

ABSTRACT

Medical Family Therapy: Conceptual Clarification and Consensus of an Emerging Profession

By
Lisa E. Tyndall, MS

Spring, 2010

The term Medical Family Therapy (MedFT) was coined in the early 1990s (McDaniel, Hepworth, & Doherty, 1992a) by a team of family therapists and a family psychologist. Since then there has been growing interest in MedFT, including the expansion of training programs and an increasing prevalence in the academic literature. While this growth is exciting, if MedFT is going to continue to move forward and gain credibility in the healthcare system, its practitioners, researchers, and scholars must first establish a common lexicon, that can thereby ground the MedFT's professional identity, regulatory oversight, and scientist-practitioner models. The first article presented in this dissertation highlights the available literature on MedFT and identifies ways to further MedFT research initiatives and possibilities. The second article is based upon based on responses from an expert panel of MedFTs and includes an analysis of their perspectives on how MedFT should be defined, practiced, and taught.

The first article is a non-systemic literature review that illustrates the state of MedFT as well as reports on the similarities and differences present in its myriad of available definitions. Additionally, the article presents the theoretical foundation and skill set of MedFTs as found in the applied clinical literature and foundational research. Researchers who have studied MedFT interventions or incorporated MedFTs as interventionists in models of clinical care are also

reviewed. Overall, 65 articles were reviewed and three distinct themes emerged from the process: 1) the inception of MedFT, 2) MedFT skills and applications, and 3) MedFT Effectiveness and Efficacy Research. During the review of these articles, variations in the definition of MedFT included or excluded concepts such as: collaboration, family systems, or the biopsychosocial perspective. These variations appeared to reflect the qualifications and educational background of the practitioners, the focus and generalizability of the research. Additionally, these variations will affect the future of MedFT as either an orientation to be practiced by a wide variety of professions or a profession to be licensed independently. Upon reviewing the literature and articulating the existing gaps, it is clear that the most salient need for future research is a cohesive definition of MedFT, quality science that demonstrates its effectiveness, and educational guidelines for those desiring to be MedFT practitioners. Therefore, three recommendations are made: 1) those with expertise in MedFT must reach a consensus on a definition from which practice, training, and research can grow, 2) the MedFT intervention framework must be strengthened through research, and 3) agreement must also be reached on a MedFT curriculum with which to train future practitioners and scholars.

The second article is the results of a research study conducted to address two of the recommendations suggested in the literature review. A modified Delphi (Dalkey, 1972; Linstone & Turoff, 1975) study was conducted bringing together 37 panelists with MedFT expertise to identify the current definition of MedFT, its scope of practice, and educational competencies believed to be essential to those who practice it. After analyzing these data, we discovered that several of the foundational elements of MedFT discussed in McDaniel et al. (1992a) still hold true, including the importance of collaboration, the connection to marriage and family therapy as a parent discipline, and the overarching goals of agency and communion. The biopsychosocial

(BPS) model (Engel 1977; 1980) also a foundational element of MedFT (McDaniel et al., 1992a), remained fundamental; however, the expert panel also argued for the inclusion of the spiritual dimension of health to be addressed. Panelists endorsed MedFT as primarily an orientation, a way of thinking; leaving it open to be practiced in a wide array of settings with a variety of conditions. However, some panelists also believed MedFT to be a developing profession. Also discovered was a general consensus for what a core MedFT curriculum would include. MedFT students should have a strong theoretical base and clinical skill set in family systems theory and the BPS framework, as well as comfort and skill working within medical settings and collaborating with medical professionals. MedFTs should be familiar with a variety of diseases, illnesses, disorders, and disabilities, as well as have taken courses in areas such as psychopharmacology, MedFT theory, medical culture and collaboration, and families and illness. Panelists called for MedFTs to be involved in the creation of healthcare policy, but also provide psychosocial support to medical professionals in an effort to help them to avoid caregiver burnout, compassion fatigue, and improve patient care. Recommendations for future research, clinical practice, and education in MedFT are offered.

MEDICAL FAMILY THERAPY:
CONCEPTUAL CLARIFICATION AND CONSENSUS FOR AN EMERGING PROFESSION

A Dissertation Presented to
The Faculty of the Department of Child Development and Family Relations
East Carolina University

In Partial Fulfillment
Of the Requirements for the Degree
Doctor of Philosophy in Medical Family Therapy

By
Lisa E. Tyndall, MS

March, 2010

MEDICAL FAMILY THERAPY:

CONCEPTUAL CLARIFICATION AND CONSENSUS FOR AN EMERGING PROFESSION

By

Lisa E. Tyndall, MS

MARCH, 2010

APPROVED BY:

DISSERTATION CHAIR

Jennifer Hodgson, Ph.D.

COMMITTEE MEMBER

Angela Lamson, Ph.D.

COMMITTEE MEMBER

Sharon Knight, Ph.D.

COMMITTEE MEMBER

Mark White, Ph.D.

CHAIR, DEPARTMENT OF CHILD DEVELOPMENT/FAMILY RELATIONS

Cynthia Johnson, Ph.D.

DEAN OF THE GRADUATE SCHOOL

Paul Gemperline, Ph.D.

DEDICATION

This dissertation is dedicated to my husband, Richard Tyndall, my two sons, Ethan and Matthew, and my parents. I am eternally grateful to my husband for his patience and support of my insatiable curiosity and pursuit of knowledge, and what seemed like my perpetual student status. Through our 10 years of marriage, Richard has endured over half of those years with my head in the books and focus on the computer without once complaining. Quite the contrary, he has been a tremendous and enthusiastic cheerleader and as he once said, “the greatest fan of my life.” To my boys, thank you for sharing me with this project. I know you sacrificed play time with me and might have woken up to a grumpy sleep deprived mother a few mornings. But your arrival and presence in my life were often times the motivation to continue the pursuit of this dream. I firmly believe it will benefit our family for years to come.

To my parents, Betty and Ed, and Brian, I am also incredibly grateful for your support in so many ways. To Betty and Ed, thank you especially for the countless hours of childcare that enabled me to balance my work and family and to pursue my academic and professional goals without sacrificing the care of my children. To my Mom, Betty, thank you for being my first and leading example of an intelligent and more-than-capable woman, and Mom, consider this your honorary doctorate, as you have been with me every step of the way and have earned it. To Ed, thank you for always encouraging my professional development and understanding what it takes to complete this process. To my Dad, Brian, it goes without saying how grateful I am that you have always told me to reach for my dreams and to see the “me I wanted to be.” You are a wonderful positive influence on the pursuit of everything I have and will continue to hope for. Thank you for always reminding me to dream big.

ACKNOWLEDGEMENTS

First and foremost, I want to thank God. While this may sound trite to some, it cannot go without saying that it is only by His grace that I have been given these opportunities and gifts and been able to accomplish this goal.

I would like to thank my advisor Dr. Jennifer Hodgson for a myriad of reasons and I fear that what is written here will not do those reasons justice, but I shall try. First, Dr. Hodgson often believed in me more than I believed in myself and that is a rare find in a faculty member. Her combination of hand holding and clever motivation was often just what was needed to keep my “eyes on the prize.” I will also always be grateful for her understanding, patience with, and support of my family commitments. She always knew, and led by example, what was most important. She once expressed a need to provide her students with a positive and challenging doctoral experience so that they find their true potential with faculty support, and I would like to assure her that she has surely met that goal in me.

I would also like to thank the rest of my committee Dr. Angela Lamson, Dr. Mark White, and Dr. Sharon Knight. Each of you has helped me grow in so many ways, both through classes as well as through this dissertation process. I would like to thank Dr. Angela Lamson for her continual support of me and my efforts over the years. As Program Director, Dr. Lamson’s availability to me and other students was wonderful and greatly appreciated. I am thankful for her desire to understand my needs as a whole person rather than just as a student. After a tragic personal incident, I ran into Dr. Lamson at Pitt County Memorial Hospital and I will never forget her comfort in those horrible moments. Dr. Mark White also played a tremendous role in tending to my balance of work and family. He endured several tearful supervision sessions and I am

grateful for the space he allowed me to be completely open and honest. I met Dr. Sharon Knight my first semester in a qualitative research class and she was the first face to make research a kind and gentle process. I am so grateful for the personal touches she gave that class and for sparking in me an appreciation for the depth and beauty of what can be gained from research.

Thank you to Sammie Kaufman who was my second brain in the analysis process. Thank you to my doctoral student colleagues. I relied on your support throughout the program, as some of the few people in this world who could relate to and sympathize and encourage me through this process. You have helped me laugh whenever I needed it, and that is priceless. Last, but not least, I would like to thank my long-time friends. To my fabulous friends, Kimberly, Karen, Jennifer, Bronwyn, Becca, and Novine, I am grateful for their continual support of my efforts. If you were not sincerely interested in every class I took, every paper I wrote, each step of my dissertation process, I could not tell. Thank you girls for always having my back.

TABLE OF CONTENTS

Signature Page	i
Dedication	ii
Acknowledgements	iii
Table of Contents	v
List of Tables	viii
Chapter 1: Preface	1
Chapter 2:	
Operationalizing Medical Family Therapy: Building a case for consensus	3
Abstract	4
Introduction	5
Theoretical Conceptualization.....	6
MedFT Training	8
MedFT Institutes	9
MedFT Internships and Fellowships	9
Cultural and Paradigmatic Differences.....	11
MedFT Interventions.....	14
Aims of Literature Review.....	16

Literature Review Method.....	17
The Inception of MedFT.....	17
MedFT Skills and Applications.....	18
MedFT Effectiveness and Efficacy Research.....	26
Recommendations for Research, Practice, and Training.....	30
Conclusion.....	35
References	36
Chapter 3: The State of Medical Family Therapy: A modified Delphi analysis.....	46
Abstract	47
Literature Review	48
Method	51
The Delphi Method.....	51
Panelists.....	52
Data Collection and Analysis.....	54
Results	57
MedFT Defined.....	58
Scope of Practice.....	60
Academics and Training.....	62
Clinical MedFT.....	66

MedFT Research.....	67
Discussion and Future Research	68
Limitations	73
Summary	73
References	75

Appendices

A: Figure 1	82
B: IRB Approval and Informed Consent.....	83
C: Demographics Questionnaire.....	87
D: Tables 1 and 2.....	89
E: Dissertation Proposal	91
F: Table 3.....	191

LIST OF TABLES

Literature Article

Figure 1: MedFT Literature by Year.....	82
---	----

Research Article

Table 1: Variables Included in the MedFT Profile.....	89
Table 2: Academics/Training Variables in the MedFT Profile.....	90
Table 3: Variable Statistics.....	191

Chapter 1: Preface

The origins for this project are slightly embarrassing. Who would enroll in a Medical Family Therapy doctoral program and then, after a year in the program, ask the question, “What is Medical Family Therapy exactly?” I was drawn to Medical Family Therapy instinctually, not because I read the program description. I came because I valued my master’s experience in Marriage and Family Therapy and believed that Marriage and Family Therapists, with a systems orientation and self-of-therapist focus, had a unique way of viewing clients and patients. I came because for most of my young life I had a front row seat to the connection between the body and the mind through personal experiences. Medical Family Therapy was, for me, the next logical step in combining my master’s education and my desire to improve patients’ and families’ experiences through practice and research. And yet, I still struggled with how to articulate its value to my friends and family and colleagues.

After many discussions with my major professor, Dr. Jennifer Hodgson, where I would ask for clarification on the role of Medical Family Therapy, we arrived at the decision that this question needed to be answered by all of those currently working in the field of Medical Family Therapy. My desire was for the field of Medical Family Therapy to establish some consensus in practice, training, and research expectations, such that this sub-discipline of marriage and family therapy could continue to move forward. In order to do this, I felt that there needed to be a meeting or conversation of sorts amongst those who have expertise in the field. Dr. Mark White brought the Delphi methodology to my attention and from there a study was born.

The first article is a review of the available MedFT literature. This article helped cement both the similarities and the differences that currently exist in how MedFT is defined, practiced, and taught. It was clear to me that, just like a city must be carefully planned and mapped, that a

discipline must also be given that same amount of attention. If growth is not done wisely and thoughtfully, it can lead to splintering, forging ahead in many different directions and lack of any real progress. The second article is my attempt to assist in the mapping of the future of MedFT and its role in the healthcare system. I believe that if MedFTs can unite and create a cohesive body of literature and training, they can also create a professional identity whose value can be understood and whose role may be perceived as essential in the changing healthcare system.

Chapter 2:

Operationalizing Medical Family Therapy: Building a case for consensus

Abstract

Medical Family Therapy (MedFT) is a relatively young sub-specialty founded initially at the intersection of Marriage and Family Therapy and Family Medicine. There has been much growth since its inception in the 1980s but a need exists for refinement of its definition, scope, and direction. The purpose of this literature review was to (i) illuminate the differences among existing definitions of MedFT, (ii) review the history and growth of MedFT, and (iii) report on available research that has been specifically conducted on MedFT. Sixty five articles that met the inclusion criteria were reviewed and three distinct themes emerged from that process: 1) the inception of MedFT, 2) MedFT skills and applications, and 3) MedFT effectiveness and efficacy research. Results suggest targeting the following for future research and development: the creation of a lexicon of MedFT interventions, effectiveness and efficacy studies, and identification of core curriculum and competencies for training.

Key words: Medical Family Therapy, collaboration, family systems, biopsychosocial

Introduction

Medical Family Therapy emerged from its parent discipline of marriage and family therapy (MFT) in the 1980s when the role of family therapists extended into the healthcare system through research, teaching, and clinical practice. McDaniel, Hepworth, and Doherty (1992a) coined the term, medical family therapy (MedFT) to refer to the practice of therapists working with patients and their families who are coping with illness and who follow a biopsychosocial systems perspective and a collaborative model of care. Linville, Hertlein, and Prouty Lyness (2007) wrote a review of the literature illustrating MedFT and family interventions as the primary mode of psychotherapy and with a MedFT as part of an interdisciplinary team. Linville et al. asserted that their review punctuated the value of collaboration and served as a first step toward demonstrating MedFT effectiveness. However, they challenged MedFTs to come to consensus regarding the definition of MedFT for the purposes of launching MedFT effectiveness research from a unified platform. MedFT has the potential to play a significant role in changing America's ailing healthcare system; however, more research must be conducted to substantiate its efficacy, effectiveness, and unique contributions.

Several other mental health disciplines also provide needed mental health services in medical settings; however, the intensive training that MedFTs receive in applying systems theory to their work with individuals, couple, families, and healthcare providers/systems across primary, secondary, and tertiary care settings offers something important and unique (Linville et al., 2007; McDaniel et al., 1992a). While the intention of this review is not to create a hierarchy among mental health providers based on who is most qualified to work in a medical setting, it is

designed to elucidate the unique strengths of MedFTs for the purpose of defining and describing this rapidly emerging sub-specialty.

Theoretical Conceptualization of MedFT

George Engel, through his groundbreaking biopsychosocial (BPS) model (1977), challenged all healthcare providers to think about healthcare from a holistic perspective. In the beginning, mental health providers were leery of involving themselves with their clients' biological issues. Conversely, most biomedically-oriented physicians felt it was neither their role to be involved with their patients' mental health nor within their expertise to manage it (Seaburn et al., 1993). However, with comprehensive training in systems theory the mental health discipline of marriage and family therapy (MFT) was well suited to begin to bridge the mind-body divide.

In the early 1990s, McDaniel et al. (1992a) labeled family therapists who specialized in integrating a BPS and systems perspective as, "medical family therapists." MedFT is a fast growing sub-specialty within its parent field of MFT; however, its definition and scope of practice varies in the literature. For example, the element of collaboration is one term that varies across definitions of MedFT even in some of the earliest publications (Doherty, McDaniel, Hepworth, 1994; McDaniel et al., 1992a). It was initially included as part of the original definition (McDaniel et al.), but the same set of authors later seemed to view collaboration more as an essential strategy rather than a core part of its definition. Current training programs have also differed on the inclusion of spirituality as part of the BPS approach, as well as the direct mention of the family therapy parent discipline and systems theory (East Carolina University, 2009; Mercer University School of Medicine, 2008; Seattle Pacific University, 2010). One of the most recent attempts to define MedFT was put forth by Linville et al. (2007). They defined it as

an approach to healthcare from a BPS perspective, informed by systems theory, spanning across a variety of clinical settings where, “The patient’s interpersonal relationships are believed to play a key role, and collaboration exists between the family therapist and other healthcare practitioners” (p. 86). However, Linville et al. noted that this was their own definition constructed by reviewing those in the literature and was not validated through research.

Among MedFTs, recognizing the biological, psychological, and social dimensions of mental health appears to be central to their research, teaching, and clinical practice. In 1994, Doherty et al. challenged therapists to step back and consider if their focus on the psychosocial was just as myopic as those who adhered strictly to the biomedical paradigm. Advocating for a focus on the BPS, they emphasized that concern for and understanding of psychosocial influences is critical in healthcare provision, “There are no psychosocial problems without biological features, and there are no biomedical problems without psychosocial features” (p. 34). MedFTs not only focus on the BPS model, as well as the spiritual dimensions to health (Anderson, Huff, & Hodgson, 2008; Hodgson, Lamson, & Reese, 2007; Phelps et al., 2009), but have uniquely combined it with general systems theory (GST) (Von Bertalanffy, 1968) and circular causality (Bateson, 1979). They believe that the system under examination does not exist solely within the patient, but also in the circular collaborative interactions between the patient and the healthcare system, the patient and his/her family, and between and among the healthcare providers themselves (Brucker et al., 2005) which all may be influenced by national policy, published research, or best practice guidelines.

MedFT is grounded in the research, theory, and application of collaborative models of care (McDaniel et al., 1992a; Ruddy & McDaniel, 2003) that involve providers, patients, families, and other members of influential larger systems. Rooted in their systemic

conceptualization of collaborative care are two overarching goals: agency and communion (McDaniel et al., 1992a; Seaburn, Lorenz, Gunn, Gawinski, & Mauksch, 1996). Agency is a concept originated by Bakan (1969) that, when applied in a healthcare setting, refers to a patient's personal choices in dealing with illness and the healthcare system (McDaniel et al.). Communion is defined as a uniting of people including both familial and community support that can surround a patient during his/her illness (McDaniel et al.). In the practice of MedFT both of these concepts help the clinician empower patients to take an active role in their healing process. These primary concepts ignited the practice of MedFT and since then the literature has blossomed, revealing opportunities for growth and development in training, research, and clinical application.

Medical Family Therapy Training

MedFT training opportunities in the United States, such as those occurring at the master's and doctoral-levels (Brucker et al., 2005; Grauf-Grounds & Sellers, 2006) ran counterpart to its growing recognition nationally and internationally. At the time of this review, there are eight professional MedFT preparation programs in the United States including two doctoral degrees, one master's degree with an emphasis in MedFT, and six programs that offer certificates. East Carolina University launched the first MedFT doctoral program in fall 2005 (ECU, 2009) with University of Nebraska-Lincoln (UNL, 2010) initiating their doctoral program in 2009. The University of San Diego offers a master's degree in MFT with an optional emphasis in MedFT (n.d.). Four institutions of higher education offer certificates of study in MedFT: Seattle Pacific University (SPU, 2010), Mercer University (2008), the University of Nebraska-Lincoln, and Drexel University Online (2010). Two educational institutions also offer a certificate in MedFT but have named it differently. Nova Southeastern University's (NSU) certificate is titled "Family

Systems Health Care” (NSU, 2009), and The Chicago Center for Family Health’s certificate is named, “Families, Illness, & Collaborative Healthcare” (Rolland & Walsh, 2005). These six certificate programs have shared the foundational underpinnings of working with families dealing with illness from a systems perspective; however each also has curriculum characteristics that make it unique.

MedFT Institutes

By definition, institutes are brief, intensive training programs offered in a specific field of study. Two training programs currently offer MedFT institutes. The University of Rochester Medical Center (URMC) has offered a MedFT summer intensive institute for 17 consecutive years (URMC, 2010). Through this institute mental health professionals receive training in mental health and healthcare collaboration, systems consultation, and examine self-of-provider issues and their potential to impact patient care. In addition, the Chicago Center for Family Health (CCFH) has offered a five-day summer institute (Rolland & Walsh, 2005) focused on training professionals and healthcare providers in how to effectively assist families coping with chronic illness, loss, and other health related problems.

MedFT Internships and Fellowships

At the time of this review, internships were an essential part of preparation in MFT and MedFT at the master’s and doctoral educational levels. It is by immersion in the culture that students learn how the biomedical context is different than a traditional mental health context, how to interact and effectively collaborate with other healthcare professionals, and how to speak the language of collaboration (Brucker et al., 2005; Grauf-Grounds & Sellers, 2006; Seaburn et al., 1996). While the availability of internship sites varies, a few of the doctoral-level internship sites have been at the University of Rochester (Seaburn et al.), the University of Nebraska, and

within the Departments of Family Medicine at the University of Connecticut (Hepworth, Gavazzi, Adlin, & Miller, 1988), Dartmouth Family Practice Residency at Concord Hospital in New Hampshire (Bill Gunn, personal communication, January 24, 2010), Duke University Cancer Support Program (Tracy Berger, personal communication, January 26, 2010), and James D. Bernstein Community Health Medical Center (Jennifer Hodgson & Angela Lamson, personal communication, March 4, 2010). Other internship and training sites include those at Seattle Pacific University, which has tailored internships toward students' interests (Grauf-Grounds & Sellers), the University of San Diego (n.d.), and the Chicago Center for Family Health (CCFH, 2003) affiliated with the University of Chicago.

Along with the development of specialized training programs and field placement opportunities was recognition of the unique supervisory needs for MedFT trainees working in healthcare settings (Edwards & Patterson, 2006). Edwards and Patterson referenced four main elements to consider when supervising a MedFT: understanding medical culture, understanding the trainees fit into the system, investigating the patients' biological needs, and paying special attention to the self-of-therapist in a medical setting. While MedFTs have been interning in healthcare settings for over 10 years (Gawinski, Edwards, & Speice, 1999), access to supervisors who are trained in MedFT and who have experience working in medical settings may be limited. Only with respect for diverse healthcare providers, a variety of health disciplines, and awareness of cultural and ethical differences can a MedFT successfully assimilate into a medical setting (Patterson, Peek, Heinrich, Bischoff, & Scherger, 2002) and these can all be emphasized through MedFT supervision.

Cultural and Paradigmatic Differences

In order for MedFTs to interact in a medical environment, they are typically trained to appreciate differences between medical and mental health professionals in theoretical foci, confidentiality, language, schedule availability, and such logistics as practice space (Edwards & Patterson, 2006; Patterson et al., 2002). At the foundation of understanding differences between medical and mental health is demonstrating respect for both the patient and the contributions of mental health and biomedical providers (Seaburn et al., 1996). For example, a MedFT working from the family systems paradigm may understand that there are multiple factors playing a role in the patient's life. In contrast, providers working from a biomedical paradigm primarily tend to focus more linearly on the source of health problems from their own expert perspective (Alfuth & Bernard, 2000; McDaniel, Campbell, & Seaburn, 1995; McDaniel et al., 1992a; Seaburn et al., 1993). However, the biomedical paradigm, even though critiqued as myopic, plays an essential role in healthcare (Patterson et al., 2002) for example if someone is acutely ill, for example, she is not always manifesting stress through her physical being. Sometimes a sore throat is just a sore throat in need of an antibiotic.

Differences also exist in the resources that inform mental health providers' and physicians' conceptualization of a patient's case. Physicians aim largely to treat patients based on research studies and evidence-based best practice guidelines (Institute of Medicine, 2001); however, this kind of information is often not available for the wide range and combination of mental health issues (Patterson et al., 2002). The available evidence-based literature in support of MedFT interventions, screening tools, and models of collaboration is only in its beginning stages (Linville et al., 2007).

In the medical setting physicians have an ethical responsibility to treat their patients and do whatever is necessary to ensure optimal health, including open collaboration with all in-house providers and staff and other specialists (Blount, 1998; McDaniel et al., 1992a; Seaburn et al., 1996). The Health Insurance Portability and Accountability Act (HIPAA) of 1996 created a unifying policy around patient health information for a variety of healthcare providers (United States Department of Health and Human Services [USDHHS], n.d.) such that patient information was confidential and only accessed when necessary for treatment. In addition to HIPAA mental health providers must follow ethical standards related to confidentiality, as one of the profession's core values, which is especially crucial to patients due to the stigma attached to mental health services (Patterson et al., 2002). MedFTs are trained to integrate themselves into the medical setting and work collaboratively to ensure that legitimate information, relevant to the treatment plan, is exchanged in an ethical manner between providers within that setting (Edwards & Patterson, 2006; Grauf-Grounds & Sellers, 2006).

Because respect and understanding are essential to a productive collaborative exchange, MedFTs must also understand important differences in the traditional language used in the two cultures (Edwards & Patterson, 2006; Seaburn et al., 1996; Seaburn et al., 1993). Most MedFTs are trained to become familiar with and use the language and abbreviations of medicine (Bischoff, Lieser, Taratua, & Fox, 2003; McDaniel et al., 1992a; Patterson et al., 2002; Seaburn, Lorenz et al.) when constructing case notes and verbally discussing shared patients. In addition, in order to enhance communication and collaboration, MedFTs are typically trained to briefly and clearly summarize a patient's situation, without using complex psychotherapy language (Bischoff et al.).

Differences between medical and mental health providers' clinical pace often includes length of appointment time (Alfuth & Bernard, 2000; McDaniel, Campbell, & Seaburn, 1990; Seaburn et al., 1996), as well as allowance of interruptions (Edwards & Patterson, 2006). MedFTS are trained to work in 5-15 minute segments, as well as traditional 50 minute appointments. Physicians' work pace is both short and quick and, because they generally are at the top of the medical hierarchy, those working with them often are required to match their pace (McDaniel et al., 1992a). When working with providers most MedFTs anticipate and adapt to these time change differences and interruptions, and are skilled in the application of brief therapy and evidence based models (e.g., CBT, Solution-Focused therapy) so they can conform to the demands of that setting (Patterson et al., 2002).

Relationship building, networking, and continued collaboration with the healthcare team are critical to the successful integration of MedFTs in a medical setting (Doherty et al., 1994; McDaniel et al., 1992a). Just as in therapy, the MedFT's strongest asset in their collaborative work is their ability to build relationships (Bischoff et al., 2003; Grauf-Grounds & Sellers, 2006; Seaburn et al., 1996). To do this, MedFTs must first observe and understand their role in the system. By respecting the hierarchical structure of the medical context, most MedFTs are skilled at determining the expected level of their involvement (Bischoff et al.; Patterson et al., 2002). They are trained to strike a balance between taking a "one-down" position where they may play the role of learner versus teacher while also being able to convey their value as members of the healthcare team (Bischoff et al.; Campbell & Patterson, 1995). For example, knowing how and when to ask the providers the critical opening question, "How can I help you?" (Seaburn & Lorenz et al.) is a basic skill. Joint meetings between the therapist, provider, and patient can also

be beneficial to the therapist-provider relationship as well as increasing provider and patient buy-in to the integration of therapy (McDaniel et al., 2001) into the treatment plan.

Once a MedFT is established as a member of a healthcare team, communication skills are critical in managing referrals and maintain collaborative relationships with the patient, family members, and other providers. To accomplish this, MedFTs apply a variety of communication modalities through use of the systems consultation model (Wynne, McDaniel, & Weber, 1986). This model involves identifying the person making the referral as well as his or her particular goals and desired outcome for the consultation. The MedFT is then able to navigate the system in a way that is helpful to both the patient and the referring physician. Rather than the referral process seeming like a dead-end street to the provider, this model facilitates an open level of communication among the team members. MedFTs also take advantage of communicating face-to-face with providers, often in the form of hallway consultations with very brief conversations highlighting the most salient aspects of the case (Seaburn et al., 1996). If MedFTs are not co-located with the provider, he or she may need to be persistent. Email and telephone conversations are critically important to maintaining collaborative relationships (McDaniel et al., 1992a). Communication and collaboration appear to be two of the most important skills of MedFTs, for it is through these mechanisms that provider and practitioner insight is increased and MedFT interventions are delivered (Anderson et al., 2008).

MedFT Interventions

MedFT interventions can include psychoeducation, a combination of psychoeducation and family relational work, as well as direct therapeutic work with the family (Campbell, 2003; Linville et al., 2007; Patterson et al., 2002). In the seminal text, *Medical Family Therapy*, McDaniel et al. (1992a) laid some groundwork with the creation of seven techniques of MedFT

aimed at the overarching goals of agency and communion: (a) ascertaining information about the patient's and/or family's biomedical concerns, (b) soliciting the illness story, (c) respecting defenses, removing blame and accepting unacceptable feelings, (d) maintaining effective communication, (e) acknowledging developmental stages, (f) increasing patient's and family's sense of agency, and (g) providing a soft termination to ensure the patient's comfort with returning to therapy if necessary. While effectiveness and efficacy studies are needed in these seven MedFT-specific interventions, they have been illustrated in non-empirical case studies involving a woman with end-stage Crohn's disease and her son (McDaniel et al., 2001), a woman with breast cancer and her spouse (Burwell et al., 2008), as well as part of a model for working with polytrauma rehabilitation (Collins & Kennedy, 2008).

One of the most recent texts designed to provide mental health providers with tools for success is a handbook of interventions for therapists working in medical settings or with clients with healthcare issues (Linville et al., 2007). Contributors to this text offer such interventions as the biopsychosocial-spiritual (BPS-S) interview (Hodgson et al., 2007), connecting families with their natural support systems (Grauf-Grounds, 2007), managing anger (Ward & Linville, 2007), improving communication and self-awareness (Pflaffy, 2007), as well offering as self care therapist strategies (Lamson & Meadors, 2007). While the interventions listed in the text are generally written for all mental health disciplines, the focus seems largely to be on interventions relevant in a medical context with a couple or family, a service MedFTs are skilled in delivering. Unfortunately, empirically supported interventions that illustrate the full range of MedFT skills are insufficient in number.

In the past decade, researchers have begun to determine how to methodologically capture the complex financial benefits of MedFT services. For example, Law and Crane (2000) found

that patients as well as members of their families experienced a drop in the utilization of medical services when marital therapy was included in their treatment (Law & Crane). Law, Crane, and Berge (2003) found this drop particularly noticeable among patients labeled as high utilizers who typically presented with chronic pain or somatization disorders. Researchers have also demonstrated a decline in healthcare services, when family therapy is employed, for youth diagnosed as having conduct-disorder when (Crane, Hillin, & Jakubowski, 2005). While Crane's work is key to demonstrating the value of mental healthcare, as well as the value of working with the family as a whole, it did not evaluate the specific elements of care (e.g., interventions, theory, collaborative models) provided by therapists and the type of training each received specific to working in collaboration with a healthcare system. The data were garnered primarily from insurance company and HMO databases, and thus do not provide detailed information about the quality and type of interventions utilized.

As MedFTs move into an increasing range of professional placements, interventions will need to be empirically studied and refined to highlight the unique contributions of MedFTs and to determine if they fit the needs of patients, providers, and the medical system at large. However, without consensus on a definition of MedFT, there is a propensity to lose theoretical and scientific focus, purpose, and understanding of who is trained to do this work.

Aims of Literature Review

This paper aims to (i) illuminate the differences among existing definitions of MedFT (ii) review the history and growth of MedFT and (iii) report on available research that has been done specifically on MedFT. The results will be used to target areas within MedFT for future research and development.

Literature Review Method

The scope of MedFT extends broadly across a variety of specialties and health conditions, thus necessitating a search for MedFT articles or reviews published in peer-reviewed professional publications was needed. In seeking to determine the extent of MedFT-focused publications in the literature, a search was conducted using several databases: Academic Search Premier, ProQuest, Psychological and Behavioral Sciences, PubMed, PsycInfo, PsycArticles and EBSCO. The search included the following parameters: 1) English language 2) all years 3) the full phrase “Medical Family Therapy” in the abstract or title. Additionally, a manual search of the journal of *Family Systems Medicine (later renamed Families, Systems, and Health)* was conducted to identify earlier works referencing MedFT in a section of the journal entitled, *Medical Family Therapy Casebook*. A total of 65 articles, empirical and non-empirical, fit the search criteria. The annual numbers of publications from 1992 to 2009 are illustrated in Figure 1 (Appendix A). Based on the main subject of the article the resulting literature was categorized into the following three themes: 1) The Inception of MedFT 2) MedFT Skills and Applications, and 3) MedFT efficacy and effectiveness research.

The Inception of MedFT

While clinicians were already practicing MedFT in the late 1980s (Ruddy & McDaniel, 2003), it was not until the early 1990s that the practice was introduced into the literature (Doherty et al., 1994). McDaniel et al’s primer text, *Medical Family Therapy* was published in 1992 with written reviews that followed one year later in the journals of *Adolescence* (Anonymous, 1993), as well as *Families, Systems, Medicine* (Shapiro, 1993). It should be noted that three articles were published contesting the emergence and coining of the term MedFT (Bell, Wright, & Watson, 1992; Czauderna & Tomson, 1994; Lask, 1994). Bell et al. asserted that the

word medical was limiting focus to the biological. Czauderna and Tomson and Lask argued that the concept of MedFT was not new and had been implemented in the United Kingdom prior to McDaniel et al.'s coining the phrase MedFT. Since these early days of MedFT, authors and researchers have applied MedFT constructs in a variety of settings and with a variety of illnesses and disabilities.

MedFT Skills and Applications

A discussion of the clinical application of MedFT with infertility issues was one of the earliest publications in the field (McDaniel et al., 1992b). In this paper, McDaniel et al. defined MedFT as an approach to psychotherapy with elements such as the BPS perspective, collaboration, and family systems, as practiced by family therapists with a focus and awareness on a medical condition. The authors then presented clinical case examples demonstrating various MedFT strategies they found helpful with couples facing infertility. Another outlet for MedFT work was in a section of the journal, *Families Systems Medicine* (renamed later as *Families, Systems and Health*). This section was entitled, *Medical Family Therapy Casebook* and was intended to be a forum for clinicians to present a clinical case alongside a commentary by a third party (Cohen, 1995, Gellerstedt & Mauksch, 1993; Knishkowsky, 1998; Leahy, Galbreath, Powell, & Shinn, 1994; Ruddy, Farley, Nymberg, & Hayden, 1994; Weiner & Lorenz, 1994; Weiss & Hepworth, 1993). While the case studies often illustrated MedFT concepts such as collaboration (Cohen; Ruddy et al.), and the BPS perspective (Cohen), the authors did not offer a definition of MedFT. Additionally, in several articles it was not clear if the clinician received any training in MedFT (Cohen; Gellerstedt & Mauksch; Knishkowsky; Ruddy et al.). However, there was one exception as Weiner and Lorenz outlined in great detail Weiner's self-taught MedFT skills by immersion and observation of the medical culture. The MedFT casebook provided an initial

attempt to provide a formal forum for discussing the integration of any mental health service in a medical setting, rather than aiming to specifically advance and refine the practice of MedFT itself.

Authors have applied the concepts of MedFT to various patient populations (Burns, 1999; McDaniel, 1994; McDaniel, Hepworth, & Doherty, 1995). Genetics and infertility (Burns) and reproductive technologies (McDaniel) were areas in which authors deemed MedFT well suited. In a non-research based article pairing MedFT with patients coping with within-family reproductive technologies (i.e. – known donors of egg or sperm), McDaniel defined MedFT according to the original definition, with a focus on the BPS perspective, as well as agency and communion, and referred to psychologists as the potential interventionists. In an applied clinical paper, Burns called for MedFT to be used as a guide in genetics counseling and infertility. Though the Burns definition of MedFT also referenced McDaniel et al.'s definition (1992a), there were differences such as the lack of inclusion of collaboration, agency, or communion. In 1995, McDaniel et al. proposed a framework for applying MedFT to patients thought to be somatizing; however, the proposal was not research based.

Soon thereafter, authors published clinical case examples outside of the *MedFT Casebook* (Streicher, 1995), with one author identifying interventions (i.e., genogram) that MedFTs used in their clinical work (Ragaisis, 1996). Interestingly, in that journal article, Ragaisis also made the case for psychiatric consultation-liaison nurses to be MedFTs and defined MedFT as a combination of elements such as systems theory, systemic belief theory, crisis theory, communication theory, developmental theory, structural-strategic theory, and the work of Milton Erickson. Absent from Ragaisis's definition was reference to collaboration or the BPS model. During the mid 1990's revealing MedFT's skills and applications, Campbell and Patterson

(1995) published an expansive literature review on family-based interventions that purportedly served as the foundation for MedFT. They defined MedFT based on the McDaniel et al. (1992a) text, and called for all family therapists to receive training in MedFT, as well as complete academic courses found in traditional medical curriculum such as psychopharmacology. Authors turned their attention toward how to implement MedFT programs and develop cross training experiences with medical professionals (Harkness & Nofziger, 1998; Yeager et al., 1999). McDaniel, Hepworth, and Doherty (1999) published an article outlining the shared themes of illness, regardless of the particular diagnosis, that may arise during MedFT such as guilt vs. forgiveness or isolation vs. connection.

In the early 2000s, authors expanded upon the theoretical perspectives and practice of MedFT, referencing stories of clinical success (McDaniel et al., 2001; Wissow, Hutton, & Kass, 2002). McDaniel et al. (2001) presented a clinical case study about their work with an older adult diagnosed with Crohn's disease and her son. A leading example of integrated care, they worked from a definition of MedFT that referenced the BPS perspective with family therapy and recognized the affect of the physical on the emotional while working toward the goals of agency and communion. *Feminist Perspectives in Medical Family Therapy* was published jointly as a book and as a volume in the *Journal of Feminist Family Therapy*. In this publication, several articles used the term "Medical Family Therapy" in the title or abstract (Bischof et al., 2003; Dankoski, 2003; Dankoski, Pais, Zoppi, & Kramer, 2003; Edwards & Patterson, 2003; Hertlein, 2003; Pratt, 2003; Prouty Lyness, 2003; Smith-Lamson & Hodgson, 2003). Only one of these articles (Bischof et al.) was research related and will be discussed in the next thematic section. Several of the articles offered ideas on training for MedFTs (Edwards & Patterson; Smith-Lamson & Hodgson) and using training techniques, rooted in family therapy, such as live

supervision with family practice residents (Dankoski et al.), but none of the ideas presented were research based. One article was a clinical case study used to present the weaving together of feminist family therapy with MedFT with special focus paid to the concepts of agency and communion (Hertlein). Interviews were also conducted with MedFT leaders Susan McDaniel (Pratt) and Shobha Pais (Dankoski) regarding their career paths and current interests as related to feminism. To round out this edition of the journal, a preface written by the editor, Prouty-Lyness, challenged MedFTs to remember that individuals' health must be considered within their social context. In this special issue, several authors defined MedFT straight from the McDaniel et al. (1992a) textbook (Bischoff et al; Hertlein; Smith-Lamson & Hodgson), and while Edwards and Patterson did not define it or reference an existing definition, the connection between MedFT and family therapy was specifically noted. This compilation of journal articles signified an increasing interest in MedFT. Since its publication, there have been four book reviews (Burge, 2005; Degges-White, 2005; Oberman, 2006; Rosenberg, 2005) on *Feminist Perspectives in Medical Family Therapy*. Similar to the interviews conducted in this journal and book an interview was also conducted with Bill Doherty, a leader in MedFT, regarding his career path, including his collaboration with Susan McDaniel and Jeri Hepworth regarding MedFT. MedFT, however, was not the focus of the interview (Jencius, 2004).

As the 2000 decade progressed, programs, healthcare interventions, and clinical recommendations related to MedFT were published for diseases such as diabetes (Robinson, Barnacle, Pretorius, & Paulman, 2004), fibromyalgia (Preece & Sandberg, 2005), somatoform and chronic fatigue syndrome (Szyndler, Towns, Hoffman, & Bennett, 2003), and cancer (Burwell, Brucker, & Shields, 2006; Dankoski & Pais, 2007). While these authors indicated MedFT in the treatment of patients with these diagnoses and their families, only two articles

were research based and the research was not related to MedFT, but to the relationship between family dynamics, resiliency, and fibromyalgia (Preece & Sandberg) and patient symptomatology, diagnosis, immediate family, and type and duration of intervention (Szyndler et al.). While not a research study, Robinson et al. illustrated the importance of including MedFTs on multi-disciplinary and collaborative treatment teams for patients diagnosed with diabetes. They created a model at the University of Nebraska Medical Center to address comorbid illnesses with diabetes, such as depression. They stated that the MedFT's systemic interviewing skills expanded the illness definition beyond its usual biomedical terms. The MedFT who was consistently available for consultation was reportedly a key component to a successful clinical outcome (as per the medical student's report). The unique element was that the providers were students in either MedFT or medical school and were being cross-trained to work collaboratively with one chronic illness. While it is known that the interventionists were students, what is not known is the MedFT training (master's or doctoral), courses, or experiences that the interventionists had prior to participating in this study. It would be difficult to replicate this model without knowledge of the level of training of the MedFT so as to ensure the fidelity of how MedFT was applied. Additionally, the goal of this article was not to highlight the MedFT's skills, but rather to focus on the benefits of cross training students on an interdisciplinary team. Interestingly, definitions of MedFT are not provided in either the Preece and Sandberg (2005) or Robinson et al's (2004) article.

Lastly, in theoretical articles, Burwell et al. (2008) and Dankoski and Pais (2007) called for MedFT to be promoted for use in oncology settings. The focus of Burwell et al., however, was more on using attachment theory in cancer patients' treatment, than on implementing MedFT techniques or interventions. Dankoski and Pais encouraged all marriage and family

therapists (MFT) to employ key MedFT techniques such as genograms, and they endorsed establishing a collaborative relationship with the patient's provider, addressing the biological needs of the patient, and called for more MFTs to specialize in medical couple and family therapy. In their description of the definition of MedFT both Burwell et al. and Dankoski and Pais seemed to adhere closely to the original McDaniel et al. (1992a) description of MedFT.

