Abstract

Medical Family Therapy in a Primary Care Setting:
A Model of Integration

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As the profession of marriage and family therapy (MFT), as well as the emerging sub-discipline of medical family therapy (MedFT), continue to grow and evolve within the current mental health care system, the arena of primary care presents an ideal environment for professionals who are relationally and systemically inclined. As such, this context is seen as a potential home for MedFTs hoping to provide integrated and collaborative health care. In order to address the unique practice based and cultural needs that manifest in medical contexts, the function of MedFTs in these sites must be apparent and accurately identified and described. Such a description is important not only to demonstrate the utility of MedFTs to potential stakeholders (e.g., physicians, medical staff, medical administration), but also to trainers who are charged with the preparation of future generations of MFTs and MedFTs for this type of work. The following dissertation seeks to address this issue from two interrelated venues: (a) to discuss how MedFT is connected to the profession of MFT in both conceptual and practical terms, and (b) to discuss a framework for integrated primary care, utilizing MedFTs, that does not service a targeted population.

MEDICAL FAMILY THERAPY IN A PRIMARY CARE SETTING:
A MODEL OF INTEGRATION

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DEDICATION

While the number of people that this work can be dedicated to truly is innumerable, the ideas, opinions, and arguments presented in the following pages would never have been made, and if they had would never have found much credibility, had it not been for the patients and families I have had the pleasure and privilege of working with for the past five years. Although it is likely that you will never read this dedication or any other part of this dissertation, it has been your ability to persevere in the face of personal tragedy and turmoil, and your willingness to allow me to share in those experiences with you, which has served as the foundation of the ideas presented here. Underneath all the research, papers, esoteric conversations about theory, philosophy, best practices, and every other idea that separates us as ‘professionals’ from our ‘clients,’ there exists the simple, although sometimes forgotten, idea of helping and serving others. All we do as professionals, I believe, must lead to the end result of improving the lives of those who come to us asking for help, and to that end, this dissertation is presented as only one very small piece in my attempt to do just that. So to you- my client, my patient, and above all else, my teacher, I give my thanks.

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While my committee has contributed much to my work and this dissertation, it undoubtedly would have never have taken place without the support of the dedicated staff at the James D. Bernstein Community Health Center in Greenville, NC. All of you have played such a large part of my professional and personal development over the course of the two years I have had the privilege of working with you all, and given that, you are much more than my colleagues, you are all my friends- my thanks. Of the staff, I would like to especially thank the behavioral health providers who allowed me to observe their work with patients and providers. You both are masterful therapists and I was truly amazed at your ability to connect with and aid in the treatment of those you worked with to achieve their desired ends.

Last, although certainly not least, I must acknowledge the very large part my wife has played in this long, and at times painful, endeavor. Angela, your unwavering support and the stability your love has graced me with over the last five years is the only reason I have been able to write and complete this dissertation and this doctoral degree. Your laughter, your concern, and your comments that I just “need to put that computer down and have fun,” or some variation thereof has been a wonderful constant in my life, and I am so grateful for you and all you represent.

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PREFACE

"But epistemology is always and inevitably personal. The point of the probe is always in the heart of the explorer: What is my answer to the question of the nature of knowing?"
-Gregory Bateson

The articles presented within this work are a culmination of five years of thought, discerning conversation (some more argument than conversation), intellectual gymnastics, and, above all else, practice- purposeful and consistent practice. My foray into the areas of medical family therapy (MedFT) and integrated/collaborative care began with my acceptance into the East Carolina University master's program in Marriage and Family Therapy (MFT) in the spring of 2006. Throughout the first year of my graduate education I was exposed to the ideas of systems theory, social constructionist philosophy, and cybernetics. These new conceptual languages helped provide me with a way of describing an implicit belief system I had held my entire life, and served as the basis for assembling those beliefs in ways that would hopefully, and eventually did, aid in the lives of others.

The apex of that new knowledge base manifested in two ways during my master's program; one avenue leading to my belief in the utility of integrated care, the view of medical family therapy as the professional and ideological mechanism by which to do so, and my desire to help develop models to that end, and the second avenue, a development of my belief that research must be directed toward those most likely to benefit from it (the practitioner and patient). The first ideological realization came during my yearlong internship at the James D. Bernstein Community Health Center where I collaborated with my faculty supervisors and fellow students to create, develop, and implement an integrated primary care model (the basis for the second article in this work). During that time I had the opportunity to work with a multitude of different medical and psychosocial professionals (e.g., physicians, nurse practitioners, social workers, dieticians), as well as the privilege of serving over 700 hundred patients. The second avenue came courtesy of my thesis, a qualitative analysis of my parents' experience regarding my mother's diagnosis with cancer when both were only in their late 20's. This study showed me that research is most potent when it has immediate applicability to address the everyday problems facing individuals' lives and relationships, as it did with my parents.

These beliefs were further intensified by my acceptance into the Medical Family Therapy (MedFT) doctoral program in the spring of 2008. Here I was given the freedom to explore, to an extraordinary degree of depth, the ideologies and philosophies that I had only scratched the surface of in my master's program, and was afforded the challenge of applying that knowledge in a state psychiatric hospital during my first year; an opportunity I was apprehensive about at the time, but one I now view as a defining moment in my professional career. While there I had the privilege to work with patients who had been termed 'treatment resistant,' which means exactly what it sounds like, that these individuals would forever reside within the walls of the institution. However, in spite of the label and the assumption, I was able to watch 95% of my patients achieve discharge within three months of their initial referral for services. This reinforced my belief in the unique and powerful orientation that a relational outlook affords a therapist, an outlook that understands people in context and views psychopathology as only one of many ways to make sense of a client's presenting concerns.

As the depth of my understanding regarding the relational and systemic foundations of family therapy grew, and by connection, my belief in the utility of the extension of that ideology into the medical arena (i.e., Medical Family Therapy), I became concerned with the tenor and tone of many conversations regarding the attempt to define the construct of MedFT. As I listened, it seemed to me that an undercurrent of conversation existed exploring the possibility of

MedFT being something separate from family therapy, a conversation whose utility existed in its ability to keep the discussion, as a whole, going, but one whose premise I wholeheartedly disagreed with. As I became a larger part of that discussion, often making the statement that we should be family therapists who happen to be MedFTs and not the other way around, I became resolved to utilize my interest in and knowledge about relational epistemology (i.e., social constructionism and cybernetics) to further clarify my position on the subject (the basis for the first article in this work).

Keeping my ideas and past experiences in mind, the first article is an attempt to explore, describe, and present an argument for the conceptual and practical connection between medical family therapy (MedFT) and marriage and family therapy (MFT). This is a difficult topic to discuss, let alone write about since all those willing to have the discussion bring with them their own biases, motivations, and ultimately, investment in the way they understand the construct. With that being said, this article, as with all research (theoretical or otherwise), is not meant to make a statement, a declaration of truth, or to offer the final word on the subject, but rather, it is presented as an argument. The intent of presenting these ideas in this way (ideas whose veracity will only be borne out through time, intelligent conversation, and careful practice, if at all) is not to end the debate, but to add to it; after all, conversations do not end they only have pauses between speakers. The second article is meant to add to the practical connection described by the first, in that it is a description of a framework of integrated primary care utilizing MedFTs as the behavioral health component. Given that the first article lays the groundwork for connecting MedFT to MFT, and thusly to the relational and systemic epistemology inherent in the discipline, the second article can be understood as a lengthy description of how systemic theory and concept manifests in real world practice by real world practitioners.

Through presenting these articles in relation to one another, both serve as catalysts in terms of defining and further clarifying the ideas presented by each: the first article, describing the conceptual underpinning of the second, and the second article bearing out that conceptual connection through a description of practice. This dissertation, aside from it being an exploration of MedFT, is also an attempt to bridge the divide that so often separates the scientist and practitioner (Green, Ottoson, Garcia, & Hiatt, 2009), whether that divide is an imagined one or not. As we continue to move forward into an era that values practice grounded in empirical support and finds comfort in the scrutiny of scientific research (social or otherwise), we as researchers must be willing and able to ask questions that are of most utility to the practitioner. After all, it is not the answer itself that is important, but how that answer can be understood and applied in relation to the improvement of the human condition.

I, as I hope we all do with our work, have attempted to discuss my ideas and opinions with a degree of quiet certainty, building the best argument I can by utilizing the work of those before me, as well as with a larger degree of brazen humility, knowing that the 'correctness' of those ideas is anything but certain. This work is my attempt to add to the ongoing conversations and debates regarding the topics that it covers, eventually subsumed by the larger professional discourse and ultimately adding to others' understanding of integrated care and MedFT, whether that understanding is based on their agreement or disagreement with the ideas presented here.

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CHAPTER 1: INTRODUCTION

Since George Engel, along with his colleagues at the Rochester University Medical Center, first proposed the biopsychosocial (BPS) model, an alternative to the traditional biomedical paradigm (Engel, 1977), there has been a persistent and continual push toward modalities of care that treat not only biomedical issues but relevant psychosocial ones as well. What this model described is a move away from the conceptualization of issues as either purely somatic or psychological in nature, and instead replaced it with a view that holds that "each biological problem has psychosocial consequences, and each psychosocial problem has biological correlates" (McDaniel, 1995, p.117). After its inception and publication in the 1970s, the BPS model was been attached to a variety of approaches, orientations, and organizational structures that all espoused to practice this typology of care in some form or fashion (e.g., Blount, 2003; Gatchel & Oordt, 2003; Gunn & Blount, 2009; McDaniel; Robinson & Reiter, 2007; Strosahl, 1996).

That burgeoning conceptual shift created an environment where medical and mental health care providers started to call and push for healthcare models incorporating both biomedical and psychosocial care, which has yielded a plethora of models designed to address the unique concerns and populations of the areas where they were initially developed. As these 'mixed methods' of care gained more recognition and popularity, researchers have sought to investigate and generalize the organizational structures of these facilities (Baird, 1998; Pruitt, Klawpow, & Epping-Jordan, 1998; Robinson & Reiter, 2007). The purpose of these investigations was to better describe and capture the underlying essence of what type of care was being practiced, by whom, and under what circumstances, which would ultimately culminate in the ability to replicate and standardize practice across sites. However, up until this time these widely published models have typically highlighted the use of psychologists (Hegel et al., 2002; Price, Beck, Nimmer, & Bensen, 2000; Robinson & Reiter, 2007; Strosahl, 1996, 1998, 2001; Valleley et al., 2007), primary care physicians (Baird, 1998; Oakley, Moore, Burford, Fahrenwald, & Woodard, 2005), social workers (Manoleas, 2008; Williams, Shore, & Foy, 2006), psychiatrists (Judd et al., 2004), and nurses (Gerada, Barrett, Betterton, & Tighe, 2000) as the main providers of mental health care.

Also worth discussing, albeit briefly here, are the types of issues these models were typically thought to address. Notably, all of the authors referenced above, as well as other contemporary authors on the subject, pointed to work with what is referred to by Blount (2003) as a ‘targeted population,’ or a specific group of people within which a disease is considered endemic. Researchers have described this particular type of integrated care modality in patients dealing with depression (Reiss-Brennan et al., 2006; Rollman et al., 2006), anxiety (Price et al., 2000), substance abuse (Gerada et al., 2000), HIV (Zaller, Gillani, & Rich, 2007), and diabetes (Meulepas et al., 2007), as well as with specific groups such as Latinos (Manoleas, 2008), the elderly (Hegel et al., 2002), rural populations (Judd et al., 2004), and children (Valleley et al., 2007). The work of these contemporary researchers has offered invaluable knowledge to clinicians (both mental health and biomedical) regarding different and optimal ways of addressing their shared patients’ varied biological and psychosocial issues.

However, what none of these authors have discussed thus far is a model of care that addresses the varied biopsychosocial needs of the diverse patient populations found in the arena of primary care. Peek, Baird, and Coleman (2009) pointed out this unaddressed need in their article entitled “Primary Care for Patient Complexity, Not Only Disease” in the journal *Families, Systems, & Health*. In it they discussed how mental health care professionals, working side by side with their medical counterparts, can do much more than simply provide quality traditional mental health services (i.e., long term psychotherapy, psychological assessment, crisis management):

> Behavioral health clinicians who are seen as part of a medical home team may be able to use their skills to enhance and extend primary care provider efforts to engage patients, set goals and customize the approaches to each person and family in addition to treating mental health conditions as an on-site member of the clinical team. (p. 17).

Another gap in the literature that pertained to integrated treatment modalities is the lack of discussion regarding how medical family therapists (MedFTs) participate in primary integrated care environments. While MedFT models have been described in several other contexts, both location and disease specific (i.e., Anderson, Huff, & Hodgson, 2008; Davey, Foster, Milton, & Duncan, 2009; Doherty & Mendenhall, 2006; Heru & Berman, 2008; Phelps et al., 2009; Willerton, Dankoski, & Martir, 2008), literature could not be located that explicitly discussed a model of care integrating the use of a MedFT in a primary care center with a non-targeted population or non-specific diagnosis.

Medical Family Therapy

Medical Family Therapy (MedFT), as conceptualized by the following authors, has been described as “an approach to health care from a biopsychosocial-spiritual perspective, [that is] informed by systems theory,” (Linville, Hertlein, & Prouty Lyness, 2007, p. 86). As it is still considered an emerging construct (‘construct’ is used in the place of profession, discipline, or sub-specialty since that is currently the question at hand), it has also been presented as a series of therapeutic techniques (Campbell & Patterson, 1995; Rolland, 1994), a way of orienting oneself toward working with medical health care providers in general (Doherty, McDaniel, Hepworth, 1994; McDaniel, Hepworth, & Doherty, 1992), and a sub-discipline of marriage and family therapy (MFT) (Tyndall, Hodgson, Lamson, Knight, & White, 2010).

From the latter perspective, MedFT represented an accentuation within family therapy in that therapists with the MedFT designation obtained specialized training in medical discourse and nomenclature (e.g., physiology, psychopharmacology, disease etiology, medical culture) (Tyndall et al., 2010), as well as training that emphasized the biological component of psychosocial experiences (Linville et al., 2007; McDaniel et al., 1992; Tyndall et al.). As is often the case with traditional family therapy training, as with most mental health disciplines (Linville et al.), there has been a lack of discussion surrounding the biological consequences of psychosocial issues and vice versa, a deficiency that has lead to the implicit idea that physical illness is an ‘intrapersonal’ phenomenon that is not always seen in the context of interpersonal relationships (Doherty, 2007; McDaniel et al.). Medical Family Therapy has specifically helped orient family therapists in a way that has allowed them to recognize and address both the biological and psychosocial components of physical and psychosocial issues, treating both as intra and interpersonal experiences simultaneously.

Given that the conversation surrounding what MedFT is or is not is still in its infancy; a conversation regarding whether or not MedFT is a sub-specialty of marriage and family therapy (MFT), an orientation, or new a profession altogether, the first article is an exploration of the theoretical connection between MedFT and the field of MFT. This connection is explored by utilizing ideas regarding the relationship between one’s professional frame of reference, or their foundational training, and the contexts where they then apply that training (Bateson, 1972, 1991; Chenail, 1995; Keeney, 1983). In adopting this particular view, MedFT is not seen as a separate profession from MFT, but the extension of relational understanding and practice into a specific venue (i.e., medicine). The extension of that relational meaning system into medicine manifested through a MedFT's ability to negotiate and connect three main areas of conceptual difference that often account for conflictual relationships between mental and biomedical health care providers: (a) patient and provider conceptualizations of issues/goals, (b) linear and circular understanding of issues/goals, and (c) consultative and expert positions on issues/goals. Two case examples are offered in order to describe how these three areas of tension are reconciled in everyday practice, as well as questions and avenues for exploration to help guide future theoreticians as they attempt to further define MedFT.

