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Ruh Sağlığı Uzmanlarının Fiziksel Hastalığı ve/veya Engeli Olan Bireylerle Çalışırken Sistemik İlkeleri Kullanımı: Türkiye'den bir Örneklem ile Anket Çalışması

Betül Kaytan

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Mental Health Professionals' Use of Systemic Principles When Working with Individuals with a Physical Illness and/or Disability: A Survey Study with a sample from Turkey

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Abstract

Many people have to cope with chronic and/or congenital illnesses/disabilities. Medical problems influence individuals physical integrity, mental health, family life, social relations, and quality of life. Based on the systemic principals, we can say that a change in an individual life affects the system that she/he is a part of. Despite the fact that many mental health professionals in Turkey work with individuals coping with health issues, there is no study on how they practice while providing mental health services to their clients.

The purpose of this study is to present a picture as to how mental health practitioners in a sample from Turkey approach their clients coping with a physical illness and/or disability. The focus is on therapeutic practices and results are discussed from a systemic point of view. The instrument used was a 34-item survey designed for the purpose of the study. The survey included demographic information such as gender, age, education level, area of specialty, work setting, number of years in practice, theoretical orientation and the population worked with. It also contained items that pertain to the process of psychotherapy. These items were formulated using a 5-point rating scale that ranged between *never* (1) and *always* (5).

The sample size was 166. Participants came from different areas of specialty and theoretical orientation. Analyses revealed that the couple and family therapists more frequently include the family members in the psychotherapy process of the client who suffer from a medical problem, and that they more frequently make interventions to strengthen the emotional connections among family members. Clinical psychologists were less likely to conduct psychotherapy together with the family of the client. Psychiatrists were more inclined to include the family during the assessment course and less likely to deliberate on family dynamics in sessions. Practitioners with analytical-psychodynamic orientation were less likely to inform clients about how their medical problems would proceed. Mental health professionals from systemic and experiential orientations were more inclined to include the family of the client into the therapy process. Strengths and limitations of the study, along with the implications of the findings were discussed.

Özet

Günümüzde çok sayıda insan kronik hastalıklar ve/veya engeller ile mücadele etmektedir. Sağlık problemleri kişinin fiziksel bütünlüğünü, ruhsal sağlığını, aile hayatını, sosyal ilişkilerini, yaşam kalitesini etkilemektedir. Sistemik prensiplere göre bireyin hayatındaki bir değişiklik o bireyin parçası olduğu sistemi etkilemektedir diyebiliriz. Türkiye'de sağlık problemi olan bireylerle çalışan çok sayıda ruh sağlığı uzmanı olmasına karşın, bu uzmanların danışanlara nasıl bir ruhsal destek sağladığına dair bir çalışma bulunmamaktadır.

Çalışmanın amacı Türkiye'den bir örneklemde ruh sağlığı uzmanlarının fiziksel hastalığı veya engeli olan bireylerle çalışırken nasıl bir terapi/danışmanlık süreci takip ettiklerine dair bilgi edinmektir. Bunun için terapötik uygulamalara odaklanılmış ve bulgular sistemik bakış açısından tartışılmıştır. Otuz dört maddeden oluşan yapılandırılmış bir anket hazırlandı ve çalışmanın amacına yönelik olarak kullanıldı. Anket cinsiyet, yaş, eğitim düzeyi, uzmanlık alanı, çalışma ortamı, deneyim yılı, teorik yönelim, çalışılan popülasyon gibi demografik sorular içermektedir. Ek olarak, ankette psikoterapi sürecine ile ilgili ifadeler yer almaktadır. Bu ifadeler *hiçbir zaman* ve *her zaman* arasında değişen 5 dereceli bir ölçekle oluşturulmuştur.

Çalışmanın örnekleminde 166 katılımcı vardır. Çalışmanın örneklemini oluşturan katılımcılar farklı uzmanlık alanları ve teorik yönelimlerden gelmektedirler. Yapılan analizler çift ve aile terapistlerinin fiziksel hastalığı olan bireylerle çalışırken diğer uzmanlıklara göre aile üyerini birlikte çalıştıkları danışanın terapi sürecine daha sık dahil ettiklerini ve ailenin duygusal bağlarını güçlendirmeye yönelik daha sık çalıştığını göstermektedir. Klinik psikologlar ise diğer uzmanlara göre danışanın terapi sürecini aile ile *birlikte* daha az yürütmektedir. Psikiyatrlar diğer uzmanlara göre *değerlendirme* sürecinde aileyi daha fazla dahil etmekte ve terapide aile dinamikleri üzerine diğer uzmanlara göre az sıklıkta durmaktadır. Analitik/dinamik yönelimli çalışan uzmanlar hastalık/engel süreçleriyle ilgili daha az sıklıkta danışanlarına bilgilendirmede bulunmaktadır. Sistemik ve deneyimsel yönelimli çalışanlar diğer yönelimlerde çalışanlara göre aileyi daha sıklıkla terapi sürecine dahil etmektedir. Çalışmanın güçlü yönleri ve sınırlılıklarının yanı sıra bulguların çıkarımları tartışılmıştır.

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CHAPTER 1 – INTRODUCTION

Chronic disease is as a health condition that persists for at least 3 months and that cannot be prevented by vaccines or fully cured by medication (Definition of Chronic Disease, 2016). Chronic illnesses or disabilities have become common experiences that people either go through themselves or closely witness in a family member. Coping with an illness and/or disability impacts our physical integrity, our relationships, mental health and quality of life. This impact has been investigated through clinical studies across different disciplines. However, up until 1970s, studies on healthcare predominantly focused on the traditional biomedical model that frames illness as a purely biological concept (Engel, 1977). As opposed to the biomedical model, Engel's (1977, 1980) biopsychosocial (BPS) approach emphasizes the biological, psychological, and social domains of life in the treatment of medical problems individuals encounter. The biopsychosocial model is grounded in the systemic perspective, which – within this context– investigates the impact of health condition on the patient, the patient's family and his/her other significant relationships. Diagnosis of a serious health problem has a profound impact on the patient and his/her family. Up to date, many researchers have investigated the psychosocial effects of different chronic diseases or disabilities on patients (see Hacıhasanoglu, Karakurt, Yıldırım & Uslu, 2010; Keles, Ekici, Ekici, Bulcun & Altınkaya, 2007; Eren, Erdi & Şahin, 2008; Öncü, Başoğlu & Kuran, 2013). Yet most clinicians have focused on the illness experiences of the patients, and there remains a need for understanding the impact of the illness in question on the family system, as well.

Medical Family Therapy (MedFT), with a developmental history that utilizes the tenets of Systemic Family Therapy and Engel’s (1997) biopsychosocial approach, offers a critical ground, both theoretically and practically, for mental health workers who work with individuals coping with a physical illness and/or disability. In understanding the impact of any illness/disability on people’s lives, the MedFT framework takes into account the larger system that the individual is a part of. The system includes the patient, his/her family and social/professional circle, his/her sources of support, the treatment team and the health care system.

As chronic diseases and disabilities have become more common and the need for psychological support for the patients has become more evident, it is essential that mental health workers comprehend the systemic impact of a chronic illness or disability on the person in order to offer efficient care for those individuals and their families affected. Medical family therapy is one of the clinical models that precisely highlights the systemic impact of a chronic disease or disability on patients and their families. Although this model is still unknown in Turkey, its principles may be used by mental health professionals from a variety of disciplines. This dissertation, which rests on the data collected from a sample from Turkey, was written to present a picture as to the extent of use of systemic principles by mental health workers when treating patients with a chronic illness and/or disability, along with their families.

Statement of the Problem

Chronic illnesses differ from communicable diseases by their noncontagious feature. This means that they are not transmitted from one person to another and that they often progress slowly and exert effects on the body over an extended period. According to World Health Organization's (WHO) report (WHO, 2014), in 2012 38 million people died as a result of a chronic disease, of which 28 million were living in low- or middle-income countries. Globally speaking, among all chronic illnesses, the cardiovascular disease (17.5 million) was the number one cause of death in 2012, followed by cancer (8.2 million), respiratory diseases (4 million), and diabetes (1.5 million). We see a similar picture in Turkey, as well: 75% of deaths result from chronic diseases every year (Turkish Ministry of Health, 2013). Turkish Statistical Institute's (2015) report on causes of death in 2014 reveals that the leading cause was circulatory system diseases (40 percent), followed by benign and malignant tumors (20.7 percent), diseases of the respiratory system (10.7 percent), and diseases related to the endocrine system, nutrition and metabolism (5.1 percent). Existing literature suggests that chronic illness has an impact on both patients and their families. According to Weihs, Fisher and Baird (2002) chronic illness impacts families' coherence, cohesion, organization, conflict resolution strategies and relationship satisfaction.

It is estimated that over one billion people all over the globe (15 percent of the world population) have at least one type of disability (WHO, 2015). According to the population census conducted in 2002, there are approximately 8.5 million people (12.3 percent of the overall population) with some form of disability in Turkey (State Institute of Statistics, 2009). Disabled people have higher health risks, as well as a wider range of health care needs compared to the general population (Inan, Peker, Tekiner, Ak & Dağlı, 2013). Results from the population census of 2002 also showed that only half of the disabled individuals receive treatment for their disability, and only 5.9 percent of the people with a disability benefit from health care and rehabilitation services.

Numerous studies highlight the psychosocial aspect of chronic illness/disability. Psychosocial needs are twofold: (1) Those of the patients who suffer from the chronic disease/disability (see Öncü, Başoğlu & Kuran, 2013; Kocaman, 2008; Işık, 2014; Hacıhasanoğlu, Karakurt, Yıldırım & Uslu, 2010; Keles, Ekici, Ekici, Bulcun & Altinkaya, 2007; Eren, Erdi & Şahin, 2008;), and (2) those of their caregivers (see Cabizuca, Marques-Portella, Mendlowicz, Coutinho & Figueira, 2009; Okyayüz, 2004; Yıkılkan, Aypak & Görpelioğlu, 2014; Özyazıcıoğlu & Buran, 2014; Tutoglu, Boyaci, Koca, Celen & Korkmaz, 2014; Yildiz, Celebioglu & Olgun, 2009; Pınar, Pınar & Ayhan, 2012; Bumin, Günal & Tükel, 2008; Yılmaz, Yıldırım, Öksüz, Atay & Turan, 2010; Mitchell, Hilliard, Mednick, Henderson, Cogen & Streisand, 2009). Currently present health care services often focus on treating the disease medically, and fall short of addressing the physiological, psychological, social and economic demands laid on the families of the patients (İnan, Peker, Tekiner, Ak & Dağlı, 2013; Atagün, Balaban, Atagün, Elagöz & Özpolat, 2011; Akkuş, 2011;

Karabuğa-Yakar & Pınar, 2013; Yıldırım-Sarı &Başbakkal, 2010; Dayapoğlu & Tan, 2009). In order to make accurate need assessment with respect to this issue within the existing health care system and to develop effective approaches, it is important to first assess the status of mental health professionals, and how they work with individuals with an illness/disability.

Among the current theoretical and practical approaches in mental health care, systemic therapy is seen as one of the competent approaches that can address the potential demands of patients and their caregivers. Likewise, medical family therapists aim to provide an effective treatment and support model for mental health care professionals who work with patients (along with their families) coping with a physical illness and/or disability. This model of practice, grounded within the systemic perspective and the biopsychosocial approach, includes principles and practices that can be utilized by mental health professionals coming from a variety of theoretical backgrounds. Moreover, collaboration with the family and other health professionals is indispensable part of the work for medical family therapists. Without communication or collaboration with the respective healthcare team, psychotherapy of an individual struggling with an illness/disability is at best risky and inadequate; it can even be harmful. Although the degree of communication and collaboration with other health providers can range from basic information exchange to designing of the treatment plan collectively, in all cases it serves to enhance the quality of care provided to people with a chronic health condition (McDaniel, Doherty & Hepworth, 2014).

As previously mentioned, MedFT is not well known in Turkey yet. Hence, as of today, there are no studies conducted on the topic. On the other hand, we see many mental health professionals who work with individuals coping with a physical illness and/or disability. In both Turkish and international literature on mental health, there are numerous empirical studies, published from different theoretical perspectives, on the processes of psychosocial support or psychotherapy conducted on patients (and their families) with a chronic disease/disability. However, there is no extensive survey study revealing the frequencies of clinical practices utilized in the treatment of individuals coping with such an illness/disability. A survey study designed to cover this need would inform the audience about the current trends in clinical practice and give an idea as to what needs to be improved, thereby guiding the research to be conducted in the future. In the present study, mental health professionals working with individuals/couples/families coping with a physical illness/disability were asked to fill out a survey that consists of statements reflecting the systemic perspective. In the context of the psychotherapy or counseling process of an individual with a physical illness/disability, the systemic perspective emphasizes the importance of the following elements: (i) Inclusion of the family into the treatment process, (ii) making interventions to strengthen the emotional connections among family members, (iii) assisting the clients to assume an active role in the decision making process of their treatment, (iv) collaboration and communication with other health care providers, (v) encouraging clients to be in contact with other individuals and families who have experienced similar health issues, (vi) helping clients in their management of the healthcare system, and (vii) taking into consideration biological, psychological, social and spiritual aspects of the client’s experiences of the illness/disability (McDaniel, Doherty & Hepworth, 2014). The present study intends to present a picture as to the extent of mental health care professionals’ use of these systemic principles and practices.

Theoretical Frameworks

As opposed to the traditional biomedical model, Engel (1977; 1980) presented a new perspective on health and disease, namely the biopsychosocial (BPS) model. Unlike the biomedical model’s reductionist view in conceptualizing patients based on chemical variations, the biopsychosocial model locates the individual in multiple systems, ranging from molecules to biosphere, all of which are in constant interaction with each other. Therefore, it proposes that in order to understand the experience of any disease, which is a human phenomenon, the other main domains of human life are to be taken into account, in both diagnosis and treatment. These domains consist primarily of the biological, psychological and social aspects of living.

One of the theoretical roots of biopsychosocial model is the general systems theory that links levels of organization in hierarchical order, postulating that a change in one level affects the neighboring levels of organization. This quality of the model makes it favored by the medical discipline, as it helps in understanding the onset and course of diseases.

Moreover, the BPS model positions the patient as an active collaborator instead of a passive recipient of treatment. One of the requirements for this active involvement is relying on the patient's own description about the experiences of the illness in question. It is therefore important for mental health workers to develop relationships that are more candid with their patients throughout the treatment process (Engel, 1977).

George Engel (1977) interpreted the status of medicine as in crisis, referring to the physicians' attempt to define "disease" solely in terms of biological data and to neglect any other aspects of human functioning when coping with an illness/disability. He criticized the gaps within the traditional reductionist biomedical model, which dominates the healthcare system.

Holman advocated the following:

"*While reductionism is a powerful tool for understanding, it also creates profound misunderstanding, when unwisely applied. Reductionism is particularly harmful when it neglects the impact of non-biological circumstances upon biologic processes. Some medical outcomes are inadequate not because appropriate technical interventions are lacking but because our conceptual thinking is inadequate*." (As cited in Engel, 1977, p.134)

Engel (1977) proposed that the psychological and sociocultural factors are as important as the biological aspect when treating a patient. He stated that patient is nested in between interwoven complex systems, ranging from the atomic structure to the biosphere. Therefore, the other systems that a person is a part of are needed to be considered in order to understand and treat human-related issues. He evaluated the particular way of practicing medicine with these words: "*Systems theory, by providing a conceptual framework within which both organized wholes and component parts can be studied, overcomes this centuries-old limitation and broadens the range of the scientific method to the study of life and living systems, including health and illness*" (Engel, 1981 p. 105).

The BPS model rests on six requirements (Engel, 1977). First, it is important to understand how the patient experiences the illness. When the health practitioners formulate the treatment plans, they should take into account the patients' psychological and social experiences as well as biochemical data. Second, the practitioner should tie up laboratory findings and clinical expression of those findings. For instance, patient's laboratory findings may point out to diabetes, however patient may manifest his/her experiences of illness as a burst of anger due to the increase in glucose level. This is because the patient experiences the disease in terms of how it affects his/her daily life, rather than the variations in blood level. Therefore, what the patient has to tell the doctor is just the experience of new bodily reactions and their impact on his/her life. Patients usually do not know technical terms. Hence, it is the practitioners' responsibility to build a connection between patient's experiences of illness and the biochemical processes that underlie them. Decent interview skills and an understanding of the patient's psychological well-being and social environment are essential in establishing a relationship with the patient and obtaining the necessary information from him/her. Third, the patient's lifestyle and living conditions are other determinants of the disease’s onset, severity and course. Therefore, one should critically evaluate the dynamics of the patient’s current life and consider incorporating this information into the case formulation and treatment plan. Forth, it is important for practitioners to ask patients when they viewed themselves or were viewed by others as sick. The reason is that viewing oneself as a sick and accepting the sick role has a psychological and social after-effect. In other words, people may ask for professional help when they are faced with the consequences of social and psychological discomfort in their daily routine. Evaluating this contributes to a more thorough comprehension about the course of the disease (Engel, 1977). Fifth, treatment of a disease is not only about regulating the biochemical abnormality. There are psychological and social inputs that may accelerate or decelerate how the disease progresses. Examples include hopelessness or absence of social support. Hence, medical professionals should consider the psychological and social variables that can affect the process of the recovery. Last but not least, the quality of the relationship between the practitioner and the patient is a crucial determinant of the course of recovery (Engel, 1977).

Havelka, Lučanin and Lučanin (2009) reviewed literature that supports the BPS approach and argued that it is important to focus on psychosocial aspects of diseases, primarily for accessing to and changing people’s health-related beliefs, attitudes and behaviors since they all play a role in both the prevention of and recovery from chronic illness. Thus, the BPS model offers to shift the focus of treatment from the disease to the patient. This alteration opens up new areas of interest about the patient's experiences of illness, such as how depression slows down the treatment process, how effective the perceived social support in recovery from the disease, and what the dopamine level says about the progress of illness or its psychological impact on the individual. In this regard, the BPS model emphasizes the importance of collaboration between disciplines, both in research and practice, in order to improve the understanding of what constitute health and disease. Health psychology, psychoneuroimmunology and behavioral medicine are among such disciplines, just to name a few.

In order to come up with a comprehensive assessment and provide a compressive treatment for chronic diseases, the adoption of a biopsychosocial-spiritual approach is necessary. Suls, Krantz and Williams (2013) listed three strategies to bind together different levels of analyses for embracing the BPS model: (1) Increasing the number of research and training programs based on multi-disciplinary collaboration, (2) conducting more relevant clinical studies that represent application of theory to research and practice, and (3) use of more representative samples and contexts that provide better results.

Alonso (2004) examined how the concept of "biopsychosocial health" was used in medical research. He did this by reviewing articles published immediately after the introduction of the BPS approach (1978-1982) and immediately before the beginning of his study (1996-2000) which took 13 years. He found no significant difference between how medical researchers conceptualized health 20 years ago and at the time of his study.

He reported that there is no significant increase on the number of papers that covered the psychological and social dimensions of health in practical areas of medicine. He interpreted this finding to be a result of the deep-rooted dominance of the biomedical model. He also argued that the BPS model increases the practitioner’s burden because it requires the adoption of an approach to both health and disease from a new and wider spectrum. This means greater investment, in terms of both knowledge and time, for the practitioner and for the health care system to provide necessary contexts and resources. On the other hand, the BPS model has been gaining more acceptance because of its power in explaining and treating somatic symptoms, and improving the patient-practitioner relations. Therefore, it can be helpful to track the evolvement of both the biomedical and the biopsychosocial perspectives in explaining the issues around health and disease, rather than competing these two paradigms with each other through a win-lose situation.

