastful**
Not at all competitive	*1*	*2*	*3*	*4*	*5*	**Very competitive**
Not at all kind	*1*	*2*	*3*	*4*	*5*	**Very kind**
Not at all aware of others' feelings	*1*	*2*	*3*	*4*	*5*	**Very aware of others' feelings**
Can make decisions easily	*1*	*2*	*3*	*4*	*5*	**Has difficulty making decisions**
Not at all greedy	*1*	*2*	*3*	*4*	*5*	**Very greedy**
Gives up easily	*1*	*2*	*3*	*4*	*5*	**Never gives up**
Not at all self-confident	*1*	*2*	*3*	*4*	*5*	**Very self-confident**
Feels very inferior	*1*	*2*	*3*	*4*	*5*	**Feels very superior**
Not at all dictatorial	*1*	*2*	*3*	*4*	*5*	**Very dictatorial**
Not at all understanding of others	*1*	*2*	*3*	*4*	*5*	**Very understanding of others**
Not at all cynical	*1*	*2*	*3*	*4*	*5*	**Very cynical**
Very cold relations with others	*1*	*2*	*3*	*4*	*5*	**Very warm in relations with others**
Not at all hostile	*1*	*2*	*3*	*4*	*5*	**Very hostile**
Goes to pieces under pressure	*1*	*2*	*3*	*4*	*5*	**Stands up well under pressure**

APPENDIX C

PATIENT PACKET 2 (T2)

Patient Packet 2
Patient Numerical Identifier (To be filled out by the researcher only):______

Please circle your first response to each statement regarding **<u>today's experience</u> at your doctor's office*

1. I am willing to listen to different opinions.	Strongly Disagree	Disagree	Neither Agree	Agree	Strongly Agree
2. I can get information from community resources.	Strongly Disagree	Disagree	Neither Agree	Agree	Strongly Agree
3. I can get information from my doctor or nurse.	Strongly Disagree	Disagree	Neither Agree	Agree	Strongly Agree
4. I can better understand the information I received from my doctor or nurse.	Strongly Disagree	Disagree	Neither Agree	Agree	Strongly Agree
5. I can make choices based on the information I received.	Strongly Disagree	Disagree	Neither Agree	Agree	Strongly Agree
6. I can take responsibility for the decisions I made.	Strongly Disagree	Disagree	Neither Agree	Agree	Strongly Agree
7. Decisions about my life are:	Very hard to	Somewhat hard to	Neither hard nor	Somewhat easy to	Very easy to
8. I am comfortable with most of my decisions.	Strongly Disagree	Disagree	Neither Agree	Agree	Strongly Agree
9. I am able to set goals for myself.	Strongly Disagree	Disagree	Neither Agree	Agree	Strongly Agree
10. I am able to follow through on the goals I set.	Strongly Disagree	Disagree	Neither Agree	Agree	Strongly Agree
11. I would describe my ability to take care of my needs as:	Unable to meet my needs	Meet a few of my needs	Meet some of my needs	Meet most of my needs	Meet all of my needs

<u>How confident are you that you can:</u>

12. Define your own needs?	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident
13. Decide what to do based on your needs?	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident
14. Act on the decisions you make based on your needs?	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident
15. Take care of your needs on a daily basis?	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident
16. Get family and friends to help you with things you need? (such as household chores and transportation)	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident
17. Get help with daily tasks from outside resources? (any group other than family and friends)	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident
18. Get emotional support from family and friends? (such as listening or talking over problems)	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident
19. Talk about personal problems with your health care professionals?	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident
20. Do the daily tasks and activities necessary to take care of yourself and your family?	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident

**Please write in your answer.*

Did you feel encouraged by your healthcare professionals to speak up about <u>your health and health care today</u>? If yes, how were you encouraged?

Did you feel encouraged by your healthcare professionals to speak up about <u>anything today</u>? If yes, how were you encouraged?