The purpose of the second research article was three-fold: (a) an attempt to begin to address the need discussed by Peek et al. (2009) for a model of integrated care that is neither disease nor population specific, (b) it served as the basis for a description of a primary care model that incorporates MedFTs/MFTs as the mental health care providers within the medical system, and (c) it further described and clarified how the theoretical connection discussed in the first article was realized through clinical practice. The vehicle through which these three aims were addressed is the presentation of a framework that detailed the MedFTs' (who in the study were termed behavioral health providers; BHPs) interactions with both patients and medical providers from initial patient contact through coordination of the treatment plan; a framework whose specificity had not yet been presented in contemporary literature.

The framework within article two initially included description of three global patient conditions that help to provide the initial context for the BHP/patient encounter; (a) new patient, (b) return visit- worsening or no change in condition, and (c) return visit- improving condition. Next, five phases were described that comprised the BHP's overall interactional process with the patient and medical provider; (a) patient briefing, (b) introduction, (c) elicitation of the illness story, (d) intervention, and (e) relaying information. The major classifications of intervention utilized by the BHP during phase four, the ‘intervention’ phase, were also presented and discussed: (a) brief problem solving/supportive therapy, (b) planting seeds, (c) psycho- and/or behavioral education, and (d) patient referral. Rules governing both solo (BHP only) and conjoint (BHP and medical provider) sessions were described and interwoven throughout, as well as how those phases and rules changed based on whom is present in the exam room. Finally, future researchers generating a description of the entire care model, comparison of a MedFT model of IC versus models incorporating other behavioral health disciplines, and effectiveness research regarding the model in question are all discussed.

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CHAPTER 2: REVIEW OF LITERATURE

The United States spent more than $6,719 per capita annually on healthcare in 2006-2007 (World Health Organization, 2009), and $121 billion has been devoted to psychological or social problems (Substance Abuse and Mental Health Administration, 2007). While these figures seem large, it is also worth mentioning that the United States sat at number 16 in terms of mortality rates compared with other industrialized nations (Fine & Peters). This implied, at least in this case, that more is not necessarily better when it comes to money spent on healthcare. These inversely related figures have risen and fallen respectively for the last 20 years, and many health economists foresee a future healthcare system burdened, and ultimately broken, by astronomical healthcare costs if these current trends remain unabated (Fine & Peters).

Over the last 15 years, there have been many theories and hypotheses regarding why the healthcare system seemed to be facing entropy. Some researchers have suggested that the lack of access to and reliance on primary care has been the impetus behind these increasing costs (Fine & Peters, 2007). Primary care as a whole has faced a 10% decline in new providers over the last ten years due to burnout (Bodenheimer, 2006; Grumbach, Selby, Damberg, et al., 1999), payment structures that favor specialty acute care (e.g., cardiology, gastroenterology, etc.) over the preventative practices of primary care (Bodenheimer; Fine & Peters, 2007), and a lack of integrated care services (Blount et al., 2007; Miller, Mendenhall, & Malik, 2009). These issues are connected in that they all point to a decreased, reliance on and access to primary care services by both the medical community and the general population.

Primary Care

As described by the Institute of Medicine (IOM) (1996), primary care is defined as ". . . the provision of *integrated, accessible health care services* by clinicians who are *accountable* for addressing a large *majority of personal health care needs*, developing a *sustained partnership* with *patients*, and practicing in the *context of family and community*"(p. 31) [emphasis not added]. The IOM's definition eluded to the fact that primary care providers (both physicians and physician extenders) deal primarily with patients that present with co-morbid, and often times complex, psychosocial and somatic complaints (Blount & Bayona, 1994; Osthye, et al., 2005; Robinson & Reiter, 2007).

Due to this complexity, and the fact that many consider medical providers the "de facto" mental health system (IOM, 1996), physicians are often left alone to maneuver and wade through the myriad of biological issues that their patients have, while at the same time being expected to address the concurrent psychosocial issues of their patients as well; issues that physicians are traditionally not well trained to handle (Adler, Shaw, Sitt, Maya, & Morrill, 2009; O'Connor, Solberg, & Baird, 1998; Strohsal, 1996). This role exhaustion has created a scenario that Bodenhemier (2006) described as one where "primary care physicians are expressing frustration that the knowledge and skills they are expected to master exceed the limits of human capability" (p. 3), a sentiment that is also echoed in research by Osthye et al. (2005) who found that primary care physicians perceived an inability on their part to manage chronic illness effectively due to training and time constraints.

The question then becomes, how does one address skyrocketing healthcare costs while at the same time provide support to primary care physicians regarding the intertwined biopsychosocial issues of their patients? The answer to this question for many physicians (Baird, 1998), as well as mental healthcare providers (McDaniel, Hepworth, & Doherty, 1992; McDaniel, 1995; Strohsal, 2001), has been to merge mental health and somatic healthcare regimens into a holistic approach to patient treatment, which has been termed integrated care (Blount, 2003; McDaniel et al., 1992; McDaniel, 1995). In this context, physicians are able to address the physiological symptoms with which their patients present, while mental healthcare providers working alongside the physician attend to the psychosocial issues. In this capacity, therapists "[have] to view themselves as health care providers, not just mental health providers", which means that therapists must "care about [a] patient's diabetes and headaches, not just. . .depression and anxiety" (Doherty, 2007, p. 35). However, several issues have been raised in relation to integrated care, such as: what is considered integrated care, how does one recognize his or her current level of integration or evolve to different levels of integration (Doherty, McDaniel, & Baird 1996; Strohsal, 1998), and what does integration look like when including various mental healthcare disciplines (Blount, 2003)?

The following review of literature was written to define and highlight two differing models of integration; one that focuses on levels of integration (Doherty et al., 1996), and another that draws distinction between ways mental health and biomedical providers work together (Blount, 2003) with integration being only one way of collaborating. Next, the authors discussed the emerging field of Medical Family Therapy (e.g., Linville, Hertlein, & Prouty Lyness, 2007; McDaniel, 1995; McDaniel et al., 1992) with an emphasis on MedFT conceptualizations of issues as biopsychosocial in nature. The author then went on to describe several models already discussed in the current literature that utilize psychologists (Hegel et al., 2002; Price, Beck, Nimmer, & Bensen, 2000; Robinson & Reiter, 2007), social workers (Gerada, Barrett, Betterton, & Tighe, 2000; Manoleas, 2008; Williams, Shore, & Foy, 2006), primary care physicians (Baird, 1998; Oakley, Moore, Burford, Fahrenwald, & Woodard, 2005), psychiatrists (Judd et al., 2004), and MedFTs (Anderson, Huff, & Hodgson, 2008; Burns, 1999; Davey, Foster, Milton, & Duncan, 2009; Doherty & Mendenhall, 2006; Phelps et al., 2009; Pratt et al., 2009; Rolland & Williams, 2005; Smith & Harkness, 2003; Willerton, Dankoski, & Martir, 2008), as the providers of integrated healthcare services with targeted populations. The chapter then closed with the delineation of the theoretical trinity (social constructionism, cybernetics, and the biopsychosocial-spiritual approach) through which the study will be conducted.

Dynamic Integrated Care

Described by Doherty et al. (1996) as "the degree of involvement and sophistication in collaborative health care involving mental health professionals and other health professionals," integrated care is described as a progression that is used not to presuppose the most optimal way for all clinics to function, but to describe "the strengths and limitations of a variety of options" (p. 25). For Doherty et al., the involvement of mental healthcare professionals in any way was enough to classify a system of care as integrated. What differed, however, was the degree of use, the proximal location of the mental health and biomedical providers, overall vision, case management, and degree of direct communication (Doherty et al.). From this standpoint, the authors attempted to delineate five ever-more encompassing modes of integrated care delivery, which are as follows:

Level One. These systems of care can be thought of as "business as usual" in that the mental health and biomedical providers are in separate locations, and have separate systems of care when treating patients. For both providers, the Cartesian notion of mind/body split is concretized in the fact that neither conceptualizes client concerns as biopsychosocial in nature; mental health is relegated to the therapist while biological issues are confined within the agency of the physician (Doherty et al., 1996). Under this type of system, there is practically no communication between mental health and biomedical providers.

Level Two. In this level of integration mental health and biomedical providers still operate at different locations, but engage in periodic communication about specific patients for specific issues (Doherty et al., 1996). While they may see one another as resources, they still tend to operate independently of one another, with little regard to the other's practice unless warranted specifically. What this denotes is a mutual respect for one another's work, but in no way implies a sharing of responsibilities regarding patient care, or one another's' professional culture (Doherty et al.).

Level Three. Sites that espouse to practice integrated care in this way make a large shift in practice from both levels one and two in that they house mental health and biomedical providers within the same physical location (Doherty et al., 1996). Under these conditions both providers engage in more frequent communication through phone and email, but also make the transition to periodic face-to-face meetings due to proximal closeness. Models of care from this perspective would most likely house a therapist within the center, which the physician would refer patients to for specific issues (grief, depression, anxiety, etc.). However, a disconnection still exists in the languages spoken, which leads to a lack of in-depth understanding of one another's professional worlds.

Level Four. This level indicates a shift in how both medical and mental health care providers conceptualize patient issues—from the linear biomedical ethos to a more holistic biopsychosocial paradigm. The system itself allows for this transition by the creation of shared charting and scheduling systems that incorporate both biomedical and mental health treatment regimens. These sites are typified by frequent face-to-face meetings about patients, as well as mutual consultation where providers' opinions and ideas regarding treatment are welcomed and utilized (Doherty et al., 1996). Team meetings take place occasionally to assess the cohesion of the process, and evaluate any changes that need to be made. It is important to mention that it is at this level that both providers begin to develop a shared language for discussing patients, while at the same time develop an understanding and appreciation for the other's professional culture and expertise; it is this appreciation that contributes to the conceptualization of issues as biopsychosocial in nature (Doherty et al.).

Level Five. At this level there is a full integration of mental health and biomedical services, with the application of integrated services implemented at multiple levels of the healthcare delivery system. In these agencies physicians and therapists work side-by-side on the vast majority of their patients, and both adhere to the same biopsychosocial ethos. This interaction plays out in the continual face-to-face discussion about patients either at team meetings, which occur frequently, or informally embedded in their daily routines of engagement with one another (Doherty et al., 1996). What truly sets this level apart from the others is the in-depth understanding of each other's roles and scope of practice. It is this depth of understanding that engenders the creation of relational orientations and pathways of collaboration that access the mental health aspects inherent in biological issues and the biological etiology present in problems of a psychosocial nature.

Static Integrated Care

Blount (2003) took a somewhat different approach to categorizing the way in which biomedical and mental healthcare providers operate in regard to managing patient issues and/or concerns. Instead of utilizing a progressive model of integration (Doherty et al., 1996), he instead opted to differentiate the way in which these providers engage in the practice of collaborative medicine, a static differentiation based on defining the “relationship between the medical and behavioral services in primary care” (Blount). Blount defined these relationships between mental health and medical services as coordinated, co-located, and integrated.

Coordinated. This relationship can be thought of as akin to the idea of level one integration discussed by Doherty et al. (1996). In this type of engagement there is belabored communication between mental health and biomedical providers when a patient is being seen at both locations consecutively. Communication between providers is usually done through venues that do not require face-to-face contact (fax, email, phone), and are typically laborious to participate in (Blount, 2003). Each center maintains a distinct identity in terms of confidentiality, professional culture, and ways of intervening in patient’s lives.

Co-location. Systems that utilize this type of collaborative care strategy make the same move that Doherty et al. (1996) discussed in that both providers are housed at the same proximal location. In these instances collaboration regarding patients is made easier by the ‘in-house’ staffing; however, there is still a referral process from one provider to another, which commonly moves from medical to mental health provider (Blount, 2003). It is also worth pointing out that many of the cases in these venues start out as medical, and are then referred to the therapist by the physician. This referral process is further reified by the fact that up to 70% of all primary care visits have a psychological basis (Strohsal, 1998), as well as the finding that 25% of patients in primary care carry a co-morbid psychiatric diagnosis (Strohsal, 1996).

Integrated. Blount (2003) made the distinction between this care modality and the others by stating that in settings utilizing this practice there is only one treatment plan for a patient that both providers adhere to. In the preceding two modalities both therapist and physician maintained separate care regimens, and only engaged with one another if there seemed to be an "overt" reason to do so. However, in an integrated care setting these providers actively engage in care together and address both physiological and psychosocial issues concurrently.

The intent of juxtaposing these two differing modes of classifying collaborative and integrated services was to begin to build a linkage between the way in which these care modalities were conceptualized. Even though Doherty et al.'s (1996) definition of integration was much more inclusive than the different types of collaboration espoused to by Blount (2003), both envisioned integrated care as the sharing of one treatment regimen by both mental health and biomedical providers. In this way, there is a shift in the ethos of medical providers as to how mental health plays a role in physical issues (McDaniel, 1995), as well as a shift in the mindset of therapists to envision psychosocial issues as presenting with physical symptoms as well (Doherty, 2007; McDaniel, 1995; Strohsal, 1996). What this shift called for is for both mental and medical healthcare providers to move from the inherent linearity of contemporary biomedical thought toward the adoption of a more systemic and inclusive conceptualization of patient issues; a conceptualization offered by the biopsychosocial approach (Engel, 1977).

In adopting such a position, one that connects and views problems of mind and of body as dual sides of the same systemic coin, professionals must be oriented in such a way as to be able to draw out the connections between seemingly separate issues (e.g., diabetic neuropathy and family stress) (Doherty, 2007). As such, the emerging sub-discipline of Medical Family Therapy is uniquely positioned to add further clarity to this ecological lens by utilizing the systemic conceptualizations (Linville, Hertlein, & Prouty Lyness, 2007; McDaniel, Hepworth, & Doherty, 1992) inherent in its parent discipline, Marriage and Family Therapy (Tyndall et al., 2010), to describe and address the various and complex facets of physical, psychosocial, and spiritual issues.

Primary Care Collaboration

Many of the models described in contemporary literature deal with collaborative practices that separate mental health and biomedical issues. In these particular models what often transpired is the housing of the mental health care professional on site (Williams, Shore, & Foy, 2006); in these instances particular “targeted populations” (Blount, 2003) are referred by the primary care physician to the mental health care professional. These “specific” issues are thought of as the more traditional mental health care concerns (i.e., depression, anxiety, bipolar disorder, PTSD) (Price, Beck, Nimmer, & Bensen, 2000; Reiss-Brennan, Briot, Daumit, & Ford, 2006; Rollman, Weinreb, Korsen, & Schulberg, 2006; Samson, Bensen, Beck, Price, & Nimmer, 1999).

Another type of care known as behavioral consultation has also gained prominence in collaborative literature, as well as in professional practice (Robinson & Strohsal, 2009; Robinson & Reiter, 2007; Stroshal, 1996, 2001). What this method of care involved is not only the housing of mental health care professionals in a primary care setting, but the close involvement of the mental health care professional with issues that may not traditionally be seen as psychological in nature, but are instead considered more “behavioral” based. In these systems of care, the mental health care professional’s expertise is not solely in the treatment of psychological dysfunction, but in the proliferation of provider treatment regimens (Robinson & Reiter; Stroshal). What this entailed is that the mental health care professional housed within the site operates in several distinctly different ways than a more traditional mental health care practitioner (Stroshal, 2001).