Ross (2000) is one of the clinicians who noticed the importance of putting the BPS model into the practice. He recognized the challenging side of the model during implementation. He proposed a method for biopsychosocial case formulation, which is organized around two axes. One of the axes represents the time frame – namely the past, present and future. The other represents the biological, psychological and social aspects of the patient’s life. The clinician needs to put the information obtained from the assessment sessions into one of the 9 cells you can see in Figure 1. According to the systems theory, a factor in any one level influences the factors in all other levels. Therefore, to create hypotheses and oversee prospective future directions for the best of the patient, the clinician should consider the biological, psychological and social changes throughout time.

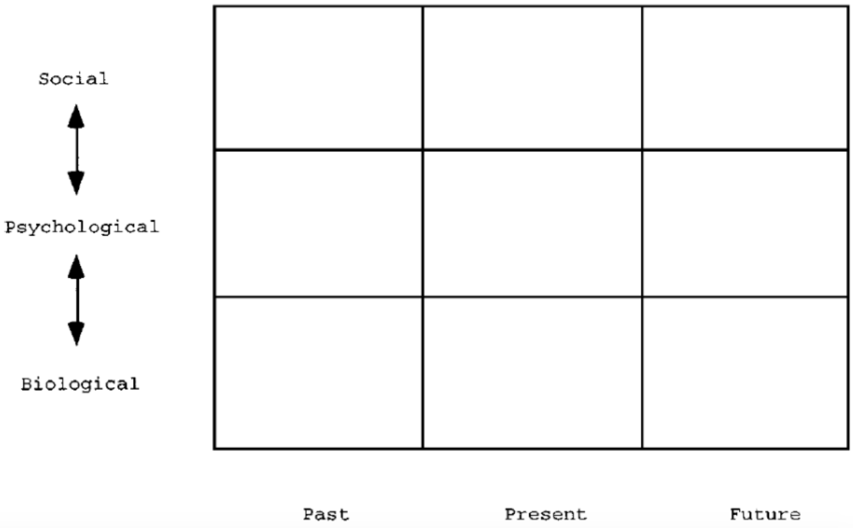

Figure 1. The biopsychosocial framework for constructing a formulation

Smith, Fortin, Dwamena and Frankel (2013), on the basis of their review, emphasized that the use of the BPS model in the areas of teaching, clinical practice and research continues to be limited due to three main limitations: (1) It is not testable, (2) it is too general, and (3) it is having no specific method to practice. They suggested that the application of a patient-centered interview model, which has been confirmed through randomized controlled trials, could guide the improvements to be made in the use of the BPS model in the areas of education, clinical practice and research.

Based on the systemic principals, we assume that a change in an individual’s life affects the system that she/he is a part of. The Medical family therapy (MedFT) is a model grounded in systemic principals and biopsychosocial-spiritual approach. It provides a framework for mental health professionals who work with individuals/couples/families coping with an illness/disability. The MedFT framework focuses on the larger system that the individuals are nested in, when understanding the impact of any illness/disability on their lives. The system includes the patient, his/her family and social/professional circle, his/her sources of support, the treatment team and the health care system.

Purpose of the Study

The purpose of this study is to explore the use of systemic principles by a sample of mental health professionals from Turkey in clinical practice. Investigation of whether the tendency of using these systemic principles differs as a function of participants' area of specialty, theoretical orientation or work setting is also aimed. For this reason, a survey that consists of questions about participants' education, professional background, practice orientation and format of therapy is developed. Upon conducting a detailed literature review, the survey questions were developed based on the fundamental principles of medical family therapy. The aim is to understand how systemic principals are used when working with individuals/couples/ families coping with an illness/disability.

In order to achieve this aim, the following steps were followed:

1. Completion of a comprehensive literature review on Medical Family Therapy, which explored its nature besides its connection with the BPS approach to healthcare and Systems Theory.

2. Designing of a mainly Likert-type survey that asks specific questions about professionals’ own way of structuring the therapy session when working with individuals with a physical illness, and/or disability.
3. Analyses of the collected data primarily with frequency statistics and correlations between demographics and certain ways of pursuing therapy/counseling.

CHAPTER 2 – LITERATURE REVIEW

Overview of Dynamics of Physical Illness and Familial Relationships

There are a number of research studies that highlight the importance of family for individuals who are suffering from a chronic illness or disability (Özkan & Kutlu, 2010; Fazlıoğlu, Hocaoğlu & Sönmez, 2010; Akmeşe, Mutlu, Öğretmen & D’Alessandro, 2015). Based on the existing literature, we can say that the roles that the family members play can be either beneficial or harmful on the person’s physical health in at least one of three ways: “*A direct biological pathway, a health behavior pathway, and a psychophysiological pathway*” (Campbell, 2003, p. 265). The biological component alludes to the genes inherited from the biological parents; the genes either put one at a high-risk situation or protect him/her from some form of disease. Moreover, it is known that the lifestyles of family members tend to be similar to each other. Through health behavioral pathways, the shared habits may play a significant role on health, depending on the type of the habit. Examples include smoking, exercising and dieting. The family’s positive/negative effect on the individual’s health cannot always be explained through biological or behavioral dynamics. Emotional context makes great difference on people’s well-being, as well. Research shows a positive correlation between the level of stress in the family and hospitalization of the person in question (Beautrais, Fergusson, & Shannon, 1982). This is an example of how psychophysiological pathways exert an influence on the individual.

Looking at the literature in Turkey, we see several studies that have focused on the impact of being diagnosed with a chronic illness/disability on the family and significant relationships. Many of them have studied the “caregiver burden”, which harbors a cultural aspect. In Turkey, when a family member is diagnosed with an illness, often another family member (usually the mother, wife or daughter; depending on who is being diagnosed) provides the necessary care (Akkus, 2011; Yilmaz, Oksuz, Atay &Turan, 2010). For this reason, the patient-caregiver relationship acquires a more crucial role in the understanding of the impact of the disease on families.

Akkuş (2011) evaluated the burden experienced by 49 caregivers of multiple sclerosis (MS) patients, using Psychological and Social Needs Scale and Zarit Caregivers Burden Interview. MS patients’ hopelessness, social isolation, leisure activity deficits and difficulties in decision making tended to increase the rate of burnout of their caregivers. It is also reported that among the variables that increased caregiver burden were low income, financial difficulties or unemployment, presence of chronic illness and problems in fulfillment of responsibilities. The author suggested that the caregivers must be assessed and supported regularly in terms of their psychological and social needs by health care providers.

In another study Yildiz, Celebioglu, and Olgun (2009) reported that mothers of children with congenital heart disease (CHD) had higher distress levels as opposed to fathers and that their distress level increased with the severity of the disease. 262 parents (132 mothers and 130 fathers) participated in the study, and their distress levels were measured by Symptom Check List. The authors suggested that psychological and emotional support were crucial for the parents of children with CHD, which seriously effects both children and other family members in various dimensions.

Based on their literature review, Fazlıoğlu, Hocaoğlu and Sönmez (2010) emphasized that childhood epilepsy, like other chronic diseases, effects the family through its impact on the family’s sources. Authors suggested that when one of the family members is diagnosed with epilepsy, the only focus should not be the patient’s symptoms; the mental health of all family members needs to be supported by preventive practices in advance. Psycho-educational programs carried out by professionals from different disciplines that target social and psychiatric support for the family can be helpful in raising awareness and assist family’s struggle with the current disease.

Pınar, Pınar and Ayhan (2012) reported that hopelessness and strain were likely to be present in caregivers of patients with gynecologic cancer. Three hundred thirty eight patients with gynecologic cancer and their caregivers (all of which were part of the family) participated in the study. The researchers evaluated the extent of strain and hopelessness using Caregiver Strain Scale and Beck Hopelessness Scale, along with Patient/Caregiver Information Form and Chemotherapy Symptom Assessment Scale. The caregiver’s age, gender, education level, income level and number of children, caregiving duration, cancer type, cancer stage, receiving chemotherapy or not, presence of social support and knowledge about the disease were all found to be important predictors of strain and hopelessness in caregivers of those with gynecological cancer. The authors pointed out to the need for support programs to reduce strain and hopelessness in caregivers of patients with chronic illness.

Yet in another study Yıkılkan, Aypak and Görpelioğlu (2014) used Beck Depression Inventory, Beck Anxiety Inventory, and Short Form 36 with 63 caregivers of long-term home-care patients in order to assess their depression, anxiety and quality of life status. The authors found that high levels of caregiver burden were positively correlated with extended duration of caregiving, and negatively correlated with education level. Almost 59% of the caregivers had depressive symptoms and 13% were in severe depression. They also identified difficulties in maintaining work life and daily routines. Authors drew attention to the need of (1) qualitative research on the experiences of caregivers of patients with chronic illnesses, in order to design advanced health care services, (2) educational support groups that focus on coping strategies, and (3) community services for the overall well-being of the family.

These studies emphasize that physical illnesses affect people's lives and their significant relationships adversely. Diagnosis of a medical problem brings along disruption in family and work routines, financial burden, limited social activities, economic and/or physical dependency and difficulty in maintaining daily routines – for both the patient and the family. Besides, patients and their families commonly experience feelings of sadness, anxiety, shame, guilt, anger, distress, hopelessness and strain during the treatment process of a medical problem. Consequently, it is essential to address all of these physiological, social, psychological and economic needs of both patients and their families within the healthcare system.

Systemic Perspective and Medical Family Therapy

The Medical Family Therapy (MedFT) is an approach to healthcare that is grounded in the biopsychosocial (BPS) perspective, marriage and family therapy, and the systems theory.

Medical family therapy started to evolve in the 1980’s as opposed to the five main splits within the health care system and sought to resolve them (Tyndall, Hodgson, Lamson, White & Knight, 2012). McDaniels, Doherty and Hepworth (2014) listed these splits as the following. First, there was a split between mind and body, which manifests itself in the very structure of the health care system. The system splits health into two as physical health and mental health, which is an artificial fragmentation. For instance, it is known that the level of psychological stress or perceived support from others has an effect (positive or negative) on the progress of any disease. Hence, in the treatment of physical illnesses one should integrate these two domains, namely mental and physical health, in order to offer effective care.

The second split exists between the individual and his/her family (or significant others). The existing health care system often focuses on the disease and the patient, and rarely addresses the patient’s family during the treatment process. Yet family is the context in which the patient lives and maintains interpersonal relationships. From a systemic perspective, diagnosis of a disease affects the individual in several aspects, one of which pertains to the impact it exerts on the person's significant others. To provide physically ill or disabled people with effective mental health care services, professionals working with such people should consider the family as a whole and see the family bigger than its parts (McDaniels, Doherty & Hepworth, 2014).

Third, there is a split between the individual, the family and the health care providers. Diagnosis of an illness/disability creates another long-term relationship between the patient, the family and the health care workers. The quality of this relationship is important in that it affects how the patient's health (hence, the disease) will progress. However, many therapists have limited knowledge and insight as to the dynamics of the interaction of these three parties.

The fourth split exists within the health care world, and stems from a disconnection of clinical, financial and operational pillars. In the clinical domain we see health care professionals, whereas there are managers in the operational domain and accountants in the financial domain. These three pillars may have conflicting agendas and interests. Mental health professionals working with people coping with a physical illness and/or disability should be aware of this split and the influence it may exert on the individual (McDaniels, Doherty & Hepworth, 2014).

The final split stems from the weak connection between the health care system and other institutions involved in the patient's process such as social services, non-governmental organizations, cultural associations, faith communities etc. Mental health professionals should realize that these groups can play an active role in many parts of the health care system (McDaniels, Doherty & Hepworth, 2014). In summary, humans are a part of numerous domains by nature, from molecules to cultural formations, and the professionals working in jobs that deal with human phenomena should be aware of all these domains as well as their interaction and influence on one another. Awareness as to these substantial splits within the health care system or being at least flexible in questioning the other domains the person is a part of leads to a better understanding of the patient and enables to address his/her needs better during the treatment process.

Medical family therapy presents a meta-framework, which implies that therapists can adopt the fundamentals and applications of medical family therapy into their work regardless of their theoretical orientation and clinical approach. It should be noted that medical family therapist is any mental health professional –regardless of his/her degree or title– who defines him/herself as working with people coping with an illness/disability from a biopsychosocial and systemic perspective on a unified, team-based work setting (McDaniels, Doherty & Hepworth, 2014).

According to Marlowe, Hodgson, Lamson, White and Irons (2012) the primary contribution MedFT makes in integrated primary care settings is its putting relationships/systems in the center. This means that the medical family therapists (MedFTs) pursue a relational focus when formulating clients' problems and generating relevant solutions. This holds true when it comes to the management of patient-health provider relationship, as well. For instance, discussing how a cancer patient's spouse might assist with taking medication can be helpful for the patient in achieving treatment goals. When there is a conflict between the patient and the health provider, (for instance the patient may refuse to receive the particular cure offered), MedFTs can position themselves as a reconciler in between the two parties, reframing the conflict and offering a mutually acceptable solution alternative. Strengthening the relationship between the patient and the family is viewed to be a powerful tool in MedFT because in a context characterized by health-related issues significant relationships can easily be negatively affected by the burden of disease or disability (McDaniels, Doherty & Hepworth, 2014).

One of the major principles of offering health care services from a systemic perspective is the collaboration between the physicians and the therapists. We see that collaborative practices are on the rise in various clinical settings all over the globe. Mary-Joan and Charles (2005) used family systems approach in the treatment of irritable bowel syndrome (IBS), which –although not regarded as a psychosomatic illness– has psychological components. They conducted three bi-weekly sessions in which the family, therapist and physician discussed together mainly the circular effects of physical symptoms and psychological distress. They found that the symptoms experienced by those patients who attended these sessions significantly decreased as compared to the group who received only medical treatment. One of the participants even said that she actually thought that her symptoms were not significantly reduced, but they seemed less upsetting to her and that she felt more hopeful about the future. Based on their significant findings, researchers of the study raised the bar to devise a group model, informed by family systems approach, in the treatment of IBS for the first time. The results suggest that the collaborative systemic perspective is helpful in working with patients suffering from chronic diseases such as IBS (Mary-Joan & Charles, 2005).

Harrington et al. (2009) published a study that presented phenomenological observations of members of a pediatric oncology treatment team. The team consisted of nine members (medical doctor, nurses, specialists on child life, a chaplain, support crew, and medical family therapists) and included Medical Family Therapists (MedFTs). Team members were asked to complete nine questionnaires along with eight open-ended questions. The aim was to investigate the "culture" of pediatric cancer and the role of medical family therapists within that culture, through a qualitative description. Findings pointed out two themes: Culture of change and significant relationships. Culture of change emphasized the constant changes that emerge in families' lives following a child's diagnosis with cancer. Significant relationships referred to the newly and deeply formed relationships between the family and the treatment team. Team members described these relationships as very powerful and long lasting. Data analyses also revealed that presence of MedFTs diminished other medical team members' burden in terms of addressing families' emotional experiences about the illness. MedFTs contribution to the care provided to the patients was found to be extremely helpful. The authors of the study put forth the main professional qualities MedFTs should have, as well. The three essential qualities to be developed by medical family therapists were found to be knowledge, awareness and skills. When conducting medical family therapy, the therapist must be knowledgeable about the disease (i.e., its etiology and prognosis) as well as its possible impact on the family system both at the time of diagnosis and throughout time. The therapist must be a part of the treatment team and act as a mediator between the medical team and the patients. Medical family therapists should be aware of their own biases and assumptions about different illnesses and different populations they may encounter. When the initial bio-psychosocial-spiritual assessment is completed, the medical family therapist should designate the necessary interventions according to the strengths, needs and weaknesses of the family (Harrington, Kimball & Bean, 2009).

Campbell (2003) reviewed the literature on the interaction between families and health, and came up with four main themes that emerged out of the relevant studies. First, families have a strong impact on health and on the risk factors threatening physical well-being. Secondly, emotional support by family members is the most significant and effective type of support that impacts health positively. Third, marriage has the most powerful influence on health. Lastly, negative, hateful and critical familial relations have a stronger impact on health than assistive relations. Therefore, it is essential to address familial relationships in therapy, be they positive or negative, when working a person dealing with a medical issue (Campbell, 2003).

McDaniel et al. (1992) suggested to evaluate several key dimensions when working with families with children who are chronically ill: Family members’ beliefs related to the disease, family triangles formed around the disease, disease’s influence on other significant relationships (friends, relatives, coworkers etc.), functionality of siblings, child’s developmental difficulties, child’s difficulties related to the illness, and level of social support. Exploring each of these dimensions critically during the assessment phase enables MedFTs to tailor their interventions for each family (McDaniel, Hepworth & Doherty, 1992).

CHAPTER 3 – METHODOLOGY

The purpose of this study is to investigate the use of systemic principles when treating patients with medical conditions with a sample of Turkish mental health practitioners. It is also aimed to explore whether the tendency of using these systemic principles differs based on participants' area of specialty, theoretical orientation and work setting. In this chapter, a detailed description of the study's methodology is presented with the rationale behind the design choices made throughout the process.

Throughout this dissertation the phrases "physical illness", "chronic illness", and "medical problems" were used interchangeably. In the recruitment flyer, the phrase "physical illness" is used and an explanation as to what is meant by the phrase is given: *A medical problem that presented itself at birth or developed later in time.* Further, these medical problems were exemplified as cerebral palsy, spina bifida, hydrocephaly, epilepsy, diabetes, high blood pressure, cardiac insufficiency, respiratory insufficiency, renal insufficiency and Alzheimer disease. The phrase "physical illness" is used in the consent form and throughout the survey, as well, since it tends to contain all chronic diseases and congenital abnormalities. If I were to use the phrase "chronic disease" in the survey, I would have left out the congenital abnormalities. On the other hand, "chronic disease" is the most commonly used phrase to refer to medical problems in the literature. In the presenting study, these words were used interchangeably and intended to mean any medical problem that people experience in life.

Research Design

In the presenting dissertation a quantitative cross-sectional descriptive survey design was used to determine the extent of a sample from Turkish mental health professionals' use of systemic principles when working with individuals who suffer from a physical illness and/or disability. Self-report surveys were collected anonymously from different groups of mental health workers such as psychiatrists, clinical psychologists, couple and family therapists, and counselling psychologists. This was the first cross-sectional study conducted in Turkey that investigated the use of systemic practices when working with individuals coping with a chronic illness and/or disability. It was descriptive in that it revealed the relationships between descriptive characteristics of the sample and the systemic principals used in counseling or psychotherapy processes carried out.

Due to cost and time effectiveness, data collection was decided to be carried out using an online survey method first. In this way, it would be possible to collect data from professionals from various locations. Later in the data collection phase, principal investigator used paper-based surveys to collect data from university hospitals to increase the number of participants in the study sample.

Sample

The target population was mental health professionals currently practicing in Turkey. The inclusion criteria were the following: (1) Working in one of the fields of mental health care in Turkey (psychiatry, clinical psychology, couple and marriage therapy, counseling psychology, psychiatric nursing and social work), and (2) having worked in the past or currently working with at least one individual with a physical illness and/or disability. If the participant answered “no” when asked if he/she ever worked with an individual coping with an illness/disability, his/her online survey was terminated automatically (or, in the case of manual administration, he/she was asked to stop filling out the survey).