Please circle your first response to each statement regarding your feelings about your family, friends, and medical community* ***after today's doctor's visit**.*

1. If I had a critical problem, even people I do not know in this medical community would be willing to help.	Strongly Disagree	Disagree	Neither Agree nor	Agree	Strongly Agree
2. I feel good about myself when I sacrifice and give time and energy to members of my family.	Strongly Disagree	Disagree	Neither Agree nor	Agree	Strongly Agree
3. The things I do for members of my family and they do for me make me feel part of my family.	Strongly Disagree	Disagree	Neither Agree nor	Agree	Strongly Agree
4. People here know they can get help from the medical community if they are in need.	Strongly Disagree	Disagree	Neither Agree nor	Agree	Strongly Agree
5. I have friends who let me know they value who I am and what I can do.	Strongly Disagree	Disagree	Neither Agree nor	Agree	Strongly Agree
6. People can depend on each other in this medical community.	Strongly Disagree	Disagree	Neither Agree nor	Agree	Strongly Agree
7. Members of my family seldom listen to my problems or concerns, I usually feel criticized.	Strongly Disagree	Disagree	Neither Agree nor	Agree	Strongly Agree
8. My friends are a part of my everyday activities.	Strongly Disagree	Disagree	Neither Agree nor	Agree	Strongly Agree
9. There are times when my family members do things that make my other family members unhappy.	Strongly Disagree	Disagree	Neither Agree nor	Agree	Strongly Agree
10. I need to be very careful how much I do for my friends because they take advantage of me.	Strongly Disagree	Disagree	Neither Agree nor	Agree	Strongly Agree
11. Coming to this medical community gives me a secure feeling.	Strongly Disagree	Disagree	Neither Agree nor	Agree	Strongly Agree
12. The members of my family make an effort to show their love and affection for me.	Strongly Disagree	Disagree	Neither Agree nor	Agree	Strongly Agree
13. There is a feeling in this medical community that people should not get too friendly with each other.	Strongly Disagree	Disagree	Neither Agree nor	Agree	Strongly Agree
14. This is not a very good medical community to bring children to.	Strongly Disagree	Disagree	Neither Agree nor	Agree	Strongly Agree
15. I feel secure that I am as important to my friends as they are to me.	Strongly Disagree	Disagree	Neither Agree nor	Agree	Strongly Agree
16. I have some very close friends outside the family who I know really care for me and love me.	Strongly Disagree	Disagree	Neither Agree nor	Agree	Strongly Agree
17. Member(s) of my family do not seem to understand me; I feel taken for granted.	Strongly Disagree	Disagree	Neither Agree nor	Agree	Strongly Agree

**Please write in your answer.*

Did you felt supported and cared for by your healthcare professionals today? If yes, how so?

Did you felt connected with and understood by your healthcare professionals today? If yes, how so?

Did you felt that your healthcare professionals encouraged you to have good relationships with your friends and family today?

Please circle the answer that best describes how you have been feeling during the* ***past 7 days* *after today's doctor's visit.*

1. Faintness or dizziness	Not at all	Occasionally	Seldom	Frequently	Always
2. Feeling no interest in things	Not at all	Occasionally	Seldom	Frequently	Always
3. Nervousness or shakiness inside	Not at all	Occasionally	Seldom	Frequently	Always
4. Pain on heart or chest	Not at all	Occasionally	Seldom	Frequently	Always
5. Feeling lonely	Not at all	Occasionally	Seldom	Frequently	Always
6. Feeling tense or keyed up	Not at all	Occasionally	Seldom	Frequently	Always
7. Nausea or upset stomach	Not at all	Occasionally	Seldom	Frequently	Always
8. Feeling blue	Not at all	Occasionally	Seldom	Frequently	Always
9. Suddenly scared for no reason	Not at all	Occasionally	Seldom	Frequently	Always
10. Trouble getting one's breath	Not at all	Occasionally	Seldom	Frequently	Always
11. Feeling worthless	Not at all	Occasionally	Seldom	Frequently	Always
12. Spells of terror or panic	Not at all	Occasionally	Seldom	Frequently	Always
13. Numbness or tingling in parts of one's body	Not at all	Occasionally	Seldom	Frequently	Always
14. Feeling hopeless about the future	Not at all	Occasionally	Seldom	Frequently	Always
15. Feeling so restless that one could not sit still	Not at all	Occasionally	Seldom	Frequently	Always
16. Feeling weak in parts of one's body	Not at all	Occasionally	Seldom	Frequently	Always
17. Thoughts of ending one's life	Not at all	Occasionally	Seldom	Frequently	Always
18. Feeling fearful	Not at all	Occasionally	Seldom	Frequently	Always

