

Chapter 2

A Review of Medical Family Therapy: 30 Years of History, Growth, and Research

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Medical Family Therapy (MedFT) began developing in the 1980s in response to several opposing forces including the fragmented system of health care, disconnection between behavioral health and medical providers, separation of the treatment of the mind from the body, and extraction of the patient from the family/community. Clinicians, educators, healthcare administrators, and researchers began to address the importance of collaboration between the medical and behavioral health fields, and the relationship between family medicine and family therapy was born (McDaniel & Amos, 1983; McDaniel & Campbell, 1986; McDaniel, Campbell, & Seaburn, 1989). McDaniel, Hepworth, and Doherty (1992a) used the term Medical Family Therapy (MedFT) to refer to 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” (p. 2).

Fifteen years after McDaniel and colleagues’ (1992a) groundbreaking text, in an effort to identify how MedFT has evolved since its inception, Linville, Hertlein, and Prouty Lyness (2007) reviewed the empirical research on its efficacy and effectiveness, as well as the research focusing on “family interventions and health.” They expressed in their paper that they included other research on “family interventions and health” due to the challenges of identifying available research branded as MedFT. It appeared that researchers were using different variables to define MedFT at times, and without a universally agreed-upon definition in place, this made determining what could be classified as MedFT difficult.

A possible explanation for the lack of a concurrent definition is the developmental changes in MedFT across time. According to some proponents of MedFT, it has grown from being a clinical orientation, or framework, to a field that is making unique contributions to the research literature and serving as the foundation for

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training programs, particularly in family therapy (Edwards & Patterson, 2003; Marlowe, 2011; Tyndall, Hodgson, Lamson, White, & Knight, 2014). The intention of this chapter is to review the literature where MedFT is mentioned by name and unveil its developmental trajectories for research, training, and practice.

Literature Review Method

This literature review process followed three phases. First, a search was conducted using several databases: Academic Search Premier, ProQuest, Psychological and Behavioral Sciences, PubMed, PsycINFO, PsycARTICLES, CINAHL, and EBSCOhost. The search included the following parameters: (a) English language, (b) all years since its inception (i.e., 1992), and (c) the full phrase “Medical Family Therapy” in the abstract or title. Second, 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*. Third, several articles were found that were professional interviews of MedFT pioneers. A total of 96 articles from 1992 through 2012, empirical and nonempirical, fit the search criteria. The resulting literature was categorized into the following four themes: (a) historical emergence of MedFT, (b) contemporary MedFT skills and applications, (c) punctuating the “family therapy” in MedFT, and (d) MedFT effectiveness and efficacy research. Most of the literature is chronologically presented within each thematic category.

Emergence of MedFT in the Literature

While clinicians were already practicing MedFT in the 1980s (Ruddy & McDaniel, 2003), it was not until the early 1990s that the practice was formally introduced into Western literature (Doherty, McDaniel, & Hepworth, 1994; McDaniel, Hepworth, & Doherty, 1992a). The primer text by McDaniel and colleagues, *Medical Family Therapy*, was published in 1992 providing the first working definition, description, and text about MedFT. Six favorable reviews in peer-reviewed journals reinforced its unique and needed contribution to the healthcare industry (Anonymous, 1993; Fulton, 1996; Griffith, 1994; Kazak, 1993; Kelley, 1993; Shapiro, 1993). It was a time when a patient’s autonomy and support system were treated as ancillary to health care and a group of systemic thinkers sought out to challenge this status quo thinking. McDaniel, Doherty, and Hepworth (2014) captured healthcare’s movement in the integration of the patient and family with the publication of their second edition MedFT text entitled *Medical Family Therapy and Integrated Care*. In their second edition, they updated the definition of MedFT to read, “Medical family therapy is a form of professional practice that uses the biopsychosocial model and systemic family therapy principles in the collaborative treatment of individuals and

families dealing with medical problems” (p. 9). However, the initial emergence of MedFT was not without controversy. Three articles were published within the next few years debating the need for and naming of MedFT. Family nurses, Wright, Watson, and Bell (1992) asserted that the word “medical” limited the focus on the biological and excluded work done in this area by nonphysician professionals. Lask (1994), a psychiatrist, argued that MedFT, as he understood it, was a biopsychosocial (BPS) approach to working with patients and their families that had been practiced for over 40 years in various forms in the United Kingdom (UK). While Czauderna and Tomson (1994) also mentioned the presence of MedFT in the UK, especially in secondary and hospital settings, they acknowledged that McDaniel and colleagues (1992a) introduced the idea of integrating family therapy into primary care, which is something that had not been done in the UK.

With continued reflection on the emergence and development of MedFT, interviews with several MedFT leaders surfaced (Burgess-Manning, 2007; Dankoski, 2003; Jencius, 2004; Pratt, 2003), populating the literature with information about this newly named way of doing family therapy in healthcare settings. In a 2012 special issue on MedFT published in the *Journal of Contemporary Family Therapy*, Dr. Barry Jacobs interviewed the pioneers of MedFT, McDaniel, Hepworth, and Doherty on the state of MedFT. They punctuated how advocates for MedFT have encouraged them to publish a second edition of their pioneering text due to continued growth and development in this area (McDaniel et al., 1992a). One of the debated topics in that interview included whether or not MedFT should be considered a subspecialty of a discipline (like Health Psychology or Medical Social Work) or a framework adoptable by any health professional operating from a systemic and BPS approach. As mentioned above, in 2012, a special edition of *Contemporary Family Therapy* was published focusing on MedFT. In it, Hodgson, Lamson, Mendenhall, and Crane (2012) described the current healthcare climate as rich with opportunity for Medical Family Therapists (MedFTs) trained in collaborative care and systemic thinking and urged those in the field to be purposeful in the training provided, research conducted, and integrating themselves into healthcare settings. This was the first special issue ever exclusively published on MedFT in any scholarly journal and marks its continued advancement since McDaniel and colleagues’ (1992a) pioneering text.

Contemporary MedFT Skills and Applications

Dissemination and training. Since 1992, when McDaniel and colleagues published their landmark text, authors and researchers from a variety of disciplines have written about how they have applied MedFT concepts and ideas. A discussion of the clinical applications of MedFT with infertility issues was one of the earliest publications (McDaniel et al., 1992). In this article, McDaniel and colleagues (1992b) noted, “The roots of medical family therapy are intertwined with the origins of the field. Pioneers such as Whitaker, Auerswald, Bowen, Wynne, and Minuchin

foresaw the use of family therapy for problems of both mental and physical health” (p.103). They reinforced the importance of using a collaborative, biopsychosocial, and family systems framework when treating medical and behavioral health conditions. They wrote, “Medical family therapy interweaves the biomedical and the psychosocial by utilizing a biopsychosocial/systems theory, with collaboration between medical providers and family therapists as a centerpiece of the approach” (p. 101). Infertility and reproductive issues continued to be fertile ground for the application of MedFT as a foundational theory (McDaniel, 1994). However, a need emerged for proponents of MedFT to have a place where they could disseminate their ideas and vision for the potential of MedFT in healthcare settings.