The final sample included in the analysis consisted of 166 participants. Out of the 232 professionals who started to fill out the survey, only this number of people indicated to have worked with at least one individual coping with a physical illness/disability.

The sampling method was non-probability. The participants were recruited using mail administration. The online link of the survey was initially sent to the largest professional mail groups and associations in particular time intervals. Later, additional data were collected via paper-based forms delivered by hand.

Of the 232 mental health workers who engaged in the survey, 66 participants’ responses (Sixty three of them marked ‘no’ to the initial question, and 3 of them marked ‘I don’t know’) were excluded from further analyses, and hence, statistical analyses were performed with the data of the remaining 166 respondents who indicated to have worked with individuals with medical problems. Forty-four of the participants (27%) were male and 121 (73%) were female (one participant did not respond to the question of gender). The mean age was 35.36 years (*SD* = 9.96). Education level of the participants differed, with 22 (13%) having a bachelor’s degree, 98 (60%) having a master’s degree, and 44 (27%) having a doctorate degree. The respondents were allowed to choose more than one option for some of the demographic questions, since one option might not have been sufficient to describe the participant’s status on the particular area. For example, a professional may be working with both couples and adolescents, or using more than one theoretical orientation. Therefore, questions on the participants’ area of specialty, workplace, theoretical orientation, and the primary population that they work with were designed in multiple-choice format. Twenty-one respondents (13 %) were couple and family therapists, 39 (24%) were psychiatrists, 92 (55%) were clinical psychologists, and 28 (17%) were counseling psychologists. Twelve respondents (7%) were working in school settings (preschool, elementary school, middle school and high school), 36 (22%) were working in the hospitals (state hospital, private hospital, nursing home), six (%4) were working in the municipalities, 17 (10%) were working in the universities, and 92 (55%) were in private practice. Eighty-two respondents (49%) described their theoretical orientation as analytical/psychodynamic, 84 (51%) as behavioral/cognitive, 17 (10%) as experiential, 58 (35%) as eclectic, 38 (23%) as systemic, 25 (15%) as humanistic, and lastly 17 (10%) as existential. Fifty-six (39%) of the respondents reported their primary population of practice as children, 87 (52%) as adolescents, 130 (78%) as adults, 51 (31%) as couples, 60 (36%) as families, 12 (7%) as groups, and 15 (9%) as geriatric people. Seventy-three respondents (44%) reported to have one to five years of experience in clinical practice; 36 (22%) had six to 10 years, 17 (10%) had 11 to 15 years, 16 (10%) had 16 to 20 years and 23 (14%) had over 20 years of experience (see Table 1).

Table 1

Demographic profile of the respondents

	N	***%***
Q1. Gender		
Female	121	73.3
Male	44	26.5
Q2. Age	35.36 ± 9.96*	
Q3. Education Level		
Bachelor’s degree	22	13.4
Master’s degree	98	59.8
Doctorate degree	44	26.8
Q4. Area of Specialty		
Couple and Family Therapy	21	12.7
Psychiatry	39	23.5
Psychology	92	55.4
Counseling Psychology	28	16.9

Q5. Workplace		
Schools	12	7.2
Hospitals	36	21.7
Municipalities	6	3.6
Private practice	92	55.4
Universities	17	10.2
Q6. Years of experience		
1-5	73	44.2
6-10	36	21.8
11-15	17	10.3
16-20	16	9.7
Over 20	23	13.9
Q7. Theoretical Orientation		
Analytical/Psychodynamic	82	49.4
Behavioral/Cognitive	84	50.6
Experiential	17	10.2
Eclectic	58	34.9
Humanistic	25	15.1
Systemic	38	22.9
Existential	17	10.2
Gestalt	10	6.0
Q8. Population Served		

Children	65	39.2
Adolescents	87	52.4
Adults	130	78.3
Couples	51	30.7
Families	60	36.1
Groups	12	7.2
Geriatric population	15	9

*Mean ± Standard Deviation

One hundred seven of the participants (65%) stated that their professional training covered materials that pertain to the mental health experiences of individuals coping with a physical illness and/or disability, whereas the remaining 57 (35%) stated that they did not have such a chance.

The participants were asked to specify the percentage of individuals in their caseload who suffered from a physical illness and/or disability. Mean percentage turned out to be 20.14 (*SD* = 23.48). When asked about the duration of therapy, 24 of respondents (15%) stated that they conduct one to five sessions on average, 35 (22%) respondents stated that they conduct six to 10 sessions, 30 (18%) respondents stated that they conduct 11 to 15 sessions, 19 (12%) of the respondents stated that they conduct 16 to 20 sessions, and 55 (34%) of the respondents stated that they conducted over 20 sessions (see Table 2).

Table 2

Frequencies and percentage distributions of respondents' answers on professional training, caseload, and average duration of therapy conducted

	N	***%***
Q9. Being trained in mental health issues of individuals with a physical illness and/or disability		
Yes	107	65.2
No	57	34.8
Q11. Percentage of caseload with a physical illness and/or disability	20.14 ± 23.48*	
Q12. Duration of therapy		
1-5 sessions	24	14.7
6-10 sessions	35	21.5
11-15 sessions	30	18.4
16-20 sessions	19	11.7
Over 20 sessions	55	33.7

* Mean ± Standard Deviation

Procedure

Development of the Survey

The only instrument used in the presenting study was a self-report survey that contained 34 items (see Appendix C). The survey was developed upon conducting a comprehensive literature review on the use of systemic principles in medical and mental health care. The participants were asked to complete the survey that explored their clinical experiences of working with individuals coping with a physical illness and/or disability. The survey was comprised of two main parts. In the first part, there were demographic questions about the participants’ gender, age, level of education, area of specialization, work setting, number of years in clinical practice, theoretical orientation, and the population they serve. There was a question, in yes/no format, which explored whether mental health issues that pertain to chronic illness and/or disability were covered –in one way or another– in participants’ formal training. Even though the number of clinical training programs that focus primarily on health psychology are limited in number in Turkey, there are mental health professionals who try to provide psychosocial support services to individuals suffering from medical problems (Borak, Boratav & Sunar, 2005). If I were to ask a question as to whether participants were trained specifically in health psychology, my guess is that only a very limited number of respondents would give a positive answer. Although they might have taken a course or attended workshop in health psychology, a comprehensive training in health psychology is rare in Turkey. Even though such a question would reveal another important information, it is thought that within the scope of this study it is sufficient to understand whether mental health professionals who work with individuals with medical problems have covered basic information as to the mental health issues of such individuals during their professional training. At the end of the first part of the survey, the participants were asked if they ever provided psychotherapy/counseling services to individuals coping with a physical illness/disability. Only those participants who responded “yes” to this question continued to the second part of the survey. The surveys of the participants who responded “no” were terminated automatically in the online format. Included in the paper form was the remark “If your response to the 10th question is ‘‘no’’, then you can stop here. If your response is ‘’yes’’, then we invite you to continue on with the following questions about how you conduct counseling/therapy with clients with a physical illness and/or disability”.

The second part of the survey contained different types of items. There were eighteen Likert-type items with response options ranging from one (*never*) to five (*always*), one multiple-choice item, one item that required to enter numeric value, and four partially open-ended questions. The multiple-choice item asked respondents the average duration of their therapy process when working with individuals with medical problems. The participants were asked to choose one of the following answers: 1-5 sessions, 6-10 sessions, 11-15 sessions, 16-20 sessions and over 20 sessions. The item that required writing down a numeric value was about the practitioners’ estimated percentage of caseload of clients with a physical illness and/or disability. Eighteen statements assessed the practitioners’ use of systemic principles in clinical practice. The following are some of the systemic principles that were evaluated within the scope of presenting study: (1) Professionals’ belief in the impact of the patient’s family and social relationships on the progress of the disease/disability, (2) inclusion of the patient’s family in the counseling/psychotherapy process, (3) making interventions to strengthen the emotional connections among family members, (4) assisting clients to play an active role in the decision making process of their treatment, (5) staying in contact with at least one of the doctors in the patient’s treatment team, (6) exploring the relationship between clients and their doctors in therapy sessions, (7) advising and/or encouraging the client to be in communication with other individuals/couples/ families/ groups who have experienced similar health issues, and (8) helping the client in his/her management of the healthcare system.

Medical Family Therapy tries to integrate mind and body (hence overcome mind-body duality) by incorporating social and psychological components that pertain to the individual into the treatment process (McDaniels, Doherty & Hepworth, 2014). This interplay between mind and body was assessed in the presenting study through two statements: “I think that when working with individuals coping with a physical illness and/or disability, family and/or (close) social environment can have a *positive effect* on the person’s physical health,” and “I think that when working with individuals coping with a physical illness and/or disability, family and/or (close) social environment can have *negative effect* on the person’s physical health”. The respondents were asked to rate these statements on a five-point Likert-type scale. Higher scores implied a belief in the presence of connection between physical and mental health, and lower scores were interpreted to represent a belief in the split between the two domains. Since all mental health professionals working from a systemic approach should incorporate the family into the therapy process, a specific question was presented to understand how often the participants include families of their clients into their therapeutic work.

In MedFT, strengthening of the patient-family relations in both health and disease contexts is described to be a powerful tool, as well (Marlowe, Hodgson, Lamson, White & Irons, 2012). Regarding this, the respondents of the survey were asked to rate a statement about making interventions to strengthen the emotional connections among family members.

There were four multiple-choice questions designed to obtain detailed information as to the use of various systemic principles. Participants were allowed to check more than one option so that they could provide more accurate information about the application of these principles in Turkey. One of the questions aimed to investigate how professionals included the family in the psychotherapy/counseling process of the client (if they did so). The answer options for this question were as follows: (1) Including the couple and/or family into the process during the assessment course, (2) making separate sessions with other family members when necessary, (3) making conjoint sessions with other family members when necessary, (4) organizing and running psycho-education and/or support groups, (5) carrying out the counseling/therapy process together with the individual's spouse and/or family, and (6) 'other' (with a space provided for the description of the intervention). In another multiple-choice question, participants were asked how they helped their clients in their management of the healthcare system. The answer options for this question were as follows: (1) Talking about the experienced difficulties in the therapy sessions, (2) offering direct and/or indirect solution alternatives for the difficulties experienced, (3) making referrals in an attempt to help solve the client's problem(s), (4) contacting the referral source to inform him/her about the needs of the patient, and (5) "other" (with a space provided for the description of the intervention). In the third multiple-choice question, researcher investigated how the participants approached the issue when they thought that their clients were exposed to some kind of discrimination (due to language, religion, race, SES etc.) when dealing with the healthcare system. Answer options for this question were as follows: (1) Talking about the difficulty the patient experiences if he/she brings it up in sessions, (2) providing information as to how to manage the healthcare system, (3) raising patients' awareness about their rights in the healthcare system, (4) actively taking the side of the patient in the healthcare system, and (5) "other" (with a space provided for the description of the intervention). The last multiple-choice question was designed to understand the different dimensions of the illness experience the professional explores in the sessions. The answer options were as follows: (1) Biological, (2) psychological, (3) social, (4) spiritual, and (5) 'other' (with a space provided for the description of the dimension addressed).

Upon completion of the development of the survey, copies of the survey in paper form were given to three faculty members and seven second year students of Clinical Psychology Program at Istanbul Bilgi University. Faculty members were to give feedback about the structure and the content of the survey, whereas clinical psychology students were to assess participant-friendliness. Upon discussing all the feedback given with the thesis advisor, relevant revisions were made. For example, one of the students commented that she found the language of the survey the language of. Based on this feedback, the structure of the sentences was changed. For instance, the question "How often do you include the client's family in your therapeutic work when working with individuals coping with a physical illness and/or disability?" was replaced with "I include the client's family in my therapeutic work when working with individuals coping with a physical illness and/or disability."

Lastly, the final version of the survey was e-mailed to Susan McDaniel, Jeri Hepworth and William J. Doherty, the founders of "Medical Family Therapy", which is developed based on the premise of integrating biopsychosocial approach with systemic principles, for their suggestions and recommendations. Both gave positive feedback about the study and the survey, and offered only minor structural revisions (see Appendix E).

Permissions

Upon approval of the thesis advisor, the proposal of the study was reviewed and approved by Istanbul Bilgi University Human Subjects Ethics Committee (see Appendix D). Following the ethics committee's approval, data collection started in November, 2015 and ended in February, 2016.

Data Collection

Due to its low cost and advantage of reaching a high number of participants in a fairly short amount of time, online surveying was the method of choice. The online form was more convenient for the participants as well, since they could complete the survey at any time and place they would choose.

Participants received a recruitment flyer online (see Appendix A), which contained information about the purpose and significance of the study, number of items in the survey, required time for completion and inclusion criteria for participation, with a link to direct the volunteers to the online survey. The participants read and accepted the informed consent form (see Appendix B) before starting the survey. There were no gifts or benefits provided in exchange for participation in the study. It was mentioned in the consent form that the participation in the study was voluntary and that participants could skip questions that they did not want to answer and that they had the right to withdraw from the study any time without stating any reason. It was also stated that their responses would be kept completely confidential and the collected data would be used only for academic purposes. There was a minor difference in the consent form of the paper version of the survey. All the information given was identical, however the participants were asked to date and sign the consent form before starting the survey. Since consent forms contained the names of the participants, they were immediately separated from the surveys to ensure anonymity. Starting from the November 2015, the invitation e-mail to enable participation in the study was sent to the predetermined mail groups periodically, once in a two week, until the beginning of February 2016.

Surveey (www.surveey.com), an online surveying system, was used to create the online version of the survey, which allowed participants to connect to the survey website through a link embedded in the invitation e-mail. A major advantage of this particular surveying system was that it could easily export the quantitative raw data into SPSS file format accurately. Completion of the demographic questionnaire and the survey (a total of 34 items) took approximately 15 minutes. The estimated risk of participation for the study was low.

In Turkey, there are several professional e-mail groups that enable contact among mental health professionals. Using these groups to reach participant candidates was a convenient way to collect data. Moreover, public and private universities' various departments related to mental health care were scanned online to reach academic staff. Invitations to participate in the survey were sent to their email addresses through undisclosed-recipients. The data collection process took approximately three and a half months, until the intended sample size of 200 participants was reached.

In order to reach more participants, the survey was administered manually, as well. Copies of the paper version were given to professionals working in the psychiatry departments of three state hospitals: Erenköy Mental Hospital, Bakırköy Mental Hospital, and Istanbul University Medical School Hospital, Psychiatry Department. Completed surveys were collected a week later and entered into SPSS file manually. Meanwhile, online surveying was closed for further data collection. All the responses were anonymous.

Accuracy of the data entered into the database was checked prior to making any analyses. All computer records were password-protected, and the original records were stored on the secure server.

Data Processing and Analysis

Statistical analyses were performed using SPSS 23.0 (Statistical Packages of Social Sciences). Data collected via the online surveying system were first transferred to SPSS 23.0 and then checked for accuracy. Descriptive statistics were presented in terms of mean ± standard deviation for continuous variables, and as frequency and percentile for categorical variables. Mann-Whitney U tests were used to compare the tendencies of the two independent groups’ responses to the survey statements. Mann-Whitney U test, which is nonparametric, was chosen because five-point Likert type items were ordinal variables. Differences between categorical variables were analyzed using the chi-square test. The reliability of the survey was checked using Cronbach alpha value, and a value of 0.70 and above was considered reliable. The level of significance was set at $p < 0.05$.

CHAPTER 4 – RESULTS

In this section, results of the analyses conducted are presented in detail. Likert-type items of the survey were analyzed using Cronbach’s alpha value. Consequently, the reliability of the survey was calculated, and it was found to be highly reliable (26 items; α = .82).

In the original form of the survey some of the demographic questions had various response categories. In order to make these variables suitable for statistical analysis, closely related categories were combined. For instance, 1% of the participants reported having completed a certification program, 13% of them had undergraduate degrees, 60% had master’s degrees and 30% had doctorate degrees. First two response categories of this question, namely having completed a certification program and having an undergraduate degree, were merged into one category. In a similar vein, three of the response categories of the question that explored the area of specialty (namely psychiatry, pediatric psychiatry and neuropsychiatry) were merged into one (psychiatry). The response categories of clinical psychology, applied psychology and neuropsychology were merged into one category, as well, and were named as clinical psychology. Similarly, response categories of counseling psychology, developmental psychology, and pedagogy were merged into one category and named as counseling psychology. Another example pertains to the responses given to the question about the participants' work setting which included kindergarten, municipality, state hospital, nursing home, primary school, women health center, high school, middle school, private counseling center, special education and rehabilitation center, private hospital, private practice, non-governmental organization, university, non-profit organization, and other. Participants working in kindergartens, primary schools, middle schools and high schools were combined and renamed as school counselors. Response categories of private hospital, state hospital and nursing home were merged as well and the new category was renamed as hospital. Response categories municipality and women health center were combined to create the new category of municipal workers. Lastly, response categories private counseling center, special education and rehabilitation center and private practice were merged and the new category was named as private practice. Lastly, response options to the question on theoretical orientation were analytical, cognitive-behavioral, experiential, behavioral, eclectic, gestalt, humanistic, psychodynamic, systemic, existential or other. Analytical and psychodynamic categories merged into one category and the new category was named as analytical/psychodynamic. Categories of cognitive-behavioral and behavioral were combined to be behavioral/cognitive.

Respondents were asked to rate a series of statements, in a scale from "never" to "always", as to how they work with individuals with a physical illness and/or disability. Options for each statement were ordered from negative to positive: Never, barely, seldom, often and always. In order to compare different groups' average scores for particular items, the Likert-type response options were numbered from one to five, "never" corresponding to one, "barely" to two, "seldom" to three, "often" to four, and "always" to five. There were no reverse items. For example, one of the statements was "I include the client's family in my therapeutic work when I work with individuals coping with a physical illness and/or disability". Participants whose response was 'never' were coded as one, and whose response was 'always' were coded as five. All the statements were positively stated and the coding direction (from one to five) was the same for each statement. If the mean value of the responses for a particular statement is close to five, it means that respondents tend to practice the principle in question almost all the time (i.e., *always*). Likewise, if the mean value of responses for a particular statement is close to one, it means that respondents tend to practice the principle in question almost *never*. Eighty-eight respondents (53%) indicated that they *often* observe a link between the reason of coming to counseling/therapy and the physical illness and/or disability one has (Q13), with mean value of all participants' responses for this item 3.66 (*SD* = 0.79). This means that, the mean value of all responses was between the categories "*seldom"* (3) and "*often"* (4), but closer to the category "*often"* (see Table 3). Eighty-one respondents (49%) *often* thought that family and/or (close) social environment have a positive effect on the individual's physical health (Q14), with mean value of all participants for this item 4.21 (*SD* = 0.71). This means that the respondents' general tendency of evaluating the family's impact on physical health as positive is between the categories *"often"* and *"always"*, but close to the category *"often"* (see Table 3). On the other hand, 58 respondents (35%) *seldom* thought that family and/or (close) social environment have a negative effect on the individual's physical health (Q15), and the mean value of all participants' responses for this item was 3.18 (*SD* = 1.09). This means that the respondents' general tendency of evaluating the family's impact on physical health as negative is between the categories *"seldom"* and *"often"*, but close to the category *"seldom"* (see Table 3).