The first major difference has to do with the types of issues that the practitioner is called to help with. No longer is a practitioner simply relegated to dealing with issues revolving around depression and anxiety, but is asked to help with issues regarding compliance, adherence, and any other issues that may impact patient care (Robinson & Reiter, 2007); the point being that issues such as depression and anxiety, while still part of the repertoire of the practitioner, are not his or her sole focus (Patterson & Strohsal, 2009). In utilizing a consultant model, anxiety and depression, in this context, are seen and treated as a consequence of treating other physiological issues, with an example being anxiety by the patient about taking a new medication for diabetes contributing to a lack of adherence on the patient's part (Strohsal, 2001). In this instance, the behavioral health provider may be called on to discuss this reticence with the patient and hopefully ameliorate his or her concerns.

Also, within this particular type of engagement the mental healthcare professional may be called on to confirm a mental health diagnosis when the medical provider is unsure of how to proceed (Strohsal, 1996, 1998). Given the fact that many primary care physicians, like many other physicians, feel that they are not well equipped to diagnose subclinical mental healthcare disorders (Adler et al., 2009), the inclusion of a mental health provider can be seen as adding to the diagnostic ability of the physician (Robinson & Reiter, 2007; Strohsal). It is worth mentioning at this point that in order to be referred, the physician must first recognize a problem and second, recognize the problem as being within the mental health care practitioner's scope of competence (Blount & Bayona, 1994). That orientation, on the part of the medical provider, implies that the provider must be able to conceptualize patient problems as being both physical and psychosocial (Baird, 1998; Blount & Bayona).

The second major ideological shift regarding this typology of care has to do with the amount of time the mental health care practitioner spends with the patient. In a traditional session the healthcare practitioners would engage in what has been called the "magic hour," a 50 minute to one hour session (Robinson & Strohsal, 2009; Strohsal, 2001). However, due to the fast pace of primary care, and the likelihood that a physician may see as many as 40 patients a day, the idea that one can see and spend 50 minutes with a patient is unrealistic (Robinson & Strohsal; Reiter & Robinson, 2007). Instead, the mental health care practitioner sees the patient within the span of 15-30 minutes, and usually does so within the exam room (Gunn & Blount, 2009; Patterson & Strohsal, 2009; Strohsal, 1996; Reiter & Robinson).

Providing care in this shorter amount of time and in an exam room requires a shift in how the practitioner conceptualizes patient issues. Instead of a lengthy assessment and diagnostic phase, the mental health clinician is concerned with the here and now of the patient’s immediate problem (Gunn & Blount, 2009; Strohsal, 1998). Several examples of psychosocial issues that are pertinent for a clinician to focus on during a visit are: weight loss, stress that manifests as substance abuse, physical violence within a relationship, possible psychiatric hospitalization, issues regarding medication compliance, as well as any other issue the physician and/or patient might find pertinent (Peek, Baird, & Coleman, 2009; Robinson & Strohsal, 2009; Robinson & Reiter, 2007).

The third ideological shift is the way in which information is disseminated to the provider about the referred patient. In a more traditional model the mental health practitioner would write a mental health note regarding the session, typically without much consultation from the provider (Gunn & Blount, 2009; Strohsal, 1996, 1998). However, within the behavioral consultant model the practitioner’s note is often times woven into the physician’s note (Blount, 2003; Doherty et al., 1996; Robinson & Reiter, 2007), since it was the initial physiological issue that served as the impetus for practitioner involvement. Also, many times within these settings provider and practitioner also engage in what is called “curb-side consultations” (Robinson & Strohsal, 2009; Strohsal, 1996). Consultations occur within the hallway or other open areas of the clinic or medical setting; these types of communiqués exemplify an informal communication channel, which delivers pertinent information in vivo regarding the patient's visit.

In these instances information is relayed from practitioner to physician or visa-versa about appropriate information regarding the patient that is currently being seen. If given from practitioner to provider, it is typically done with the intent of relaying information gathered from the initial session in regard to the concerns expressed by the physician (Strohsal 2001). If, however, the provider has questions about how to proceed with a particular patient, he or she might seek out and consult with the mental health practitioner as well. In these instances the information is given in direct temporal proximity to the patient's visit, so as to be used within that visit or the next one (Doherty et al., 1996; Robinson & Strohsal, 2009; Peek, Baird, & Coleman, 2009); the idea here is that since both providers are in constant discussion regarding the patient, no information is lost (Robinson & Reiter, 2007; Strohsal).

The main issue surrounding the models discussed above existed in how the consultant and/or therapist is used to augment patient care. In each study referenced below, the model was used to address either specific mental health concerns or disease states such as depression (Reiss-Brennan, Briot, Daumit, & Ford, 2006; Rollman, Weinreb, Korsen, & Schulberg, 2006), anxiety (Price, Beck, Nimmer, & Bensen, 2000), substance abuse (Gerada, Betterton, & Tighe, 2000), HIV (Zaller, Gillani, & Rich, 2007), diabetes (Meulepas et al., 2007), or was used to target specific populations such as Latinos (Manoleas, 2008), the elderly (Hegel et al., 2002), rural populations (Judd et al., 2004), and children (Valleley et al., 2007). These particular models of care did not specifically address the diverse patient populations or issues that are encountered by physicians working in a primary care environment (Robinson & Strohsal, 2009; Peek, Baird, & Coleman, 2009). What is being called for by proponents of primary integrated care are models of integration that are able to address multiple issues with a multitude of populations, and are tailored specifically to a particular site's needs (Robinson & Strohsal; Peek et al.). As Peek et al. observed:

> Behavioral health clinicians who are seen as part of a medical home team may be able to use their skills to enhance and extend primary care provider efforts to engage patients, set goals and customize the approaches to each person and family in addition to treating mental health conditions as an on-site member of the clinical team. (p. 17)

The behavioral consultant model is a useful description regarding a form of augmenting the relationship between biomedical and psychosocial conditions in that it ensures the close working proximity of mental health and biomedical providers in a primary care environment; effectively allowing them to work not only 'under the same roof,' but 'within the same room' if the situation warrants it (Strohsal, 1996, 2001). However, within contemporary literature, the model is typically run by psychologists, and as such, tends to accentuate a more individual, intrapersonal focus (Linville et al., 2007). As it stands, no primary care model utilizing medical family therapists or marriage and family therapists in this consultant capacity has been explicated and as such, there exists little idea as to how this model may manifest under the auspices of a systemic conceptualization.

Medical Family Therapy

Medical Family Therapy (MedFT) has been presented as a series of therapeutic techniques (Campbell & Patterson, 1995; Rolland, 1994), a way of orienting oneself toward working with medical health care providers (McDaniel, Hepworth, & Doherty, 1992), and a sub-discipline of Marriage and Family Therapy (Linville et al., 2007; Tyndall et al., 2010).

Described by Linville et al. as “an approach to health care from a biopsychosocial-spiritual perspective, [that is] informed by systems theory” (p. 86), and augmented further by Tyndall et al.’s added professional descriptor of MedFTs as also being “endorsers of patient agency and [stewards] of the larger system” (p. 24), MedFT, for the purpose of the current study, was conceptualized through the contours of both Linville et al.’s and Tyndall et al’s combined definition.

From this perspective MedFT, as a sub-discipline, represented a shift within contemporary family therapy in that psychological and biological issues are conceptualized as two sides of the same systemic coin. While systems theorists (both general and natural) have always seen biology as playing a part in any issue there has not always been the training or subsequent emphasis on a biological component (Linville et al., 2007; McDaniel et al., 1992, Tyndall et al., 2010). MedFT, however, emphasized the idea that physical illness/health and mental illness/health are both intra- and interpersonal phenomena that cannot be separated, understood, or treated outside of the contexts within which they are embedded (McDaniel, 1995); a “both/and” conceptualization (Keeney, 1983). In this way, MedFT is concerned with both physical and mental health and how those varying dimensions are connected and experienced in relation to another. Due to this recursive conceptualization, emphasis on collaboration between the MedFT and other mental health, as well as biomedical providers, is a hallmark of this particular orientation to care.

Although relatively new to the field of mental and collaborative healthcare, several researchers have already examined the roles that MedFTs play in serving targeted populations. These studies have presented models of care incorporating MedFTs in the treatment of Latino families (Willerton, Dankoski, & Martir, 2008), youths diagnosed with HIV/AIDS (Davey, Foster, Milton, & Duncan, 2009), overweight and obese pediatric/adolescent girls (Pratt et al., 2009), Hispanic and African American diabetic patients (Phelps et al., 2009), patients with severe and persistent mental health diagnoses in an inpatient setting (Anderson, Huff, & Hodgson, 2008), community based health initiatives (Doherty & Mendenhall, 2006), genetics (Rolland & Williams, 2005; Smith & Harkness, 2003), and infertility (Burns, 1999). It is worth mentioning that all of these researchers have indicated that the MedFT worked in close collaboration with not only the medical provider, but other members of the health care staff (nutritionists, social workers, diabetic health educators, etc.).

Notably, all of the studies referenced above point to work with what is referred to by Blount (2003) as a "targeted population," which are specific groups of people or populations within which a disease is considered endemic. It is also worth mentioning that all the studies referenced, with the exception of three (Doherty & Mendenhall, 2006; Phelps et al.; Pratt et al.), were housed within hospitals, or other specialized care programs. What contemporary literature has failed to expound upon is the use of MedFTs in primary care settings, and with a population of patients that do not present with a specific disease process; a deficiency that the current study sought to address.

Theoretical Framework

To better understand and develop a cogent description of how MedFTs work in integrated and collaborative primary care sites, a theoretical grounding must be explored that touches on both the essential underpinnings of their work, as well as how those theories might play out in practice. In keeping these ideas in mind, the theoretical lenses that informed this study are: social constructionism, constructivism (cybernetics), and the biopsychosocial-spiritual approach. From this vantage point constructionism and constructivism served as the underlying relational basis for the methodology chosen (ethnography of communication), as well as descriptive of MedFTs relational/systemic orientation. The biopsychosocial-spiritual approach not only accentuated the relational approach of MedFT (Tyndall et al., 2010), but also served to inform the ethos of most integrated and collaborative care ideology (Blount, 2003; Doherty, McDaniel, Baird, 1996; McDaniel, Hepworth, & Doherty, 1992).

Social Constructionism

This multidisciplinary orientation is best summed up by Gergen (1999) as a critique of the “taken-for-granted character of language” (p. 19). While lacking the solidarity of modernist precepts of truth, objectivity, and reality as a cohesive aggregate of concepts and suppositions, Anderson (1997) described it as a “discontinuous philosophical direction,” which can be thought of as “a disorienting crossroads where similar and dissimilar traditions meet” (p. 35). The point of this orientation is to entertain multiple descriptions of events since all descriptions are merely that, and in no way encapsulate or describe a reality outside of itself; in other words, no description of reality captures the truth of a situation (Gergen, 2006).

Ontology. From a constructionist perspective the dichotomous nature of the subject-object distinction falls apart since observers can never be separated from that which they observe (Gergen, 1999; Keeney, 1983, 1987). In this vein there is no ontological reality ‘out there’ to be compared to and contrasted with the ‘in here’ mental state of the mind (Bateson, 1972; Gergen, 2006). Reality is not something seen or something that is experienced ‘as it is,’ but is in a constant state of negotiation (Gergen; Shotter, 2008). It is important at this juncture to state that the idea of mind from a constructionist perspective is very different from that of a modernist discourse. The term is not being used to denote an internal state separate from an external one, an insular ‘I’ that exists somewhere within the contours of the skull making sense of and passing judgment on everything that it perceives (Anderson, 1997). Instead, ‘I’ is seen as a consequence of ‘we;’ meaning that the notion of ourselves can never be separated out from the relationships in which we are embedded; mind becomes an ecological function that exists not intrapersonally but interrelationally (Bateson, 1991; Flemons, 2002, 1991; Keeney, 1983, Keeney & Ross, 1985).

Epistemology. If one follows along with the notion that there is not an ontological reality ‘out there,’ then knowledge itself is not discovered but created. Again, knowledge becomes a social process of existing within relationships of ever-encompassing complexity and is not fixed and static, but contingent on “context: the relational, historical, and linguistic domains in which behaviors, feelings, emotions, understandings, and so forth are communal constructions” (Anderson, 2007, p. 12). In this way the ability to have *a priori* knowledge is impossible, since knowledge becomes a discursive practice that is local, fluid, and context dependent (Anderson, 1997; Gergen, 1999). The discursive orientation toward knowledge within the postmodern perspective precludes the creation of grand-narratives about reality or human behavior, and as such creates a context where knowledge is not disseminated through interaction but is constructed by it (Gergen, 1999, 2006).

Linguistics. Language from a postmodern view is not reflective of ontology (reality), but is the medium through which it is constructed. In this way language is not simply used for the dissemination of knowledge about reality from one insular being to another, but becomes the very fabric of reality itself (Gergen, 1999, 2006). Words in and of themselves hold no meaning, but only through their use do they achieve such (Seikkula, 2003). Language, in this view is generative, in that it becomes the means through which we coordinate with one another, as well as come to a communal construction of the world around us (Anderson, internet; Anderson & Goolishian, 1988; Seikkula, 1993).

In summary, a constructionist position treats language as constructive rather than descriptive, reality as interpreted rather than experienced ‘as is,’ and knowledge as negotiated rather than discovered. From this outlook an individual orienting themselves in this way becomes interested in how others are “making sense” of a situation presented to them, instead of judging how well their description of the situation matches an “out there” objective reality; how “correct” their observation might be (Anderson, 1997; Gergen, 1999; Shawver, 2001).

Where this orientation is helpful, especially in an integrated care context, is the belief in the constructive and constitutive nature of language (Gergen, 1999), and its effect on problem description and the subsequent resolution of said problem. In adopting a constructionist position, and with it the idea that language both creates and describes the objects/people/issues being discussed, multiple descriptions of a particular issue are open to be adopted (Gergen, 2006). What this means is that instead of having to look at an issue (e.g., diabetes, cancer, depression, anxiety) as either a biological or psychological issue, essentially creating a zero sum orientation for everyone involved, descriptions can be offered that encompass and present issues from a multiplicity of perspectives (Anderson, 1997; Gergen). This orientation helps to facilitate an environment where collaboration naturally occurs, since the descriptions offered by those involved (physician, mental health provider, patient, family, etc.) provide useful information to understanding the issue at hand.

With a move away from finding the “right” answer where descriptions must compete, participants are able to freely engage one another to find the answer that presents the greatest utility given the situation. This is especially important in integrated care environments since competing conceptualizations (i.e., biomedical vs. psychosocial) of patient issues serve as a significant impediment to collaboration (Doherty, 2007). In this way participants are able to orient to one another in a way that allows each to be respectful of the information presented (Anderson, 1996).

Constructivism

Constructivism is concerned with how people draw distinctions, and how the drawing of those distinctions both inform, and are informed by their actions (Flemons, 1991). This recursive interplay between distinction and action is not only conceptualized at the individual level, but also the group and ecological levels (Bateson, 1972; Keeney, 1983), with each conceptualization informing the other; essentially, how action and context inform one another recursively.

