https://doi.org/10.53964/jmnpr.2025011

https://www.innovationforever.com

Journal of
Modern Nursing Practice and Research

ISSN 2708-2202 (Online)

Open Access

Research Article

Evaluating the Effect of Family Counselling Training for Family Physicians on Contextual Variables in a Contextual Health Care Model

Sultan Zortul[1*]

[1]Family Medicine Clinics, Tortum State Hospital, Tortum, Türkiye

[*]**Correspondence to: Sultan Zortul, MD,** Tortum State Hospital, Tortum Merkez, Tortum, 25430, Türkiye; Email: sultan.oksuz11@gmail.com

Received: October 17, 2025 **Revised:** December 1, 2025 **Accepted:** December 16, 2025 **Published:** December 18, 2025

Abstract

Objective: This study seeks to investigate family physicians' knowledge, attitudes, and practices concerning family counselling and contextual care in Türkiye. Additionally, it examines the extent to which formal training shapes physicians' diagnostic reasoning, contextual awareness, and clinical decision-making amid ongoing sociodemographic transformations.

Methods: A cross-sectional survey was conducted among 106 family physicians in Erzurum using a 33-item questionnaire. Data were analysed using descriptive statistics, the Chi-square test, the Mann-Whitney U test, and logistic regression.

Results: Only 16% of participants had received certified training in family counselling. Trained physicians adopted a more holistic diagnostic approach, with significantly considering all contextual factors important (47.1% vs. 23.6%, p=0.047). Weekly patient volume was higher among trained physicians (p=0.011). Logistic regression revealed that age, experience, and patient load significantly predicted training status. Notably, none of the trained physicians identified domestic violence prevention as part of family counselling services (0% vs. 33.7%, p=0.005), potentially reflecting ethical or legal concerns and gaps in training.

Conclusion: Training in family counselling improves physicians' contextual awareness and communication skills. However, key topics, especially domestic violence, remain insufficiently addressed. Integrating structured, ethically grounded family counselling training into medical education is essential for enhancing the quality and safety of primary care services.

Keywords: family medicine, contextual care, family counselling, contextual error

Citation: Zortul S. Evaluating the Effect of Family Counselling Training for Family Physicians on Contextual Variables in a Contextual Health Care Model. *J Mod Nurs Pract Res*, 2025; 5(4): 11. DOI: 10.53964/jmnpr.2025011.

1 INTRODUCTION

The World Health Organization (WHO) defines health not merely as the absence of disease or infirmity, but as a state of complete physical, mental, and social well-being[1]. This comprehensive definition calls for a multidimensional understanding of health, extending beyond biomedical

indicators to include environmental, cultural, economic, and psychological determinants. Family medicine adopts this holistic perspective by addressing individuals in the context of their life circumstances, social relationships, cultural background, and mental health, not just their physical symptoms[2]. As a scientific discipline, family medicine provides continuous, accessible, and person-centered primary care, irrespective of age, gender, or diagnosis. It takes responsibility for interpreting health issues not only at the individual level but also within the broader social systems and the life course[3]. In doing so, it goes beyond clinical diagnosis and treatment to encompass lifestyle, psychosocial dynamics, environmental influences, and family structures. Given that the family is the fundamental unit of society, healthcare must be addressed both individually and collectively. Within this field, the concept of "context" refers to the interplay of various factors -social, economic, familial, cultural, and psychological-that shape health outcomes[4]. Contextual care considers account not only pathophysiological data but also the unique personal and social realities in which illness occurs. This understanding also includes the physician's own professional, social, and cultural context[5]. Contextual care has gained growing recognition in clinical practice, emphasizing the need to consider social, cultural, and economic factors alongside biological ones[6]. Failure to incorporate contextual information in primary care settings can lead to diagnostic errors, suboptimal treatment, and reduced patient satisfaction[6]. Therefore, fostering contextual awareness in family physicians is essential not only for professional competence but also for improving patient safety and healthcare quality[5,7,8]. A contextualized approach that listens attentively to patients' life narratives builds trust and enhances the effectiveness of preventive care[9].

In Türkiye, recent sociodemographic shifts, such as increasing divorce rates, rising domestic violence, delayed age of marriage, growing social isolation, and economic hardship, have significantly altered family dynamics. As a result, the responsibilities of family physicians have expanded to include addressing complex family-related issues. Family counselling has emerged as a valuable extension of family medicine practice, aimed at understanding systemic family structures, improve communication, manage conflicts, and set healthy boundaries[10]. This approach targets not only individual psychopathology but also the broader familial context underlying such conditions.

Despite its relevance, family counselling remains insufficiently integrated into the routine practice of family medicine in Türkiye. The lack of structured training in medical education and limited opportunities for in-service professional development have left many family physicians ill-equipped to manage family-related concerns, despite encountering them regularly in clinical settings[11]. This underscores the need to enhance physicians' skills in communication, psychosocial assessment, and problem-solving alongside their medical expertise. Accordingly, there is a growing emphasis on training programs that promote contextual sensitivity and patient-centeredness in clinical care. Studies have shown that such programs can lead to measurable improvements in clinical decision-making and patient outcomes[12-14].

This study aims to critically assess the knowledge, attitudes, and practices of family physicians in Türkiye regarding family counselling and contextual care. It investigates the extent to which prior training in family counselling influences clinical decision-making, contextual responsiveness, and patient engagement. In doing so, the study seeks to identify patterns, gaps, and discrepancies in practice. Additionally, it explores physicians' perceptions of patient-centered care and their educational needs to inform the design of targeted training interventions. The ultimate goal is to contribute actionable insights for integrating family counselling and contextual care into routine primary care, thereby improving healthcare delivery and patient satisfaction.