The initiation of the *Medical Family Therapy Casebook* section of the journal *Family Systems Medicine* (now renamed the journal of *Families, Systems, and Health*) began in 1993. The MedFT Casebook was intended to be a forum for clinicians to present a clinical case and commentary with the first article published in 1993 by Weiss and Hepworth. The MedFT Casebook was published through 2009 with a total of 18 articles, not inclusive of commentaries separately published from the main article (Altum, 2007; Bayona, 2007; Candib & Stovall, 2002; Harp, 1998; Siegel, 2009) illustrating how MedFT concepts could be applied clinically. Many of these articles were written to highlight collaborative and training opportunities (Weiner & Lorenz, 1994). For example, casebook authors advocated for clinical observation and immersion to serve as the two main mechanisms for building MedFT skills. They targeted application of skills across certain diagnostic areas, including, but not limited to, somatization disorders (Cohen, 1995), congestive heart failure (Clabby & Howarth, 2007), diabetes (Munshower, 2004), Munchausen (Kannai, 2009), fibromyalgia (Navon, 2005), neurologic impairment (Gellerstedt & Mauksch, 1993), parenting children with health challenges (Rosenberg, Brown, & Gawinski, 2008; Thomasgard, Boreman, & Metz, 2004), and HIV/AIDS (Lowe, 2007). MedFT Casebook authors also addressed navigating cultural differences in establishing care (Schirmer & Le, 2002), supporting the doctor–patient relationship (Knishkowsky & Herman, 1998; Radomsky, 1996), and facilitating the act of collaboration (Leahy, Galbreath, Powell, & Shinn, 1994; Prest, Fitzgibbons, & Krier, 1996; Ruddy et al., 1994). A recent review of these casebook articles was conducted by Bischoff, Springer, Felix, and Hollist (2011). The review revealed that not all casebook articles were using the same language (i. e., lexicon) to describe MedFT, and over time, articles appeared to be written more about the act of collaboration rather than the practice of MedFT. Bischoff and colleagues (2011) noted, “It would be more appropriate to label what is reflected in the Casebooks as ‘collaborative care’” (p. 195). This could explain why this section of the journal appears to change names from “Medical Family Therapy Casebook” to “Casebook” (Berkley, 2000; Fogarty, 2001; Riccelli, 2003; Souza, 2002) and then to “Family Therapy Casebook” (Edwards & Turnage, 2003) throughout the years. While the lack of consistency with titling may seem insignificant to some, it reflected a symptom of either uncertainty surrounding the definition and practice of MedFT (Bischoff et al., 2011; Linville et al., 2007) or its adoption as part of the collaborative care movement.

MedFT with diverse patient populations and diagnoses. The work of MedFT with diverse patient populations has been written about with particular respect for marginalized groups. In the early 2000s, family therapy and public policy journals published pieces that expanded the theoretical perspectives and practice of MedFT, while referencing stories of clinical success with highly complex patients and families (McDaniel, Harkness, & Epstein, 2001; Wissow, Hutton, & Kass, 2002). Around this time, *Feminist Perspectives in Medical Family Therapy* was published with articles that paid special attention to the role of gender and power dynamics in the medical environment (Bischof, Lieser, Taratua, & Fox, 2003; Dankoski, 2003; Edwards & Patterson, 2003; Hertlein, 2003; Pratt, 2003; Prouty Lyness, 2003; Smith-Lamson & Hodgson, 2003). Several largely favorable reviews of the compilation were published shortly thereafter (Burge, 2005; Degges-White, 2005; Oberman, 2006; Rosenberg, 2005; Trepal, 2005). Developmentally, MedFT was at the point where it was building general clinical skills, and thinking about how to do so with cultural sensitivity, while building a theoretical infrastructure central to its practice.

Over time, more literature emerged highlighting the skills and applications of MedFT with patients diagnosed with a variety of illnesses such as diabetes (Phelps et al., 2009; Robinson, Barnacle, Pretorius, & Paulman, 2004), pediatric HIV/AIDS (Wissow et al., 2002), fibromyalgia (Preece & Sandberg, 2005), somatoform and chronic fatigue syndrome (Szyndler, Towns, Hoffman, & Bennett, 2003), and cancer (Burwell, Templeton, Kennedy, & Zak-Hunter, 2008; Dankoski & Pais, 2007; Hodgson, McCammon, & Anderson, 2011; Hodgson, McCammon, Marlowe, & Anderson, 2012). Research was beginning to take a more central place in the evolution of MedFT as clinicians, educators, and scholars wanted to understand what was making the difference. For example, Robinson and colleagues (2004) wrote about how they incorporated a MedFT student in their work with patients on an interdisciplinary team. The medical family therapist was tasked with assessing for psychosocial strengths and or challenges related to the patient's health condition, as well as other life stressors that may also involve the family. The medical family therapist gained invaluable experience through cross-training and collaborating with medical and pharmacy students, and the medical students learned the value of the psychosocial aspects of the illness.

While researchers were beginning to think about how to study the effectiveness of MedFT with a variety of cultural groups and diagnoses, Willerton, Dankoski, and Sevilla Martir (2008) made the case for how MedFTs are well trained in a systems orientation and, therefore, afforded a skill set to better respect the cultural importance of the family in Latino communities. Willerton and colleagues (2008) also listed a variety of potential skills brought to the table by MedFTs, including conducting therapy with patients in a medical setting, consulting with healthcare teams in the care of patients, and providing education for medical students and residents. MedFT and collaborative care were becoming inseparable. Phelps and colleagues (2009) took it a step further and presented a culturally and spiritually sensitive integrated care model for working with underserved African-American and Hispanic patients with type 2 diabetes. In it they utilized a medical family

therapist as a member of a community health center team who enacted his skill set as systems interventionist and collaborator and worked with each identified patient, their support system, nutritionist, and primary care provider collaboratively so that the patient could benefit from a more cohesive healthcare team. Included in the cultural competency skills noted by Phelps and colleagues (2009), the authors addressed the influence of spirituality and the impact it had on some patients' healthcare decisions.

One of the most recent articles applied the seven MedFT techniques developed by McDaniel and colleagues (1992a) to sexual dysfunction (Hughes, Hertlein, & Hagey, 2011). They presented MedFT as a framework that was previously shown to be helpful with chronic illness but had not yet been utilized to help couples cope with sexual dysfunction as a result of an illness. These techniques are as follows: (a) recognize the biological dimension, (b) solicit the illness story, (c) respect defenses and remove blame and unacceptable feelings, (d) maintain communication, (e) attend to developmental issues, (f) increase a sense of agency in the patient and the family, and (g) leave the door open for future contact. Hughes and colleagues (2011) provided a case example and outlined possible examples of how to employ these techniques; however, they did not specify any training necessary for a clinician to implement these techniques.