Context. Described by the Oxford English Dictionary (2009) as "‌. . the parts which immediately precede or follow any particular passage or 'text' and determine its meaning. . .," the idea of context can be understood as both constructive and mutually self-defining (Chenail, 1995). Context is often objectified, and as such, treating it as an actuality, as if it existed out there ready to grab and mold in some physical way, misses the fluid and recursive nature of the idea. This is a trapping of our language, one which Bateson (1972, p. 338) warned of and discussed the problems inherent therein:

> …I speak of an action or utterance as occurring "in" context, and this conventional way of talking suggests that the particular action is a "dependent" variable, while the context is the "independent" or determining variable. But this view of how an action is related to its context is likely to distract the reader-as it has distracted me-from perceiving the ecology of the ideas which together constitute the small subsystem which I call "context."

> It is important to see the particular utterance or action as *part* of the ecological subsystem called context and not as the product or effect of what remains of the context after the piece which we want to explain has been cut out from it.

This idea is such that all the events leading up to a particular interaction go into shaping the context, while that particular punctuated experience is shaping the interactions and context that come thereafter (Bateson, 1972, 1991; Chenail, 1991). This is not to imply a linear relationship between past, present, and future; as we find ourselves presently engaged in interaction our relationship to past interactions changes, as our present relationships (the "here and now" of our relating) contextualize both past and future interactions simultaneously (Chenail; Keeney, 1987).

Context is something that is held constant and fluid simultaneously (Flemons, 1991, 2002), informing how one is making sense of the "here and now" relationship, as well as how one makes sense of past relationships and anticipated ones. If one follows in this vein of thought, a context is constantly being created, broken down, and reconstituted concurrently as we orient ourselves in relation to one another.

In regard to MedFT and its study, this theory presents a way of orienting oneself to the interrelated and defining engagement between context and practice. As MedFTs function in their clinical work with patients and staff, the way they draw the distinction between that which is MedFT and that which is not, informs and is informed by their actions simultaneously. What this means for the practice of MedFT specifically (as with any profession), is that as one attempts to capture and define its practice, one does so only within a narrowly defined scope (Bateson, 1972), conceptually divorcing that which is described from the ecology of total description.

If one is sensitive to this idea, then those offering that description also issue the caveat that whatever is being presented may look different at different points in time, and will differ depending on who does the describing. This presentation of findings as tentative and incomplete, allows both researcher and practitioner the flexibility to alter practice as needed to suit the diverse environments where these are ideas are applied. This orientation of partial description also facilitates collaboration in that multiple descriptions of the same event become acceptable and even necessary to arrive at ever more complete understandings of the object of study (Keeney, 1983), whether that be descriptions of best practice (from a research perspective) or a patient's presenting concern (from a clinical perspective).

Biopsychosocial-Spiritual Approach

The biopsychosocial (BPS) approach is an ideology pioneered by George Engel at the University of Rochester. First published in the journal *Science* in 1977, the BPS approach offered a differing perspective on disease and illness along with a concurrent shift in how individuals are conceptualized (Engel, 1977). While the BPS approach took into account societal and psychological factors in regard to their relationship with somatic experience, it was not until later that clinicians and researchers thought to expand the biopsychosocial approach to incorporate the spiritual aspect of an individual's experience (e.g., Wright et al., 1996).

What set the biopsychosocial-spiritual (BPS-S) approach apart from the traditional biomedical conceptualization of illness and disease is that biological processes are not viewed as mutually exclusive from their psychological, social (Engel, 1977, 1980) and spiritual counterparts (Wright, Watson, & Bell, 1996) within an individual. In effect, disease is conceptualized as an interpersonal and intrapersonal event. These spheres of influence begin at the subatomic level and reach all the way to the biosphere, each one acting on the other simultaneously (Engel; Taylor, 2002; Weston, 2005). It is only through the conceptualization of presenting concerns in a way that elucidates their impact on varying facets of the patient's life, can a physician or mental health care professional begin to understand and assess the true nature of the issue (Weston), treating the individual and not simply the somatic concern (Engel, 1992).

The BPS-S approach may be used to support the idea of holistic care, or care that encompasses all aspects of a patient's life, not simply the presenting biological concern. Biological impacts of disease and illness can be mediated or exacerbated by psychological stress (Engel, 1977), which in turn can be impacted by relational or societal issues (Biderman et al., 2005; Taylor, 2002). This is not to say that any of these issues are separate from one another; one occurring then the other like dominos, but rather each occurring simultaneously and impacting the other as they transpire. This conceptualization of illness falls in line with the recursive and relational disposition inherent in constructionism and constructivism, and as such is seen as a foundational theoretical lens from which medical family therapists work (Linville et al., 2007; McDaniel et al., 1992; Tyndall et al., 2010).

Theoretical Summary

Although each theory was chosen for its unique contribution to the study and description of how MedFTs function, all are foundationally connected in their espousal of understanding events at both their macro and micro levels simultaneously (Bateson, 1972; Gergen, 1999; Keeney, 1983). From this perspective, each theory was created to acknowledge the importance and necessity of understanding events/ideas/actions through both their components and gestalt, with an understanding of one accentuating and adding to the understanding of the other (Keeney). In this way these theories/epistemologies emphasized the mutuality of contextual construction and the need for individuals to both reduce and connect these aspects of experience to arrive at ever more complete and useful descriptions.

For MedFTs, as with any mental health professional who practice in a medical setting, the pitfall exists of having to engage in ideological jockeying for the most “correct” description of presenting issues (Doherty, 2007; McDaniel et al., 1992). Furthermore, taking the position of being/seeing things as either reductionist or holistic, solution or problem focused, patient or disease centered an environment is created where ideas are debated rather than combined is not collaboration (Anderson, 1997, 1996). Social constructionism, constructivism, and in a different capacity, the BPS-S approach, make room for these ideological opposites since they, from an epistemological standpoint, treat these “binaries” as necessary compliments to offering an ecological understanding of how each side is related to and functions in relationship to the other. Not only do these epistemologies/stances allow for flexible and adaptable practice on the part of the clinician, but in being applied to research methodologies also provide the basis for producing flexible and adaptive descriptions as well.

Summary

The behavioral consultant model is a useful description to bridge the gap between biomedical and psychosocial conditions in that it ensures the close working proximity of mental health and biomedical providers; effectively allowing them to work not only ‘under the same roof,’ but ‘within the same room’ if the situation warrants it (Strohsal, 1996, 2001). However, within contemporary literature, this model is typically run by psychologists, and as such, tends to accentuate a more individual and behavioral focus (Linville et al., 2007). Although MedFTs’ use and utility has been outlined in multiple venues with specific disease states and populations (Anderson et al., 2008; Davey et al., 2009; Phelps et al., 2009; Pratt et al., 2009; Willerton et al., 2008), as it stands no primary care model utilizing MedFTs in this consultant capacity has been explicated, and as such there exists little idea as to how this model may look if family therapists served as the cornerstone of its application. If MedFT is to align itself with the current call for models of care that are neither disease nor population specific (Robinson & Strosahl, 2009; Peek et al., 2009), and with that gain utility in the varied and diverse setting of primary care, research must take place that describes MedFT models of care already being practiced in primary care settings.

With that said, the following study has not attempted to offer a definitive description of integrated practice by MedFTs in a primary care setting. What the authors sought to put forward is a flexible and adaptive description of a model of practice, which might then be used to elicit a broader conversation by the MedFT, marriage and family therapy (MFT), and medical communities about what is useful and what is not, in regard to working as a MedFT/MFT in an integrated primary care setting.

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[1]CHAPTER 3: BRIDGING CONVERSATIONS: DISCUSSING THE INTRA-PROFESSIONAL RELATIONSHIP BETWEEN MEDICAL FAMILY THERAPY AND FAMILY THERAPY

Since its inception, Medical Family Therapy (MedFT) has been viewed as a series of techniques (Campbell & Patterson, 1995), a way of clinically orienting toward patients and medical providers (McDaniel, Hepworth, & Doherty, 1992), and a distinct sub-discipline of family therapy (Linville, Hertlein, & Lyness, 2007). As MedFTs have struggled to develop a cogent description of what MedFT *is*, they have often taken the stance of first articulating what it is *not* (e.g., we are not reductionistic or linear thinkers), as well as punctuating descriptors of what they believe it to be: it is systemic (Linville et al.; McDaniel et al.), it is collaborative (McDaniel et al.; Tyndall et al., 2010), it operates from a biopsychosocial-spiritual perspective (Hodgson, Lamson, & Reese, 2007; Hodgson, Garcia, & Tyndall, 2004; McDaniel et al.; Smith & Harkness, 2004; Tyndall et al.). As these attempts have clarified to a degree certain aspects of what constitutes being or orienting oneself as a MedFT (McDaniel et al.; Tyndall et al., 2010), none have described theoretically how that orientation is clinically informed by our inherently relational thinking as family therapists. The importance of describing this relationship speaks to the foundational tie between MedFT and family therapy, and is essential to offering a cogent description as Tyndall et al. point out, “MedFT is a field that requires a strong base in marriage and family therapy first” (p. 57).

Do we, as MedFTs, consider ourselves systemic because we take into account family members and providers when working with patients (McDaniel, Harkness, & Epstein, 2001; McDaniel et al., 1992), view healthcare from a multi-world view (Doherty, 2007), and/or understand the impact of relationship quality on disease etiology/trajectory (Rolland, 1994)? If

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so, the question can then be raised regarding how we, as MedFTs, make sense of those systems; do we see them as being distinct and separate from one another, different worlds with different goals interacting with and impacting one another, a traditionally linear view (Keeney, 1983), or do we understand the idea of systems as a metaphor for the relational connection between things like disease and health, patient and provider, MedFT and family therapy? If we agree with the assertion that MedFTs' foundational understanding of family therapy serves as a basis for their work (Tyndall et al., 2010), we must be able to also discuss how that foundation manifests and informs our actions both conceptually and practically.

Linville et al. (2007) offered a conceptual definition of MedFT based on their non-systematic review of previous works. They defined it as "an approach to health care from a biopsychosocial-spiritual perspective, informed by systems theory" (p. 86). Along those same lines, in a 2010 Delphi study, Tyndall et al. reported that their Delphi panelists also embraced many components of this definition as foundational to a MedFT's orientation with the added emphasis on their collaborative abilities. From this vantage point what we are as a sub-discipline or specialization is not somewhere in between Family Therapy and medicine, but can be conceptualized as the immersion of Family Therapy in a specific context (i.e., healthcare), an augmentation of family therapy offered in response to working with a specific population and within a specific venue (Tyndall et al.). It is also worth mentioning that context in this "context" does not simply mean the environment where one practices, but the ecology of relationship between training, practice, and (in some instances) physical location (Bateson, 1972).

If we follow along with the idea that MedFT is an extension of family therapy, then we can rightfully ask what exactly "is the difference that makes the difference;" what both separates and connects MedFTs and family therapists from and to one another? If we are willing to entertain that question and the subsequent discussion, then the difference becomes the healthcare contexts in which MedFTs find themselves embedded in training, clinical practice, and research, as well as the essential skills that are required of them to function properly based on the needs and expectations of those settings. Regardless of the differences between MedFTs and family therapists, regardless of context what both are, and what both continue to be is systemic. What changes for MedFTs specifically are the voices that enter their conversations and relationships based on that contextual immersion (Chenail, 1991, 1995; McDaniel et al., 1992), as well as the specifics of practice based on training (e.g. M.S., Ph.D., postgraduate certification) (Tyndall et al.). The distinction is then drawn not in what we do professionally, but the contexts in which we apply our inherently systemic frames of reference, and how those contexts in turn shape those frames (Bateson, 1972; Chenail, 1995).

With all of this in mind, the goal of this article is to offer a theoretical discussion regarding MedFT as it relates to family therapy that does not present MedFT as a separate profession, but the extension of a relational epistemology into a specific context/venue; namely, how the immersion in a healthcare context shapes and is shaped by a relational epistemology. Along with this conversation about connection, a concurrent discussion will take place regarding three areas for a MedFT to recognize, address, and navigate in order to maintain a relational perspective: 1) patient and provider conceptualizations, 2) linear and circular conceptualizations, and 3) being a consultant and being an expert.

A Frame of Reference for Referencing Frames

Highlighting the conceptual and practical connection between the specialization of MedFT and family therapy will be done through the use of constructivist ideas, especially those dealing with the relational interplay between context and frames. To develop a better understanding of what is being discussed when those terms are used, as well as how they relate to one another, a brief description of each is offered.

Context

The concept of context can be understood as constructive and self-defining (Chenail, 1995), in that all events leading up to a particular interaction shape the context, while that particular interactional experience then shapes the context that comes afterwards (Bateson, 1972, 1991; Chenail, 1991). This does not mean that there is a linear relationship between past, present, and future; as we find ourselves presently engaged in an interaction, our relationship to past interactions changes, as our present relationships (the ‘here and now’ of our relating) give context to both past and future interactions simultaneously (Chenail; Flemons, 1991, 2002; Keeney, 1987).

An example of this interactional interdependence would be a normally ‘gruff’ physician that walks into a patient’s room and seems ‘nicer’ and more attentive than usual, which the patient may be thrown off by and even see as grounds for suspicion. This ‘unusual’ encounter can only be considered unusual if the patient recalls the more ‘gruff’ encounters to measure this one against, and unfortunately the nicer the physician is in her present visit the more unusual the patient will consider this particular encounter. The patient may also anticipate the possibility of bad news as the reason for the sudden shift in demeanor, which in turn will offer a new way of understanding both their past (the physician’s pleasantness as she entered the room) and present interactions. In this way the context of past encounters shapes the present, as the present shapes our understanding of past and anticipated future encounters, as the future shapes both past and present simultaneously.

Just as patient and provider define themselves in relationship to one another, we too, as MedFTs, engage in a similar act of sense making regarding our systemic selves as family therapists and the linear understandings that are presented to us in medical contexts and education. The context generated for a MedFT by their relational training is the framework through which they define thought and practice, which is then informed by their exposure to medical ethos and nomenclature (Tyndall et al., 2010), not the other way around.

Frames

Another way of discussing the idea of the relationship between meaning and context is through the metaphor of frames. As discussed by Bateson (1972) and Chenail (1991), frames are the means by which we mark events and/or experiences as being distinct and different from one another. An analogy often used is the notion of a hanging picture frame. In this example, the frame itself marks what is inside it from that which is outside, giving context to the picture contained inside as being separate from both the frame and the wall upon which the frame rests. However, just as the frame creates an understanding of the picture as something distinct from both the frame and wall, the picture contained inside also marks the frame as something distinct from the picture inside it and the wall it is hung on. Meanwhile, the picture and frame are embedded within a larger ecology (the wall) that contextualizes them both, and serves as yet another frame, so on and so forth. From this vantage point “a frame could only be understood in relation to what it framed” (Chenail, 1991, p. 29); what this means is that a frame achieves meaning by its relationship to the event/picture being framed.

Relating these ideas back to MedFT, as we work with a patient in a medical environment (a picture) this event is informed by our frame of reference as MedFTs (a frame), with the visit itself also informing how we understand ourselves and our work. However, both the visit itself and our frame of reference as MedFTs are also informed by the larger, foundational context of our training as Family Therapists (a wall). In this way the ecological interplay between the visit, our MedFT orientation, and our foundational Family Therapy training all inform and are informed by one another. Again, the idea here is that MedFT is one way of describing ourselves embedded within our professional understanding as family therapists, and is a way of both differentiating ourselves from and connecting ourselves to family therapy.