2 METHODS AND MATERIALS

This study was conducted in accordance with the principles of the Helsinki Declaration and scientific ethical standards. The study population consisted of 235 family physicians working in Erzurum between October 1, 2024, and November 1, 2024. Although all physicians were invited to participate, data were collected from 106 individuals who voluntarily agreed to take part in the study.

2.1 Sample Size

Although the response rate was 45.1%, the sample of 106 participants was sufficient to detect a medium effect size (Cohen's d =0.3) with a significance level of α =0.05 and a power of 0.80, as evaluated using G*Power 3.1 software. The study was based on voluntary participation, and the sample was intended to be representative of the 235 eligible participants. However, potential selection bias should be acknowledged.

2.2 The Data Collection Tool

The data collection tool was a 33-item structured questionnaire developed by the researcher through a comprehensive literature review and reviewed by field experts for content validity. The questionnaire was administered online via a WhatsApp group of family physicians. Participation was voluntary, no personal data were collected, and all responses were anonymized.

2.2.1 The Questionnaire

The questionnaire consisted of three main sections:

- Section 1 (Questions 1-9): These items gathered socio-

demographic and professional information, including age, gender, years of experience, workplace location (urban or rural), number of patients served, and specialty status.

- Section 2 (Questions 10-23): This section explored variables in the contextual care model, assessing how physicians' practice environments influenced their ability to provide appropriate care and the potential for context-related errors.
- Section 3 (Questions 24-33): These items addressed topics related to family counselling, including whether participants had received any training in family counselling, their views on whether other physicians should receive such training, and their opinions on the inclusion of family counselling services within the scope of family medicine.

Internal consistency analysis was conducted for the items in Sections 2 and 3 (Questions 10-33) yielding a Cronbach's Alpha coefficient was calculated as 0.71, indicating acceptable internal reliability. Reliability analysis was not applied to the descriptive socio-demographic section (Questions 1-9).

2.3 Statistical Methods

This was a descriptive and cross-sectional study. Data were analysed using SPSS version 26. Since the continuous variables did not follow a normal distribution, they were presented as medians (minimum-maximum or interquartile range). Categorical variables were presented as frequencies and percentages. Relationships between categorical variables were examined using Pearson's Chi-square test. When expected cell counts were less than 5, Fisher's Exact Test was used. Comparisons of continuous variables were made using the Mann-Whitney U test due to the non-normal distribution of the data. A p-value of less than 0.05 was considered statistically significant.

2.4 Ethical Approval

Ethical approval for this survey-based study was obtained from the Erzurum Faculty of Medicine Ethics Committee (Decision No: Scientific Research Ethics Committee of Erzurum Faculty of Medicine 2024/11-193, Date: 13.11.2024).

3 RESULTS

A total of 106 family physicians participated in this study. The mean age of the participants was 33.3±6.1 years, ranging from 24 to 46. In terms of gender distribution, 58.5% were female (n=62) and 41.5% were male (n=44). Regarding marital status, (n=57) 53.8% were married while (n=49) 46.2% were single. Additionally (n=41) 38.7% of the participants had children. Concerning workplace distribution, (n=68) 64.2% of the participants worked in rural areas, while (n=38) 35.8% worked in urban centers. The average duration of professional experience was 7.8 ± 5.7 years, and the average number of patients seen per week was 159 ± 110.8. A total of 34% (n=36) were specialists in family medicine, while (n=70) 66% were not. Furthermore, 16% (n=17) of the participants reported having received certified training in family counselling, whereas 84% (n=89) had not (see Table 1).

3.1 Relationship Between Family Counselling Training and Demographic Variables

There was no statistically significant relationship between having received training in family counselling and variables such as gender, age, years of professional experience, marital status, having children, workplace location, or being a family medicine specialist (Chi-Square and Mann-Whitney U tests were applied) (p=0.976, p=0.520, p=0.769, p=0.649, p=0.439, p=0.293, p=0.322). However, physicians who had received training reported seeing significantly more patients per week (214.7 ± 107 vs. 148.4 ± 109; p=0.011).

3.2 Factors Influencing the Diagnostic Process and Training Status

Overall, the most frequently cited diagnostic factors were the patient's age (n=73, 68.9%) and gender (62.3%) (Figure 1). However, trained physicians were significantly less likely to consider these factors necessary in their diagnostic process.

The proportion of those who answered "yes" to the question "When evaluating a patient, does the patient's age influence your diagnosis in addition to their complaints, physical examination, and test results?" was (n=67) 75.3% among those without training, compared to and (n=6) 35.3% among those with training, p<0.001.

Similarly, the proportion of those who answered "yes" to the question "When evaluating a patient, does the patient's gender influence your diagnosis in addition to their complaints, physical examination, and test results?" was (n=60) 67.4% among those without training and (n=6) 35.3% among those with training (p=0.012).

Additionally, the proportion of those who answered "yes" to the question "When evaluating a patient, do all the factors mentioned above influence your diagnosis, along with their complaints, physical examination, and test results?" was 47.1% among physicians with training and 23.6% among those without training (p=0.047) (Table 2).