Lastly, Marlowe, Hodgson, Lamson, White, and Irons (2012) conducted a study using ethnography of communication to outline an integrated care framework for behavioral health providers functioning in a primary care setting where the behavioral health providers were trained marriage and family therapists and MedFTs. As primary care presents a wide range of possible patient interactions, this article was especially helpful in providing the interactional sequences between MedFTs, primary care providers, and patients that take place during the patient encounter. Also highlighted in this contribution was the importance of the relational training of a MedFT to the success of the integrated care framework. In a military healthcare setting, Lewis, Lamson, and Leseuer (2012) made the case for the inclusion of a BPS assessment to be done earlier and more regularly for veterans and their partners. Lewis and colleagues (2012) argued that MedFTs are the most prepared behavioral health clinicians to address the connection between relationships, stress, and health for military members.

While family therapy concepts and ideas have helped to form the basis of MedFT research and application, MedFT still remained something that only a subset of family therapists, and members of other behavioral health disciplines, did. Unfortunately, across the articles reviewed under this theme, there is not a consensus regarding what skills or training is required to become a medical family therapist (e.g., family therapists or systemic providers) or even on the definition of MedFT. For example, using MedFT as a framework (Hughes et al., 2011; McDaniel, Doherty, & Hepworth, 2013; Wissow et al.; 2002) alludes to the idea that MedFT can be used by a variety of healthcare clinicians and practitioners, but this then furthers the question: What are the required training components of MedFT? The constant through each article and research study reviewed was the

endorsement of biopsychosocial and systemic intervention and adherence in varying degrees to family therapy principles and practices.

Punctuating the “Family Therapy” in Medical Family Therapy

The systemic nature of MedFT. Authors have demonstrated that the practice of MedFT can have an impact on the clinician as well as the family, illustrating the breadth of the treatment system and the bidirectional influences impacting it. For example, citing the application of family systems theory and MedFT, Streicher (1995) provided a case study of a patient with seizure disorder that highlighted a transformative process for her as a therapist and a transformative process for her client. She highlighted the importance of recognizing the limits of the therapist’s power and control in the therapeutic process and how that might mirror a patient’s experience with power and control in coping with an illness. McDaniel, Hepworth, and Doherty (1995) endorsed the importance of systemic thinking as a foundation for MedFT through their work with somaticizing patients. These same leading authors, McDaniel, Hepworth, and Doherty (1999), outlined emotional themes that patients and families may experience regardless of the illnesses and discussed ways that MedFTs can be useful in working through those challenges systemically.

After an introduction highlighting the benefits of family-centered care (Alvarez, 1996), Ragaisis (1996) referenced MedFT while using a combination of elements from systems theory, systemic belief theory, crisis theory, communication theory, developmental theory, structural–strategic theory, and Milton Erickson’s work. Ragaisis (1996) articulated the application of MedFT by psychiatric consultation–liaison nurses (PCLN) due to their knowledge about diseases and the ability to move easily among the family, medical professionals, and staff. While Ragaisis (1996) noted that the PCLN would benefit from outside supervision by a colleague skilled particularly in family therapy, she saw MedFT as an orientation to be adopted by other professions and not necessarily belonging exclusively to the field of family therapy.

The case for MedFT as a subspecialty of family therapy. In 1995, Campbell and Patterson published an expansive literature review on family-based interventions that served as the foundation for MedFT. They defined MedFT based on the McDaniel and colleagues’ (1992a) primer text and called for all family therapists in training to receive training in MedFT or, at the very least, training in how to operate from a BPS framework. They also recommended MedFTs complete academic courses via a traditional medical curriculum (e.g., psychopharmacology). Twelve years later Dankoski and Pais (2007) made a similar plea to all marriage and family therapists (MFT) to employ key MedFT techniques such as genograms, establishing a collaborative relationship with the patient’s provider and addressing the biological needs of the patient. This workforce development need was recently reinforced

in an editorial written by Hodgson and colleagues (2012) for the MedFT special issue published in the *Journal of Contemporary Family Therapy*. They called for more MFTs to specialize in MedFT as described by McDaniel and colleagues (1992a), particularly due to the opportunities created for behavioral health professionals as a result of healthcare reform. In what seems to be an effort to emphasize the importance of MFTs being trained in MedFT, throughout the years authors have also turned their attention toward field-based cross-training experiences with medical professionals (Edwards & Patterson, 2003; Harkness & Nofziger, 1998; Yeager et al., 1999). These publications appeared as integrated health care was beginning to take root (Blount, 1998). Articles reflecting the training process of MedFTs, with respect to training techniques (Smith-Lamson & Hodgson, 2003), also appeared in 2003. Soon after, Brucker and colleagues (2005) discussed existing MedFT internship experiences offered to marriage and family therapy doctoral students that outlined the importance of the development of a particular skill set needed to work in healthcare settings.

MedFT gained international recognition as authors paid special attention to the evolution of family therapy and application of the BPS approach in MedFT (Kojima, 2006; Pereira & Smith, 2006; Wirtberg, 2005). However, some differences or confusion regarding the definition and practice of MedFT became apparent. For example, Kojima (2006) mentioned that MedFT was conducted via co-therapy by a physician and a therapist in one room with the family. While Kojima (2006) did not illustrate specific MedFT skills, in the brief history and evolution of family therapy and MedFT, the importance of involving the family in the treatment of psychosomatic medicine and any healthcare practice was highlighted. Pereira and Smith (2006) argued that several of the seven techniques cited by McDaniel and colleagues (1992a) were not unique to MedFT and rather were very similar to traditional family therapy; however, they believed illness- and health-related techniques (recognize the biological dimension, solicit the illness story, and maintain communication), along with the focus of the presenting problem being illness or health related, were considered to set MedFT apart from other therapies. Pereira and Smith (2006) further stated that MedFT was a metaframework, in which family therapy is applied to medical problems.

In a clinical case study of a pediatric patient with HIV/AIDS, interventionists were designated as family therapists, rather than MedFTs, indicating a link between family therapy and MedFT but rendering the difference between family therapists and MedFTs unclear (Davey, Duncan, Foster, & Milton, 2008). In a clinical case illustration involving the application of MedFT with polytrauma rehabilitation, MedFT and ambiguous loss were cited as being helpful perspectives from which to work (Collins & Kennedy, 2008). These authors again referenced the influence of family systems by defining MedFT as a BPS and family systems perspective whose proponents utilize MedFT techniques authored by McDaniel and colleagues (1992a) (soliciting the illness story, respecting defenses, remove blame, and accepting unacceptable feelings). Furthermore, the concepts of agency and communion were referenced as important therapeutic goals, but the element of collaboration was largely absent. In an article written by Collins and Kennedy (2008), the

words family therapy and MedFT were used interchangeably. The authors' heavy emphasis on family systems further supported the strong and developing epistemological connection between family therapy and MedFT.