Framing a Relational Context

Medical Family Therapy

A way of orienting to the point of difference between MedFT and Family Therapy is not necessarily to discuss what each focuses on, but (as with most things) how each focuses on whatever the ‘it’ is. Whether one uses the work of von Bertalanfy, von Forrester, Maturna, Bateson, a combination thereof, or something in between to inform their orientation, the metaphor of biology and living systems has always served as the basis for our understanding of recursion and the relational embeddedness of individuals and groups (Hoffman, 2002). With that said, what differs when MedFT is compared with family therapy as a whole, as with any specialization within a profession, is the depth and degree to which a knowledge base is utilized and incorporated into both thought and practice.

Where family therapy has historically relied on biology as an implicit basis for describing and understanding systems, MedFT takes that idea and made its inclusion more explicit in the training process (Tyndall et al., 2010). What we learn as MedFTs in addition to our training as family therapists are the standard biologic paradigms (e.g. physiology, disease process, psychopharmacology) along with, and arguably most important, the traditions, world views, cultures, and understandings of how medical professionals make sense of their world, and how the way they make sense of things makes sense to them. In the same way we as family therapists have to learn about and validate our clients' understanding of their issues before we can engage in an intervention, we as MedFTs have to understand the medical world to offer an augmentation to any kind of medical practice (Edwards & Patterson, 2006; McDaniel, Hepworth, & Doherty, 1992). In this way what connects MedFT to family therapy, biology, also serves as a way of describing how the two are different, a both/and position marvelously at work!

Contextual Tension

Where this theoretical rubber meets the road, or how our relational orientation informs our practice, is in our recognition of and attending to the tension that our particular training instills in us as both family therapists and MedFTs. Tension in this respect takes on a dual meaning; it is used to describe the straining of ourselves as providers to punctuate connection where none is thought to exist, and our ability to walk the conceptual tightrope between two worlds that have traditionally been conceptualized as being both separate and distinct (biomedical and psychosocial) (McDaniel et al., 1992). The metaphor of a bridge is often used to describe how a MedFT orients himself or herself to provide a connection between psychosocial and biomedical punctuations of experience, and as such is an excellent framework from which to describe this idea of tension. A bridge only works if the right balance of tension between both sides is found; if either side is too tight or too loose the stability and integrity of that particular connection becomes compromised. As MedFTs we do not function as the bridge itself, but as engineers that continuously help to adjust the tension between both sides in order to achieve the right proportion of each. In this way a MedFT does not necessarily attempt to create a connection between the two (since a connection already exists), but offers adjustments to that tension to better solidify the relationship between patient and provider.

Practical Thoughts

What is being proposed is that a MedFT's understanding of what MedFT is can only be understood in relation to how they first make sense of themselves as a Family Therapist, with that understanding embodied in and exemplified by the acceptance of the tension between the varying contexts and epistemologies they are exposed to through their training. With that being said, MedFTs do face a unique challenge in that they often times find themselves housed, almost exclusively, in settings that are hierarchical, expertise-laden, and predominantly linear, and as such are constantly challenged to maintain a systemic outlook. This is not meant to discount or minimize the medical professionals and settings that embrace a systems/biopsychosocial orientation, however as Steinglass (2006), Geyman (2003), and Himmelstein and Woolhandler (2003) point out, it is meant to give credence to fact that these settings and professionals do not embody the prevailing practices and ideologies in the field of medicine presently.

For those MedFTs lucky enough to work with and within these systemically minded organizations the following ideas are likely common in practice, however, for the majority of us that are not so fortunate, and for the sake of making ideas explicit that are usually implicit in application, what are offered are three areas of tension to be addressed if MedFTs are going to remain contextually sensitive, along with relationally informed assumptions that may help guide MedFTs in their practice. The hope here is the generation of ideas and ways that we can embrace the lessons learned by the medical professionals we work with, while at the same time maintain fidelity to our collaborative and context sensitive disposition (Anderson, 1996).

Tension between patient and provider conceptualizations: Set the bridge do not be it

In MedFT literature the idea that the medical community sees biomedical and psychosocial health as separate has been the reasoning behind the drive to insert mental health clinicians in medical settings (McDaniel et al., 1992; Rolland, 1994; Tyndall et al., 2010). The analogy presented to describe MedFTs has been that of a bridge, one that serves as the point of connection between the medical and psychosocial parts/silos of a patient's broader experience and work with the medical community. However, if, like any analogy, we take that logic at face value it can create problems for several reasons.

To start, if one can picture two silos sitting in a Midwestern field what you would probably notice first is that they do in fact seem disconnected if there is no bridge between them, that if someone was to stand on one there would be no way to move to the other safely and efficiently. However, this is only one way of understanding their relationship. If we look again, what we might notice is that both silos, even without a bridge, are connected in a very real and concrete way; they are both resting on the ground. In fact, someone standing on one silo could easily climb down, cross the field between the two and climb up the other. The importance of this analogy is in the idea of how we as MedFTs frame our professional identity, especially in relation to the providers and patients we work with, and to the idea of exactly what a MedFT is or is supposed to be. If we believe that we serve as the point of connection between both the patient and physician, we are inclined to impose a specific kind of connection or relationship between the two, while discounting the connection each may already acknowledge and experience. In this way we force a specific kind of connection between patient and provider, and fail to be both relational and contextually sensitive.

A different way of understanding the idea of bridging and what it looks like is the notion that MedFTs serve as one way of augmenting (or enhancing) the relationship between the patient and provider. From this position, a MedFT does not connect two halves of some disconnected whole, but offers a way of connecting differently (Flemons, 1991, 1999, 2002). What this means is that what a MedFT does or does not do, evolves in relationship to the system in which he or she practices (Bateson, 1991; Chenail, 1991; Keeney, 1983). In other words, MedFTs are trained to remain contextually sensitive, and because of that allow the kind of care they provide to evolve directly in the sites where they provide it. So, in order to do this a MedFT must become interested in how the provider and patient understand their connection, what they appreciate about it, and what they wish to change. By becoming interested and engaging them in this way, a MedFT is able offer an augmentation to the connection that already exists, tailored specifically to that local relationship, since the addition offered by the MedFT is informed directly by how both are relating to one another. What evolves from this is a MedFT that remains contextually sensitive and adapts to any site, patient, physician, or issue, something that behavioral health providers are being called to do in current integrated care literature (Peek, 2009; Robinson & Strosahl, 2009).

Tension between linear and circular conceptualizations: Be "both/and"

Tension, in this context, speaks to how we, as MedFTs, make sense of our circular understanding of causality in relationship to the often times linear causality of medical thought and practice, and how a both/and position is the mechanism by which we are able to embrace these positions simultaneously. A hallmark of relational thinking, the both/and position allows family therapists to acknowledge and understand the recursive nature of every interaction (Keeney 1983; Keeney & Ross, 1985), and as such is considered a foundational ingredient of a relational stance. However, many times as family therapists attempt to learn about and apply this idea of circularity to real world practice, they do so in a very linear way (Keeney, 1983). We have a tendency to see things as being disconnected and separate, a trademark of our more Western philosophical approach to the world (Evans & Watson, 1991; Flemons, 2002). So, when we are presented with ideas regarding circularity and the connection this implies, our first inclination is to understand the idea in opposition to linearity, thereby conceptually disconnecting the two, instead of understanding it as an extension of circularity (Flemons, 1991). What this means, is that we tend to adopt a position that is either circular or linear, and in effect miss the whole point of the exercise. We miss the idea that a circular stance and linear one are both essential and required pieces of a larger, systemic picture (Keeney), and our job is to acknowledge the contextual legitimacy and see the connection between both.

If we as MedFTs walk into a medical context, one we see as predominantly linear and believe that these professionals must adopt a more circular/relational disposition, we have failed before we even begin. We will be inclined to believe that our way is the right way, and not only find that our ability to work effectively through collaboration becomes almost non-existent, but more than likely will be viewed as a sanctimonious “know-it-all.” Not to mention the fact that we will be adopting the same linear either/or position in regard to our own circular/linear understanding. In order to help us, as MedFTs remain relational, the idea that both linearity and circularity only exist in relationship to one another helps us to remain so in the presence of linear biomedical thought and practice. From this disposition we both acknowledge and accept the position of the providers we work with, even if we disagree; remember, acceptance does not imply agreement (Anderson, 1997). Validation and acknowledgment of ideas must run both ways in order to function collaboratively, whether that is of provider to MedFT or vice versa.

Tension between consultant and expert: Be non-pathological

At face value this area of tension can seem like an easy one to acknowledge, given the fact that most of western medicine works off of the notion of pathology, but a difficult one to embrace as MedFTs, due to our recursive understanding of issues. However, the non-pathological stance that is being discussed here is not extended to the patients alone, but is extended to the providers that MedFTs work with as well. There are many ways to pathologize and not all of them are exercises in DSM diagnostics. If we adopt a linear position in our understanding of the linearity/circularity connection, our inclination, especially if we become frustrated, is to say that the providers just “Don’t get it.” Now, these three small words imply three very large ideas: 1) there is an “it” to get, 2) that you as the MedFT do in fact “get it,” and 3) if the provider and/or system just “got it” then everything would work perfectly.

In embracing the tension between linearity and circularity (the recursive idea that one cannot exist without the other) we, as MedFTs, are able to adopt a non-pathological stance in our understanding of and engagement with the providers we work with in healthcare settings. What this means is that given a medical provider’s immersion in the cause and effect nature of medical education, we, as MedFTs, understand that their position on patient issues is informed directly by their training, which means their assertions make sense given their frame of reference (Flemons, 2002; Keeney, 1983). When we embrace this tension, what changes is an orientation taken by the MedFT that tells the provider and patient “We can do this differently if it makes sense for you to do so,” instead of “Do this differently because the way you are doing it now is wrong.” In this way, we are able to remain consultative in our attempt to find areas in which we can discuss change, allowing the providers and patients to locate areas of interest with us, while being experts in how those areas can function and/or look differently once identified.

Connecting Thoughts

As we discuss how these areas of tension impact a MedFT’s work, it is important to keep in mind that these three areas do not exist separately from one another, but are present to varying degrees in every interaction a MedFT has in any healthcare environment, and as a consequence inform and impact one another recursively. A MedFT's ability to accept both a provider and patient's conceptualization of an issue as having validity can only be achieved by understanding both positions in relationship to one another; this includes the linearity of medical thought (area one). As such, a MedFT is not inclined to pathologize either side (area two), but instead allows their relationship to inform where the area of connection is to be found, which then informs the specifics of the intervention that is utilized (area three). In this way, a both/and position informs a non-pathological stance, as the stance itself informs the position. Both the stance and position also inform how the MedFT attempts to find the point of connection and engage in the subsequent intervention, with that connection and intervention further informing the MedFT's position and stance.

Practical Practice

The following two examples are offered to show how a MedFT can adequately navigate these three areas of tension.

Case Example 1

While working at a community health center, a MedFT encountered a 94 year old man who came in due to pain and swelling in his legs. Upon entering the room the MedFT found a delightful elderly gentleman and his granddaughter. The gentleman was coherent, and able to carry on a conversation, at length, about his life and his relationships with friends and family. As the conversation continued the MedFT learned that the patient did not like or trust doctors, and this visit in particular was the result of his granddaughter tricking him into coming. Upon asking him more about his condition, the client lifted his pant leg and revealed a very black and swollen leg. As it turned out, the patient had gotten cut a month or two ago, and had been placing vegetable oil on the wound to clean it. This unfortunately had caused bacteria present in the cut *to remain, and had resulted in gangrene setting into his leg. The patient had feared coming to the clinic due to his thought that the physician would want to "cut off his leg."*

Area One. Here we can already see how the patient's understanding of the current situation and his assumption of how the provider would view it created a context where he feared coming in, which in turn has exacerbated his condition. Based on this knowledge, the MedFT gathered information for the provider pertinent to how the patient was making sense of the situation (e.g., cleaning the wound with oil, not trusting doctors, being tricked into coming in), as well as how the patient might respond to the provider once in the room. It is here that the MedFT must recognize the tension between the patient and provider by asking questions geared toward the patient's concerns as they relate to the provider's ability to provide care.

The MedFT continued his conversation with the patient, gathering as much information as he could in regard to his fears about treatment and what his goals were for coming in today. He also took the time to discuss both issues at length so he would be able to flesh out each concern and desire into very specific increments. Upon leaving the room the MedFT was able to meet up with the adult nurse practitioner (ANP) to whom he then relayed all the pertinent information: the patient's fears about amputation, his physical history, the fact that he was lucid and able to carry on a conversation, etc. While in the room the ANP did find that his right leg was almost completely necrotic (dead), *and that his left leg had also started down a similar trajectory, a condition of the patient's treatment for a cut on that leg as well.*

The ANP informed the patient that he would indeed need to have both legs amputated, above the knee, which would effectively confine him to a wheelchair for the rest of his life, and more than likely place him in an assisted living facility. The patient adamantly refused to have his legs amputated, stating that he had had a long life, and that he was going to let God "do *what he had to do." The ANP was frustrated at this point, and explained that if he did not have the procedure done that he would get sepsis in both legs, and he would only have about six months left to live. The patient did not seem fazed by this, and simply stated that he had always lived on his own and no intention of changing that anytime soon. More and more medical professionals began to enter the room; medical assistants, nurses, his granddaughter, all in all, there were six people trying to convince the patient to go to the hospital and have the procedure done. However, regardless of the amount of people, or the echoing of concern, the patient emphatically stated that he had no intention to go anywhere but home. Upon hearing this, and knowing that the man was coherent and lucid in his thoughts, the ANP asked the MedFT to talk with him while he drew up the medical waiver for the patient to sign.*

Area Two. We are able to see how the understanding of the situation by the patient and the understanding of the same situation by the medical providers' have placed them at odds with one another, albeit with the providers intending to be helpful. By making a statement about not wanting to seek care the patient is also making a statement about the how the provider can or cannot care for him. In effect, the patient's desire for no treatment runs counter to how the providers frame their professional identity, and serves as a rejection of the providers by the patient. At least in regard to this interaction, the provider cannot be a provider since he has no patient to administer care to. Now, at this point the MedFT can do three things, he can a) side with the patient in promoting his right to not seek care, which also alienates himself from the medical professionals he works with by pathologizing them as not understanding the patient's desire; b) side with the provider by insisting that the patient get care, and see the patient's refusal as indicative of him not thinking rationally, which then pathologizes the patient and robs him of agency; or c) find the common thread between both sides in that the ANP wants to provide care to ensure the patient's quality of life, and the patient denies that care in order to ensure quality of life. In the third option the MedFT acknowledges that the point of difference between both parties is not in quality but in quantity of life, and is then able to refrain from pathologizing either party since both stances make sense given how each side is conceptualizing the situation.

The MedFT entered the room, and immediately assured the patient that he was not there to push him to go to the hospital, to which the patient thanked him. The MedFT then began discussing with both the patient and his granddaughter the nature of what was going on, and what the patient wanted to do with the time that he had left. The patient and his granddaughter then began a dialogue about the things that he wanted to do and the things she wanted to do with him before he passed. The MedFT also discussed the fact that toward the end it may be very painful, and inquired what the patient wanted to do during that time as well. The patient said that he did not know, to which the MedFT suggested discussing that topic with the ANP when he came back into the room. The ANP then entered the room, had the patient sign the form, and proceeded to stay and discuss some of the patient's questions with him. After a lengthy conversation with the ANP, the patient thanked the ANP, nurses, and MedFT for their time and left with his granddaughter.