3.3 Attitudes Toward Counselling Training and Services

The vast majority of participants (n=94), 88.7% responded "yes" to the question "In your opinion, should family physicians receive training in family counseling?" Additionally, (n=90) 84.9% agreed with the statement, "In your opinion, should family physicians provide family counseling services?" However, in some variables (e.g., religion or nationality), high homogeneity limited statistical interpretation. Unexpectedly, the agreement regarding the need for training was higher among those who had

https://doi.org/10.53964/jmnpr.2025011

Table 1. Descriptive Characteristics of Participants (n=106)

Variable	Category	n	(%)
Gender	Male	44	41.5%
	Female	62	58.5%
Marital status	Single	49	46.2%
	Married	57	53.8%
Having Children	No	65	61.3%
	Yes	41	38.7%
Practice Location	Rural	68	64.2%
	Urban	38	35.8%
Received Family Counselling Training	No	89	84%
	Yes	17	16%
Specialist physician	No	70	66%
	Yes	36	34%
	Mean± SD	**Median**	**Min-max**
Age	33.3±6.1	31	24-46
Years of Experience	7.8±5.7	6	0.3-20
Weekly Number of Patients	159±110.8	150	15-500

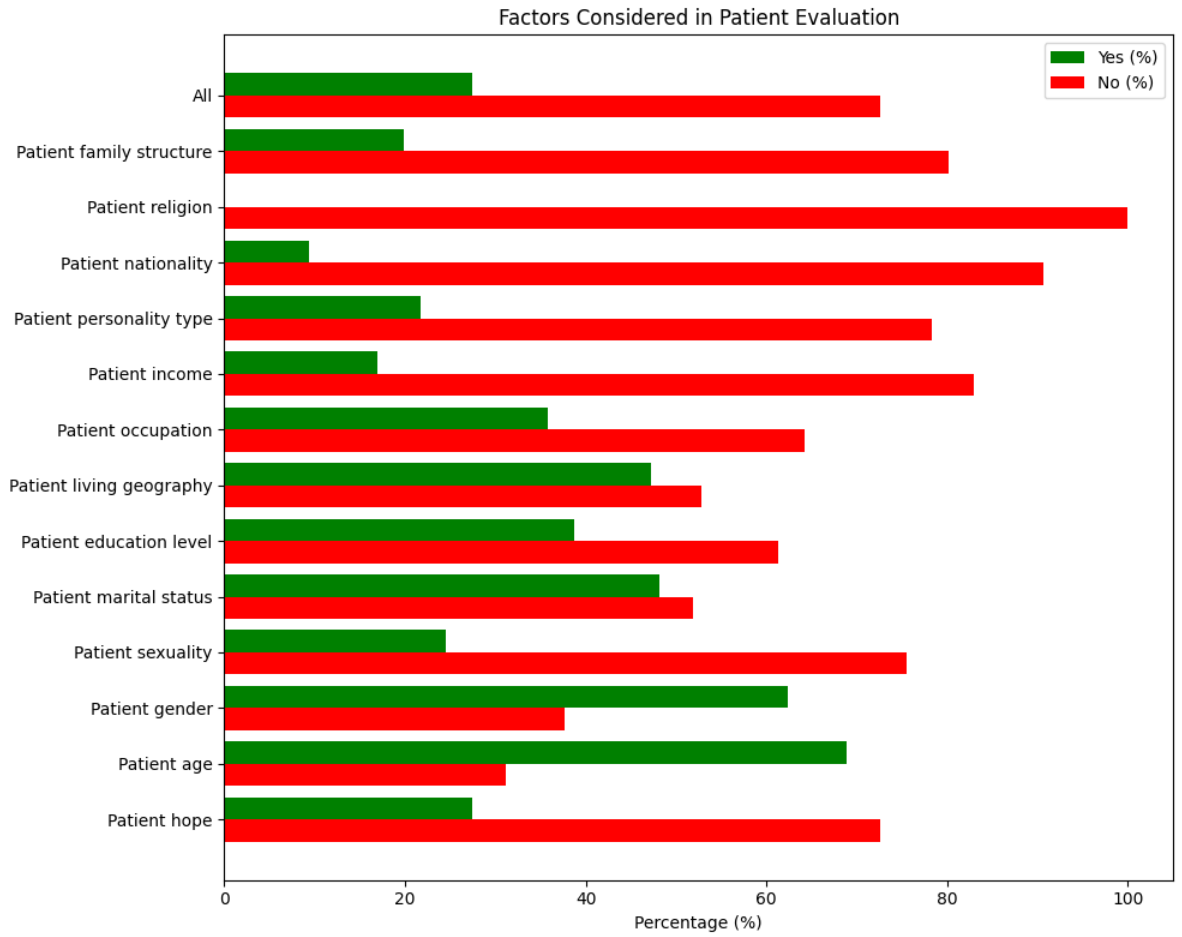

Figure 1. Distribution of Factors Considered Important by Family Physicians in the Diagnostic Process. This figure illustrates the distribution of individual and environmental patient-related factors that family physicians consider important during the diagnostic process. The most frequently emphasized factors were the patient's age (68.9%) and gender (62.3%), while the least emphasized were the patient's religion (0%) and nationality (9.4%). Differences were observed between physicians with and without certified family counselling training, particularly in how they prioritized age and gender as diagnostic indicators.

https://doi.org/10.53964/jmnpr.2025011

Table 2. Comparison of Family Physicians with and Without Counselling Training: Patient Factors and Service Opinions