Key elements of McDaniel and colleagues' (1992a) original definition of MedFT (i.e., BPS perspective, collaboration, and family systems) continued to be referenced in the literature. While another group noted that the practitioner's field did not matter as much as their skills in systemic orientation and thinking (Willerton et al., 2008), others like Marlowe (2011) contended that MedFT was an extension of family therapy using the same systemic and relational lens but in a different context. Marlowe (2011) also stated that family therapy was the professional home of MedFT drawing a very clear connection. These inconsistencies punctuate the need for a clear definition and set of core competencies for MedFT, as well as an agreed-upon list of metrics to help evaluate its outcomes.

MedFT Effectiveness and Efficacy Research

Campbell and Patterson (1995) discussed that family therapy research and family-based intervention research in the form of controlled trials were sparse. Only a few researchers have attempted to study the effectiveness of MedFT in healthcare settings (all of which were authored by family therapists); no known researchers have measured its efficacy. There are no known randomized control trials comparing the outcomes of family therapists practicing MedFT with other behavioral health disciplines. The first study to examine the MedFT skill set and its benefit was conducted on an outpatient medical oncology unit (Sellers, 2000). Quantitative surveys and qualitative interviews revealed that healthcare providers, patients, and their partners benefitted from the addition of MedFT services. The three most noted areas of benefit from the physicians and staff included the convenience of having the medical family therapist on-site, the support and hope provided to the patients, and the relief that was brought to the physicians and staff by having this support in place. Additionally, patients and their families were also surveyed and reported benefits included a 90 % reduction in emotional suffering due to the work with the MedFT, a 91 % increase in being able to access personal resources, and a 73 % increase in the ability to remain hopeful and maintain clarity about their cancer experience.

Hodgson and colleagues (2011) identified a need for delving further into the systemic interactions of the MedFT through a phenomenological study conducted in an oncology setting. Investigators interviewed patients and their partners. They identified some of the following characteristics of MedFTs to be most helpful: (a) ability to anticipate and address anxiety in a systemic manner, (b) ability to mobilize and go where the patient needed him/her to go in terms of physical setting or location, and (c) ability to provide and address the couple relationship. Participants particularly noted that the medical family therapist offered more than a patient-centered outcome—they offered a family-centered one.

Bischof and colleagues (2003) conducted a qualitative study of MedFTs' experiences working in a primary and secondary healthcare setting. While the researchers did not define MedFT, they did reference the foundational McDaniel and colleagues (1992a) text. Qualitative interview data revealed themes of power and gender dynamics in the healthcare 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 they could be seen both as a potential threat to other healthcare providers and as an ally in helping providers care for themselves. Again, while this study is important to understanding the skills and value added by MedFTs, it does not demonstrate that their work resulted in outcomes similar to or different from other behavioral health disciplines.

In an attempt to further understand MedFTs' contributions in secondary care settings, Anderson, Huff, and Hodgson (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 and colleagues (1992a), Anderson and colleagues (2008) referenced the systems framework, biopsychosocial-spiritual perspective, the importance of collaboration, and the concepts of agency and communion. However, one slight difference in their definition was the expansion of the BPS perspective to include spirituality. While Anderson and colleagues (2008) highlighted the collaborative model and approach used to integrate into an inpatient psychiatric setting, they did not report on the specific strategies MedFTs used to address the spiritual needs of their patients and patients' families. They deconstructed the timeline of the MedFTs' involvement in a patient care encounter into three phases: pre-session preparation, during session, and post-session follow-up. For each phase they included data evidencing the skills and applications of the MedFTs. This was the first field study of MedFTs in an inpatient behavioral health setting. A follow-up commentary on this article by psychiatrists Heru and Berman (2008) suggested that the addition of a medical family therapist to an inpatient unit would be beneficial, because historically families have sometimes been either avoided or demonized on these units by staff members.

In 2009, Harrington, Kimball, and Bean explored the inclusion of a medical family therapist on a pediatric oncology multidisciplinary team. While the authors did not define MedFT, they did reference McDaniel and colleagues' (1992a) guiding therapeutic principles when working with children diagnosed with a chronic illness. The researchers revealed that participants perceived relief in having the availability of a medical family therapist 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 families' 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 subdiscipline. 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, the research base must be strengthened with a wider variety of research methodologies that demonstrate the efficacy of MedFT. Mendenhall, Pratt, Phelps, and Baird (2012) outlined the variety of research methodologies that could be employed to deepen the MedFT research base. They included both quantitative, qualitative, and mixed-method designs, all while focusing on the importance of examining MedFT from a clinical, operational, and financial lens in health care.

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 (a) to establish a current definition of MedFT, (b) to implement effectiveness and efficacy studies of MedFTs and MedFT interventions, and (c) to develop a curriculum and core competencies for MedFT that are grounded in systemic skills and family therapy practice and research.

A Current Definition

Analysis of the literature reveals that the practice of MedFT has grown since its inception in the late 1980s (Ruddy & McDaniel, 2003). This was evidenced by the number of publications ($n = 96$) that have been produced since 1992 with the words “Medical Family Therapy” in the abstract or title. Given the absence of a consistent definition or agreement on its relationship to a specific discipline (i.e., family therapy), Linville and colleagues (2007) challenged MedFTs to operationalize their work to advance their science. To date, no one has accepted this challenge, despite evidence in the literature that McDaniel and colleagues’ (1992a) original definition of MedFT continues to mature and develop. Though the differences in definitions of MedFT may be subtle, such variances can alter how MedFT is taught, practiced, and studied. It does not have a consistent lexicon, or language, used to describe it. For example, throughout the literature, the BPS perspective is pervasive (e.g., Burwell et al., 2008; McDaniel et al., 2001; Smith-Lamson & Hodgson, 2003), but the spiritual dimension endorsed by some proponents of the BPS model is mentioned less frequently (e.g., Linville et al., 2007; Phelps et al., 2009). Hodgson, Lamson, and Reese (2007) published a chapter attempting to help all behavioral health clinicians envision a method for including spirituality into their BPS interview, but this area still remains largely understudied.

