Contemp Fam Ther (2012) 34:156–170
DOI 10.1007/s10591-012-9183-9

ORIGINAL PAPER

# Medical Family Therapy: A Theoretical and Empirical Review

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Published online: 18 March 2012


**Abstract** Medical Family Therapy (MedFT) is a relatively young sub-specialty founded initially at the intersection of Family Therapy and Family Medicine. The purpose of this article is to synthesize and review scholarly literature covering almost 30 years of history, growth, and available research on MedFT. Eighty-two articles that met specific inclusion criteria were reviewed and the literature was categorized into four distinct themes: (a) Emergence of MedFT in the literature; (b) Contemporary MedFT skills and applications; (c) Punctuating the "family therapy" in MedFT; and (d) MedFT effectiveness and efficacy research. What was learned was that MedFT is growing so rapidly there is now a need for a current definition, identification of core curriculum standards and competencies for training, as well as a commitment to produce rigorous research on its effectiveness and efficacy. Recommendations to advance efforts across the foci are provided.

**Keywords** Medical family therapy · Family therapy · Biopsychosocial · Collaboration

## Introduction

Medical Family Therapy began developing in the 1980s in response to several opposing forces: the fragmented system of healthcare, disconnection between mental health and medical providers, separation of the treatment of the mind from the body, and extraction of

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the patient from the family/community. Researchers began to address the importance of collaboration between the medical and mental health fields and the relationship between family medicine and family therapists was born (McDaniel and Amos 1983; McDaniel and Campbell 1986; McDaniel et al. 1989). McDaniel et al. (1992a) used the term medical family therapy (MedFT) to refer to "…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). In an effort to identify how MedFT has evolved since its inception, Linville et al. (2007) reviewed the empirical research on its efficacy and effectiveness. For the purposes of their paper, they defined MedFT based on the original McDaniel et al. (1992a) definition as well as definitions of family interventions by Campbell and Patterson (1995), however this was developed more for the purpose of the paper rather than as a definitive source from which to base future research. The focus of Linville et al.'s (2007) article was also empirical research that focused not only on work specifically called MedFT, but was also inclusive of other research that might not have specifically been labeled MedFT but may have included many of the elements, i.e.—family interventions and health. There is a need to track the growth of MedFT by examining its presence in the literature by name and by nature in an effort to assist in creating the cohesive identity that is needed.

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 making unique contributions to the research literature and serving as the foundation for training programs, particularly family therapy (Edwards and Patterson 2003; Marlowe 2011; Tyndall et al. 2010). The intention of this article is to review the literature where MedFT is mentioned by name and unveil its developmental trajectories for the research, training, and practice with this rapidly emerging sub-specialty.

## 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 82 articles from 1992 through 2011, empirical and non-empirical, 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 medical family therapy; and d) MedFT effectiveness and efficacy research. Most of the literature is presented chronologically within each thematic category.

### Emergence of MedFT in the Literature

While clinicians were already practicing MedFT in the 1980s (Ruddy and McDaniel 2003), it was not until the early 1990s that the practice was introduced into western literature

formally (Doherty et al. 1994; McDaniel et al. 1992a). McDaniel et al's primer text, *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 the patient's autonomy and support system were treated as ancillary to healthcare and a group of systemic thinkers sought out to challenge this status quo thinking. The emergence of MedFT was not without controversy. Three articles were published within the next few years debating the need for and naming of MedFT. Bell et al. (1992), family nurses, asserted that the word "medical" limited the focus on the biological and excluded work done in this area by non-physician professionals. Lask (1994), a psychiatrist, argued that MedFT, as he understood it, was a biopsychosocial 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 et al. (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. Over the years, the inclusion of family therapy in articles written about MedFT was a common trend in majority of the 82 articles published from 1992 to 2011 and will be described in further detail under theme three.