		Have you received any certified training in family counselling?				
		No Training n (%)	Trained n (%)	Total n	*p*-value	χ^2
Patient hope	no	65 (73%)	12 (70.6%)	106	0.836	0.00
	yes	24 (27%)	5 (29.4%)			
Patient age*	no	22 (24.7%)	11 (64.7%)	106	***0.003***	-
	yes	67 (75.3%)	6 (35.3%)			
Patient gender	no	29 (32.6%)	11 (64.7%)	106	***0.012***	4.976
	yes	60 (67.4%)	6 (35.3%)			
Patient sexuality*	no	66 (74.2%)	14 (82.4%)	106	0.556	-
	yes	23 (25.8%)	3 (17.6%)			
Patient marital status	no	43 (48.3%)	12 (70.6%)	106	0.092	2.015
	yes	46 (51.7%)	5 (29.4%)			
Patient education level	no	51 (57.3%)	14 (82.4%)	106	0.052	2.794
	yes	38 (42.7%)	3 (17.6%)			
Patient living geography	no	46 (51.7%)	10 (58.8%)	106	0.589	0.076
	yes	43 (48.3%)	7 (41.2%)			
Patient occupation	no	57 (64%)	11 (64.7%)	106	0.958	<0.001
	yes	32 (36%)	6 (35.3%)			
Patient income*	no	75 (84.3%)	13 (76.5%)	106	0.482	-
	yes	14 (15.7%)	4 (23.5%)			
Patient personality type*	no	69 (77.5%)	14 (82.4%)	106	1	-
	yes	20 (22.5%)	3 (17.6%)			
Patient nationality*	no	79 (88.8%)	17 (100%)	106	0.359	-
	yes	10 (11.2%)	0			
Patient family structure*	no	72 (80.9%)	13 (76.5%)	106	0.741	-
	yes	17 (19.1%)	4 (23.5%)			
All factors	no	68 (76.4%)	9 (52.9%)	106	***0.047***	2.861
	yes	21 (23.6%)	8 (47.1%)			
In your opinion, should family physicians receive certified training in family counselling*?	no	6 (6.7%)	6 (35.3%)	106	***0.004***	-
	yes	83 (93.3%)	11 (64.7%)			
In your opinion, should family physicians provide family counselling services*?	no	16 (18%)	0	106	0.069	-
	yes	73 (82%)	17 (100%)			

Notes: *Distributions of responses from family physicians with and without certified family counselling training were compared. Chi-square tests were used to compare categorical variables. However, Fisher's Exact Test* was applied to variables with expected cell counts were less than 5. All variables are categorical. A p-value of <0.05 was considered statistically significant.

not received it (n=83,93.3% vs. n=11, 64.7%, $p<0.001$), possibly reflecting awareness of a training gap (Table 2).

3.4 Views on the Scope of Family Counselling Services

Regarding the scope of family counseling services, 49.1% (n=5) of participants agreed that family counseling and responded "yes" to the question "In your opinion, does family counseling provide premarital counseling services?", 37.7% (n=40) answered "yes" to "In your opinion, does family counseling provide intermarital counseling services?", 24.5% (n=26) responded "yes" to "In your opinion, does family counseling address family members' needs and mental health?", and 67.9 % (n=72) answered "yes" to "In your opinion, does family counseling provide services regarding all the factors mentioned above?"

The proportion of participants who answered "yes" to the question "In your opinion, does family counseling provide counseling services aimed at preventing domestic violence?" was 28.3% (n=30).

A notable finding was that physicians who had received certified training in family counseling were significantly less likely to consider domestic violence prevention as a component of family counselling services compared to untrained physicians (0% vs. n=30, 33.7%, $p=0.005$) (see

https://doi.org/10.53964/jmnpr.2025011

Table 3. Comparison of Family Physicians' Views on the Service Areas of Family Counselling Based on Their Training Status

" In your opinion, in which areas does family counselling typically provide services?"						
		No training n (%)	Trained n (%)	Total n	*p*	χ^2
Premarital	no	47 (52.8%)	7 (41.2%)	106	0.379	0.377
	yes	42 (47.2%)	10 (58.8%)			
Intermarital	no	59 (66.3%)	7 (41.2%)	106	**0.050**	2.838
	yes	30 (33.7%)	10 (58.8%)			
Counselling on the prevention of domestic violence*	no	59 (66.3%)	17 (100%)	106	**0.003**	-
	yes	30 (33.7%)	0			
Counselling on the needs and mental well-being of family members*	no	69 (77.5%)	11 (64.7%)	106	0.355	-
	yes	20 (22.5%)	6 (35.3%)			
Counselling related to planning before and after divorce*	no	73 (82%)	14 (82.4%)	106	1	-
	yes	16 (18%)	3 (17.6%)			
All	yes	57 (64%)	15 (88.2%)	106	**0.050**	2.804
	no	32 (36%)	2 (11.8%)			
No idea	no	82 (92.1%)	16 (94.1%)	106	1	-
	yes	7 (7.9%)	1 (5.9%)			

Notes: *This table presents the comparison of family physicians' opinions on the areas that family counselling services should cover, based on whether they had received certified training in family counselling. Chi-square tests were used to compare categorical variables. However, Fisher's Exact Test* was applied for variables where the expected cell counts were less than 5. A p-value of <0.05 was considered statistically significant.

Table 3 and Figure 2).

This divergence may suggest that trained physicians tend to adopt a more narrowly defined or specialized understanding of family counselling, possibly influenced by the legal framework in which they practice and concerns about regarding the medico-legal responsibilities in handling domestic violence cases. Furthermore, the potential for such interventions to affect trust dynamics between patient and physician, particularly in sensitive or high-risk contexts, could explain why trained practitioners are reluctant to view domestic violence prevention as part of the routine scope of family counseling.