Sixty five respondents (39.4%) stated that they *often* include the client's family into their therapeutic work (Q16). The related item's mean value was 3.52 (*SD* = 1.06), which means that participants' general tendency to include family in the treatment process is between the categories "*seldom"* and "*often"*, but slightly closer to the category "*often"*. The respondents who chose options other than "*never"* were directed to another question that explored the inclusion of the family into the therapeutic process in more detail. This was a multiple-choice question, not a statement to be rated: "When you work with individuals coping with a physical illness and/or disability, how do you include the family into the therapeutic process?" (Q17). The participants were allowed to check more than one option if applicable. For this particular question, 109 of the respondents (66%) chose the option ''Making conjoint sessions with other family members if necessary'', 89 (54%) chose ''Making separate sessions with other family members if necessary'', 75 (45%) chose ‘‘Including the couple and/or family into the process during the assessment course'', 53 (32%) chose ‘‘Organizing and running psycho-education and/or support groups'', 47 (28%) chose ‘‘Carrying out the counseling/therapy process together with the individual's spouse and/or family'', and three respondents (2%) chose the option "other" (see Table 4). Participants who chose the option "other" stated that they include the family into the process only when they work with children or adolescents.

The survey contained additional Likert-type items about the possible interventions mental health professionals make, both in their sessions and outside of the therapy room. The respondents were asked to rate these items in the same manner as all the other Likert-type items. Again, the response options ranged from *never* (1) to *always* (5). Eighty respondents (49%) indicated that they *always* try to learn more about their clients' illness and/or disability in between the sessions (Q18). The average score for this item was 4.24 (*SD* = 0.92), indicating that the participants' general tendency to learn about how the illnesses/disability in question proceeds in between the sessions was between the categories "*often"* and "*always"*, but slightly close to the category *"often"*. On the other hand, only 64 respondents (39%) stated they *often* inform their clients about how the illness and/or disability in question proceeds (Q19), with mean value of this item 3.53 (*SD* = 0.99). This means that the participants' general tendency to inform clients about their illness/disability is between the categories "*seldom"* and "*often"*, but slightly closer to the category *"often"* (see Table 3). One hundred and one participants (62%) indicated that they *often* think that the psychological support they provide has a positive effect on the prognosis of the illness/disability (Q20), with mean value for the item assessing this 4.01 (*SD* = 0.70). Hence, participants' general tendency to view psychological support as an effective means to improve the treatment process is between the categories *"often"* and *"always"*, but closer to the category *"often"* (see Table 3). Seventy six participants (47%) indicated that they *always* emphasize the strengths of their clients as they cope with their illness/disability (Q21), with mean value of the item assessing this 4.32 (*SD* = 0.74). This means that respondents' general tendency to accentuate the strengths of the client is between the categories "*often"* and "*always"*, but closer to the category "*often"* (see Table 3). Seventy one respondents (44%) stated that they *often* make interventions to strengthen the emotional connections among family members (Q22), with mean value assessing this item 3.73 (*SD* = 0.94). Hence, we understand that participants' general tendency to make interventions that strengthen the connections among family members is between the categories "*seldom"* and "*often"*, but closer to the category "*often"* (see Table 3).

The participants were asked to rate the frequency of their practices that pertain to assisting their clients in assuming an active role in the decision making process of their treatment (Q23). Seventy four of the respondents (46%) reported that they *often* do this, and the average score for the whole sample turned out to be 4.09 (*SD* = 0.84). This means that participants' general tendency to assist their clients in their active involvement in the treatment process is between the categories "*often*" and "*always*", but closer to the category "*often*" (see Table 3). The respondents were also asked to rate the statement ''I stay in contact with at least one of the doctors (healthcare providers) who follow up the progress of the illness my client has.''(Q24). Forty five participants (27%) chose the option "*barely*", with mean value for all participants' responses 3.10 (*SD* = 1.21). This indicates that the mental health workers' tendency to communicate with the treatment team is between the categories "*seldom*" and "*often*", but close to the category "*seldom*" (see Table 3). Fifty three of the participants (32%) stated that they *seldom* explore the patient-doctor relationship in their sessions (Q25), with mean value assessing this item 3.37 (*SD* = 1.10). This implies that the respondents' tendency to explore patient-doctor relations is between the categories "*seldom*" and "*often*", but closer to the category "*seldom*" (see Table 3). In another question, 106 of the respondents (65%) stated that they *never* see their clients and their doctors together in a session to evaluate mental health status in conjunction with physical health status (Q26). Mean score of the item assessing this was 1.47 (*SD* = 0.75). This implies that the general tendency of the respondents to bring together different parts of the treatment team is between the categories "*never*" and "*barely*", yet closer to the category "*never*" (see Table 3). As to the question concerning advising and/or encouraging client(s) to be in communication with other individuals/couples/families/ groups who have experienced similar health issues (Q27), 61 of the respondents (37%) chose the option "*seldom*". Mean value for the item assessing this turned out to be

3.01 (*SD* = 1.04). This indicates that the participants' tendency to encourage their clients to contact other people who have similar experiences is between the categories "*seldom"* and "*often"*, but very close to the category "*seldom"* (see Table 3).

Table 3

Frequencies, percentage distributions and mean values of respondents' answers to questions as to how they work with individuals with medical problems

	Never (1)		**Barely (2)**		**Seldom (3)**		**Often (4)**		**Always (5)**		***M***	***SD***
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**		
Q13. I observe a link between the reason of coming to counseling/therapy and the physical illness and/or disability one has.	1	.6	12	7.2	47	28.3	88	53	18	10.8	3.66	0.79
Q14. I think that family and/or (close) social environment can have a positive effect on the individual's physical health.	0	0	2	1.2	20	12.1	81	49.1	62	37.6	4.21	0.71
Q15. I think that family and/or (close) social environment can have negative effect on the individual's physical health.	11	6.7	31	18.8	58	35.2	44	26.7	21	12.7	3.18	1.10
Q16. I include the client's family into my therapeutic work.	7	4.2	23	13.9	41	24.8	65	39.4	29	17.6	3.52	1.06

Q18. I try to learn more about my client’s illness and/or disability in between the sessions.	3	1.8	5	3	22	13.3	55	33.3	80	48.5	4.24	0.92
Q19. I provide my clients with information about how to cope with the particular illness and/or disability they suffer from.	5	3	20	12.2	49	29.9	64	39	26	15.9	3.53	0.99
Q20. I think that the psychological support I give to my clients has a positive effect on the prognosis of their illness/disability.	1	.6	3	1.8	23	14.1	101	62	35	21.5	4.01	0.70
Q21. I emphasize the strengths of my clients as they cope with their illness/disability.	0	0	3	1.8	18	11	66	40.5	76	46.6	4.32	0.74
Q22. I make interventions to strengthen the emotional connections among family members.	2	1.2	16	9.8	40	24.5	71	43.6	34	20.9	3.73	0.94
Q23. I assist my client(s) to assume an active role in the decision making process of their treatment.	1	.6	7	4.3	24	14.9	74	46.0	55	34.2	4.09	0.84
Q24. I stay in contact with at least one of the doctors who follow up the progress of my client’s illness.	15	9	45	27.1	38	22.9	43	25.9	25	15.1	3.10	1.21
Q25. I explore the relationship between my clients and their doctors in the sessions.	5	3	32	19.3	53	31.9	45	27.1	31	18.7	3.37	1.10
Q26. I see my clients together with their doctors in a session in order to evaluate mental health status	106	64.6	41	25	14	8.5	2	1.2	1	.6	1.47	0.75

in conjunction with physical health status.												
Q27. I advise and/or encourage my clients to be in communication with other individuals/couples/ families/ groups who have experienced the similar health issues.	14	8.5	35	21.2	61	37	44	26.7	11	6.7	3.01	1.04
Q28. I help my clients in their management of the healthcare system.	26	15.8	47	28.5	46	27.9	35	21.2	11	6.7	2.73	1.16
Q30. I think that my clients with a psychical illness/disability are exposed to some kind of discrimination (due to language, religion, race, SES etc.) inflicted by the healthcare system.	37	22.8	52	32.1	45	27.8	23	14.2	5	3.1	2.43	1.09

Note. M= Mean. *SD* = Standard Deviation. Mean score ranges from 1 (Never) to 5 (Always).

Forty seven respondents (29%) stated that they *barely* help their clients in their management of the healthcare system (Q28). Mean score assessing this turned out to be 2.73 (*SD* = 1.16), which shows that the respondents' tendency to support their clients in their management of the healthcare system is between the categories "*barely"* and "*seldom"*, yet close to the category "*seldom"* (see Table 3). The respondents who chose any option other than *never* were directed to another question to obtain more detailed information about how they support their clients in their problems related to the healthcare system. This was a multiple-choice question, not a statement to be rated. The question asked how participants assist their clients in their management of the healthcare system (Q29). The participants were allowed to check more than one option if applicable. One hundred six of the respondents (64%) chose the option “By talking about the experienced difficulty in our sessions”, 98 (59%) chose “By referring them to a source from which they could get assistance on the experienced difficulty”, 83 (50%) chose ‘‘By providing direct and/or indirect solutions for the difficulty experienced’, 40 (24%) chose ‘‘By getting in touch with an helpful source about the needs of my client’’ and only two (1%) chose the option “other” (see Table 4). The participants who chose the option “other” stated that they ask their friends or relatives who work in the healthcare system to help their clients.

Table 4

Frequencies and percentage distributions of respondents’ answers to the questions on how they work with individuals with medical problems

		N	***%***
Q17. How do you include the family into the treatment process?			
(i)	Including the couple and/or family in the assessment course	75	45.2
(ii)	Making separate sessions with other family members if necessary	89	53.6

(iii)	Making conjoint sessions with other family members if necessary	109	65.7
(iv)	Organizing and running psychoeducation and/or support groups	53	31.9
(v)	Carrying out the counseling/therapy process together with the individual's spouse and/or family	47	28.3
(vi)	Other	3	1.8
Q29. How do you assist your clients in their management of the healthcare system?			
(i)	By talking about the experienced difficulty in our sessions	106	63.9
(ii)	By providing direct and/or indirect solutions about the difficulty experienced	83	50
(iii)	By referring them to a source that could give them assistance on the experienced difficulty	98	59
(iv)	By getting in touch with a helpful source about the needs of my client	40	24.2
(v)	Other	2	1.2
Q31. In your sessions how do you deal with issues that pertain to discrimination (due to language, religion, race, SES etc.) inflicted by the healthcare system?			
(i)	By talking about it when the client brings it up in the session	105	63.3

(ii)	By giving information about how to manage the healthcare system	33	19.9
(iii)	By raising awareness about the rights, one has in the healthcare system	54	32.5
(iv)	By making an effort to act as a bridge between the healthcare system and the patient	15	9
(v)	Other	0	0
Q34. Which aspects of the client's experience do you take into consideration when you work with individuals/couples/families/groups coping with a physical illness/disability?			
Biological		88	53
Psychological		162	97.6
Spiritual		63	38
Social		147	88.6
Other		7	4.2

Fifty two of the participants (32%) stated that they *barely* think that their clients are exposed to some kind of discrimination (due to language, religion, race, SES etc.) in the healthcare system (Q30). The overall mean score of the 166 participants for this item was 2.43 (*SD* = 1.09). This indicates that the tendency of the respondents to think that their clients are discriminated by the healthcare system is between the categories "*barely*" and "*seldom*", and slightly closer to the category "*barely*" (see Table 3).

The respondents who chose any option other than *never* were directed to another question to obtain more detailed information as to how they approach issues that pertain to discrimination in the sessions. This item of the survey was a multiple-choice question rather than a statement to be rated and it asked ‘‘When working with individuals with a physical illness and/or disability, how do you approach the issue if you think that your client is exposed to some kind of discrimination (due to language, religion, race, SES, etc.)?’’ (Q31). The participants were allowed to check more than one option if applicable. One hundred five participants (63%) chose the statement ‘‘By talking about it when the client brings it up in the sessions’’, 54 (33%) chose ‘‘By raising the client’s awareness about his/her rights in the healthcare system’’, 33 (20%) chose ‘‘By giving information about how to manage the healthcare system’’, and 15 (9%) chose ‘‘By making an effort to act as a bridge between the healthcare system and the patient’’ (see Table 4).

Participants were also asked to indicate how much they focus on different time frames (i.e., past, present and future) in the therapeutic process when working with clients coping with a physical illness and/or disability (Q32). Eighty-one respondents (49%) stated that they *often* focus on the past, and the overall mean value of all responses for this item was 3.59 (*SD* = 0.87). Hence, the tendency of the participating mental health professionals to deliberate on the past is between the categories “*seldom”* and “*often”*, but slightly closer to the category “*often”* (see Table 5). Eighty-five of the participants (52%) asserted they *often* focus on the present. The mean value of all responses for this item was 4.43 (*SD* = 0.56), meaning that the respondents' tendency to focus on the present is between the categories "*often*" and "*always*", yet slightly closer to the category "*often*" (see Table 5). Lastly, 89 mental health professionals (55%) stated that they *often* focus on the future, with mean value of all the responses for the corresponding item 3.90 (*SD* = 0.78). This reveals that the tendency of focusing on the future in the sessions is between the categories "*seldom*" and "*often*", yet closer to the category "*often*" (see Table 5).

Table 5

Time frames deliberated in therapy

Q32. How often do you focus on the below time frames when working with clients with a physical illness and/or disability?	**Never (1)**		**Barely (2)**		**Seldom (3)**		**Often (4)**		**Always (5)**		***M***	***SD***
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**		
Past	2	1.2	18	11	44	26.8	81	49.4	19	11.6	3.59	0.87
Present	0	0	1	.6	2	1.2	85	52.1	75	46	4.43	0.56
Future	0	0	8	4.9	32	19.6	89	54.6	34	20.9	3.90	0.78

Note. M = Mean. *SD* = Standard Deviation. Mean score ranges from 1 (Never) to 5 (Always).

Question 33 explored mental health workers' addressing various topics when working with clients with a physical illness and/or disability (see Table 6). These topics were emotions (*M* = 5.57, *SD* = 0.53), family dynamics (*M* = 4.18, *SD* = 0.78), illness/disability (*M* = 3.96, *SD* = 0.90), internal dynamics (*M* = 4.13, *SD* = 0.82), observable behaviors (*M* = 4.24, *SD* = 0.70), social factors (*M* = 3.99, *SD* = 0.81), and thoughts and beliefs (*M* = 4.43, *SD* = 0.66). Based on the findings, it can be said that respondents' tendency to deliberate on clients' emotions is between the categories "*often*" and "*always*", but slightly closer to the category "*always*". The tendency to deliberate on clients' family dynamics is between the categories "*often*" and "*always*", but closer to the category "*often*"; the tendency to deliberate on clients' illness/disability is between the categories "*seldom*" and "*often*", but closer to the category "*often*"; the tendency to deliberate on clients' internal dynamics is between the categories "*often*" and "*always*", but closer to the category "*often*"; the tendency to deliberate on clients' observable behaviors is between the categories "*often*" and "*always*", but closer to the category "*often*"; the tendency to deliberate on social factors surrounding the client is between the categories "*seldom*" and "*often*", but very close to the category "*often*"; and the tendency to deliberate on clients' thoughts and beliefs is between the categories "*often*" and "*always*", yet slightly closer to the category "*often*" (see Table 6).

Table 6

Topics deliberated in therapy

Q33. How often do you deliberate on the below topics when working with clients with a physical illness and/or disability?	**Never (1)**		**Barely (2)**		**Seldom (3)**		**Often (4)**		**Always (5)**		***M***	***SD***
	N	%	N	%	N	%	N	%	N	%		

Emotions	0	0	0	0	3	1.8	64	39	97	59.1	4.57	0.53
Family dynamics	0	0	3	1.8	28	17.1	69	42.1	64	39	4.18	0.78
Illness/Disability	1	.6	9	5.5	36	22	68	41.5	50	30.5	3.96	0.90
Internal dynamics	0	0	6	3.7	27	16.6	69	42.3	61	37.4	4.13	0.82
Observable behaviors	0	0	4	2.4	13	7.9	86	52.4	61	37.2	4.24	0.70
Social Factors	1	.6	5	3	33	20.1	80	48.8	45	27.4	3.99	0.81
Thoughts and Beliefs	0	0	1	.6	12	7.4	66	40.7	83	51.2	4.43	0.66

Note. M= Mean. *SD* = Standard Deviation. Mean score ranges from 1 (Never) to 5 (Always).

Survey’s last question was about the different aspects of the illness experience that mental health professionals consider as they work with individuals coping with a physical illness/disability (see Table 4). This item was a multiple-choice question rather than a statement to be rated, and asked, “Which aspects of the client’s experience do you take into consideration as you work with individuals/couples/families/groups coping with a physical illness/disability?” (Q34). The participants were allowed to check more than one option if applicable. For this particular question, 162 of the respondents (98%) indicated that they take into consideration the psychological aspect of the client’s experience in they work, whereas 147 (89%) stated to consider the social aspect, 88 (53%) stated to consider the biological aspect, and 63 (38%) stated to consider the spiritual aspect. 7 participants (4%) chose the option ‘other' (see Table 4), stating that they take into account the familial aspect.

Results of Analysis

On survey items assessing the use of systemic principles, further statistical analyses were conducted. For example, independent groups (ex:

couple and family therapist, and those who do not work with couples or families) were compared with respect to the practice of inclusion of the family into the therapy process, which is one of the main principles of the systemic approach. The analyses were carried out via Mann-Whitney U tests. Mean values for each item and number of participants who chose each option for any particular item are presented in Table 3. The mean scores range between one and five, and each represents the tendency to practice the particular strategy in question. Higher values represent more tendency to practice the strategies explored in the study.

The participants were allowed to choose more than one option for items on their area of specialty, work setting, theoretical orientation, and primary client population. This means that they could choose all the applicable options. However, this had a drawback. Because any one person might be in more than one group, comparison of specific groups could not be made. Instead, the mean value of the responses of a particular group was compared with all the other responses. For instance, psychiatrists' responses were compared with other mental health professionals' responses. Mann-Whitney U test was used to compare the tendencies of two independent groups' responses to survey statements. Differences between categorical variables were analyzed using the chi-square test.

A Mann-Whitney U test was conducted to compare couple and family therapists with other professionals who do not work with couples or families, in their practice of including the patient' family in the therapy process (Q16). Table 7 displays the results. The mean value of 21 couple and family therapists’ responses were 4.00 (*SD* = 0.89), whereas the remaining 144 professionals’ responses had a mean value of 3.45 (*SD* = 1.08). The couple and family therapists’ tendency to include the family in the psychotherapy process of the client was significantly higher as compared to other professionals ($p = .022$). Moreover, mean value of the 21 couple and family therapists’ responses on the frequency of making an intervention to strengthen emotional connections among family members (Q22) turned out to be 4.33 (*SD* = 0.86), whereas it was 3.64 (*SD* = 0.93) for the 142 professionals who do not work with couples or families. The couple and family therapists’ tendency to make an intervention that would strengthen the emotional connections among family members was significantly higher as compared to the others ($p = .001$). There was also a statistical difference between the 21 couple and family therapists’ responses (*M* = 2.62, *SD* = 0.97) and the 145 other professionals’ (*M* = 3.18, *SD* = 1.24) on the frequency of being in contact with at least one of the client’s medical doctors who follow up the progress of the illness (Q24). The couple and family therapists’ tendency to be in contact with the client’s doctors was significantly lower as compared to the others ($p = .040$). Results also revealed that number of couple and family therapists’ responses counted for the option ‘Including the couple and/or family during the assessment course’ (Q17-i) was significantly higher than the expected count, whereas that of the other professionals was significantly lower than the expected count, X^2 (1, $N = 166$) = 4.48, $p = .034$. Table 8 displays the results.