Published articles in the Medical Family Therapy casebook section of *Families, Systems, and Health* continued (Candib & Stovall, 2002; Clabby & Howarth, 2007; Munshower, 2004; Navon, 2005, Schirmer & Le, 2002; Thomasgard, Boreman, & Metz, 2004), several of which were written by physicians (Munshower; Thomasgard et al.). Though included in the MedFT Casebook section of the journal, none of the articles defined MedFT, described the clinician's training in MedFT, or indicated employment of MedFT principles, skills, or applications. It appeared that the MedFT Casebook became less associated with the actual field of MedFT and more inclusive of cases where there was an interest in both the mental and physical health of the patients or collaboration among treatment providers.

MedFT gained international recognition as well (Kojima, 2006; Pereira & Smith, 2006; Wirtberg, 2005). Authors discussed the evolution of family therapy and the application of the BPS model by MedFTs (Kojima; Pereira & Smith; Wirtberg). While authors referenced to the McDaniel et al. (1992a) definition, some differences or variations in the definition became apparent. For example, Kojima mentioned that MedFT was conducted via co-therapy and referred to the co-therapists as physician and a therapist in one room with the family. While Wirtberg focused on the BPS aspect of MedFT, the author made no reference to the importance of collaboration in their definition, which was in direct contrast to the definition presented by Pereira and Smith which did emphasize collaboration. Again, these articles focused on the

history, development, and application of MedFT, with a notable absence of effectiveness research.

Towards the end of the decade in 2008 alone, eight articles referencing MedFT were published (Anderson, Huff, & Hodgson, 2008; Burwell, Templeton, Kennedy, Zak-Hunter, 2008; Collins & Kennedy, 2008; Davey, Duncan, Foster, & Milton, 2008; Heru & Berman, 2008; Rosenberg, Brown, & Gawinski, 2008; Willerton, Dankoski, & Martir, 2008), only two of which were research based (Anderson et al.; Harrington, Kimball, & Bean, 2009). In a clinical case study of a pediatric patient with HIV/AIDS, the term MedFT was used only in the abstract of the article. Throughout the remainder of the text, the authors referred to clinicians as family therapists, not MedFTs (Davey et al.). Along with the absence of a definition of MedFT in this article, the authors did not address the clinician's level of training or experience in MedFT. Though a focus on collaboration between the mental health provider and the physicians existed, designating the interventionists as family therapists, rather than MedFTs, also rendered it unclear if the authors believed the only difference between MedFTs and MFTs was the act of collaborating with physicians or working with someone who has a medical diagnosis. In a clinical case study of an infant struggling with a failure-to-thrive diagnosis, Rosenberg et al. referred to concepts such as collaboration and agency, as defined by McDaniel et al. (1992a), but did not operationalize MedFT specifically. Lastly, in a clinical case study involving the application of MedFT with polytrauma rehabilitation, MedFT was defined as including a BPS and family systems perspective (Collins & Kennedy). The concepts of agency and communion were referenced as important therapeutic goals, but the authors did not emphasize the element of collaboration. Though their training in MedFT was unclear, the authors reference four of the seven MedFT techniques first composed by McDaniel et al. as helpful in working with their

population. While these case studies were written to demonstrate the clinical benefits of MedFT, effectiveness research was needed to further substantiate these claims.

Authors have continued to claim that MedFT is a good fit for various healthcare and mental healthcare models (Burwell et al., 2008; Phelps et al., 2009; Willerton et al., 2008). By other more recent authors, the definition of MedFT has been consistent with the definition put forth by McDaniel et al. (1992a), including the key elements of the BPS perspective, collaboration, and family systems. Willerton et al. contended, however that the field of the practitioner did not matter as much as their skills in systemic orientation and thinking. Burwell et al. paired MedFT with Feminist Theory to create a Feminist-Informed Medical Family Therapy (FIMedFT) model for working with breast cancer patients. The authors proposed that FIMedFTs encourage an examination of the roles of gender and power within the healthcare system, including those found within patients and their families. The authors illustrated nine techniques, building on McDaniel's work that were to be conducted when working with patients and families from this perspective. The two additional techniques included addressing gender and power issues and facilitating communication between the healthcare system and the family. While these techniques are clinically helpful both effectiveness and efficacy studies evaluating the added benefit FIMedFT brings to MedFT would be helpful.

Also critical to the development of the sub-discipline of MedFT were the recognition of cultural differences and the adaptation of MedFT to meet the needs of different cultural groups. Willerton et al.(2008) made the case for MedFTs to assist the Latino population with their mental health needs. They stated that, for reasons such as the cultural importance of the family, MedFTs would be well suited to help serve the Latino population. While important to the social justice issues surrounding healthcare, this clinical argument has not been supported by research.

However, Phelps et al. (2009) presented a collaborative care model for working with underserved African American and Hispanic patients with type II diabetes. In it they utilized a MedFT as a member of the healthcare team. While the focus of the MedFT's sessions was articulated clearly, for example areas such as stress relief and emotional eating, the emphasis was more on the collaborative care model and the BPS-S model. While spirituality was not a primary focus of the MedFT's role in the model, the researchers used a quantitative instrument regarding spirituality to monitor depressive symptoms.

MedFT Effectiveness and Efficacy Research

While the above publications have been written to help demonstrate the unique skills and wide applications of MedFT, only a few researchers have attempted to study the effectiveness of MedFT in healthcare settings; no known studies have measured its efficacy. There are currently no known randomized control trials, for example, comparing the effectiveness of MedFT with that of other disciplines, interventions, or treatment-as-usual conditions. Sellers (2000) conducted a six month pilot project with the placement of a MedFT within the healthcare team in an outpatient medical oncology unit. Quantitative surveys and qualitative interviews revealed that healthcare providers, patients, and their partners benefitted from the addition of MedFT services. Providers stated that the psychosocial support of their patients was a relief to them, and enabled them to do other medically necessary tasks. Patients and loved ones reported decreased emotional suffering and increased ability to access resources and feel hopeful about the future. While this study was beneficial in demonstrating the value of adding a MedFT service in general and outlining needs of the oncology clinic that might match the skills of the MedFT, it did not specify the contributions of the MedFT. The researcher did not compare these study findings to that of other mental health providers in a similar setting or report the benefits perceived by

providers and patients. The researcher did not address the type of training the MedFTs received prior to joining the team. Sellers also did not define MedFT, thus leaving the reader to make assumptions about the nature and intent of their work. It would also be difficult to replicate this pilot study without knowing how the researcher operationalized MedFT, was trained to provide MedFT, and intervened in an oncology setting.

Using MedFT as the guiding framework Wissow et al. (2002) conducted a qualitative study involving parents and guardians of pediatric HIV/AIDS patients. They interviewed 10 families in an effort to create a values-history profile that would serve as a tool for future advance-directive conversations. The authors defined MedFT as the intersection of mental and medical health with an emphasis on agency and communion. They did not reference collaboration, the BPS-S perspective, or maintaining a family systems perspective. Also unclear in this study was how or if the clinicians were trained in MedFT. It appears that the authors were medically trained physicians who viewed MedFT as a treatment modality (Liddle, Breunlin, & Schwartz, 1998) applied as an interventional method by those not associated with the sub-discipline of MedFT or family therapy in general.

Bischoff et al. (2003) conducted a qualitative study of MedFTs' experiences working in a primary and secondary care medical setting. While the researchers did not define MedFT, they did reference the foundational McDaniel et al. (1992a) text was referenced. Qualitative interview data revealed themes of power and gender dynamics in the medical setting, the ways in which MedFTs began and maintained collaborative relationships, practical and professional considerations, the need for MedFTs to accommodate to the healthcare system, and how MedFTs could be seen as a threat to other healthcare providers.

In an attempt to further understand MedFTs contributions in secondary care settings, Anderson et al. (2008) published a grounded theory study that specifically addressed the skills of MedFTs working in an inpatient psychiatric unit. Using a definition of MedFT consistent with McDaniel et al. (1992a), Anderson et al. referenced the systems framework, BPS-S perspective, the importance of collaboration and the concepts of agency and communion. One slight difference in their definition was the expansion of the BPS perspective included spirituality. It is unclear how the researchers studied or understood strategies MedFTs used to address the spiritual needs of their patients and patients' families. Anderson et al. deconstructed the timeline of MedFTs involvement in a patient care encounter into three phases: pre-session preparation, during session, and post-session follow up. In the pre-session period, the specific skills MedFTs used included data gathering, conducting separate but brief sessions with the patient and family/support members, setting the agenda for the family meeting, and working with the multidisciplinary team to facilitate treatment planning. During the family session phase, the MedFT focused on creating a safe environment that facilitated open communication among family members. Focusing on patient and family strengths, the MedFT also worked to identify process and content that would not otherwise be revealed to the treatment team through usual interviewing and assessment methods. Through the process of discussing family issues and motions, the MedFT aimed to improve familial relationships and systemic change and prepared patients and family members for a successful transition from an inpatient unit to reintegration into their homes and communities. Following the family sessions, the MedFT maintained communication with the providers in the post-session follow-up period. If families chose to follow up with them for outpatient MedFT services, the MedFT continued to evaluate and work with the family to maintain the systemic changes initiated during the inpatient session. The

authors attributed the success of the MedFT service to the collaborative skills of the MedFT that helped all participants involved have a voice in the healthcare process. A follow up commentary on this article by psychiatrists Heru and Berman (2008) suggested that the addition of a MedFT to an inpatient unit would be beneficial, since historically families have sometimes been either avoided or demonized on these units by staff members. While they described the inclusion of MedFT as a sort of utopia, the authors also suggested the necessity of involving a MedFT with patients on a psychiatric unit depended on the level of need evidenced or expressed by the patient and his or her family or the healthcare providers. Anderson et al's study provides an excellent deconstruction of the MedFT intervention, what is not exactly known and may be determined through a replication study, is if the training and skills of the MedFTs were effective or the simply the unique skill set of each independent therapist.

In 2009, Harrington, Kimball, and Bean explored the inclusion of a MedFT on a pediatric oncology multi-disciplinary team. While the authors did not define MedFT, they did reference McDaniel et al. (1992a) in guiding therapeutic work with children diagnosed with a chronic illness. Harrington et al. conducted a phenomenological study with nine participants, including the team chaplain, nurses, and physicians, that revealed participants perceived relief in having the availability of a MedFT to assist patients and families with the systemic and emotional effects of cancer. MedFTs provided a sense of holistic treatment to patients and their families and enabled other team members to provide better patient and family care because they knew that the family's emotional needs were being addressed. The authors reported the skills and possible interventions MedFTs could employ in oncology, but it was not clear if the MedFTs involved in the study actually do employ these interventions or how the interventions were perceived by other providers.

The above studies are foundational for MedFT and critical for identifying the variables needed for further study of the sub-discipline. The descriptions are helpful in clarifying MedFT practice. While such studies are invaluable to clinicians for their practice and academicians for their instruction of students, if MedFT is going to persevere and MedFTs are to be competitive for jobs and reimbursement, the research base must be strengthened with a wider variety of research methodologies that demonstrate MedFT efficacy.

Recommendations for Research, Practice, and Training

The following recommendations are suggested after a thorough review and analysis of the available literature. The three recommendations are: 1) to establish a consensus definition of MedFT 2) study the effectiveness and efficacy of MedFTs and MedFT interventions, and 3) develop a MedFT core curriculum.

A Consensus Definition

Analysis of the research literature reveals that the practice of MedFT has grown since the late 1980s (Ruddy & McDaniel, 2003) as evidenced by the number of publications (N = 65) with MedFT as the primary focus. Recognizing this, Linville et al's (2007) challenged MedFTs to operationalize their work in order to advance their science. To date no one has accepted this challenge. Though the differences in definitions of MedFT may be subtle, such variances can alter how MedFT is taught, practiced, and studied. For example, while the inclusion of spirituality and family systems theory appear to be core components in MedFT training (ECU, 2009; SPU, 2010), these components are not overtly described by all training locations (Drexel, 2010; MUSM, 2008) nor commonly included in the MedFT literature. This may be due to an absence of reference to spirituality and family systems theory in the original definition set forth by McDaniel et al. (1992a) leading MedFT researchers and clinicians to deem these inclusions as

incidental and not critical. Additionally, throughout the literature, the BPS perspective is frequently mentioned (Burwell et al., 2006; McDaniel et al., 2001; Smith-Lamson & Hodgson, 2003) but the spiritual component of the BPS model is rarely mentioned (Hodgson et al., 2007; Phelps et al., 2009). At times, when MedFT was used by other disciplines, its definition included a variety of elements and foundational theories not otherwise mentioned in foundational MedFT literature (Ragaisis, 1996).

A lack of a cohesive definition or core training standards compromises the ability to capture outcomes attributable to MedFTs and thus controlling for sources of confounding. For example, a recent case study on the application of MedFT with polytrauma rehabilitation defined MedFT as an approach combining BPS and family systems perspectives with cognitive-behavioral and narrative methodologies (Collins & Kennedy, 2008). In this study, the intervention was conducted by a psychologist and social worker where training in MedFT or marriage and family therapy was unknown. In another recent article on the application of MedFT to address mental health disparities among Latinos (Willerton, Dankoski, & Martir, 2008), the authors defined MedFT as "...an attempt to better integrate the components of the BPS model in the delivery of mental health services through active collaboration of family therapists as members of health care teams" (p. 200). The former definition did not mention collaboration or the need for a family therapist, while the latter did not mention cognitive-behavioral and narrative methodologies. Consensus regarding the definition of MedFT and consistency in training would help to create a solid body of MedFT research with more established boundaries for those conducting the research and those practicing its interventions.

MedFT Intervention Framework

The MedFT literature references family interventions and their effectiveness (Campbell, 2003; Law & Crane, 2000; Law et al., 2003); but does not demonstrate the effectiveness of MedFT. There have been increased efforts to understand and illustrate MedFT interventions reported in the literature (Anderson et al., 2008, Rosenberg et al., 2008; Sellers, 2000). Researchers have reported perceived MedFT benefits in an inpatient psychiatric setting (Anderson et al.), as part of a diabetic treatment team (Robinson et al., 2004), and in oncology settings (Sellers; Harrington et al., 2008), but more detail is needed in exactly what MedFT interventions were conducted that were effective. Through a clinical case study, Rosenberg et al. illustrated the focus of MedFT sessions which included aiming to empower the patients' sense of agency as well as facilitating and nurturing the relationship between the patient and the healthcare team. It is unclear, however, how or if it was these specific interventions that impacted the patient outcome or if it was another element of treatment such as the collaboration that existed among the treatment team. Similarly, Robinson et al. included MedFTs as part of a treatment team for diabetics, and while it was articulated that the MedFT was of value to the team, the overall goal of the article was the demonstration of value of collaboration for treatment and training purposes and the specific MedFT interventions were not outlined. Collins and Kennedy (2008) stated that four of the seven MedFT techniques (McDaniel et al., 1992a) have been particularly helpful in working with polytrauma patients, but more than a case study is needed to determine if these elements are consistently effective. MedFT researchers must focus specifically on demonstrating that interventions conducted by trained MedFTs are effective either by comparing them to other treatment/control groups, exploring various patient and systemic outcomes, improving patient provider communication, or benefitting the providers

themselves. Additionally, these interventions must be employed with a larger population rather than singular case studies to add weight to their generalizability. Researchers must continue to build on these descriptive, qualitative studies that illuminate the practice and role of MedFT (e.g., Anderson et al.; Harrington et al.; Robinson et al.; Rosenberg et al.) taking these descriptions and creating a body of interventions conducted by MedFT trained clinicians that can be studied further and integrated into a curriculum for the training of future MedFTs.

Most studies have been done in conjunction with academic programs and by MedFTs in training at the master's or doctoral levels. With the relative youth of MedFT, it is understandable that controlling for years in formal training may be a challenge as there are few clinicians who have received a doctorate, post-doctorate, masters, or certificate in MedFT as compared to those who learned through experience in context. While several researchers have identified the MedFTs conducting the interventions or the object of their investigations were graduate level students (e.g., Anderson et al., 2008; Davey et al., 2008; Robinson et al., 2004; Rosenberg et al., 2008) and were sometimes labeled as "family therapists," other researchers who have studied MedFT in action did not specify the background or type of training the MedFTs received (Harrington et al., 2008; Sellers, 2000). As stated earlier, Collins and Kennedy (2008) illustrated MedFT in the treatment of patients with polytraumatic injuries, however the MedFT training and background of the interventionists is unclear. Research is needed in which the interventionists have clearly documented what their MedFT training and approaches are to treatment. In addition, efficacy research is needed where MedFT is compared to treatment as usual or the work of other disciplines (e.g., health psychology, medical social work, professional counselors) so that we can begin to demonstrate the unique contributions and strengths of MedFTs and argue for their place in the medical setting.

Lastly, MedFT effectiveness research, and ideally efficacy research, is needed to demonstrate the success of MedFTs not only in the clinical world, but also in the financial and operational worlds (Peek & Heinrich, 1995). Knowledge of their effectiveness may remain in the literature if MedFTs cannot help chart a new path for reimbursement. While acquisition of Medicare codes and usage of “incident to” and “health and behavior codes” for billing may resolve some reimbursement barriers, they do not ensure that providers and patients share the same understanding about MedFT and who is most qualified to provide this service.

MedFT Curriculum

MedFT training has grown from one summer institute in its early years (URMC, 2010) to eight training programs, including two doctoral programs, and most recently, a post-master’s online certification program at Drexel University (2010). With the expansion of training programs, a need exists to establish a foundational curriculum. Published articles have focused on the availability (Brucker et al., 2005) and development of internship sites (Grauf-Grounds & Sellers, 2006), as well as specific skills needed to supervise students in medical settings (Edwards & Patterson, 2006). However, there has not been an effort to elucidate core courses or core competencies. No research has been done on level of training and clinical effectiveness. Students who have graduated from a MedFT training institute or program may vary in their core training, theories, and practicum experiences. It is not known if a MedFT who received training in an intense workshop is any more or less effective than a MedFT trained through a doctoral or masters program. Agreement on core courses and the context for instruction would give credibility and fidelity to the practice of MedFT. Consistency in training has future implications for MedFT accreditation and licensing/certification.

Conclusion

MedFT has been a growing sub-specialty of marriage and family therapy for approximately the last 20 years and with this growth comes responsibility. It is the responsibility of the current MedFTs to: 1) clarify their role, scope, and intent in a clinical context, 2) identify and adopt core competencies that set standards for training of MedFTs, and 3) produce research demonstrating the efficacy and effectiveness of MedFT. In order to accomplish the integration of MedFT into the healthcare system there must be sufficient supporting evidence of positive impact. Development of this evidence base will include building a research-based consensus definition of MedFT, empirically studying MedFTs' effectiveness in primary, secondary, and tertiary care settings, and identifying a core curriculum that experts in MedFT share as fundamental to effective professional practice and the growth and advancement of the profession.

References

- Alfuth, R., & Barnard, C. P. (2000). Family physicians and family therapists: Understanding the interdependent synergism. *Contemporary Family Therapy, 22*(3), 253-277.
- Anderson, R., Huff, N., & Hodgson, J. (2008). Medical family therapy in an inpatient psychiatric setting. *Families, Systems, and Health, 26*, 164-180.
- Anonymous. (1993). Book reviews - Medical Family Therapy: A biopsychosocial approach to families with health problems. *Adolescence, 28*, 753.
- Bakan, D. (1969). *The duality of human existence*. Chicago: Rand McNally.
- Bateson, G. (1979). *Mind and nature*. New York: E. P. Dutton.
- Bell, J. M., Wright, L. M., & Watson, W. L. (1992). The medical map is not the territory: "Medical Family Therapy" watch your language. *Families, Systems, and Health, 10*(1), 35-39.
- Bischof, G. H., Lieser, M. L., Taratua, C. G., & Fox, A. D. (2003). Power and gender issues from the voices of medical family therapists. *Journal of Feminist Family Therapy, 15*, p.23-54.
- Blount, A. (Ed.) (1998). *Integrated primary care: The future of medical and mental health collaboration*. New York: Norton
- Brucker, P. S., Faulkner, R. A., Baptist, J., Grames, H., Beckham, L. G., Walsh, S., et al. (2005). The internship training experiences in medical family therapy of doctoral-level marriage and family therapy students. *The American Journal of Family Therapy, 33*, 131-146.
- Burge, B. (2005). Feminist perspectives in medical family therapy (book review). *Australian and New Zealand Journal of Family Therapy, 26*, 175-176.

- Burns, L. H. (1999). Genetics and infertility: Psychosocial issues in reproductive counseling. *Families, Systems, and Health, 17*, 87-110.
- Burwell, S. R., Brucker, P. S., & Shields, C. G. (2006). Attachment behaviors and proximity-seeking in cancer patients and their partners. *Journal of Couple & Relationship Therapy, 5*, 1-16.
- Burwell, S. R., Templeton, B., Kennedy, K. S., & Zak-Hunter, L. (2008). Feminist-informed medical family therapy techniques across biopsychosocial. *Journal of Feminist Family Therapy, 20*, 99-125.
- Campbell, T. L. (2003). The effectiveness of family interventions for physical disorders. *Journal of Marital and Family Therapy, 29*, 263-281.
- Campbell, T. L., & Patterson, J. M. (1995). The effectiveness of family interventions in the treatment of physical illness. *Journal of Marital and Family Therapy, 21*, 545-583.
- Candib, L. M., & Stovall, J. G. (2002). Response to Schirmer and Le. *Families, Systems, and Health, 20*, 311-320.
- Clabby, J., & Howarth, D. (2007). Managing CHF and depression in an elderly patient: Being open to collaborative care. *Families, Systems, and Health, 25*, 457-464.
- Cohen, J. L. (1995). Somatization revisited: A case of migraine headaches. *Family Systems Medicine, 13*, 395-404.
- Collins, R. C., & Kennedy, M. C. (2008). Serving families who have served: Providing family therapy and support in interdisciplinary polytrauma rehabilitation. *Journal of Clinical Psychology, 64*, 993-1008.

- Crane, D. R., Hillin, H. H., & Jakubowski, S. (2005). Costs of treating conduct disorder Medicaid youth with and without family therapy. *The American Journal of Family Therapy, 33*, 281-291.
- Czauderna, J., & Tomson, D. (1994). Family therapy and primary care: Connections and challenges. *Journal of Family Therapy, 16*, 342-345.
- Dankowski, M.E. (2003). An interview with Shobha Pais, PhD. *Journal of Feminist Family Therapy, 15*, 149-164.
- Dankowski, M. E., & Pais, S. (2007). What's love got to do with it? Couples, illness, and MFT. *Journal of Couple & Relationship Therapy, 6*, 31-43.
- Davey, M. P., Duncan, T. M., Foster, J., & Milton, K. (2008). Keeping the family in focus at an HIV/AIDS pediatric clinic. *Families, Systems, and Health, 26*, 350-355.
- Degges-White, S. (2005). Book review: Feminist perspectives in medical family therapy. *The Family Journal, 13*, 236-237.
- Doherty, W. J., McDaniel, S. H., & Hepworth, J. (1994). Medical family therapy: An emerging arena for family therapy. *The Association for Family Therapy, 16*, 31-46.
- Drexel University Online (2010). "Online post masters certificate in medical family therapy"
Retrieved January 18, 2010 from <http://www.drexel.com/online-degrees/nursing-degrees/cert-pm-mft/index.aspx>
- East Carolina University (ECU). (2009) "Doctor of Philosophy in Medical Family Therapy"
Retrieved January 15, 2010 from <http://www.ecu.edu/che/cdfr/phdmft.html>

- Edwards, T. M., & Patterson J. E. (2003). A "Golden Girl" tarnished: Amplifying one patient's (and family's) voice through collaborative care in a family medicine setting. *Journal of Feminist Family Therapy, 15*, 75-88.
- Edwards, T. M. & Patterson, J. E. (2006). Supervising family therapy trainees in primary care medical settings: Context matters. *Journal of Marital and Family Therapy, 32(1)*, 33-43.
- Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196*, 129-136.
- Gawinski, B.A., Edwards, T.M., & Speice, J. (1999). A family therapy internship in a multi-disciplinary healthcare setting: Trainees' and supervisors' reflections. *Journal of Marital and Family Therapy, 25*, 469-484.
- Gellerstedt, M. E., & Mauksch, L. (1993). Chronic neurologic impairment: A family problem. *Family Systems Medicine, 11*, 425-431.
- Grauf-Grounds, C. (2007). Increasing social support to manage chronic illness. In D. Linville & K. M. Hertlein (Eds.), *The therapist's notebook for family health care: Homework, handouts, and activities for individuals, couples, and families coping with illness, loss, and disability*. New York: Haworth Press.
- Grauf-Grounds, C., & Sellers, T. S. (2006). Creating internships and potential jobs for medical family therapists: Lessons learned. *Families, Systems, and Health, 24*, 230-237.
- Harkness, J. L., & Nofziger, A. (1998). Medical family therapy casebook: Training in a collaborative context: What we did not know then...we know now. *Families, Systems, and Health, 16*, 443-450.

- Harrington, A. D., Kimball, T. G., & Bean, R. A. (2009). Families and childhood cancer: An exploration of the observations of a pediatric oncology treatment team. *Families, Systems, and Health, 27*(1), 16-27.
- Hepworth, J., Gavazzi, S. M., Adlin, M. S., & Miller, W. L. (1988). Training for collaboration: Internships for family-therapy students in a medical setting. *Family Systems Medicine, 6*, 69-79.
- Hertlein, K. M. (2003). Reflecting on feminist suggestions and the practice of medical family therapy: One therapist's personal framework. *Journal of Feminist Family Therapy, 15*, 127-136.
- Heru, A., & Berman, E. (2008). Family meetings and integrated patient care. Commentary: Medical family therapy in an inpatient setting. *Families, Systems, and Health, 26*, 181-184.
- Hodgson, J. L., Lamson, A., & Reese, L. (2007). The biopsychosocial-spiritual interview method. In D. Linville & K. M. Hertlein (Eds.), *The therapist's notebook for family health care: Homework, handouts, and activities for individuals, couples, and families coping with illness, loss, and disability*. New York: Haworth Press.
- Institute of Medicine [IOM] (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, D.C.: National Academy Press.
- Jencius, M. (2004). Citizen therapist: An interview with William Doherty. *The Family Journal, 12*, 82-88.
- Knishkowsky, B. (1998). Medical family therapy casebook: Ruth's dizziness. *Families, Systems, and Health, 16*, 325-327.

- Kojima, T. (2006). The development of family therapy in Japanese psychosomatic medicine. *International Congress Series, 1287*, 154-157.
- Lamson, A. L., & Meadors, P. L. (2007). Building your home project. In D. Linville & K. M. Hertlein (Eds.), *The therapist's notebook for family health care: Homework, handouts, and activities for individuals, couples, and families coping with illness, loss, and disability*. New York: Haworth.
- Lask, B., & Matthew, D. (1979). Childhood asthma: A controlled trial of family psychotherapy. *Archives of Disease in Childhood, 54*, 116-119.
- Law, D. D., & Crane, D. R. (2000). The influence of marital and family therapy on health care utilization in a health-maintenance organization. *Journal of Marital and Family Therapy, 26*, 281-291.
- Law, D. D., Crane, D. R., & Berge, J. M. (2003). The influence of individual, marital, and family therapy on high utilizers of health care. *Journal of Marital and Family Therapy, 29*(3), 353-363.
- Leahy, D., Galbreath, L., Powell, R., & Shinn, M. A. (1994). A case of collaboration HMO style. *Family Systems Medicine, 12*, 437-449.
- Liddle, H. A., Breunlin, D. C., & Schwartz, R. C. (1988). Family therapy training and supervision: An introduction. In H. A. Liddle, D. C. Breunlin, & R. C. Schwartz (Eds.), *Handbook of family therapy training and supervision*. New York: Guilford.
- Linville, D., Hertlein, K. M., & Prouty Lyness, A. M. (2007). Medical family therapy: Reflecting on the necessity of collaborative healthcare research. *Families, Systems, and Health, 25*(1), 85-97.

- McDaniel, S. H. (1994). Within-family reproductive technologies as a solution to childlessness due to infertility: Psychological issues and interventions. *Journal of Clinical Psychology in Medical Settings, 1*, 301-308.
- McDaniel, S. H., Campbell, T. L., & Seaburn, D. B. (1990). *Family-oriented primary care: A manual for medical providers*. New York: Springer-Verlag.
- McDaniel, S. H., Campbell, T. L., & Seaburn, D. B. (1995). Principles for Collaboration between health and mental health providers in primary care. *Families Systems Medicine, 13*, 283-298
- McDaniel, S. H., Harkness, J. L., & Epstein, R. M. (2001). Medical family therapy for a woman with end stage Crohn's disease and her son. *The American Journal of Family Therapy, 29*, 375-395.
- McDaniel, S. H., Hepworth, J., & Doherty, W. J. (Eds.). (1992a). *Medical family therapy: A biopsychosocial approach to families with health problems*. New York: BasicBooks.
- McDaniel, S. H., Hepworth, J., & Doherty, W. J. (1992b). Medical family therapy with couples facing infertility. *The American Journal of Family Therapy, 20*, 101-122.
- McDaniel, S. H., Hepworth, J., & Doherty, W. J. (1995). Medical family therapy with somaticizing patients: The co-creation of therapeutic stories. *Family Process, 34*, 349-361.
- McDaniel, S.H., Hepworth, J., & Doherty, W. J. (1999). The shared emotional themes of illness. *Journal of Family Psychotherapy, 10*, 1-8.
- Mercer University School of Medicine, "Master of Family Therapy" (2008). Retrieved January 14, 2010 from

http://medicine.mercer.edu/Introduction/Degree%20Programs/Synapse%20Newsletter/certificate/pm_medical_therapy

Munshower, J. C. (2004). Group visits for diabetic patients: One physician's experience.

Families, Systems, and Health, 22, 497-500.

Navon, S. (2005). Listening to illness/nonillness motifs: A case of fibromyalgia. *Families,*

Systems, and Health, 23, 358-361.

Nova Southeastern University (NSU), "M.S. in Family Therapy" (2009). Retrieved January 10,

2010 from http://shss.nova.edu/programs/certificate/family_systems.htm.

Oberman, A. (2006). Review of feminist perspectives in medical family therapy. *The Family*

Journal, 14, 453.

Patterson, J., Peek, C. J., Heinrich, R. L., Bischoff, R. J., & Scherger, J. (2002). *Mental health*

professionals in medical settings: A primer. New York: Norton.

Peek, C. J., & Heinrich, R. L. (1995). Building a collaborative healthcare organization: From

idea to invention to innovation. *Family Systems Medicine, 13*, 327-342.

Pereira, M. G. & Smith, T. E. (2006). Evolution of the biopsychosocial model in the practice of

family therapy. *International Journal of Clinical & Health Psychology, 6*, 455-467.

Phelps, K.W., Howell, C.D., Hill, S.G., Seeman, T.G., Lamson, A.L., Hodgson, J.L., & Smith,

D. A. (2009). A collaborative care model for patients with Type-2 diabetes. *Families,*

Systems, and Health, 27, 131-141.

Pflaffy, C. (2007). Family-oriented diabetes management: Good nutrition and portion control. In

D. Linville & K. M. Hertlein (Eds.), *The therapist's notebook for family health care:*

Homework, handouts, and activities for individuals, couples, and families coping with

illness, loss, and disability. New York: Haworth.

- Pratt, D. M. (2003). Interview with Dr. Susan McDaniel: Medical family therapy and feminism. *Journal of Feminist Family Therapy, 15*, 137-147.
- Preece, J. C., & Sandberg, J. G. (2005). Family resilience and the management of fibromyalgia: Implications for family therapists. *Contemporary Family Therapy, 27*, 559-576.
- Prouty Lyness, A. M. (2003). Preface: Perspectives in medical family therapy. *Journal of Feminist Family Therapy, 15*, xvii.
- Ragaisis, K. M. (1996). The psychiatric consultation-liaison nurse and medical family therapy. *Clinical Nurse Specialist, 10*, 50-56.
- Robinson, W. D., Barnacle, R. E. S., Pretorius, R., & Paulman, A. (2004). An interdisciplinary student-run diabetes clinic: Reflections on the collaborative training process. *Families, Systems, and Health, 22*, 490-496.
- Rolland, J. S., & Walsh, F. (2005). Systemic training for Healthcare professionals: The Chicago Center for Family Health Approach. *Family Process, 44*, 283-301.
- Rosenberg, M. (2005). Feminist perspectives in medical family therapy (book review). *Families, Systems, and Health, 23*, 113-114.
- Rosenberg, T., Brown, E., & Gawinski, B. (2008). Multidisciplinary intervention for failure to thrive: Casebook. *Families, Systems, and Health, 26*, 365-371.
- Ruddy, N., Farley, T., Nymberg, J., & Hayden, K. (1994). Multiple personality disorder in primary care: A collaboration. *Family Systems Medicine, 12*, 327-338.
- Ruddy, N. B., & McDaniel, S. H. (2003). Medical family therapy. In T. Sexton, G. Weeks, & M.S. Robbins (Eds.), *Handbook of family therapy: The science and practice of working with families and couples*. Bruner-Routledge: New York.

- Schirmer, J. M., & Le, N. H. (2002). The Vietnam Family Medicine Development Project: A cross cultural collaboration. *Families, Systems, and Health, 20*, 303-311.
- Seaburn, D. B., Gawinski, B. A., Harp, J., McDaniel, S. H., Waxman, D., & Shields, C. (1993). Family systems therapy in a primary care medical setting: The Rochester experience. *Journal of Marital and Family Therapy, 19*(2), 177-190.
- Seaburn, D. B., Lorenz, A. D., Gunn Jr., W. B., Gawinski, B. A., & Mauksch, L. B. (1996). *Models of collaboration: A guide for mental health professionals working with health care practitioners*. New York: BasicBooks.
- Seattle Pacific University (SPU) (2010) "Medical Family Therapy Certificate". Retrieved January 15, 2010 from <http://www.spu.edu/depts/spfc/medical/>
- Sellers, T. S. (2000). A model of collaborative healthcare in outpatient medical oncology. *Families, Systems, and Health, 18*, 19-33.
- Shapiro, J. (1993). A book review. *Family Systems Medicine, 11*, 219-221.
- Smith-Lamson, A., & Hodgson, J. (2003). Medical family therapy: From the big screen to a collaborative learning environment. *Journal of Feminist Family Therapy, 15*, 165-169.
- Streicher, P. J. (1995). A suicidal client: The limits of power and control. *Family Systems Medicine, 13*, 91-95.
- Szyndler, J. E., Towns, S., Hoffman, R. C., & Bennett, D. L. (2003). Clinical assessment, management and outcomes of a group of adolescents presenting with complex medico-psychosocial conditions. *Annals Academy of Medicine Singapore, 32*, 51-57.
- The Chicago Center for Family Health (CCFH), "Families, Illness, & Collaborative Healthcare Offerings" (2003). Retrieved January 15, 2010 from <http://www.ccfhchicago.org/families2.html>.

- Thomasgard, M., Boreman, C., & Metz, W. P. (2004). A family under siege: Empathic mirroring and collaborative care. *Families, Systems, and Health*, 22, 245-254.
- Todahl, J. L., Linville, D., Smith, T. E., Barnes, M. F., & Miller, J. K. (2006). A qualitative study of collaborative health care in a primary care setting. *Families, Systems, and Health*, 24, 45-64.
- United States Department of Health and Human Services. (n.d.) *Understanding health information privacy*. Retrieved January 20, 2010, from <http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html>
- University of Nebraska-Lincoln (UNL). (2010). "Child, youth, and family studies" Retrieved January 15, 2010 from <http://cehs.unl.edu/cyaf/grad/mftPhD.shtml>.
- University of Rochester Medical Center (URMC), Department of Psychiatry. (2010). "15th Annual Medical Family Therapy Intensive." Retrieved January 16, 2010 from http://www.urmc.rochester.edu/smd/psych/educ_train/family/MFTI.cfm.
- University of San Diego (USD) (n.d.). "Marital and Family Therapy." Retrieved February, 16, 2008 from http://www.sandiego.edu/soles/programs/marital_and_family_therapy/about_the_program/medical_family_therapy_emphasis.php
- Von Bertalanffy, L. (1986). *General systems theory*. New York: George Braziller.
- Ward, M. R., & Linville, D. (2007). The angry feelings toolbox. In D. Linville & K. M. Hertlein (Eds.), *The therapist's notebook for family health care: Homework, handouts, and activities for individuals, couples, and families coping with illness, loss, and disability*. Haworth Press: New York.

- Weiner, E. L., & Lorenz, A. (1994). Initiation of a behavioral scientist: Lessons from a boy who wouldn't poop. *Family Systems Medicine, 12*, 73-79.
- Weiss, M., & Hepworth, J. (1993). A case for solutions. *Family Systems Medicine, 11*, 297-302.
- Willerton, E., Dankoski, M.E., & Sevilla Martir, J.F. (2008). Medical family therapy: A model for addressing mental health disparities among latinos. *Families, Systems, and Health, 26*, 196-206.
- Wirtberg, I. (2005). Introduction to medical family therapy. *Acta Paediatrica, 94*, 45-46
- Wissow, L. S., Hutton, N., & Kass, N. (2002). Preliminary study of a values-history advance directive interview in a pediatric HIV clinic. *AIDS & Public Policy Journal, 17*, 17-28.
- Wynne. L. C., McDaniel, S. H., & Weber, T. T. (Eds.). (1986). *Systems consultation: A new perspective for family therapy*. New York: Guilford.
- Yeager, B., Auyang, M., Brown, D. L., Dickinson, P., Goldstein, J. A., Jaffe, N., McKay, L., Roche, P., & Workman, G. (1999). MFT student training in medical family therapy: A collaborative hospital project with radiation oncology. *Families, Systems, and Health, 17*, 427-436.

Chapter 3:

The State of Medical Family Therapy: A modified Delphi analysis

Abstract

Medical Family Therapy (MedFT) is a young sub-specialty founded at the intersection of Marriage and Family Therapy and Family Medicine (McDaniel, Hepworth, & Doherty, 1992). Because of its growing professional contributions and recognition in the literature, a need for a current definition and scope of practice on which MedFT training, research and practice is based. The purpose of this study was to reach consensus among MedFT professionals regarding a definition, scope of practice, and characteristics of Medical Family Therapy (MedFT) and its' practitioners. The researcher conducted a Delphi study (Dalkey, 1972) since the Delphi process and outcome can purportedly help move fields of study in a particular direction (Linstone & Turoff, 1975). Results indicated that the sub-discipline of MedFT is viewed by professionals in the field as an orientation that is moving toward a profession, driven by systems theory and the biopsychosocial-spiritual framework, serving an important role within the healthcare system, and has an emerging curriculum that is being driven by academicians and practitioners. Study results identify competencies, specific skills, and guidelines that inform future research directions in MedFT.

Literature Review

Over the past 18 years, scholars and clinicians have contributed to the professional literature on the emerging specialty of Medical Family Therapy (MedFT) (Anderson, Huff, & Hodgson, 2008; Bischoff, Lieser, Taratua, & Fox, 2003; Burwell, Templeton, Kennedy, & Zak-Hunter, 2008; Doherty, McDaniel, & Hepworth, 1994; Harkness & Nofziger, 1998; McDaniel, Hepworth, & Doherty, 1992a; Robinson, Barnacle, Pretorius, & Paulman, 2004). While the research demonstrating MedFT's place in the healthcare system is growing, authors such as Linville, Hertlein, and Prouty Lyness (2007) have noted that advancement of MedFT training requirements, scope of practice, as well as effectiveness and efficacy research requires an agreed upon definition of Medical Family Therapy.

In 1992, McDaniel et al. coined the term, MedFT, to refer to the practice of therapists working with patients and their families who are coping with illness and disease. These therapists adopted a biopsychosocial (BPS) systems perspective and collaborative model of care; however, the growth of MedFT has brought changes to its initial definition and scope of practice. A recent review of the literature (Tyndall, Hodgson, Lamson, Knight, & White, 2010) revealed several recurring MedFT constructs. For example, MedFTs continued to profess allegiance to a BPS perspective (Engel, 1977, 1980), informed by Von Bertalanffy's General Systems Theory (1968) as well as Bateson's idea of circular causality (1979). By combining these theories and

perspectives, MedFTs recognized that the focus of care does not exist solely within the patient, but also within the collaborative interactions between the patient and the healthcare system, the patient and his/her family, and between and among the healthcare providers themselves (e.g., Anderson et al., 2008; Brucker et al., 2005; Burwell et al., 2008; Doherty et al., 1994; Grauf-Grounds & Sellers, 2006; McDaniel et al., 1992a; Willerton, Dankoski, & Martir, 2008). The importance of systemic thinking and the work done by MedFTs has been reported in various case studies over the years (Clabby & Howarth, 2007; McDaniel, Harkness, & Epstein, 2001; Thomasgard, Boreman, & Metz, 2004); but, a large gap in the literature exists that necessitates empirical methods to investigate the efficacy and effectiveness of this work.