3.5 Findings of the Logistic Regression Analysis

A logistic regression analysis was performed to identify predictors of whether family physicians had received certified training in family counselling. The model was statistically significant overall (χ^2=14.282, df = 7, p=0.046), indicating that the set of included variables contributed meaningfully to distinguishing between trained and untrained participants. The model explained approximately 21.5% of the variance in training status (Nagelkerke R^2 = 0.215), indicating moderate lexplanatory power.

3.6 Significant Predictors

Three variables emerged as statistically significant predictors of having received family counselling training:

● Age (B = 0.329, p=0.041, Exp(B) = 1.390): Increasing age was positively associated with training status. Specifically, each additional year of age was associated with a 39% increase in the odds of having received certified training. This may reflect increased exposure over time to continuing education opportunities or a higher likelihood among older physicians to pursue additional qualifications. Although no statistically significant difference was observed between age and training status in the Mann-Whitney U test, logistic regression analysis identified age as a significant independent predictor of having received training. This discrepancy can be explained by the differing nature of the two statistical methods. The Mann-Whitney U test assesses whether there is a difference in the distribution of a single variable (in this case, age) between two independent groups, without controlling for other factors. In contrast, logistic regression evaluates the effect of each variable while controlling for the influence of other predictors in the model. Therefore, age may not show a significant difference when analysed in isolation; however, it may emerge as a statistically significant predictor when the effects of other variables such as years of experience or patient volume are accounted for. This suggests that age could exert an indirect or context-dependent influence on training status, which becomes evident only in a multivariate analysis. Such differences in findings are not uncommon in social and health sciences, and they underscore the value of using complementary statistical methods for a more comprehensive understanding of the data.

● Years of Professional Experience (B=-0.391, p=0.020, Exp(B)=0.676): Surprisingly, years of experience were negatively associated with training status. Each additional year of professional experience decreased the odds of having received training by approximately 32.4%. This counterintuitive result may point to a cohort effect, where

https://doi.org/10.53964/jmnpr.2025011

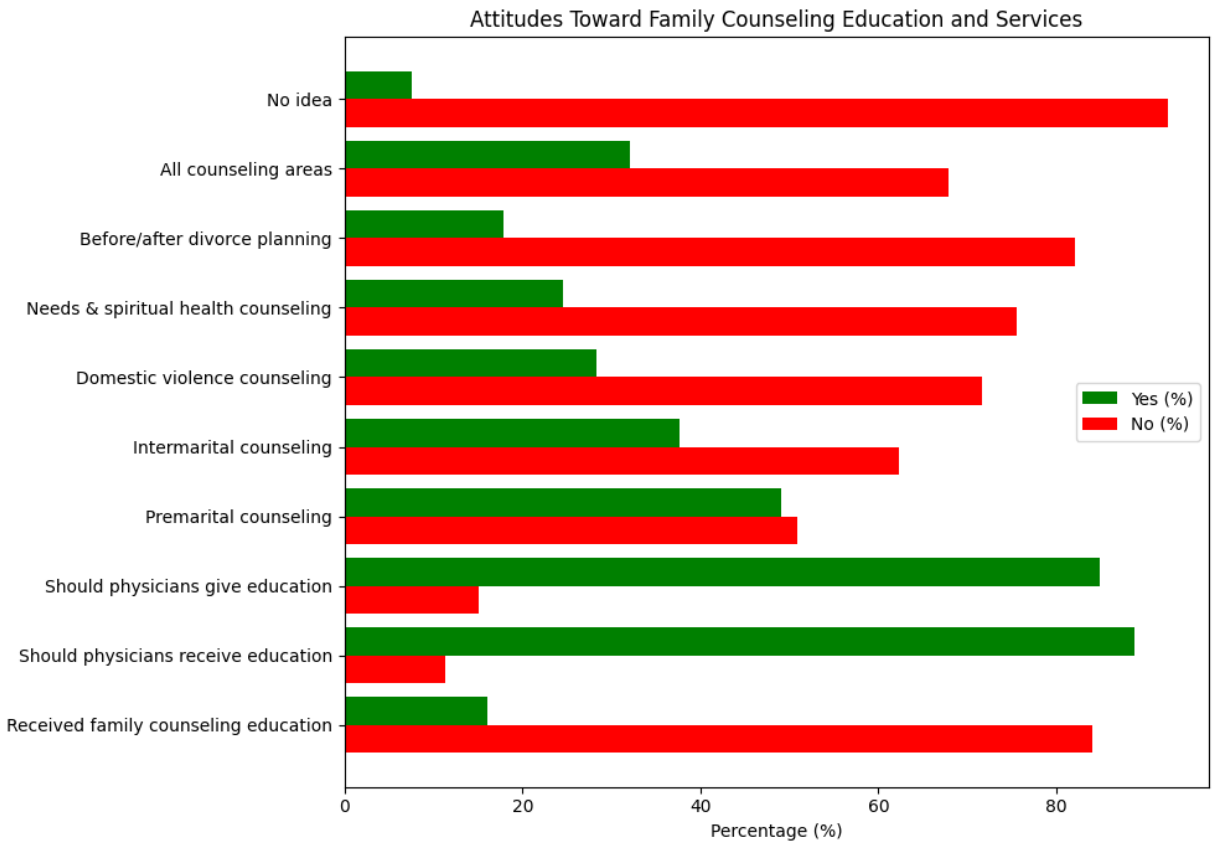

Figure 2. Distribution of Family Physicians' Opinions on the Service Areas of Family Counselling. This figure presents the distribution of family physicians' views on the domains family counselling services should encompass. The most commonly endorsed areas included premarital counselling (49.1%) and marital relationship issues (37.7%). Counselling related to pre- and post-divorce (17.9%) and prevention of domestic violence (17%) were the least frequently cited. Notably, 67.9% of all participants indicated that family counselling should address all listed areas comprehensively, although physicians with training were significantly less likely to include domestic violence prevention within the scope.

older physicians who entered the profession later were more likely to access recent training opportunities, whereas long-serving physicians may have lacked access or incentives for such training earlier in their careers.