Area Three. In acknowledging the patient's position as being valid the MedFT is able to engage him and his granddaughter in a conversation that does not target his refusal of care, but how his refusal of care will offer both opportunities and difficulties in the coming months. Along with this conversation the MedFT is also able to help create a context where the ANP can be useful, since he encourages the patient to talk with the ANP about the physical difficulties he might encounter as his condition reaches its end. This helps shift the context away from the ANP being a detriment to maintaining his quality of life, and a resource to how he might maintain it.

In this way, the MedFT is able to offer a specific kind of augmentation to the patient provider relationship that is based on how both are relating to one another and the diagnosis. In helping them to connect differently, around the patient's quality of life toward the end of his disease process, the patient and provider can coordinate a shared goal, which leaves the patient thanking all involved for their assistance instead of cursing them for their interference.

After the patient left, the MedFT found three of the providers (two medical assistants and a nurse) in his office discussing their frustration with the case, and how they could not understand how someone would essentially "kill themselves" by not getting "proper" medical care. They reasoned that perhaps something was mentally wrong with the individual due to his refusal to be treated. The MedFT helped facilitate this conversation as well, and ended up discussing with them the notion of agency, and some of the psychosocial aspects of illness and its treatment, along with the idea of autonomy and how important that is to individuals as they deal with illness. Throughout the conversation the MedFT also punctuated the fact that this must have been agonizing for them to watch since they wanted to help the patient and felt like they were prevented from doing so by his refusal. At the end, the medical assistants seemed to find solace in the fact that he was 94 and had lived a long life, but there still remained an underlying frustration that many still talk about.

Again, we see how the MedFT is able to acknowledge both the patient's (his desire for autonomy and agency) and the providers' (their desire to heal and ameliorate) positions in such a way that does not present them as separate wants, but as different means to the same end. The MedFT in this situation was able to successfully navigate the tension between the biomedical and psychosocial aspects of the patient's disease and the providers' professional frames of reference in a way that allowed both parties to experience this refusal not as a rejection of them or of life, but as a way of embracing life differently.

Case Example 2

While working in a family medicine residency program at a university medical center, a MedFT was approached by a third year medical resident and asked to consult on a 54-year-old female patient who had presented with transient, unexplainable pain. The resident said that this particular patient had been seen in clinic for the last two years and so far, the physicians were unable to find a biological reason for her condition leading them to think it is all "in her head." The resident suggested to the patient, as have other physicians for the last two years, that she pursue psychotherapy for her "depression," which the patient had repeatedly and emphatically denied doing. Upon entering the room alone, the first words out the patient's mouth to the MedFT were "I'm not crazy, I'm not depressed, it's not in my head, and I sure as hell don't need to talk to some therapist!"

Area One. As with the first example, we can already see a difference in how both patient and provider are conceptualizing what the presenting issue is or might be. For the resident this is a case of somatization and if the patient would seek out the right treatment (psychotherapy), her pain issue would be resolved. However, based on the patient's reaction when the MedFT entered the room, this does not seem to be the case for her. Their discrepancy in description at this point has gone from being a potential point of conflict to a direct point of conflict, with the relational consequences of that difference playing out not only between the patient and provider, but now between patient and MedFT. The MedFT has gathered important information about how the provider views the patient prior to entering the room, and now must engage the patient in a way that allows her to gather information about how the patient views both her condition and her relationship with the provider. Only once the MedFT successfully understands both positions can she offer a difference in their relating that connects through consensus rather conflict.

After some careful explaining about whom she was and what she did, the MedFT was able to engage the patient in a conversation about her pain and how it had "robbed" her of her ability to enjoy life for the past two years. The patient described constant alternating periods of numbness and aching in her lower abdomen and legs, tingling in the bottoms of her feet, and a constant feeling of "fullness" that at times was extraordinarily painful. However, as frustrating as this constant and ongoing condition might be for this woman, what bothered her most and caused her the most anger was the feeling that no one "believed" that she was in pain. For this patient, every time she was told that she needed to seek psychotherapy for her "depression" it was tantamount to calling her a liar, that all this constant misery was "in her head" and that she was either "faking" or could just "turn it off" if she really wanted to. Now, not only did she feel that she had to fight what was going on in her body in order to maintain some degree of quality of life, which in and of itself was "exhausting", but every time she came to see the doctor she felt like she had to "fight" for them to "believe in" her condition.

Area Two. The importance of the issue's description at this point cannot be overstated. The provider does not question whether the patient is experiencing pain, but does have questions about where the pain originates from, convinced that it is a physical reaction to a mental health diagnosis. In describing his thoughts to the patient, as medical providers before him have done, the patient sees this as challenging the legitimacy of her condition, and is rightfully both angry and frustrated. Presented with a seemingly untenable position the MedFT again has three options, she can a) side with the patient in her anger with/at the medical team, which pathologizes the providers as uncaring by writing off the patient's pain as "in her head"; b) side with the provider by insisting that the patient is suffering from a mental health diagnosis and seek psychotherapy, which pathologizes the patient; or c) offer a difference in connection that accentuates both patient and provider's frustration with the pain itself, and more importantly, how that frustration is communicated with one another. In this way the MedFT can help foster a connection around both parties' frustration with the pain rather than their frustration within one another over where the pain originates.

The MedFT and patient discussed how this constant fighting on both "fronts" must not only be extremely frustrating for her, but how it must also be exhausting, to which the patient stated, "it only took two years, but finally someone gets it." It was at this point that the MedFT was able to talk with the patient about how frustrating it must also be for the physicians providing care, wanting to be able to help but feeling powerless because she was still hurting. The patient was struck by this possibility, and after some thought said that she could "see how they would be frustrated too." After they had talked further, the MedFT was able to ask the patient if she thought coming to see her again might be useful, not necessarily to talk about her pain, but to talk about her frustration and fatigue in regard to having to "fight" all the time, as well as, and most importantly for the patient, ways she could communicate with her physicians differently so that she might feel like they are on "her side." The patient thought that this would be a great idea and scheduled an appointment to meet with the MedFT at the beginning of the next week. Afterwards, the MedFT discussed the consult with the resident and attending, who both were happy to continue providing physical care for her pain in light of her decision to seek therapy.

Area Three. Instead of providing a description of therapy as a way to help the patient no longer "be crazy", the patient is offered therapy as a way to engage in a conversation about her anger and frustration with her physical pain and her relationship with the physician. This was only possible because the MedFT was able to help facilitate a connection for both patient and provider that highlighted their frustration as a shared experience of the pain and the way that their frustration was communicated, and not necessarily frustration with one another. Initially, the patient expressed her frustration with the pain by eliciting the help of the medical team in finding the cause of and dealing with it; however, after feeling that he and the other physicians were unable to find a cause, the provider expressed that same frustration with the pain by conceptualizing it as an issue of somatization and suggesting psychotherapy. The patient and physician’s shared frustration connected them in conflict with one another not necessarily because of its presence, but because of the way it was communicated between them. By eliciting a conversation with the patient that highlighted her and the physician’s frustration, as well as describing therapy as a venue to discuss that frustration, both patient and provider’s goals were able to be met, which in turn allowed the patient the freedom to receive the care she wanted and the physician the peace of mind to continue to provide that care.

In each example, the ability to embrace these areas of tension could only have occurred if the MedFT was able understand the position of both the medical professionals and patient simultaneously. The need of the patient in the first case to maintain a quality of life that consisted of independence of living, as well as the need of the patient in the second case to assert her right to deny care she felt was not useful is an easy enough need to identify with since we culturally push for the autonomy of an individual. The difficulty in the MedFTs’ work, and a product of their exposure to medical ethos and nomenclature, was their ability to understand and accept the position of the medical professionals as well. Their training had afforded them the background and contextual understanding to fully embrace the medical professionals’ ideas without labeling them as resistant to the patient's desires, and in fact helped them connect differently to the patient by providing a different avenue for them to be useful.

Conclusion

As we continue to engage in reflective and anticipatory conversations regarding MedFT, along with the concepts, ideas, and practices that define it, we need to also be aware of how those discussions frame and describe its relationship to family therapy. If through that act of description we come to understand MedFT as something more dissimilar than analogous with family therapy, we will be compelled to search for new models, theories, and epistemologies to inform and guide our work. However, if we are to accept the notion that MedFT is a specialization (Tyndall et al., 2010) and specific augmentation of family therapy, our time is then best spent investigating and understanding how our relational epistemology changes when implemented in a healthcare context. A both/and position, a non-pathological stance, and a consultative orientation are all systemically informed, and are a product of being trained in a relational way of thinking. These ideas are foundational to family therapy, and as such should be foundational to MedFT. In this way, our exercise in embracing medical understandings and explanations is done with the intent of learning about how healthcare professionals are making sense of things, and not done with the intent of replacing our foundational systemic training.

The questions of connection and separation raised here are not novel ones for family therapy since we have, from the beginning, attempted to highlight our differences from the rest of the psychosocial field (Hoffman, 2002). However, in this case, we as MedFTs must take care not to draw a distinction that presents us as something separate from family therapy. Simply put, the question worth asking is, "If difference is determinative, what determines our difference from and connection to family therapy as medical family therapists?" That question, along with this article, is not meant to deliver a definitive word on what MedFT is or is not, nor does it necessarily capture all that is needed to ensure that one is a competent MedFT. It is only meant to add yet another voice to the ongoing discussion and negotiation regarding how we make sense of what we think and what we do; how we make sense of ourselves as both MedFTs and family therapists. In closing, Keeney and Ross (1985) discussed the kind of conversation we are currently engaged in by stating that "When any differentiation is made, two ways of talking about its sides are always present: (1) we may speak of their *distinction*; or (2) we may talk about their *connection*" (p. 47). This position resonates with the current question facing MedFT: are we adequately capturing our connection to our professional home in the way we are drawing our distinction from it?

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CHAPTER 4: METHODOLOGY

Design

Ethnography of Communication (EOC), the methodology employed within the study, is a marriage of both sociolinguistic and anthropological research traditions (Hymes, 1972; Saville-Troike, 2003). The goal of this kind of research is a description/analysis of communicative events that "extends understandings of cultural systems to language, at the same time relating language to social organization, role-relationships, values and beliefs, and other shared patterns of knowledge. . ." (Saville-Troike, pp. 6-7). This type of description yields information not only regarding patterns within the communicative code of certain groups (i.e., a code that includes both verbal and non-verbal vernacular), but also produces a broader overview concerning "ways of speaking {and acting}," which are tied in a systematic way to the overall cultural zeitgeist of the group under investigation.

Given the descriptive and interactional nature of the this particular brand of ethnographic inquiry it was the design best thought to address the following research question: "What are the interactional processes and accompanying ideologies that constitute an integrated care delivery system utilizing a Medical Family Therapist (MedFT) during a standard, non-referral, family medicine, primary care visit?" It is important to note that while the ability of the MedFT to function appropriately within the medical system requires his or her engagement and interaction with multiple levels of the care delivery system (nurses, medical assistants, front staff, administration, etc.), the scope of the study focused primarily on how the MedFT engaged in the patient-provider relationship.

Ethnography of communication is employed by various fields of study and as such differs regarding the units of analysis, as well as the overall purpose in describing those units; however for the study, an anthropological orientation was adopted. This orientation ultimately produced a description/analysis of the overall communicative event itself. Saville-Troike (2003) described the purpose of this type of analysis as the production of a description that allows someone not acquainted with the group under investigation to adequately participate in interactions within the group, which is achieved through the development of an in depth understanding of why those particular behaviors are preferred over others.

This overall analytic description must be able to produce a 'framework' or 'schema' that outlines the interactional sequences constitutive of the event, which is anchored within the various cultural institutions/belief systems of the group under investigation (Hymes, 1972; Saville-Troike, 2003). The purpose of the framework is to provide an understanding of the various components of interaction between individuals, which are required for the group to function as a coherent, autonomous unit. The term describing this culturally and institutionally bound conduct of group members is *communicative competence*.

Communicative Competence

Defined as "knowing not only the language code [words, syntax, grammar] but also what to say to whom, and how to say it appropriately in any given situation" (Saville-Troike, 2003, p. 18), demonstration of communicative competence is also achieved by the extension of knowledge and expectation about who may or may not speak in certain settings, when or when not to speak, to whom to speak, how status and roles change how/whom one may speak to, what non-verbal communicative acts are appropriate in various contexts, turn-taking in conversations, how to ask for/give information, how to request, how to offer/decline assistance/collaboration, and how to give commands (Saville-Troike). It is the ability of any individual within the group to demonstrate this attribute that determines his or her success or failure at interacting with others situated within the community, and thus is a major component of analysis within this analytic tradition (Saville-Troike). As such, any description must provide enough information for the reader/participant to understand each component individually, as well as how they fit together as an aggregate (Gumperz, 1984). To help facilitate this systemic understanding of communication within groups, the reduction of these groups by the EOC process typically produces three increasingly specific units of analysis; speech communities, speech situations, and speech acts (Hymes, 1972).

Speech Communities

Speech communities are defined as “a community sharing rules for the conduct and interpretation of speech, and the rules for the interpretation of at least one linguistic variety” (Hymes, 1972, p. 54). This is the broadest analytic unit and is the vehicle through which the act of communication is viewed as constitutive of a social body, and not a singular individual act or interactional exchange (Hymes, 1972; Saville-Troike, 2003). In a classic anthropological sense this would constitute the basic unit of analysis, and would be comprised of the culture as a whole under investigation. However, as this methodology has moved into the realm of organizational development (the theoretical basis of this study) another basic social unit, Communities of Practice (CoP), has been substituted to denote the specificities of organizational interaction/exchange.

Communities of Practice. Any group “whose joint engagement in some activity or enterprise is sufficiently intensive to give rise over time to a repertoire of shared practices” (Eckert & McConnell-Ginet, 1999, p. 185) can be considered a community of practice. These communities can be either formal (organizations such as the Bernstein Medical Center) or informal (therapist peer supervision groups; i.e., therapists that consult one another on cases). Wenger, McDermott, and Synder (2002) asserted that the foundational defining characteristic of a CoP, either formal or informal, was that this group of individuals assemble themselves in such a way as to address common problems/issues together, and that they value their interaction and the mutual insight their collaboration produces. It is from this mutual interchange of problem resolution and shared knowledge building that patterns of relating develop, which in turn facilitate the creation of a whole host of shared implicit and explicit organizational structures (Wenger, McDermott, & Synder). Structural components of the community include a common vernacular, shared understanding of their particular niche topic, collections of techniques, as well as, a tacit understanding of their relational rules/mores (Lave & Wenger, 1991; Wenger, McDermott, & Synder). Lave & Wenger asserted that each CoP can be constituted in any number of ways depending on the desires of its members; however, three foundational elements transcend the specificities of any CoP in order for the community to sustain itself: domain, community, and shared practice.