Table 7

Comparison of the responses given by couple and family therapists with those of others on some of the items

	Couple and Family therapists			**Other Mental Health Professionals**			***p* value**
	N	***M***	***SD***	***N***	***M***	***SD***	
Q16.I include the client's family in my therapeutic work.	21	4.00	0.89	144	3.45	1.08	.022*
Q22. I make interventions to strengthen the emotional connections among family members.	21	4.33	0.86	142	3.64	0.93	.001*
Q24. I stay in contact with at least one of the doctors (healthcare providers) who follow up the progress of the illness/disability my client has.	21	2.62	0.97	145	3.18	1.24	.040*
Q33. How often do you deliberate on the below topics when working with clients with a physical illness and/or disability?							
Emotions	20	4.55	0.61	144	4.58	0.52	.965
Family dynamics	20	4.35	0.81	144	4.16	0.77	.228
Illness/Disability	20	3.95	0.83	144	3.96	0.91	.790
Internal dynamics	20	4.05	0.83	143	4.15	0.82	.593
Observable behaviors	20	4.45	0.61	144	4.22	0.71	.169
Social Factors	20	4.15	0.81	144	3.97	0.14	.304
Thoughts and Beliefs	20	4.55	0.51	142	4.41	0.68	.496

* $p < .05$ obtained from Mann-Whitney u test

Note. M = Mean. *SD* = Standard Deviation. Mean score ranges from 1 (Never) to 5 (Always).

Table 8

Comparison of the responses given by couple and family therapists with those of others on question 17

	Couple and Family therapists		**Other Mental Health Professionals**		***p* value**
	N	***%***	***N***	***%***	
Q17 (i). Including the couple and/or family during the assessment course					
No	7	7.7	84	92.3	.034*
Yes	14	18.7	61	81.3	
Q17 (ii). Making <u>separate</u> sessions with other family members if necessary					
No	7	9.1	70	90.9	.199
Yes	14	15.7	75	84.3	
Q17 (iii). Making <u>conjoint</u> sessions with other family members if necessary					
No	5	8.8	52	91.2	.277
Yes	16	14.7	93	85.3	
Q17 (iv). Organizing and running psycho-education and/or support groups					
No	14	12.4	99	87.6	.882
Yes	7	13.2	46	86.8	
Q17 (v). Conducting the counseling/therapy process <u>together</u> with the individual's spouse and/or family					
No	13	10.9	106	89.1	.287
Yes	8	17	39	83	
Q17 (vi). Other					
No	21	12.9	142	87.1	1.000

Yes	0	0	3	100

* $p < .05$ obtained from Chi-square test

Mann-Whitney U tests were conducted on a number of items to compare counseling psychologists with all the other members of the sample (see Table 9). The mean value of the responses given to the item that asked the frequency of including the family into the therapy process (Q16) was 4.00 (*SD* = 0.98) for the 28 counseling psychologists, whereas it turned out to be 3.42 (*SD* = 1.06) for the 137 other professionals. The difference was significant, meaning that counseling psychologists were more inclined to include the family into the therapeutic process as compared to the other occupational groups ($p = .007$). Table 9 displays the results. Moreover, there were also statistically significant differences between these two groups on the frequency of using different means to include the family in the therapy process (Q17). Accordingly, the number of counseling psychologists' responses counted for the option 'Making separate sessions with other family members if necessary' (Q17-ii) was significantly higher than expected count, whereas that of the others was significantly lower than expected count, X^2 (1, $N = 166$) = 8.44, $p = .004$. Also, the number of counseling psychologists' responses counted for the 'Conducting psychoeducation and/or support groups' (Q17-iv) was significantly higher than expected count, whereas that of the others was significantly lower than expected count X^2 (1, $N = 166$) = 5.06, $p = .024$. You may view the results in Table 10.

Table 9

Comparison of the responses given by counseling therapists with those of others on some of the items

	Counseling psychologists			**Other Mental Health Professionals**			***p* value**
	N	***M***	***SD***	***N***	***M***	***SD***	
Q16. I include the client's family in my therapeutic work.	28	4.00	0.98	137	3.42	1.06	.007*
Q22. I make interventions to strengthen the emotional connections among family members.	28	3.86	0.85	135	3.70	0.96	.575
Q24. I stay in contact with at least one of the doctors (healthcare providers) who follow up the progress of the illness/disability my client has.	28	3.18	1.34	138	3.09	1.20	.851
Q33. How often do you deliberate on the below topics when working with clients with a physical illness and/or disability?							
Emotions	28	4.57	0.50	136	4.57	0.54	.886
Family dynamics	28	4.21	0.74	136	4.18	0.79	.899
Illness/Disability	28	3.96	0.99	136	3.96	0.88	.815
Internal dynamics	28	4.14	0.76	135	4.13	0.84	.887
Observable behaviors	28	4.04	0.96	136	4.29	0.70	.063
Social Factors	28	3.86	0.76	136	4.02	0.82	.252
Thoughts and Beliefs	28	4.25	0.70	134	4.46	0.65	.116

* p <.05 obtained from Mann-Whitney u test

Note. M = Mean. *SD* = Standard Deviation. Mean score ranges from 1 (Never) to 5 (Always).

Table 10

Comparison of the responses given by counseling therapists with those of others on question 17

	Counseling psychologists		**Other Mental Health Professionals**		***p* value**
	N	***%***	***N***	***%***	
Q17. Including the couple and/or family during the assessment course					
No	16	17.6	75	82.4	.786
Yes	12	16.0	63	84.0	
Q17. Making separate sessions with other family members if necessary					
No	6	7.18	71	92.2	.004*
Yes	22	24.7	67	75.3	
Q17. Making conjoint sessions with other family members if necessary					
No	11	19.3	46	80.7	.545
Yes	17	15.6	92	84.4	
Q17. Organizing and running psycho-education and/or support groups					
No	14	12.4	99	87.6	.024*
Yes	14	26.4	39	73.6	
Q17. Carrying out the counseling/therapy process together with the individual's spouse and/or family					
No	21	17.6	98	82.4	.670
Yes	7	14.9	40	85.1	
Q17. Other					
No	28	17.2	135	82.8	1.000
Yes	0	0	3	100	

* $p < .05$ obtained from Chi-square test

Various analyses were performed to compare the practices of clinical psychologists with others, as well (see Table 11). The mean value of the responses given to the item that assessed the frequency of deliberating on patients' observable behaviors in the sessions (Q33) turned out to be 4.33 (*SD* = 0.70) for the 90 clinical psychologists, whereas it was 4.14 (*SD* = 0.69) for the other 74 professionals. The difference was statistically significant, indicating that as compared to other professionals clinical psychologists were more inclined to deliberate on their clients' observable behaviors in the sessions (*p* = .044). Table 11 displays the results. When it comes to deliberating on emotions (Q33), the difference was again significant in favor of clinical psychologists (*p* = .040). The mean value of the responses given to this item was 4.64 (*SD* = 0.53) for the clinical psychologists, and it was 4.49 (*SD* = 0.53) for the others (Table 11). Another sub-item of question 33 was on the frequency of deliberating on family dynamics in the session. Clinical psychologists were again more concerned as to this issue, with mean value of their responses being 4.31 (*SD* = 0.80) and mean value of the responses given by the other 74 participants being 4.03 (*SD* = 0.72). The difference was statistically significant (*p* = .007). Lastly, the mean value of the responses given by 89 clinical psychologists to the sub-item assessing the frequency of deliberating on internal dynamics in the sessions turned out to be 4.27 (*SD* = 0.84), yielding a significantly higher score as compared to the responses given by the other 74 professionals (*M* = 3.97, *SD* = 0.78) . This indicates that clinical psychologists are more inclined to address their clients' internal dynamics in the sessions (*p* = .008). Table 11 displays the results.

Although no statistically significant difference was found between clinical psychologists' and other professionals' practice as to the frequency of including the family into therapeutic work (Q16), there were statistically significant differences between these two groups as to how they did it (Q17). Accordingly, the number of clinical psychologists' responses counted for the option '*conducting the counseling/therapy process together with the individual's spouse and/or family'* (Q17-v) was significantly lower than expected count, whereas that of the others was significantly higher than expected count X^2 (1, *N* = 166) = 4.39, *p* = .036. Table 12 displays the results.

Table 11

Comparison of the responses given by clinical psychologists with those of others on some of the items

	Clinical psychologists			**Other Mental Health Professionals**			***p* value**
	N	***M***	***SD***	***N***	***M***	***SD***	
Q16. I include the client's family in my therapeutic work.	91	3.37	1.16	74	3.70	0.92	.091
Q22. I make interventions to strengthen the emotional connections among family members.	90	3.74	1.06	73	3.71	0.79	.593
Q24. I stay in contact with at least one of the doctors (healthcare providers) who follow up the	92	2.95	1.24	74	3.31	1.18	.054

progress of the illness/disability my client has.							
Q33. How often do you deliberate on the below topics when working with clients with a physical illness and/or disability?							
Emotions	90	4.64	0.53	74	4.49	0.53	.040*
Family dynamics	90	4.31	0.80	74	4.03	0.72	.007*
Illness/Disability	90	4.03	0.84	74	3.86	0.96	.336
Internal dynamics	89	4.27	0.83	74	3.97	0.78	.008*
Observable behaviors	90	4.33	0.70	74	4.14	0.69	.044*
Social Factors	90	4.07	0.80	74	3.91	0.81	.204
Thoughts and Beliefs	89	4.49	0.68	73	4.34	0.63	.071

* *p* < .05 obtained from Mann-Whitney u test

Note. M = Mean. *SD* = Standard Deviation. Mean score ranges from 1 (Never) to 5 (Always).

Table 12

Comparison of the responses given by clinical psychologists with those of others on question 17

	Clinical psychologists		**Other Mental Health Professionals**		***p* value**
	N	***%***	***N***	***%***	
Q17 (i). Including the couple and/or family during the assessment course					
No	55	60.4	36	39.6	.152
Yes	37	49.3	38	50.7	
Q17 (ii). Making separate sessions with other family members if necessary					

No	46	59.7	31	40.3	.298
Yes	46	51.7	43	48.3	
Q17 (iii). Making conjoint sessions with other family members if necessary					
No	33	57.9	24	42.1	.643
Yes	59	54.1	50	45.9	
Q17 (iv). Organizing and running psychoeducation and/or support groups					
No	60	53.1	53	46.9	.379
Yes	32	60.4	21	39.6	
Q17 (v). Carrying out the counseling/therapy process together with the individual's spouse and/or family					
No	72	60.5	47	39.5	.036*
Yes	20	42.6	27	54.7	
Q17 (vi). Other					
No	91	55.8	72	44.2	.586
Yes	1	33.3	2	66.7	

* $p < .05$ obtained from Chi-square test

Table 13 displays the results of the analyses conducted to compare the practices of psychiatrists with other mental health professionals. Addressing family dynamics in the sessions was one of the topics of comparison. Results revealed that psychiatrists ($N = 39$, $M = 3.95$, $SD = 0.76$) did not address familial dynamics as much as other professionals ($N = 125$, $M = 4.26$, $SD = 0.77$) [$p = .020$]. One other topic concerned inclusion of family members in the sessions. Although no statistically significant difference was found between psychiatrists' and other professionals' practice as to the frequency of including the family into therapeutic work (Q16), there were statistically significant differences between these two groups as to how they did it (Q17). Accordingly, the number of psychiatrists' responses counted for the 'Including the couple and/or family during the *assessment course'* (Q17-i) was significantly higher than expected count, whereas that of others was significantly lower than expected count X^2 (1, N = 166) = 7.37, p = .007, as shown in Table 14. On the other hand, the number of psychiatrists' responses counted for the 'Conducting *psychoeducation* and/or *support groups'* (Q17-iv) was significantly lower than expected count, whereas that of others was significantly higher than expected count X^2 (1, N = 166) = 6.42, p = .011, as shown in Table 14.

Table 13

Comparison of the responses given by psychiatrists with those of others on some of the items

	Psychiatrists			**Other Mental Health Professionals**			***p* value**
	N	***M***	***SD***	***N***	***M***	***SD***	
Q16. I include the client's family in my therapeutic work.	39	3.69	0.92	126	3.47	1.11	.281
Q22. I make interventions to strengthen the emotional connections among family members.	38	3.63	0.85	125	3.76	0.97	.417
Q24. I stay in contact with at least one of the doctors (healthcare providers) who follow up the progress of the illness/disability my client has.	39	3.33	1.13	127	3.04	1.24	.187

Q33. How often do you deliberate on the below topics when working with clients with a physical illness and/or disability?							
Emotions	39	4.51	0.56	125	4.59	0.53	.427
Family dynamics	39	3.95	0.76	125	4.25	0.77	.020*
Illness/Disability	39	3.85	1.01	125	3.99	0.86	.544
Internal dynamics	39	3.92	0.84	124	4.20	0.81	.056
Observable behaviors	39	4.10	0.75	125	4.27	0.69	.370
Social Factors	39	3.90	0.88	125	4.02	0.79	.503
Thoughts and Beliefs	39	4.36	0.67	123	4.45	0.66	.430

* *p* < .05 obtained from Mann-Whitney u test

Note. M = Mean. *SD* = Standard Deviation. Mean score ranges from 1 (Never) to 5 (Always).

Table 14

Comparison of the responses given by psychiatrists with those of others on question 17

	Psychiatrists		**Other Mental Health Professionals**		***p* value**
	N	**%**	***N***	**%**	
Q17 (i). Including the couple and/or family during the assessment course					
No	14	15.4	77	84.6	.007*
Yes	25	33.3	50	66.7	
Q17 (ii). Making <u>separate</u> sessions with other family members if necessary					
No	19	24.7	58	75.3	.138
Yes	20	22.5	69	77.5	

Q17 (iii). Making conjoint sessions with other family members if necessary					
No	13	22.8	44	77.2	.880
Yes	26	23.9	83	76.1	
Q17 (iv). Organizing and running psychoeducation and/or support groups					
No	33	29.2	80	70.8	.011*
Yes	6	11.3	47	88.7	
Q17 (v). Carrying out the counseling/therapy process together with the individual's spouse and/or family					
No	25	21.0	94	79.0	.229
Yes	14	29.8	33	70.2	
Q17 (vi). Other					
No	38	23.3	135	76.7	.555
Yes	1	33.3	2	66.7	

* $p < .05$ obtained from Chi-square test

Work setting was another factor whose impact was investigated within the scope of this study. Analyses were performed to see if it played a significant role in the work conducted with individuals coping with medical problems (see Table 15). Some survey items were thought be more related to the working environment, and they were the ones chosen for analysis. These items were on the following topics:

- percentage of caseload with medical problems (Q11)
- observing a link between the reason of coming to counseling/therapy and the physical illness and/or disability the client has (Q13)
- inclusion of the family into the therapy process (Q16)

- staying in contact with at least one of the doctors (healthcare providers) who follow up the progress of the illness/disability the client has (Q24)
- exploring the relationship between the clients and their doctors in the sessions (Q25)
- seeing clients with their doctors together in a session in order to evaluate mental health status in conjunction with physical health status (Q26)
- helping clients in their management of the healthcare system (Q28)
- thinking that clients are exposed to some kind of discrimination (due to language, religion, race, SES etc.) inflicted by the healthcare system (Q30)

Mann-Whitney U tests were conducted, with *workplace* taken as the independent variable. For each test, one of the response options that pertain to the workplace was compared with all the rest. It was seen that professionals working in a school setting (*N* = 11) saw a much lesser number of clients with medical problems as compared to the others (*N* = 152), with mean values of the responses given to the item assessing percentage of caseload 5.73 (*SD*= 3.66) and 21.51 (*SD* = 24.07) respectively (*p* =.006). You may view the results in Table 15. Yet those who work in school settings (*N* = 12) were more willing to include the families of their clients into the therapeutic process as opposed to all the others (*N* = 153) [*p* = .004]. The mean values of the responses given to the item assessing the frequency of inclusion of the family into the process were 4.33

(*SD* = 0.49) and 3.46 (*SD* = 1.08), respectively. Table 15 displays the results.

Table 15

Comparison of the responses given by professionals working in a school setting with those of others

	Working in a School Setting			**Working elsewhere**			***p* value**
	N	***M***	***SD***	***N***	***M***	***SD***	
Q11. Percentage of the caseload with physical illness and/or disability	11	5.73	3.66	152	21.51	24.07	.006*
Q13. I observe a link between the reason of coming to counseling/therapy and the physical illness and/or disability one has.	12	3.75	0.87	154	3.66	0.79	.688
Q16. I include the client's family in my therapeutic work.	12	4.33	0.49	153	3.46	1.08	.004*
Q24. I stay in contact with at least one of the doctors (healthcare providers) who follow up the progress of the illness my client has.	12	2.83	1.19	154	3.13	1.22	.401
Q25. I explore the relationship between my clients and their doctors in the sessions.	12	2.92	0.90	154	3.43	1.10	.084

Q26. I see my clients together with their doctors in a session in order to evaluate mental health status in conjunction with physical health status	12	1.33	0.65	152	1.49	0.76	.455
Q28. I help my clients in their management of the healthcare system.	12	2.67	1.23	153	2.75	1.14	.907
Q30. I think that my clients are exposed to some kind of discrimination (due to language, religion, race, SES etc.) inflicted by the healthcare system.	12	2.50	1.24	150	2.42	1.08	.974

* *p* < .05

Note. M = Mean. *SD* = Standard Deviation.

Same analyses were conducted, taking the hospital setting as the independent variable. As expected, the picture was very different in terms of percentage of caseload with medical problems. Mean percentage of caseload of clients with medical problems was 27.14 (*SD* = 24.20) for the 36 professionals working in a hospital, whereas the number dropped to 18.54 (*SD* = 23.16) for the 127 professionals who work in other work settings. The difference was statistically significant, meaning that those who work in hospitals come across clients with medical conditions more often (*p* = .005) You may view the results in Table 16.

Table 16

Comparison of the responses given by professionals working in a hospital setting with those of others

	Working in a Hospital Setting			**Working elsewhere**			***p* value**
	N	***M***	***SD***	***N***	***M***	***SD***	
Q11. Percentage of the caseload with physical illness and/or disability caseload	36	27.14	24.20	127	18.54	23.16	.005*
Q13. I observe a link between the reason of coming to counseling/therapy and the physical illness and/or disability one has.	36	3.67	0.83	130	3.66	0.78	.853
Q16. I include the client's family in my therapeutic work.	35	3.57	0.98	130	3.51	1.09	.825
Q24. I stay in contact with at least one of the doctors (healthcare providers) who follow up the progress of the illness my client has.	36	3.25	1.23	130	3.07	1.22	.429
Q25. I explore the relationship between my clients and their doctors in the sessions.	36	3.58	1.11	130	3.34	1.08	.228
Q26. I see my clients together with their doctors in a session	35	1.51	0.92	129	1.47	0.71	.777

in order to evaluate mental health status in conjunction with physical health status.							
Q28. I help my clients in their management of the healthcare system.	35	2.80	1.16	130	2.73	1.16	.766
Q30. I think that my clients are exposed to some kind of discrimination (due to language, religion, race, SES etc.) inflicted by the healthcare system.	36	2.31	0.98	126	2.46	1.12	.569

* *p* < .05

Note. M = Mean. *SD* = Standard Deviation.