Please circle your first response to each statement after today's doctor's visit. Think of the people close to you—**friends and/or family****—in responding to each statement.*

1. I *always* place the needs of others above my own.	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree
2. I never find myself getting overly involved in others' problems.	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree
3. For me to be happy, I need others to be happy.	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree
4. I worry about how other people get along without me when I am not there.	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree
5. I have *no* trouble getting to sleep at night when other people are upset.	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree
6. It is impossible for me to satisfy my own needs when they interfere with the needs of	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree
7. I can't say no when someone asks me for help.	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree
8. Even when exhausted, I will always help other people.	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree
9. I often worry about others' problems.	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree

Please circle your first response to each statement regarding your experiences with your doctor(s)* ***after today's visit*.

1. If I have a health care question, I can reach my health care provider without any problems.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
2. My health care provider always does his or her best to keep me from worrying.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
3. My health care provider always treats me with respect.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
4. Sometimes my health care provider makes me feel foolish.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
5. My health care provider causes me to worry a lot because he or she doesn't explain medical	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
6. My health care provider respects my feelings.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
7. My health care provider hardly ever explains my medical problems to me.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
8. My health care provider is not as thorough as he or she should be.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
9. My health care provider encouragers me to get a yearly exam.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
10. My health care provider is very careful to check everything when examining me.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
11. My health care provider asks what foods I eat and explains why certain foods are best.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
12. My health care provider ignores medical problems I've had in the past when I seek care for new problems.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
13. My health care provider doesn't explain about ways to avoid illness or injury.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
14. I'm very satisfied with the care I receive from my health care provider.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
15. The care I receive from my health care provider is just about perfect.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
16. My health care provider could give better care.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
17. There are things about the care I receive from my health care provider which could be better.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
18. The type of health care I need is available from my health care provider.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree

***<u>The items below inquire about what kind of person you think you are</u>**. Each item consists of a PAIR of characteristics, with the numbers 1-5 in between. For example:

Not at all artistic *1 2 3 4* [✓ *5*] **Very artistic**

Each pair describes contradictory characteristics - that is, you cannot be both at the same time, such as very artistic and not at all artistic. The numbers form a scale between the two extremes. **<u>Please choose a number which describes where YOU fall on the scale</u>**. For example, if you think that you have no artistic ability, you would choose 1. If you think that you are pretty good, you might choose 5. If you are only medium, you might choose 3, and so forth.

Not at all arrogant	*1*	*2*	*3*	*4*	*5*	**Very arrogant**
Not at all independent	*1*	*2*	*3*	*4*	*5*	**Very independent**
Not at all emotional	*1*	*2*	*3*	*4*	*5*	**Very emotional**
Looks out for self	*1*	*2*	*3*	*4*	*5*	**Looks out for others**
Very passive	*1*	*2*	*3*	*4*	*5*	**Very active**
Not at all egotistical	*1*	*2*	*3*	*4*	*5*	**Very egotistical**
Difficult to devote self completely to others	*1*	*2*	*3*	*4*	*5*	**Easy to devote self completely to others**
Very rough	*1*	*2*	*3*	*4*	*5*	**Very gentle**
Not at all helpful to others	*1*	*2*	*3*	*4*	*5*	**Very helpful to others**
Not at all boastful	*1*	*2*	*3*	*4*	*5*	**Very boastful**
Not at all competitive	*1*	*2*	*3*	*4*	*5*	**Very competitive**
Not at all kind	*1*	*2*	*3*	*4*	*5*	**Very kind**
Not at all aware of others' feelings	*1*	*2*	*3*	*4*	*5*	**Very aware of others' feelings**
Can make decisions easily	*1*	*2*	*3*	*4*	*5*	**Has difficulty making decisions**
Not at all greedy	*1*	*2*	*3*	*4*	*5*	**Very greedy**
Gives up easily	*1*	*2*	*3*	*4*	*5*	**Never gives up**
Not at all self-confident	*1*	*2*	*3*	*4*	*5*	**Very self-confident**
Feels very inferior	*1*	*2*	*3*	*4*	*5*	**Feels very superior**
Not at all dictatorial	*1*	*2*	*3*	*4*	*5*	**Very dictatorial**
Not at all understanding of others	*1*	*2*	*3*	*4*	*5*	**Very understanding of others**
Not at all cynical	*1*	*2*	*3*	*4*	*5*	**Very cynical**
Very cold relations with others	*1*	*2*	*3*	*4*	*5*	**Very warm in relations with others**
Not at all hostile	*1*	*2*	*3*	*4*	*5*	**Very hostile**
Goes to pieces under pressure	*1*	*2*	*3*	*4*	*5*	**Stands up well under pressure**