The concept of domain is used to reference the specific area of knowledge that the group specializes in, and is the basis from which the structure of the group is derived (Wenger, McDermott, & Synder, 2002). This component of a CoP not only differentiates the group from the larger culture, but also gives a shared and common purpose to all members, essentially codifying the overall purpose of their interactions within the community. A well-defined domain of knowledge allows its members to know “exactly what is worth sharing, how to present their ideas, and which activities to pursue” (Wenger, McDermott, & Synder, p. 28). Lave and Wenger (1991) viewed the construct of community as serving as the fabric from which the social learning environment of the CoP is created. With one of the fundamental elements of any CoP being a mutual respect and desire for cooperation, the idea of *community* functions as a facilitator of these close collaborative relationships between individuals. It is through this construct that individuals are able to openly expose their ignorance in certain areas, actively seek out/give help to others, and share/brainstorm ideas. The last element, practice, refers to the shared set of techniques, frameworks, ideas, tools, languages, and styles that a community of practice may store as their cultural repertoire (Wenger, McDermott, & Synder). This particular element differs from domain in that rather than the aggregate concepts that constitute a community; practice refers to the actual "doing" or praxis of the community, which is coupled with the creation, maintenance, and dissemination of a shared body of knowledge (Lave & Wenger, 1991; Wenger, McDermott, & Synder).

Lave and Wenger (1991) believed that communities of practice not only serve as repositories for the shared bodies of knowledge that their members develop but also as knowledge structures. These structures, which facilitate the movement of members within the community, as well as help outsiders assimilate to the cultural norms and practices of that community, serve as conduits through which their members 'learn by doing.' This notion of knowledge by engagement in practice, a term called situated learning, lies at the core of all CoPs (Lave & Wenger). Those who hold this view believe that knowledge; its creation, maintenance, and dissemination, is done within the context of social environments, and as such, is rooted within the social exchanges/realities of the individuals engaged in "practice" with one another, rather than as an aggregate of individual perceptions and cognitions (Lave & Wenger). The process by which situated learning occurs, legitimate peripheral participation, ". . .provides a way to speak about relations between newcomers and old-timers, and about activities, identities, artifacts, and communities of knowledge and practice. It concerns the process by which newcomers become part of the community. . .” (Lave & Wenger, p. 29). This relational orientation to learning provides the framework for any community of practice. The idea of situated learning serves as the overall process by which individuals learn the practices of the community they wish to become a part of, with legitimate peripheral participation serving as the mechanism by which individuals navigate from the position of outsider to full-member within the community (Lave & Wenger; Wenger, McDermott, & Synder, 2002), which is denoted by the demonstration of communicative competence.

Speech/Communicative Situations

The next unit of analysis taken into account by EOC methodology is the context in which the communicative event occurs; the speech situation. This unit is devoid of the rules/mores of the speech event (the next analytical unit), and serves as demarking the culturally defined communicative situation (e.g., a primary care visit) (Hymes, 1972). Where speech communities denote the overall population under study (e.g., an integrated family medicine center), speech situations serve the purpose of defining the setting. Speech situations are characterized by the maintenance of a general configuration of activities and the same overall ecology in which the communicative event takes place (Saville-Troike, 2003).

Speech/Communicative Event

Speech events serve as the basic unit within EOC methodology. Saville-Troike (2003) stated that the extrication of a singular speech event from within the totality of interaction requires that the event “is defined by a unified set of components throughout, beginning with the same general purpose of communication, the same general topic, and involving the same participants, generally using the same language variety, maintaining the same tone or key and the same rules for interaction” (Saville-Troike, p. 23). Speech events can be discontinuous if the participants are interrupted but then resume their interaction (e.g., a physician visit is interrupted by the provider having to take a phone call). However, the ending of a speech event is denoted by a change in the major participants, their role-relationships, or the focal point of attention during the interaction. Hymes (1972) stated that it is the speech event that is governed directly by the rules and norms of the community, and the situation in which communicative competence is demonstrated.

Events can be labeled within a community by name (e.g., a doctor’s visit) or by a change in tone and/or tenor of the communication between participants (e.g., two medical assistants discussing a difficult patient with one another and then later with the physician). In all cases, defining these events is the corner stone of any ethnographic inquiry into communication (Saville-Troike, 2003). The communicative event chosen for analysis by the researcher should have the following characteristics:

I. Brief self-contained sequences
II. A readily identifiable beginning and ending
III. Recurrence in similar form and frequency so that patterns can be observed

Speech/Communicative Act

Speech acts can be considered constitutive of speech events, and serve an interactional function within the social exchange. Declarations, questions, referential statements, and commands all serve as speech acts, as well as non-verbal events such as raised eyebrows, frowns, smiles, etc (Saville-Troike, 2003). The study of speech acts is typically relegated to the comparison of events within linguistic theory, and is more quantitative than qualitative in nature (Hymes, 1972; Saville-Troike).

Participant Community of Practice (CoP)

One integrated primary care center, The James D Bernstein Community Medical Center (BMC), utilizing MedFTs from the East Carolina University master's marriage and family therapy and doctoral medical family therapy programs, served as the CoP under study. The clinic itself is a community health center owned by a single private corporation, Greene County Health Care Inc. This section will be comprised of an overall description of the professionals at the site, as well as a site-specific description for the center.

Setting

Being that the BMC is focused on primary care, the composition of its providers is diverse. The center's staff composition will be described below although it is subject to change by the time data is collected and reported.

Community Health Center

The BMC staff was comprised of five physicians; one trained in internal medicine, two in family medicine, one pediatrician, and one obstetrician. The center also contained one nurse practitioner, two nurses, and four medical assistants. At the time of the study, MedFT as a member of the healthcare team had existed at the facility for two and one half years. The site housed two master's level MFT student-therapists and one PhD level MedFT student-therapist (the primary researcher). The MFT master's and MedFT PhD students all came from the Commission of Accreditation for Marriage and Family Therapy Education (COAMFTE) accredited training programs located in eastern North Carolina, and had taken or were in the process of taking classes designed to introduce the students to basic concepts and practices of MedFT. The master's students were in the second and final year of their program, and had been practicing therapy at this center one year prior to data collection. It is important to mention that due to the master’s students’ medical site placement, daily collaboration with medical providers, and their exposure to and training in both the BPS-S approach and medical nomenclature and culture, they were considered to have a strong foundation in the clinical application of MedFT. The PhD student was in his second year of his program, and had been practicing therapy in this medical setting for two years. Both master’s and PhD level students spent 20 clock hours a week at the site. The master’s level student-therapists were provided supervision by the PhD student on-site, as well as bi-weekly site visits from both MedFT and MFT program faculty.

Role of Investigator

Being that the primary researcher was a member of the CoP under investigation; his biases could not be underestimated nor ignored. It is for these reasons that the following bias statement was included as part of the methodology of this study:

Given that during my master’s program I, along with Dr. Jennifer Hodgson (my dissertation advisor), and several other critical faculty members and students, played a large part in developing the kind of model in use at the center included in the study, I know that I already have a predisposition to expecting the kind of interactional patterns I am trying to investigate and describe. My observations of other therapists engaging in this type of patient interaction will be impacted by my own practice of this type of collaborative care. My expectations and practice of addressing patient issues such as psychosocial stressors, patient-provider rapport, medication/treatment adherence, along with the ways in which this information is elicited, synthesized, and disseminated to the providers will invariably influence the way I perceive others’ actions throughout the study.

It remains that I am a firm and fervent believer in the type of work that is being conducted at this site, both in my expectation of their ability to improve patient care, as well as *their facilitative function in regard to aiding physicians. With that being said, my devotion to Dr. Hodgson's and my previous work in this area along with my future career aspirations involving teaching, consultation, and clinical practice of this integrated model of care, must also be mentioned as adding to my personal bias when engaging in this study.*

Procedure

The EOC methodology (Saville-Troike, 2003) used within this study was achieved through the observation of and fields notes regarding multiple therapists' and providers' engagement with the model at the site. The inclusion criteria for the BMC medical providers were as follows: a) practicing medical practitioner, b) practicing at the BMC for 9 months or longer, c) current collaboration with MedFTs at the BMC, and d) willingness to refer patients to MedFTs and see patients with MedFTs. The inclusion criteria for the MedFTs are as follows: a) practicing MedFT intern/student b) practice at the health center for 5 months or longer, and c) current engagement with the BMC providers. An inclusion criterion regarding length of employment was decided using the legitimate peripheral participation framework, which can also be understood as 'situated learning' (Lave & Wenger, 1991). From this standpoint those providers existing within a CoP for an extended period of time move toward a greater degree of embededness, which then afforded them greater knowledge of the system/CoP (i.e., a greater degree of communicative competence).

Observation Method

The hallmark of any ethnographic study is the ability of the researcher to engage the population of inquiry in such a way as to become privy to understanding their behaviors, as well as the meaning systems recursively connected to those interactions (Rosen, 2000). It is from this kind of complete emersion that the researcher can then produce descriptions that lead to second-order analytic (theoretical) understandings (Van Maanen, 2002). These understandings are produced by the comparison of the singular described events to the larger cultural context the investigator is embedded within. The level of embeddedness required to produce such description cannot be achieved solely though the review of organizational documents or the conducting of interviews. Researchers must place themselves within the interactional milieu of the organization under investigation, which then allows for the researcher to ". . .study first-hand the day-to-day experience and behavior of subjects in particular situations" (Taylor & Bogdan, 1984, p. 15). This type of inclusion within the study is achieved through a participant/observer method of data collection.

For the purposes of this study the observer-as-participant method was used; which is defined by Burgess (1984) as an orientation where the researcher's interactions with the organization's participants are brief, formal, and openly classified as "observation." The method was utilized in such instances where the PI was watching other therapists at the site participate in the integrated care model. While the PI's experiences in practicing this model were an important source of information, a theoretical framework for communicative competence could not be abstracted from his actions alone. The level of induction required to produce an adequate description of the method of engagement under study must come from an aggregate of interactional experiences, which could only be achieved by the observation of multiple MedFTs at the site. It is in this vein that the observer-as-participant method of data collection was thought to be the most useful.

Data Collection

As stated above, data was collected through the observer-as-participant observational method. After institutional review board (IRB) approval for the study was granted the PI contacted site supervisors at the center who were asked to identify which therapists had been providing services the longest and which providers utilized the services of the MedFTs most frequently. These individuals were subsequently approached and asked about their participation in the observation process. Upon agreement and after completion of an informed consent, a series of times were scheduled with the respondents in order to shadow them during their time at the clinic.

Given the nature of the method of inquiry, timeframes of studies employing an ethnographic lens can range from weeks to years to decades (Saville-Troike, 2003). However, to ensure that the current study could be carried out in a logistically feasible manner, and coupled with the fact that no specific timeframe is referenced within available ethnographic literature (Rosen, 2000; Schwartzman, 1993; Van Maanen, 2002), the primary investigator spent a total of two weeks at the site (20 hours total); one week devoted to acclimating to the organization, and one week devoted to recording the actions/experiences of practitioners at the site. During and/or after each specified speech event (patient visit), which was identified through the one-week acclimation process; the PI entered the exam room with the therapist and observed his/her interaction with the patient. Prior to the PI entering the room, however, the medical assistants explained the study to the patients and, if the patients agreed to be participants, had them sign an informed consent. The PI then shadowed the therapist-patient visit, as well as the therapist's conversation with the provider following his or her patient encounter. Immediately following such an engagement, brief field note taking was conducted at the earliest temporal point expounding upon the encounter.

The notes themselves included ". . .descriptions of people, events, and conversations, as well as the observer's actions, feelings and hunches or working hypotheses. . .The sequence and duration of events and conversations. . .[and] The fabric of the setting" (Taylor & Bogdan, 1984, p. 53). The medical specifics regarding a patient's visit were not the topic of inquiry in this case. Instead, the PI chronicled the way in which the MedFT, patient, provider, and direct patient care staff interacted (tenor of conversation, themes of questioning, duration of encounter, ways in which topics are broached or suppressed, etc). Descriptions of the event were such that everything that could be recalled about the observation was transcribed onto paper (Waddington, 2004). This process of description can be considered to have, in some instances, a ratio of transcription to observation of 6:1; spending six hours transcribing for every one hour of observation (Waddington). Written transcriptions were kept in a bound notebook, which were stored in a locked brief case when not in use. Verbal notation was moved from the digital voice recorder to a password-encrypted laptop each evening by the PI.

Data Analysis

After the subsequent observational period, the primary researcher began to review his collected field notes from the site for each speech event that was observed. The goal of the analytic process was to produce a written framework constitutive of the essential elements of interaction between therapist, physician, direct care staff, and patient. This framework served as a codified diagram of how the MedFTs operated, and thusly, what actions were performed or not performed in order for the MedFT to demonstrate communicative competence. This aggregate framework was achieved through the cataloguing and description of the essential features of each speech event, which Hymes (1972) and Saville-Troike (2003) labeled as the *genre*, *topic*, *purpose/function*, *setting* (the totality of these four initial elements is referred to as the *scene*), *key*, *participants*, *message form*, *message content*, *act sequence*, *rules for interaction*, and *norms of interpretation*.

In studying speech communities, not every feature will be important to consider, and this will be based primarily on the specificities of the community under investigation (Saville-Troike, 2003), which is reached through a consideration of the *frame* of the event in question. The use of the concept of *frame* allows the researcher to decide which components are required to create an adequate description of the event under observation (Saville-Troike). Frame refers to the overall structure of the event; how the beginning and ending of the event is categorized, as well as how the event is continued. This concept also provides the participants with the interpretive context to weigh the significance and meaning of the interaction itself (Schwartzman, 1993). The concept of frame must be taken into account by the researcher before the description of any of the following components can begin, since understanding the frame of the event directly informs what components are then applicable for description (Saville-Troike; Schwartzman).

Scene. The scene is a conglomeration of the first four essential elements mentioned above and functions to denote the extra-personal context of the speech event under study (Saville-Troike, 2003). Genre serves to highlight the type of event being observed/participated in by the researcher; joke, story, lecture, conversation, etc. This element functions as the organizing factor of the event itself that Bauman (2002) defined as:

> . . .a constellation of systemically related, co-occurent formal features and structures that serves as a conventionalized orienting framework for the production and reception of discourse. . . (p. 84).

Topic typically refers to the focus of the conversation/event at hand (Saville-Troike, 2003), and can be understood as closely related to the idea of domain using Wenger, McDermott, & Synder’s (2002) defining characteristics of CoPs. Purpose refers to the reason behind the interaction, and speaks to both the explicit and implicit goals/objectives for those involved. This component of the event is multifaceted and the other layers of the interaction must be taken into account in order to adequately describe this aspect (Hymes, 1972; Saville-Troike, 2003). Setting denotes the physical characteristics in which the interaction takes place and is considered by Saville-Troike the only part of the event that the researcher can directly observe without having to make reference back to other cultural/organizational mores or rules in order to describe. Included in this particular element is the space and time in which the engagement takes place, as well as the arrangement of the physical area (Schwartzman, 1993). Saville Troike suggested several questions to ask in order to adequately address this aspect of the event (p. 112):

- How do individuals organize spatially in groups for various purposes?
- What geospatial concepts, understandings, and beliefs exist in the group or are known to individuals?
- What significance is associated with different directions or places?
- What beliefs or values are associated with concepts of time of day or season, and are there particular behavioral prescriptions or taboos associated with them?