Another work place alternative put into analysis was private practice. With respect to the percentage of caseload with medical problems, the mean value of responses given by the 92 professionals who stated to be in private practice was 16.83 (*SD* = 20.27), whereas it was much higher for the 71 practitioners who work in various other settings (*M* = 25.13, *SD* = 26.73). Hence, it can be argued that clients with medical problems make up a smaller portion of the overall caseload of those who work in private practice, as opposed to professionals who work in other settings (*p* = .027). You may view respective the statistics in Table 17. Another comparison made was on the practice of helping clients in their management of the healthcare system. The mean value of the responses given by the 92 professionals in private practice was 2.58 (*SD* = 1.12), whereas it turned out to be 2.96 (*SD* = 1.17) for the other 73 professionals. This indicates that professionals in private practice are less inclined to help their clients in their management of the healthcare system (*p* = .039). Again, you may refer to Table 17 for the respective statistics. Lastly, 88 of the professionals in private practice provided an answer to the item assessing the frequency of considering the presence of some kind of a discrimination their clients are exposed to in the healthcare system. The mean value of responses were 2.61 (*SD* = 1.12), whereas it was 2.20 (*SD* = 1.01) for the 74 professionals working in other settings. This finding reveals that professionals in private practice more often think that clients with medical problems are exposed to some kind of discrimination inflicted by the healthcare system (*p* = .019). Table 17 displays the results.

Table 17

Comparison of the responses given by professionals in private practice with those who work in other settings

	Professionals in Private Practice			**Professionals Working in Other Settings**			***p* value**
	N	***M***	***SD***	***N***	***M***	***SD***	
Q11. Percentage of caseload with physical illness and/or disability	92	16.83	20.27	71	25.13	26.73	.027*

Q13. I observe a link between the reason of coming to counseling/therapy and the physical illness and/or disability one has.	92	3.71	0.76	74	3.61	0.83	.525
Q16. I include the client’s family in my therapeutic work.	92	3.42	1.15	73	3.64	0.95	.225
Q24. I stay in contact with at least one of the doctors (healthcare providers) who follow up the progress of the illness my client has.	92	2.99	1.25	74	3.26	1.17	.142
Q25. I explore the relationship between my clients and their doctors in my sessions.	92	3.48	1.04	74	3.28	1.14	.295
Q26. I see my clients together with their doctors in a session in order to evaluate mental health status in conjunction with physical health status.	92	1.46	0.75	72	1.51	0.80	.603
Q28. I help my clients in their management of the healthcare system.	92	2.58	1.12	73	2.96	1.17	.039*
Q30. I think that my clients are exposed to some kind of	88	2.61	1.12	74	2.20	1.01	.019*

discrimination (due to language, religion, race, SES etc.) inflicted by the healthcare system.

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* $p < .05$

Note. *M* = Mean. *SD* = Standard Deviation.

Impact of theoretical orientation on therapeutic practices was examined, as well (see Table 18 for statistics). Some survey items were thought be more related to practitioners' theoretical orientation, and they were the ones chosen for analysis. These items were on the following topics:

- inclusion of the family into the therapy process (Q16)
- different means of including the family into the process (Q17)
- trying to be informed about the clients' illness and/or disability in between sessions (Q18)
- providing information to clients about how their illness and/or disability proceeds (Q19).

Mann-Whitney U tests were conducted, with *theoretical orientation* taken as the independent variable. For each test, one of the response options that pertain to theoretical orientation was compared with all the rest. Differences between categorical variables were analyzed using the chi-square test. With respect to the issue of providing information to clients about how their illness and/or disability proceeds, the mean value of the responses given by the 82 practitioners who position themselves in the analytical-psychodynamic camp turned out to be 3.24 (*SD* = 1.08). This was significantly lower than the mean value of responses of the 82 professionals who do not pursue this orientation (*M* = 3.80, *SD* = 0.82). Hence, we can say that analytically-dynamically oriented mental health professionals are less inclined to provide information on the progression of the illness/disability in question [*p* = .001]. You may refer to Table 18 for respective statistics. Also, the number of responses of the practitioners who embrace the analytic-psychodynamic perspective counted for the option '*carrying out the counseling/therapy process together with the individual's spouse and/or family*' (Q17-v) was significantly lower than expected count, whereas that of the others was significantly higher than expected count X^2 (1, *N* = 166) = 4.59, *p* = .032, as shown in Table 19.

Table 18

Comparison of the responses given by professionals who work analytically-psychodynamically with those who pursue other theoretical orientations

	Professionals Who Work Analytically-Psychodynamically			**Professionals Who Pursue Other Theoretical Orientations**			***p* value**
	N	***M***	***SD***	***N***	***M***	***SD***	
	82	3.34	1.23	83	3.70	0.85	.101

Q16. I include the client's family into my therapeutic work.							
Q18. I try to learn more about the illness and/or disability my client has in between the sessions.	82	4.13	0.95	83	4.34	0.89	.114
Q19. I provide clients with information about how to cope with the illness and/or disability they suffer from.	82	3.24	1.08	82	3.80	0.82	.001*

* *p* < .05

Note. M = Mean. *SD* = Standard Deviation.

Table 19

Comparison of the responses given by professionals who work analytically-psychodynamically with those who pursue other theoretical orientations on question 17

	Professionals Who Work Analytically-Psychodynamically		**Professionals Who Pursue Other Theoretical Orientations**		***p* value**
	N	***%***	***N***	***%***	
Q17 (i). Including the couple and/or family during the assessment course					
No	45	49.5	46	50.5	.988
Yes	37	49.3	38	50.7	

Q17 (ii). Making separate sessions with other family members if necessary					
No	42	54.5	35	45.5	.217
Yes	40	44.9	49	55.1	
Q17 (iii). Making conjoint sessions with other family members if necessary					
No	29	50.9	28	49.1	.783
Yes	53	48.6	56	54.1	
Q17 (iv). Organizing and running psychoeducation and/or support groups					
No	60	53.1	53	46.9	.164
Yes	22	41.5	31	58.5	
Q17 (v). Carrying out the counseling/therapy process together with the individual's spouse and/or family					
No	65	54.6	54	45.4	.032*
Yes	17	36.2	30	63.8	
Q17 (vi). Other					
No	79	48.5	84	51.5	.118
Yes	3	100	0	0	

* *p* <.05

Existential approach was another theoretical orientation on which various analyses were conducted. One topic of exploration was again the inclusion of the family into the therapy process. Results revealed that existentially oriented mental health practitioners are more inclined to include the family of the client into the process ($p = .000$). Mean values for the two groups turned out to be 4.41 ($N = 17$, $SD = 0.82$) and 3.42 ($N = 148$, $SD = 1.06$) respectively. You may refer to Table 20 for the statistics. In addition, the number of responses given by the practitioners pursuing an experiential approach counted for the option ‘including the couple and/or family during the *assessment course’* (Q17-i) was significantly higher than expected count, whereas that of others was significantly lower than expected count X^2 (1, N = 166) = 4.99, p = .038, as shown in Table 21. Lastly, the number of responses given by the practitioners who pursue an experiential approach counted for the option ‘conducting the counseling/therapy process <u>together</u> with the individual’s spouse and/or family*’* (Q17-v) was significantly higher than the expected count, whereas that of the others was significantly lower than the expected count X^2 (1, N = 166) = 5.12, p = .024, as shown in Table 21.

Table 20

Comparison of the responses given by professionals who work experientially with those who pursue other theoretical orientations

	Professionals Who Work Experientially			**Professionals Who Pursue Other Theoretical Orientations**			***p* value**
	N	***M***	***SD***	***N***	***M***	***SD***	
Q16. I include the client’s family in my therapeutic work.	17	4.41	0.62	148	3.42	1.06	.000*
Q18. I try to learn more about the illness and/or disability my	17	4.18	0.64	148	4.24	0.95	.338

client has in between the sessions.							
Q19. I provide clients with information about how to cope with the illness and/or disability they suffer from.	17	3.47	0.80	147	3.53	1.02	.700

* *p* < .05 obtained from Mann-Whitney u test

Note. M = Mean. *SD* = Standard Deviation

Table 21

Comparison of the responses given by professionals who work experientially with those who pursue other theoretical orientations on question 17

	Professionals Who Work Experientially		**Professionals Who Pursue Other Theoretical Orientations**		***p* value**
	N	***%***	***N***	***%***	
Q17 (i). Including the couple and/or family during the assessment course					
No	5	5.5	86	94.5	.038*
Yes	12	16	63	84	

Q17 (ii). Making <u>separate</u> sessions with other family members if necessary					
No	7	9.1	70	90.9	.649
Yes	10	11.2	79	88.8	
Q17 (iii). Making <u>conjoint</u> sessions with other family members if necessary					
No	4	7.0	53	93.0	.322
Yes	13	11.9	96	88.1	
Q17 (iv). Organizing and running psychoeducation and/or support groups					
No	9	8.0	104	92.0	.158
Yes	8	15.1	45	84.9	
Q17 (v). Carrying out the counseling/therapy process <u>together</u> with the individual's spouse and/or family					
No	8	6.7	111	93.3	.024*
Yes	9	19.1	38	80.9	
Q17 (vi). Other					
No	16	9.8	147	90.2	.278
Yes	1	33.3	2	66.7	

* $p < .05$ obtained from Chi-square test

The mean value of the tendency to include the family into therapy process (Q16) was 4.03 (*SD* = 0.76) for the 37 practitioners who were employing a systemic approach to treatment, whereas it was 3.37 (*SD* =

1.10) for 128 practitioners who stated to be using some other approach. This indicates that the professionals who use a systemic approach are more likely to include the family in the therapy process as opposed to professionals with other theoretical orientations ($p = .001$). Table 22 displays the results. Also, the number of systemic practitioners' responses counted for the option 'conducting the counseling/therapy process together with the individual's spouse and/or family' (Q17-v) was significantly higher than the expected count, whereas the number of responses of the practitioners with other theoretical orientations was significantly lower than the expected count X^2 (1, $N = 166$) = 8.82, $p = .003$. You may refer to Table 23 to view the statistics.

Table 22

Comparison of the responses given by professionals who work systemically with those who pursue other theoretical orientations

	Professionals Who Employ a Systemic Approach			**Professionals Who Pursue Other Theoretical Orientations**			***p* value**
	N	***M***	***SD***	***N***	***M***	***SD***	
Q16. I include the client's family into my therapeutic work.	37	4.03	0.76	128	3.37	1.10	.001*

Q18. I try to learn more about the illness and/or disability my client has in between the sessions.	37	4.27	0.77	128	4.23	0.97	.829
Q19. I provide clients with information about how to cope with the illness and/or disability they suffer from.	37	3.65	0.86	127	3.49	1.04	.534

* *p* < .05 obtained from Mann-Whitney u test

Note. M = Mean. *SD* = Standard Deviation

Table 23

Comparison of the responses given by professionals who work systemically with those who pursue other theoretical orientations on question 17

	Professionals Who Employ a Systemic Approach		**Professionals Who Pursue Other Theoretical Orientations**		***p* value**
	N	***%***	***N***	***%***	
Q17 (i). Including the couple and/or family during the assessment course					
No	16	17.6	75	82.4	.073
Yes	22	29.3	53	70.7	

Q17 (ii). Making separate sessions with other family members if necessary					
No	14	18.2	63	81.8	.179
Yes	24	27.0	65	73.0	
Q17 (iii). Making conjoint sessions with other family members if necessary					
No	11	19.3	46	80.7	.426
Yes	27	24.8	82	75.2	
Q17 (iv). Organizing and running psycho-education and/or support groups					
No	25	22.1	88	87.9	.731
Yes	13	24.5	40	75.5	
Q17 (v). Carrying out the counseling/therapy process together with the individual's spouse and/or family					
No	20	16.8	99	83.2	.003*
Yes	18	38.3	29	61.7	
Q17 (vi). Other					
No	38	23.3	125	76.7	1.000
Yes	0	0	3	100	

* $p < .05$ obtained from Chi-square test

The Spearman's rank-order correlation was run to determine the relationship between being informed about the client's medical illness/disability outside the therapy room and informing clients about the medical illness/disability in the sessions. The level of significance was set at $p < .05$. It turned out that there was a weak but positive correlation between the two variables, which was statistically significant ($r_s = 0.249$, $p = .001$). Lastly, another correlation test was performed to detect the relationship between being informed about the medical illness/disability in question outside the therapy room and being in communication with at least one of the client's medical health providers who follow up the process. Again a weak but positive correlation was found between the two variables, which was statistically significant ($r_s = 0.343$, $p = .000$). Results of the correlation tests are displayed in Table 24.

Table 24

Correlations/Spearman's rho for the being informed outside of the sessions, informing clients in the sessions, and being in contact with clients' doctors

		Q18. I try to learn more about my clients' illness and/or disability in between the sessions.	**Q19.** I provide my clients with information about how to cope with the illness and/or disability they have.	**Q24**. I stay in contact with at least one of the doctors who follow up the progress of the illness my client has.
Q18. I try to learn more about my clients' illness and/or disability in between the sessions.	Correlation Coefficient	1.000	$.249^{**}$	$.343^{**}$
	Sig. (2-tailed)	.	.001	.000
	N	165	164	165
Q19. I provide my clients with	Correlation Coefficient	$.249^{**}$	1.000	$.328^{**}$

information about how to cope with the illness and/or disability they have.	Sig. (2-tailed)	.001	.	.000
	N	164	164	164
Q24. I stay in contact with at least one of the doctors who follow up the progress of the illness my client has.	Correlation Coefficient	.343**	.328**	1.000
	Sig. (2-tailed)	.000	.000	.
	N	165	164	166

**. Correlation is significant at the 0.01 level (2-tailed).

CHAPTER 5 – DISCUSSION

Overview of Study

Purpose

The primary aim of this study was to investigate the use of systemic principles among mental health practitioners in Turkey, who work with clients with medical problems. The study explored whether the tendency of using these systemic principles differs as a function of the participants' area of specialty, theoretical orientation and work setting. Even though there are many mental health professionals who work with individuals coping with an illness/disability, up until today no research was conducted in Turkey on the clinical practices used in the mental health treatment of individuals with such a medical condition. Systemic principles within the medical family therapy model provide practitioners a comprehensive and effective approach for treatment of this client population. The principal investigator developed a survey to assess the use of various systemic principles by mental health practitioners in a sample from Turkey. The findings are discussed to understand the trends in current clinical practices and to enable incorporation of systemic principles into mental health practices.

Based on the extensive amount of literature findings, the principal investigator identified a number of systemic practices that are used across the globe when working with individuals coping with medical issues. These practices are (a) inclusion of the family into the therapy process (Linville, Hertlein & Lyness, 2007), (b) making interventions to strengthen the emotional connections among family members (Anderson, Huff & Hodgson, 2008; Marlowe, Hodgson, Lamson, White & Irons, 2012; Linville, Hertlein & Lyness, 2007) (c) assisting clients to assume an active role in the decision making process of their treatment, (d) collaboration and communication with the other health care providers (Linville, Hertlein & Lyness, 2007), (e) encouraging clients to be in contact with other individuals and families who have experienced similar health issues, (f) helping clients with their management of the healthcare system (Bischoff, Springer, Felix & Hollist, 2011), and (g) taking into consideration the biological, psychological, social and spiritual aspects of the client's experiences of the illness/disability (McDaniel, Doherty & Hepworth, 2014). To put it differently, the aim of the current study was to investigate how frequently each one of these principles were utilized by mental health professionals, and to see if they were associated with the demographic data.

Summary and Discussion of Findings

Regarding the demographic characteristics of the participants, the sample was composed predominantly of female participants. Participants were young in general and most had master's degrees. Majority of them were clinical psychologists. Private practice was the work setting of many of them. They had one to five years of experience in practice. Theoretical orientation was mainly cognitive-behavioral and/or analytical-psychodynamic. Practitioners in the sample were working with adults in general. Table 1 displays all the demographic data.

Ideally, professional training of practitioners working with people coping with a physical illness and/or disability should cover specific topics (such as health psychology, psycho-oncology, medical family therapy) that pertain to the experience of living with a medical condition. Such a training would enable the practitioner to understand and address all aspects of the clients' experiences about the illness in question. Yet it is known that traditional training in psychology provides limited information to the trainees on human biology. We see a similar picture when it comes to medicine, which falls short on fully covering the psychosocial aspects of human life (McDaniel, Hepworth & Doherty, 1992). According to the biopsychosocial model (Engel, 1977) the biological, psychological and social aspects of the person need to be considered for both the diagnosis and the treatment of any disease. In the present study, majority of the respondents stated that they were informed about the mental health processes of individuals with a physical illness and/or disability during their trainings. Yet the notion 'being informed' is certainly not the same as 'being trained in health psychology or an equivalent program’. Borak Boratav and Sunar (2005) investigated the number of trainings in Turkey on health psychology (or an equivalent subject), and saw that there was no doctorate program in health psychology in Turkey. Besides the master’s programs, which were very few in number, had very diverse contents compared to one another. Even though we do not have ample information as to the current status of trainings in health psychology in Turkey, research studies point at the need to develop education programs that will assist professionals in providing services that address the psychosocial needs of both patients and their families. It is obvious that the more equipped the mental health professionals who serve this population, the better the patient outcomes will be. In the present study, the intention was to explore whether mental health professionals in Turkey were informed, in some way or another, about the mental health processes of individuals with medical problems. It is important to investigate the quality and quantity of the currently active training programs that specifically target this population in the studies to be conducted in the future.

Having sufficient information as to the mental processes of individuals with medical problems has another advantage apart from giving adequate services to clients. When informed about such processes, the practitioners will feel comfortable with providing their clients with the relevant information about how to cope with the particular disease or disability in question. Results of this study indicate that when practitioners obtain information about the medical conditions their clients experience in between the sessions, they are more likely to inform clients in the sessions on how to cope with the illness. Obtaining information about the illness in between the sessions also increases the likelihood of staying in touch with at least one of the client's medical doctors. We can say that as mental health workers acquire more knowledge on the topic in question (i.e., the illness the client has), they become more willing to share/exchange their knowledge, along with their experiences, with their clients as well as other professionals.

Findings reveal that mental health workers, regardless of profession or theoretical orientation, are not very inclined to inform clients about their illness ("*seldom").* Respondents with analytical-psychodynamic perspective is even less willing to do this as compared to the others. This can be a result of the character of psychoanalytic work, which advocates following the lead of the client and working on only the material the client brings to the sessions. Criticizing any theoretical approach is surely not within the scope of this study, but it must be asserted that from the systemic viewpoint it is essential to inform and assist clients about their biological, psychological, and social experiences related to illness/disability they have (Linville, Hertlein & Lyness, 2007; Anderson, Huff & Hodgson, 2008).

This study provides information on the differences in percentage of caseload with medical problems as a function of the work setting, as well. Participants who work at schools had a significantly lower percentage of clients with medical problems in their caseload as compared to all the others, whereas participants who work in hospital settings had a significantly higher percentage. Similar to school settings, participants who are in private practice had a significantly lower percentage of clients with medical problems in their caseload. This implies that psychotherapy clients who have medical problems and/or disabilities receive mental health services mostly in hospital settings. These findings are expected and understandable since hospitals are the primary locations where medical illnesses are diagnosed and treated. Yet, the number of mental health professionals who work in hospitals is small in Turkey (Turkish Ministry of Health, 2011). This, together with the high number of individuals coping with an illness (Turkish Ministry of Health, 2013), necessitates the mental health professionals who work in other settings to pay more attention to medical issues in their practices. Practice of including the family in the psychotherapy process of individuals with medical problems is one of the main principles of systemic perspective (Hodgson, McCammon, Marlowe & Anderson, 2012; McDaniel, Harkness & Epstein, 2001) and also one of the main focuses of this study. The data from this study suggest that Turkish mental health workers, regardless of profession or theoretical orientation, *seldom* include the family in their therapeutic work when working with clients suffering from a medical problem. Couple/family therapists and counseling psychologists tend to include the family in the therapy process more frequently as opposed to other mental health practitioners. Additionally, regardless of profession, participants who embrace an experiential approach to therapy and those who embrace the systemic perspective tend to include the family in therapy process more, as compared to all the other theoretical orientations. It is expected of the professionals working from a systemic perspective to include the family in their therapeutic work, since they hold the view that both the diagnosis and the prognosis of the illness affects the family system.