- Weekly Patient Volume (B=0.005, p=0.048, Exp(B)=1.005): The number of patients seen weekly was also a significant positive predictor. Each additional patient per week was associated with a 0.5% increase in the odds of having received training. Physicians with higher patient loads may encounter more diverse family-related issues, increasing the perceived need or motivation for obtaining counselling skills.

3.7 Non-significant Predictors

Other variables included in the model -gender, practice location (urban vs. rural), specialist status, and parental status -were not found to be statistically significant predictors. This suggests that demographic or professional characteristics alone may not be sufficient to explain who receives family counselling training.

3.8 Interpretation and Implications

The combined findings highlight a complex interaction between personal and professional factors: While age positively predicted training, years of experience did not, suggesting that training may be more common among specific professional subgroups rather than uniformly distributed across career stages; The association with higher patient volume may indicate a greater clinical demand or awareness among these physicians, potentially motivating them to pursue additional skills. These results suggest that training uptake is influenced more by individual clinical context and professional development pathways rather than fixed demographic attributes. From a policy perspective, these findings emphasize the need for proactive integration of family counselling training into continuing medical education programs; Particular attention to mid-career physicians who may not have previously had access to such training; And targeted efforts in high-volume primary care settings, where the need for such competencies is likely more pronounced.

3.9 Data Reliability and Methodological Consistency

The findings of this study were examined for internal consistency, statistical coherence, and methodological appropriateness. All categorical and numerical variables were reported with complete values (n=106), and proportions were calculated accurately. No missing data or

sample inconsistencies were detected across demographic characteristics, subgroups, or comparative analyses. The statistical tests used were appropriate for the data types: Chi-square tests were applied to categorical variables, Mann-Whitney U tests were used for non-normally distributed numerical variables, and logistic regression analysis was conducted to identify predictors of training status. Each method was employed correctly according to the structure of the data, and cross-methodological variations (e.g., differing results between Mann-Whitney U and logistic regression) were transparently addressed and interpreted in line with statistical theory. Figures and tables were fully aligned with the text, accurately reflecting the descriptive and inferential results. In particular, graphical presentations of diagnostic factors (Figure 1) and service area opinions (Figure 2) reinforced and illustrated the statistically significant group differences discussed in the results. In summary, the study demonstrates a high degree of methodological soundness, and the data presented are both statistically and structurally reliable. This enhances the validity of the conclusions drawn and supports the generalizability of the findings within similar primary care contexts.

4 DISCUSSION

Family medicine, by its biopsychosocial orientation, aims to evaluate patients not only based on clinical symptoms but also in relation to their psychological, familial, and social context[15].

In this study, physicians who had received family counselling training were significantly more likely to consider multiple contextual factors in the diagnostic process. The higher agreement with the statement that "all factors are important" (47.1% vs. 23.6%, p=0.047) among trained physicians supports the view that training contributes to more comprehensive and person-centered care. These findings align with those of Taştan et al.[16], who reported that family counselling-trained physicians adopt a more integrative viewpoint in patient evaluation.

Notably, trained physicians placed less emphasis on fundamental demographic indicators such as age and gender, suggesting a more nuanced diagnostic framework. Moreover, the fact that these physicians managed a significantly higher number of patients per week (214.7 vs. 148.4; p = 0.011) may indicate both increased exposure to complex family dynamics and a stronger perceived need for advanced communication skills. These findings align with prior research showing that communication training improves physician-patient interactions and long-term satisfaction[17]. For example, Helitzer et al.[12] demonstrated that communication-focused educational interventions enhanced patient-centered care, with effects lasting beyond 18 months. Similarly, Hardee et al.[13] found that a concentrated three-day communication skills course significantly enhanced patient satisfaction, with effects persisting for at least a year. Additionally, Boissy et al.[14] demonstrated that system-based communication training positively influences physician empathy, motivation, and burnout levels.

Logistic regression analysis in our study revealed three key predictors of receiving family counselling training: older age, higher weekly patient volume, and, surprisingly, fewer years of professional experience. This suggests that early-career physicians and those managing high patient loads may be more motivated or have more opportunities to pursue such training. This analysis revealed that age positively predicted the likelihood of receiving family counselling training (Exp(B)=1.39, p=0.041), whereas professional experience was inversely related (Exp(B)=0.676, p=0.020). This suggests that older physicians who entered the profession later are more inclined to pursue such training, while those with extensive experience may perceive less need for additional education. Moreover, an increased weekly patient volume was also significantly associated with higher training uptake (p=0.048), implying that busier clinicians recognize the necessity of enhanced communication and family-oriented skills. Unexpectedly, physicians without prior training showed a greater consensus on the need for family counselling education (93.3% vs. 64.7%, p<0.001), possibly reflecting a heightened awareness of skill gaps or professional dissatisfaction. Conversely, none of the trained physicians included domestic violence prevention within the aim of family counselling (0% vs. 33.7%, p= 0.005), which may reflect concerns about ethical boundaries, legal responsibilities, or the potential impact on physician-patient trust.