A lack of a cohesive definition or core training standards compromises the ability to capture outcomes attributable to MedFTs. 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 family therapy was unknown. In another recent article on the application of MedFT to address behavioral health disparities among Latinos (Willerton et al., 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 Studies

The MedFT literature references family interventions and their effectiveness (e.g., Campbell & Patterson, 1995) but does not demonstrate the effectiveness of a medical family therapist performing these interventions in a healthcare setting. Since 2000, there have been increased efforts to understand and study MedFT interventions. Researchers have reported perceived MedFT benefits in an inpatient psychiatric setting (Anderson et al., 2008), as part of a diabetic treatment team (Robinson et al., 2004), in primary care (Marlowe, 2011), and in oncology settings (Harrington, Kimball, & Bean, 2009; Sellers, 2000), but more detail is needed to understand exactly what MedFT interventions were conducted that were effective. Through a clinical case study, Rosenberg and colleagues (2008) illustrated the focus of MedFT sessions that included aiming to increase the patient’s 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 and colleagues (2004) included MedFTs as part of a treatment team for patients with diabetes, and while it was articulated that the medical family therapist was of value to the team, the overall goal of the article was the demonstration of the value of collaboration for treatment and training purposes. Therefore, the specific MedFT interventions were not outlined. MedFT researchers must focus 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 single case studies to add weight to their generalizability. Researchers must continue to build on the descriptive, qualitative studies that have already been conducted to illuminate the practice and role of MedFT (e.g., Anderson et al., 2008; Harrington et al., 2009; Robinson et al., 2004; Rosenberg et al., 2008), thereby 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 of the research studies have been done by family therapists 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, postdoctorate, master's, or certificate in MedFT as compared to those who have learned through experience in context. While several researchers have identified MedFT interventionists as being graduate-level students (e.g., Anderson et al., 2008; Davey et al., 2008; Marlowe et al., 2012; Robinson et al., 2004; Rosenberg et al., 2008), other researchers who have studied MedFT in action did not specify the background or type of training received (e.g., Harrington et al., 2009; Sellers, 2000). Efficacy research is needed to determine whether or not individuals who identify as MedFTs and hold degrees in family therapy apply MedFT concepts and applications differently than those who do not, whether or not those who identify as MedFTs and who have been trained to offer it yield different outcomes than those who do not, and whether or not MedFT produces results beyond treatment as usual.

MedFT Curriculum and Core Competencies

While most of the articles referenced in this review did not include material specific to MedFT training standards or competencies, a few authors noted some important concepts, skills, or practices such as immersion and observation (Weiner & Lorenz, 1994), family systems theory and the BPS approach (e.g., McDaniel et al., 1992b), spirituality associated with the BPS approach (e.g., Phelps et al., 2009), collaborative skills (e.g., Anderson et al., 2008), and psychopharmacology (Campbell & Patterson, 1995). MedFT training has grown from one summer institute in its early years (University of Rochester Medical Center, 2013) to eight training programs, including two doctoral programs (East Carolina University, 2013; University of Nebraska-Lincoln, 2013; please see Chap. 3 for a complete listing of academic institutions). With the expansion of training (Ungureanu & Sandberg, 2008), 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 healthcare settings (e.g., Edwards & Patterson, 2006; Hodgson, Boyd, Koehler, Lamson, & Rambo, 2013). However, there has not yet been an effort to elucidate core courses or core competencies pertaining to MedFT. No research has been done

on level of training and clinical effectiveness among MedFT providers. 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 medical family therapist who received training in an intense workshop is any more or less effective, in practice, research, and training, than one trained through a master's or doctoral program. Agreement on core courses and the context for instruction would give credibility, improve fidelity, and increase opportunities to the study, practice, and research of MedFT.

Conclusion

The themes found through this review regarding the historical emergence of MedFT, the skill set and application of MedFT, the connection to family therapy, and the effectiveness of research all indicate signs of growth in MedFT. While growth seems apparent by both the total number of articles, the heightened interest from other disciplines, and the beginnings of effectiveness research, it is also clear that MedFT is still young in its development. It is the responsibility of current MedFTs to (a) clarify their role, scope, and unique skill set; (b) produce research demonstrating the efficacy and effectiveness of MedFT; and (c) identify and adopt core competencies that set standards for training of MedFTs. As a newer member to the healthcare team, it makes sense to not have these already established. Other disciplines such as Health Psychology and Medical Social Work are also pursuing this work. The development of MedFT as a specialization begins with a need and creative solutions and then moves into testing those solutions and implementing training programs to disseminate them. Reviews like this are important for highlighting the work that has been done and what has yet to be accomplished. While we recognize that a recommendation for a more contemporary definition is needed, at this time we refrain from providing one based on anecdotal evidence but prefer to report one grounded in empirical support. In 2010, a Delphi study was done surveying those with expertise in MedFT to take steps toward accomplishing this goal (Tyndall, Hodgson, Lamson, Knight, & White, 2010). Some of the outcomes of this study, particularly as related to the development of core competencies, are reported in Chap. 3 of this text. Researchers are encouraged to build on these results and conduct field research to confirm that what experts think MedFT should look like in its application is actually what is happening in the field. Lastly, future researchers should empirically examine the effectiveness of MedFT in primary, secondary, and tertiary care settings and identify a core curriculum that experts in MedFT share as fundamental to effective professional practice and the growth and advancement of the profession.

Reflective Questions

- 1.) How would you define MedFT to a client/patient? Healthcare provider? Healthcare administrator? Researcher? Legislator?
- 2.) What are some of the ways MedFTs can contribute innovation to clinical, political, training, and empirical work?
- 3.) What competencies do you believe all behavioral health professions integrating into healthcare settings should have and which ones do you identify as unique to MedFT?

References¹

- Altum, S. (2007). Commentary: Managing CHF and depression in an elderly patient: Being open to collaborative care. *Families, Systems, and Health*, 25, 465–467. doi:[10.1037/1091.7527.25.4.465](https://doi.org/10.1037/1091.7527.25.4.465).
- Alvarez, C. A. (1996). Medical family therapy: Therapeutic and financial benefits of family centered care in the hospital. *Clinical Nurse Specialist*, 10, 50–56. doi:[10.1097/00002800-199601000-00017](https://doi.org/10.1097/00002800-199601000-00017).
- Anderson, R., Huff, N., & Hodgson, J. (2008). Medical family therapy in an inpatient psychiatric setting. *Families, Systems, and Health*, 26, 164–180. doi:[10.1037/10917527.26.2.164](https://doi.org/10.1037/10917527.26.2.164).
- Anonymous. (1993). Book reviews—medical family therapy: A biopsychosocial approach to families with health problems. *Adolescence*, 28, 753. Retrieved from http://www.vjf.cnrs.fr/clk/php/va/Page_revue.php?ValCodeRev=ADO.
- Bayona, J. (2007). Finding hope in tragedy and chaos: A commentary on “I finally got real parents, and now they’re gonna die. *Families, Systems, and Health*, 25, 234–235. doi:[10.1037/1091-7527.25.2.234](https://doi.org/10.1037/1091-7527.25.2.234).
- Berkley, M. (2000). Keith and Ashley: Treating a reluctant HIV+ client. *Families, Systems, and Health*, 18, 499–506. doi:[10.1037/h0091897](https://doi.org/10.1037/h0091897).
- 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. doi:[10.1300/J086v15n02_02](https://doi.org/10.1300/J086v15n02_02).
- *Bischoff, R. J., Springer, P. R., Felix, D. S., & Hollist, C. S. (2011). Finding the heart of medical family therapy: A content analysis of medical family therapy casebook articles. *Families, Systems, and Health*, 29, 184–196. doi:[10.1037/a0024637](https://doi.org/10.1037/a0024637).
- Blount, A. (Ed.). (1998). *Integrated primary care*. New York, NY: W. W. Norton. doi:[10.1300/J086v15n02_03](https://doi.org/10.1300/J086v15n02_03).
- Brucker, P. S., Faulkner, R. A., Baptist, J., Grames, H., Beckham, L. G., Walsh, S., & Willert, A. (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. doi:[10.1080/01926180590915518](https://doi.org/10.1080/01926180590915518).
- Burge, B. (2005). Feminist perspectives in medical family therapy (book review). *Australian and New Zealand Journal of Family Therapy*, 26, 175–176. Retrieved from <http://www.anzjft.com/pages/index.php>.