This study aims to cast light on the different ways of including the family into the therapeutic process. These are specified as follows: Including the family during the assessment course, making separate sessions with the family if necessary, making conjoint sessions with the family if necessary, organizing and running psychoeducation and/or support groups, and carrying out the therapy process together with the family. Based on the findings, we can say that professionals from different backgrounds use different methods for including the family into the process. Couple and family therapists are more likely to include the family during the assessment course, as compared to the others. On the other hand, clinical psychologists are less likely to carry out the therapy process together with the family. A plausible explanation for this outcome is that majority of the clinical psychology training programs in Turkey educate practitioners in modalities of working with only individuals (i.e., one person at a time). Hence, lack of experience, supervision or interest on working with more than one person in the sessions may play a role. Another reason may be the theoretical orientation of the practitioners. It is known that psychoanalytically or psychodynamically oriented therapists are more likely to conduct individual sessions, and the number of analytically/dynamically oriented practitioners is high in the sample of the present study. When it comes to psychiatrists, we see that they tend to include the family into the process only during the assessment course, and are less likely to run psycho-education and/or support groups as compared to other mental health practitioners. Lastly, counseling psychologists are more likely to make separate sessions with family members and more likely to run psychoeducation or support groups. This may be because counseling psychologists are inclined make use systemic principles when working with clients who have medical problems. On the other hand, as compared to the other professionals with systemic perspective and experiential perspective are more likely carry out the therapy process together with the family, whereas professionals with analytical/psychodynamic perspective are less likely to do so.

One other principle of the systemic perspective is making interventions to strengthen the emotional connections among family members. Results reveal that mental health practitioners, regardless of profession or theoretical orientation, *seldom* make interventions to strengthen the emotional connections among family members when they are working with a client coping with a medical problem. Among all participants, only couple and family therapist are likely to make interventions to strengthen familial bonds.

Collaboration and communication with the other health care providers of the client has an important place within systemic principles (McDaniel, Doherty, & Hepworth, 2014; Edwards, Patterson, Grauf-Grounds & Groban, 2001). Thus the presenting survey contained five items addressing this: (1) I stay in contact with at least one of the doctors (healthcare providers) who follow up the progress of the illness my client has, (2) I explore the relationship between my patients and their doctors in the sessions, (3) I see my clients together with their doctors in a session in order to evaluate mental health status in conjunction with physical health status, (4) I advice and/or encourage my clients to be in communication with other individuals/couples/families/groups who have experienced similar health issues, (5) I help my clients in their management of the healthcare system. It is also intended to obtain information about the tendencies of mental health professionals to take the side of their clients. Taking side of the client is an essential feature and distinctive characteristic of the systemic perspective among other approaches to health and disease (Bischoff, Springer, Felix & Hollist, 2011). Results reveal that mental health professionals are not very inclined to practice systemic principles that pertain to collaboration and communication with other health care providers. In other words, mental health practitioners *barely* communicate with other health care professionals in order to provide better care for their clients. Needless to say, this is a core element of medical family therapy. There is no study that addresses the possible reasons behind the weakness of the communication and collaboration between mental health professionals and other health care workers. However, Borak Boratav and Sunar (2005) have done two field studies with 141 psychologists working in various health care institutions, the first in 1993 and the second in 2004, and published the findings. Findings from these studies reveal that more than 60% of the psychologists think that they have a say in the decisions about the patients and stated that they can make decisions by themselves. Those psychologists who think they are restricted with respect to this point attributed their restriction mainly to “lack of collaboration with the psychiatrist” in the first study. Yet in the second study lack of collaboration with the psychiatrist was not stated to be the primary reason, but there was an increase in the number of psychologists who complained from psychiatrist’ having the last word. Even though these studies fall short of explaining why mental health professionals rarely collaborate with other health care workers, they underline the fact that in order to build an instrumental collaboration between the two parties, it is important to evaluate how each one of them perceives the attitudes of the other. Gavin, Wagers, Leslie, Price, Thorland and deGroot (1998) presented the findings of their pilot study conducted within Kaiser Permanente of Colorado. The study was on collaboration in health care services. The authors studied the attitudes of 138 medical experts and 77 mental health professionals with respect to this issue. Results revealed that attitudes of health care institutions on collaboration were determinative of those of the professionals working in them. For instance, when institutions engage in practices such as allowing the working professionals sufficient time and opportunity for interdisciplinary communication, preparing lists that contain the contact information of other professionals and establishing shared charting systems, it leads to an expectation for collaborative practices. On the other hand, intense work schedules, medical and mental health professionals’ working in physically distant locations and separate charting systems are suggested to be the factors that complicate collaboration within the institution in question. At the end of the study, participants were asked which factors they thought would enhance the collaboration within the institution, and most of them pointed out to the need of good communication and easy access. The authors asserted that the more the time passed after the medical professionals' completion of their formal training, the less they believed in the effectiveness of interventions that pertain to mental health issues. On the other hand, those mental health professionals who recently completed their training viewed collaboration more difficult and less instrumental, as opposed to the more experienced ones. This study, which investigated the attitudes of doctors and mental health professionals on collaborative practices, was conducted in the US nearly 20 years ago. New studies are needed to understand how health professionals in Turkey view issues related to collaboration.

Another significant finding in the present study is that mental health professionals in private practice are less likely to help their clients in their management of the healthcare system, as compared to the others. These professionals may feel detached from the treatment team and the healthcare system due to their work setting. There may be a need to remind mental health professionals the importance of supporting their clients in their management of the healthcare system, and this can be done in supervisions and training programs (Bischoff, Springer, Felix & Hollist, 2011, p.190).

Strengths and Limitations

Strengths of the Study

The main strength of the current study was the focal point of the research. The focus was on the prevalence of use of systemic principles among mental health professionals in Turkey, when working with clients with a medical condition. This is the first study that explores the above defined issue in Turkey.

Collection of data from different professional groups such as couple and family therapists, psychiatrists, clinical psychologists, and counseling psychologists enabled to come up with a rich sample. It allowed presenting the differences in clinical practices utilized when working with clients coping with medical problems.

The instrument used is the first survey developed to assess the use of systemic practices when working with people who have medical conditions. The survey was designed to cover a wide range of topics. Each item was carefully evaluated in terms of whether or not it represented the systemic principle it intended to address and was grounded in literature.

The final draft of the survey was mailed to the pioneers of medical family therapy for their feedbacks on the content and structure. All feedbacks were positive with only minor additions (see Appendix E). The

Cronbach alpha value was found to be high, indicating that the current survey was a reliable instrument.

Limitations of the Study

The purpose of the present study was to draw a picture of the mental health professionals' use of systemic principles when working with individuals with a physical illness and/or disability. Given that the target population, namely mental health practitioners, compromised a large group, the number of practitioners included in the sample was crucial. It can be said that the primary limitation of the present study is the small sample size. Because of time limitations and difficulties in accessing the members of the targeted population for various reasons, it was not possible to administer the study to a greater number of participants.

Secondly, the survey did not include a question about the geographical area where respondents live/work. For this reason, the generalizability of the findings across Turkey is limited.

Moreover, because this study is the first one conducted on the topic, a new measurement instrument was needed to be designed. The survey developed for the purposes of this study was not used in any other research studies, which might have posed a challenge in terms of the reliability of the study.

One other limitation pertains to the format of the survey. The survey was composed of self-report items, which makes it impossible to ensure that the participants who completed the survey were fully eligible in terms of the inclusion criteria. In addition, although completion of the survey took approximately 15 minutes, participants might have felt tired while completing the survey and this might have resulted in potentially arbitrary or conflicting responses. Because the data were collected anonymously, it was not possible to track which participant's responses were missing or ambiguous.

Since the survey contained 34 items, a great number of analyses could be made and more information on the subject could be obtained. Specifically, due to time limitations, analyses on only several selected topics were completed and presented.

Future Directions

Although the current study was descriptive in nature, the findings could instruct practitioners and researchers to be conscious of various significant issues when addressing individuals diagnosed with a medical problem and/or disability. Clinical and research implications are provided in the hope of increasing and spreading both practitioners' and researchers' understanding of what systemic principles can offer in the mental health care of individuals with a disease and/or disability.

Clinical Implications

The findings of the current study reveal several implications for practitioners working with individuals who are coping with a physical illness and/or disability. First, the survey developed is comprehensive and covers a wide range of topics that pertain to the use of systemic principles by practitioners. Given the fact that the systemic perspective has proved to be an effective treatment approach for this population, the items included in the survey may be considered as a guideline for practitioners serving this population.

This study also points out the handicaps the health care system in Turkey has. They pertain to both mental health and physical health and are criticized from a systemic point of view. I believe that as practitioners working within this system, we all have the responsibility to contribute to the development and enhancement of the field the way we can. Therefore, it is essential for every one of us to broaden our knowledge and practices in order to provide more effective and complete care for the individuals dealing with medical issues. Systemic principles within the medical family therapy model can be a starting point for practitioners regardless of their profession and theoretical orientation.

Considering the prevalence of chronic diseases and disabilities, it is evident that the demands and needs of individuals with medical problems increase rapidly. Mental health cannot be separated from physical health, and both individuals and their families and close social environment can be affected adversely following the diagnosis of a medical problem. Mental health professionals can provide significant care for both the patient and the family. However, the findings of this study lay certain areas that need to be improved in the overall health care system bare. One of them pertains to the professional training programs. Almost half of the participants indicated that they did not undergo sufficient trainings with respect to working with individuals with medical conditions. Hence, it can be said that number of training programs must be increased, especially those that thoroughly address the mental health issues of individuals with medical problems.

As mentioned before, the tendency of mental health practitioners to include the family in the patient’s therapeutic process turned out to be at moderate levels. Since the family can have a positive and/or negative effect on the prognosis of the disease/disability in question, the inclusion of the family into the therapy process can serve to explain the plausible effects of the illness/disability on familial relationships to the family members. Including the family into the process can have a positive influence, as it serves to strengthen the sense of unity and support among family members, providing a space for the ones who did not voice their concerns to be heard and relieved. Anderson, Huff and Hodgson (2008) reported in their qualitative study of medical family therapy that was conducted in a psychiatric setting that conjoint sessions with the family enable the members to experience an emotional discharge, which contributes the symptom reduction and/or relief.

According to the findings of the present study, mental health practitioners in Turkey are not inclined to engage in practices that require efforts outside of the sessions (like being in contact with one of the health providers of the patient, assisting clients to be in contact with other people who have experienced similar problems, helping clients in their management of the healthcare system).

Implications For Future Research and Future Directions

The findings of the present study will hopefully inspire mental health professionals to conduct further research that will broaden the knowledge regarding the clinical practices employed when working with individuals coping with a disease or disability.

In the current study, the sample size for each professional group was different and each was considered to be small. In future studies, researchers should consider reaching more number of practitioners from various professions, and try to come up with a sample that better represents the population in question.

Although there are several studies in the international literature on the effectiveness of medical family therapy, along with its systemic perspective, no such study was conducted in Turkey before. Future research should focus on investigating the impact of practices employed from a systemic perspective/MedFT in the treatment of individuals with medical problems/ disabilities.

Conclusion

In conclusion, this dissertation presented a portrait on the tendencies of mental health care professionals' use of systemic principles in their practice when working with clients with a medical condition. Systemic perspective asserts that a change in an individual's life affects the system that she/he is a part of. The Medical family therapy (MedFT) is a model grounded in systemic principals and biopsychosocial-spiritual approach, which provides a framework for working with individuals/couples/families coping with an illness/disability.

Despite the fact that there are many mental health professionals in Turkey who work with individuals coping with health issues, up until today there was no study on how they practice when providing mental health services to their clients. Therefore, a structured survey containing a total of 34 items on the demographics of the participants and their use of systemic principles was designed and used for the purposes of the study. The results of the study revealed various ways of practicing systemic principles among mental health practitioners. Couple and family therapists, counseling psychologists, and practitioners that embrace the systemic and the experiential approaches were found to be more inclined to include the client’s family in their therapeutic work, as compared to clinical psychologists and psychiatrists. This descriptive study was the first in Turkey to bring light to the current trends and practices of mental health care practitioners when treating clients with medical problems.

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Appendix A – Recruitment Flyer

Değerli hocalarım ve meslektaşlarım,

Ben İstanbul Bilgi Üniversitesi Klinik Psikoloji Yüksek Lisans programından Betül Küçükardalı. Bitirme tezim için Psk. Dr. Senem Zeytinoğlu süpervizörlüğünde bir araştırma yapmaktayım. Çalışmanın amacı; Türkiye’de çalışan Ruh Sağlığı uzmanlarının fiziksel hastalığı veya engeli olan danışanlarıyla çalışırken nasıl bir terapi/danışmanlık süreci takip ettiklerine dair bilgi edinmektir. Fiziksel hastalıktan kastımız doğuştan gelen ya da sonradan gelişen herhangi bir sağlık sorunudur. Örneğin; serebral palsi, spina bifida, hidrosefali, epilepsi, şeker, tansiyon, kanser, kalp yetmezliği, solunum yetmezliği, böbrek yetmezliği, Alzheimer bu tür hastalıklara dahildir.

- Bu ve benzeri bir hastalığı ya da herhangi bir türde engeli olan (fizyolojik, zihinsel ya da fiziksel) danışanlarla nadiren de olsa çalışıyorsanız ya da geçmişte çalıştıysanız (terapi yapmak/danışmanlık vermek),

bu konuda hazırlamış olduğumuz ankete katılmanızı önemle rica ederiz. Anket, çoğu likert tip olmak üzere toplam 34 sorudan oluşmaktadır ve ortalama 10 dakika sürmektedir. Bu araştırmadan çıkacak bulgular ile Türkiye'de sağlık problemi yaşayan bireylerin ruhsal süreçlerinin ne şekilde desteklendiğine dair bir tablo ortaya koyabilmeyi ve bu tablonun gelecekte bu alanda daha kapsamlı çalışmalara yardımcı olacağını ümit etmekteyim.

Araştırma ile ilgili sorularınız olursa bize [illegible] veya [illegible] adreslerinden ulaşabilirsiniz.

Anketin elektronik formuna aşağıdaki linki tıklayarak ulaşabilirsiniz. Şimdiden zamanınızı ayırarak çalışmaya sağladığınız katkı için çok teşekkür ederiz.

Ankete katılım linki: http://www.surveey.com/SurveyStart.aspx?lang=1&surv=8fd4a8d0664042e68a2da37b00889898

Psk. Betül Küçükardalı
İstanbul Bilgi Üniversitesi
Klinik Psikoloji Yüksek Lisans Programı

Appendix B – Informed Consent Form

Fiziksel Hastalık veya Engellerin Terapide İşlenişi

Sayın Katılımcı,

Bu araştırmanın amacı Türkiye'deki ruh sağlığı çalışanlarının fiziksel hastalığı ve/veya engeli olan danışanlarla/hastalarla nasıl çalıştıkları hakkında bilgi edinmektir. Bu araştırma Dr. Senem Zeytinoğlu süpervizörlüğünde İstanbul Bilgi Üniversitesi Klinik Psikoloji Yüksek Lisans Programı Çift ve Aile Terapisi Alt-dalı öğrencisi Betül Küçükardalı tarafından bitirme projesi kapsamında yürütülmektedir.

Anketi tamamlamanız yaklaşık 15 dakika sürmektedir. Anketi doldururken sizden öncelikle uzmanlığınız ve klinik deneyiminiz hakkında bazı bilgiler istenmektedir. Sonrasında ise, kendi deneyimlerinizi göz önünde bulundurarak, fiziksel hastalıkların ve/veya engellerin terapi/danışmanlık sürecinde işlenişiyle ilgili hazırlanmış ifadeleri değerlendirmeniz beklenmektedir. Bu araştırma kapsamında sizden kesinlikle isim ve kimlik bilgileri istenmeyecektir.

Bu araştırmaya katılım tamamen gönüllülük esasına dayalıdır. Cevap vermek istemediğiniz soruları boş bırakabilirsiniz. Araştırmanın herhangi bir noktasında hiçbir gerekçe belirtmeden yarıda kesme hakkına sahipsiniz. Yanıtlarınız tamamen gizli tutulacaktır. Toplanan veriler sadece bu araştırmanın amaçları için kullanılacaktır. Bu araştırmadan çıkan sonuçlar bilimsel kongre ve dergilerde yayınlanabilir. Yayınlarda yalnızca genellenmiş sonuçlardan bahsedilecektir.

Araştırma ile ilgili sorularınız olursa bize veya adreslerinden ulaşabilirsiniz.

Bu çalışmaya tamamen gönüllü olarak katılıyorum ve istediğim zaman yarıda kesebileceğimi biliyorum. Verdiğim bilgilerin bilimsel amaçlı yayınlarda kullanılmasını kabul ediyorum.

(Bilgilendirme formunu imzaladıktan sonra anketten ayırıp uygulayıcıya geri veriniz.)

Ad-Soyad Tarih

İmza

__ / __ / ____

Appendix C – Survey

1. Cinsiyetiniz

   - ☐ Kadın
   - ☐ Erkek

2. Yaşınız

   ___

3. Uzmanlığınızla ilgili eğitim düzeyiniz

   - ☐ Sertifika Programı Mezunu
   - ☐ Lisans derecesi
   - ☐ Yüksek Lisans derecesi
   - ☐ Doktora derecesi

4. Yukarıda belirtiğiniz uzmanlığınız hangi alandadır? Birden fazla işaretleyebilirsiniz.

   - ☐ Çift ve Aile Terapisi
   - ☐ Çocuk Psikiyatrisi
   - ☐ Gelişimsel Psikoloji
   - ☐ Psikiyatri hemşireliği
   - ☐ Klinik Psikoloji
   - ☐ Nöropsikoloji

- ☐ Nöropsikiyatri
- ☐ Pedagoji
- ☐ Psikiyatri
- ☐ Rehberlik ve Psikolojik Danışmanlık
- ☐ Sanat Terapisi
- ☐ Sosyal Hizmetler
- ☐ Uygulamalı Psikoloji
- ☐ Diğer ________________

5. Danışmanlık/terapi görüşmelerinizi yaptığınız kurum aşağıdakilerden hangisidir? Birden fazla işaretleyebilirsiniz.
    - ☐ Anaokulu
    - ☐ Belediye
    - ☐ Devlet Hastanesi
    - ☐ Huzurevi/Yaşlı Bakım Merkezi
    - ☐ İlkokul
    - ☐ Kadın Sağlığı Merkezi
    - ☐ Lise
    - ☐ Ortaokul
    - ☐ Özel Danışmanlık Merkezi
    - ☐ Özel Eğitim ve Rehabilitasyon Merkezi
    - ☐ Özel Hastane
    - ☐ Özel Muayenehane
    - ☐ Sivil Toplum Örgütü
    - ☐ Üniversite

   - ☐ Vakıf
   - ☐ Diğer ________________

6. Kaç yıldır vaka görüyorsunuz?
   - ☐ 1-5
   - ☐ 6-10
   - ☐ 11-15
   - ☐ 16-20
   - ☐ 20 üstü

7. Teorik yöneliminizi nasıl tanımlarsınız? Birden fazla işaretleyebilirsiniz.
   - ☐ Bilişsel Davranışçı
   - ☐ Deneyimsel
   - ☐ Davranışçı
   - ☐ Eklektik
   - ☐ Geştalt
   - ☐ İnsancıl
   - ☐ Psikodinamik
   - ☐ Sistemik
   - ☐ Varoluşçu
   - ☐ Diğer _________________

8. Danışmanlık/terapi hizmeti sağladığınız popülasyon nedir? Birden fazla işaretleyebilirsiniz.
   - ☐ Çocuk
   - ☐ Ergen

☐ Yetişkin

☐ Çift

☐ Aile

☐ Grup

☐ Geriatrik

9. Tamamladığınız eğitim programlarınızda fiziksel hastalığı ve/veya engeli olan bireylerin ruh sağlığı süreçleri hakkında bilgilendirildiniz mi?