## Contemporary MedFT Skills and Applications

### *Dissemination and Training*

Since 1992b when McDaniel et al. wrote their landmark text, authors and researchers from a variety of disciplines have written about how they 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. 1992b). According to McDaniel et al. (1992b), "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 saw the focus and awareness of the importance of collaborative skills, the biopsychosocial perspective, and family systems concepts as applied to medical conditions, "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, *Families 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 published separately from the main article (Altum 2007; Bayona 2007;

Candib and 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 and 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 and Howarth 2007), diabetes (Munshower 2004), munchausen (Kannai 2009), fibromyalgia (Navon 2005), neurologic impairment (Gellerstedt and Mauksch 1993), parenting children with health challenges (Rosenberg et al. 2008; Thomasgard et al. 2004) and HIV/AIDS (Lowe 2007). MedFT Casebook authors also addressed navigating cultural differences in establishing care (Schirmer and Le 2002), supporting the doctor-patient relationship (Knishkowy and Herman 1998; Radomsky 1996), and facilitating the act of collaboration (Leahy et al. 1994; Prest et al. 1996; Ruddy et al. 1994). A recent review of these casebook articles was conducted by Bischoff et al. (2011). What was revealed through their work was 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 et al. (2011) noted that "…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 and Turnage 2003) throughout the years. While 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 et al. 2001; Wissow et al. 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 et al. 2003; Dankoski 2003; Edwards and Patterson 2003; Hertlein 2003; Pratt 2003; Prouty Lyness 2003; Smith-Lamson and 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 the general clinical skills, thinking about how to do it 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 (Robinson et al. 2004), pediatric HIV/AIDS (Wissow et al. 2002), fibromyalgia (Preece and Sandberg 2005), somatoform and chronic fatigue syndrome (Szyndler et al. 2003), and cancer (Burwell et al. 2008; Dankoski and Pais 2007; Hodgson et al. 2011). 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 et al. (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 researches were beginning to think about how to study the effectiveness of MedFT with a variety of cultural groups and diagnoses, Willerton et al. (2008) made the case for how medical family therapists 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 et al. also listed a variety of potential skills brought to the table by medical family therapists, including conducting therapy with clients in a medical setting, consulting with healthcare teams in the care of clients, and providing education for medical students, and residents. MedFT and collaborative care were becoming inseparable. Phelps et al. (2009) took it a step further and presented a culturally and spiritually sensitive collaborative 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 their skill set as systems interventionists and collaborators 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 et al. (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 (McDaniel et al. 1992a) to sexual dysfunction (Hughes et al. 2011). The authors 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. The authors provided a case example and outlined possible examples of how to employ these techniques. This article stayed true to the original definition of MedFT by McDaniel et al. (1992a), and did not specify any training necessary for a clinician to implement these techniques.

While family therapy concepts and ideas have helped to form the basis of MedFT research and application, it still remained something that only a subset of family therapists did. Unfortunately, across the articles reviewed under this theme, there is not a consensus regarding what skills or training are 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, such as indicated by Wissow et al. (2002) and Hughes et al. (2011) alludes to the idea that MedFT can be used by a variety of healthcare clinicians and practitioners but this then continues the question of required training components. 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. 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 et al. (1995) highlighted the importance of systemic thinking as a foundation for MedFT through their work with somaticizing patients. These same leading authors, McDaniel et al. (1992a), outlined emotional themes that patients and families may experience regardless of the illnesses and discussed ways that Medical Family Therapists 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 Subdiscipline 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 et al. (1992a) primer text, and called for all family therapists in training to receive training in MedFT or at the very least be trained how to operate from a biopsychosocial framework, as well as 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. They called for more MFTs to specialize in MedFT as described by McDaniel et al. (1992a). 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 and Patterson 2003; Harkness and Nofziger 1998; Yeager et al. 1999). These publications appeared as integrated healthcare was beginning to take root (Blount 1998). Articles reflecting the training process of medical family therapists, with respect to training techniques (Smith-Lamson and Hodgson 2003) also appeared in 2003. Soon thereafter, Brucker et al. (2005) discussed existing MedFT internship experiences offered to marriage and family therapy doctoral students, which outlined the importance of the development of a particular skill set that was needed to work in medical settings.

MedFT gained international recognition as authors paid special attention to the evolution of family therapy and application of the biopsychosocial approach in MedFT (Kojima 2006; Pereira and 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

medical practice was highlighted. Pereira and Smith (2006) argued that several of the seven techniques cited by McDaniel et al (1992a) were not unique to MedFT and rather were very similar to traditional family therapy (respect defenses and remove blame, attend to developmental issues, increase a sense of agency, and leave the door open for future contact); 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 it is the application of family therapy to medical problems.