¹ An asterisk has been used to note references that the chapter authors recommend for further reading.

- Burgess-Manning, J. (2007). Bringing two worlds together: A collaborative interview with JoEllen Patterson. *Australian and New Zealand Journal of Family Therapy*, 28, 38–43. Retrieved from <http://www.anzjft.com/pages/index.php>.
- 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. doi:10.1080/08952830802023276.
- *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. doi:10.1111/j.1752-0606.1995.tb00178.x.
- Candib, L. M., & Stovall, J. G. (2002). Response to Schirmer and Le. *Families, Systems, and Health*, 20, 311–320. doi:10.1037/h0089586.
- 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. doi:10.1037/1091-7527.25.4.457.
- Cohen, J. L. (1995). Somatization revisited: A case of migraine headaches. *Family Systems Medicine*, 13, 395–404. doi:10.1037/h0089233.
- 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. doi:10.1002/jclp.20515.
- Czauderna, J., & Tomson, D. (1994). Family therapy and primary care: Connections and challenges. *Journal of Family Therapy*, 16, 342–345. doi:10.1111/j.1467-6427.1994.00799.x.
- Dankoski, M. E. (2003). An interview with Shobha Pais, PhD. *Journal of Feminist Family Therapy*, 15, 149–164. doi:10.1300/J086v15n02_11.
- Dankoski, M. E., & Pais, S. (2007). What's love got to do with it? Couples, illness, and MFT. *Journal of Couple and Relationship Therapy*, 6, 31–43. Retrieved from <http://www.tandfonline.com/loi/wcrt20>.
- 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. doi:10.1037/a0013056.
- Degges-White, S. (2005). Book review: Feminist perspectives in medical family therapy. *The Family Journal*, 13, 236–237. doi:10.1177/1066480704271117.
- Doherty, W. J., McDaniel, S. H., & Hepworth, J. (1994). Medical family therapy: An emerging arena for family therapy. *Journal of Family Therapy*, 16, 31–46. doi:10.1111/j.1467-6427.1994.00775.x.
- East Carolina University (ECU). (2013). *Doctor of philosophy in medical family therapy*. Retrieved 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. doi:10.1300/J086v15n02_04.
- 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, 33–43. doi:10.1111/j.1752-0606.2006.tb01586.x.
- Edwards, T., & Turnage, J. (2003). “Cheating almost killed me:” Collaborative care for a man who believed he had AIDS. *Families, Systems, and Health*, 21, 233–239. doi:10.1037/1091-7527.21.2.233.
- Fogarty, C. T. (2001). Examining the influence of physicians in the lives of patients over time: Taking a history of the doctor-patient relationship. *Families, Systems, and Health*, 19, 221–226. doi:10.1037/h0089546.
- Fulton, R. (1996). Medical family therapy: A biopsychosocial approach to families with health problems (book review). *Journal of Psychosomatic Research*, 40, 108–109. Retrieved from <http://www.us.elsevierhealth.com/product.jsp?isbn=00223999>.
- Gellerstedt, M. E., & Mauksch, L. (1993). Chronic neurologic impairment: A family problem. *Family Systems Medicine*, 11, 425–431. doi:10.1037/h0089034.

- 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. doi:[10.1037/1091-7527.24.2.230](https://doi.org/10.1037/1091-7527.24.2.230).
- Griffith, J. L. (1994). Review of “Medical family therapy”. *Family Systems Medicine*, 12, 87–89. doi:[10.1037/h0089245](https://doi.org/10.1037/h0089245).
- 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. doi:[10.1037/1091-7527.24.2.230](https://doi.org/10.1037/1091-7527.24.2.230).
- Harp, J. (1998). Ruth’s dizziness: A commentary. *Families, Systems, and Health*, 16, 329–331. doi:[10.1037/h0089944](https://doi.org/10.1037/h0089944).
- *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, 16–27. doi:[10.1037/a0014909](https://doi.org/10.1037/a0014909).
- 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. doi:[10.1300/J086v15n02_08](https://doi.org/10.1300/J086v15n02_08).
- 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. doi:[10.1037/1091-7527.26.2.181](https://doi.org/10.1037/1091-7527.26.2.181) DOI:[10.1037%2F1091-7527.26.2.181](https://doi.org/10.1037%2F1091-7527.26.2.181).
- Hodgson, J., Lamson, A., Mendenhall, T., & Crane, R. (2012). Medical family therapy: Opportunity for workforce development in healthcare. *Contemporary Family Therapy*, 34, 143–146. doi:[10.1007/s10591-012-9199-1](https://doi.org/10.1007/s10591-012-9199-1).
- *Hodgson, J., Lamson, A., & Reese, L. (2007). The biopsychosocial-spiritual interview method. In D. Linville, D. Lusteran, & K. Hertlein (Eds.), *Therapist notebook for family healthcare* (pp. 3–12). New York, NY: Hayworth Press.
- *Hodgson, J. L., McCammon, S. L., & Anderson, R. J. (2011). A conceptual and empirical basis for including medical family therapy services in cancer care settings. *The American Journal of Family Therapy*, 39, 348–359. doi:[10.1080/01926187.2010.537944](https://doi.org/10.1080/01926187.2010.537944).
- *Hodgson, J. L., McCammon, S. L., Marlowe, D. P., & Anderson, R. J. (2012). Medical family therapy in cancer care: Patient and family experiences. *Contemporary Family Therapy*, 40, 258–266. doi:[10.1080/01926187.2011.611783](https://doi.org/10.1080/01926187.2011.611783).
- Hodgson, J., Boyd, T., Koehler, A., Lamson, A., & Rambo, A. (2013). Supervision in evolving contexts. In T. Todd & C. Storm (Eds.), *The complete systemic supervisor: Context, philosophy, and pragmatics* (2nd ed.). Bloomington, IN: iUniverse.
- Hughes, A., Hertlein, K. M., & Hagey, D. W. (2011). A medft informed sex therapy for treating sexual problems associated with chronic illness. *Journal of Family Psychotherapy*, 22, 114–127. doi:[10.1080/08975353.2011.577689](https://doi.org/10.1080/08975353.2011.577689).
- Jacobs, B. J. (2012). “Here’s how we’re seeing it”: An interview with Susan H. McDaniel, PhD, Jeri Hepworth, PhD, and William J. Doherty, PhD. *Contemporary Family Therapy*, 34, 147–155. doi:[10.1007/s10591-012-9190-x](https://doi.org/10.1007/s10591-012-9190-x).
- Jencius, M. (2004). Citizen therapist: An interview with William Doherty. *The Family Journal*, 12, 82–88. doi:[10.1177/1066480703258947](https://doi.org/10.1177/1066480703258947).
- Kannai, R. (2009). Munchausen by mommy. *Families, Systems, and Health*, 27, 105–112. doi:[10.1037/a0015031](https://doi.org/10.1037/a0015031).
- Kazak, A. E. (1993). Medical family therapy: A biopsychosocial approach to families with health problems (book review). *Journal of Pediatric Psychology*, 18, 529–531. doi:[10.1093/jpepsy/18.4.529](https://doi.org/10.1093/jpepsy/18.4.529).
- Kelley, P. (1993). Medical family therapy: A biopsychosocial approach to families with health problems (book review). *Contemporary Psychology: APA Review of Books*, 38, 1071–1072. Retrieved from <http://www.apa.org/pubs/journals/cnt/index.aspx>.
- Knishkowsky, B., & Herman, J. (1998). Medical family therapy casebook: Ruth’s dizziness. *Families, Systems, and Health*, 16, 325–327. doi:[10.1037/h0089858](https://doi.org/10.1037/h0089858).