☐ Evet

☐ Hayır

10. Fiziksel hastalığı ve/veya engeli bulunan bireylere danışmanlık/terapi hizmeti veriyor musunuz? (Ör. Kanser, şeker, konjenital anomali, nörolojik hastalıklar vb.)

☐ Evet

☐ Hayır

☐ Bilmiyorum

<u>10. SORUYA VERDİĞİNİZ YANIT ‘‘HAYIR’’ İSE ANKETİMİZİ BURADA SONLANDIRABİLİRSİNİZ. YANITINIZ ‘‘EVET’’ İSE FİZİKSEL HASTALIĞI VE/VEYA ENGELİ OLAN BİREYLERLE DANIŞMANLIK/TERAPİ SÜRECİNİ NASIL TAKİP ETTİĞİNİZE YÖNELİK SORULARIMIZA DEVAM ETMENİZİ RİCA EDERİZ.</u>

11. Vaka yükünüzü düşündüğünüzde yaklaşık olarak yüzde kaçı fiziksel hastalığı ve/veya engeli olan bireylerden oluşmaktadır? 0 ile 100 arasında bir sayı yazınız.

___

12. Fiziksel hastalığı ve/veya engeli olan bireylerle çalışırken genellikle ne uzunlukta bir terapi süreci izliyorsunuz?
    - ☐ 1-5 seans
    - ☐ 6-10 seans
    - ☐ 11-15 seans
    - ☐ 16-20 seans
    - ☐ 20 ve üstü
13. Fiziksel hastalığı ve/veya engeli olan bireylerle çalışırken danışmanlık alma/terapiye gelme sebeplerinin fiziksel hastalık ve/veya engelleri ile bağlantılı olduğuna şahit olurum.
    - ☐ Hiçbir zaman
    - ☐ Az
    - ☐ Bazen
    - ☐ Sıklıkla
    - ☐ Her zaman
14. Fiziksel hastalığı ve/veya engeli olan bireylerle çalışırken ailenin ve/veya yakın sosyal çevrenin bireylerin fiziksel sağlığı üzerine yararlı etkisi olabileceğini düşünürüm.
    - ☐ Hiçbir zaman
    - ☐ Az
    - ☐ Bazen
    - ☐ Sıklıkla
    - ☐ Her zaman

15. Fiziksel hastalığı ve/veya engeli olan bireylerle çalışırken ailenin ve/veya yakın sosyal çevrenin bireylerin fiziksel sağlığı üzerine zararlı etkisi olabileceğini düşünürüm.
    - ☐ Hiçbir zaman
    - ☐ Az
    - ☐ Bazen
    - ☐ Sıklıkla
    - ☐ Her zaman
16. Fiziksel hastalığı ve/veya engeli olan bireylerle çalışırken aileyi danışmanlık/terapi sürecine dahil ederim.
    - ☐ Hiçbir zaman
    - ☐ Az
    - ☐ Bazen
    - ☐ Sıklıkla
    - ☐ Her zaman

16. MADDEYE ‘’HİÇBİR ZAMAN’’ YANITINI VERDİYSENİZ 17. SORUYU ATLAYIP 18. MADDEDEN DEVAM EDEBİLİRSİNİZ. YANITINIZ DİĞER 4 SEÇENEKTEN BİRİYSE 17. SORUYU DA CEVAPLAMANIZI RİCA EDERİZ.

17. Fiziksel hastalığı ve/veya engeli olan bireylerle çalışırken aileyi nasıl dahil edersiniz? Birden fazla işaretleyebilirsiniz.
    - ☐ Değerlendirme sürecine çifti ve/veya aileyi dahil etme
    - ☐ Diğer aile bireyleriyle gerek duydukça ayrı seans yapma
    - ☐ Diğer aile bireyleriyle gerek duydukça birlikte seans yapma

- ☐ Aileler için psiko-eğitim ve/veya destek grupları yürütme
- ☐ Terapi/danışmanlık sürecini bireyin eşi ve/veya ailesi ile birlikte yürütme
- ☐ Diğer ____________________________________

18. Fiziksel hastalığı ve/veya engeli olan bireylerle çalışırken seans dışında söz konusu olan hastalık ve/veya engel hakkında bilgi edinirim.
    - ☐ Hiçbir zaman
    - ☐ Az
    - ☐ Bazen
    - ☐ Sıklıkla
    - ☐ Her zaman
19. Fiziksel hastalığı ve/veya engeli olan bireylerle çalışırken söz konusu hastalık ve/veya engel süreçleri ile ilgili seans içerisinde bilgilendirmelerde bulunurum.
    - ☐ Hiçbir zaman
    - ☐ Az
    - ☐ Bazen
    - ☐ Sıklıkla
    - ☐ Her zaman
20. Fiziksel hastalığı ve/veya engeli olan bireylerle çalışırken sağladığım psikolojik desteğin hastalığın/engelin seyri açısından olumlu bir etkisi olduğunu düşünürüm.
    - ☐ Hiçbir zaman

☐ Az

☐ Bazen

☐ Sıklıkla

☐ Her zaman

21. Fiziksel hastalığı ve/veya engeli olan bireylerle çalışırken danışanların güçlü yanlarına vurgu yaparım.

☐ Hiçbir zaman

☐ Az

☐ Bazen

☐ Sıklıkla

☐ Her zaman

22. Fiziksel hastalığı ve/veya engeli olan bireylerle çalışırken ailenin duygusal bağlarını güçlendirmek üzerine çalışırım.

☐ Hiçbir zaman

☐ Az

☐ Bazen

☐ Sıklıkla

☐ Her zaman

23. Fiziksel hastalığı ve/veya engeli olan bireylerle çalışırken danışanın hastalık ve/veya engelinin tedavisinde aktif rol oynamasına yardımcı olurum.

☐ Hiçbir zaman

☐ Az

☐ Bazen

☐ Sıklıkla

☐ Her zaman

24. Fiziksel hastalığı ve/veya engeli olan bireylerle çalışırken hastalığı/engeli takip eden doktorlar takımından en azından biri ile iletişim içinde olurum.

☐ Hiçbir zaman

☐ Az

☐ Bazen

☐ Sıklıkla

☐ Her zaman

25. Fiziksel hastalığı ve/veya engeli olan bireylerle çalışırken danışanın doktor(lar)ıyla olan ilişkilerini incelerim.

☐ Hiçbir zaman

☐ Az

☐ Bazen

☐ Sıklıkla

☐ Her zaman

26. Fiziksel hastalığı ve/veya engeli olan bireylerle çalışırken danışanın ruhsal ve fiziksel sağlık durumunu bütünleştirmek adına danışan ile doktorunu birlikte görürüm.

☐ Hiçbir zaman

☐ Az

☐ Bazen

☐ Sıklıkla

☐ Her zaman

27. Fiziksel hastalığı ve/veya engeli olan bireylerle çalışırken benzer sıkıntılar yaşayan diğer birey/çift/aile/gruplar ile iletişime geçmesini teşvik ve/veya teklif ederim.

☐ Hiçbir zaman

☐ Az

☐ Bazen

☐ Sıklıkla

☐ Her zaman

28. Fiziksel hastalığı ve/veya engeli olan bireylerle çalışırken sağlık sistemi ile yaşadıkları olası problemleri çözmelerine yardım ederim.

☐ Hiçbir zaman

☐ Az

☐ Bazen

☐ Sıklıkla

☐ Her zaman

<u>28. MADDEYE ‘’HİÇBİR ZAMAN’’ YANITINI VERDİYSENİZ 29. SORUYU ATLAYIP 30. MADDEDEN DEVAM EDEBİLİRSİNİZ. YANITINIZ DİĞER 4 SEÇENEKTEN BİRİYSE 29. SORUYU DA CEVAPLAMANIZI RİCA EDERİZ.</u>

29. Evet ise, birlikte çalıştığınız birey/çift/aile/grupların sağlık sistemi ile yaşadıkları bu problemleri çözmelerine nasıl yardım edersiniz?

☐ Yaşadığı problemi seansta konuşarak

☐ Yaşadığı probleme doğrudan ve/veya dolaylı çözümler üreterek

☐ Yaşadığı problemle ilgili yardım alması için yetkili mercilere yönlendirerek

☐ Birlikte çalıştığım birey/çift/aile/grupların ihtiyaçları ile ilgili yetkili mercilerle iletişime geçerek

☐ Diğer ______________________________________

30. Fiziksel hastalığı ve/veya engeli olan bireylerle çalışırken sağlık sisteminden kaynaklanan ayrımcılığa (dil, din, ırk vb.) uğradıklarını düşünürüm.

☐ Hiçbir zaman

☐ Az

☐ Bazen

☐ Sıklıkla

☐ Her zaman

<u>30. MADDEYE ‘’HİÇBİR ZAMAN’’ YANITINI VERDİYSENİZ 31. SORUYU ATLAYIP 32. SORUDAN DEVAM EDEBİLİRSİNİZ. YANITINIZ DİĞER 4 SEÇENEKTEN BİRİYSE 31. SORUYU DA CEVAPLAMANIZI RİCA EDERİZ.</u>

31. Evet ise, bu konuyu seans içerisinde nasıl ele alırsınız?

☐ Danışan/hasta seansa getirdiği sürece seans içinde konuşarak

☐ Sağlık sisteminin işleyişi hakkında bilgi vererek

☐ Sağlık hakları konusunda bilinçlendirerek

☐ Sağlık sistemi ve hasta arasında aktif bir köprü görevi görmeye çabalayarak

☐ Diğer ________________________________

32. Fiziksel hastalığı ve/veya engeli olan birey/çift/aile/gruplar ile çalışırken aşağıdaki hangi zaman kavramları üzerinde ne sıklıkta durduğunuzu derecelendiriniz.

	Asla	Az	Bazen	Sıklıkla	Her zaman
Geçmiş					
Bugün					
Gelecek					

33. Fiziksel hastalığı ve/veya engeli olan birey/çift/aile/gruplar ile çalışırken vaka formülasyonunuzda aşağıda sıralanan hangi etkenler üzerinde ne sıklıkta durduğunuzu derecelendiriniz.

	Asla	Az	Bazen	Sıklıkla	Her zaman
Gözlemlenebilen davranışlar					
Duygular					
Düşünceler/inançlar					
İç dinamikler					
Aile dinamikleri					
Sosyal faktörler					

Hastalık/engel					

34. Danışanın fiziksel hastalığının ve/veya engelinin aşağıdaki alanlara olan etkilerini terapi sürecinde işlerim. (Birden fazla işaretleyebilirsiniz.)

    ☐ Psikolojik

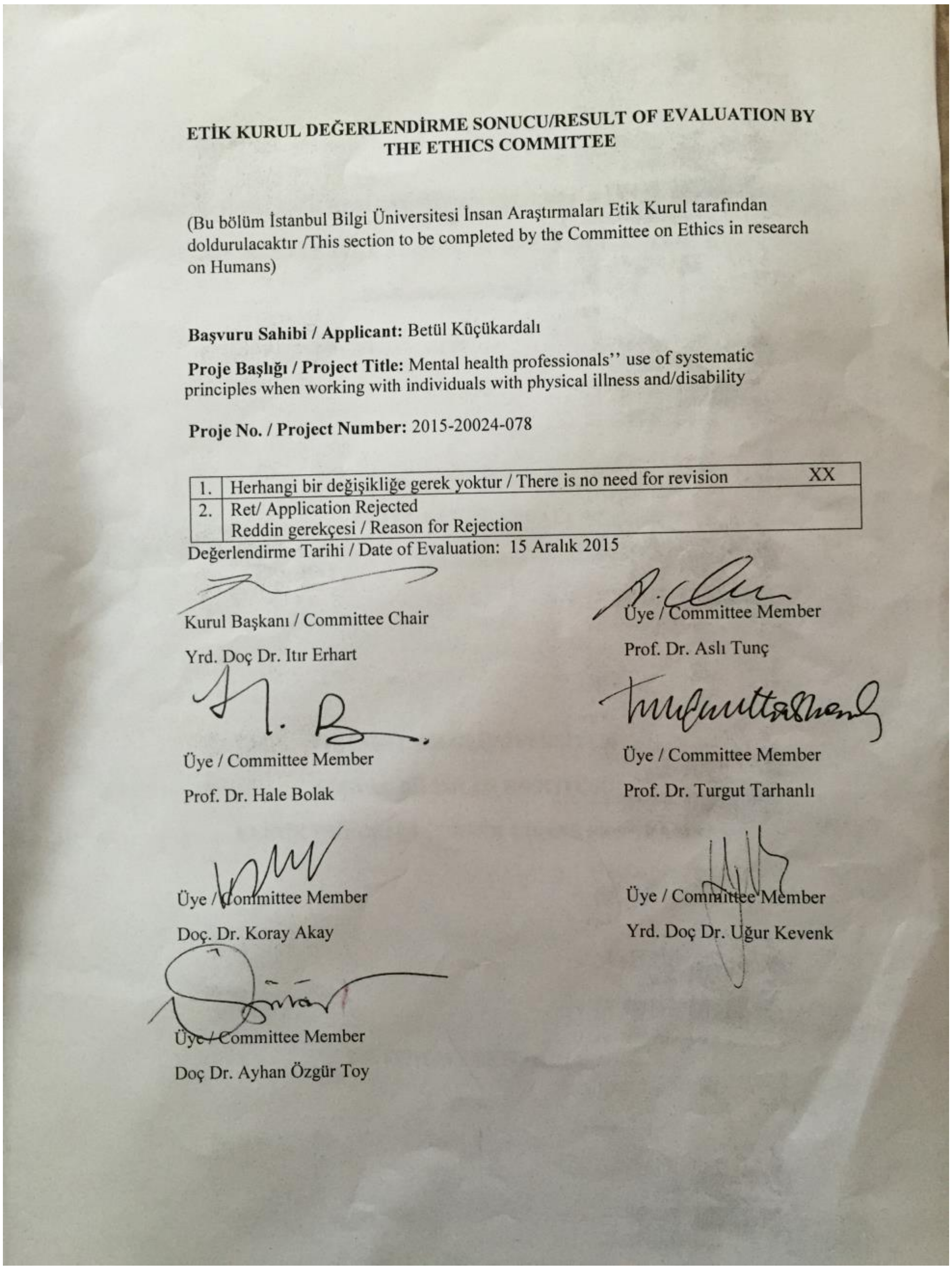
    ☐ Biyolojik

    ☐ Sosyal

    ☐ Ruhani

    ☐ Diğer ______________________

Appendix D – Approval from Istanbul Bilgi University Human Subjects Ethics Committee



ETİK KURUL DEĞERLENDİRME SONUCU/RESULT OF EVALUATION BY THE ETHICS COMMITTEE

(Bu bölüm İstanbul Bilgi Üniversitesi İnsan Araştırmaları Etik Kurul tarafından doldurulacaktır /This section to be completed by the Committee on Ethics in research on Humans)

Başvuru Sahibi / Applicant: Betül Küçükardalı

Proje Başlığı / Project Title: Mental health professionals'' use of systematic principles when working with individuals with physical illness and/disability

Proje No. / Project Number: 2015-20024-078

1.	Herhangi bir değişikliğe gerek yoktur / There is no need for revision	XX
2.	Ret/ Application Rejected Reddin gerekçesi / Reason for Rejection	

Değerlendirme Tarihi / Date of Evaluation: 15 Aralık 2015

Kurul Başkanı / Committee Chair
Yrd. Doç Dr. Itır Erhart

Üye / Committee Member
Prof. Dr. Aslı Tunç

Üye / Committee Member
Prof. Dr. Hale Bolak

Üye / Committee Member
Prof. Dr. Turgut Tarhanlı

Üye / Committee Member
Doç. Dr. Koray Akay

Üye / Committee Member
Yrd. Doç Dr. Uğur Kevenk

Üye / Committee Member
Doç Dr. Ayhan Özgür Toy

Appendix E – Correspondences with the Pioneers of Medical Family Therapy

October 15, 2015

Hello Dr. Susan McDaniel,

My name is Betul Kucukardali, and I am a clinical psychology student at Istanbul Bilgi University, Turkey. I completed my curriculum in Marriage and Family Therapy, and am currently working on my thesis about the use of Medical Family Therapy principles by mental health workers in Turkey. In the past six months, my advisor Dr. Senem Zeytinoglu and I reviewed the literature on MedFT. First of all, I would like to personally thank you and your colleagues for the efforts you put for the development of Medical Family Therapy, which inholds crucial elements in terms of both theory and practice, for mental health professionals who work particularly with people with a physical illness or disability.

The notion of family therapy took hold in Turkey at the beginning of 2000s, and studies on the topic started to be conducted thereafter. As the number of training programs on family therapy increased, so did the prevalence of the approach within the field, with more and more people finding it to be an efficient modality of practice. However, medical family therapy is an area that is barely known by mental health workers in Turkey. Although many would not define themselves as a medical family therapist, we wonder how they treat clients/patients who are coping with a physical illness and/or disability. Therefore, following a detailed literature review, we designed a survey that serves to explore whether mental health professionals in Turkey use the principles/core values of MedFT when working with individuals coping with an illness/disability. I wonder if you could you take a look at the survey which contains 32 items, and give me some feedback about possible adds and drops?

Thank you,

Sincerely

Betul Kucukardalı

October 15, 2015

Dear Betul: Thank you for your interest in Medical Family Therapy. Of course, I will be happy to look at your survey, and I will ask Drs Hepworth and Doherty to look at it as well.

Regards,

Susan

Susan H McDaniel PhD

October 27, 2015

Susan, I'm sending you my feedback to pass on. I read through it but don't have time (I leave for Italy in two hours) for comments on specific items. Overall, I thought this was a thorough assessment of how Turkish therapists approach clients with medical problems. Betul did her homework.

I have one recommendation: to add a question about what percentage of the respondent's current caseload have a medical condition that influences their life. In the professional practice survey I did with AAMFT members in the mid-1990s, we asked how many of their current clients had a serious or chronic medical problem in addition to their medical problems. Then for those cases we asked if there had been contact with a medical provider.

Bill
William J. Doherty, Ph.D.

October 28, 2015

Betul:
I have now reviewed your survey. Very nice job. There are two areas I would add:

*whether the therapist works in a healthcare setting (like a rehab hospital or primary care clinic)

*whether the therapist ever sees the patient with the patient’s physician or other health care clinician, to further integrate their mental and physical healthcare

Nice job, Susan