The skills of MedFTs are revealed in the literature on collaboration and multi-disciplinary work in healthcare (e.g., Anderson & Winkler, 2006; McDaniel et al., 1992a; Robinson et al., 2004; Ruddy & McDaniel, 2003). Some MedFTs, for example, have adopted the Systems Consultation Model as introduced by Wynne, McDaniel, and Weber (1986), noting that collaboration in medical settings not only improved provider satisfaction (Feierabend & Bartee, 2004; Robinson et al.; Todahl, Linville, Smith, Barnes, & Miller, 2006), but also improved patient outcomes (Earles, 2001; Katon, 1995). Researchers have speculated that positive provider perspectives and patient outcomes were due to MedFTs' skills and training. MedFTs' knowledge and skills aided them in recognizing and bridging the paradigmatic gap between the medical and mental health cultures (Alfuth & Bernard, 2000; Edwards & Patterson, 2006; McDaniel, Campbell, & Seaburn, 1995; McDaniel et al., 1992a; Patterson, Peek, Heinrich, Bischoff, & Scherger, 2002; Seaburn et al., 1993; Seaburn, Lorenz, Gun, Gawinski, & Mauksch, 1996). While such knowledge and skills seem to be common to MedFTs, a standardized curriculum with expected competencies has yet to be established (Tyndall et al., 2010). At the time of this

study, one characteristic that many MedFT training programs shared in common was an immersion experience in a health care setting (East Carolina University, 2009; Seattle Pacific University, 2010; University of Nebraska-Lincoln, 2010).

Internships and fellowships have become the focal point of training MedFTs, allowing students to learn in context how to effectively collaborate with other healthcare professionals. While there have been several established internship sites over the years, such as the University of Rochester (Seaburn et al., 1996), the Chicago Center for Family Health (Rolland & Walsh, 2005), the University of Nebraska (UNL, 2010), University of Connecticut's Family Medicine Program (Hepworth, Gavazzi, Adlin, & Miller, 1988), and the Dartmouth Family Practice Residency at Concord Hospital in New Hampshire (Bill Gunn, personal communication, January 24, 2010), the continuation of optimal internship sites were often dependent on available funding. Training programs embedded within existing family therapy graduate programs varied across medical internship sites, based upon individual students' interests (Grauf-Grounds & Sellers, 2006). This dispersion of MedFTs into a variety of healthcare contexts has enabled more widespread dissemination of information about MedFT, but also has opened the door for greater variance in the scope of practice of MedFT student interns in various healthcare settings.

Since MedFT has only relatively recently been recognized as a mental health specialty, curricula in MedFT professional training programs remain nonstandardized. Without a standardized curriculum, program administrators and faculty members are left to make educated guesses regarding courses that will best prepare students for professional practice in the discipline. As a result, program graduates might present a disparate image of MedFT to an already uncertain healthcare industry. The healthcare system is already cautious about the involvement and funding of mental health professionals in general (Kessler, 2008) and may defer

to the status quo rather than expand their provider panels to include MedFTs. Therefore, communicating clearly and effectively the unique training and strengths that MedFTs bring to a medical setting is as important as the interventions, research, leadership, and program development that such mental health professionals provide.

As interest in MedFT continues to grow, and the parameters of MedFT scope of practice become more clearly delineated, more research will be needed to demonstrate the contributions of MedFT practitioners in the healthcare system. The purpose of this study was to define and identify the scope of MedFT practice. The researchers conducted a Delphi Study (Dalkey, 1972; Linstone & Turoff, 1975) that involved a panel of professionals with MedFT expertise. These experts assisted in constructing an agreed upon definition, scope of practice, and curriculum for MedFT. With this agreed upon definition, MedFT researchers can now begin to create a cohesive body of literature that addresses the role, scope of practice, efficacy, and effectiveness of this sub-specialty. This information will not only broaden MedFTs' employment, reimbursement, and practice opportunities but will help to build a research foundation that is robust, rigorous, and empirically supported.

Method

The Delphi Method

The researchers chose the Delphi Method for this study, as it had purportedly been effective in clarifying positions and moving professions and fields of study in a particular direction (Dalkey, 1972; Linstone & Turoff, 1975). The Delphi Method originated as a way for individuals with a particular shared knowledge and background to come together anonymously (participants blinded to each other) and discuss a topic related to their field of expertise (Dalkey). The method is driven by a goal of obtaining consensus among study participants and has been

characterized as “a method for structuring a group communication process so that the process is effective in allowing a group of individuals, as a whole, to deal with a complex problem” (Linstone & Turoff, 1975, p. 3). In the Delphi design, panelists act independently without direct confrontation by an interviewer (Dalkey & Helmer, 1963) or undue influence by the other participants (Linstone & Turoff).

The standard Delphi technique typically involves three phases of questionnaires, but due to the exploratory nature of this study and potential panelist issues (Stone Fish & Busby, 2005), the researchers utilized a modified Delphi technique that involved two phases of questionnaires (Figley & Nelson, 1989; Godfrey, Haddock, Fisher, & Lund, 2006; Jenkins, 1996; Sori & Sprenkle, 2004; Stone Fish & Osborn, 1992; White & Russell, 1995; White, Edwards, & Russell, 1997). Researchers made this decision to reduce the number of questionnaire rounds in order to avoid a process that quickly becomes too repetitive (Stone Fish & Busby) and to prevent drop out due to participation fatigue. The study was approved by the East Carolina University and Medical Center Institutional Review Board (Appendix B).

Panelists

The purpose of the Delphi methodology in this study was to obtain the informed opinion of those who had extensive expertise in MedFT, thus necessitating a purposive sampling technique (Dalkey, 1972; Jenkins & Smith, 1994; Linstone & Turoff, 1975). The criteria for identifying experts typically includes one or more of the following: number of publications by the expert, years spent teaching the subject, number of professional presentations, type of degree or license held, or years of clinical experience (Blow & Sprenkle, 2001; Dienhart & Avis, 1994; Godfrey et al., 2006; Jenkins, 1996; Sori & Sprenkle, 2004; Stone Fish & Osborn, 1992; White & Russell, 1995). Due to the exploratory nature of this study and the relatively recent appearance

of the field of MedFT, as well as the desire to include clinicians as well as academics, the panelist criteria included one or more of the following: (a) self identification as a MedFT professional, (b) current focus of professional work in a clinical or academic setting as a MedFT, and (c) self identification as a healthcare provider who collaborated with a self-identified MedFT in their professional work. The exclusion criteria were: mental health providers whose professional work involved engagement in collaborative healthcare or integrated care work but who did not self-identify as MedFTs or work collaboratively with a self-described MedFT.

The search for potential panelists began with a review of the academic literature and individuals affiliated with institutions of higher education that offered MedFT academic courses or educational programs. Individuals who met study inclusion criteria were contacted via email and asked to confirm their adherence to the criteria for panelist inclusion and willingness to participate in a Delphi study. Additionally, the researcher sent an email to the Collaborative Family Healthcare Association's (CFHA) membership listserv that included the purpose of the study and criteria for study participation and extended an invitation to eligible professionals to contact the researcher about study participation. CFHA was chosen as an appropriate listserv because of its publication of the journal *Families, Systems, and Health*, and the high number of articles pertinent to MedFTs found in this journal. Since panelists were required to be experts in MedFT, this organization was thought to be the most logical source of possible panelists. Panelists were chosen when they confirmed that they met the study criteria and that they were willing and able to participate in the study.

Once researchers identified study participants, individuals indicated their willingness to participate in the study by reviewing and signing informed consent (Appendix B). As part of the consent process, the researchers retained permission to contact participants during any phase of

process to clarify responses, address discrepancies, and obtain greater depth of insight in a particular response. The researcher maintained anonymity among participants.

Thirty seven panelists met study criteria and completed the first round questionnaire. There were 21 females and 16 males, with an average age of 41 years. Forty three percent (n=16) of panelists held terminal degrees in Marriage and Family Therapy while 30% (n=11) held terminal degrees in Medical Family Therapy (MedFT), 11% held nursing or medical degrees, and 16% held degrees in other areas (3% in Theology, 3% in Clinical Psychology, 10% in Developmental Psychology, Sociology, Education, and Family Studies). The majority of panelists (n=30, 81 %) reported receiving formalized training in MedFT. Approximately 60% of panelists identified themselves as faculty at an academic institution, while 16% were doctoral students. Panelists reported current employment in medical settings, including conducting clinical work in a medical setting (68%), teaching (57%), and research (43%).

Data Collection and Analysis

The researcher initiated data collection after panelists received an email with a link to the first Delphi Questionnaire I (DQ I) via an online questionnaire survey tool. The DQI included 8 open-ended questions and 12 demographic items (Appendix C) and took respondents approximately 30-45 minutes to complete. The panelists could either respond to the link provided or request an individualized link that would allow them to start and stop the survey at will. While the convenience of the tool was helpful in maximizing efficiency in the Delphi process, a small number of panelists who selected the latter option reported difficulty re-accessing the survey. The survey tool also enabled the researcher to send periodic reminders to panelists who had not yet responded to the initial email. A pilot test run of the DQI was conducted with several colleagues who provided vital feedback. The initial distribution of the

DQI occurred in November 2008, with follow up emails sent twice during the subsequent six week period. The eight questions included in the DQ I were as follows:

1a.) How is Medical Family Therapy defined?

1b.) Is MedFT a profession (requiring specific credentials), an orientation (how one views patients/situations), a treatment modality (one of many choices that may or may not be appropriate for a given patient), or a field (a body of knowledge existing more in the public domain, used to supplement a variety of professions) or other ? Or do you believe it is something altogether different? You may use any, all, or none of the possibilities mentioned above in your response.

2.) What is the current scope of practice of MedFT?

3.) What is the current role of MedFTs?

4.) What unique skills, if any, do MedFTs possess as compared to other mental health professionals?

5.) What criteria must be met in order to classify a mental health professional as a MedFT?

6.) In what areas are MedFTs employed?

7.) What core courses, training and field experiences, and core competences (i.e., essential skills) do you believe MedFTs should have successfully completed as part of their MedFT curriculum? Indicate if courses should be taken at the MS or PhD levels by inserting (MS) or (PhD) after each course.

8.) Assume you are reading the results of a research study that purported to be medical family therapy research. How would you know that it is a medical family therapy study, versus some other type of research (family therapy, mental health, biomedical)?

The DQ II was generated from panelists' responses to the DQ I. As Delphi studies are meant to facilitate a conversation among experts (Dalkey, 1972; Linstone & Turoff, 1975), it was important to the researcher to preserve as much of the panelists' original wording as possible in the second round of the process. However, in instances, where panelists' responses were lengthy their responses were divided into shorter statements for ease of rating the statements in the second round.

Panelists generated 600 statements from DQ I. The researcher deleted redundant statements and collapsed the remaining statements into 17 distinct categories. Two additional researchers assisted in this categorization process. A change in category required that all three researchers agree to either eliminate a redundant phrase or follow up with a panelist for clarification on a statement. In three instances, the researcher contacted panelists to clarify their responses. The organization and clarification of statements from the DQ I, revealed a total of 552 items. To avoid panelist fatigue in response to the presence of a large number of items on a second survey, the researchers randomly distributed the items into two separate DQII questionnaires. The primary researcher randomly selected items from each of the 17 categories so that each questionnaire would contain one half of the items in each of the categories. The final DQIIA contained 278 items and the DQIIB contained 274 items.

Concerned that respondents from the same institution might share similar views, the primary researcher first sorted panelists into DQIIA or DQIIB based on institution. When more than one person from a particular institution served as a panelist, these individuals were assigned to DQIIA and DQIIB based on their affiliation with the university (e.g., faculty or student). Panelists not affiliated with a university (e.g., clinicians) were evenly divided among the two groups. A total of 19 panelists were surveyed for DQII A and 18 for DQIIB. Their task was to

rate their level of agreement with the item on a seven point Likert scale, with seven indicating a strong level of agreement and one indicating a strong level of disagreement. Of the 37 panelists who completed the DQ I, 34 completed the DQ II, a response rate of 92%.

Results

Upon receiving the responses from the DQ IIA and DQIIB, the ratings were entered into SPSS version 17.0 and the median and interquartile range (IQR) was calculated for each item. There were 320 out of 552 items in the final profile that fit these statistical parameters. These 320 items were grouped into the five main categories that are discussed below.

In this Delphi study, consensus was determined by an analysis of the median and interquartile range of each survey item. The higher end of the Likert scale indicated the highest level of agreement, while the lower values of the scale indicated disagreement (Stone Fish & Busby, 2005). The interquartile range, a measure of variability, and indicated how much the panelists differed in their responses. A high median indicated a high level of agreement between panelists (Stone Fish & Busby) while a larger IQR demonstrated more dissonance (Stone Fish & Busby). An item that had both a high median and a small IQR indicated that a majority of panelists agreed with the statement. Items from the DQII A and DQII B with a median of six or higher (agree/strongly agree) and an IQR of 1.5 or less were included in the final profile. The number of items included in a category is indicated in parenthesis (i.e., $n = X$). The researcher noted statements that received the highest possible score (median = 7; IQR = 0.0) as this indicated that all panelists agreed that this statement was very important.

In an effort to organize and examine themes in the statements, the researcher analyzed the 320 items (i.e., variables) included in the final profile were analyzed through an inductive process and were categorized into five main categories. Within four of the five categories the

variables were placed into a total of 11 conceptual clusters to increase clarity of the findings. A second researcher reviewed and confirmed the variables' placement into both the conceptual clusters, as well as the placement of those clusters into the five main categories. The results below are organized by the five main categories that reflected the panelists' agreement on the current state of MedFT. The total number of statements within each cluster and category are also noted in Table 1 and Table 2 (Appendix D).

Medical Family Therapy Defined

In effort to construct a definition and an assertion of the current state of MedFT, panelists were asked first to determine if MedFT is a profession, orientation, treatment modality, field, or other. Panelists agreed with a majority of statements (n=6) that MedFT is currently an orientation (i.e. way of thinking and practice) that can be utilized in a variety of healthcare settings. However, panelists approved an additional statement that reflected their agreement that MedFT was a developing profession categorized as a sub-type of family therapy. Lastly, panelists approved the possibility of designating a "MedFT intern status" for students acquiring clinical experience in a healthcare setting.

The overall focus of MedFT also helps clarify its definition. Panelists endorsed the idea that the two main goals of MedFT are still agency and communion (n = 1). While more specific MedFT clinical goals are mentioned throughout the survey, agency and communion were clearly defined as written by McDaniel et al. (1992a) and endorsed by the panelists as the two overarching goals of MedFT. These two meta-goals are a critical part of answer the question, "What is MedFT?"

Panelists also established a definitive theoretical base for MedFT. Their inclusion of five statements in the final profile, reflected strong acknowledgement of the close ties between

MedFT and its parent discipline of Marriage and Family Therapy. One of these statements related directly to the connection between the two fields (e.g., “MedFT is a field that requires a strong base in marriage and family therapy first.”) The remaining four statements more specifically referred to MedFT being an expansion of MFT, but also how this expansion of MFT fits in the healthcare system (e.g., “MedFT is the application of MFT theory in a healthcare setting working with families”). An analysis of the five statements revealed panelists’ belief in the existence of a strong foundational tie between MFT and MedFT.

In terms of the theoretical base of MedFT, panelists agreed on the importance of applying the biopsychosocial-spiritual (BPS-S) model, or a holistic approach, to patient treatment. Panelists agreed with three statements referencing the BPS model; however, one statement actually referenced the model as the “biopsychosocial-spiritual model” while the others did not include the spiritual dimension. Systems theory was also included in the final profile. Again, the inclusion of the BPS model and systems theory but no mention of additional theories, supports the strength and stability of the core MedFT theories as first introduced by McDaniel et al (1992a).

One area that strongly reflected the current state of MedFT was the perceived need for advocacy for the field of MedFT and its place in the healthcare system (n = 4). Panelists agreed that, while MedFT was an inclusive field, it also had its own role that must be made known to the larger healthcare system and to patients as well, “MedFTs role is to teach of the benefits of MedFT, to our patients and other professionals, and to increase visibility of our skill set.” They also reported that the field of MedFT must continue to move forward in terms of licensure and insurance, but was in need of research to provide a supportive evidence base.

The results in this section support many of the original tenets of MedFT as written by McDaniel et al. (1992a), and reflect continued growth when considering the need for advocacy and potentially MedFT as a distinct profession. With the growth of MedFT comes an increasing span for MedFTs' scope of practice in both clinical and non-clinical environments.

Scope of Practice

The scope of practice category was divided into nonclinical and clinical conceptual clusters. The majority of statements were related to MedFTs' clinical scope of practice. The largest number of variable statements (n=11) focused on MedFTs' provision of mental healthcare. In general, these statements addressed MedFTs role in assessing, diagnosing, and treating patients and their families coping with mental health needs. Panelists also endorsed a number of statements (n = 9) referencing the provision of clinical care that involved both mental and physical health needs. Endorsed statements addressed MedFTs' role in bridging the clinical gap between physical and mental healthcare, as well as simply providing psychoeducation to patients and families and helping them adapt to various medical illnesses. Also related to the role of MedFTs with patients and their families, were statements that MedFTs served as ambassadors of patient agency (n = 6). The inclusion of patient agency in the clinical scope of practice reflected its permanency as a foundational element in MedFT. Clinical scope of practice did not stop with patients and their families as panelists indicated consensus about the idea that MedFTs must also be aware of and care for the larger healthcare system. Four variable statements addressed MedFTs' care of the larger system and reflected the idea that care for the larger system also impacts patient care (e.g., "MedFTs role is to nurture and maintain relationships among providers that maximize the care available to patients"). Their responsibilities for the larger system of healthcare as part of the MedFT scope of practice also included the provision of

clinical supervision (n = 2). The MedFT clinical scope of practice reflected collaborative engagement in the healthcare system on all levels.

In the nonclinical cluster, panelists indicated almost equal support for research (n = 5) and teaching (n = 4) for inclusion in the final profile. Two statements in the research subcategory received the highest score possible (median of 7 and an IQR of 0). These two statements were general in nature, and referred to the onus of responsibility for MedFTs to conduct research that is consistent with the three world view in which the triad operational, financial, and clinical elements must be considered when providing care in healthcare settings (Peek & Heinrich, 1995). Panelists also endorsed, though not as strongly, the idea that MedFT research should help establish field efficacy and effectiveness, and address issues associated with health, families, and clinical services.

With respect to teaching, panelists also strongly agreed with the highest level of consensus and agreement (median = 7; IQR = 0) that MedFTs should teach healthcare providers about collaboration and appropriate referral processes. They also endorsed the ability and role expectation for MedFTs to teach a wide variety of audiences, including medical, mental health, and child and family studies' students to established healthcare providers with topics ranging from the BPS perspective to knowing when to collaborate and when to refer. It appears that panelists are calling on MedFTs to serve as leaders in conducting research and, teaching professionals, students, and families about systemic, holistic, and collaborative care.

Two other areas of non-clinical scope of practice included administration and policy making. Consensus among panelists occurred in response to three statements related to administration, reflecting the appropriateness of MedFTs serving as program directors or lead administrators. Of the two statements regarding MedFTs involvement in policy that were

endorsed by the panelists, overwhelming support and agreement (median = 7; IQR = 0.0) occurred relating to the role MedFTs can play in healthcare policy and legislation. As researchers, teachers, lead administrators, and policy makers, the non-clinical scope of practice for MedFTs is wide reaching. While panelists endorsed these nonclinical roles, they were also careful to endorse a general statement recognizing the variations in MedFT scope of practice depending on individual's level of training, certification, and type and level of degrees earned.

Academics and Training

Courses. An inquiry about academic courses that MedFTs should complete during their training, revealed panelists' approval of thirteen content areas. Some panelists indicated the training (masters or doctorate) at which particular courses should be taken, while others offered recommendations for courses of study only in a post-master's training environment.

Field training. Panelists endorsed a total of 22 statements indicating a need for training within medical settings. Three statements, two referencing training at the doctoral level and one referencing an unspecified level of training, reflected the highest possible score (median = 7; IQR = 0.0). These statements generally emphasized the need for supervised practical experience under supervision (i.e., a MedFT internship) in a medical setting.

Research and statistics. Panelists indicated doctoral level training for the greatest number of research and statistics courses (n=7); however, they endorsed four such courses at the master's level. Doctoral courses reflected a greater diversity and sophistication in terms of including entire courses on qualitative research, collaborative care research, and advanced statistics, while master's courses reflected a more basic and general research knowledge base.

Special topics. Overall, the panelists approved 13 courses that would serve to complement a MedFT education. At both the doctoral level and the master's levels, panelists

included courses on sexuality, gender and diversity, and death and dying. At the doctoral level they recommended a course that addressed medical disparities. At the master's level, they identified courses related to community resources and crisis assessment. Substance abuse was included at both the master's and the post-master's level.

Theories. Twelve of the course content areas approved by the panel focused on the theoretical underpinnings of MedFT. Panelists endorsed MedFT theory at the masters (1) and post-masters (1) level but most prevalently at the doctoral level (3). Systems, relational theories, behavioral health, and the BPS-S were only mentioned at the master's (3) and post masters level (3). This led us to assume that at the doctoral level, a MedFT would have already received training in these theories. Health policy theory (1) was endorsed as a course at the doctoral level only.

Ethics. The panelists identified four ethics courses as important at the master's level of study: two general ethics, working within a medical setting, and research ethics. The researchers interpreted panelists' recommendations as the need for students to have completed ethics course prior to enrolling in doctoral level courses.

Families and illness. As a content area, panelists reached consensus that MedFTs at the post-masters level, masters level, and doctoral should take general courses on families and illness (i.e., illness across both the individual and familial developmental cycle and family interactions and dynamics) (n = 13). A statement at the post-masters level reflecting the general necessity of a course on health and families received the highest possible level of endorsement (median = 7; IQR = 0.0).

Marriage and family therapy (MFT). In this content area, panelists strongly agreed with three statements that a MedFT must have training in MFT. With a strong knowledge base in

MFT, the panelists' statements reflected the inclusion of courses more medical in nature, "MedFTs should have all the training one would get to be a family therapist, and then additional courses/training in appropriate medical issues and the related BPS issues that individuals/families face."

Physiology and pharmacology. The panelists endorsed courses on human physiology and pharmacology at all three levels (n=10). Panelists suggested a basic level for these courses so in order to provide MedFTs with a foundation from which they can collaborate with other providers.

Medical culture and collaboration. The final content area included courses that would be essential to the successful function of MedFTs in a medical system (n=9). The courses endorsed by the panelists addressed the importance of learning how to collaborate with medical professionals and work effectively within the medical system. At the doctoral level, panelists endorsed as critical a statement addressing the importance of understanding and relating to physicians (median = 7; IQR = 0.0) in order to collaboratively provide care.

Competencies. Panelists were asked to address the competencies MedFTs should have at the master's and doctoral levels. Some panelists did not indicate the level of training for the competency and so some are considered post-masters level.

Beginning with clinical competencies, the largest content area of competencies was medical culture and collaboration. While there were 18 statements at consensus, 6 reflected the strongest possible findings (median = 7; IQR = 0.0). These six statements included the following: the ability to communicate with providers (n=2), act as a facilitator between providers and patients and their families (n=1), and maintain an awareness of the cultural differences within a medical environment as compared to a traditional therapy setting (n=3).

Continuing on with clinical care, panelists endorsed 17 statements related to MedFTs clinical competencies with patients and their families. The statements that received the highest possible agreement (median = 7; IQR = 0.0) reflected being skilled at systemic therapy, integrative care, empowering patients, general family therapy skills, and being culturally competent. Closely related to clinical skills was treatment planning, which was also approved by the panelists as a necessary competency for prepared MedFTs at all three levels of training.

Panelists agreed that the MedFT foundation of knowledge at both the master's and doctoral levels related to the importance of family therapy and family systems knowledge (n=4). Three of four statements in this area received panelists' strongest endorsement. With family therapy as its base, panelists agreed on four statements related to competency in advanced, applied MedFT. The statements that received the strongest agreement among panelists included those related to levels of collaboration, coordinated/integrated delivery systems/services, and the overlap of medical and mental health problems. Panelists strongly agreed that a doctoral level MedFT should demonstrate the highest level of expertise in applied MedFT concepts.

Additional fundamental competencies at the post-master's level include training in health and relationships, including knowledge of common diseases (n=4), as well as proficiency in using the DSM-IV-TR (n=2). Theoretical competencies (n=7) at the post-masters level that were also included in the final profile included systems theory, the BPS-S model, the three-world view, and the concepts of agency and communion. Panelists also reached consensus on the idea that being competent as a MedFT included being informed and knowledgeable about medical, psychological, social, and spiritual research (n=3).

Panelists also reached consensus on non-clinical competencies. They approved four statements reflecting the importance of MedFTs' ability to educate others about MedFT and capability to

teach systems theory and the BPS-S model. Research competencies were endorsed by panelists at the master's level and doctoral levels. For MedFTs competence in evaluating research was endorsed at the master's level and competence in conducting research was endorsed at the doctoral level.

Lastly, panelists indicated that MedFTs should be competent in self-care (n=2) and making a place for themselves in the healthcare system (n=3). Two statements that reflected MedFT self care were strongly endorsed: encouragement of MedFTs to avoid burn-out and to be aware of their own self-of-provider issues. As MedFTs work to assimilate into a medical system, panelists agreed that they be competent in marketing their skills and creating a niche for themselves. Once in a medical system, panelists agreed that MedFTs should be competent in implementing and managing an integrated care practice model.

Clinical MedFT

Items in the category of clinical MedFT reflected realities of MedFT in practice. Clinical practice essentially merges the academic and applied competencies into a complete picture. The largest cluster of statements (n=15) related to the conceptual base of clinical MedFT. Panelists endorsed statements that indicated family and relationships played a key role in MedFT clinical treatment (n = 4). Among these statements, one that received the highest possible agreement (median = 7; IQR = 0.0) acknowledged MedFTs as skilled in recognizing the role of family and disease and taking a holistic approach to patient care: "Although many providers recognize the role of family in disease and health and take a holistic approach, this seems to be a particular strength of MedFT." Panelists agreed with statements that MedFTs had a systems focus (n = 4), maintained a BPS-S perspective (n = 3), were culturally competent (n = 3), and the included MFT techniques in their practice (n = 1).

Panelists endorsed that MedFTs were able to work in a variety of areas (n = 9) such as clinical work in primary, secondary, and tertiary care settings as well as employment areas such as research and academic programs. Presenting issues for which MedFT may be helpful were also approved by the panel (n = 7). Three of the statements in this cluster reflected the idea that MedFT is helpful for any presenting issue and across many levels of intervention. The inclusion of these statements in the final profile is consistent with the idea presented earlier that MedFT is currently more of an orientation or way of thinking, which would allow them to be useful in a myriad of situations and environments. The presenting issue most heavily endorsed by panelists was chronic illness (median = 7; IQR = 0.0).

Lastly, the panelists completed the clinical picture of MedFTs work by including statements about collaboration (n=9), as well as attributes that led to success in the medical culture (n=4). The strongest agreement (median = 7; IQR = 0.0) was in response to two statements that included many of the theoretical underpinnings of MedFT. These statements highlighted the importance of collaboration with other providers, thinking systemically and viewing patient care through a BPS-S lens. Panelists endorsed four statements that indicated how MedFTs functioned and succeeded in the medical world referencing the attribute of flexibility within the medical system and ability to work as part of a healthcare team.

MedFT Research

The fifth and final response category addressed MedFT research. Three main clusters were included in the final profile. The first cluster involved consensus statements on elements that inform MedFT research [e.g., BPS-S (n=4) and systemic perspectives (n = 4), a focus on families and illness (n = 2), family therapy (n = 3) and collaborative or integrated care (n = 1)].

Panelists also generally believed that research would reference or be consistent with the tenets of MedFT as outlined by McDaniel et al. (1992a) (n = 1).

Panelists achieved consensus that MedFT research would reflect the connections between relationships and health (n = 4). Statements included the importance of improving quality of life for patients coping with illness, as well as examining the effects of the illness on the entire family system. Panelists also agreed that MedFT research should have systemic goals, as well as a focus on health problems and the need for collaborative systemic treatment that keeps the overarching goals of agency and communion in sight (n = 7).

Panelists addressed the implications of MedFT research (n = 4). They approved a statement calling for clinical implications to be included in MedFT research, as well as the role of current research findings in informing future MedFT research. One of the most detailed statements endorsed by panelists for research implications included the idea that MedFT research should paint a holistic portrait of the element of the healthcare system under study, reflecting the BPS-S focus of MedFT. Lastly, panelists agreed that MedFT research should be made applicable to a variety of healthcare providers who may all work together at some point for the sake of the patient and his/her family.

Discussion and Future Research

The goal of this study was to respond to a clear need to cohesively define MedFT (Linville et al., 2007) and to conduct a conversation among its experts to determine its current state and how to improve its future. Through the results of this study MedFT can be defined as an approach to healthcare sourced from a BPS-S perspective and marriage and family therapy, but also informed by systems theory. The practice of MedFT spans a variety of clinical settings with a strong focus on the relationships of the patient and the collaboration between and among

the healthcare providers and the patient. MedFTs are endorsers of patient agency and facilitators of healthy workplace dynamics.

In an effort to arrive at the above definition, the researchers initially ascertained from the panel how they classified MedFT (i.e. profession, orientation, treatment modality or field). The panelists' consensus was that MedFT is currently an orientation with the potential to crystallize into a profession. With MedFT endorsed as an orientation, or a way of thinking, it can be practiced anywhere and is not relegated to a particular medical or mental health context. The choices of orientation and developing profession also speak to the depth of training MedFTs receive as both would require more in depth training (Gawinski, Edwards, & Speice, 1999; Liddle, Breunlin, & Schwartz, 1998; Tyndall et al., 2010). Categorizing MedFT as a treatment modality would lead to a view of MedFT as a tool available for adoption by any profession (Liddle et al.). Clearly, however, this was not how the MedFT experts who comprised this panel viewed the scope of practice. As MedFT continues to develop, information from this study will offer guidance about whether an effort should be made to create a licensed profession, in addition to that of MFT or designate MedFT as a division within MFT its parent field, similar to the inclusion of Health Psychology within the American Psychological Association. It could be argued that creating a MedFT division within the American Association of Marriage and Family Therapy (AAMFT) would lend more credibility and cohesiveness to MedFT practice, as well as broaden and strengthen the contributions of MFT.

Panelists were consistent in their agreement about the existence of strong ties between MFT and MedFT. Clearly, as MedFT training programs develop and faculty plan curricula and practica and internships in medical settings, the profession of MFT should serve as a foundation for decision making related to training content. These results were not surprising since a heavy

proportion of the panel were marriage and family therapists. However, the tie between MedFT and MFT can be found in the origins of MedFT. As stated by the authors of the MedFT textbook, "...the strategies and techniques (of MedFT) are intended primarily for therapists who are fully trained in family systems therapy." (McDaniel et al., 1992a, p. xviii). Likewise, MFT programs should recognize designated MedFT degree granting programs, coursework, and readings, as critical in the development of a MFT to becoming a MedFT at the master's, post-master's, or doctoral level. While those holding licensure in other mental health and medical fields may become trained in MedFT, panelists agreed about the clear need for a solid foundation of knowledge and skills in MFT theories, interventions, and research.

Panelists overwhelmingly agreed on the inclusion of a BPS-S perspective and systems theory as theoretical underpinnings of MedFT. McDaniel et al (1992a) first described MedFTs as therapists who specialized in integrating BPS and systems theory perspectives. This initial definition of MedFTs, and the focus of their work evolved to include the spiritual dimension (Hodgson, Lamson, & Reese; Katerndahl, 2008; Onarecker & Sterling, 1995; f et al., 2009; Wright, Watson, & Bell, 1992). While at times it seemed that BPS and BPS-S were used interchangeably throughout panelists' statements, the spiritual component was included more often than it was left out. This frequent inclusion of spirituality within the BPS perspective, suggests that trainers, clinicians, and supervisors should address spirituality in their curriculum.

McDaniel et al. (1992a) outlined the earliest goals of MedFT as promoting agency and communion. According to panelists, both of these concepts remain relevant. With special regard to the idea of agency, panelists agreed about the importance of MedFTs as patient advocates and as those who can empower patients to be in charge of their healthcare. While much of the literature on collaboration has focused on collaboration between and among healthcare providers

(Brucker & Shields, 2003; Doherty, 1995; McDaniel et al., 1992a; Seaburn et al., 1996), the panelists from this study asserted that MedFTs must advocate for the patient and his/her as partners in the collaborative process of healthcare planning and decision-making and as active participants in their healthcare.

One of the strongest findings from this study was the importance of MedFTs being skilled collaborators. Panelists called on MedFTs to integrate themselves into the medical environment, supporting providers in their efforts, and acting as bridges between the medical and psychological dimensions of health in an effort to improve the quality of patient care and the inclusion of families in such care. McDaniel et al.'s primer text first mentioned collaboration as an important skill for MedFTs (1992a), and it continues to be noted as a critical skill throughout the literature (Tyndall et al., 2010). Panelists suggested that training in the art and science of collaboration should be at the forefront of MedFT education and clinical supervision.

To be an effective collaborator, MedFTs must be comfortable educating themselves and be well versed in other disciplines' research and literature. When interacting in a clinical position, MedFTs should be current on relevant research, not only from the social sciences perspective, but also from the perspective of other healthcare professions. In fact, panelists agreed that MedFT programs should include basic human physiology and pharmacology in the curriculum. The exposure to medical courses helps students learn how to communicate with healthcare professionals thereby reducing misinterpretations of the spoken and written language. Additionally, MedFT core competencies included medical knowledge and collaboration, but also hold MedFTs accountable for competencies ranging from general therapy skills to self-care and implementing an integrated care business plan.

The last theme to extend throughout the results of this study was that of MedFTs as facilitators of healthy workplace dynamics in the healthcare system. MedFTs, with their systemic and BPS-S perspective (Brucker et al., 2005; Grauf-Grounds & Sellers, 2006; McDaniel et al., 1992a), are in a position to be meta-observers of and interventionists in the medical system as a whole (Meadors & Lamson, 2008). More attention should be given to the impact MedFTs have on working with and caring for patients as well as the provider systems.

The results of this study echoed some of the earliest writings on MedFT (Doherty et al., 1994; McDaniel et al., 1992a; Shapiro, 1993) but it also illuminated new directions for MedFT as a developing profession. In 2007, Linville et al. defined MedFT, while stating the need to determine a consistent agreed upon definition. They referenced MedFT as an approach to healthcare that was informed by a BPS-S perspective and by systems theory. In their definition, the practice of MedFT could span a variety of clinical settings. This observation has been supported by these study findings. In MedFT focus is on the relationships of the patient and the collaboration between and among the healthcare providers and the patient. It is safe to say that Linville et al.'s definition continues to be supported. However, based on findings from this study, MedFTs as endorsers of patient agency and facilitators for healthy workplace dynamics in the healthcare system needs to be added to the scope of practice in order to present a current and comprehensive definition. Embedded within this definition are variables in need of future study

These findings provide some parameters and directions for MedFT research. For example, being sure to include a systems and/or BPS-S perspective when conducting interventions and examining the connection between health and relationships in primary, secondary, and tertiary care settings. MedFT research should examine the many systemic processes in healthcare, for example the relationships between and among patients and their

families as well as those relational processes that exist among the healthcare providers. Additionally, MedFT research should include an examination of collaborative and integrated healthcare, while also addressing the role of MedFT in caring for these healthcare systems. Researchers should examine and determine the effectiveness of MedFT coursework for its students and eventually their experience in the workforce, thereby making a significant contribution to the profession of MedFT and America's healthcare system.

Limitations

This study was not without its limitations. The inclusion of eight questions in the first survey led to a very large number of items for the second survey. As a result, even when divided into two surveys, the second survey was very lengthy and made have led panelists to tire and answer quickly toward the end of the survey. Delphi studies are generally used to provide broad suggestions rather than specifics (Godfrey et al., 2006), this study simply scratches the surface and helps lead MedFT in a general direction. In fact, several of the questions in the first survey could have served as one Delphi study all its own. Additionally, as is typical with Delphi studies, individual viewpoints were likely sacrificed in search of the goal of consensus (Stone Fish & Busby, 2005). Lastly, due to the nature of a Delphi study the sample is purposive, however with only 19% of the 37 panelists having terminal degrees from fields other than MFT and MedFT, the panelists were very similar in their educational backgrounds possibly leading to a lack of diversity.

Summary

The results from this study will help cement a path for MedFT clinicians, academicians, and researchers. All three contingencies must work together so that researchers are studying and testing relevant clinical interventions, clinicians are drawing on these evidence-based

interventions for their practice, and academicians are training students in the competencies needed to both conduct MedFT research and practice effectively. With a cohesive and agreed upon definition in place, the sub-discipline can move forward in a more coherent manner that will allow MedFTs to better serve patients and families, as well as clarify their unique contributions in the existing healthcare system.

References

- Alfuth, R., & Barnard, C. P. (2000). Family physicians and family therapists: Understanding the interdependent synergism. *Contemporary Family Therapy, 22*(3), 253-277.
- Anderson, F. J., & Winkler, A. E. (2006). Benefits of long-term fibromyalgia syndrome treatment with a multi-disciplinary program. *Journal of Musculoskeletal Pain, 14*, 11-25.
- Anderson, R., Huff, N., & Hodgson, J. (2008). Medical family therapy in an inpatient psychiatric setting. *Families, Systems, and Health, 26*, 164-180.
- Bateson, G. (1979). *Mind and nature*. New York: E. P. Dutton.
- Bischof, G. H., Lieser, M. L., Taratua, C. G., & Fox, A. D. (2003). Power and gender issues from the voices of medical family therapists. *Journal of Feminist Family Therapy, 15*, p.23-54.
- Blow, A. J., & Sprenkle, D. H. (2001). Common factors across theories of marriage and family therapy: A modified Delphi study. *Journal of Marital and Family Therapy, 27*(3), 385-401.
- Brucker, P.S., & Shields, C.G. (2003). Collaboration between mental and medical healthcare providers in an integrated primary care center medical setting. *Families, Systems, and Health, 21*, 181-191.
- Brucker, P. S., Faulkner, R. A., Baptist, J., Grames, H., Beckham, L. G., Walsh, S., et al. (2005). The internship training experiences in medical family therapy of doctoral-level marriage and family therapy students. *The American Journal of Family Therapy, 33*, 131-146.

- Burwell, S. R., Templeton, B., Kennedy, K. S., & Zak-Hunter, L. (2008). Feminist-informed medical family therapy techniques across biopsychosocial. *Journal of Feminist Family Therapy, 20*, 99-125.
- Clabby, J., & Howarth, D. (2007). Managing CHF and depression in an elderly patient: Being open to collaborative care. *Families, Systems, and Health, 25*, 457-464.
- Dalkey, N. (1972). *Studies in the quality of life*. Lexington, MA: Lexington Books.
- Dalkey, N., & Helmer, O. (1963). An experimental application of the Delphi method to the use of experts. *Management Science, 9*, 458-467.
- Dienhart, A., & Avis, J. M. (1994). Working with men in family therapy: An exploratory study. *Journal of Marital and Family Therapy, 20*(4), start page 397. Retrieved July 21, 2008, from ProQuest database.
- Doherty, W. J. (1995). The why's and levels of collaboration. *Families, Systems, and Medicine, 13*, 275-281.
- Doherty, W. J., McDaniel, S. H., & Hepworth, J. (1994). Medical family therapy: An emerging arena for family therapy. *The Association for Family Therapy, 16*, 31-46.
- Earles, J.E. (2001). Interdisciplinary treatment of diabetes mellitus in a military treatment facility. *Military Medicine, 166*, 848-852.
- East Carolina University (ECU). (2009) "Doctor of Philosophy in Medical Family Therapy"
Retrieved January 15, 2010 from <http://www.ecu.edu/che/cdfr/phdmft.html>.
- Edwards, T. M. & Patterson, J. E. (2006). Supervising family therapy trainees in primary care medical settings: Context matters. *Journal of Marital and Family Therapy, 32*(1), 33-43.
- Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196*, 129-136.