Patient Numerical Identifier (To be filled out by the researcher only):______________

Please fill-in your information *(Please write clearly)***:**

One-Week Later Telephone Call Scheduling Appointment

Please write in when you will be available for a phone call next week to complete the study with a final set of questions? The phone call should take about 20 minutes. Please include the exact time. e.g. Monday - 5 to 5:20pm.

Sunday	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	

$100 Gift Card to Wal-Mart Drawing Information

Name:_______________________________________

Address: _____________________________________

Phone Number: ________________________________

Alternate Phone Number: _________________________

Any other contact information (e.g. *e-mail address*): ___________________________________

APPENDIX D

PATIENT PACKET 3 (T3)

Patient Packet 3

Telephone Call Script:

“Hello, my name is __________ with Loma Linda University's Department of Counseling and Family Sciences. May I speak to _________?

I am calling to conclude the research study that you started last week. Would it be convenient for me to talk to you about the last part of the study right now? The questions should take about 20 minutes of your time.”

(If not, set time for re-call.)

(Begin with question 1…)

“I am going to read aloud a set of questions. Please let me know what your response is based on the five choices I will give you.”

(After going through all the questions listed in the following packet…)

“Thank you for your time and participation. You have now completed the study and are eligible for the drawing for a $100 Wal-Mart gift card. You will be notified if you have won the gift card once the study is complete and all the participants have been included in the drawing. If you have any questions or comments about this study, feel free to contact Dr. Brian Distelberg at (909) 558-4547 x47019. Thank you, once again, and have a good day.”

Patient Numerical Identifier (To be filled out by the researcher only):__________

Date and time patient was called:_______________________________________

Date and time patient completed the study:______________________________

"Please let me know your first response to each statement regarding what you have experienced at [the medical clinic]."

1. I was willing to listen to different opinions.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
2. I could get information from community resources.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
3. I could get information from my doctor or nurse.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
4. I could understand the information I received from my doctor or nurse.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
5. I could make choices based on the information I received.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
6. I could take responsibility for the decisions I made.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
7. Decisions about my life were:	Very hard to make	Somewhat hard to make	Neither hard nor easy	Somewhat easy to make	Very easy to make
8. I was comfortable with most of my decisions.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
9. I was able to set goals for myself.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
10. I was able to follow through on the goals I set.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
11. I would describe my ability to take care of my needs as:	Unable to meet my needs	Meet a few of my needs	Meet some of my needs	Meet most of my needs	Meet all of my needs

<u>How confident are you that you can:</u>

12. Define your own needs?	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident
13. Decide what to do based on your needs?	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident
14. Act on the decisions you made based on your needs?	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident
15. Take care of your needs on a daily basis?	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident
16. Get family and friends to help you with things you need? (such as household chores and	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident
17. Get help with daily tasks from outside resources? (any group other than family and	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident
18. Get emotional support from family and friends? (such as listening or talking over	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident
19. Talk about personal problems with your health care professionals?	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident
20. Do the daily tasks and activities necessary to take care of yourself and your family?	Not very confident	A little confident	Somewhat confident	Very confident	Extremely confident

"Please answer based on your current experiences with your family, friends, and medical community"