In a clinical case study of a pediatric patient with HIV/AIDS, interventionists were designated as family therapists, rather than medical family therapists, indicating a link between family therapy and MedFT but rendering the difference between MFTs and medical family therapists unclear (Davey et al. 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 and Kennedy 2008). These authors again referenced the influence of family systems by defining MedFT as a biopsychosocial and family systems perspective whose proponents utilize four MedFT techniques authored by McDaniel et al. (1992a) (soliciting the illness story, respecting defenses and accepting unacceptable feelings, and externalizing the illness). 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) they used the words family therapy and MedFT interchangeably. Their heavy emphasis on family systems, further supported the strong and developing epistemological connection between family therapy and MedFT.

Key elements of the McDaniel et al's (1992a) original definition (i.e., biopsychosocial 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 MFT using the same systemic and relational lens but in a different context. Marlowe (2011) also stated that MFT 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 was 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 mental 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 to have this support in place. Additionally, patients and their families were also surveyed and benefits included a 90%

reduction in emotional suffering due to the work with the medical family therapist, 91% reported an increase in being able to access personal resources, and 73% reported an ability to remain hopeful and maintaining clarity about their cancer experience.

Bischoff et al. (2003) conducted a qualitative study of medical family therapist's 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. Qualitative interview data revealed themes of power and gender dynamics in the medical setting, the ways in which medical family therapists began and maintained collaborative relationships, practical and professional considerations, the need for medical family therapists to accommodate to the healthcare system, and how they could be seen as a both a potential threat to other healthcare providers but also as an ally in helping providers care for themselves. Again, while this study is important to understanding the skills and value added by medical family therapists, it does not demonstrate that their work resulted in outcomes similar to or different than other mental health disciplines.

In an attempt to further understand medical family therapists' contributions in secondary care settings, Anderson et al. (2008) published a grounded theory study that specifically addressed the skills of medical family therapists working in an inpatient psychiatric unit. Using a definition of MedFT consistent with McDaniel et al. (1992a), Anderson et al. (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 biopsychosocial perspective to include spirituality. However, it was unclear how the researchers studied or understood strategies medical family therapists used to address the spiritual needs of their patients and patients' families. Anderson et al. (2008) deconstructed the timeline of the medical family therapists' 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 medical family therapists in this context. This was the first field study of medical family therapists 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, since historically families have sometimes been either avoided or demonized on these units by staff members.

In 2009, Harrington et al. explored the inclusion of a medical family therapist on a pediatric oncology multi-disciplinary team. While the authors did not define MedFT, they did reference McDaniel et al's (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. Medical family therapists 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 medical family therapists could employ in oncology, but it was not clear if the medical family therapists 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, 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: (a) to establish a current definition of MedFT, (b) to implement effectiveness and efficacy studies of MedFTs and MedFT interventions, (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 and McDaniel 2003). This was evidenced by the number of publications ($N = 82$) 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 et al. (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 et al's (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 biopsychosocial perspective is pervasive (e.g., Burwell et al. 2008; McDaniel et al. 2001; Smith-Lamson and Hodgson 2003) but the spiritual dimension endorsed by some proponents of the biopsychosocial model is mentioned less frequently (e.g., Linville et al. 2007; Phelps et al. 2009).

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 biopsychosocial and family systems perspectives with cognitive-behavioral and narrative methodologies (Collins and 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 mental 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 and 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 et al. 2009; Sellers 2000), but more detail is needed on

exactly what MedFT interventions were conducted that were effective. Through a clinical case study, Rosenberg et al. (2008) illustrated the focus of MedFT sessions which included aiming to increase 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. (2004) included medical family therapists 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 value of collaboration for treatment and training purposes and the specific MedFT interventions were not outlined. MedFT researchers must focus specifically on demonstrating that interventions conducted by trained medical family therapists 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 medical family therapists.