- Engel, G. L. (1980). The clinical application of the biopsychosocial model. *American Journal of Psychiatry, 137*, 535-544.
- Feierabend, R. H., & Bartee, Z. L. (2004). A collaborative relationship between a community mental health center and family practice program. *Families, Systems, and Health, 22*, 231-237.
- Figley, C. R., & Nelson, T. S. (1989). Basic family therapy skills: I. Conceptualization and initial findings. *Journal of Marital and Family Therapy, 15*, 349-365.
- Gawinski, B. A., Edwards, T. M., & Speice, J. (1999). A family therapy internship in a multidisciplinary healthcare setting: Trainees' and supervisor's reflections. *Journal of Marital and Family Therapy, 25*, 469-484.
- Godfrey, K., Haddock, S. A., Fisher, A., & Lund, L. (2006). Essential components of curricula for preparing therapists to work effectively with lesbian, gay, and bisexual clients: A Delphi study. *Journal of Marital and Family Therapy, 32*, 491-504.
- Grauf-Grounds, C., & Sellers, T. S. (2006). Creating internships and potential jobs for medical family therapists: Lessons learned. *Families, Systems, and Health, 24*, 230-237.
- Harkness, J. L., & Nofziger, A. (1998). Medical family therapy casebook: Training in a collaborative context: What we did not know then...we know now. *Families, Systems, and Health, 16*, 443-450.
- Hepworth, J., Gavazzi, S. M., Adlin, M. S., & Miller, W. L. (1988). Training for collaboration: Internships for family-therapy students in a medical setting. *Family Systems Medicine: A journal at the confluence of family therapy, systems theory, modern medicine, 6*, 69-79.
- Hodgson, J. L., Lamson, A., & Reese, L. (2007). The biopsychosocial-spiritual interview method. In D. Linville & K. M. Hertlein (Eds.), *The therapist's notebook for family*

- health care: Homework, handouts, and activities for individuals, couples, and families coping with illness, loss, and disability.* Haworth Press: New York.
- Jenkins, D. (1996). A reflecting team approach to family therapy: A Delphi study. *Journal of Marital and Family Therapy*, 22, 219-238.
- Jenkins, D. A., & Smith, T. E. (1994). Applying Delphi methodology in family therapy research. *Contemporary Family Therapy*, 16, 411-430.
- Katon, W. (1995). Collaborative care: Patient satisfaction, outcomes, and medical cost-offset. *Family Systems Medicine*, 13, 351-365.
- Kessler, R. (2008). Integration of care is about money too: The health and behavior codes as a new element of a new financial paradigm. *Families, Systems, and Health*, 26, 207-216.
- Katerndahl, D. A. (2008). Impact of spiritual symptoms and their interactions on health services and life satisfaction. *Annals of Family Medicine*, 6, 412-420.
- Liddle, H. A., Breunlin, D. C., & Schwartz, R. C. (1988). Family therapy training and supervision: An introduction. In H. A. Liddle, D. C. Breunlin, & R. C. Schwartz (Eds.), *Handbook of family therapy training and supervision*. New York: Guilford.
- Linstone, H. A., & Turoff, M. (1975). Introduction. In H. A. Linstone & M. Turoff (Eds.), *The Delphi method: Techniques and applications* (pp. 1-14), Reading, MA: Addison-Wesley.
- Linville, D., Hertlein, K. M., & Prouty Lyness, A. M. (2007). Medical family therapy: Reflecting on the necessity of collaborative healthcare research. *Families, Systems, and Health*, 25(1), 85-97.
- McDaniel, S. H., Campbell, T. L., & Seaburn, D. B. (1995). Principles for collaboration between health and mental health providers in primary care. *Families Systems Medicine*, 13, 283-298

- McDaniel, S. H., Harkness, J. L., & Epstein, R. M. (2001). Medical family therapy for a woman with end stage Crohn's disease and her son. *The American Journal of Family Therapy*, 29, 375-395.
- McDaniel, S. H., Hepworth, J., & Doherty, W. J. (Eds.). (1992a). Medical family therapy: A biopsychosocial approach to families with health problems. New York: BasicBooks.
- Meadors, P., & Lamson, A. (2008). Compassion fatigue and secondary traumatization: Provider self care on intensive care units for children. *Journal of Pediatric Health Care*, 22, 24-34.
- Onarecker, C. D., & Sterling, B.C. (1995). Addressing your patient's spiritual needs. *Family Practice Management*, 2,44-49.
- Patterson, J., Peek, C. J., Heinrich, R. L., Bischoff, R. J., & Scherger, J. (2002). *Mental health professionals in medical settings: A primer*. New York: W. W. Norton & Company.
- Peek, C. J., & Heinrich, R. L. (1995). Building a collaborative healthcare organization: From idea to invention to innovation. *Family Systems Medicine*, 13, 327-342.
- Robinson, W. D., Barnacle, R. E. S., Pretorius, R., & Paulman, A. (2004). An interdisciplinary student-run diabetes clinic: Reflections on the collaborative training process. *Families, Systems, and Health*, 22, 490-496.
- Rolland, J. S., & Walsh, F. (2005). Systemic training for Healthcare professionals: The Chicago Center for Family Health Approach, *Family Process*, 44, 283-301.
- Ruddy, N. B., & McDaniel, S. H (2003). Medical family therapy. In T. L. Sexton, G. R. Weeks, & M. S. Robbins (Eds.), *Handbook of family therapy: The science and practice of working with families and couples*. (pp. 365-379). New York: Bruner-Routledge.

- Seaburn, D. B., Gawinski, B. A., Harp, J., McDaniel, S. H., Waxman, D., & Shields, C. (1993). Family systems therapy in a primary care medical setting: The Rochester experience. *Journal of Marital and Family Therapy, 19*(2), 177-190.
- Seaburn, D. B., Lorenz, A. D., Gunn Jr., W. B., Gawinski, B. A., & Mauksch, L. B. (1996). *Models of collaboration: A guide for mental health professionals workign with health care practitioners*. New York: BasicBooks.
- Seattle Pacific University (SPU) (2010) "Medical Family Therapy Certificate". Retrieved January 15, 2010 from <http://www.spu.edu/depts/spfc/medical/>.
- Shapiro, J. (1993). A book review. *Family Systems Medicine, 11*, 219-221.
- Sori, C. F., & Sprenkle, D. H. (2004). Training family therapists to work with children and families: A modified Delphi study. *Journal of Marital and Family Thearpy, 30*, 479-496.
- Stone Fish, L. S., & Busby, D. (2005). The Delphi method. In D. H. Sprenkle & F. P. Piercy (Eds.) *Research methods in family therapy* (pp.238-253). New York: Guilford Press.
- Stone Fish, L., & Osborn, J. L. (1992). Therapists' view of family life: A Delphi study, *Family Relations, 41*, 409-416.
- Thomasgard, M., Boreman, C., & Metz, W. P. (2004). A family under siege: Empathic mirroring and collaborative care. *Families, Systems, and Health, 22*, 245-254.
- Todahl, J. L., Linville, D., Smith, T. E., Barnes, M. F., & Miller, J. K. (2006). A qualitative study of collaborative health care in a primary care setting. *Families, Systems, and Health, 24*, 45-64.
- Tyndall, L., Hodgson, J., Lamson, A., Knight, S., & White, M. (2010). *Operationalizing medical family therapy: Building a case for consensus*. Unpublished manuscript.

University of Nebraska-Lincoln (UNL). (2010). "Child, youth, and family studies" Retrieved January 15, 2010 from <http://cehs.unl.edu/cyaf/grad/mftPhD.shtml>.

Von Bertalanffy, L. (1986). *General systems theory*. New York: George Braziller.

White, M. B., & Russell, C. S. (1995). The essential elements of supervisory systems: A modified Delphi study. *Journal of Marital and Family Therapy*, 21, 33-53

White, M. B., Edwards, S. A., & Russell, C. S. (1997). The essential elements of successful MFT a modified Delphi study. *The American Journal of Family Therapy*, 25, 213-231.

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

Bell, J. M., Wright, L. M., & Watson, W. L. (1992). The medical map is not the territory: "Medical Family Therapy" watch your language. *Families, Systems, and Health*, 10(1), 35-39.

Wynne. L. C., McDaniel, S. H., & Weber, T. T. (Eds.). (1986). *Systems consultation: A new perspective for family therapy*. New York: Guilford Press.

Appendix A

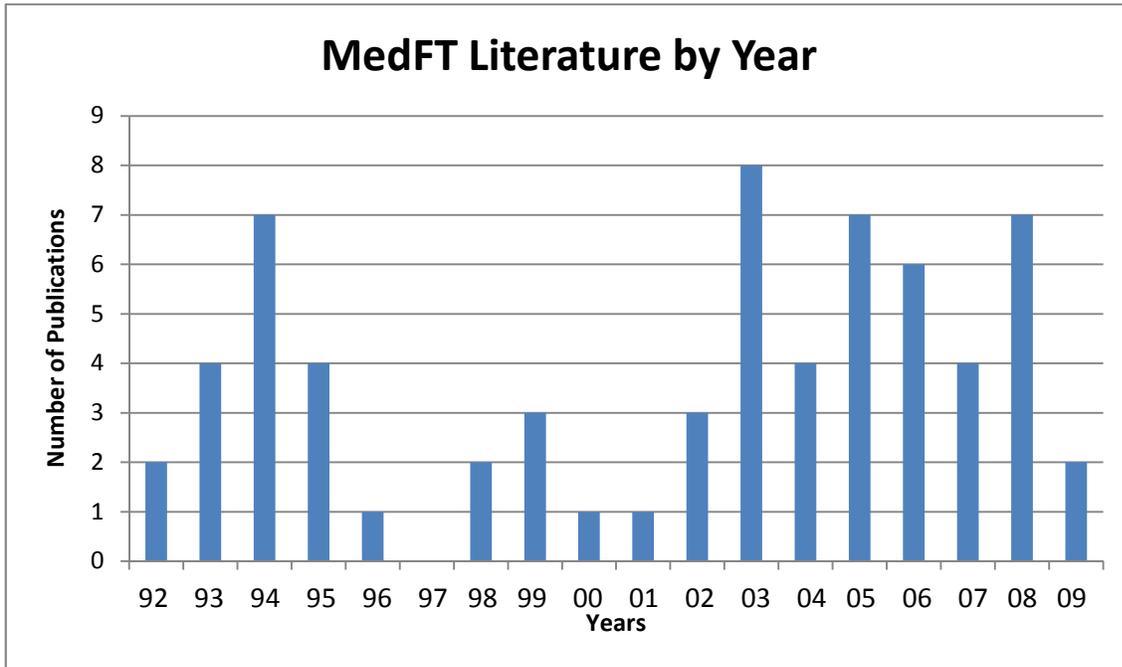


Figure 1

Appendix B



University and Medical Center Institutional Review Board
East Carolina University
Ed Warren Life Sciences Building • 600 Moyer Boulevard • LSB 104 • Greenville, NC 27834
Office 252-744-2914 • Fax 252-744-2284 • www.ecu.edu/irb
Chair and Director of Biomedical IRB: L. Wiley Nifong, MD
Chair and Director of Behavioral and Social Science IRB: Susan L. McCammon, PhD

FILE COPY

FAKED
11-18-08

MAILED
11-18-08

TO: Lisa Tyndall, MS, Department of CDFR, ECU, 150 Rivers Building
FROM: UMCIRB JTC
DATE: November 17, 2008
RE: Expedited Category Research Study
TITLE: "The State of Medical Family Therapy: A Modified Delphi Study"

UMCIRB #08-0688

This research study has undergone review and approval using expedited review on 11/13/08. This research study is eligible for review under an expedited category because it is research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. (NOTE: Some research in this category may be exempt from the HHS regulations for the protection of human subjects. 45 CFR 46.101(b)(2) and (b)(3). This listing refers only to research that is not exempt.). The reviewer deemed this **unfunded** study **no more than minimal risk** requiring a continuing review in **12 months**. Changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must submit a continuing review/closure application to the UMCIRB prior to the date of study expiration. The investigator must adhere to all reporting requirements for this study.

The above referenced research study has been given approval for the period of **11/13/08 to 11/12/09**. The approval includes the following items:

- Internal Processing Form
- Informed Consent
- Demographics Questionnaire
- Delphi Questionnaire (DQ 1)
- COI disclosure form
- Invitation letter (dated 11/10/08)

The reviewer does not have a potential for conflict of interest on this study.

The UMCIRB applies 45 CFR 46, Subparts A-D, to all research reviewed by the UMCIRB regardless of the funding source. 21 CFR 50 and 21 CFR 56 are applied to all research studies under the Food and Drug Administration regulation. The UMCIRB follows applicable International Conference on Harmonisation Good Clinical Practice guidelines.



University and Medical Center Institutional Review Board
East Carolina University • Brody School of Medicine
600 Moye Boulevard • Old Health Sciences Library, Room 1L-09 • Greenville, NC 27834
Office 252-744-2914 • Fax 252-744-2284 • www.ecu.edu/irb
Chair and Director of Biomedical IRB: L. Wiley Nifong, MD
Chair and Director of Behavioral and Social Science IRB: Susan L. McCammon, PhD

FILE COPY

TO: Lisa Tyndall, MS, CDFR, ECU
FROM: UMCIRB *JD*
DATE: October 16, 2009
RE: Expedited Continuing Review of a Research Study
TITLE: "The State of Medical Family Therapy: A Modified Delphi Study"

E-MAILED
10-16-09

MAILED
10-16-09

UMCIRB #08-0688

The above referenced research study was initially reviewed and approved by expedited review on 11/13/08. This research study has undergone a subsequent continuing review using expedited review on 10/13/09. This research study is eligible for expedited review because it is research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. (NOTE: Some research in this category may be exempt from the HHS regulations for the protection of human subjects. 45 CFR 46.101(b)(2) and (b)(3). This listing refers only to research that is not exempt.) The Chairperson (or designee) deemed this **unfunded** study **no more than minimal risk** requiring a continuing review in **12 months**. Changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must submit a continuing review/closure application to the UMCIRB prior to the date of study expiration. The investigator must adhere to all reporting requirements for this study.

The above referenced research study has been given approval for the period of **10/13/09** to **10/12/10**. The approval includes the following items:

- Continuing Review Form (dated 10/8/09)
- Informed Consent
- Protocol Summary

The Chairperson (or designee) does not have a conflict of interest on this study.

The UMCIRB applies 45 CFR 46, Subparts A-D, to all research reviewed by the UMCIRB regardless of the funding source. 21 CFR 50 and 21 CFR 56 are applied to all research studies under the Food and Drug Administration regulation. The UMCIRB follows applicable International Conference on Harmonisation Good Clinical Practice guidelines.

CONSENT DOCUMENT

Title of Research Study: The State of Medical Family Therapy: A Modified Delphi Study
Principal Investigator: Lisa Tyndall, MS and Jennifer Hodgson, PhD
Institution: East Carolina University
Address: 150 Rivers Building, Family Therapy Clinic, Greenville, NC 27858
Telephone #: 252-737-1415

INTRODUCTION

You have been asked to participate in a research study being conducted by Lisa Tyndall, MS and Jennifer Hodgson, PhD. This purpose of the research study is to survey those professionals with expertise in the field of Medical Family Therapy (MedFT) to come to a consensus of a working definition and scope of practice for MedFTs from which to base future research. A modified Delphi study will be conducted, with the use of two rounds of questionnaires. The sample will be purposive as panelists must have experience in the field of MedFT in order to participate.

PLAN AND PROCEDURES

Participants will be recruited through several different mechanisms. Primarily, participants will be recruited via e-mail, in person at professional conferences, or phone. Potential participants will then receive an email with an invitation letter to participate and the option to complete the survey through the direct link provided in that email to the online survey tool Survey Monkey or to respond to the investigator to receive an individualized link that will direct them to Survey Monkey. If a participant chooses to have an individualized link, he or she will have the ability to complete the questionnaire at different times. However, if the participant chooses to access the direct link in the invitation email, the survey must be completed at the time they initiate the survey. Upon connecting to either link, participants will have the opportunity to read over the informed consent and fill out the demographics questionnaire and the first of two Delphi questionnaires. If participants choose to first view the questions and answer them in a Word document, they will be able to copy and paste these answers into the survey. Follow up phone calls or emails may be made to encourage participation in both phases of the study. Additionally, we will ask potential participants to let us know of any other possible participants in a snowballing sampling technique. Lastly, a general e-mail through the Collaborative Family Healthcare Association's listserv, will be sent out asking for anyone who might be interested to respond and send an email to the primary investigators so that they may send an invitation email. The initial questionnaire should not take longer than 30-45 minutes and responding to the second questionnaire through the online survey tool will take approximately 30 minutes.

POTENTIAL RISKS AND DISCOMFORTS

There are no anticipated harmful effects either physically, psychologically, socially, or spiritually. Through a series of open ended questions on the first questionnaire and a rating of responses on a likert scale on the second questionnaire, this study will ask the participant to define and describe the process of Medical Family Therapy and how they interpret its scope of practice.

FROM: JENNIFER HODGSON
APPROVED: JENNIFER HODGSON
DATE: 11/15/08

POTENTIAL BENEFITS

Benefits to participants and others include increased knowledge and understanding of the definition, process, and scope of practice common to Medical Family Therapy. Additionally, the study will provide a foundation for future research on Medical Family Therapy as a formalized definition for it will assist in its operationalization. Lastly, this study will help increase the knowledge base of Medical Family Therapy for dissemination to healthcare providers, funding entities, and educational programs training MedFTs.

SUBJECT PRIVACY AND CONFIDENTIALITY OF RECORDS

Contents of e-mail and other forms of written communication will be stored in a password protected Word document in the possession of Lisa Tyndall. All participants who respond to the e-mail will be de-identified.

COSTS OF PARTICIPATION

There are no foreseen costs of participating.

COMPENSATION

Participants will not receive monetary compensation; however, there are benefits to participating as stated above.

VOLUNTARY PARTICIPATION

Participating in this study is voluntary. If you decide not to be in this study after it has already started, you may stop at any time without losing benefits that you should normally receive. You may stop at any time you choose without penalty and your identity will remain anonymous.

PERSONS TO CONTACT WITH QUESTIONS

The investigators will be available to answer any questions concerning this research, now or in the future. You may contact the investigators, Lisa Tyndall, MS (252-412-3488) or Jennifer Hodgson, PhD (252-258-4224) days, nights, and weekends. If you have questions about your rights as a research subject, you may call the Chair of the University and Medical Center Institutional Review Board at phone number 252-744-2914.

CONSENT TO PARTICIPATE

Title of research study: The State of Medical Family Therapy: A Modified Delphi Study

I have read all of the above information, asked questions and have received satisfactory answers in areas I did not understand. I know that I may stop participating at any time or decline any question that I would not like to answer, and that I may withdraw my consent and my data at any time. I also understand that unless I request otherwise, my name will not be associated with the research findings. By proceeding with the questionnaires and marking the yes box below in this online survey tool, you are giving your consent to participate.

UNMC IRB
APPROVED
11-15-05
TO

Appendix C

Demographics Questionnaire

The following information is important to better understanding the results of our study. Even if you choose not to participate in the full Delphi study, it would still be helpful to have you fill out this brief demographics questionnaire.

1.) Please indicate your name and contact information.

Name
Company
Address
City/Town
State
Zip
Country
Email Address
Phone Number

2.) What is your age? _____

3.) Sex Male Female Other

4.) Please select your highest degree.

Drop down list will be provided with the following choices:

MS
MSW
M.Th.
M. Div
Ph.D.
Ed.D.
Psy. D.
D. Min
D. Th.
M.D.
J. D.

Other, please indicate in box below

5.) Field within which you received that degree. (Drop down menu with the following)

Medical Family Therapy
Marriage and Family Therapy
Clinical Psychology
Health Psychology
Nursing
Social Work

Medical
Psychiatry
Law
Theology
Other, please explain in box below

6.) Have you received a certificate or any formal training in Medical Family Therapy? For example, this might include certificates, workshops, institutes, degrees, as well as internships.

Yes

No

7.) What license(s) do you current hold (click on one or more of the following options provided in Survey Monkey, options to be LMFT, LCSW, LPC, MD, PA, RN, NP, LPN, Other, please specify)

8.) What is your current occupation? _____

9.) Please indicate the percentage of time you spend doing the following in your current job as well as the number of years you have been professionally active in that category.

_____ % _____ Teaching
_____ % _____ Clinical Supervision
_____ % _____ Conducting Therapy
_____ % _____ Research & Writing
_____ % _____ Administrative
_____ % _____ Other, please indicate in box below

10.) Please check any of the following that apply to your current professional work
_____ Clinical work within a medical setting
_____ Clinical work separate from a medical setting
_____ Teaching within a medical school
_____ Teaching within a nonmedical school
_____ Research in a medical setting
_____ Research in a nonmedical setting
_____ Other, please indicate in box below.

11.) If teaching is a part of your current professional work, please indicate what courses you are teaching that relate to Medical Family Therapy.

12.) Please indicate the number of articles, books, chapters and/or presentations you have published regarding Medical Family Therapy.

Appendix D

Table 1

Variables Included in the MedFT Profile

MedFT Defined N = 22	Scope of Practice N = 49	Clinical N = 45	Research N = 26
Professional Status	Non-Clinical	Foundational	Informed By
Orientation 6	Research 5	Clinical Concepts 15	BPSS 4
Developing Profession 1	Teaching 4	Locale 9	Systemic Processes 4
Intern-status 1	Policy Making 2	Presenting Issues 7	Family Therapy Concepts 3
Focus & Goals	Administration 3	Collaboration 9	Families & Illness 2
Agency & Communion 1			
Theoretical Base	Scope is training dependant 1	How to Succeed in Medical World 4	Collaborative/Integrated Care 1
MFT 5			
BPSS 3	Clinical Provision of mental healthcare 11	PhD not needed for good clinical work 1	MedFT Tenets 1
Systems theory 1	Provision of clinical care, mental & physical 9		Goals Relationships & Health 4
MedFT Advocacy 4	Ambassadors of patient agency 6		Systemic Goals 1
	Larger systems care 4		Populations with health presentations 1
	Supervision 2		Agency/Communion 1
			Implications Clinical 1
			BPSS portrait 1
			Future research 1
			Wide Audience 1

Table 2

Academics/Training Variables in MedFT Profile								
N = 178								
	Courses (N = 101)				Competencies (N = 77)			
	PhD	MS	PM		PhD	MS	PM	
Field Training	12	6	4	Medical Culture and Collaboration	1	3	14	
Family & Illness	5	8	3	Therapy Skills	-	-	17	
Special Topics	5	7	1	Theoretical Base	-	-	7	
Research/Stats	7	4	-	Knowledge of Health/Relationships	-	-	4	
Physiology/Pharmacology	2	3	5	Knowledge of Diseases	-	-	4	
Medical Culture and Collaboration	4	3	2	Family Systems Knowledge	1	2	1	
Systems/Relational Theories	-	3	3	Teaching	-	-	4	
MedFT Theory	3	1	1	BPSS/Applied MedFT	3	-	1	
Ethics	-	4	-	Evidence Base	-	-	3	
MFT Training	-	3	-	Self-care	-	-	2	
Health Policy	1	-	-	Treatment Planning	1	1	1	
Behavioral Health Theory	-	1	-	Administration	-	-	3	
				Self-care	1	1	-	
				DSM Knowledge	-	-	2	

Appendix E

Dissertation Proposal

Introduction

Medical Family Therapy (MedFT) has the potential to play a significant role in changing America's ailing healthcare system; however, research must be conducted to substantiate this growing sub-specialty. It cannot be denied that the American healthcare system is in a state of disrepair. Patients, providers, insurance companies, politicians, and citizens in general are calling for change. The Institute of Medicine (IOM) has published numerous reports, such as *Crossing the Quality Chasm* (2001), with long-term strategic goals for improvement. In 2001, the IOM set forth six aims that would help heal the ailing system and MedFT appears to be positioned well to help achieve those aims. However, as MedFT is a relatively young mental health specialization, it is necessary to first establish a concrete definition of and scope of practice for MedFT and to conduct more MedFT-based efficacy and effectiveness studies.

MedFT emerged from its parent discipline of marriage and family therapy (MFT) (McDaniel, Hepworth, & Doherty, 1992a). With MFT rooted in systems theory (Von Bertalanffy, 1968), MedFT extended the understanding of families and their systems to be included into the healthcare system. McDaniel et al. coined the term, MedFT, to refer to the practice of therapists working with patients and their families who are coping with illness, who follow a biopsychosocial systems perspective and collaborative model of care. At its inception, MedFT naturally paired with family medicine since both were focused on acknowledging the patient and his or her family in the context of illness or disability and the larger healthcare system (McDaniel et al.). Since then, MedFT has expanded to include working with a variety of medical specialties (Patterson, 2002).

According to McDaniel et al. (1992a), MedFT is rooted in several core models and theories. First, the biopsychosocial model (Engel, 1977) is critical to MedFT as it endorses interrelatedness between the mind and body, mending the 20th century mind-body split. MedFTs built upon the biopsychosocial model by incorporating Von Bertalanffy's General Systems Theory (GST) (1968). GST acknowledges that the whole is more than the sum of its parts. For example, it is used to appreciate how it takes the entire body to heal a wounded part. It is the whole person within a larger system who must be treated, rather than the body or system labeled with the pathology.

Examining interactions among and between the patient, family members, and members of their healthcare team, MedFTs embraced the unique skill of nurturing the whole system (Sellers, 2000). As they are working with these various systems, MedFTs bring the systems together with various models of collaboration and put the ideas of systems and circular causality into action (Anderson, Huff, & Hodgson, 2008; Doherty, McDaniel, & Hepworth, 1994; McDaniel, Harkness, & Epstein, 2001; McDaniel et al., 1992a). They focus on the interaction among and between all of the systems. No entity in healthcare exists in isolation and most MedFTs are trained to recognize and intervene accordingly. Most healthcare disciplines focus exclusively on their particular specialty, thus excluding the voices of the other disciplines, their patients, and/or support persons (e.g., family), and forgetting about the self of provider and the importance of psychosocial data in the healing process.

There has been an undeniable growth and interest in MedFT since its creation in the early 1990s. From the original definition offered by McDaniel et al. (1992a), several professional training programs and authors have contributed to that definition and changed the intensity of emphasis on various elements, for example collaboration and spirituality. Originally, McDaniel

et al.'s definition of MedFT included working with patients and their families with an illness through a biopsychosocial lens, while also collaborating with other health professionals. While collaboration seemed an integral part of the original definition for a time, it was labeled as a strategy rather than incorporation as an integral part of the definition of MedFT (Doherty, McDaniel, & Hepworth, 1994). With the development of other training programs, the component of spirituality was integrated into the definition of MedFT (East Carolina University [ECU]; Seattle Pacific University [SPU], 2008), however not all MedFT programs include a spirituality component. Most recently, Linville, Hertlein, and Prouty-Lyness (2007) authored what appears to be the most inclusive definition of MedFT to date. Their definition includes the elements of not only the biopsychosocial lens, but also spirituality, systems theory, the importance of interpersonal relationships, as well as collaboration among the family members and healthcare providers.

Statement of the Problem

While the growth of MedFT is encouraging, it creates some of the same problems that other emerging sub-specialties might encounter. Noticeable differences exist in six of the published definitions of MedFT (ECU, 2006; Linville, Hertlein, & Prouty Lyness, 2007; McDaniel et al., 1992a; Doherty, McDaniel, & Hepworth, 1994; Mercer University School of Medicine [MUSM], 2004; SPU, 2008). For example, the inclusion of spirituality is only noted in half of the aforementioned definitions (ECU; Linville et al.; SPU). Moreover, neither a standardized curriculum, nor a level of certification or a specific set of interventions characterizes the preparation of MedFTs. Some argue that supervising a MedFT in a medical setting requires a different theoretical lens and skill set (Edwards & Patterson, 2006; Gawinski,

Edwards, & Speice, 1999). If students are not being trained to integrate knowledge and practice differently in healthcare settings, their likelihood for clinical and professional may diminish.

As it stands currently, clinicians may call themselves a MedFT regardless of their level of training. For example, a graduate of a week-long institute at the University of Rochester may call him or herself a MedFT, as would a master's student from the University of San Diego, but their level of training and how they view their qualifications may be vastly different. Currently, there are seven training programs in the United States and they vary from a three day institute to a doctoral program (ECU, 2006; MUSM, 2004; Nova Southeastern University [NSU], 2007; Rolland & Walsh, 2005; SPU, 2006; University of Nebraska Medical Center [UNMC], 2008; University of Rochester Medical Center [URMC], 2008; University of San Diego [USD], 2008). These training programs differ in length as well as in curriculum. To date, no individual or professional organization has identified a core set of skills that MedFTs should develop to competency before beginning to practice independently.

As Liddle, Breunlin, and Schwartz (1988) illustrated for marriage and family therapy, MedFT may be viewed differently by different professionals, for example one may see it as a profession requiring specific credentials or as a body of knowledge that exists more in the public domain from which a variety of other professions may use to supplement their work. MedFT is a sub-specialty in and of itself with a set of skills that, if deconstructed and used without attention to structure, process, interaction, and culture, may be less effective (Anderson et al., 2008). The question of which category MedFT falls into, body of knowledge, orientation, or profession, has ramifications for how the practice of MedFT is regulated, accredited, and formally incorporated into the healthcare system. As the interest in MedFT has grown steadily, we must be able to concretely define its boundaries, foundational theory, common interventions, evolution, and

identify professional preparation competencies and standards. It will also be important that MedFTs know how to enter and be sustainable in primary, secondary, and tertiary care settings according to the three world view which requires us to consider the operational, administrative, and clinical worlds when making changes in the healthcare system and policy (Peek & Heinrich, 1995). And finally, at the base of these changes, is the need for evidence-based research that demonstrates the utility and necessity for MedFT to be involved at all levels of the healthcare system.

Plan for Proposed Study

The aim of this proposed study is to survey those with expertise in Medical Family Therapy for the purpose of developing an agreed upon definition of MedFT, its current scope of practice, and training curriculum through a modified Delphi study (Dalkey, 1972). In addition to seeking a definition and scope of practice, participants will also be asked to classify MedFT as a profession, orientation, treatment method, or body of knowledge (Liddle, 1988). To examine the utility of MedFT, panelists will be asked what they perceive MedFTs role in healthcare to be. To begin to clarify the definition of MedFT, panelists will consider how MedFTs differ from other mental health professionals, and the unique skills needed to practice within this sub-specialty. Responses to the aforementioned questions will assist in evaluating the current state of MedFT and constructing a definition from which future MedFT education, clinical practice, and research can be launched.

The Delphi survey method is designed to bring together experts within a particular field. for the purpose of gathering data about that discipline. A panel of participants with expertise in MedFT will be recruited. They will be asked to complete two rounds of Delphi questionnaires via an online survey tool. Potential panelists will be emailed a link to the study site where they

will first complete an informed consent, a demographics questionnaire and then the first Delphi questionnaire (DQ I). The DQ I will include eight open-ended questions. The responses to those questions will be aggregated and returned to each panelist for them to rate on an interval scale indicating their level of importance and only those that fit within specific statistical parameters will be included.

This study is critical to MedFT academicians, clinicians, supervisors, scholars, and policy makers. The study will provide academicians with an understanding of the knowledge and skills that should be included in the core curriculum. The results of this study will also help academicians and budding MedFT clinicians know where to focus their research studies and clinical work. It will provide already practicing MedFTs with a more cohesive identity and this cohesive identity may translate into the formal development of MedFT perhaps with its own division in the American Association of Marriage and Family Therapy (AAMFT), AAMFT's code of ethics, academic accreditation process, billing and reimbursement codes, and licensure. With the results of this study, supervisors and educators will have a better understanding of how to teach and mentor those MedFTs already practicing in the field, providing them with concrete recommendations rooted in research about their unique value, skills, and professional distinction. Healthcare policy makers of all backgrounds will likely benefit from an increased understanding of the importance of collaboration throughout the system, making changes that benefit not only the patients but healthcare providers as well.

Upon graduating from various training programs, MedFTs can seek employment in a wide variety of practice settings. While it seems that a significant amount of the focus of those working, researching, and practicing MedFT has been on primary care, in particular family medicine (e.g., Brucker et al., 2005; Burgess-Manning, 2007; Edwards & Patterson, 2006),

others have written about healthcare specialty and sub-specialty services where MedFTs are making a positive impact on patient and system outcomes (Anderson et al., 2008; Doherty, 2007; McDaniel, Hepworth, & Doherty, 1992b; Robinson, Barnacle, Pretorius, & Paulman, 2004). With a rapid expansion in the interest in MedFT has come the need to conduct research illustrating the effectiveness and efficacy of MedFT (Linville et al., 2007). However, MedFT, due to its systemic focus, faces some of the same measurable outcome challenges as its parent field, Marriage and Family Therapy (Kazak, 2002). However, without measurable outcomes and widely recognized descriptives, advocating for the hiring, billing, and reimbursement of MedFT in healthcare settings, as well as making changes at the policy and administrative levels, (Kessler, 2008) will remain a challenge.

Review of the Literature

Many people in the western world seem to have awakened to the idea of the mind-body connection, in particular how the mind can help heal the body. George Engel's (1977) groundbreaking biopsychosocial model challenged us to think about healthcare from a holistic perspective. While Engel called for a merging of the biological, psychological, and social dimensions of care, the idea was initially met with some initial opposition. Mental health providers were leery of involving themselves with their clients' biological issues, and most biomedically-oriented physicians felt it was neither their role to be involved with their patients' mental health nor within their expertise to manage it (Seaburn et al., 1993). However, with comprehensive training in systems theory, research, and application, the mental health discipline of marriage and family therapy was well suited to begin to bridge the mind-body divide through the development of a sub-specialty, Medical Family Therapy.

In the early 1990s, Susan McDaniel, Jeri Hepworth and William Doherty (1992a) labeled those family therapists who specialized in integrating a biopsychosocial and systems perspective as, “medical family therapists.” Over time an influx of researchers, clinicians, training programs, institutes, and organizations have endorsed medical family therapy (MedFT) as part of their mission. The preponderance of literature recognizes MedFT as a fast growing sub-specialty within its parent field of marriage and family therapy (MFT). However, with advancements in research, theory, and practice related to MedFT, the definition and scope of practice needs formalization.

Definitions of MedFT vary in the degree of inclusion of specific elements of practice. In the seminal text, *Medical Family Therapy: A Biopsychosocial Approach to Families with Health Problems*, (McDaniel et al., 1992a, p.2) defined MedFT as the, “biopsychosocial treatment of individuals and families who are dealing with medical problems. As we conceptualize it, MedFT works from a biopsychosocial systems model and actively encourages collaboration between therapists and other health professionals.” In a journal article introducing MedFT two years later, the same group of authors (Doherty et al., 1994), defined it as a sub-specialty of family therapy in a more abbreviated way, “We propose that medical family therapy brings a biopsychosocial systems perspective to the treatment of individuals and their families, a perspective that is unavailable in any established area of psychotherapy” (p. 33). The authors viewed collaboration as an essential strategy but did not include it in their 1994 definition. The definitions of MedFT offered by several professional preparation programs, including those associated with East Carolina University (ECU), Seattle Pacific (SPU), and Mercer University, also differ. East Carolina University, for example, included the component of spirituality:

Medical family therapy offers a systemic, approach to psychotherapy with patients and families experiencing a medical illness, trauma, or disability. Its theoretical foundation and clinical expertise is based upon the field of family therapy. Medical family therapists address issues from a relational and systemic perspective through the incorporation of a biopsychosocial-spiritual approach. (ECU, 2006, ¶3)

Similar to ECU, SPU (2006) framed MedFT as, “the interplay of all components of a person's life and health ~ the biomedical, psychological, relational, and spiritual” (SPU, 2008, ¶1) but did not directly mention the influence of the family therapy field or systems theory. Mercer University specified MedFT as having a family therapy and collaborative focus, but did not include mention of spirituality or systems theory in their definition:

The Primary Mission of this program is to equip family therapists to work confidently and collaboratively with physicians and other healthcare providers in addressing the unique psychosocial problems of individuals, couples and families with acute and chronic medically related concerns. (MUSM, 2004, ¶1)

In 2007, authors Linville et al. defined MedFT inclusively as an approach to healthcare from a biopsychosocial-spiritual perspective, informed by systems theory, spanning across a variety of clinical settings where, “The patient’s interpersonal relationships are believed to play a key role, and collaboration exists between the family therapist and other healthcare practitioners” (p. 86).

Along with varying definitions of MedFT, the question arises above whether or not MedFT is considered a body of knowledge, a treatment method, an overall orientation, or a separate profession. Will a clinician be able to practice and research MedFT if he or she is simply utilizing a few MedFT techniques, or will MedFT become a profession with an identity of its own? Liddle, Breunlin, and Schwartz (1988) first referenced this issue with regard to family

therapy. They asserted that family therapy is often seen through each of these lenses by different groups of people. The differences in these lenses may affect the type and depth of training a student receives in family therapy and therefore those individuals calling themselves family therapists may be more different than alike.

Current definitions of MedFT (ECU, 2006; SPU, 2008; MUSM, 2004) are broadly similar with differences in their use of terms such as biopsychosocial, biopsychosocial-spiritual, collaboration, systems theory, family therapy, and healthcare. One might also argue that these different institutions view MedFT through Liddle, Breunlin, and Schwartz's (1988) different lenses, resulting in different perspectives on the professional training needed to become a MedFT. As a result, students are enrolling in training programs with the same name, but may not be leaving with the same skills and foundational knowledge. Deconstructing the theoretical conceptualizations included in the aforementioned definitions is critical to understanding the professional preparation programs' intentions.

Theoretical Conceptualizations. Among MedFTs, recognizing the connection among the biological, psychological, and social systems appears to be central. Engel argued that linear thinking in healthcare had become so ingrained in our culture that it has reached the dogma status (1977). Providers worked primarily to identify organic causes for illnesses and minimized or did not consider the influences of psychosocial variables. Concern about psychosocial influences is critical in healthcare provision, as MedFTs Doherty et al. (1994) asserted, "all human problems are biopsychosocial systems problems. There are no psychosocial problems without biological features, and there are no biomedical problems without psychosocial features" (1994, p. 34).

In the early 1980s, Engel's biopsychosocial model was incorporated into the training of family physicians. As McDaniel et al. (1992a) noted, texts such as *Working with the Family in Primary Care* (Christie-Seely, 1984), *The Family in Medical Practice: A Family Systems Primer* (Crouch & Roberts, 1987), *Family Therapy and Family Medicine: Towards the Primary Care of Families* (Doherty & Baird, 1983), and *Family-oriented Primary Care: A Manual for Medical Providers* (McDaniel, Campbell, & Seaburn, 1990) served as resources for this training. At the same time, Doherty et al. (1994) challenged therapists to step back and consider if their focus on the psychosocial was just as myopic as those who adhered strictly to the biomedical paradigm.

While other disciplines have incorporated the idea of a biopsychosocial perspective, it was MedFTs who uniquely combined it with systems theory. Von Bertalanffy, a biologist, introduced the idea of General Systems Theory (GST), and defined being able to view a system as more than the sum of its parts (1968). In addition to GST, anthropologist, social scientist, linguist, and cyberneticist, Gregory Bateson, built on these concepts with his descriptions of circular causality (1979). He eschewed the idea of linearity and introduced the idea of examining the interactions and the meanings behind the interactions to effect change. His was a radically different perspective from that of the biomedical linear model where a problem was identified and a cause was determined. Both of these concepts, GST and circular causality, translate well into MedFT where elements of the system do not exist solely with the patient, but also in the collaborative interactions between the patient and the healthcare system, the patient and his/her family, and between and among the healthcare providers themselves (Brucker et al., 2005).

MedFT is grounded in the research, theory, and application of collaborative models of care (McDaniel et al., 1992a; Ruddy & McDaniel, 2003) that involve providers, patients, families, and other members of influential larger systems. In reality, implementation of

collaboration typically has been multidisciplinary (different disciplines working together) rather than interdisciplinary (different disciplines involved in the work). Pioneering behavioral medicine scholars, MedFTs, and family medicine physicians argued that in order to treat the whole person they must encourage the different disciplines to engage in multidisciplinary efforts (Blount, 1998; Doherty, McDaniel, & Baird, 1996; McDaniel et al.; Patterson et al, 2002.; Seaburn & Lorenz et al., 1996).

Collaboration can mean different things to different providers as there is still a struggle to reach an agreed upon definition of this practice strategy (Blount, 1998; Blount, 2003; Todahl, Linville, Smith, Barnes, & Miller, 2006). However, researchers have shown the benefits of collaboration when the goal among providers is to strategize and communicate on behalf of improved patient care (Todahl et al.). While providers have used the biopsychosocial model to treat the whole person, and systems thinking to address the interrelated systems involved, collaboration helps marry these two concepts and has become foundational for the practice of MedFT.

Lastly, MedFTs theoretical aim has been to improve patients' overall healthcare experiences through their contributions toward two overarching goals: encouraging agency and communion (McDaniel et al., 1992a; Seaburn & Lorenz et al., 1996). Agency is a concept originated by Bakan (1969) that, when applied in a healthcare setting, refers to a patient's personal choices in dealing with illness and the healthcare system (McDaniel et al.). Communion is defined as a uniting of people including both familial and community support that can surround a patient during their illness (McDaniel et al.). Seaburn and Lorenz et al. referenced various ways that clinicians can incorporate agency and communion into their practices, including helping patients and families determine the areas where they have the most influence

in their healthcare and helping families better communicate across generations about illness. In the practice of MedFT both of these concepts help the clinician empower patients to take an active role in their healing process.

Integrating Mental Health in Biomedical Settings

Since its inception in the late 1980s (Ruddy & McDaniel, 2003), MedFT has been practiced and studied largely in academic settings (Doherty, 2007). The birthplace for MedFT was Family Medicine (McDaniel et al., 1992a), where the family was readily acknowledged as part of the patient system. McDaniel et al. observed that MedFT has since expanded into other primary, secondary, and tertiary care settings. Today MedFTs practice in a wide diversity of healthcare settings (Patterson et al., 2002).

The advancements that other mental health disciplines have made in the healthcare context have been helpful to MedFTs in practice strategies as well as empirical support. Psychologists, for example, have worked in medical settings since the 1950s, studying the impact of psychosocial issues on physical health. They have made exceptional contributions to the literature in areas such as smoking cessation, depression, anxiety, and the importance of the physician-patient relationship (Callahan, 1997). However, psychologists and MedFTs differ in that psychologists traditionally are not trained to practice from a family systems perspective, and are limited in their experience of working concurrently with more than one family member in the room (Linville et al., 2007).

Social Work has a long history in the medical field. With the first social work position in the United States in 1905, social workers have become integral to healthcare service provision in medical settings (Beder, 2006). Social workers in a medical context often strive to help patients be viewed in the context of a larger social system, including the family, social network, and

governmental policy (Cowles, 2000; Gehlert & Brown, 2006). However, managed care has had a strong impact on the tasks of medical social workers, including an increase in their primary roles as discharge planners as well as case managers and utilization reviewers (Beder; Gehlert & Brown). With discharge planning as one of their primary roles, medical social workers differ from MedFTs in that MedFTs' primary purpose and training when working with patients is typically to provide therapy and work collaboratively with patients' families and their healthcare providers.