This divergence likely stems not only from these legal and ethical concerns but also from a lack of specific training in how to safely and effectively address domestic violence within primary care settings[18]. These findings highlight the need to revise training curricula to explicitly equip physicians with the skills and frameworks necessary to manage such sensitive, high-risk situations. Domestic violence constitutes not only a legal concern but also a critical public health issue that necessitates coordinated, multidisciplinary responses.

Family physicians, often serving as patients' first point of medical contact, should prioritize early identification and risk assessment, creating a safe environment, and referral to specialized services such as psychologists, social workers, legal support, or domestic violence shelters, rather than assuming the role of direct counsellors[18].

In fact, in the absence of clear guidelines, health care providers frequently feel that interpreting and managing cases of domestic violence exceeds their scope of

responsibility, compounded by emotional, practical, and legal barriers[19]. Additionally, research highlights that primary care practitioners may perceive engagement in domestic violence cases as intrusive or risky, likening it to "opening Pandora's box", which underscores the need for streamlined referral mechanisms to specialists[20]. Current expert consensus holds that a multidisciplinary approach, where the family physician acts as an identifier and facilitator rather than a counsellor, is the most ethically and operationally appropriate strategy in primary care settings[21].

In contrast to several Organisation for Economic Co-operation and Development (OECD) countries, where family counselling is integrated into primary care through specialized training tracks or co-located multidisciplinary teams, Türkiye still lacks established legal and institutional frameworks for such integration. In the UK, models like Improving Access to Psychological Therapies (IAPT) embed psychological therapists directly within GP practices, enhancing collaboration with family physicians in both prevention and long-term care[22]. Likewise, collaborative care models, such as behavioural health consultants (BHCs) embedded in primary care teams, have proven effective in the UK and the US, enabling coordinated delivery of medical, psychological, and social interventions[23].

Given Türkiye's lack of structured policy frameworks or interdisciplinary collaboration models, implementing family counselling in routine primary care remains substantially constrained. Communication training is known to foster empathy-based, shared decision-making approaches, which benefit chronic disease management through improved patient adherence, learning, and trust. However, systematic reviews have reported inconsistent effects of these trainings on clinical outcomes such as blood pressure and HbA1c control[24].

In summary, family counselling education enhances physicians' diagnostic capabilities and communication competencies, ultimately improving patient satisfaction and physician motivation while elevating service quality. Consequently, integrating this education systematically and comprehensively into specialty curricula is crucial, particularly for physicians with high patient loads and those early in their careers. Additionally, updating training curricula to explicitly address ethical dilemmas, legal obligations, and risk management strategies, especially around sensitive issues like domestic violence, would enhance both physician preparedness and service safety.

5 CONCLUSION

This study highlights the positive impact of family counselling training on physicians' clinical orientation, diagnostic breadth, and communication skills. Trained physicians demonstrated a more holistic, patient-centered approach and were more likely to integrate psychosocial and contextual factors into clinical decision-making. Despite facing heavier patient loads, these clinicians appeared better equipped to manage complex family dynamics, reinforcing the value of such training in primary care settings.

However, notable gaps remain, particularly in addressing sensitive issues like domestic violence. The reluctance among trained physicians to include domestic violence within the scope of counselling suggests limitations in current curricula and unresolved ethical and legal ambiguities. These findings underline the necessity of refining training content and developing supportive systems to ensure safe, effective, and ethically sound care delivery.

6 SUGGESTIONS

To advance the integration of family counselling into primary care and improve physician preparedness, the following recommendations are proposed:

- Define Legal Scope and Boundaries: Establish clear legal and ethical guidelines for family counselling in primary care to protect both physicians and patients, particularly in sensitive situations such as domestic violence.
- Enhance Training Curricula: Incorporate comprehensive, skills-based modules into both family medicine residency programs and continuing professional development, with a specific focus on high-risk scenarios, including domestic abuse, child protection, and suicide prevention.
- Develop Multidisciplinary Models: Foster collaborative care systems by embedding psychologists, social workers, and legal advisors into primary care teams, following successful international models such as IAPT and BHC.
- Establish Structured Referral Pathways: Create standardized protocols for identifying, documenting, and referring psychosocial cases, reducing physician burden and legal uncertainty.
- Target High-Need Groups for Training: Prioritize training for early-career physicians and those with high patient volumes, who may benefit most from communication and psychosocial intervention competencies.

Implementing these strategies will not only strengthen the quality of primary care services in Türkiye but also support a more ethical, resilient, and responsive health system capable of addressing complex family and community health needs.

7 STRENGTHS

A key strength of this study lies in its focus on a relatively underexplored area: the impact of family counselling training on clinical practice within primary care. By examining both attitudes and behaviours of trained versus untrained family physicians, the study provides nuanced insight into how such education shapes

diagnostic reasoning and communication strategies. The use of quantitative data, such as weekly patient volume, and multivariate logistic regression, strengthens the validity of the findings, while the inclusion of real-world indicators (e.g., sensitivity to domestic violence) enhances the study's practical relevance. Furthermore, drawing comparisons with established international practices helps contextualize the findings within a broader healthcare policy framework.

8 LIMITATIONS

Despite its contributions, the study has several limitations. First, its cross-sectional design limits causal inference; while associations between training and clinical behaviour were identified, directionality cannot be definitively established. Second, self-reported data may be subject to response bias, particularly on socially sensitive topics like domestic violence. Third, the sample may not fully represent all regions or socioeconomic contexts in Türkiye, as urban-rural disparities and institutional differences could affect both training access and clinical practice. Finally, the study did not include direct observation or patient outcome data, which would have allowed for a more comprehensive assessment of training efficacy.