- Kojima, T. (2006). The development of family therapy in Japanese psychosomatic medicine. *International Congress Series*, 1287, 154–157. doi:[10.1016/j.ics.2005.12.050](https://doi.org/10.1016/j.ics.2005.12.050).
- Lask, B. (1994). The illness network. *Journal of Family Therapy*, 16, 47–51. Retrieved from <http://www.wiley.com/bw/journal.asp?ref=0163-4445>.
- Leahy, D., Galbreath, L., Powell, R., & Shinn, M. A. (1994). A case of collaboration HMO style. *Family Systems Medicine*, 12, 437–449. doi:[10.1037/h0089376](https://doi.org/10.1037/h0089376).
- Lewis, M., Lamson, A., & Leseuer, B. (2012). Healthy dynamics of military and veteran couples: A biopsychorelational overview. *Contemporary Family Therapy*, 34, 259–276. doi:[10.1007/s10591-012-9193-7](https://doi.org/10.1007/s10591-012-9193-7).
- *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, 85–97. doi:[10.1037/1091-7527.25.1.85](https://doi.org/10.1037/1091-7527.25.1.85).
- Lowe, W. (2007). “I finally got real parents, and now they’re gonna die” – a case study of an adolescent with two HIV-positive parents. *Families, Systems, and Health*, 25, 227–233. doi:[10.1037/1091-7527.25.2.227](https://doi.org/10.1037/1091-7527.25.2.227).
- *Marlowe, D. (2011). Bridging conversations: Discussing the intra-professional relationship between medical family therapy and family therapy. *Journal of Family Therapy*, 16, 1–20.
- *Marlowe, D., Hodgson, J., Lamson, A., White, M., & Irons, T. (2012). Medical family therapy in a primary care setting: A framework for integration. *Contemporary Family Therapy*, 34, 244–258. doi:[10.1007/s10591-012-9195-5](https://doi.org/10.1007/s10591-012-9195-5).
- 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. doi:[10.1007/BF01991074](https://doi.org/10.1007/BF01991074).
- McDaniel, S. H., & Amos, S. (1983). The risk of change: Teaching family as the unit of care. *Family Systems Medicine*, 1, 25–30. doi:[10.1037/h0090088](https://doi.org/10.1037/h0090088).
- McDaniel, S. H., & Campbell, T. (1986). Physicians and family therapists: The risks of collaboration. *Family Systems Medicine*, 4, 4–8. doi:[10.1037/h0090176](https://doi.org/10.1037/h0090176).
- McDaniel, S. H., Campbell, T., & Seaburn, D. (1989). Somatic fixation in patients and physicians: A biopsychosocial approach. *Family Systems Medicine*, 7, 5–16. doi:[10.1037/h0089761](https://doi.org/10.1037/h0089761).
- McDaniel, S. H., Doherty, W. J., & Hepworth, J. (2013). *Medical family therapy and integrated care* (2nd ed.). Washington, DC: American Psychological Association.
- McDaniel, S. H., Doherty, W. J., & Hepworth, J. (2014). *Medical family therapy and integrated care* (2nd ed.). 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. doi:[10.1037/10395-027](https://doi.org/10.1037/10395-027).
- McDaniel, S. H., Hepworth, J., & Doherty, W. J. (1992a). Medical family therapy with couples facing infertility. *The American Journal of Family Therapy*, 20, 101–122. doi:[10.1080/01926189208250882](https://doi.org/10.1080/01926189208250882).
- *McDaniel, S. H., Hepworth, J., & Doherty, W. J. (Eds.). (1992b). *Medical family therapy: A biopsychosocial approach to families with health problems*. New York, NY: Basic Books.
- 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. doi:[10.1111/j.1545-5300.1995.00349.x](https://doi.org/10.1111/j.1545-5300.1995.00349.x).
- McDaniel, S. H., Hepworth, J., & Doherty, W. J. (1999). The shared emotional themes of illness. *Journal of Family Psychotherapy*, 10, 1–8. doi:[10.1300/J085v10n04_01](https://doi.org/10.1300/J085v10n04_01).
- *Mendenhall, T. J., Pratt, K. J., Phelps, K. W., & Baird, M. A. (2012). Advancing medical family therapy through research: A consideration of qualitative, quantitative, and mixed-methods designs. *Contemporary Family Therapy*, 34, 187–203. doi:[10.1007/s10591-012-9186-6](https://doi.org/10.1007/s10591-012-9186-6).
- Munshower, J. C. (2004). Group visits for diabetic patients: One physician’s experience. *Families, Systems, and Health*, 22, 497–500. doi:[10.1037/1091-7527.22.4.497](https://doi.org/10.1037/1091-7527.22.4.497).
- Navon, S. (2005). Listening to illness/nonillness motifs: A case of fibromyalgia. *Families, Systems, and Health*, 23, 358–361. doi:[10.1037/1091-7527.23.3.358](https://doi.org/10.1037/1091-7527.23.3.358).