Most of the research studies have been done by family therapists in conjunction with academic programs and by medical family therapists 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, master's, or certificate in MedFT as compared to those who 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 2011; 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 medical family therapists who hold degrees in family therapy apply MedFT concepts and applications differently than those who do not, whether those who identify as medical family therapists and who have systems training 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 that concepts such as immersion and observation (Weiner and Lorenz 1994), family systems theory and biopsychosocial (e.g., McDaniel et al. 1992b), spirituality associated with the biopsychosocial approach (e.g., Phelps et al. 2009), collaborative skills (e.g., Anderson et al., 2008), and psychopharmacology (Campbell and Patterson 1995) were important concepts, skills, or practices. MedFT training has grown from one summer institute in its early years (University of Rochester Medical Center 2011) to eight training programs, including two doctoral programs (East Carolina University 2011; University of Nebraska-Lincoln 2011). With the expansion of training programs (Ungureanu and 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 and Sellers 2006), as well as specific skills needed to supervise students in medical settings (e.g., Edwards and Patterson 2006). 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 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 improve opportunities to study, practice, and research 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 effectiveness research each indicate signs of growth in MedFT. While growth seems apparent by both the total number of articles, heightened interest from other disciplines, and the beginnings of effectiveness research, what is also clear is that MedFT is still young in its development. It is the responsibility of the 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 medical family therapists. As a newer member to the healthcare team it makes sense to not have all of this 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, 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 definitions is needed, at this time we refrain from providing one based on anecdotal evidence, but prefer to report one grounded in empirical support. An ideal way to reach a research-based consensus would be through a Delphi study (Dalkey 1972) in which a survey of experts is conducted. Researchers would then work to build on these results to conduct field research and confirm that what the experts think of MedFT is actually happening in practice. Lastly, future research 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.

## References

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:10.1037/10917527.25.4.465.

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.

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.

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/clt/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.

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*, 35–39. doi:10.1037/h0089250.

Berkley, M. (2000). Keith and Ashley: Treating a reluctant HIV+ client. *Families, Systems, and Health, 18*, 499–506. doi: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.

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.

Blount, A. (Ed.). (1998). *Integrated primary care*. New York: W. W. Norton. doi:10.1300/J086v15n02_03.

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. doi: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.

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.

Dalkey, N. (1972). *Studies in the quality of life*. Lexinton, MA: Lexington Books.

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). (2011). *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/J086vI5n02_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.

Griffith, J. L. (1994). Review of "Medical family therapy". *Family Systems Medicine, 12*, 87–89. doi: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.

Harp, J. (1998). Ruth's dizziness: A commentary. *Families, Systems, and Health, 16*, 329–331. doi: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.

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/J086v1502_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.

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.

Hughes, A., Hertlein, K. M., & Hagey, D. W. (2011). A med-ft informed sex therapy for treating sexual problems associated with chronic illness. *Journal of Family Psychotherapy, 22*, 114–127. doi:10(1080/08975353),2011,577689.

Jencius, M. (2004). Citizen therapist: An interview with William Doherty. *The Family Journal, 12*, 82–88. doi:10.1177/1066480703258947.

Kannai, R. (2009). Munchausen by mommy. *Families, Systems, and Health, 27*, 105–112. doi:0.1037/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.

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.

Knishkowy, B., & Herman, J. (1998). Medical family therapy casebook: Ruth's dizziness. *Families, Systems, and Health, 16*, 325–327. doi: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.

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.

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.

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.

Marlowe, D. (2011). Bridging conversations: Discussing the intra-professional relationship between medical family therapy and family therapy. *Journal of Family Therapy, 16*, 1–20. doi:10.1111/j.1467-6427.2011.00553.x.

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.

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.

McDaniel, S. H., & Campbell, T. (1986). Physicians and family therapists: The risks of collaboration. *Family Systems Medicine, 4*, 4–8. doi: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.

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.

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., Hepworh, J., & Doherty, W. J. (1992b). Medical family therapy with couples facing infertility. *The American Journal of Family Therapy, 20*, 101–122. doi:10.1080/01926189208250882.

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.

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.

Navon, S. (2005). Listening to illness/non illness motifs: A case of fibromyalgia. *Families, Systems, and Health, 23*, 358–361. doi: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., et al. (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/wfft20.

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., 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.

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.

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 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. Unpublished PhD dissertation, East Carolina University, Greenville.

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). (2011). *Medical family therapy—PhD program*. Retrieved from http://cehs.unl.edu/cyaf/grad/mftPhD.shtml.

University of Rochester Medical Center (URMC). (2011). *18th Annual medical family therapy intensive*. Retrieved from http://www.urmc.rochester.edu/psychiatry/institute-for-the-family/familytherapy/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 Pediatrica, 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/.

Yeager, B., Auyang, M., Brown, D. L., Dickinson, P., Goldstein, J. A., Jaffe, N., et al. (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.