Interestingly, the first social worker was actually trained as a nurse (Beder, 2006), which is another profession that has studied the connection between the psychosocial and biological dimensions of health. Psychiatric nurses are specifically trained to address the gap and relationship between the mind and the body. According to the American Psychiatric Nurses Association website (n.d.) there are two levels of psychiatric nursing, one that involves registered nurses working with patients, families, and communities to address mental health needs and nurse practitioners with graduate degrees who serve to, "assess, diagnose, and treat individuals or families with psychiatric problems/disorders or the potential for such disorders" (APNA, about PMHNS, ¶1). Roles for psychiatric mental health nurse practitioners (PMHNP) vary according to setting and differ based on the needs of the population and the area served (Wheeler & Haber, 2004). PMHNPs work in a variety of settings including hospitals, outpatient mental health settings, long-term care placements, and primary care offices (Wheeler & Haber). PMHNPs are able to prescribe medications and sometimes act in lieu of a psychiatrist. However, as of 2004, few educational programs provide nurses with training in psychotherapy (Wheeler & Haber). This lack of training in therapy for PMHNPs is a key difference between their scope of practice and that of MedFTs.

The American Counseling Association (ACA) currently stands as the central association for professional counselors and counselor educators with its own code of ethics recently updated in 2005 (ACA, 2008). Counseling draws from the field of education, where most of their training programs are housed, and despite the apparent conflicted history between these two disciplines (Hanna & Bemak, 1997). In a recent review of literature, interviews with senior counseling professionals revealed a desire to focus on normal and healthy development, steering away from pathologizing clients and moving toward including preventative care (Gale & Austin, 2003). Based on their close connections to the fields of education and psychology, counselors appear to lack experience and training in providing systems theory and working with patients and families experiencing health crises.

Pastoral Counseling, with its emphasis on spirituality, is a profession that plays a role in healthcare settings. The American Association of Pastoral Counseling (AAPC), the organization through which pastoral counselors receive certification, has been in existence since 1963. Standards for certification include a minimum of a master's level theological, biblical studies, or pastoral counseling degree, endorsement for ministry by a religious body, as well as 375 hours of pastoral counseling and 125 hours of supervision (AAPC, 2008). Pastoral counselors aim to work with individuals, couples, and families to combine psychotherapy and spiritual resources. While spirituality is declared by some training programs to be part of the definition of MedFT, the inclusion of this element has yet to be clarified. However it does not appear that training in working alongside healthcare professionals, or in systems theory is a part of pastoral counseling education.

Mental health practitioners from a variety of disciplines have long worked in medical settings, but despite this history, the biomedical and psychosocial worlds have remained distinct.

Professions such as nursing, health psychology and medical social work have much to offer patients as members of healthcare teams. The difference among these mental health professions and MedFT, however lies in the systems theory foundation and the clinical training to work simultaneously with multiple healthcare systems, all of which MedFTs receive (Linville et al., 2007; McDaniel et al., 1992a). However, there are exceptions to what is noted above and there are professionals from disciplines other than MedFT who practice from a systems oriented perspective. Dr. Susan McDaniel, family psychologist and co-author of the primer text in MedFT exemplifies the incorporation of a systems orientation in professional practice. This intention of this review is not to create a hierarchy among mental health providers but to elucidate the unique strengths of MedFTs for the purpose of defining and describing this rapidly emerging sub-specialty.

Growth of Medical Family Therapy

Beginning largely in primary care (McDaniel et al., 1992a), the scope of MedFT has broadened to include working within secondary and tertiary inpatient and outpatient settings such as psychiatry, hospice care, families with chronic illness, oncology, women's health, rheumatology, and infertility (McDaniel & Hepworth, 1992; SPU). In a recent article, MedFT pioneer Bill Doherty (2007) called for family therapists to be more involved in central healthcare issues such as: obesity, diabetes mellitus type II, Alzheimer's, end-of-life care and genetics. Doherty stated that obesity and diabetes are two conditions that can be effectively improved with behavioral modification, in which MedFTs can be helpful. Doherty also asserts that MedFTs can be helpful with this families by exploring the inner workings of the family systems that maintain these harmful behavioral patterns. Alzheimer's and end-of-life care present tremendous strain on the family in terms of caregiving. As baby boomers age, Doherty predicted an increase in

families coping with these conditions. Both situations heighten emotions, and MedFTs are able to help families successfully navigate these emotions. Additionally, genetics counseling is a relatively uncharted territory where MedFTs may be effective in helping families navigate potentially painful situations (Miller, McDaniel, Rolland, & Fleetham, 2006; Rolland & Williams, 2005; Smith & Harkness, 2003). With genetic counseling, families will be armed with knowledge about an illness before the illness itself occurs, and potentially even before the baby is born. MedFTs are trained to help the patient cope with the results of genetic testing, as well as the ramifications of the diagnosis on the rest of the family system.

While there seems to be more reports of MedFTs practicing clinically, there has also been a growth in MedFT academic literature. Since the emergence of three publications in 1992 regarding MedFT (Bell, Wright, & Watson, 1992; McDaniel et al., 1992a; McDaniel et al., 1992b), the presence of MedFT in the literature has increased. In seeking to determine the number of MedFT-focused articles and other publications, a literature search was conducted using several databases. Academic Search Premier, ProQuest, Psychological and Behavioral Sciences, PubMed, PsycInfo, PsycArticles and EBSCO were searched using the terms “Medical Family Therapy” and inclusive of all years. Quotations were placed around the phrase “Medical Family Therapy” and it was searched through use of the “all text” function because the authors were specifically interested in publications that referenced that particular phrase. The search criteria was limited to those articles with MedFT in the title or abstract. Additionally, through a manual search, earlier articles were found that were included in a designated section of *Family Systems Medicine* entitled, “Medical Family Therapy Casebook.” There were several articles that mentioned MedFT in the discussion or reference list, however these did not fit the search criteria. Also excluded were articles that included aspects of MedFT but did not specifically use the term

MedFT. A total of 62 articles fit the search criteria and the number of publications per year are illustrated in Figure 1 (Appendix A).

The growth of MedFTs assuming positions in healthcare contexts can be examined in several different ways. While clinicians were already practicing in the field in the late 1980s (Ruddy & McDaniel, 2003), in the early 1990s authors introduced the concept of MedFT (Doherty et al., 1994). They debated its naming and contributions to healthcare (Bell et al., 1992; Czauderna & Tomson, 1994; Lask, 1994). Some contended that the title “Medical Family Therapy” was dismissive of the contributions of other professions such as nursing and social work and served to potentially further isolate the professions rather than foster a sense of collaboration (Bell et al.). Other authors questioned the idea that MedFT was a new concept as it had been practiced in the United Kingdom prior to being formerly named as MedFT (Czauderna & Tomson; Lask). McDaniel et al.’s primer text, *Medical Family Therapy* was published in 1992. A written review of it followed one year later in the journal of *Adolescence* (Anonymous, 1993) as well as in the journal of *Families, Systems, Medicine* (Shapiro, 1993). The reviews indicated that MedFT would be helpful in working toward caring for patients in a more personal and holistic manner. Since that time, authors and researchers have applied MedFT constructs in a variety of settings and with a variety of illnesses and disabilities.

The clinical application of MedFT with infertility issues was one of the earliest published in academic journals (McDaniel et al., 1992b). Its authors (McDaniel et al., 1992a) also wrote the first textbook for MedFT. Another first was the increasing prevalence of articles in a section of the journal, *Families Systems Medicine* (renamed later as *Families, Systems and Health*). This section was entitled, *Medical Family Therapy Casebook* (Cohen, 1995, Gellerstedt & Mauksch, 1993; Knishkowsky, 1998; Leahy, Galbreath, Powell, & Shinn, 1994; Rudd, Farley, Nymberg, &

Hayden, 1994; Weiner & Lorenz, 1994; Weiss & Hepworth, 1993). Articles in this special section included case studies of particular patient conditions such as multiple personality disorder (Rudd et al.), neurologic impairments (Gellerstedt & Mauksch), somatization (Cohen), as well as challenging cases (Knishkowsky), and lessons in integration and collaboration of services (Weiner & Lorenz). Soon thereafter, authors from MedFT and other disciplines began publishing case examples (Streicher, 1995) as well as using MedFT as a technique (Ragaisis, 1996). The literature landscape was soon dotted with articles on how to implement MedFT programs and develop cross training experiences with medical professionals (Harkness & Nofziger, 1998; Yeager et al., 1999).

In the early 2000s, the MedFT literature began to include theoretical perspectives on practice and more examples of clinical success. Case studies remained popular (McDaniel et al., 2001) and MedFT techniques were developed during this time to assist families in their navigation of difficult decisions such as advance-care planning (Wissow, Hutton, & Kass, 2002). In 2003, *Feminist Perspectives in Medical Family Therapy* was published jointly as a book and as a volume in the *Journal of Feminist Family Therapy*. In this publication, several authors used the term “Medical Family Therapy” in their title or abstract (Bischof, Lieser, Taratua, & Fox, 2003; Dankoski, Pais, Zoppi, & Kramer, 2003; Edwards & Patterson, 2003; Hertlein, 2003; Pratt, 2003; Prouty Lyness, 2003; Smith-Lamson & Hodgson, 2003). This compilation of journal articles signified an increasing interest in MedFT as there have since been four book reviews (Burge, 2005; Degges-White, 2005; Oberman, 2006; Rosenberg, 2005) on *Feminist Perspectives in Medical Family Therapy*.

As the decade progressed, practitioners from a variety of healthcare professions, such as family medicine, psychiatry, osteopathy, and marriage and family therapy, were interested in the

practical application of MedFT. Programs, healthcare interventions, and clinical recommendations related to MedFT were demonstrated for diseases such as diabetes (Munshower, 2004, Robinson et al., 2004), fibromyalgia (Preece & Sandberg, 2005), somatoform and chronic fatigue syndrome (Szyndler, Towns, Hoffman, & Bennett, 2003), and cancer (Burwell, Brucker, & Shields, 2006; Dankoski & Pais, 2007). Submissions for the Medical Family Therapy casebook continued (Candib & Stovall, 2002; Clabby & Howarth, 2007; Munshower; Navon, 2005, Schirmer & Le, 2002; Thomasgard, Boreman, & Metz, 2004). While interest had increased in the clinical world, the literature also reflected a continued interest in the conceptualization and furthering of the sub-specialty of MedFT as a whole.

In the mid 2000's information about MedFT was gaining international interest (Cook-Darzens, 2005; Kojima, 2006; Pereira & Smith, 2006; Wirtberg, 2005). As this international interest grew, training opportunities in the U.S. advanced with the initiation of master's and doctoral-level MedFT internships (Brucker et al., 2005; Grauf-Grounds & Sellers, 2006) and an articulation of the specific supervisory needs for MedFT trainees (Edwards & Patterson, 2006). Interviews with MedFT pioneers, Bill Doherty (Jencius, 2004) and Jo Ellen Patterson (Burgess-Manning, 2007) documented some of the history of MedFT as well as the passion shared by these experts. A 2007 article on MedFT decried the paucity of research on the field specifically (Linville et al.). In the year in which the present study was conducted (2008) four articles related to MedFT were published (Anderson et al., 2008; Burwell, Templeton, Kennedy, Zak-Hunter, 2008; Heru & Berman, 2008; Willerton, Dankoski, & Martir, 2008). These authors addressed a range of topics from the value of MedFT for the Latino population (Willerton et al.), to feminist informed MedFT model for patients with breast cancer (Burwell et al.), as well as an article (Anderson et al.) and commentary (Heru & Berman) on that article regarding the usage of

MedFT in an inpatient psychiatric setting. While the above articles were written and published with a MedFT focus, there has yet to be an efficacy study conducted (Linville et al.).

The MedFT literature base has evolved over the last decade. From case studies to text books, journal articles, book reviews, and expert interviews with MedFT pioneers, the sub-specialty of MedFT has seen a positive progression towards inclusion in the healthcare community. MedFT continues its trajectory toward the acquisition of evidence-based data; however, this cannot be done until MedFT professionals immersed in the field reach a consensus on its definition (Linville et al., 2007) and scope of practice. Perhaps understanding MedFT from the perspective of professionals in the field warrants exploring practitioner training currently received in institutes, workshops, and degree programs worldwide.

Medical Family Therapy Training

Professional Degrees and Certifications. At the time of the present study, there were seven professional MedFT preparation programs in the United States including one doctoral degree, one master's degree with an emphasis in MedFT, and five programs that offer certificates. In addition to these seven programs, the University of Nebraska-Lincoln (UNL), was in the planning stages to launch its doctoral program in MedFT in the fall of 2009 (R. J. Bischoff, personal communication, October 24, 2008). East Carolina University launched the first MedFT doctoral program in fall 2005 (ECU, 2006) with a focus on research, leadership, supervision, and clinical skills. In this program, students gained clinical experience by means of practicum sites located in a variety of medical settings (inpatient psychiatry, family medicine, community health). Examples of courses included *Illness and Disability Across the Lifespan*, *Family Therapy Supervision Methods and Practice*, *Advanced Research and Statistics*, *Gender and Ethnicity in Medical Family Therapy*, and *Advanced Theories in MedFT*. Students also

chose 12 elective and cognate classes that were tailored to complement and further their individual interests in MedFT. They were expected to complete a minimum of a nine month internship in a medical environment and a dissertation that advanced the sub-specialty of MedFT. At the time of this study, ECU offered the only MedFT doctoral program in the nation. Five other academic preparation programs offered a post-graduate degree and graduate certificate and the second doctoral program was set to be launched in the fall of 2009 at last report.

The University of San Diego offered a master's degree in MFT with an optional emphasis in MedFT. The program (USD, 2008) recognized the growing interest in MedFT and the connection between the mind and body. The program had several MedFT training sites including Pediatrics and Adolescent Medicine, University of California San Diego Family Medicine, and Reproductive Medicine. Courses offered through the program that focused on MedFT included "Family, Systems, Health" and "Psychopharmacology and the Brain."

Three of the five institutions offering certificates of study, Seattle Pacific University (SPU), Mercer University, and the University of Nebraska, named the certificate MedFT, however, two institutions chose to name it differently. Nova Southeastern University's (NSU) certificate was "Family Systems Healthcare" (NSU, 2007), and The Chicago Center for Family Health offered a certificate in, "Families, Illness, & Collaborative Healthcare" (Rolland & Walsh, 2005).

The five certificate programs shared the foundational underpinnings of working with families dealing with illness from a systems perspective; however each also had characteristics that made it unique. For example, a large focus for SPU's MedFT certificate program was integrated care with a foundation in spirituality and faith practice (SPU, 2006). Courses at SPU

included psychopharmacology, spirituality and beliefs, MedFT, MedFT clinical practicum, supervision, and a 12 month internship placement providing psychosocial care within a multi-disciplinary healthcare team to families and individuals with an illness.

The certificate program at Mercer University School of Medicine (MUSM) was a post-master's certificate in MedFT and Pediatric Family Therapy (MUSM, 2004). Mercer's program addressed training from two different focal points, the therapist and the burgeoning doctor. Their aims included training marriage and family therapists (MFTs) to successfully provide mental healthcare in both medical and non-medical settings, as well as training medical students to conceptualize the patient and his/her illness within a broader social and family context and also to facilitate and improve the relationship between provider and patient.

The certificate program at University of Nebraska was offered through a collaborative initiative between the Department of Child, Youth, and Family Studies at University of Nebraska-Lincoln and the University of Nebraska Medical Center's Department of Family Medicine (UNMC, 2008). No admission requirements regarding prior therapy experience existed. Graduate students in any allied health profession who desired training in MedFT were allowed to enroll in the program. As stated earlier, both the Chicago Center for Family Health (Rolland & Walsh, 2005) and NSU (NSU, 2007) provided training similar to MedFT, albeit with different certificate titles. The education offered at Chicago had a strong systemic focus on family resilience in coping with illness and disability. Trainees at the Chicago institute were taught to:

think contextually in a family-oriented, resilience-based systemic way about healthcare problems; (b) competently convene couples and families for consultation and assessment; (c) provide psychoeducation and brief three-four session interventions; and

(d) know when a referral for more intensive family therapy would be appropriate

(Rolland & Walsh, 2005, p. 290)

The intensive advanced certificate was offered at two different levels, a one and two year track. Both tracks involved training in foundational coursework regarding therapy with families, couples, children, and coursework directly related to families dealing with illness, disability, and death. However, the two year program offered an additional year for a student to select the track of “Families, Illness, & Collaborative Healthcare.”

Nova Southeastern’s certificate program was for those who already had a master’s degree in their professional field and desired further training in family systems healthcare. The department also offered a specialized track in Family Systems Healthcare in their Family Therapy doctoral program (NSU, 2007). Students were taught how the family and the healthcare system could come together to provide the best care possible. Patients’ health was understood using a biopsychosocial model, and students were also instructed on ways to succeed in the medical environment. Students also engaged in two clinical practicum experiences in medical settings. Training included an examination of the business aspects of the healthcare system in order to provide students a more complete picture of the field in which they would be working.

Internships and Fellowships. At the time of the present study, internships were an essential part of preparation in MFT and MedFT at the graduate level. It is by immersion in the culture that students learn how the biomedical context is different than a traditional mental health context, how to interact and effectively collaborate with other healthcare professionals, and how to speak the language of collaboration (Seaburn et al., 1996). MedFT internships and post-doctoral training took place in a variety of institutions. The availability of specific internships created by various training programs changed from year to year. In 2005, Brucker et al.

published an article outlining seven MedFT doctoral-level internships. Several of those internships were still active in 2008; but some of the conditions of the internships and availability had changed. Because of the flux of these opportunities, publishing an exhaustive list here was not warranted. However, the opportunities for master's and doctoral level experiences in MedFT were increasing in availability at the time of the present study. A few of the primary ones are discussed below.

The University of Rochester, arguably the home of MedFT, offered a doctoral level internship in the department of Family Medicine (Seaburn & Lorenz et al., 1996). Students from institutions across the country were encouraged to apply for placement in the final year of their MFT doctoral program. They worked with a team of primary care healthcare professionals who worked with patients diagnosed with a wide range of physical and mental health problems. They were provided opportunities to experience the difference between the medical and mental health cultures, and to develop an ability to collaborate effectively (Seaburn et al., 1993). Other internship sites where family therapy interns were successfully incorporated into the Departments of Family Medicine have included the University of Connecticut (Hepworth, Gavazzi, Adlin, & Miller, 1988) and the Dartmouth Family Practice Residency at Concord Hospital in New Hampshire (Bill Gunn, personal communication, April 20, 2008).

The Chicago Center for Family Health (CCFH, 2007) affiliated with the University of Chicago, offered a fellowship for marriage and family therapy doctoral students, as well as doctoral students in other mental health professions. It provided the opportunity to work with families who were dealing with chronic or life-threatening illness, disability, or loss in a variety of settings and client constellations. The core components of Chicago's Families, Illness, and Collaborative Healthcare model included a focus on the family through a normative and

resiliency based lens, collaborating with the family, as well as examining the impact of the illness on the family through a developmental perspective. Collaboration with other healthcare providers was viewed as essential to the work being done with families. CCFH offered courses that were open to the public, including those addressing children, adolescents, and couples therapy, with a specific focus on families, illness, and disability.

The University of Nebraska offered both a master's level and doctoral level internship in MedFT (UNMC, 2008) focused on collaborative care and the biopsychosocial family systems model. Internships associated with the University of Nebraska's Department of Family Medicine, enabled students to work with a diversity of families and a wide variety of patient diagnoses. While clinical work with families and other healthcare team members was a central focus of the internship associated with the program, opportunities also existed for students to conduct research.

Seattle Pacific University (SPU) also successfully partnered with local physicians and physician groups to place students in outpatient medical sites (Grauf-Grounds & Sellers, 2006). SPU tailored internships toward students' interests, including medical specialties as well as general primary care (Grauf-Grounds & Sellers). SPU had created and sustained internships since the inception of its program in 2000. While some students were hired at internship sites post-graduation, thus creating the need for new internship sites, the hiring of these students reflected the need for and recognition of the value of MedFT in a healthcare setting.

Institutes. By definition, institutes are brief intensive training programs offered in a specific field of study. In 2008 there were two such institutes offered in the field of MedFT. The University of Rochester Medical Center (URMC) has offered a summer institute for MedFT 15 consecutive years (URMC, 2008). The "Medical Family Therapy Intensive" was a week-long

session with a focus on educating healthcare professionals about the connection between healthcare and mental health, and the role of collaboration in that process. In addition, the Chicago Center for Family Health (CCFH) offered a three day summer institute (CCFH, 2003) focused on training professionals and healthcare providers how to effectively assist families coping with chronic illness, loss, and other health related problems.

Summary. In 2008, the various degrees and training opportunities in MedFT, including internships, varied in duration, scope, and credentials earned. Several underlying facets characterize these programs. The practicum sites included in the trainings generally involved the placement of MedFTs within a family medicine, primary care, or specialty setting where they learn to function within a medical culture. Coursework tended to focus on therapy with families affected by chronic illness, trauma, disability, or loss and was informed by a biopsychosocial perspective. A theme of collaboration with healthcare professionals and families defined a majority of the programs. Programs differed on the inclusion of specific training foci such as spirituality, psychopharmacology, and family resiliency, but shared a view of MedFT as a biopsychosocial, collaborative effort within a variety of medical settings. To become more clearly defined as a sub-specialty or emerging profession, programs must begin to clearly define the key elements of MedFT and determine if each program is working toward the same MedFT goals. As MedFTs increasingly provide care in the workplace and healthcare system, it is important for them to be able to articulate the theoretical foundation, skills, training, and evidence to support the profession and be able to more effectively collaborate with their patients, families, and other providers.

Fundamental Skills in MedFT

In order to function effectively in a healthcare context, MedFTs must learn to navigate the differences in medical and mental health culture such as diagnosis process, logistics, confidentiality, language, as well as honing and extending their relationship skills to include working with all providers in the larger system. As of 2008, MedFTs appeared to receive specific training in collaborating with providers, patients, and individuals within the patient's social context (McDaniel et al., 1992a; Patterson et al., 2002). However, before MedFTs learned to interact in a medical environment, they tend to be trained to differentiate between the medical and the mental health context. It is through this training and increased understanding that MedFT aims to foster respect for the medical culture. Only with respect for healthcare providers and awareness can a MedFT successfully assimilate into a medical culture and setting (Patterson et al.).

Cultural Differences. The culture and environment of the medical workplace setting is unique. Medical cultures differ to some degree depending on the specialty (Patterson et al., 2002). MedFTs are often trained to respect the inherent differences in traditional medical and psychotherapy cultures. Many accommodations must be made on the part of the MedFT in an effort to assimilate into the medical culture (Bischof et al., 2003). Differences in theoretical focus, confidentiality, language, schedule availability, and such logistics as physical treatment space are apparent as mental health providers begin to immerse themselves in medical settings (Edwards & Patterson, 2006; Patterson et al., 2002). With their training, however, many MedFTs are prepared to understand and navigate those differences as soon as they begin working in a medical context.

At the foundation of understanding differences in medical and mental health culture is demonstrating respect for both the patient and the contributions of mental health and biomedical

providers (Seaburn & Lorenz et al., 1996). Mental health professionals practicing outside healthcare systems may not understand medical culture with its focus largely on a reductionistic pathocentric approach. Systems trained mental health providers look at a broader more systemic range of nonlinear possibilities (Alfuth & Barnard, 2000; Seaburn & Lorenz et al.; Seaburn et al., 1993). A MedFT working from the perspective of a family systems may understand that there are multiple factors playing a role in the patient's life, whereas providers working from a biomedical primarily paradigm tends to focus on, identify and extract the source of health problems (Alfuth & Bernard; McDaniel, Campbell, & Seaburn., 1995; McDaniel et al., 1992a; Seaburn et al., 1993). Additionally, in discussing a patient's case, a physician may focus on the source of the physical health problem while the mental health provider may focus on the systemic factors involved in the illness (Alfuth & Bernard). However, many MedFTs are prepared to manage differences successfully and can work with providers to construct models of collaboration that include everyone working together in the holistic treatment of the patient.

Differences also exist in the resources that inform mental health providers and physicians conceptualization of a patient's case. When discussing the process of a patient's situation and the relational dynamics, mental health providers are apt to rely on elements of intuition and experience to begin to understand the dynamics involved (Patterson et al., 2002). Physicians aim largely to treat patients based on research studies and evidence based best practice guidelines (Institute of Medicine, 2001); however, this kind of information is often not available for the wide range and combination of mental health issues that medical and mental health providers encounter (Patterson et al.). While best practice guidelines may not be readily available for every type of mental health need, MedFTs are often trained to utilize available literature to search for evidence based support of their choice of interventions, screening tools, and models of

collaboration (ECU, 2006). This difference in intuition and experience versus research based practice could be a point of contention for the untrained mental health provider. However, many MedFTs are aware of and respect this difference. They can work to pull the two pools of resources together to create a best case scenario for the patient.

Patient Confidentiality. Confidentiality is an area that requires understanding, clarity, and respect before a MedFT begins his/her work. For example, in the medical setting physicians have an ethical responsibility to treat their patients and do whatever is necessary to ensure their health, including open collaboration with all in house providers and staff and other specialists (Blount, 1998; McDaniel et al., 1992a; Seaburn & Lorenz et al., 1996). However, mental health providers have the ethic of confidentiality as one of the profession's core values, in which a release of information is required to talk to anyone outside of the immediate therapeutic relationship. That ethic of confidentiality is especially crucial to patients due to the stigma attached to mental health services (Patterson et al., 2002). MedFTs are typically trained to integrate themselves into the medical setting and become accustomed to a culture that permits the free flow of information exchange between providers within that setting. True collaboration cannot take place unless all providers involved recognize the responsibility of patient confidentiality held by all members of the healthcare team (Edwards & Patterson, 2006).

The Language of Medicine. While respect and understanding are key, MedFTs must also understand important differences in the language used in the two cultures (Edwards & Patterson, 2006; Seaburn & Lorenz et al., 1996; Seaburn et al., 1993). Most MedFTs are trained to become familiar with and use the language and abbreviations of medicine (Bischoff et al., 2003; McDaniel et al., 1992a; Patterson et al., 2002; Seaburn & Lorenz et al.). Diseases, prescription directions, and other medical notes are often shortened and like all healthcare providers, MedFTs

are trained to understand this medical terminology. MedFTs also need to play an important role in translating mental health language into one that a medical professional who is not trained in systems thinking and psychotherapy theories can understand. Mental health providers working in traditional settings are not faced with the severe time constraints characterizing physicians' medical practice. The language used by therapists differs from that spoken in medical settings that may seem like another language to those outside medical culture (i.e., *medicaleze*) (Bischoff et al.; Seaburn & Lorenz et al). In order to enhance communication, MedFTs are typically trained to avoid more abstract terminology such as *enmeshment*, and to use more concrete, familiar terms such as *relationship stress*. MedFTs aim to understand that typically they must match the biomedical provider's treatment pace. An ability to briefly and clearly summarize a patient's situation is critical to successful communication and collaboration in medical care settings (Bischoff et al.).

Pace of Practice. The differences in language between the medical and mental health cultures also parallel the differences in the pace and daily schedule of a private mental health practice and a medical practice. Physicians' language and work pace are both short and quick, and because they generally are at the top of the medical hierarchy, those working with them often are required to match their pace (McDaniel et al., 1992a). Understanding the time constraints of most medical providers and communicating accordingly demonstrates respect for the medical context of the problem and the characteristics of the provider system (Alfuth & Bernard, 2000). Length of appointment in medical settings, for example, differs from that of mental health settings (Alfuth & Bernard; McDaniel, Campbell, & Seaburn, 1990; Seaburn & Lorenz et al., 1996). Mental health professionals typically employ a 50-60 minute appointment schedule, with minimal overlap between appointments (Alfuth & Bernard; McDaniel et al.,

1992a; Seaburn & Lorenz et al.); while physicians, on the other hand, schedule multiple short appointments over the course of an hour (Alfuth & Bernard; McDaniel et al.; Patterson et al., 2002; Seaburn & Lorenz et al.). Providers typically have tightly scheduled consecutive appointments, often booked into brief 10-15 minute slots (Patterson et al.). Research indicates that even when managing patients with a diagnosis of depression or anxiety, appointments are brief, sometimes lasting no longer than 13 minutes (Callahan et al., 1998). In fact, one research team recorded that the average family physician's office visits ranged from 2 to 65 minutes with a mean of 19.3 minutes (Flocke, Frank, & Wenger, 2001) while another study reported such office visits ranging from 3 to 39 minutes with a mean of 13 minutes (Cole-Kelly, Yanoshik, Campbell, & Flynn, 1998). Mental health professionals also protect the sanctity of the therapeutic hour and interruptions are rare; interruptions are normative in medical settings (Edwards & Patterson, 2006). When working with providers most MedFTs are trained to anticipate and adapt to these time change differences and interruptions, and develop skills in brief versus lengthy therapeutic consultations.

While there are noted differences between medical and mental health cultures, MedFTs and medical providers share some commonalities. Both MedFTs and medical providers conduct a review of the patient's various systems. For example, until the introduction of the biopsychosocial model (Engel, 1977; 1980), it was common for physicians to limit their reviews to a patient's biological systems. Now, with the increasing utilization of the biopsychosocial model in healthcare, physicians are increasingly viewing their patients in a more holistic manner (e.g. psychological factors, relational issues, family histories, and social support). MedFTs acknowledge and typically conduct a review of systems as well; however, while their primary focus is psychosocial, they also conduct a general review of a patient's physical concerns

(McDaniel et al., 1992a). In the end, MedFTs, and other healthcare providers are working toward the same goals, including decreasing discomfort and pain and increasing quality of life.

Relationship Skills. With their training and appreciation of both the similarities and differences between the medical and mental health cultures, MedFTs are uniquely positioned to incorporate this understanding into the creation and development of relationships with other providers. Just as in therapy, the MedFT's first meeting with another provider is critical to the success of the relationship (Bischoff et al., 2003; Seaburn & Lorenz et al., 1996).

The joining process for a MedFT with other healthcare providers involves elements similar to the joining process in therapy (Patterson et al., 2002). MedFTs must first observe and understand their role in the system. By respecting the hierarchical structure of the medical context, most MedFTs are skilled at determining the expected level of their involvement by aiming to understand the environment first rather than demanding that their role be understood (Bischoff et al., 2003; Patterson et al.). MedFTs have reported about the merits of taking a "one-down" position where they may play the role of learner versus teacher in effort to open themselves up to learning and joining with other providers before being fully accepted (Bischoff et al.). However, others have cautioned that MedFTs must convey their value as members of the healthcare team (Bischoff et al.) as demonstrated by Robinson et al. (2004) in their study of the treatment of diabetes using a multi-disciplinary team-based model. In a literature review on the use of family interventions in the treatment of physical illness, Campbell and Patterson (1995) called for family therapists to see themselves as healthcare providers and as part of the healthcare team.

Once the MedFT's role is established, rather than feeling pressured to impart psychosocial knowledge, MedFTs are typically trained to connect with the provider by simply

offering to help as well as inviting the provider's input on psychosocial issues. Central to the rapport building between the MedFT and other providers is the skill of simply knowing how and when to ask the providers the critical healthcare question, "How can I help you?" (Seaburn & Lorenz et al., 1996). Researchers have also found that successful MedFT sessions often take this invitation a step further by initiating a joint meeting that includes the patient as well as the MedFT and physician (McDaniel et al., 2001). Not only does this joint session benefit the relationship between the MedFT and the physician, but it also may increase patient buy-in if he or she is not particularly amenable to the idea of therapy (McDaniel et al.). Additionally, inviting a physician to share thoughts on a case fosters collaboration, and may increase the physician's comfort level in the psychosocial realm (Edwards & Patterson, 2006; Seaburn et al.). Joining, networking, and continued collaboration with the healthcare team is critical to the successful integration of MedFTs into the healthcare team in an effort to help provide the best possible patient care (Doherty et al., 1994; McDaniel et al., 1992a).

Once a MedFT is established as a healthcare team member, communication skills are critical in continuing to manage referrals and maintaining collaborative relationships with the patient, family members, and other providers. MedFTs are trained in a variety of communication modalities often employing the systems consultation model (Wynne, McDaniel, & Weber, 1986). This systems consultation model involves identifying the person making the referral as well as their particular goals and desired outcome for the consultation. The MedFT then navigates the healthcare system on behalf of the patient in a way that is helpful to the patient as well as the referring physician. MedFTs are also often trained to employ medical notes in the form of a Subjective Objective Assessment Plan (S.O.A.P.) notes (Woody & Mallison, 1973) in an effort to work in ways congruent with other healthcare providers. MedFTs are typically

skilled at keeping written communication concise and clear, respecting the timing and pacing constraints of the medical context (Seaburn & Lorenz et al., 1996).

MedFTs also receive training in communication with medical providers. When a MedFT is co-located with a physician, face-to-face contact is ideal, and often takes the form of hallway consultations with very brief conversations highlighting the most salient aspects of the case (Seaburn & Lorenz et al., 1996). These conversations often happen spontaneously and a MedFT understands that he or she should be available and ready to consult when the moment presents itself (Patterson et al., 2002). If the MedFT is not co-located with the provider, email and phone conversations are critically important to maintaining the collaborative relationship. While other mental health professionals may give up after one or two unsuccessful attempts to follow up with a provider, most MedFTs understand the provider's schedule and demands and know the value of persistence (McDaniel et al., 1992a). The communication skills of MedFTs are one of their most important assets for it is through this communication that provider and MedFT insight are increased and patient care is potentially improved (Harkness & Nofziger, 1998).

MedFT Interventions

MedFTs employ their skills in a variety of interventions. These interventions can include psychoeducation, a combination of psychoeducation and family relational work, as well as direct therapeutic work with the family (Campbell, 2003; Linville & Hertlein, 2007; Patterson et al., 2002). Campbell defined three levels of MedFT interventions: family education and support, family psychoeducation, and family therapy. The following is a review of interventions at these three levels, as well as interventions designed specifically for MedFT. The three somewhat overlapping levels stated above demonstrate a variety of ways MedFT can be incorporated into

and enhance already existing structures, while the MedFT specific interventions are tailored toward specific MedFT skills and training.

Campbell (2003) acknowledged that, while there is some overlap among the three levels of MedFT, the levels are still helpful in beginning to organize the literature. Family education and support is defined as an intervention aimed at informing family members about the disease and its management. Campbell indicated that families involved in these interventions are typically viewed as functional and the role of the therapist is in providing emotional support for coping with the illness. While these interventions can be conducted by MedFTs, it does not require a high level of training and can also be facilitated by a mental health para-professional (Campbell). The second category, family psychoeducation, provides families with a deeper level intervention than education and support. Through this level of intervention families are provided with specific coping and problem solving skills and insight into the illness's impact on family relationships as well as the impact of relationships on the illness. MedFTs may be more involved with this type of intervention; however, the level of intervention may lack a systemic focus (Campbell). The third level of intervention is family therapy, which is conducted from a systemic lens and has as its focus an improvement in family relationships (Campbell). The illness education component plays much less of a role than in the first two levels. While each of these levels of intervention differs in the requirement of training needed to implement them, MedFT can include any of these three types of interventions in the services they offer (Campbell).

In an effort to be consistent with Campbell's (2003) categories, the studies discussed below are organized similarly. They represent some of the core literature found in several review articles developed on family-based and family-focused interventions (Campbell; Weihs, Fisher, & Baird, 2002), as well as case studies and research from the field of family therapy. These

sources were identified manually searching several journals that published MedFT-related research such as the *Journal of Marital and Family Therapy*, *Families, Systems and Health* (formerly *Family Systems Medicine*), and *Family Process*. A search was also conducted using the Medline, Proquest, Psycinfo, and Academic Search Premier databases with the following search terms: “family psychoeducation and illness,” “family support and illness,” and “family based intervention and illness.” While those conducting the research and the interventions listed below represented a range of professions, their work illustrates the benefits of healthcare providers focusing on the family and as such are an essential part of understanding the field of MedFT.

Family-Based Interventions. Family-based interventions have been shown to be effective for a variety of physical and mental health conditions. Patterson et al. (2002) cited psychoeducation as a timely and effective intervention for conditions such as anxiety: its importance has also been cited recently as an element of several MedFT interventions (Hodgson, Lamson, & Reese, 2007; Lavelle, 2007; Prest & Grames, 2007; Robinson, Prest, & Carroll, 2007). Campbell’s (2003) review of family-based interventions emphasized the need for these interventions and summarized the research on particular physical conditions that improve with family-based interventions. One of the most important ways noted that families impact health was through the influence of emotional support (Kiecolt-Glaser & Newton, 2001; Uchino, Cacioppo, & Kiecolt-Glaser, 1996). In a commissioned report on these issues (Weihs et al., 2002), family process variables such as family closeness, mutually supportive family relationships, clear family organization, caregiver coping skills, and direct communication about the illness were found to be consistently linked to disease management in various chronic diseases. In a recent study, negative family emotional climate was found to predict child

depression, which was then correlated with the severity of the child's asthma (Wood et al., 2008). As a result, it is logical to conclude that the most helpful intervention for families struggling with an illness would be to help them increase their emotional support for one another (Campbell). In fact, Rolland (1994) suggested that all families faced with an illness or disability should have a psychosocial consultation at the time of diagnosis. He stated that a family consult at illness onset would act as a preventative measure, ensuring that a systems-oriented psychosocial provider would be included as part of the healthcare team and that the family would be treated as the unit of care. Rolland believed that this would reduce the stigma of psychosocial care by demonstrating to families that psychosocial stressors are to be expected when facing such an illness.

Family Education and Support. This level of intervention, also termed family-focused interventions (Weihs et al., 2002), involves educating the family about physical and psychosocial strategies and providing information that can help them to more effectively manage the illness. Family education and support interventions have been found to be effective with illnesses such as cystic fibrosis (Bartholomew et al., 1991, 1997), diabetes (Mendez & Belendez, 1997; McNabb et al., 1994, Thomas-Dobersen, Butler-Simon, & Flehner, 1993), sickle-cell anemia (Kaslow et al., 1997) and schizophrenia (Magliano, Fiorillo, Malangone, De Rosa, & Maj, 2006; Sota et al., 2008). Interventions have included providing educational literature, encouragement of ongoing communication with the healthcare team (Bartholomew et al.), education on stress management, self care, general illness information (Kaslow et al.; Mendez & Belendez; McNabb et al.), assisting parents in managing their child's illness (Thomas-Dobersen et al.), homework tasks aimed at managing the illness (Kaslow et al.) and improving communication and problem solving skills (Magliano et al.). The goals of these interventions often echoed the overarching

MedFT goals of agency and communion (McDaniel et al., 1992a). Goals, for example, included developing independence and developmentally appropriate illness-management strategies (Bartholomew et al.; Magliano et al.; McNabb et al.).

Family education and support interventions may also include group formats where families are brought together to exchange stories, experiences, and coping mechanisms (Gonzalez, Steinglass, Reiss, 1989; Kazak et al., 2004; McDonell, Short, Hazel, Berry, & Dyck, 2006; Steinglass, 1998; Wamboldt & Levin, 1995.). Multi-family groups can help families learn from one another, seek new coping strategies, and empower one another to increase their sense of agency (Rolland, 1994). Multi-Family Discussion Groups (MFDG) have been used with specific illnesses such as asthma (Wamboldt & Levin), cancer (Steinglass), diabetes (Steinglass), general chronic illness (Gonzalez et al.), and for those recovering from illness (Kazak). These MFDGs are typically structured and time limited beginning with a discussion about the impact of illness on the family and including the entire family in the intervention. Most recently MFDGs have been cited as a MedFT intervention to help families of color who are battling chronic illnesses (Lavelle, 2007).

Group formats can also help mental health providers focus on couple interactions and processes. Interventions for couples may be used to focus on improving communication and understanding for each person's coping style (Manne et al., 2005). In a study of a couple's group for women with breast cancer, women were found to have lower distress levels than those in the control group (Manne et al.). MedFT researchers Shields and Rousseau (2004) found that group interventions for couples can also focus on re-creating and discovering new meaning around the illness and creating a future together. Information gathering can be the first step in developing and creating a sense of agency; however, MedFTs can build upon these interventions by assisting

family members in connecting with and understanding one another's, as well as other families', experience with the illness. These groups are fertile ground for developing and increasing a sense of agency and communion among family members.

Family Psychoeducation. The second level of family intervention is entitled family psychoeducation (Campbell, 2003), which includes educational interventions that affect family relationship quality and functioning (Weihs et al., 2002). Psychoeducation also works to increase a sense of the patient's agency by providing specific information on what to expect, how to plan, and exploring possible reactions to a variety of illness-related situations (McDaniel & Cole-Kelly, 2003; Ruddy & McDaniel, 2003). Family psychoeducation interventions have been found effective in the management of high blood pressure (Morisky et al., 1983; Morisky DeMuth, Field-Fass, Green, & Levine, 1985) Alzheimer's disease (Mittleman, Ferris, Shulman, Steinberg, & Levin, 1996) and Asthma (Ng et al., 2008).

Interventions often include brief interviews with the patient and his/her main caregiver, attendance in small group sessions focusing on increasing confidence in illness management and emotional support groups and counseling sessions that include an illness education element (Mittleman et al.). In a family psychoeducation intervention, researchers studying hypertension reported improved treatment adherence, blood pressure control and weight control (Morisky et al.). Additionally, family psychoeducation interventions for Alzheimer's caregivers have been found to reduce levels of depression and improve physical health among caregivers, as well as allowing them to serve as the primary caregiver for their loved one longer than those without the intervention (Mittleman et al.). A family-based psychoeducation intervention for children with asthma included parallel and same-time groups covering topics such as living with asthma, preventing asthma attacks, relating with a child with asthma, and understanding and appreciating

the child and the self (Ng et al.). While these studies involved the family, the goals were often more focused on illness outcome and the interplay between the family and the illness. With family therapy training, MedFTs are well suited to implement this type of intervention as long as they have the expertise in the particular illness, and are also trained to work through additional, more entrenched issues with families when necessary.