9 IMPLICATIONS

Future studies should adopt longitudinal designs to examine how family counselling training influences physician behaviour and patient outcomes over time. Incorporating patient perspectives, particularly in terms of satisfaction, trust, and treatment adherence, would offer a more holistic evaluation of the training's real-world impact. Additionally, qualitative research exploring physicians' emotional and ethical experiences in dealing with complex family dynamics, such as domestic violence, could inform the development of more targeted and supportive educational interventions. Comparative research involving international models may also help identify scalable best practices suitable for adaptation within the Turkish healthcare system.

Acknowledgements

Not applicable.

Conflicts of Interest

The authors declare that there were no potential conflicts of interest with about the research, authorship, and/or publication of this article.

Data Availability

All data generated or analyzed during this study are included in this published article and its supplementary information files.

Author Contribution

The author was solely responsible for the entire content of this manuscript, including conceptualization, study design, data collection, analysis, and manuscript writing.

Abbreviation List

BHC, Behavioral Health Consultant

IAPT, Improving Access to Psychological Therapies

OECD, Organisation for Economic Co-operation and Development

WHO, World Health Organization

References

[1] World Health Organization. WHO remains firmly committed to the principles set out in the preamble to the Constitution. Available at:[Web]

[2] van Weel C. Person-centred medicine in the context of primary care: a view from the World Organization of Family Doctors (Wonca). *J Eval Clin Pract*, 2011; 17: 337-338.[DOI]

[3] WONCA. The European Definition of GP/ FM. Available at:[Web]

[4] Ward B, Lane R, McDonald J et al. Context matters for primary health care access: a multi-method comparative study of contextual influences on health service access arrangements across models of primary health care. *Int J Equity Health*, 2018; 17: 78.[DOI]

[5] Weiner SJ, Schwartz A, Weaver F et al. Contextual errors and failures in individualizing patient care: a multicenter study. *Ann Intern Med*, 2010; 153: 69-75.[DOI]

[6] Al-Azzawi R, Halvorsen PA, Risor T. Context and general practitioner decision-making-a scoping review of contextual influence on antibiotic prescribing. *BMC Fam Pract*, 2021; 22: 225.[DOI]

[7] Weiner SJ. Contextualizing care: An essential and measurable clinical competency. *Patient Educ Couns*, 2022; 105: 594-598.[DOI]

[8] Weiner SJ, Schwartz A. Listening for what matters: avoiding contextual errors in health care. Oxford University Press, 2023.

[9] Domenach P, Krause KR, Malmartel A et al. Identifying psychosocial and contextual markers considered by physicians to personalize care. *BMC Med*, 2024; 22: 415.[DOI]

[10] Algan T. Aile danışmanlığı uygulaması: Dünü, bugünü ve yarını. *Insan ve Toplum Bilimleri Arastromalari Dergisi*, 2016; 5: 2208-2217.[DOI]

[11] DOGAN M, TASTAN K. Aile Danismanliginn Tanim ve Tarihcesi. *Turkiye Klinikleri Family Medicine-Special Topics*, 2022; 13: 1-4.[DOI]

[12] Helitzer DL, LaNoue M, Wilson B et al. A randomized controlled trial of communication training with primary care

providers to improve patient-centeredness and health risk communication. *Patient Educ Couns*, 2011; 82: 21-29.[DOI]

[13] Hardee JT, Rehring TF, Cassara JE et al. Effect and durability of an in-depth training course on physician communication skills. *Perm J*, 2019; 23: 18-154.[DOI]

[14] Boissy A, Windover AK, Bokar D et al. Communication skills training for physicians improves patient satisfaction. *J Gen Intern Med*, 2016; 31: 755-761.[DOI]

[15] Kusnanto H, Agustian D, Hilmanto D. Biopsychosocial model of illnesses in primary care:A hermeneutic literature review. *J Family Med Prim Care*, 2018; 7: 497-500.

[16] Tastan K, Isik M, Set T et al. Aile hekimlerinin aile danismanlig1 hakkindaki goris ve onerileri. *Konuralp Tip Dergisi*, 2016; 8: 137-140.[DOI]

[17] Haskard KB, Williams SL, DiMatteo MR et al. Physician and patient communication training in primary care: Effects on participation and satisfaction. 2009.

[18] Moreira DN, Pinto da Costa M. The role of family doctors in the management of domestic violence cases-a qualitative study in Portugal. *BMC Health Serv Res*, 2023; 23: 571.[DOI]

[19] Artz L, Meer T, Aschman G. Legal duties, professional obligations or notional guidelines?Screening, treatment and referral of domestic violence cases in primary health care settings in South Africa. *Afr J Prim Health Care Fam Med*, 2018; 10: 1-7.[DOI]

[20] Gerbert B, Moe J, Caspers N et al. Simplifying physicians' response to domestic violence. *West J Med*, 2000; 172: 329.[DOI]

[21] Usta J, Taleb R. Addressing domestic violence in primary care: what the physician needs to know. *Libyan J Med*, 2014; 9.[DOI]

[22] England N. Integrating mental health therapy into primary care, 2021.

[23] Dale H, Lee A. Behavioural health consultants in integrated primary care teams: a model for future care. *BMC Fam Pract*, 2016; 17: 97.[DOI]

[24] Yao M, Zhou XY, Xu ZJ et al. The impact of training healthcare professionals communication skills on the clinical care of diabetes and hypertension: a systematic review and meta-analysis. *BMC Fam Pract*, 2021; 22: 152.[DOI]