1. If I had a critical problem, even people I do not know in this medical community would be willing to	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
2. I feel good about myself when I sacrifice and give time and energy to members of my family.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
3. The things I do for members of my family and they do for me make me feel part of my family.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
4. People here know they can get help from the medical community if they are in need.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
5. I have friends who let me know they value who I am and what I can do.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
6. People can depend on each other in this medical community.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
7. Members of my family seldom listen to my problems or concerns, I usually feel criticized.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
8. My friends are a part of my everyday activities.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
9. There are times when my family members do things that make my other family members unhappy.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
10. I need to be very careful how much I do for my friends because they take advantage of me.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
11. Coming to this medical community gives me a secure feeling.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
12. The members of my family make an effort to show their love and affection for me.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
13. There is a feeling in this medical community that people should not get too friendly with each other.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
14. This is not a very good medical community to bring children to.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
15. I feel secure that I am as important to my friends as they are to me.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
16. I have some very close friends outside the family who I know really care for me and love me.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
17. Member(s) of my family do not seem to understand me; I feel taken for granted.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree

“Please let me know your answer that best describes how you felt during the past 7 days.”

1. Faintness or dizziness	Not at all	Occasionally	Seldom	Frequently	Always
2. Feeling no interest in things	Not at all	Occasionally	Seldom	Frequently	Always
3. Nervousness or shakiness inside	Not at all	Occasionally	Seldom	Frequently	Always
4. Pain on heart or chest	Not at all	Occasionally	Seldom	Frequently	Always
5. Feeling lonely	Not at all	Occasionally	Seldom	Frequently	Always
6. Feeling tense or keyed up	Not at all	Occasionally	Seldom	Frequently	Always
7. Nausea or upset stomach	Not at all	Occasionally	Seldom	Frequently	Always
8. Feeling blue	Not at all	Occasionally	Seldom	Frequently	Always
9. Suddenly scared for no reason	Not at all	Occasionally	Seldom	Frequently	Always
10. Trouble getting one's breath	Not at all	Occasionally	Seldom	Frequently	Always
11. Feeling worthless	Not at all	Occasionally	Seldom	Frequently	Always
12. Spells of terror or panic	Not at all	Occasionally	Seldom	Frequently	Always
13. Numbness or tingling in parts of one's body	Not at all	Occasionally	Seldom	Frequently	Always
14. Feeling hopeless about the future	Not at all	Occasionally	Seldom	Frequently	Always
15. Feeling so restless that one could not sit still	Not at all	Occasionally	Seldom	Frequently	Always
16. Feeling weak in parts of one's body	Not at all	Occasionally	Seldom	Frequently	Always
17. Thoughts of ending one's life	Not at all	Occasionally	Seldom	Frequently	Always
18. Feeling fearful	Not at all	Occasionally	Seldom	Frequently	Always

“Please answer based on the people close to you—friends and/or family—in responding to each statement.”

1. I *always* place the needs of others above my own.	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree
2. I never find myself getting overly involved in others' problems.	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree
3. For me to be happy, I need others to be happy.	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree
4. I worry about how other people get along without me when I am not there.	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree
5. I have *no* trouble getting to sleep at night when other people are upset.	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree
6. It is impossible for me to satisfy my own needs when they interfere with the needs of	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree
7. I can't say no when someone asks me for help.	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree
8. Even when exhausted, I will always help other people.	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree
9. I often worry about others' problems.	Strongly Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Strongly Agree

“Please let me know your first response to each statement regarding your experiences with your doctors at [the medical clinic].”

1. If I have a health care question, I can reach my health care provider without any problems.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
2. My health care provider always does his or her best to keep me from worrying.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
3. My health care provider always treats me with respect.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
4. Sometimes my health care provider makes me feel foolish.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
5. My health care provider causes me to worry a lot because he or she doesn’t explain medical	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
6. My health care provider respects my feelings.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
7. My health care provider hardly ever explains my medical problems to me.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
8. My health care provider is not as thorough as he or she should be.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
9. My health care provider encouragers me to get a yearly exam.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
10. My health care provider is very careful to check everything when examining me.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
11. My health care provider asks what foods I eat and explains why certain foods are best.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
12. My health care provider ignores medical problems I’ve had in the past when I seek care for new problems.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
13. My health care provider doesn’t explain about ways to avoid illness or injury.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
14. I’m very satisfied with the care I receive from my health care provider.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
15. The care I receive from my health care provider is just about perfect.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
16. My health care provider could give better are.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
17. There are things about the care I receive from my health care provider which could be better.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
18. The type of health care I need is available from my health care provider.	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree

“When thinking about what kind of person you are, please let me know what your response is based on 1 to 5 scale. One means you do not really have this quality. Two, three, and four mean you have increasing amounts of this quality. Five means you have a lot of this quality. Question 1: How would you describe yourself if 1 meant you were not at all arrogant and 5 meant you were very arrogant?”

Not at all arrogant	*1*	*2*	*3*	*4*	*5*	**Very arrogant**
Not at all independent	*1*	*2*	*3*	*4*	*5*	**Very independent**
Not at all emotional	*1*	*2*	*3*	*4*	*5*	**Very emotional**
Looks out for self	*1*	*2*	*3*	*4*	*5*	**Looks out for others**
Very passive	*1*	*2*	*3*	*4*	*5*	**Very active**
Not at all egotistical	*1*	*2*	*3*	*4*	*5*	**Very egotistical**
Difficult to devote self completely to others	*1*	*2*	*3*	*4*	*5*	**Easy to devote self completely to others**
Very rough	*1*	*2*	*3*	*4*	*5*	**Very gentle**
Not at all helpful to others	*1*	*2*	*3*	*4*	*5*	**Very helpful to others**
Not at all boastful	*1*	*2*	*3*	*4*	*5*	**Very boastful**
Not at all competitive	*1*	*2*	*3*	*4*	*5*	**Very competitive**
Not at all kind	*1*	*2*	*3*	*4*	*5*	**Very kind**
Not at all aware of others’ feelings	*1*	*2*	*3*	*4*	*5*	**Very aware of others’ feelings**
Can make decisions easily	*1*	*2*	*3*	*4*	*5*	**Has difficulty making decisions**
Not at all greedy	*1*	*2*	*3*	*4*	*5*	**Very greedy**
Gives up easily	*1*	*2*	*3*	*4*	*5*	**Never gives up**
Not at all self-confident	*1*	*2*	*3*	*4*	*5*	**Very self-confident**
Feels very inferior	*1*	*2*	*3*	*4*	*5*	**Feels very superior**
Not at all dictatorial	*1*	*2*	*3*	*4*	*5*	**Very dictatorial**
Not at all understanding of others	*1*	*2*	*3*	*4*	*5*	**Very understanding of others**
Not at all cynical	*1*	*2*	*3*	*4*	*5*	**Very cynical**
Very cold relations with others	*1*	*2*	*3*	*4*	*5*	**Very warm in relations with others**
Not at all hostile	*1*	*2*	*3*	*4*	*5*	**Very hostile**
Goes to pieces under pressure	*1*	*2*	*3*	*4*	*5*	**Stands up well under pressure**

APPENDIX E

MEDICAL FAMILY THERAPIST FORM

Medical Family Therapist Form

Patient Numerical Identifier (To be filled out by the researcher only):__________

Please fill-in the following information:

1. Approximately how much time did you spend with the patient(s)? __________

2. Every Medical Family Therapist participating in this study SHOULD use the following techniques. Please check all that were used in this session.

☐ Solicit the illness story

☐ Increase a sense of agency in the patient and the family (increase a sense of competency)

☐ Maintain communication (strengthen a sense of connectedness)

3. Which additional Medical Family Therapy techniques did you use? Please check all that apply.

☐ Recognize the biological dimensions

☐ Respect defenses, remove blame, and accept unacceptable feelings

☐ Attend to developmental issues (the patient's and/or family's)

☐ Leave the door open for future contact

4. Please circle a number to indicate the overall "amount" of typical MedFT interventions and processes you felt you provided for this patient(s). A score of 10 indicates that you provided the most concentrated amount of MedFT in this session.

Not a lot	1	2	3	4	5	6	7	8	9	10	A lot

5. Additional comments regarding interventions/techniques/frameworks that you used in this session:

____

____

____

____

____

____

____