Family Therapy. Family therapy, as an intervention, is less researched than other family-based interventions for a variety of reasons. One main reason involves the systemic focus of family therapy in that no one person in a family is given a psychiatric diagnosis that can be tracked for improvement (Kazak, 2002). While clinicians are forced into making these diagnoses on a daily basis due to reimbursement requirements, when a clinician sees family therapy as an orientation rather than a method (Liddle, Breunlin, & Schwartz, 1988) the research is more difficult to conduct due to the truly systemic focus. However, Gustafsson, Kjellman, and Cederblad (1986) conducted a study with a focus on improving families' interpersonal relationships in a case where a child was diagnosed with severe asthma. Improvement was indicated on several outcome measures, including reduced hospitalizations and medication usage. Lask and Matthew (1979) also conducted a study of a family therapy intervention in the case of childhood asthma that focused on providing systemic therapy to the whole family. The intervention focus was systems based family therapy designed to reduce fear of the illness and physician and upsetting emotions among family members. The intervention resulted in improved day-wheeze scores and thoracic gas volume for the child. The researchers hypothesized from this work that a reduction in stress would result in improved physical status, leading to a decreased incidence of asthmatic attacks. However, these conclusions were not generalizable or the interventions replicable as the sample was small and the researchers did not indicate the training

backgrounds of the clinicians who provided the therapy. Both of these research teams focused on physical biomedical improvement; however, as MedFTs aim to focus on healthcare from a biopsychosocial perspective, our research outcomes must also reflect that same paradigm.

Most MedFT interventions are rooted in family therapy theories, in which MedFTs receive extensive training. Family therapy based interventions have included solution focused therapy (Kok & Leskela, 1996; Neilson-Clayton & Brownlee, 2003; Smock et al., 2008; Viner, Christie, Taylor, & Hey, 2003), narrative family therapy (Gellerstedt & Mauksch, 1993; Latz, 1994), structural and strategic family therapy (Friedrich & Copeland, 1983), family grief therapy (Bloch & Kissane, 2000; Kissane et al., 1998), and emotion focused therapy (Greenberg & Johnson, 1988). Solution focused therapy has been found to help improve psychosocial adjustment for occupational therapy patients (Cockburn, Thomas, & Cockburn, 1997), as well as diabetes (Viner et al.) and substance abuse (Smock et al.) outcomes. Case studies have also illustrated a solution-focused model in a psychiatric hospital (Kok & Leskela), and solution-focused therapy with cancer patients (Neilson-Clayton & Brownlee) and patients coping with a loved one's suicide (de Castro & Guterman, 2008).

Narrative family therapy (Freedman & Combs, 1996; White & Epston, 1990) is a useful intervention for families when they need to take control over the influence the illness has on their lives. One of the values in narrative family therapy is enabling families to own their experience with the absence of assumptions or normative rules of functioning. As a result, it is difficult to quantify narrative family therapy's effectiveness in a typical evidence based outcome study. However, this does not mean that interventions utilizing narrative family therapy have not been helpful for situations involving a child with ADHD (Gellerstedt & Mauksch, 1993), somatization (Griffith & Griffith, 1992), body image (Leahy & Harrigan, 2006), and self-care among

adolescent girls (Cowley, Farley, & Beamis, 2002). For example, researchers have illustrated the utility of the narrative technique of externalization with a boy with a neurological deficit (Gellerstedt & Mauksch). In a study of externalization with a general client population, researchers found that externalization helped give power back to clients and increased their sense of agency (Keeling & Bermudez, 2006). Another element of narrative family therapy illustrated in a case study involved the use of a reflecting team (Andersen, 1987) or taking a reflecting position (Griffith & Griffith). Taking a reflecting position can be as simple as the physician and MedFT having a conversation about the patient in front of the patient, which allows the patient a different space in which to hear the providers' thoughts (Griffith & Griffith).

Techniques used by structural and strategic family therapists may help families understand the interactional patterns, boundaries, roles, rules, and hierarchy defining the family in its current state. Effectiveness for structural therapy has been demonstrated for attention deficit disorder (Barkley, Guevremont, Anastopoulos, & Fletcher, 1992) and anorexia nervosa (Fishman, 2006; Minuchin, Rosman, & Baker, 1978). In fact, in a recent review of the research regarding the effectiveness of structural family therapy with anorexia nervosa, Fishman asserted, "Anorexia Nervosa is contextually and socially based, and as such the family therapist is particularly well qualified to do the essential work of restructuring the family" (p. 506). Case examples are also available in the literature utilizing strategic based interventions. For example, an intentional paradox (Madanes, 1981) was used with an adolescent daughter diagnosed with cancer and refusing chemotherapy. The therapist reframed the daughter's behavior as something that was beneficial for the entire family, and recommended that the family refrain from making any decision about further treatment. Subsequently, the daughter decided to resume chemotherapy treatment (Friedrich & Copeland).

Though not a widely recognized family therapy theory, Family Grief Therapy is an intervention process that works directly with the families of cancer patients who are in palliative care stages, as well as after a loved one's death (Bloch & Kissane, 2000; Kissane et al., 1998). By identifying families who are at risk for maladaptive coping upon the death of the loved one, initiating family therapy prior to the death helps the family unite against the grief, a similar position that a Narrative family therapist would take. Family Grief Therapy typically lasts for 6 to 12 months with an average of 6-10 sessions (Kissane et al.). Themes discussed in therapy include death, saying goodbye, emotional suffering, and intimacy.

Emotion Focused Family Therapy (EFT) is an intervention predicated on the idea that emotional connections and patterns can greatly impact chronic illness (Greenberg & Johnson, 1988). Emotion Focused Family Therapy interventions include working toward having each partner's emotions and experience validated and reprocessed within a safe environment. The first session begins with the therapist forming an alliance with each partner and obtaining a marital and family of origin history, as well as their experience with the illness. Together, the couple and therapist progress toward exploring emotional patterns and heightening the couples' understanding of each others' illness experiences and its effects. Some examples of areas where EFT has been explored include couples with chronic illness (Kowal, Johnson, & Lee, 2003), couples with children with chronic illness (Cloutier, Manion, Gordon-Walker, & Johnson, 2002; Gordon-Walker, Johnson, Manion, & Cloutier, 1996), chronic depression (Denton & Burwell, 2006; Dessaulles, Johnson, & Denton, 2003), trauma (Johnson, 2005) and bulimia (Johnson, Maddeaux, & Blouin, 1998). While these theories are rooted in family therapy, MedFTs are also trained in a variety of other psychosocial and health theories.

Cognitive-behavioral therapy (CBT) first known as cognitive therapy (Beck, 1964) has been shown to be helpful with various physical and mental health disorders such as fibromyalgia (Anderson & Winkler, 2006, 2007), insomnia (Sivertsen et al., 2006), obsessive compulsive disorder (Keeley, Storch, Merlo, & Geffken, 2008; Storch et al., 2007), post traumatic stress disorder (Schnurr et al., 2007), somatization (Allen, Woolfolk, Escobar, Gara, Hamer, 2006), depression (TADS, 2004), bulimia nervosa (Wilfley et al., 2002), panic disorder (Barlow, Gorman, Shear, & Woods, 2000), irritable bowel syndrome (Szigethy et al., 2004), childhood obesity (Vignolo et al., 2008) and chronic fatigue syndrome (Knoop et al., 2008; Stulemeijer et al., 2005). Two examples of this work involve the demonstration of the efficacy of CBT in the treatment of chronic fatigue syndrome for adolescents after a two year follow up period (Knoop et al.; Stulemeijer et al.). The interventions in the original study (Stulemeijer et al.) included a restructuring of thoughts, for example facilitating recognition and acceptance of limitations caused by fatigue and/or challenging faulty beliefs such as the idea that activity would increase the severity of their symptoms. Stulemeijer et al. also emphasized working with the parents' belief systems and behaviors in relation to the diagnosis. Additionally, within the context of a multi-disciplinary team and integrated care, interventions such as exercise, massage, nutrition, and pharmacotherapy, paired with CBT therapy, have also demonstrated effectiveness with long-term fibromyalgia syndrome (Anderson & Winkler). Cognitive-behavioral interventions that were found to be particularly helpful were coping skills classes, group exercises, homework assignments, and readings. The coping skills classes addressed specific topics such as effective communication, relaxation skills, managing family conflict, restructuring self-talk, esteem building, and managing feelings (Anderson & Winkler). An intervention designed for families with a child newly diagnosed with cancer included an adapted version of the Surviving Cancer

Competently Intervention Program – Newly Diagnosed (SCCIP-ND) that utilized CBT combined with family therapy (Kazak et al., 2005). When implemented, this intervention helps families identify their beliefs about the cancer and treatment, improve family functioning, and explore beliefs about the future of the family.

Acceptance and Commitment Therapy (ACT) (Hayes, Strosahl, & Wilson, 1999) has been developed as a branch of CBT and is growing in popularity (Forman, Herbert, Moitra, Yeomans, & Geller, 2007). Acceptance and Commitment Therapy has been found to be effective with treating anxiety and depression (Forman et al.), generalized social anxiety disorder (Dalrymple & Herbert, 2007), diabetes (Gregg, Callaghan, Hayes, & Glenn-Lawson, 2007) as well as reducing self-stigma related to substance abuse (Kohlenberg, Hayes, Bunting, Rye, & Luoma, 2008). Unlike CBT, in ACT therapists do not necessarily attempt to change a subjective experience such as anxiety, but rather fully acknowledge it. Acceptance and Commitment Therapy emphasizes six core processes that encourage development of psychological skills, including acceptance, cognitive defusion, being present, self as context, values, and committed action. Clients' work with these core process helps move them toward the overarching goal of, "increasing psychological flexibility – the ability to contact the present moment more fully as a conscious human being, and to change or persist in behavior when doing so serves valued ends" (Hayes, Luoma, Bond, Masuda, & Lillis, 2006, p. 7). In employing ACT with a patient, a MedFT might strive to help the patient form and strengthen existing values and develop those into goals and behavior changes (Forman et al.). While all of the aforementioned family-based interventions and techniques can be conducted by a MedFT, they were not designed to utilize the specific skills and training of a MedFT.

MedFT Specific Techniques. In their seminal text, *Medical Family Therapy*, McDaniel et al. (1992a) dedicated a chapter to seven techniques of MedFT aimed at the overarching MedFT goals of agency and communion. The first technique involves **ascertaining information about the patient's and/or family's biomedical concerns**. One way MedFTs can incorporate this technique as part of their routine practice strategy is by checking in with the patient/family regarding their health and medication adherence, as well as collaborating with the patient and physician on the assessment, diagnosis process, and plan of treatment (McDaniel et al., Seaburn & Lorenz et al., 1996). As patients feel their biological needs are validated, **soliciting the illness story** helps broaden the perspective from the biological to fuller biopsychosocial context (McDaniel et al.). Genograms are a tool that can add additional detail to the story, recognizing intergenerational relational and health patterns and beliefs for the patient quickly and efficiently for the physician (McDaniel et al.; Rolland, 1994; Schilson, Braun, & Hudson, 1993). As the context is understood MedFTs also recognize that the patient and family members may be moving through the coping process of the illness at their own pace. McDaniel et al. noted that MedFTs can help families with their coping process by **addressing four key emotional tasks** (i.e., accepting denial, externalizing the illness, removing blame, and normalizing negative feelings). Inherent in achieving these tasks is helping families and systems of care to **maintain effective communication**. Honest and open communication among family members and between patients and their physicians aids in increasing a sense of communion (McDaniel et al.). These communication needs will differ depending on the developmental stages of family members, of the family as a whole, and as the development of the illness changes. Illnesses often have developmental stages that range from acute to chronic, with symptoms at differing stages of severity. MedFTs can help the patient and family **acknowledge these developmental stages** and

navigate the accompanying fluctuations into their lives in a way that does not allow the illness to take over the family life (McDaniel et al.).

Putting the illness in its place is an example of the patient and family **increasing their sense of agency**, which is the sixth technique of MedFTs outlined by McDaniel et al. MedFTs can help facilitate a patient's sense of agency by encouraging them to express concerns, questions, and even differences of opinion with their provider. A MedFT should continue to encourage a patient's sense of power and agency throughout the illness experience, culminating in the seventh technique of **terminating with the option to return** again for additional care. A soft termination helps the patient and family feel comfortable that they have the resources to continue on without therapy; however and ensuring they availability of therapy should it be needed by them in the future. While effectiveness and efficacy studies are lacking in these seven MedFT-specific interventions, the above techniques are illustrated in a case study involving a woman with end-stage Crohn's disease and her son (McDaniel et al., 2001). Since the inception of these original seven techniques, other authors and researchers have begun to expand the MedFT toolbox of techniques.

One of the most recent MedFT texts published is a handbook for activities, handouts, and homework for therapists working in medical settings or with clients with healthcare issues (Linville & Hertlein, 2007). Contributors to this text offer such interventions as the biopsychosocial-spiritual (BPS-S) interview (Hodgson et al., 2007), connecting families with their natural support systems (Grauf-Grounds, 2007), managing anger (Ward & Linville, 2007), improving communication and self-awareness (Pflaffy, 2007), as well as MedFT self care therapist issues (Lamson & Meadors, 2007). The BPS-S interview (Hodgson et al.) provides MedFTs with an interview method designed to ascertain biopsychosocial data that can bring the

patient, family, MedFT, and healthcare providers to a common understanding about steps needed to improve the health of the patient. Researchers have shown that viewing patients from a biopsychosocial perspective leads to improvements in patient outcomes for diagnoses such as stroke (Claiborne, 2006), lower back pain (Buchner, Zahlten-Hinguranage, Schiltenswolf, & Neubauer, 2006; Wand et al., 2004), osteo-arthritis (Baird & Sands, 2006), rheumatoid arthritis and asthma (Smyth, Stone, Hurewitz, & Kaell, 1999) and heart disease (Wolfgang, Stossel, & Maurice, 1996). MedFTs are trained to work with their patients through a biopsychosocial lens. Through adaptation of example questions in the BPS-S interview, the MedFT can assess the different coping mechanisms and supports of the patient, as well as the impact the illness has had on the family system. While the interventions listed in the text are helpful, the focus seems to largely be on direct intervention with the family. Unfortunately, scripted interventions that illustrate the full range of MedFT skills are lacking. For example, interventions that focus on MedFT skills such as specific ways to collaborate with other medical providers or ways to help the patient and family collaborate with other medical providers. Additionally, if spirituality is a focus of MedFT, more interventions are needed in order to illustrate its inclusion in practice. As MedFTs move into an increasing range of professional placements, interventions will continue to be expanded and refined to fit the needs of patients and providers; however the range of interventions is best grounded in a consensus definition of MedFT, something that has yet to be established.

The Importance and Relevance of MedFT Research

While the above interventions and studies help demonstrate the unique skills and wide applications of MedFT, only a few researchers have attempted to address the integrations of MedFT in healthcare settings and their direct impact on elements such as the larger healthcare

system and patient care. In a study done in an outpatient medical oncology unit, Sellers (2000) found that the providers, patients, and their partners benefitted from the addition of MedFT services. Providers stated that the psychosocial support of their patients was a relief, and that it enabled them to do other medically necessary tasks. Patients reported a decrease in emotional suffering and an increase in their ability to access resources and feel hopeful about the future. While this study was most beneficial in demonstrating the value of adding a MedFT service in general, and outlining needs of the oncology clinic that might match the skills of the MedFT, it did not articulate what the MedFT specifically did that the providers and patients found beneficial.

The importance of including MedFTs on multi-disciplinary and collaborative treatment teams has been illustrated by Robinson et al. (2004) with patients diagnosed with diabetes. They created a model at the University of Nebraska Medical Center to address comorbid illnesses with diabetes, such as depression. They found that MedFTs brought in new patient interviewing skills that expanded the illness definition beyond its usual biomedical terms, and the MedFT being onsite and consistently available for consultation was reportedly a key component to their success. The unique element was that the providers were students in either MedFT or medical school and reported learning together the value of one another's professions and the art of collaboration.

Most recently, Anderson et al. (2008) published a grounded theory study that specifically addressed the skills of MedFTs working in an inpatient psychiatric setting. Anderson et al. deconstructed the timeline of involvement in therapy into pre-session preparation, during session, and post-session follow up. In the pre-session period, the specific skills MedFTs used included data gathering, conducting separate but brief sessions with the patient and

family/support members, setting the agenda for the family meeting, and working with the multidisciplinary team to facilitate treatment planning. During the family session, the MedFT focused on creating a safe environment that facilitated open communication among family members. Focusing on strengths of the patient and family, the MedFT also worked to identify process and content that would not otherwise be revealed to the treatment team through usual interviewing and assessment methods. Through the process of discussing family issues and emotions, the MedFT worked to initiate improvement in familial relationships and systemic change and prepared patients and family members for a successful transition from an inpatient unit to reintegration into their homes and communities. Following the family sessions, the MedFT maintained communication with the providers. If families chose to follow up with them for outpatient MedFT services, the MedFT continued to evaluate and work with the family to maintain the systemic changes initiated during the inpatient session. The authors attributed the success of the MedFT service to the collaborative skills of the MedFT that helped all participants involved have a voice in the healthcare process. A follow up commentary on this article by Heru and Berman (2008), two professors of psychiatry, suggested that the addition of a MedFT to an inpatient unit would be beneficial, since historically families have sometimes been either avoided or demonized on these units by staff members. While they described the inclusion of MedFT as a sort of utopia, the authors also suggested the necessity of involving a MedFT in cases depended on the level of need evidenced or expressed by the patient and his or her family or the healthcare providers.

Financial Reimbursement for MedFT

MedFT was initiated and nurtured in a protective academic environment (Doherty, 2007). In this type of environment, therapists, physicians, academicians, and patients have been able to

work together in ways that are ideal and create the best possible outcomes for the patient (Anderson et al., 2007; Grauf Grounds & Sellers, 2006; Robinson et al., 2004). When working outside an academic setting, concerns about billing and reimbursement, cost containment, and business needs are critical to the viability of MedFTs inclusion in healthcare settings (Patterson et al., 2002). Researchers have shown that when treated with a multi-disciplinary team approach, the patient outcome is more favorable and cost-effective than with standard patient treatment without the involvement of a psychosocial professional (Katon & Robinson, 1996; Katon et al., 1995; Smith, Rost, & Kashner, 1995). Not only does MedFT involvement in care improve outcomes, but also other healthcare team professionals benefit from this collaborative process (Graham, Senior, Lazarus, Mayer, & Asen, 1992; Robinson et al., 2004).

Reimbursement for services is frequently a point of contention raised by those wishing to practice MedFT in collaborative healthcare settings (Davis, 2001; Feierbend & Bartee, 2004). At the 2007 Collaborative Family Healthcare Association's Annual conference, a specialized administration and finance track was devoted to just such issues (CFHA, 2008). Presentations focused on how to make integrated and collaborative care work effectively as well as how to produce data to demonstrate its effectiveness. While clinicians and patients might view collaboration as helpful and necessary for quality care, insurance and managed care companies must approach collaboration from the perspective of cost (Seaburn & Lorenz et al., 1996; Todahl et al., 2006). Determining reimbursement for three different providers working within the same clinical hour is a challenge. It is not easy to decipher and determine how to bill for services provided by a MedFT during a primary care visit (Patterson et al., 2002). Reimbursement is one issue that must find its solution in the three world view where one must consider the financial, operational, and clinical worlds in order to be successful (Peek & Heinrich, 1995). Those

practicing MedFT cannot simply note positive clinical changes in their patients to warrant reimbursement in services. MedFTs must examine the financial, operational, and clinical aspects of their services by conducting evidence based research in an effort to demonstrate the cost-effectiveness of the services they provided.

While Anderson et al. (2008) are some of the most recent researchers to tackle the value-added aspect of MedFT services minimal evidence currently supports the financial viability of such services. Researchers are beginning to determine how to methodologically capture the complex financial benefits of MedFT services. For example, Law and Crane (2000) found that patients as well as members of their families experienced a drop in the utilization of medical services when marital therapy was included in their treatment (Law & Crane). Law, Crane, and Berge (2003) found this drop particularly among patients labeled as high utilizers who typically presented with chronic pain or somatization disorders. Researchers have also demonstrated a decline in healthcare services for youth diagnosed as having conduct-disorder. According to one study, youth with conduct disorders who received in-home family therapy incurred a 32% reduction in healthcare costs compared to those receiving no family therapy (Crane, Hillin, & Jakubowski, 2005). In fact, in a recent summary report, Crane (in press) stated that overall family therapy reduced healthcare visits without increasing healthcare costs. While Crane's work is key to demonstrating the value of mental healthcare as well as the value in working with the family as a whole, it did not evaluate the specific elements of care (e.g., interventions, theory, collaborative models) provided by therapists and the type of training each had received specific to working in collaboration with a healthcare system. The data were garnered primarily from insurance company and HMO databases, and thus do not provide detailed information about the quality and type of interventions utilized.

Discussion

The notion of combining medical and mental healthcare is not a new one. The Institute of Medicine's statement on primary care, *Primary Care: America's Health in a New Era* (1996), definition of primary care included the holistic perspective that both mental and physical health should be treated and such treatment should occur within a supportive provider-patient relationship. The provision of mental and medical healthcare in the same healthcare practice, is referred to as the "medical home" (Pettersen et al., 2008). Having a "medical home" benefits patients in a myriad of ways including longer life expectancy, improved general health, and increased patient satisfaction (Primary Centered Patient Care Collaborative [PCPCC], 2007). Not only does the presence of a "medical home" benefit the patient by providing preventive healthcare, both patient and healthcare system may experience financial savings (Robeznieks, 2007). If noted experts declare the need for a change in healthcare that includes the provision of healthcare from a holistic biopsychosocial perspective, and MedFTs are trained in exactly this type of collaborative and integrated healthcare, then MedFTs must begin to advocate for their formal inclusion in the healthcare team.

Since its inception in the late 1980s (Ruddy & McDaniel, 2003), the field of MedFT has blossomed. There have been an increased number of publications, trainings and job opportunities, for MedFTs. Elements of MedFT interventions have been reported to be beneficial to the patient and healthcare system. For example, researchers have demonstrated the connection between the body and mind through effective treatment using a biopsychosocial perspective (Baird & Sands, 2006; Buchner et al., 2006; Claiborne, 2006; Wand et al., 2004) thus providing a rationale for the critical inclusion of each dimension of MedFT practice. Family-based interventions have also been shown to be effective in helping manage a variety of illnesses

(Campbell, 2003). Multi-disciplinary teams, something that MedFTs are trained to facilitate, also appear to be beneficial to medical providers, mental health providers, and patients (Robinson et al., 2004). Researchers have shown that collaboration increased provider satisfaction and improved patient outcomes (Katon, 1995; Todahl et al., 2006). MedFTs' understanding of medical culture and relationship building skills, provides the fundamentals needed to be effective collaborators, yet a need exists for a concise definition of MedFT (Linville et al., 2007), agreement regarding core curriculum, empirical validation of effectiveness, and appreciation for the scope of MedFT. With each new partnership in primary, secondary, and tertiary care setting comes the need for an expanded skill set, training, and research measuring the effectiveness and efficacy of MedFT services.

As MedFTs evolve in their contributions to healthcare settings, from work with individuals (Davey, Gulish, Askew, Godette, & Childs, 2005; Hegleson, Cohen, Schulz, & Yasko, 2000; Szigethy et al., 2004) to work with families in family therapy (Gustaffson, Kjellman, & Cederblad, 1986; Lask & Matthew, 1979), understanding the levels of possible intervention is essential. Campbell (2003) offered a framework of three categories for examining family interventions and, while this framework has been helpful in advancing the inclusion of the family in health issues, those working in the field of MedFT must begin to create a framework that specifically includes MedFTs as the interventionists. The type and depth of training of the interventionists in the studies may impact the studies' design and implementation, and as a result, the outcome.

Research is still lacking with regard to published interventions specific to MedFT (e.g. the seven techniques of MedFT, McDaniel et al., 1992a). Being able to demonstrate MedFT effectiveness helps to determine exactly what the process of MedFT interventions should

include. However, until a clear definition of MedFT can be demonstrated, research will continue to be vague and scattered. In general, the above studies point to the effectiveness of MedFT interventions, but do not address the skills and knowledge that MedFT brings to patient care. While there may be difficulties in capturing systemic change (Kazak, 2002), a brick must be added to the wall of research involving families living with illnesses that has thus far been constructed mainly by other professions and sub-specialties.

Being able to research the effectiveness of MedFT and refine MedFT-related interventions, techniques, and training will help reinforce MedFTs place and contributions in healthcare. The sub-specialty of MedFT will continue to fight for reimbursement and privileges in certain medical settings until steps are taken to formalize, research, and document what is involved in the provision of MedFT care. In an effort to move MedFT forward several things must take place:

1.) Reaching a Consensus Definition. As suggested by Hertlein et al. (2007), those in the field of MedFT must reach an agreement regarding the elements that capture the process of MedFT. From this agreement, training programs can become more specialized and focused on providing students with core MedFT elements. Potential employers will have an understanding of what MedFTs offer their practice or place of business because the core elements of MedFT have been articulated. Equally important, researchers will be better able to argue that they are all measuring the same variable.

2.) Conducting MedFT Effectiveness and Efficacy Research. Once a confirmed definition is reached, there must be an increase in measuring the effectiveness and efficacy of MedFT. Effectiveness research will help practicing clinicians refine

interventions, theories, and general elements of what works and what does not work in every day settings (Pinsof & Wynne, 2000). Efficacy research, with its higher level of variable control and random assignment of participants, aims to isolate clearly whether or not MedFT has its claimed effects (Pinsof & Wynne). Both may have different audiences of interest, perhaps effectiveness studies more so for those practicing in the field, and efficacy more for third-party payers and researchers; however both are important to move a well-rounded profession forward (Sprenkle, 2003). The family-based literature framework must begin to include studies and validated interventions with evidence supporting how MedFTs excel clinically, operationally, and financially in healthcare contexts (Peek & Heinrich, 1995).

3.) Policy Change that Promote Integration. In conjunction with consensus regarding MedFT preparation, practice, and research illustrating the effectiveness and efficacy of MedFT, MedFTs practicing in the field must also be charged with the responsibility to affect change on a broader policy level. Because the healthcare system has become fragmented, MedFTs are in a position as systems thinkers to help advance collaborative and integrated models of care.

MedFTs must position themselves for reimbursement for services by becoming aware of and active in lobbying at the federal level for the inclusion of a wider range of mental health practitioners in the health and behavior codes covered by Medicare (Kessler, 2008). While Medicare codes encourage providers to work together to provide quality patient care, they are not a panacea. As suggested by Kessler, MedFTs also must continue to advocate for mental health professionals on an individual level, contacting health insurance agencies and local Medicare entities in a

proactive fashion to encourage changes regarding the reimbursement of mental health services these policies. If there is not and cannot be a central clearinghouse for how all insurance agencies handle integrated care, those providing the service can and should advocate for mental health service reimbursement on an individual level so that eventually a collective voice is heard.

4.) *Developing Standards for MedFT Training.* To continue to advance the subspecialty of MedFT professional training programs must have a unified foundational base for curriculum. All students who graduate from a MedFT training institute or program should have been exposed to similar core training theories and practicum experiences. While course diversity should also be encouraged, their foundation must be the same. Documenting a unified perspective among clinicians, researchers, and academicians will begin to give MedFT an identity of its own. Through the creation of this identity, there are possibilities of establishing its own professional society and the evolution of program accreditation standards which will serve to improve the services, research, and advocacy for the incorporation of MedFT into the healthcare system.

Conclusion

The needs of the American population are changing. There has been a shift from patients coping with acute illnesses to those coping with chronic illnesses (IOM, 2001). Patients and their families are presenting to primary care physicians with complaints that are in need of both medical and mental health attention (Blount, 2003). While there will always be a need for traditional mental health services, researchers have shown that more often than not patients are turning to their primary care physician for mental healthcare even if they are not calling it such

(Regier, 1993). Primary care physicians continue to face time constraints that are in direct conflict with what may be more intensive needs of these patients. With this conflict between patient needs and physician time, patients may not be receiving the quality care that would be possible with the addition of a mental health professional trained to integrate the medical and mental healthcare systems in the mental health treatment of patients. A space must be made in the healthcare system for a mental health provider who can assimilate quickly, respectfully, and collaboratively in primary, secondary, and tertiary care settings and who can intervene systemically at the patient, family, provider, larger system, and policy levels. Based on what is known currently regarding MedFT and the training of its clinicians, their skills and training seem to meet these needs.

MedFT has been a growing sub-specialty of marriage and family therapy for approximately the last 20 years and with this growth comes responsibility. It is the current MedFT professionals' responsibility to assure that its clinicians, academicians, supervisors, and researchers move forward with a purpose and a concerted effort to provide quality care, to improve patient care and the healthcare system in general. In order to accomplish the integration of MedFT into the healthcare system there must be sufficient supporting evidence. The creation of this evidence will start with exploring a research based consensus definition and classification of MedFT and the characteristics of its clinicians, and scope of practice.

Methodology

MedFT is a quickly growing sub-specialty (Doherty, 2007) that lacks a cohesive definition (Linville et al., 2007) regarding its theoretical foundation, skills, and scope of practice. An agreed upon definition is critical to the continued success and evolution of MedFT and its inclusion as a viable and respected member of the healthcare team.

The purpose of this study is to determine and reach consensus on a definition, scope of practice, curriculum, characteristics of Medical Family Therapy (MedFT), and its practitioners among those of self-identify as having expertise in MedFT, who have either practiced in the field, studied MedFT through academic institutions, or worked with a MedFT. With the definition derived from this study, MedFT researchers can begin to create a cohesive body of work that addresses the role, scope of practice, efficacy, and effectiveness of this sub-specialty.

The Delphi method (Dalkey, 1972), in which experts are surveyed anonymously for their opinion, will be used to help those in the sub-specialty of MedFT more clearly define several aspects of their clinical and research work in an effort to advance the sub-specialty. Specifically, the following research questions will be addressed:

- 1) a. How is Medical Family Therapy (MedFT) defined?
 - b. Is Medical Family Therapy a profession (requiring specific credentials), an orientation (how one views patients/situations), a treatment modality (one of many choices that may or may not be appropriate for a given patient), or a field (a body of knowledge existing more in the public domain, used to supplement a variety of professions) or other (Liddle, Breunlin, & Schwartz, 1988)? Or do you believe it is something altogether different? You may use any, all, or none of the possibilities mentioned above in your response.
- 2) What is the current scope of practice for MedFT?
- 3) What is the current role of MedFTs?
- 4) What unique skills, if any, do MedFTs possess as compared to other mental health professionals?
- 5) What criteria must be met in order to classify a mental health professional as a MedFT?
- 6) In what areas are MedFTs currently employed?

- 7.) What core courses, training and field experiences, and core competences (i.e. – essential skills) do you believe MedFTs should have successfully completed as part of their MedFT curriculum? Indicate if courses should be taken at the MS or PhD levels by inserting (MS) or (PhD) after each course.
- 8.) Assume you are reading the results of a research study that purported to be **medical family therapy** research. How would you know that it is a medical family therapy study, versus some other type of research (family therapy, mental health, biomedical)?

The Delphi Method

As a methodology that can purportedly clarify positions and help move professions and fields of study in a particular direction, it has been argued that the Delphi Method (Dalkey, 1972) is appropriate in clarifying aspects of a particular discipline. MedFT is a growing and evolving sub-specialty within marriage and family therapy (MFT). The Delphi Method is appropriate for investigating the research questions posed for this study. The Delphi Method will be used to gather and synthesize those with expertise in MedFTs' opinions on the current definition, classification, direction, scope of, and preparation of MedFT in this country.

The Delphi Method originated as a way for individuals with a particular shared knowledge and background, to come together anonymously (participants blinded to each other) and discuss a topic related to their field of expertise, "Delphi may be characterized as a method for structuring a group communication process so that the process is effective in allowing a group of individuals, as a whole, to deal with a complex problem" (Linstone & Turoff, 1975, p.3), by allowing each panelist to act as independently as possible without direct confrontation by an interviewer (Dalkey & Helmer, 1963) or undue influence by the other participants

(Linstone & Turoff). The first notable Delphi study was conducted in 1955 by the Rand Corporation (Linstone & Turoff). The Rand study, named “Project Delphi,” was initially used to survey seven geographically disparate military experts through a series of five written questionnaires. While many of the initial Delphi studies were conducted for military purposes, the 1960s saw adaptation of the Delphi method by other industries and for other purposes.

Delphi studies have been used for a diversity of purposes including formulating consensus on policy, values and goals, and developing curriculum in academic institutions (Linstone & Turoff, 1975). The Delphi method was first introduced into the family therapy profession in the early 1980s through the work of Winkle during his doctoral dissertation which was later published in the *Journal of Marital and Family Therapy* (Stone Fish & Busby, 2005; Winkle, 1980; Winkle, Piercy, & Hovestadt, 1981). A member of Winkle’s dissertation committee had formerly worked with the Rand Corporation and brought his experience with the Delphi Method to East Texas State University where Winkle used the method in a dissertation concerning family therapy curriculum (Stone Fish & Busby). Since then, there have been a number of published family therapy studies using Delphi methodology. These Delphi studies have examined different theories, techniques, strategies (Blow & Sprenkle, 2001; Dienhart & Avis, 1994; Jenkins, 1996; Stone Fish & Piercy, 1987), therapist skills and necessary curricula (Figley & Nelson, 1989; Godfrey, Haddock, Fisher, & Lund, 2006; Nelson & Figley, 1990; Nelson, Heilbrun, & Figley, 1993; Sori & Sprenkle, 2004; White, Edwards, & Russell, 1997; Winkley, Piercy, & Hovestadt, 1981), elements of supervision (White & Russell, 1995), and current trends in family life (Nelson, Piercy, & Sprenkle, 2005; Stone Fish & Osborne, 1992).

While the specific format of a Delphi methodology can be modified, as will be done in the current study, there are four general data collection and analysis phases (Linstone & Turoff,

1975). The first part of the data collection phase consists of a questionnaire, typically labeled Delphi Questionnaire I (DQ I), that participants complete related to the research question(s) under investigation. In the field of family therapy the DQ I typically has involved the use of open-ended questions. The second phase of the Delphi Method consists of a compilation of panelists' responses to DQ I, and a rating scale for each response listed. All of the compiled answers and the rating scale are returned to respondents for their feedback through the utilization of a second Delphi questionnaire (DQ II). On the second questionnaire, panelists rate their level of agreement on the inclusion of each item by using a likert scale with a range of one to five or one to seven. The third phase involves exploring participant agreement and disagreement with question items and evaluating those differences through a third questionnaire (DQ III). The third questionnaire provides the panelist with each his or her ratings associated with items from DQ II, as well as a measure of central tendency, typically the median and interquartile range, for each item. Panelists are given the option to reconsider their original rating on DQ II, in light of the group statistical feedback (Stone Fish & Busby, 2005). The fourth phase is a repeat of the third phase with new group statistical feedback and a final invitation to the panelist to revise his or her response to each item on DQ III.

A degree of balance must be attained when considering the number of rounds of questionnaires in a Delphi methodology. While the standard Delphi technique involves three levels of questionnaires, due to the exploratory nature of this study and in an effort to avoid panelist issues described below (Stone Fish & Busby, 2005), this researcher will utilize a modified Delphi technique that involves two phases of questionnaires (Figley & Nelson, 1989; Godfrey et al., 2006; Jenkins, 1996; Sori & Sprenkle, 2004; Stone Fish & Osborn, 1992; White & Russell, 1995; White, Edwards, & Russell, 1997). This decision is in keeping with the general

agreement among researchers that only a few rounds of questionnaires are needed since the process quickly becomes too repetitive (Stone Fish & Busby).

While the Delphi method offers a way to bring together experts in the field to help guide important decisions and processes, it is not without its flaws. For example, if too many rounds of questionnaires are conducted, participants may eventually start to change their answers to be closer to the presented medians, or responses may regress to the mean (Stone Fish & Busby, 2005). This weakness can be avoided by sending out the measure of central tendency with only one questionnaire. Additionally, while researchers typically employ the Delphi method to reach consensus on a particular topic, a divergence of opinions can also be a valuable discovery. Researchers should be able to allow for ways to report and include possible areas of diversity of opinion on the topic (Stone Fish & Busby). If a diverse expert panel is not chosen, researchers run the risk of having experts with too narrow of a perspective (Stone Fish & Busby). The time commitment required of panelists is also a weakness of the methodology. Depending on the questions, panelists may expend a great deal of energy and time on each survey thus leading to a high risk of participant attrition as the process continues. Panelists can be encouraged to complete the entire Delphi process by offering financial incentives or simply using brief questionnaires (Stone Fish & Busby). Lastly, as much energy is put into a Delphi study by its researchers and participants, it must be a study that will contribute vital information to the field. Recruitment of panelists will be even more cumbersome if the questionnaire is not interesting or seemingly irrelevant to the field of study (Stone Fish & Busby).

Participant Identification and Selection

The purpose of the Delphi methodology is to obtain the informed opinion of those who have extensive expertise in the field under question, thus necessitating a purposive sampling

technique (Dalkey, 1972; Jenkins & Smith, 1994; Linstone & Turoff, 1975). Choosing the panelists and seeking their participation is perhaps one of the most important steps in the Delphi process (Scheele, 1975; Stone Fish & Busby, 2005). In order to conduct a thorough survey of experts, a balance should exist among input from four distinct groups: stakeholders, facilitators, experts, and those who might supply an alternative viewpoint (Scheele). While a balance among these stated four groups will be the goal for this study, the proportion of participants comprising each group will vary based on the inclusion criteria and the willingness of participants to engage in the study. Regardless of the proportions, the participants in this Delphi study will be purposively selected as they must be able to speak to the question and topic at hand (Jenkins & Smith, 1994; Stone Fish & Busby).

Although various inclusion criteria have been outlined in studies using the Delphi method, the specification of experts typically includes one or more of the following: number of publications by the expert, years spent teaching the subject, number of professional presentations, type of degree or license held, or years of clinical experience (Blow & Sprenkle, 2001; Dienhart & Avis, 1994; Godfrey, Haddock, Fisher, & Lund, 2006; Jenkins, 1996; Nelson et al., 2005; Sori & Sprenkle, 2004; Stone Fish & Osborn, 1992; White & Russell, 1995). Due to the exploratory nature of this study and the relatively recent appearance of the field of MedFT, the panelist criteria will include one or more of the following.

- 1.) Self identify as a MedFT professional
- 2.) MedFT as the current focus of professional work, whether clinical or academic
- 3.) Self identify as a healthcare provider who collaborates with a self-identified MedFT in their professional work.

These criteria exclude those mental health providers whose professional work is limited to engagement in collaborative healthcare or integrated care work and who do not identify themselves as MedFTs.

The researcher will recruit those who, based on various academic and professional hallmarks, meet the stated criteria. The search for potential panelists will begin with a review of the academic literature and institutions of higher education with MedFT educational programs. A grid will be created listing the potential participants and the criteria they meet from the list above (Appendix B). Those who meet the requirements for participants will be contacted for participation in the study. They will be asked to confirm that they meet the requirements for panelist inclusion as stated above. Additionally, an email will be sent to the Collaborative Family Healthcare Association's listserv asking for panelists to self-identify if they meet one or more of the inclusion criteria (Appendix C). This is to make sure that researcher bias has not excluded any eligible participants willing to consent. Lastly, MedFTs who consent to the study will also be asked for the names and contact information of those stakeholders with whom they collaborate on a regular basis and are therefore familiar with their work for inclusion in the study.

Recruitment Procedure

Prior to the recruitment of potential panelists, the study will be reviewed by the East Carolina University Institutional Review Board (Appendix D). After approval of the study is granted, panelists will be recruited through multiple methods, including email, telephone, and in person if the opportunity arises at professional conferences or at other local meetings. They will be asked to voluntarily participate in this study through an online survey website (www.surveymonkey.com). Each potential panelist will receive a cover letter via email inviting them to participate in the study and if they are interested to respond to the email (Appendix E). If

participants are recruited in person or by telephone, their email addresses will be recorded and they will receive the email within 48 hours. Once they respond to the email, indicating their interest to participate, they will receive a personalized email with their individual link to the Survey Monkey website. This link will enable them to return to their survey periodically if they do not finish the survey in one sitting. Once logged onto the online survey, participants will be directed to read and submit the informed consent (Appendix F), demographics form (Appendix G), and first questionnaire (DQI) (Appendix H). Follow up phone calls, with participant consent, may be made to encourage participation in both phases of the study. Additionally, as several researchers have done in prior studies (Godfrey et al., 2006, Jenkins, 1994, Nelson, et al., 2005, Stone Fish & Piercy, 1987), the researcher will ask potential participants to assist in recruiting additional participants who would fit the inclusion criteria. Lastly, a general e-mail through the Collaborative Family Healthcare Association's listserv (www.cfha.net), will be distributed requesting potential participants who meet study criteria to contact the primary investigator indicating interest in study participation.

Completion of the initial questionnaire packet and the second questionnaire should take no longer than 30 minutes each, with the initial questionnaire perhaps taking up to 45 minutes. Participants will submit their names and contact information along with their completed informed consent forms. A list of names and pseudonyms will be compiled and stored on the primary researcher's computer in a password protected document. It will be necessary to have names associated with both the DQ I and the DQ II so that tracking the completion of questionnaires can occur. Additionally, should a participant's response vary greatly from others or need clarification, follow up may be conducted in order to ensure a fair representation of their

input. While names will be needed to complete the questionnaire, no names will be included in the reported findings.