- Oberman, A. (2006). Review of feminist perspectives in medical family therapy. *The Family Journal*, 14, 453. doi:10.1177/1066480706289564.
- Pereira, M. G., & Smith, T. E. (2006). Evolution of the biopsychosocial model in the practice of family therapy. *International Journal of Clinical and Health Psychology*, 6, 455–467. Retrieved from <http://www.aepc.es/ijchp/index.php?coid=English>.
- 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. doi:10.1037/a0015027.
- Pratt, D. M. (2003). Interview with Dr Susan McDaniel: Medical family therapy and feminism. *Journal of Feminist Family Therapy*, 15, 137–147. doi:10.1300/J086v15n02_09.
- Preece, J. C., & Sandberg, J. G. (2005). Family resilience and the management of fibromyalgia: Implications for family therapists. *Contemporary Family Therapy*, 27, 559–576. doi:10.1007/s10591-005-8242-x.
- Prest, L. A., Fitzgibbons, P. M. R., & Krier, J. (1996). Head injury and decisions about care: A collaborative approach. *Families, Systems, and Health*, 14, 387–393. doi:10.1037/h0089923.
- Prouty Lyness, A. M. (2003). Preface: Perspectives in medical family therapy. *Journal of Feminist Family Therapy*, 15, xvii. Retrieved from <http://www.tandfonline.com/loi/wff20>.
- Radomsky, N. A. (1996). The essence of family medicine: Story of a doctor-patient partnership. *Families, Systems, and Health*, 14, 497–502. doi:10.1037/h0089984.
- Ragaisis, K. M. (1996). The psychiatric consultation-liaison nurse and medical family therapy. *Clinical Nurse Specialist*, 10, 50–56. doi:10.1097/00002800-199601000-00018.
- Riccelli, A. (2003). Memoirs of a “poop lady”. *Families, Systems, and Health*, 21, 109–117. doi:10.1037/h0089507.
- 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. doi:10.1037/1091-7527.22.4.490.
- Rosenberg, M. (2005). Feminist perspectives in medical family therapy (book review). *Families, Systems, and Health*, 23, 113–114. doi:10.1037/1091-7527.23.1.113.
- Rosenberg, T., Brown, E., & Gawinski, B. (2008). Multidisciplinary intervention for failure to thrive: Casebook. *Families, Systems, and Health*, 26, 365–371. doi:10.1037/a0013333.
- 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* (pp. 418–436). New York, NY: Bruner-Rutledge.
- Ruddy, N. (with Farley, T., Nymberg, J., & Hayden, K.) (1994). Multiple personality disorder in primary care: A collaboration. *Family Systems Medicine*, 12, 327–338. doi:10.1037/h0089056.
- Schirmer, J. M., & Le, N. H. (2002). The Vietnam Family Medicine Development Project: A cross cultural collaboration. *Families, Systems, and Health*, 20, 303–311. doi:10.1037/h0089585.
- *Sellers, T. S. (2000). A model of collaborative healthcare in outpatient medical oncology. *Families, Systems, and Health*, 18, 19–33. doi:10.1037/h0091851.
- Shapiro, J. (1993). A book review. *Family Systems Medicine*, 11, 219–221. doi:10.1037/h0089192.
- Siegel, D. M. (2009). Munchausen syndrome by proxy: A pediatrician's observations. *Families, Systems, and Health*, 27, 113–115. doi:10.1037/a0015030.
- 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. doi:10.1300/J086v15n02_11.
- Souza, J. M. (2002). End of life decision-making: An interdisciplinary perspective. *Families, Systems, and Health*, 20, 449–453. doi:10.1037/h0089596.
- Streicher, P. J. (1995). A suicidal client: The limits of power and control. *Family Systems Medicine*, 13, 91–95. doi:10.1037/h0089343.
- 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 of the Academy of Medicine Singapore*, 32, 51–57. Retrieved from <http://www.annals.edu.sg/>.
- Thomasgard, M., Boreman, C., & Metz, W. P. (2004). A family under siege: Empathic mirroring and collaborative care. *Families, Systems, and Health*, 22, 245–254. doi:10.1037/1091-7527.22.2.245.
- Trepal, H. C. (2005). Book review: Feminist perspectives in medical family therapy. *The Family Journal*, 13, 368. doi:10.1177/1066480704273644.
- Tyndall, L., Hodgson, J., Lamson, A., Knight, S., & White, M. (2010). *Medical family therapy: Conceptual clarification and consensus for an emerging profession* (Doctoral dissertation). Retrieved from <http://thescholarship.ecu.edu/handle/10342/2794>
- Tyndall, L., Hodgson, J., Lamson, A., White, M., & Knight, S. (2014). Medical family therapy: Charting a course in competencies. In J. Hodgson, A. Lamson, T. Mendenhall, & R. Crane (Eds.), *Medical family therapy: Advanced applications* (pp. 33–53). New York, NY: Springer.
- Ungureanu, I., & Sandberg, J. G. (2008). Caring for dying children and their families: MFTs working at the gates of elysian fields. *Contemporary Family Therapy*, 30, 75–91. doi:10.1007/s10591-008-9059-1.
- University of Nebraska-Lincoln (UNL). (2013). *Medical family therapy – PhD program*. Retrieved from <http://cehs.unl.edu/cyaf/grad/mftPhD.shtml>
- University of Rochester Medical Center (URMC). (2013). *20th Annual medical family therapy intensive*. Retrieved from <http://www.urmc.rochester.edu/psychiatry/institute-for-the-family/family-therapy/mfti.cfm>
- 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. doi:10.1037/h0089340.
- Weiss, M., & Hepworth, J. (1993). A case for solutions. *Family Systems Medicine*, 11, 297–302. doi:10.1037/h0089301.
- 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. doi:10.1037/1091-7527.26.2.196.
- Wirtberg, I. (2005). Introduction to medical family therapy. *Acta Paediatrica*, 94, 45–46. doi:10.1080/08035320510035483.
- Wissow, L. S., Hutton, N., & Kass, N. (2002). Preliminary study of a values-history advance directive interview in a pediatric HIV clinic. *AIDS and Public Policy Journal*, 17, 17–28. Retrieved from <http://www.upgbooks.com/appj/>.
- Wright, L. M., Watson, W. L., & Bell, J. M. (1992). The medical map is not the territory: “Medical Family Therapy” watch your language. *Families, Systems, and Health*, 10, 35–39. doi:10.1037/h0089250.
- Yeager, B., Auyang, M., Brown, D. L., Dickinson, P., Goldstein, J. A., Jaffe, N., . . . , & Workman, G. (1999). MFT student training in medical family therapy: A collaborative hospital project with radiation oncology. *Families, Systems, and Health*, 17, 427–436. doi:10.1037/h0089894.

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