Procedures

Panelists will first receive an email invitation letter (Appendix E) and a link to a secured website on which an online informed consent is posted. Upon reading the informed consent, potential panelists will indicate whether they agree to participate in the study and, if so, they will proceed to the demographics form and first questionnaire (DQ I). If they do not agree, they will be instructed to exit the website. The consent will address the purpose and importance of the panelists' participation, and clearly articulate the researcher's goal to publish the study in an effort to impact future MedFT education, practice, and research. The introductory information will also indicate the need for participants to engage in a second follow-up questionnaire (DQ II), and the estimated time involved of approximately 30 minutes for each questionnaire (total of 60 minutes). The demographics questionnaire will include space for the panelists' biographical information and a confirmation of them meeting the inclusion criteria.

The researcher will assure each participant's anonymity through the use of pseudonyms. The key to the coding system linking participants' names with their pseudonyms will be stored in a password protected file on the researcher's computer. Hard copies of the demographics questionnaire, and the DQ I will be stored in a locked filing cabinet in the principle researcher's home office.

The DQ I will involve eight open-ended questions (Appendix H) to explore the panelists' opinion on the definition and current state of MedFT. A time allotment of two weeks will be given for panelists to return the surveys. After the two week deadline, a reminder email or phone call may be made to panelists encouraging their participation (Appendix I). Upon receiving the

responses from DQ I, the researcher will compile the responses, while avoiding duplication of responses. Frequencies will be calculated for responses mentioned by more than one participant. The primary researcher and two research assistants external to the study will review the list of responses to assess each response for clarity and redundancy. Should an item be deemed redundant, the primary researcher will re-evaluate the list of responses and strike the redundant response from the DQ II. Once finalized, the list of responses will be formulated into DQ II.

The DQ II will be distributed to respondents via the online website. Responses will be organized under each question subheading, so that each response for question one will be presented as a bulleted list under question one and so on. Next to each response will be a likert scale of one through seven, with seven indicating a strong level of agreement and one indicating a strong level of disagreement. Panelists will be asked to examine each response and then rate the response on the likert scale according to the strength of their agreement that the item be included in an optimal answer to the question. As is standard protocol, responses to DQ II will be analyzed for the median and interquartile range (Stone Fish & Busby, 2005). Responses that are selected for inclusion in the results will have a median of six or higher, indicating a high level of agreement, as well as an interquartile range (IQR) of 1.5 or smaller indicating a high level of consensus. The objective of this phase of the study will be to determine, by these measures of central tendency, which items will be included in the final responses to the research questions. Again, the time constraints for responses will be two weeks, at which time panelists will be sent a reminder email or potentially a phone call encouraging their participation. The results will be presented in both narrative and table format, with the table including the median and IQR. The results of the Delphi findings will be disseminated to participants.

While the goal of this study is to reach consensus on a definition and classification of MedFT preparation for MedFTs, scope of practice, and future issues, it is also important to investigate any extreme outliers or differences of opinions. If there are items on which a particular respondent differs greatly from the median, the researchers may contact that respondent via email or phone to seek clarification and those responses will be outlined in the results as well as the items that met the criteria for inclusion. If the researcher is unable to contact a panelist whose responses are in need of clarification for the DQ I, their answers will be included to the best of the primary researcher's ability to represent them. For the DQ II, if the researcher is unable to reach the panelist, it will be noted in the results section that outliers did exist for certain answers, to acknowledge that there were differences of opinion and these differences will be illustrated in a narrative format.

The goal of this research study is to bring together those currently working, practicing, and studying MedFT in an effort to agree on a consensus definition, clarify the scope of practice, the current roles and skills of MedFTs, as well as bring clarity to the type of and depth of preparation needed to practice. The most effective and efficient way to bring these professionals together is through the use of a two phase Delphi study conducted online. Responses to these research questions are needed so that MedFTs practicing, teaching, researching, and supervising can move forward individually and collectively in a more unified way and MedFT can create a distinct professional identity. The results from this work will be published in two formats. The first article will be a literature review, *The State of Medical Family Therapy*, while the second will contain the results of this proposed study, *The State of Medical Family Therapy: A Modified Delphi Study*.

References

- Alfuth, R., & Barnard, C. P. (2000). Family physicians and family therapists: Understanding the interdependent synergism. *Contemporary Family Therapy*, 22(3), 253-277.
- Allen, L. A., Woolfolk, R. L., Escobar, J. I., Gara, M. A., Hamer, R. M. (2006). Cognitive-behavioral therapy for somatization disorder. *Archives of Internal Medicine*, 166, 1512-1518.
- American Association of Pastoral Counseling (AAPC). "About pastoral counseling." Retrieved July 21, 2008 from <http://www.aapc.org/content/about>.
- American Counseling Association (ACA). (2008). "Ethics." Retrieved February 16, 2008 from <http://www.counseling.org/Counselors/>.
- American Psychiatric Nurses Associations (APNA) home page, (n.d.) "About PMHNs". Retrieved February 16, 2008 from <http://www.apna.org/i4a/pages/index.cfm?pageid=1>).
- Andersen, T. (1987). The reflecting team: Dialogue and meta-dialogue in clinical work. *Family Process*, 26, 415-428.
- Anderson, R., Huff, N., & Hodgson, J. (2008). Medical family therapy in an inpatient psychiatric setting. *Families, Systems, and Health*, 26, 164-180.
- Anderson, F. J. , & Winkler, A. E. (2006). Benefits of long-term fibromyalgia syndrome treatment with a multi-disciplinary program. *Journal of Musculoskeletal Pain*, 14, 11-25.
- Anderson, F. J., & Winkler, A. E. (2007). An integrated model of group psychotherapy for patients with fibromyalgia. *International Journal of Group Psychotherapy*, 57, 451-474.
- Anonymous. (1993). Book reviews - Medical Family Therapy: A biopsychosocial approach to families with health problems. *Adolescence*, 28, 753.

- Baird, C. L., & Sands, L. P. (2006). Effect of guided imagery with relaxation on health-related quality of life in older women with osteoarthritis. *Research in Nursing & Health, 29*, 442-451.
- Bakan, D. (1969). *The duality of human existence*. Chicago: Rand McNally.
- Barkley, R. A., Guevremont, D. C., Anastopoulos, A. D., & Fletcher, K. E. (1992). A comparison of three family therapy programs for treating family conflicts in adolescents with Attention-Deficit Hyperactivity Disorder. *Journal of Consulting and Clinical Psychology, 60*, 450-462.
- Barlow, D. H., Gorman, J. M., Shear, K. M., & Woods, S. W. (2000). Cognitive-behavioral therapy, Imipramine, or their combination for panic disorder: A randomized controlled trial. *The Journal of the American Medical Association, 283*, 2529-2536.
- Bartholomew, L. K., Parcel, G.S., Seilheimer, D. K., Czyewski, D. I., Spinelli, S. H., & Congdon, B. (1991). Development of a health education program to promote self-management of cystic fibrosis. *Health Education & Behavior, 18*, 429-443.
- Bartholomew, L. K., Czyewski, D. I., Parcel, G. S., Swank, P. R., Sochrider, Mariotto, Schidlow, Fink, & Seilheimer, M. M. (1997). Self-management of cystic fibrosis: Short-term outcomes of the cystic fibrosis family education program. *Health Education & Behavior, 24*(5), 652-666.
- Bateson, G. (1979). *Mind and nature*. New York: E. P. Dutton.
- Beck, A., T. (1964). Thinking and depression: Theory and therapy. *Archives of General Psychiatry, 10*, 561-571.
- Beder, J. (2006). *Hospital social work: The interface of medicine and caring*. New York: Routledge.

- Bell, J. M., Wright, L. M., & Watson, W. L. (1992). The medical map is not the territory: "Medical Family Therapy" watch your language. *Families, Systems, and Health*, 10(1), 35-39.
- Bischof, G. H., Lieser, M. L., Taratua, C. G., & Fox, A. D. (2003). Power and gender issues from the voices of medical family therapists. *Journal of Feminist Family Therapy*, 15, 23-54.
- Bloch, S., & Kissane, D. (2000). Psychotherapies in psycho-oncology. *British Journal of Psychiatry*, 177, 112-116.
- Blount, A. (Ed.) (1998). *Integrated primary care: The future of medical and mental health collaboration*. New York: Norton.
- Blount, A. (2003). Integrated primary care: Organizing the evidence. *Families, Systems, & Health*, 21, 121-134.
- Blow, A. J., & Sprenkle, D. H. (2001). Common factors across theories of marriage and family therapy: A modified Delphi study. *Journal of Marital and Family Therapy*, 27(3), 385-401.
- Brucker, P. S., Faulkner, R. A., Baptist, J., Grames, H., Beckham, L. G., Walsh, S., et al. (2005). The internship training experiences in medical family therapy of doctoral-level marriage and family therapy students. *The American Journal of Family Therapy*, 33, 131-146.
- Buchner, M., Zahlten-Hinguranage, A., Schiltenwolf, M., & Neubauer, E. (2006). Therapy outcome after multidisciplinary treatment for chronic neck and chronic low back pain: a prospective clinical study in 365 patients. *Scandinavian Journal of Rheumatology*, 35, 363-367.
- Burge, B. (2005). Feminist perspectives in medical family therapy (book review). *Australian and New Zealand Journal of Family Therapy*, 26, 175-176.

- Burgess-Manning, J. (2007). Bringing two worlds together: A collaborative interview with Jo Ellen Patterson. *Australian & New Zealand Journal of Family Therapy*, 28(1), 38-43.
- Burwell, S. R., Brucker, P. S., & Shields, C. G. (2006). Attachment behaviors and proximity-seeking in cancer patients and their partners. *Journal of Couple & Relationship Therapy*, 5, 1-16.
- Burwell, S. R., Templeton, B., Kennedy, K. S., & Zak-Hunter, L. (2008). Feminist-informed medical family therapy principles and techniques across biopsychosocial systems levels for younger women with breast cancer and their partners. *Journal of Feminist Family Therapy*, 20(2), 99-125.
- Callahan, E. J. (1997). The future of psychology in family medicine. *Journal of Clinical Psychology in Medical Settings*, 4(2), 155-166.
- Callahan, E. J., Jaen, C. R., Crabtree, B. F., Zyzanski, S. J., Goodwin, M. A., & Stange, K. C. (1998). The recent impact of emotional distress and diagnosis of depression or anxiety on the physician-patient encounter in family practice. *The Journal of Family Practice*, 46, 410-418.
- Campbell, T. L. (2003). The effectiveness of family interventions for physical disorders. *Journal of Marital and Family Therapy*, 29, 263-281.
- Campbell, T. L., & Patterson, J. M. (1995). The effectiveness of family interventions in the treatment of physical illness. *Journal of Marital and Family Therapy*, 21, 545-583.
- Candib, L. M., & Stovall, J. G. (2002). Response to Schirmer and Le. *Families, Systems, and Health*, 20, 311-320.
- Chicago Center for Family Health (CCFH). (2003). "Families, Illness & Healthcare Offerings." Retrieved from February 6, 2008 from <http://www.ccfhchicago.org/families2.html>.

- Chicago Center for Family Health (CCFH). (2007). "Families, illness & collaborative healthcare program." Retrieved February 6, 2008 from <http://www.ccfhchicago.org/families.html>.
- Christie-Seely, J. (1984). *Working with family in primary care: A systems approach to health and illness*. New York: Praeger.
- Clabby, J., & Howarth, D. (2007). Managing CHF and depression in an elderly patient: Being open to collaborative care. *Families, Systems, and Health, 25*, 457-464.
- Claiborne, N. (2006). Effectiveness of a care coordination model for stroke survivors: A randomized study. *Health & Social Work, 31*(2), 87-98.
- Cloutier, P. F., Manion, I. G., Walker, J. G., & Johnson, S. M. (2002). Emotionally focused interventions for couples with chronically ill children: A 2 year follow up. *Journal of Marital and Family Therapy, 28*, 391-398.
- Cole-Kelly, K., Yanoshik, M. K., Campbell, J., & Flynn, S. P. (1998). Integrating the family into routine patient care: A qualitative study. *Journal of Family Practice, 47*, 440-445.
- Cockburn, J. T., Thomas, F. N., & Cockburn, O. J. (1997). Solution-focused therapy and psychosocial adjustment to orthopedic rehabilitation in a work hardening program. *Journal of Occupational Rehabilitation, 7*, 97-106.
- Cohen, J. L. (1995). Somatization revisited: A case of migraine headaches. *Family Systems Medicine, 13*, 395-404.
- Collaborative Family Healthcare Association (CFHA) (2008). *Conference info*. Retrieved March 25, 2008 from http://www.cfha.net/conf_info.asp.
- Cook-Darzens, S. (2005). Family therapy: From multiple approaches to integration. *Pratiques Psychologiques, 11*, 169-183.
- Cowles, L. (2000). *Social work in the health field*. New York: Haworth Press.

- Cowley, C. B., Farley, R., & Beamis, K. (2002). "Well, maybe I'll try the pill for just a few months..." Brief motivational and narrative-based interventions to encourage contraceptive use among adolescents at high risk for early childbearing. *Families, Systems, & Health, 20*, 183-204.
- Crane, D. R. (2008). The cost effectiveness of family therapy: A summary and progress report. *Journal of Family Therapy, 30*, 399-410.
- Crane, D. R. (2007). Research on the cost of providing family therapy: A summary and progress report. *Clinical Child Psychology and Psychiatry, 12*, 313-320.
- Crane, D. R., Hillin, H. H., & Jakubowski, S. (2005). Costs of treating conduct disorder medicaid youth with and without family therapy. *The American Journal of Family Therapy, 33*, 281-291.
- Crouch, M., & Roberts, L. (1987). *The family in medical practice*. New York: Springer-Verlag.
- Czuderna, J., & Tomson, D. (1994). Family therapy and primary care: Connections and challenges. *Journal of Family Therapy, 16*, 342-345.
- de Castro, S., & Guterman, J. T. (2008). Solution-focused therapy for families coping with suicide. *Journal of Marital and Family Therapy, 34*, 93-106.
- Dalkey, N. (1972). *Studies in the quality of life*. Lexington, MA: Lexington Books.
- Dalkey, N., & Helmer, O. (1963). An experimental application of the Delphi method to the use of experts. *Management Science, 9*, 458-467.
- Dalrymple, K. L., & Herbert, J. D. (2007). Acceptance and commitment therapy for generalized social anxiety disorder: A pilot study. *Behavior Modification, 31*, 543-568.
- Dankowski, M. E., & Pais, S. (2007). What's love got to do with it? Couples, illness, and MFT. *Journal of Couple & Relationship Therapy, 6*, 31-43.

- Dankowski, M. E., Pais, S., Zoppi, K. A., & Kramer, J. S. (2003). Popcorn moments: Feminist principles in family medicine education. *Journal of Feminist Family Therapy, 15*, 55-73.
- Davey, M., Gulish, L., Askew, J., Godette, K., & Childs, N. (2005). Adolescents coping with mom's breast cancer: Developing family intervention programs. *Journal of Marital and Family Therapy, 31*, 247-258.
- Davis, T. F. (2001). From pilot to mainstream: Promoting collaboration between mental health and medicine. *Families, Systems, and Health, 19*, 37-45.
- Dawson, M. D., & Brucker, P. S. (2001). The utility of the Delphi method in MFT research. *The American Journal of Family Therapy, 29*, 125-140.
- Degges-White, S. (2005). Book review: Feminist perspectives in medical family therapy. *The Family Journal, 13*, 236-237.
- Denton, W. H., & Burwell, S. R. (2006). Systemic couple intervention for depression in women. *Journal of Systemic Therapies, 25*, 43-57.
- Desseulles, A., Johnson, S. M., & Denton, W. (2003). Emotion-focused therapy for couples in the treatment of depression: A pilot study. *The American Journal of Family Therapy, 31*, 345-353.
- Dienhart, A., & Avis, J. M. (1994). Working with men in family therapy: An exploratory study. *Journal of Marital and Family Therapy, 20*(4), start page 397. Retrieved July 21, 2008, from ProQuest database.
- Doherty, W. J. (2007, May). Fixing health care: What role will therapists play? *Psychotherapy Networker, 31*(3), 24-60.
- Doherty, W. J., & Baird, M. A. (1983). *Family therapy and family medicine*. New York: Guilford.

- Doherty, W. J., McDaniel, S. H., & Hepworth, J. (1994). Medical family therapy: An emerging arena for family therapy. *The Association for Family Therapy, 16*, 31-46.
- Doherty, W. J., McDaniel, S. H., & Baird, M. A. (1996). Five levels of primary care/behavioral healthcare collaboration. *Behavioral Healthcare Tomorrow, 5*(5), 25-28.
- Dyrbye, L. N., Thomas, M. R., & Shanafelt, T. R. (2006). Systematic review of depression, anxiety, and other indicators of psychological distress among U. S. and Canadian medical students. *Academic Medicine, 81*, 354-373.
- East Carolina University (ECU). (2006) "Doctor of Philosophy in Medical Family Therapy"
Retrieved February 16, 2008 from <http://www.ecu.edu/che/cdfr/medphd.html>.
- Edwards, T. M., & Patterson, J. E. (2003). A "Golden Girl" tarnished: Amplifying one patient's (and family's) voice through collaborative care in a family medicine setting. *Journal of Feminist Family Therapy, 15*, 75-88.
- Edwards, T. M., & Patterson, J. E. (2006). Supervising family therapy trainees in primary care medical settings: Context matters. *Journal of Marital and Family Therapy, 32*(1), 33-43.
- Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196*, 129-136.
- Engel, G. L. (1980). The clinical application of the biopsychosocial model. *The American Journal of Psychiatry, 137*, 535-544.
- Feierabend, R. H., & Bartee, Z. L. (2004). A collaborative relationship between a community mental health center and family practice residency program. *Families, Systems, and Health, 22*, 231-237.
- Figley, C. R., & Nelson, T. S. (1989). Basic family therapy skills: I. Conceptualization and initial findings. *Journal of Marital and Family Therapy, 15*, 349-365.

- Figley, C. R., & Nelston, T. S. (1990). Basic family therapy skills, II: Structural family therapy. *Journal of Marital and Family Therapy*, 16, 225-239.
- Fishman, H. C. (2006). Juvenile anorexia nervosa: Family therapy's natural niche. *Journal of Marital and Family Therapy*, 32, 505-514.
- Flock, S. A., Frank, S. H., & Wenger, D. A. (2001). Addressing multiple problems in the family practice office visit. *The Journal of Family Practice*, 50, 211-216.
- Forman, E. M., Herbert, J. D., Moitra, E., Yeomans, P. D., & Geller, P. A. (2007). A randomized controlled effectiveness trial of acceptance and commitment therapy and cognitive therapy for anxiety and depression. *Behavior Modification*, 31, 772-799.
- Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. New York: Norton.
- Friedrich, W. N., & Copeland, D. R. (1983). Brief family-focused intervention on the pediatric cancer unit. *Journal of Marital and Family Therapy*, 9, 293-298.
- Gale, A. U., & Austin, B. D. (2003). Professionalism's challenges to professional counselor's collective identity. *Journal of Counseling and Development*, 81, 2-9.
- Gawinski, B. A., Edwards, T. M., & Speice, J. (1999). A family therapy internship in a multidisciplinary healthcare setting: Trainees' and supervisor's reflections. *Journal of Marital and Family Therapy*, 25, 469-485.
- Gehlert, S., & Brown, T. A. (Eds.). (2006). *Handbook of health social work*. Hoboken, NJ: Wiley.
- Gellertstedt, M. E., & Mauksch, L. (1993). Chronic neurologic impairment: A family problem. *Family Systems Medicine*, 11, 425-431.

- Godfrey, K., Haddock, S. A., Fisher, A., & Lund, L. (2006). Essential components of curricula for preparing therapists to work effectively with lesbian, gay, and bisexual clients: A Delphi study. *Journal of Marital and Family Therapy, 32*, 491-504.
- Gonzalez, S., Steinglass, P., & Reiss, R. (1989). Putting the illness in its place: Discussion groups for families with chronic medical illnesses. *Family Process, 28*, 69-87.
- Gordon -Walker, J. G., Johnson, S., Manion, I., Cloutier, P. (1996). Emotionally focused marital intervention for couples with chronically ill children. *Journal of Consulting and Clinical Psychology, 64*, 1029-1036.
- Graham, H., Senior, R., Lazarus, M., Mayer, R., & Asen, K. (1992). Family therapy in general practice: Views of referrers and clients. *British Journal of General Practice, 42*, 25-28.
- Grauf-Grounds, C. (2007). Increasing social support to manage chronic illness. In D. Linville & K. M. Hertlein (Eds.), *The therapist's notebook for family health care: Homework, handouts, and activities for individuals, couples, and families coping with illness, loss, and disability*. New York: Haworth.
- Grauf-Grounds, C., & Sellers, T. S. (2006). Creating internships and potential jobs for medical family therapists: Lessons learned. *Families, Systems, and Health, 24*, 230-237.
- Greenberg, L. S., & Johnson, S. M. (1988). *Emotionally focused therapy for couples*. New York: Guilford.
- Gregg, J. A., Callaghan, G. M., Hayes, S. C., & Glenn-Lawson, J. L. (2007). Improving diabetes self-management through acceptance, mindfulness, and values: A randomized controlled trial. *Journal of Consulting and Clinical Psychology, 75*, 336-343.
- Griffith, J. L., & Griffith, M. E. (1992). Speaking the unspeakable: Use of the reflecting position in therapies for somatic symptoms. *Family Systems Medicine, 10*, 41-50.

- Gustafsson, P. A., Kjellman, N. M., & Cederblad, M. (1986). Family therapy in the treatment of severe childhood asthma. *Journal of Psychosomatic Research*, 30, 369-374.
- Hanna, F. J., & Bemak, F. (1997). The quest for identity in the counseling profession. *Counselor Education and Supervision*, 36(3). 194-207.
- Harkness, J. L. , & Nofziger, A. (1998). Medical family therapy casebook: Training in a collaborative context: What we did not know then...we know now. *Families, Systems, and Health* , 16, 443-450.
- Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behaviour Research and Therapy*, 44, 1-25.
- Hayes, S. C., Strosahl, K., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: Guilford.
- Hegleson, V. S., Cohen, S., Schulz, R., & Yasko, J. (2000). Group support interventions for women with breast cancer: Who benefits from what? *Health Psychology*, 19,107-114.
- Hepworth, J., Gavazzi, S. M., Adlin, M. S., & Miller, W. L. (1988). Training for collaboration: Internships for family-therapy students in a medical setting. *Family Systems Medicine: A Journal at the Confluence of Family Therapy, Systems Theory, Modern Medicine*, 6, 69-79.
- Hertlein, K. M. (2003). Reflecting on feminist suggestions and the practice of medical family therapy: One therapist's personal framework. *Journal of Feminist Family Therapy*, 15, 127-136.
- Heru, A., & Berman, E. (2008). Family meetings and integrated patient care. *Families, Systems, and Health*, 26, 181-184.

- Hodgson, J. L., Lamson, A., & Reese, L. (2007). The biopsychosocial-spiritual interview method. In D. Linville & K. M. Hertlein (Eds.), *The therapist's notebook for family health care: Homework, handouts, and activities for individuals, couples, and families coping with illness, loss, and disability*. New York: Haworth.
- Institute of Medicine (1996). *Primary care: America's health in a new era*. Washington, D.C.: National Academy Press.
- Institute of Medicine (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, D.C.: National Academy Press.
- Jencius, M. (2004). Citizen therapist: An interview with William Doherty. *The Family Journal*, 12, 82-88.
- Jenkins, D. (1996). A reflecting team approach to family therapy: A Delphi study. *Journal of Marital and Family Therapy*, 22, 219-238.
- Jenkins, D. A., & Smith, T. E. (1994). Applying Delphi methodology in family therapy research. *Contemporary Family Therapy*, 16, 411-430.
- Johnson, S. M. (2005). *Emotionally focused therapy with trauma survivors: Strengthening attachment bonds*. New York: Guilford.
- Johnson, S. M., Maddeaux, C., & Blouin, J. (1998). Emotionally focused family therapy for bulimia: Changing attachment patterns. *Psychotherapy*, 35, 238-247.
- Jones, C. G. (1975). A Delphi evaluation of agreement between organizations. In H. A. Linstone & M. Turoff (Eds.), *The Delphi method: Techniques and applications* (pp. 160-167), Reading: MA: Addison-Wesley.

- Kaslow, N. J., Collins, M. H., Loundy, M. R., Brown, F., Hollins, L. D., & Eckman, J. (1997). Empirically validated family interventions for pediatric psychology: Sickle cell disease as an exemplar. *Journal of Pediatric Psychology, 22*, 213-227.
- Katon, W. (1995). Collaborative care: Patient satisfaction, outcomes, and medical cost-offset. *Family Systems Medicine, 13*, 351-365.
- Katon, W., Von Korff, M., Lin, E., Walker, E., Simon, G. E., Bush, T., et al. (1995). Collaborative Management to Achieve Treatment Guidelines: Impact on Depression in Primary Care. *The Journal of the American Medical Association, 273*(13), 1026-1031.
- Katon, W., & Robinson, P. (1996). A multifaceted intervention to improve treatment of depression in primary care. *Archives of General Psychiatry, 53*(10), 924-932.
- Kazak, A. E. (2002). Challenges in family health intervention research. *Families, Systems, and Health, 20*, 51-59.
- Kazak, A. E., Alderfer, M. A., Streisand, R., Simms, S., Rourke, M., Barakat, L. P., Gallagher, P., & Cnaan, A. (2004). Treatment of posttraumatic stress symptoms in adolescent survivors of childhood cancer and their families: A randomized control trial. *Journal of Family Psychology, 18*, 493-504.
- Kazak, A. E., Simms, S., Alderfer, M. A., Rourke, M. T., Crump, T., McClure, K., et al. (2005). Feasibility and preliminary outcomes from a pilot study of a brief psychological intervention for families of children newly diagnosed with cancer. *Journal of Pediatric Psychology, 30*, 644-655.
- Keeley, M. L., Storch, E., Merlo, L. J., & Geffken, G. R. (2008). Clinical predictors of response to cognitive-behavioral therapy for obsessive-compulsive disorder. *Clinical Psychology Review, 28*, 118-130.

- Keeling, M. L., & Bermudez, M. (2006). Externalizing problems through art and writing: experiences of process and helpfulness. *Journal of Marital and Family Therapy*, 32, 405-419.
- Kessler, R. (2008). Integration of care is about money too: The health and behavior codes as an element of a new financial paradigm. *Families, Systems, & Health*, 26, 207-216.
- Kiecolt-Glaser, J. K., & Newton, T. I. (2001). Marriage and health: His and hers. *Psychological Bulletin*, 127, 472-503.
- Kissane, D. W., Bloch, S., McKenzie, M., McDowall, A. C., & Nitzan, R. (1998). Family grief therapy: A preliminary account of a new model to promote health family functioning during palliative care and bereavement. *Psycho-Oncology*, 7, 14-25.
- Knishkowsky, B. (1998). Medical family therapy casebook: Ruth's dizziness. *Families, Systems, and Health*, 16, 325-327.
- Knoop, H., Stulemeijer, M., de Jong, J.W., Fiselier, T. J., & Bleijenberg, G. (2008). Efficacy of cognitive-behavioral therapy for adolescents with chronic fatigue syndrome: Long term follow up of a randomized control trial. *Pediatrics*, 121, 619-625.
- Kohlenberg, B. S., Hayes, S. C., Bunting, K., Rye, A. K., & Luoma, J. B. (2008). Reducing self-stigma in substance abuse through acceptance and commitment therapy: Model, manual development and pilot outcomes. *Addiction Research and Theory*, 16, 149-185.
- Kojima, T. (2006). The development of family therapy in Japanese psychosomatic medicine. *International Congress Series*, 1287, 154-157
- Kok, C. J., & Leskela, J. (1996). Solution focused therapy in a psychiatric hospital. *Journal of Marital and Family Therapy*, 22, 397-406.

- Kowal, J., Johnson, S. M., & Lee, A. (2003). Chronic illness in couples: A case for emotionally focused therapy. *Journal of Marital and Family Therapy*, 29, 299-310.
- Lamson, A. L., & Meadors, P. L. (2007). Building your home project. In D. Linville & K. M. Hertlein (Eds.), *The therapist's notebook for family health care: Homework, handouts, and activities for individuals, couples, and families coping with illness, loss, and disability*. (pp. 225-232). New York: Haworth.
- Lask, B. (1994). The illness network: Commentary on Doherty et al., *Journal of Family Therapy*, 16, 47-51.
- Lask, B., & Matthew, D. (1979). Childhood asthma: A controlled trial of family psychotherapy. *Archives of Disease in Childhood*, 54, 116-119.
- Latz, M., & Baird, M. (1994). At the heart of the matter: One woman's bypass experience. *Family Systems Medicine*, 12, 205-212.
- Lavelle, L. (2007). The health families project. In D. Linville & K. M. Hertlein (Eds.), *The therapist's notebook for family health care: Homework, handouts, and activities for individuals, couples, and families coping with illness, loss, and disability*. (pp. 59-63). New York: Haworth.
- Law, D. D., & Crane, D. R. (2000). The influence of marital and family therapy on health care utilization in a health-maintenance organization. *Journal of Marital and Family Therapy*, 26, 281-291.
- Law, D. D., Crane, D. R., & Berge, J. M. (2003). The influence of individual, marital, and family therapy on high utilizers of health care. *Journal of Marital and Family Therapy*, 29(3), 353-363.

- Leahy, D., Galbreath, L., Powell, R., & Shinn, M. A. (1994). A case of collaboration HMO style. *Family Systems Medicine, 12*, 437-449.
- Leahy, T., & Harrigan, R. (2006). Using Narrative therapy in sport psychology practice: Application to a psychoeducational body image program. *The Sport Psychologist, 20*, 480-494.
- Liddle, H. A., Breunlin, D. C., & Schwartz, R. C. (1988). Family therapy training and supervision: An introduction. In H. A. Liddle, D. C. Breunlin, & R. C. Schwartz (Eds.), *Handbook of family therapy training and supervision*. New York: Guilford.
- Linstone, H. A., & Turoff, M. (1975). Introduction. In H. A. Linstone & M. Turoff (Eds.), *The Delphi method: Techniques and applications* (pp. 1-14), Reading, MA: Addison-Wesley.
- Linville, D., & Hertlein, K. M. (Eds.). (2007). *The therapist's notebook for family health care: Homework, handouts, and activities for individuals, couples, and families coping with illness, loss, and disability*. Haworth Press: New York.
- Linville, D., Hertlein, K. M., & Prouty Lyness, A. M. (2007). Medical family therapy: Reflecting on the necessity of collaborative healthcare research. *Families, Systems, and Health, 25*(1), 85-97.
- Madanes, C. (1981). *Strategic family therapy*. San Francisco: Jossey-Bass.
- Magliano, L., Fiorillo, A., Malangone, C., De Rosa, C., Maj, M., and the Family Intervention Working Group. (2006). Patient functioning and family burden in a controlled, real-world trial for family psychoeducation for schizophrenia. *Psychiatric Services, 57*, 1784-1791.
- Manne, S. L., Ostroff, J. S., Winkel, G., Fox, K., Grana, G., Miller, E., Ross, S., & Frazier, T. (2005). Couple-focused group intervention for women with early stage breast cancer. *Journal of Counseling and Clinical Psychology, 73*, 634-646.

- McDaniel, S. H., Campbell, T. L., & Seaburn, D. B. (1990). *Family-oriented primary care: A manual for medical providers*. New York: Springer-Verlag.
- McDaniel, S. H., Campbell, T. L., & Seaburn, D. B. (1995). Principles for collaboration between health and mental health providers in primary care. *Families Systems Medicine, 13*, 283-298
- McDaniel, S. H., & Cole-Kelly, K. (2003). Gender, couples, and illness: A feminist analysis of medical family therapy. In L. B. Silverstein & T. J. Goodrich (Eds.). *Feminist family therapy: Empowerment in social context*. (pp.267-280), Washington, DC: American Psychological Association.
- McDaniel, S. H., Harkness, J. L., & Epstein, R. M. (2001). Medical family therapy for a woman with end stage Crohn's disease and her son. *The American Journal of Family Therapy, 29*, 375-395.
- McDaniel, S. H., Hepworth, J., & Doherty, W. J. (Eds.). (1992a). *Medical family therapy: A biopsychosocial approach to families with health problems*. New York: BasicBooks.
- McDaniel, S. H., Hepworth, J., & Doherty, W. J. (1992b). Medical family therapy with couples facing infertility. *The American Journal of Family Therapy, 20*, 101-122.
- McDaniel, S. H., Hepworth, J., Doherty, W. J. (1995). Medical family therapy with somaticizing patients: The co-creation of therapeutic stories. *Family Process, 34*, 349-361.
- McDaniel, S. H., & Hepworth, J. (1992). Medical family therapy with couples facing infertility. *Journal of Family Therapy, 20*, 101-122
- McDonnell, M. G., Short, R. A., Hazel, N. A., Berry, C. M., & Dyck, D. G. (2006). Multi-family group treatment of outpatients with schizophrenia: Impact on service utilization. *Family Process, 45*, 359-373.

- McNabb, W. I., Quinn, M. T., Murphy, D. M., Thorp, F. K., & Cook, S. (1994). Increasing children's responsibility for diabetes self-care: The In Control study. *Diabetes Educator*, 20(2), 121-124.
- Mercer University School of Medicine [MUSM], "Master of Family Therapy" (2004). Retrieved February 16, 2008 from http://medicine.mercer.edu/Introduction/Degree%20Programs/Synapse%20Newsletter/certificate/pm_medical_therapy
- Mendez, F., & Belendez, M. (1997). Effects of a behavioral intervention on treatment adherence and stress management in adolescents with IDDM. *Diabetes Care*, 20(9), 1370-1375.
- Miller, S. M., McDaniel, S. H., Rolland, J. S., & Fleetham, S. (2006). *Individuals, families, and the new era of genetics: Biopsychosocial perspectives*. New York: Norton.
- Minuchin, S., Rosman, B. L., & Baker, L. (1978). *Psychosomatic families: Anorexia nervosa in context*. Oxford: Harvard University Press.
- Mittleman, M. S., Ferris, S., Shulman, E., Steinberg, G., & Levin, B. (1996). A family intervention to delay nursing home placement of patients with Alzheimer disease: A randomized controlled trial. *Journal of the American Medical Association*, 276, 1725-1731.
- Morisky, D. E., Levine, D. M., Green, L. W., Shapiro, S., Russell, R. P., & Smith, C. R. (1983). Five-year blood pressure control and mortality following health education for hypertensive patients. *American Journal of Public Health*, 73, 153-162.
- Morisky, D. E., DeMuth, N. M., Field-Fass, M., Green, L. W., & Levine, D. M. (1985). Evaluation of family health education to build social support for long-term control of high blood pressure. *Health Education Quarterly*, 12, 35-50.

- Munshower, J. C. (2004). Group visits for diabetic patients: One physician's experience. *Families, Systems, and Health*, 22, 497-500.
- Navon, S. (2005). Listening to illness/nonillness motifs: A case of fibromyalgia. *Families, Systems, and Health*, 23, 358-361.
- Neilson-Clayton, H., & Brownlee, K. (2003). Solution-focused brief therapy with cancer patients and their families. *Journal of Psychosocial Oncology*, 20, 1-13.
- Nelson, T., & Heilbrun, G., & Figley, C. (1993). Basic family therapy skills, IV: Transgenerational theories of family therapy. *Journal of Marital and Family Therapy*, 19, 253-266.
- Nelson, T., Piercy, F. P., & Sprenkle, D. H. (2005). Internet infidelity: A multi-phase Delphi study. *Journal of Couple and Relationship Therapy*, 4, 173-194.
- Ng, S. M., Li, A. M., Lou, V. W. Q., Tso, I.F., Wan, P.Y.P., Chan, D. F.Y. (2008). Incorporating family therapy into asthma group intervention: A randomized waitlist-controlled trial. *Family Process*, 47, 115-129.
- Nova Southeastern University, "M.S. in Family Therapy" (2007). Retrieved February 16, 2008 from http://shss.nova.edu/Academic_Programs/MastersPrograms/MSFT.htm.
- Oberman, A. (2006). Review of feminist perspectives in medical family therapy. *The Family Journal*, 14, 453.
- Patient Center Primary Care Collaborative [PCPCC]. (2007). *Joint principles of the patient centered medical home*. Retrieved March 16, 2008 from <http://www.pcpcc.net>.
- Patterson, J., Peek, C. J., Heinrich, R. L., Bischoff, R. J., & Scherger, J. (2002). *Mental health professionals in medical settings: A primer*. New York: Norton.

- Peek, C. J., & Heinrich, R. L. (1995). Building a collaborative healthcare organization: From idea to invention to innovation. *Family Systems Medicine, 13*, 327-342.
- Pereira, M. G., & Smith, T. E. (2006). Evolution of the biopsychosocial model in the practice of family therapy. *International Journal of Clinical & Health Psychology, 6*, 455-467.
- Petterson, S. M., Phillips, R. L., Bazemore, A. W., Doodoo, M. S., Xingyou, Z., & Green, L. A. (2008). Why there must be room for mental health in the medical home. *American Family Physician, 77*, 757-757.
- Pflaffy, C. (2007). Family-oriented diabetes management: Good nutrition and portion control. In D. Linville & K. M. Hertlein (Eds.), *The therapist's notebook for family health care: Homework, handouts, and activities for individuals, couples, and families coping with illness, loss, and disability*. (pp. 125-129). New York: Haworth.
- Pinsof, W. M., & Wynne, L. C. (2000). Toward progress research: Closing the gap between family therapy practice and research. *Journal of Marital and Family Therapy, 26*(1), 1-8.
- Pratt, D. M. (2003). Interview with Dr. Susan McDaniel: Medical family therapy and feminism. *Journal of Feminist Family Therapy, 15*, 137-147.
- Preece, J. C., & Sandberg, J. G. (2005). Family resilience and the management of fibromyalgia: Implications for family therapists. *Contemporary Family Therapy, 27*, 559-576.
- Prest, L. A., & Grames, H. (2007). Coping and adapting to developmental changes, challenges, and opportunities using a patient education tool in family therapy. In D. Linville & K. M. Hertlein (Eds.), *The therapist's notebook for family health care: Homework, handouts, and activities for individuals, couples, and families coping with illness, loss, and disability*. (pp.31-39). New York: Haworth.

- Prouty Lyness, A. M. (2003). Preface: Perspectives in medical family therapy. *Journal of Feminist Family Therapy, 15*, xvii.
- Ragaisis, K. M. (1996). The psychiatric consultation-liaison nurse and medical family therapy. *Clinical Nurse Specialist, 10*, 50-56.
- Regier, D., Narrow, W., Rae, D., Manderscheid, R., Locke, B., & Goodwin, F. (1993). The de facto U. S. mental and addictive services system: Epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry, 50*, 85-94.
- Robinson, W. D., Barnacle, R. E. S., Pretorius, R., & Paulman, A. (2004). An interdisciplinary student-run diabetes clinic: Reflections on the collaborative training process. *Families, Systems, and Health, 22*, 490-496.
- Robinson, W. D., Prest, L. A., & Carroll, J. S. (2007). An adaptive world model for meeting the demands of chronic illness. In D. Linville & K. M. Hertlein (Eds.), *The therapist's notebook for family health care: Homework, handouts, and activities for individuals, couples, and families coping with illness, loss, and disability*. (pp. 41-47). New York: Haworth.
- Robeznieks, A. (2007). Of primary importance. *Modern Healthcare, 37*, 6-7.
- Rolland, J. S., (1994). *Families, illness, and disability*. New York: Basic Books
- Rolland, J. S., & Walsh, F. (2005). Systemic training for healthcare professionals: The Chicago Center for Family Health Approach, *Family Process, 44*, 283-301.
- Rolland, J. S., & Williams, J. K. (2005). Toward a biopsychosocial model for the 21st century genetics. *Family Process, 44*, 3-24.

- Rosenberg, M. (2005). Feminist perspectives in medical family therapy (book review). *Families, Systems, and Health*, 23, 113-114.
- Rudd, N., Farley, T., Nymberg, J., & Hayden, K. (1994). Multiple personality disorder in primary care: A collaboration. *Family Systems Medicine*, 12, 327-338.
- Ruddy, N. B., & McDaniel, S. H. (2003). Medical family therapy. In T. L. Sexton, G. R. Weeks, & M. S. Robbins (Eds.), *Handbook of family therapy: The science and practice of working with families and couples*. (pp. 365-379). New York: Bruner-Routledge.
- Scheele, D. S. (1975). Reality construction as a product of Delphi interaction. In H. A. Linstone & M. Turoff (Eds.), *The Delphi method: Techniques and applications*. (pp. 37-71). Reading, MA: Addison-Wesley.
- Schilson, E., Braun, K., & Hudson, A. (1993). Use of genograms in family medicine: A family physician/family therapist collaboration. *Family Systems Medicine*, 11, 201-208.
- Schirmer, J. M., & Le, N. H. (2002). The Vietnam Family Medicine Development Project: A cross-cultural collaboration. *Families, Systems, and Health*, 20, 303-311.
- Schnurr, P. P., Friedman, M. J., Engel, C. C., Foa, E. B., Shea, M. T., Chow, B. K., et al. (2007). Cognitive behavioral therapy for posttraumatic stress disorder in women: A randomized controlled trial. *Journal of the American Medical Association*, 297, 820-830.
- Seaburn, D. B., Gawinski, B. A., Harp, J., McDaniel, S. H., Waxman, D., & Shields, C. (1993). Family systems therapy in a primary care medical setting: The Rochester experience. *Journal of Marital and Family Therapy*, 19(2), 177-190.
- Seaburn, D. B., Lorenz, A. D., Gunn Jr., W. B., Gawinski, B. A., & Mauksch, L. B. (1996). *Models of collaboration: A guide for mental health professionals workign with health care practitioners*. New York: BasicBooks.

- Seattle Pacific University, "Medical Family Therapy Certificate" (2006). Retrieved February 16, 2008 from <http://www.spu.edu/acad/grcatalog/20078/schoolscolleges/spfc/MedicalMarriageandFamilyTherapyCertificate.asp>.
- Seattle Pacific University, "Medical Family Therapy Certificate" (2008). Retrieved April 24, 2008 from <http://www.spu.edu/depts/spfc/medical/Overview/philosophy.asp>.
- Sellers, T. S. (2000). A model of collaborative healthcare in outpatient medical oncology. *Families, Systems, and Health, 18*, 19-33.
- Shapiro, J. (1993). A book review. *Family Systems Medicine, 11*, 219-221.
- Shields, C. G., & Roussea, S. J. (2004). A pilot study of an intervention for breast cancer survivors and their spouses. *Family Process, 43*, 95-107.
- Sivertsen, B., Omvik, S., Pallesen, S., Bjorvatn, B., Havik, O. E., Kvale, G., Nielsen, G. H., & Nordhus, I. H. (2006). Cognitive behavioral therapy vs. zopiclone for treatment of chronic primary insomnia in older adults. *Journal of the American Medical Association, 295*, 2851-2858.
- Smith, A., & Harkness, J. (2003, May/June). Genetic counseling and family therapy: Exploring present and future possibilities. *Family Therapy Magazine*.
- Smith Lamson, A. L., & Hodgson, J. L. (2003). Medical family therapy: From the big screen to a collaborative learning environment. *Journal of Feminist Family Therapy, 15*, 165-169.
- Smith, R. G., Rost, K., & Kashner, T. M. (1995). A Trial of the effect of a standardized psychiatric consultation on health outcomes and costs in somatizing patients. *Archives of General Psychiatry 52*(3), 238-243.

- Smock, S. A., Trepper, T. S., Wetchler, J. L., McCollum, E. E., Ray, R., & Pierce, K. (2008). Solution-focused group therapy for level 1 substance abusers. *Journal of Marital and Family Therapy*, 34, 107-120.
- Smyth, J., Stone, A., Hurewitz, A., & Kaell, A. (1999). Effects of writing about stressful experiences on symptom reduction in patients with asthma or rheumatoid arthritis: A randomized trial. *Journal of the American Medical Association*, 1999(14), 1304-1309.
- Sori, C. F., & Sprenkle, D. H. (2004). Training family therapists to work with children and families: A modified Delphi study. *Journal of Marital and Family Therapy*, 30, 479-496.
- Sota, S., Shimodera, S., Kii, M., Okamura, K., Suto, K., Suwaki, M., Fujita, H., Fujito, R., & Inoue, S. (2008). Effect of family psychoeducation program on relatives of schizophrenia patients. *Psychiatry and Clinical Neurosciences*, 62, 379-385.
- Sprenkle, D. H. (2003). Effectiveness research in marriage and family therapy: Introduction. *Journal of Marital and Family Therapy*, 29, 85-96.
- Steinglass, P. (1998). Multiple family discussion groups for patients with chronic medical illness. *Families, Systems, and Health*, 16, 55-69.
- Stone Fish, L. S., & Busby, D. (2005). The Delphi method. In D. H. Sprenkle & F. P. Piercy (Eds.) *Research methods in family therapy* (pp. 238-253). New York: Guilford.
- Stone Fish, L., & Osborn, J. L. (1992). Therapists' view of family life: A Delphi study. *Family Relations*, 41, 409-416.
- Stone Fish, L., & Piercy, F. P. (1987). The theory and practice of structural and strategic family therapies: A Delphi study. *Journal of Marital and Family Therapy*, 13, 113-125.

- Storch, E. A., Geffken, G. A., Merlo, L. J., Mann, G., Duke, D., Munson, M., et al. (2007). Family-based cognitive-behavioral therapy for pediatric obsessive-compulsive disorder: Comparison of intensive and weekly approaches. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*, 469-478.
- Streicher, P. J. (1995). A suicidal client: The limits of power and control. *Family Systems Medicine, 13*, 91-95.
- Stulemeijer, M., de Jong, W. L., Fiselier, T. J., Hoogveld, S., Bleijenberg, G. (2005). Cognitive behaviour therapy for adolescents with chronic fatigue syndrome: randomised controlled trial. *British Medical Journal, 330*, start page 14.
- Szigethy, E., Whitton, S.W., Levy-Warren, A., DeMaso, D. R., Weisz, J., Beardslee, W. R. (2004). Cognitive-behavioral therapy for depression in adolescents with inflammatory bowel disease: A pilot study. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*, 1469-1477.
- Szyndler, J. E., Towns, S., Hoffman, R. C., & Bennett, D. L. (2003). Clinical assessment, management and outcomes of a group of adolescents presenting with complex medico-psychosocial conditions. *Annals Academy of Medicine Singapore, 32*, 51-57.
- The Chicago Center for Family Health (CCFH), "Families, Illness, & Collaborative Healthcare Offerings" (2003). Retrieved February 16, 2008 from <http://www.ccfhchicago.org/families2.html>.
- Thomas-Dobersen, D., Butler-Simon, N., & Fleshner, M. (1993). Evaluation of a weight management intervention program in adolescents with IDDM. *Journal of the American Dietetic Association, 93*(5), 535-540.

- Thomasgard, M., Boreman, C., & Metz, W. P. (2004). A family under siege: Empathic mirroring and collaborative care. *Families, Systems, and Health* , 22, 245-254.
- Todahl, J. L., Linville, D., Smith, T. E., Barnes, M. F., & Miller, J. K. (2006). A qualitative study of collaborative health care in a primary care setting. *Families, Systems, and Health* , 24(1), 45-64.
- Treatment for Adolescents with Depression Study Team (TADS). (2004). Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression. *Journal of the American Medical Association*, 292, 807-820.
- Uchino, B. N., Cacioppo, J. T., & Kiecolt-Glaser, J. K. (1996). The relationship between social support and psychological processes: A review with emphasis on underlying mechanisms and implications for health. *Psychological Bulletin*, 119(3), 488-451.
- University of Nebraska Medical Center (UNMC), "Family Therapy Program" (2008). Retrieved February 16, 2008 from <http://app1.unmc.edu/fammed/familytherapy/program.htm>.
- University of Rochester Medical Center (URMC), Department of Psychiatry. (2008). "15th Annual Medical Family Therapy Intensive." Retrieved February 16, 2008 from http://www.urmc.rochester.edu/smd/psych/educ_train/family/MFTI.cfm
- University of San Diego (USD) (2008). "Marital and Family Therapy." Retrieved February, 16, 2008 from <http://www.sandiego.edu/academics/soles/acadprog/mft/medical.php>
- Vignolo, M., Rossi, R., Bardazza, G., Pistorio, A., Parodi, A., Spigno, S., et al. (2008). Five-year follow-up of a cognitive-behavioural lifestyle multidisciplinary programme for childhood obesity outpatient treatment. *European Journal of Clinical Nutrition*, 62, 1047-1057.

- Viner, R. M., Christie, D., Taylor, V., & Hey, S. (2003). Motivational/solution focused intervention improves HbA1c in adolescents with Type 1 diabetes: A pilot study. *Diabetic Medicine, 20*, 739-742.
- Von Bertalanffy, L. (1968). *General system theory*. New York: George Braziller.
- Wamboldt, M. Z., & Levin, L. (1995). Utility of multi-family psychoeducational groups for medically-ill children and adolescents. *Family Systems Medicine, 13*, 151-161.
- Wand, B. M., Bird, C., McAuley, J. H., Dore, C. J., MacDowell, M., & De Souza, L. (2004). Early Intervention for the Management of Acute Low Back Pain: A Single-Blind Randomized Controlled Trial of Biopsychosocial Education, Manual Therapy, and Exercise. *Spine, 29*(21), 2350-2356.
- Ward, M. R., & Linville, D. (2007). The angry feelings toolbox. In D. Linville & K. M. Hertlein (Eds.), *The therapist's notebook for family health care: Homework, handouts, and activities for individuals, couples, and families coping with illness, loss, and disability*. Haworth Press: New York.
- Watson, W. H., & McDaniel, S. H. (2000). Relational therapy in medical settings: Working with somatizing patients and their families. *Journal of Clinical Psychology, 56*, 1065-1082.
- Weih, K., Fisher, L., & Baird, M. (2002). Families, health and behavior: A section of the commissioned report by the Committee on Health and Behavior: Research, practice, and policy. *Families, Systems, and Health, 20*, 7-46.
- Weiner, E. L., & Lorenz, A. (1994). Initiation of a behavioral scientist: Lessons from a boy who wouldn't poop. *Family Systems Medicine, 12*, 73-79.
- Weiss, M., & Hepworth, J. (1993). A case for solutions. *Family Systems Medicine, 11*, 297-302.

- Wheeler, K., & Haber, J. (2004). Development of psychiatric-mental health nurse practitioner competencies: Opportunities for the 21st century. *Journal of the American Psychiatric Nurses Association, 10*.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: W. W. Norton & Company.
- White, M. B., & Russell, C. S. (1995). The essential elements of supervisory systems: A modified Delphi study. *Journal of Marital and Family Therapy, 21*, 33-53
- White, M. B., Edwards, S. A., & Russell, C. S. (1997). The essential elements of successful MFT a modified Delphi study. *The American Journal of Family Therapy, 25*, 213-231.
- Wilfley, D. E., Welch, R. R., Stein, R. I., Spurrell, E. B., Cohen, L. R., Saelens, B. E., Douchis, J. Z., Frank, M. A., Wiseman, C. V., & Matt, G. E. (2002). A randomized comparison of group cognitive-behavioral therapy and group interpersonal psychotherapy for the treatment of overweight individuals with binge-eating disorder. *Archives of General Psychiatry, 59*, 713-721.
- Willerton, E., Dankoski, M. E., & Sevilla Martir, J. F. (2008). Medical family therapy: A model for addressing mental health disparities among Latinos. *Families, Systems, & Health, 26*(2), 196-206.
- Winkle, W. C. (1980). A graduate-level curriculum for marriage and family therapy education. *Dissertation Abstracts International, 41* (06), 2461.
- Winkle, W. C., Piercy, F. P., & Hovestadt, A. J. (1981). A curriculum for graduate-level marriage and family therapy education. *Journal of Marital and Family Therapy, 7*, 201-210.

- Wirtberg, I. (2005). Introduction to medical family therapy. *Acta Paediatrica*, 94(Suppl 448), 45-46
- Wissow, L. S., Hutton, N., & Kass, N. (2002). Preliminary study of a values-history advance directive interview in a pediatric HIV clinic. *AIDS & Public Policy Journal*, 17, start page 17.
- Wolfgang, L., Stossel, C., & Maurice, J. (1996). Psychosocial interventions for patients with coronary artery disease: A meta-analysis. *Archives of Internal Medicine*, 156(7), 745-752.
- Wood, B. L., Lim, J. , Miller, B. D., Cheah, P., Zwetsch, T., Ramesh, S., & Simmens, S. (2008). Testing the biobehavioral family model in pediatric asthma: Pathways of effect. *Family Process*, 47, 21-40.
- Woody, M., & Mallison, M. (1973). The problem-oriented system for patient-centered care. *The American Journal of Nursing*, 73, 1168-1175.
- Wynne. L. C., McDaniel, S. H., & Weber, T. T. (Eds.). (1986). *Systems consultation: A new perspective for family therapy*. New York: Guilford Press.
- Yeager, B., Auyang, M., Brown, D. L., Dickinson, P., Goldstein, J. A., Jaffe, N., McKay, L., Roche, P., & Workman, G. (1999). MFT student training in medical family therapy: A collaborative hospital project with radiation oncology. *Families, Systems, and Health* , 17, 427-436.

Table 3

VARIABLE STATISTICS		
Variable Statement	Median	IQR
MedFT Defined		
<i>Orientation</i>		
MedFT is first and foremost an orientation of how you understand illness and the way it systemically influences the family dynamic. In addition, the understanding that no illness truly exists without psychosocial implications that should be addressed if the best standard of care is to be given.	6	1.5
MedFT is at the least an orientation to all patients that includes these biopsychosocial-spiritual aspects.	6	1
As an orientation, MedFT can serve as a collaborative initiative to include multiple disciplines in the treatment of illness and disability in the families we see.	7	1
If MedFT is an orientation, the criteria would be a way of thinking and practicing.	6	1.5
A Medical Family Therapist can work in any setting, which relates to medical family therapy being more a way of thinking than a place to work.	7	1
MedFT is all of these choices (profession, orientation, etc) as it is a way of thinking about couples and families.	6	1.5
<i>Developing Profession</i>		
MedFT is most specifically categorized as a developing profession that is a sub-type of family therapy that distinguishes itself through a specialized orientation, specific body of knowledge, and holistic (or systemic) and specialized treatment method.	6	1
<i>Intern Status</i>		
An “intern” status could be available prior to licensure in a mental health discipline where a person could classify themselves as MedFTs if they are in the process of acquiring the appropriate clinical experience within a medical setting.	6	1

Focus and Goals

MedFT involves two general meta-goals including promoting agency, defined as active commitment to and active involvement in one's own care, and communion, defined as important emotional bonds, which can often be negatively affected by the strains of disease and disability. 7 1

Theoretical Base

MedFT is the study and application of the biopsychosocial domains as it relates to the human condition. 7 1

MedFT rests on the biopsychosocial-spiritual model that compliments a medical setting and acts as a reminder to medical providers that they are not treating individuals. The patients they look at and work with in exam rooms are part of families and a larger community. 7 1

MedFT involves a holistic view of patient treatment. 7 1

MedFT is based on the theoretical foundation of systems theory. 7 1

MedFT primarily involves a therapist with specialized training beyond marriage and family therapy that incorporates knowledge of all facets of patient/family care, ie. Medical, pharmacological, social, etc. 7 1

MedFT is an expansion and application of family therapy. 7 1

MedFT is a field that requires a strong base in marriage and family therapy first. 7 1

MedFT is the application of Marriage and Family Therapy theory in a healthcare setting working with families. 6 1.5

MedFT is the integration of family therapy into behavioral medicine and biomedicine creating an integrated team-based healthcare delivery system. 6 1.5

MedFT Advocacy

The roles of MedFT are somewhat dependent on advocacy, to get us into the systems in terms of license and insurance, and research to show which interventions really work with health problems. 6 1

MedFT represents a multidisciplinary woven cloth, a multicolored, textured, and seamless blending revealing new information. This is very different from the monochromatic strands that make a cloth woven from one guild OR another.	6	1
The problem I have seen is that psychologists and social workers have been integrating themselves for much longer than family therapists. The result is that no one knows who family therapists are, and they have certainly never heard of medical family therapy. So, those who are employed in settings really had to make a spot for themselves.	6	1
MedFTs role is to teach of the benefits of MedFT, to our patients and other professionals, and to increase visibility of our skill set.	6	1
Scope of Practice (non-clinical)		
<i>Research</i>		
Scope of practice for those with a PhD in MedFT may include conducting MedFT research.	7	0
MedFTs role is to conduct research for MedFT methods and efficacy for the MedFT field.	6	1.5
MedFTs role is to conduct research for the wide range of issues associated with families, health, and clinical services.	6	1
MedFTs may also work in the research world due to their understanding of the clinical, financial, and operational worlds.	7	0
Research.	6	1.5
<i>Teaching</i>		
MedFTs are teachers of medical students, physicians, and other medical personnel about the importance of understanding families and patients from a systemic lens.	6	1
Scope of practice for those with a PhD may include teaching in a variety of settings including child and family departments as well as medical schools.	7	1

MedFTs should be involved in teaching young medical students about BPS-S aspects of healthcare.	7	.5
---	---	----

MedFTs can train future healthcare providers (biomedical and mental health) to work collaboratively and to know when to refer.	7	0
--	---	---

Administration

MedFTs' role can be that of administrator.	7	1
--	---	---

MedFTs' role can be that of program director.	7	1
---	---	---

Scope of practice for those with a PhD may include establishing a MedFT program within an existing school.	7	1.5
--	---	-----

Policy Making

Scope of practice for those with a PhD in MedFT may include making policy backed by his/her training in theory, illness over the lifespan, research, and diversity.	7	1
---	---	---

MedFTs should be involved in policy making and legislation in the improvement of the care of patients/clients.	7	0
--	---	---

Training Dependent

The scope of practice for a MedFT varies depending on their level of training, certification, or degree earned.	7	1
---	---	---

Scope of Practice (clinical)

Provision of Mental Healthcare

MedFTs role is to help address emotional and mental health co-morbidities by helping to motivate patients and families and providing behavioral solutions (e.g. for kids with ADHD).	6	1
--	---	---

MedFTs diagnose mental health conditions and illnesses.	6	1.5
---	---	-----

MedFTs treat mental health conditions and illnesses.	6	1
--	---	---

MedFTs role is providing systemic or relationally-oriented psychotherapeutic services to individual, couples, families, and groups in a range of contexts.	7	1
--	---	---

MedFTs scope of practice includes behavioral consultation.	7	1
MedFTs assess mental health conditions and illnesses.	6	1
MedFTs role with families and patients include brief therapy.	6	1.5
MedFTs provide integrated care brief therapy or traditional psychotherapy and retain their ability to collaborate and coordinate care regardless of which form of therapy is employed.	6	1
MedFTs role with families and patients includes evaluating their psychosocial needs.	7	1
MedFTs role with families and patients is to aid in patient assessment.	7	1.5
MedFTs role with families and patients includes assisting with their adaptation to the effects of mental health problems.	7	.5
<i>Provision of Clinical Care, Mental and Physical</i>		
MedFTs scope of practice includes psychotherapy with individuals/families regarding chronic and acute illness.	7	.5
MedFTs can provide brief therapy, as well as traditional longer-term therapy, for individual patients, couples, and families, focusing on the intersection of biological, psychological social, and spiritual processes.	7	1
MedFTs role is to bridge the gap between medical, psychological, social, and spiritual care.	6	1.5
MedFT is also counseling (i.e. – lifestyle modifications with patients).	6	1.5
MedFTs role with families and patients includes assisting with their adaptation to the effects of medical problems.	7	.5
MedFTs role with families and patients is to help with self-management and medical.	7	1
MedFT can build on providing family education and support by also providing psychoeducation to help build coping skills, skills for illness management.	7	1
MedFTs roles include working with diagnosis-specific issues and coping.	7	1

MedFTs role with families and patients is to aid in treatment planning.	6	1.5
MedFT is the assessment of patients, provision of brief therapy, and serving as a bridge between medical and mental health.	6	1.5
<i>Ambassadors of Patient Agency</i>		
MedFT helps families navigate and utilize the healthcare system.	6	1
MedFT is the practice of engaging families around all aspects of their health.	6	1
MedFTs role is to elevate patients to position of collaborators in their own health and mental health care.	7	1
MedFTs work to maximize self-management, support, coping, healing, and adaptation to adverse challenges.	7	1
MedFTs can help patients develop agency in their care, which can facilitate treatment planning and adherence.	7	1
MedFTs role is to collaborate with families and other providers to treat patients and/or their families to promote a sense of agency, psychological healing, and coping with difficult diagnoses and procedures.	7	.5
<i>Larger Systems Care</i>		
MedFTs role is to nurture and maintain relationships among providers that maximize the care available to patients.	6	1.5
MedFTs role is to provide consultation and overall care to systems dealing with illness, loss, and disability.	7	1
MedFTs roles include assisting healthcare providers with processing of challenging cases, burnout, and caregiver fatigue.	7	1
MedFTs scope of practice includes supporting medical providers in collaborative treatment modalities with patients and their families.	7	1
<i>Supervision</i>		
Scope of practice for those with a PhD in MedFT may include providing clinical supervision to marriage and family therapists or those with training in MedFT.	7	1

The role of MedFTs with a PhD includes a supervisor. 6 1

Clinical MedFT

Foundational Clinical Concepts

MedFTs bring family focused interventions to the typically individually-focused medical settings. 7 1

Although many providers recognize the role of family in disease and health and take a holistic approach, this seems to be a particular strength of MedFT. 7 0

MedFT will always consider the relationships among and between family members and other larger systems. 7 1

MedFT involves cases where the patient's interpersonal relationships are believed to play a key role in his/her health. 7 1

MedFTs are skilled in the synthesis of these theories (systems, three world view, biopsychosocial, etc.) into a comprehensive conceptualization of illness which is unique to MedFT. 6 1

MedFTs maintain a systemic awareness when any one of the BPS-S domains are the focus of clinical care in that moment. 7 1

MedFTs' systemic focus allows them the ability to appreciate both individual and broader perspectives, thereby stimulating the medical setting with new knowledge and perspective. 6 1

MedFTs broaden the focus of the treatment team to consider sociocultural, financial, and other ecosystemic variables as well. 7 1

MedFTs INTEGRATE physical and mental health in their approach, diagnosis, and treatment. 7 1

MedFT involves a holistic view of patient treatment. 7 1

MedFTs have the ability to integrate the biopsychosocial model into teaching, training, clinical work, and research. 7 0

MedFT must involve an appreciation for sex, race, ethnicity, socioeconomic status, and sexual orientation. 7 1

MedFT values all voices, including family members, collaborators, other stakeholders, and even medical issues or the illness itself. 7 1

MedFTs have a self awareness around their own experiences with illness, loss, and disability. 7 1

MedFT is the application of Marriage and Family Therapy techniques in a healthcare setting working with families. 6 1

Locale

Marriage and Family Therapy, Masters and Doctoral Programs 7 1.5

Oncology Centers 6 1.5

MedFTs are qualified to work in a variety of settings, including primary, secondary, and tertiary care settings. 7 .75

MedFTs are employed in Primary Care. 7 .75

MedFTs are employed in Primary Care Centers as Behavioral Health Consultants. 7 1

Some MedFTs work outside medical facilities but serve as specialists with clients for whom biomedical issues are prominent. 6 1

MedFTs are part of the healthcare system. 7 1

MedFT does not have to take place in a medical context and can span across a variety of clinical settings. 6 1

MedFT roles include working in integrated care to aid in assessment, treatment planning, adherence, and maintenance. 6 1

Presenting Issues

MedFT can include focus on acute illness. 7 1.25

MedFTs can focus on chronic illness. 7 0

MedFTs work with trauma. 7 1

Any presenting issue can benefit from use of the core MedFT principles or approaches. 6 1

Future roles for MedFTs would be needed in areas in which the medical conditions/issues facing the affected person/family are either severe (life or

function-threatening) or chronic, requiring self-management and affecting normal function.

The skills within MedFT are applicable across different presenting problems, systems consultations, teaching, such that it can be a meta-approach to many levels of intervention. 6 1

MedFTs have the ability to provide various levels of intervention. 7 1

Collaboration

MedFTs have an understanding of the ethical responsibility to collaborate with other professionals to provide the treatment patients deserve. 7 1

MedFT necessitates collaboration with all those areas of a patient's life that may influence his/her health for example, family, friends, medical providers, mental health professionals, community influences, and spiritual leaders. 7 1

MedFT must involve collaborative care with individuals, couples, families, or larger systems. 7 .5

MedFTs provide integrated care brief therapy or traditional psychotherapy and retain their ability to collaborate and coordinate care regardless of which form of therapy is employed. 6 1

MedFTs have the ability to take a meta-perspective and collaborate with a range of healthcare providers. 7 0

MedFTs have experience working and collaborating with medical providers around issues of illness, loss, and disability. 6 1

The MedFTs role is to collaborate with other providers, both medical and mental health, to achieve treatment plans that are both holistic and systemic in nature through a biopsychosocial-spiritual lens. 7 0

MedFTs role is to help leverage the efforts of the rest of the medical team and provide an in-depth assessment of family structure and its role in disease and health to help create and implement an effective therapeutic plan. 6 1

MedFTs collaborate with healthcare professionals toward constructing a coordinated treatment plan. 7 1

Succeeding in the Medical World

MedFTs who have been successful working in medical settings tend to be comfortable with taking a “one-down” position in order to learn about certain medical procedures, illnesses, medications, etc.	7	1
MedFTs are persistent with patient follow up and referral.	6	1
MedFTs can be flexible in terms of working around the constraints of the medical system, and work well with others (a team player).	7	0
MedFTs have the ability to work as a bridge between culturally diverse systems—medical, psychotherapy, and family systems.	7	1

PhD Not Necessary for Clinical Work

A PhD isn't necessary to be a good behavioral health specialist.	6	1.5
--	---	-----

MedFT Research

Informed By

Mental health and physical health would not be considered separate entities in a MedFT study. They might be analyzed separately but only in order to gather relevant data. In other words, we need to collect the data separately because those are the measures that we have available, but MedFTs really believe that health is comprised of all four parts of the biopsychosocial-spiritual construct.	6	1
I would want to know that the study was informed by a working definition of MedFT and that there was some bridging of treatment between the medical and psychosocial domains of healthcare.	6	.5
MedFT research would include the use of a systemic lens with respect to one or more of the BPS-S domains in application to the study of an illness or disability.	6	1
MedFT is the study and application of the biopsychosocial domains as it relates to the human condition.	7	1
MedFT is based on the theoretical foundation of systems theory.	7	1
MedFT will always consider the relationships among and between family members and other larger systems.	7	1

MedFT research would have recognition of the different language and meaning systems of different members of health care setting (biomedical, MFT, patient/clients).	6	1
MedFT research involves the addressing/awareness of treatment worldviews using systems ideas within collaborative (mental/medical health) care contexts.	6	.5
MedFT research would include a thorough application of systemic/marriage and family therapy work to key interpersonal medical process issues and documentation of collaboration with other medical professionals.	6	1
MedFT research is the inclusion of theoretical concepts of family therapy in a medical setting.	6	1.5
MedFT research is the inclusion of theoretical concepts of family therapy with an acute or chronic illness.	6	1
MedFT research would have recognition of the recursive nature of illness and family dynamics.	6	1.5
MedFT research would include families or context.	7	1
Collaborative and Integrated care would likely be in MedFT research although these words are used in many contexts lately.	6	1
It would either reference the tenets of MedFT (as outlined by McDaniel, Hepworth, & Doherty, 1992) or be specifically in line with those guidelines.	6	1.5
<i>Research Goals</i>		
MedFT's role is to conduct research for the wide range of issues associated with families, health, and clinical services.	6	1
Illness effects on entire family/system would be discussed in MedFT research.	6	1
MedFT research involves anything that relates to relationships and health. Anything that involves relationships and health is relevant to MedFT which draws from many disciplines.	6	1.5
First, the dependent variables would be health oriented or the participants/patients in the study would be suffering with an illness. Second, the study would be seeking to understand couple or family relationships	6	1

features that are associated or predict improved quality of life OR are testing couple or family interventions to improve quality of life or health outcome.

MedFT researchers would focus on the need for collaborative systemic treatment.	6	1
MedFT research would include populations with health problems.	6	.5
MedFT research is indicated because it would incorporate the goals of agency and communion.	6	1.5

Implications

If the MedFT research is applied research, there would be a discussion of the clinical implications.	7	1
MedFT research would include the results integrated into research findings that emphasized biological, psychological, social, and spiritual aspects that make up a holistic portrait of the patient, illness, and/or healthcare process/system under review.	6	1
If the MedFT research is basic research, there would be a discussion of how results will inform future MedFT research.	6	1
The study would be applicable to a variety of healthcare providers.	6	.75

MedFT Academics/Training

Courses

Field Training – PhD

Internship in medical setting.	7	0
At least 6 months of supervised experience within medical setting providing family systems therapy and collaborating with medical professionals.	7	1
Practicum of at least one year in a medical setting.	7	1
Inpatient training	6	1
Intensive experience in a clinical setting.	7	1
Ongoing clinical placement throughout the program	7	1
Integrated care field experience.	7	1

Internship in MedFT	7	0
Collaborative Care Field experience	7	1
Practicum in Medical Setting	7	1
Clinical supervision by a MedFT	7	1
Supervision of Supervision	7	1
<i>Field Training – MS</i>		
Practicum in medical settings	7	1
MedFTs at the Masters level should have at least 6 months of supervised experience within a medical setting providing family systems therapy and collaborating with medical professionals.	7	1
MedFTs at the Masters level should have clinical practica in MedFT at both non-medical and medical sites.	7	1.5
MedFTs at the Masters level should have a Collaborate Care Field Experience.	7	1
MedFTs at the Masters level should have a practicum of at least one year in a medical setting.	7	1
Clinical supervision by a MedFT.	6	1.5
<i>Field Training – Post Masters</i>		
MedFTs have experience in working with other health professionals.	7	.5
MedFTs should do internships in medical settings.	7	0
Training experience would include using practicum (Masters or Phd) to have a case where you go through the MedFT techniques (ie. – recognizing the biological dimension, soliciting the illness story, etc.).	7	1
MedFT includes advanced training in practice/supervision.	7	1
<i>Research/Stats – PhD</i>		
Research Methods in MedFT	7	0

Qualitative Methods	7	1
Quantitative Methods	7	1
Advanced Research Methods	7	1
Advanced Statistics	7	0
Dissertation	7	1
Research experiences in collaborative care research	7	1
<i>Research/Stats – MS</i>		
Quantitative Research Methods	6	1
Basic Research Methods	7	1
Basic Statistics	6	1
Research in Spirituality and Health	6	1.5
<i>Special Topics – PhD</i>		
Electives related to specialization	7	1
Sex Therapy	6	1
Gender and Diversity in MedFT	7	1
Medical disparity and gender/race	7	1
Death and Dying	7	1
<i>Special Topics – MS</i>		
Electives related to specialization	6	.5
Crisis Assessment	7	1
Death and Dying	7	1
Gender and Diversity in MedFT	6	1.5
Sexuality	6	1
Substance Abuse	7	1.5

Community Resource	6	1
<i>Special Topics – Post Masters</i>		
MedFTs should have training in substance abuse.	7	1.5
<i>Family and Illness – PhD</i>		
Doctoral courses should pertain to family systems.	7	1
Advanced families, illness, and disabilities	7	1
Families and Aging	6	1
Illness Across the Lifecycle	7	1
Chronic Illness and Families	7	1
<i>Families and Illness – MS</i>		
Lifecycle and Illness – peds through aging	7	1
Clinical Skills/Interventions	7	1
Family Interviewing	7	1
Family and child development	7	1
Lifespan Development	6	1
Chronic illness and families	7	1
Family dynamics – this would get at the roles that families and couples adopt and then would shed more light on treatment later as therapists learn how the illness has shifted the roles.	7	1
Families and Aging	6	1
<i>Families and Illness – Post Masters</i>		
MedFTs should take courses in health and families.	7	0
MedFTs have specific training in how disease and illness impact the life-cycle itself and what these impacts look like and mean for various levels of experience.	6	1
<i>Medical Culture and Collaboration – PhD</i>		

Medical Terminology	6	1.5
20 most common problems in primary care	7	1
Collaborating in Medical Settings	7	0
Advanced collaborative care with physicians including understanding and skills of relating with them	7	0
<i>Medical Culture and Collaboration – MS</i>		
Collaboration with Medical Providers – brushstroke conceptual coverage, hx, paradigms, cultural difference, own perceptions and illness story, healthcare past present future, basics of collaboration with medical provider, charting, pace, language, confidentiality, expectations, conversing with medical providers, etc.	7	1
Medical Terminology	6	1.5
Introduction to MedFT course to learn more about hierarchy within medical systems, functions of departments within a hospital context and other medical contexts such as community health centers, also important is ethics, language, and the art of collaboration.	7	1
<i>Medical Culture and Collaboration – Post Masters</i>		
MedFTs have some book training about medical content and medical contexts/culture.	6	1
MedFTs may work in a variety of settings after being trained in Medical Culture and Collaboration.	6	1
<i>MedFT Theory – PhD</i>		
Medical Family Therapy Theory	7	.5
Advanced Medical Family Therapy Theory	7	1
Advanced Medical Family Therapy	7	0
<i>MedFT Theory – MS</i>		
MedFTs at the Masters level should have a course in Medical Family Therapy Theory.	7	.75

MedFT Theory – Post Masters

MedFTs training allows for increases in patients’ sense of agency and improvements in the adherence to treatment (due to co-creation of plans). 7 1

Physiology/Pharmacology – PhD

Pharmacology 7 1

Basic Pharmacology 7 1

Physiology/Pharmacology – MS

Psychopharmacology 7 1

Basic Physiology 6 1

Pharmacology 6 1

Physiology/Pharmacology - Post Masters

MedFT encompasses theory/research regarding medical health presentations. 6 1

Psychopharmacology (basic knowledge of how drugs that treat physical illness can affect mental health and vice versa). 7 1

Probably a biology and human systems course, though I am not sure one exists. This course would incorporate HOW systems work, at the level of cells or organisms, and would apply some of the concepts that MedFTs study-how these mechanism also collaborate with one another, how elements of each have agency in their own right, and how an individuals’ biological/physiological issue might also be manifesting these same concepts. 6 1.5

Ideally, MedFTs should take some kind of course in the brain and mental illness so that one can converse well with physicians. 6 1

MedFTs should have coursework on common medical issues. 7 1

Health Policy- Post Masters

Doctoral courses should pertain to health policy theories. 6 1.5

Systems/Relational Theories – MS

Systems theory	7	1.5
Masters course should pertain to clinical practice theories.	7	.5
MedFTs at the Masters level should have a course in Family Therapy Theory.	7	0

Systems/Relational Theories – Post Masters

Intense training in systems theory and others (three world view, biopsychosocial, etc.) allow the MedFT to navigate the biomedical paradigm and systems theory, which are two seemingly contradictory orientations, blending them in a way that is mindful of both and excludes neither.	6	1
Training in relational theories allows MedFTs to bridge worlds when conflicts arise between family members or patients and providers.	7	.5
MedFTs have a systems perspective with a theoretical basis in family therapy.	7	1

Ethics – MS

General Ethics	7	1.5
Professionalism and Ethics of a Therapist in a Medical Setting	7	1
Ethical Issues Related to Collaboration	6	1
MedFTs should have training in research ethics	7	1

Behavioral Health Theory – Post Masters

MedFT encompasses theory/research regarding behavioral health presentations.	6	1
--	---	---

MFT Training – MS

Family therapy in relation to medical issues	7	1
Marriage and Family Therapy Training	7	0
MedFTs should have all the training one would get to be a family therapist, and then additional courses/training in appropriate medical issues and the	7	0

related biopsychosocial issues that individuals/families face.

Competencies

Therapy Skills

MedFTs have family therapy skills.	7	0
As a competency: individual, couple, and group MedFT interventions for biomedical issues.	7	.75
Core competencies include solid skills as a systemic therapist.	7	0
Core competencies include if working in a specialty area (e.g. oncology), sufficient understanding of the relevant biomedical issues, language, and providers.	7	1
Basic application of MFT models to medical family therapy cases.	7	1
Core competencies include skills in helping families manage the demands of acute and chronic illness.	7	0
Core competencies include skills in providing integrative care.	7	0
MedFTs should have competency in advanced interviewing techniques in medicine and psychosocial integration.	6	1.5
MedFTs should have competency in family oriented care of common problems in medicine.	7	0
MedFTs should be able to provide clinical evaluations.	7	.75
MedFTs should be competent in basic application of family systems concepts developmentally to acute, chronic & terminal illnesses.	7	1
MedFTs should have a personal theoretical approach to working with families.	7	1
Core competencies include the ability to empower patients to advocate for themselves in the health care environment.	7	0
MedFTs should be competent in treating stress and other harmful health behaviors.	7	1
MedFTs should be skilled in evidence-based approaches, such as cognitive behavioral therapy.	6	1.5

MedFTs have enhanced psychotherapy skills.	6	1
MedFTs should be culturally competent.	7	0

Medical Culture and Collaboration – PhD

MedFTs should have an advanced understanding of medical culture and basics about how physicians are trained.	6.5	1
--	-----	---

Medical Culture and Collaboration – MS

Basic MedFT core concepts (e.g. Levels of Collaboration, collocation, coordinated/integrated delivery systems/services, the overlap of medical and mental health problems)	7	1
Basic collaborative care with physicians including understanding and skills of relating to them.	7	0
Basic knowledge of the various disciplines involved with medical care.	7	.75

Medical Culture and Collaboration – Post Masters

All MFTs regardless of whether they consider themselves to be a MedFT should be an effective collaborator, understand some psychopharmacology, and know how to work with health related issues and loss. These issues affect our clients universally!	7	1
MedFTs should be able to collaborate with other providers (medical, mental health, and otherwise) clinically, through research and teaching.	7	1
Advanced collaboration with complex cases (anxiety, depression, high-utilizers, PTSD, dual dx, etc)	7	1
Core Competencies include the ability to facilitate communication between families and health care providers and invite coordination of services.	7	0
MedFTs have an understanding and integration of collaborative care.	7	.75
MedFTs should have a basic understanding of medical culture and basics about how physicians are trained.	6	1
MedFTs should be competent in basics of how to refer, chart and communicate with medical professionals.	7	1
Sensitivity understanding the culture and context of the medical environment.	7	0
MedFTs have knowledge of the medical culture regarding expectations about communication and what is professional.	6	1

MedFTs have basic knowledge of medical care systems (e.g. time, finances, diagnoses, treatment protocols).	6	1
MedFTs should have competency in basic medical culture & medical charting/lingo.	7	1
How to work within the medical environment as a mental health professional.	7	0
MedFTs should be able to understand the ethical issues of delivering mental health care within a medical system.	7	0
Core competencies include the ability to speak the language and communicate with a range of health care providers.	7	0
<i>Theoretical Base – Post Masters</i>		
MedFTs have an understanding of the concepts of agency and communion.	7	1
MedFTs should be able to extend ethical clinical service to diverse populations using the BPSS lens, systems, and three world view.	7	1
MedFTs have a mastery of systems theory.	7	1
MedFTs have an understanding of key theoretical and foundations of MedFT.	6	1
Core competencies include sufficient knowledge of biopsychosocial issues associated with health and illness.	7	0
Diagnostics through a BPSS lens.	7	0
MedFTs have an understanding of systemic treatment.	7	0
<i>Knowledge of Health and Relationships – Post Masters</i>		
MedFTs have an understanding of systemic treatment.	7	1
MedFTs should be competent I the impact of health and wellness on mental health functioning and the impact of mental health functioning on health and wellness.	7	0
MedFTs have an understanding of the impact of illness on the individual and the family.	7	.75
MedFTs are knowledgeable about the impact of physical conditions on the psychosocial and spiritual domains.	7	1
<i>Knowledge of Diseases – Post Masters</i>		
MedFTs should be competent in medical knowledge including varieties of illness, pharmacology, medical professionals etc.	6	1
MedFTs have a better understanding of psychopharmacology and its systemic effects.	6	1

MedFTs have knowledge of acute and chronic illness and their ever expanding treatments.	6	1
---	---	---

MedFTs should have competency in basic disease processes & treatments.	7	1
--	---	---

Teaching – Post Masters

MedFTs should be able to educate others on what MedFT is and how it is different from other mental health professions.	7	1
--	---	---

MedFTs should have the ability to teach systems.	7	1
--	---	---

MedFTs should have strong abilities to teach BPSS.	6.5	1
--	-----	---

MedFTs should be able to give feedback and receive feedback to other students practicing MedFT through reflecting teams, supervision, and cotherapy.	6	1
--	---	---

Administration/Business – Post Masters

MedFTs know how to implement and manage an integrated care practice model.	6	1
--	---	---

MedFT Core Competencies include the ability to enter a medical system and create a niche for self.	6	1.5
--	---	-----

MedFTs should be competent in marketing to physician groups and how to do a market analysis for MedFT opportunities.	6	1
--	---	---

Evidence Base – Post Masters

MedFTs should know the research on interventions with health problems and with psychiatric problems.	7	1
--	---	---

MedFTs are knowledgeable about the medical, psychological, social, and spiritual.	7	1
---	---	---

MedFTs should have a good grasp on the literature and what evidence based (and other) research exist in related to MedFT.	7	1
---	---	---

Family Therapy/Family Systems – PhD

MedFTs should have competency in advanced application of family systems concepts developmentally to acute, chronic & terminal illnesses.	7	0
--	---	---

Family Therapy/Family Systems – MS

Family Systems knowledge	7	0
--------------------------	---	---

Clinical competence in child, family, couples therapy.	7	0
--	---	---

Family Therapy/Family Systems – Post Masters

Marriage and Family Therapists graduating with medical family therapy	6	1.5
---	---	-----

skills are able to introduce the concept into their practice.

BPSS/Applied MedFT – PhD

MedFTs should have competency in advanced applied MedFT with variety of chronic, acute and terminal illnesses. 7 .5

MedFTs should have competency in advanced spirituality and health assessment using biopsychosocial-spiritual tools. 7 1

MedFTs should have competency in advanced Medical Family Therapy core concepts (eg Levels of collaboration, colocation, coordinated/integrated delivery systems/services, the overlap of medical and mental health problems). 7 0

BPSS/Applied MedFT – Post Masters

MedFTs should have competency in basic applied MedFT with variety of chronic, acute and terminal illnesses. 7 .5

Self Care – Post Masters

MedFTs should be able to understand their own family illness stories, self-of-provider issues, and biases since they will impact care they deliver. 7 0

MedFTs should have competency with regards to self care to avoid burnout. 7 .5

DSM Knowledge – Post Masters

MedFTs have knowledge in the DSM-IV-TR in order to be able to communicate effectively with medical personnel. 6 1

MedFTs should be competent in DSM basic knowledge. 7 .5

Treatment Planning – PhD

Advanced treatment planning from holistic assessment. 7 .75

Treatment Planning – MS

Basic treatment planning from holistic assessment. 7 0

Treatment Planning – Post Masters

MedFTs have a competency in assimilating medical, social, spiritual, psychological, and general knowledge into an assessment and treatment plan. 6 1