Key. Hymes (1972) states that the key provides an understanding of the tone, manner, or spirit of the act under investigation. This component of description is considered an essential feature of communicative events since even though redundancy is common in such events the factor that may change is the tone of the engagement. An example of this change in tone would be the communication of patient’s lower back pain to the physician by a nurse, compared with the same statement made in regard to a patient known for seeking pain medication. In this instance the first patient’s complaint would probably be communicated with a degree of concern while the second patient’s same concern would be communicated with a degree of suspicion and possibly sarcasm. While the content of the message remained the same for both patients the tone or manner in which it was delivered changed.

Participants. The description of the participants is essential to the study of any community of practice. In order to accurately define this essential feature of the event under investigation, the researcher must not only describe the actual participants in the event itself, but must also describe those individuals on the periphery of the interactional engagement as well. The description must include physical characteristics, role-relationships, hierarchical power structures, social status, ways of dress, and ways of talking (formal vs. informal).

Message Form. This aspect of communicative engagement refers to the manner in which the message is delivered; channel (face-to-face, written, etc), as well as the way that the message is conveyed; code (verbal VS non-verbal) (Saville-Troike, 2003). Researchers must not only be able to describe the overt act of expression through both verbal and non-verbal communication, but must also be able to describe the selection rules governing the event. Selection rules refer to the implicit organizational mores that dictate which channel/codes are chosen for a communicative event (Hymes, 1972; Saville-Troike). Once these selection rules have been defined and the channel/code choice described, the researcher must also be able to describe the paradigmatic and syntagmatic constraints of that selection. Paradigmatic constraints refer to the rules governing the selection of the form of the message while syntagmatic constraints refer to the rules governing the sequential selection of forms within the same communication (Saville-Troike).

Message Content and Act Sequence. Message content and form are closely related, and as such can only be understood when examined within the context of each other. This aspect of communication refers to what the communicative act is about and what meaning is trying to be conveyed through the interaction (Saville-Troike, 2003). In face-to-face interactions (the ones being analyzed in the present study) meaning is derived not only from verbal and non-verbal communication, but also from the extra-linguistic context, as well as, the information and expectations each member of the event brings with them (Hymes, 1972; Saville-Troike). Due to these aspects' interconnectedness the distillation of any one specific characteristic from the content as a whole is a conceptual improbability. The researcher must instead be able to surmise the expectational frames of each participant from their antecedent exposure to the community, which in turn gives clues to the overall goal of the interaction itself as well as how the participants are constructing the meaning of their encounter (Saville-Troike). Act sequence refers to the temporal position of certain speech acts within a communicative event (Saville-Troike). This aspect is often characterized in terms of its function with content and form also used to further enhance its description.

Rules for Interaction. This aspect of the communicative event refers to rules governing the use of speech and action for the participants of the interactional exchange. The rules themselves may be codified in terms of manuals, protocols, dictates, etc., but a physical medium is not necessarily required for their existence and expected adherence (Hymes, 1972). Although these rules can serve a prescriptive purpose in terms of behavior, and thus can describe the kind of physical interaction required, this is not a prerequisite for their inclusion in the description of the event (Hymes, 1972; Saville-Troike, 2003). What the researcher must take care to describe in regard to the rules is how, and the degree to which, this idyllic interactional code is real and the positive and negative sanctions applied to those who adhere to or violate it (Saville-Troike).

Norms of Interpretation. This final component of the communicative event provides the remaining cultural/organizational information required for an adequate description and understanding of the event (Hymes, 1972; Saville-Troike, 2003). This aspect of the event constitutes the shared standard of interaction by those involved, and while they may or may not be prescriptive in terms of behavior (like rules for interaction), their sanction or validity is not necessarily a prerequisite to their inclusion in the description of the communicative event itself (Saville-Troike).

Communicative Schemata

Once a description of these essential elements was generated for the site, the PI created a synthesized aggregate of the concepts from the field notes taken. This archetype elucidated the core elements of general communicative competence at the site, and served to highlight some degree of standardization in practice across MedFTs and providers. The interactional schemata included the following elements described in the preceding paragraphs: *function/purpose, setting, participants, act sequence, rules for interaction, message form, and norms of interpretation*. The schema resembled an action tree delineating out what engagement constituted the beginning of the communicative event, what information was pertinent, what information was not, and the rules of conduct for each participant (Saville-Troike, 2003). Also represented are the conditions required for particular action sequences to take place within the specified engagement (e.g., condition A dictated therapist and provider discussing a patient prior to the provider entering the room, whereas condition B dictated they meet with the patient together). In effect, what was being created is a frame of reference for how these medical provider/MedFT dyads operated within the primary care system.

Verification Strategies

To ensure that the results of any study are accurate, and thus suitable to inform future work in the area being investigated, the characteristics of that research must be studied and evaluated. Quantitative research methodologies have specific characteristics that must be observed within the study for the results of that study to carry any weight: external validity, internal validity, reliability, and objectivity. These essential characteristics are tied to the conceptual framework of all quantitative studies in that their methodologies are seeking out conceptual absolutes from which to make isomorphic comparisons from the sample to the population at large (Lincoln & Guba, 1985). Given that qualitative methods view information as constructed and subjective, specific to the person being studied and the researcher conducting the study, a different set of essential elements must be identified and used to measure the "trueness" of the information obtained (Lincoln & Guba). Following this ideological path Lincoln and Guba state that four questions must be answered so that any obtained data may be seen as valid:

1. "How can one establish confidence in the 'truth' of the findings of a particular inquiry for the subjects [participants] with which and the context in which the inquiry was carried out?" (p. 290)
2. "How can one determine whether the findings of a particular inquiry have applicability in other contexts or with other subjects [participants]?" (p. 290).
3. "How can one determine whether the findings of an inquiry would be repeated if the inquiry were replicated with the same (or similar) subjects [participants] in the same (or similar) fashion?" (p. 290)
4. "How can one establish the degree to which the findings of an inquiry are determined by the subjects [participants] and conditions of the inquiry and not by the biases, motivations, interests, or perspectives of the inquirer?" (p. 290)

From these four questions Lincoln and Guba coined concepts that delineated out the essential elements required within a qualitative methodology in order to ensure the study's resulting accuracy or "trueness;" credibility, transferability, dependability, and confirmability. The following section will discuss each concept and the techniques employed by the primary investigator to ensure the presence of these methodological elements.

Credibility

Defined by Cook and Campbell (1979) as "the approximate validity [the best available approximation of the truth or falsity of the statement] with which we infer that a relationship between two variables is causal or that the absence of a relationship implies the absence of a cause" (p. 37), credibility can be thought of as akin to internal validity in quantitative research. However, whereas internal validity assesses the accuracy with which the study measures the absolute nature of the construct under investigation, this definition cannot be isomorphically applied to qualitative studies. Rather than looking at an absolute construct "out there" to be compared against the occurrences within/between the object/s of the inquiry, credibility refers to the researchers ability to accurately describe and re-create through that description the event or person under study. The goal therefore is not to establish a degree of fit so to speak between the event and some absolute construct, but instead a reconstruction whose adequacy is judged by the participants themselves.

In order to ensure the presence of this essential element a triangulated researcher was brought in during the analytical process to help establish credibility of the results. A triangulated researcher is a second investigator to help verify any findings made by the primary researcher (Lincoln & Guba, 1985). Throughout the analytical process the triangulated and primary investigators were required to reach agreement regarding how the data is analyzed. This agreement produced an aggregate analysis that had been informed by two separate individuals looking at the same data and drawing the same conclusion as to its meaning/interpretation.

Transferability

This essential element, in quantitative terms, is related to the concept of external validity in that it measures the ability of the results to be applied to the larger population. This would seem to run counter intuitive to the underlying philosophical stance adhered to in qualitative methodologies in that the data collected is usually very subjective and perceptually situated in the specificities of individual/s under study (Lincoln & Guba, 1985). What this means is that while the data collected from the subject may in fact be an accurate reconstruction of the event in question (adhering to the notion of credibility), it is only true for that subject specifically. It is here where quantitative and qualitative ideologies differ. Lincoln and Guba stated that the responsibility of the qualitative researcher lies in producing descriptions of the event with such depth and reconstructive accuracy (context-sending) that researchers who wish to later use that information may make a comparative statement about the information's contextual similarity (context-receiving). The responsibility of establishing similarity in this case falls on those that wish to use the results of the study, and not the progenitor of the study itself; it is the responsibility of the researcher to provide enough information for subsequent researchers to do so.

In order to ensure the presence of this essential element the primary investigator kept a log of his thoughts about the analytic process, which Lincoln and Guba (1985) described as a reflexive journal. A reflexive journal's functionality can be thought of as a diary, which allows researchers to record their thoughts throughout the analytic process, and describes why certain conclusions were drawn. The use of this type of technique helped the PI to understand theirs and their triangulated investigator's biases and their evolution throughout the analytic process so as not to compromise the resulting descriptive framework. The journal did not function as data to be analyzed, but served as part of the audit trail to assist others in understanding how the PI arrived at his conclusions; allowing those who are so inclined to follow his thoughts through the research process from data collection to analysis to synthesis.

Dependability

Dependability as conceptualized by Merriam (1998) is the supposition that instead of “demanding that outsiders get the same results, a researcher wishes outsiders to concur that, given the data collected, the results make sense-they are consistent and dependable” (Merriam, p. 206).What this means is that the resulting conclusions drawn from the use of the analytic strategy are an accurate abstraction of the data collected by the researcher. This component of the four essential elements is to be established by the use of the triangulated investigator; in that his or her (whatever is the case) analytic opinions will serve as a recursive form of “fact-checking,” as well as the use of what Lincoln and Guba (1985) call an audit trail. This trail is a component of the primary investigator’s reflexive journal, and tracks analysis of information from dialogic exchange, to transcription, to analysis; through which the ideological paths taken by the researcher become known, thereby establishing the dependability of the communicative description (Lincoln & Guba).

Confirmability

Confirmability’s presence in the findings denote that the results are abstracted from some degree of truthfulness, which in this case is an accurate description of the event being studied, and is not a byproduct of the researchers own thoughts, opinions, beliefs, and biases (Lincoln & Guba, 1985). This essential component is established by the use of the aforementioned techniques employed for the three earlier components: triangulated investigator, reflexive journal, and audit trail. Through the agreement reached as an amalgam of both researchers’ consensus regarding the data, the recording of the primary investigator's thoughts about the analysis, and the path by which the varying communicative acts are synthesized into one cohesive communicative event framework; confirmability was established.

Schematic Example

In order to clarify exactly what the analytic process will produce, the following is an example of the schema that will be derived from the data collection phases of the study, using the example of a cultural "greeting event" as the event under investigation (Saville-Troike, 2003, pp. 130-131).

FUNCTION/PURPOSE: Reaffirming the good relationship between participants at the beginning of the visit.

KEY: Friendly

PARTICIPANTS:
- P1- Resident of home
- P2- Visitor

ACT SEQUENCE:

Condition A

- Phase One- "Greeting and Response"
  - P2- Greeting
  - P1- Acceptance of greeting
  - P1 looks for chair for P2 (if none is immediately available, this may involve a long pause in the greeting sequence)

- Phase Two- "Having a Seat"
  - P1 offers P2 a seat
  - P2 returns greeting

- Phase Three- "Asking the news"
  - P1 and P2 sit down
  - P1 asks P2 of the news
  - P2 gives standard, formulaic response

Condition B

- Phase One and Phase Two are the same
- P2 then rushes to seek nearest man to complete greeting sequence

If she does not find any, she breaks the rules, apologizes, and completes the greeting herself by "Asking the news"

Condition C

If P1 is a young child, no greeting takes place
P2 asks P1 to call parents
If P1 is older child, Phase One and Phase Two may be completed before seeking an adult

Condition D

The youngest visitor who is considered an adult is the one who carries out the news
For Phase Three, P1 talks directly to the one who has been appointed by the group to give the news; the person must consult the group before responding

RULES FOR INTERACTION:

A child beyond age ten has a "right" to be greeted.
Between friends, the order of greeting may be relaxed, but "a woman who always greets first would not be well-judged."

NORMS OF INTERPRETATION:

If Phase Two or Phase Three is omitted, or there is any change in order, it indicates there is something amiss in the relationship between P1 and P2.
"Asking the news" is part of the greeting and not considered the point of the visit.
After conventional responses regarding the "news," P2 will bring up the actual reason for the visit (beginning another speech event).

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CHAPTER 5: MEDICAL FAMILY THERAPY IN A PRIMARY CARE SETTING: A MODEL OF INTEGRATION

Presently, the United States spends more than $6,719 annually per capita on healthcare (World Health Organization, 2009), and $121 billion total devoted to psychological or social problems (Substance Abuse and Mental Health Administration, 2007). While these figures seem large, it is also worth mentioning that the United States sits at number 37 in terms of mortality rates compared with other industrialized nations when the World Health Organization (2000) last calculated and compared rates.. Some researchers have suggested that the lack of access to and reliance on primary care has been the reason behind these increasing costs (Fine & Peters, 2007). Primary care as a whole has faced a 10% decline in new providers over the last ten years due to burnout (Bodenheimer, 2006; Grumbach, Selby, Damberg, et al., 1999), payment structures that favor specialty acute care (cardiologists, cardiac surgeons, gastroenterologists, etc.) over the preventative nature of primary care physicians (Bodenheimer, 2006; Fine & Peters), and a lack of integrated care services (Blount et al., 2007; Miller, Mendenhall, & Malik, 2009). These issues are seemingly connected in that they all point to an underutilization of and disparity regarding access to primary care services by the medical community and the general population.

Primary Care

As described by the Institute of Medicine (IOM) (1996), primary care is defined as "... the provision of *integrated, accessible health care services* by clinicians who are *accountable* for addressing a large *majority of personal health care needs*, developing a *sustained partnership* with *patients*, and practicing in the *context of family and community*"(p. 31) [emphasis not added]. The IOM's definition alludes to the fact that primary care providers, both physicians and physician extenders (i.e., physician assistants and nurse practitioners), deal primarily with patients who present with co-morbid, and often times complex, psychosocial and somatic complaints (Blount & Bayona, 1994; Ostbye, et al., 2005; Robinson & Reiter, 2007). Due to this complexity, and the fact that many consider primary care the “de facto” mental health system (IOM, 1996), physicians are often left alone to maneuver and wade through the myriad of biological issues that their patients have, while at the same time being expected to address the concurrent psychosocial issues of their patients as well; issues that physicians are traditionally not well trained to handle (Adler, Shaw, Sitt, Maya, & Morrill, 2009; O’Connor, Solberg, & Baird, 1998; Strohsal, 1996). This role exhaustion has created a scenario that Bodenhemier (2006) described as one where “primary care physicians are expressing frustration that the knowledge and skills they are expected to master exceed the limits of human capability” (p. 3), a sentiment that is also echoed in research by Ostbye et al. (2005) who found that primary care physicians perceived an inability on their part to manage chronic illness effectively due to training and time constraints.

The answer to this frustration for many physicians (Baird, 1998), as well as for mental healthcare providers (McDaniel, Hepworth, & Doherty, 1992; McDaniel, 1995; Strohsal, 2001), has been to merge mental health and somatic healthcare regimens into a holistic approach to patient treatment (McDaniel et al., 1992), which has been termed integrated care (IC) (Blount, 2003; McDaniel; Peek, 2003). In this context, physicians are able to address the physiological symptoms that patients present with, while mental healthcare providers (in this context called behavioral health providers: BHPs) working alongside the physician attend to the psychosocial issues. However, as with any emerging model of care, several issues have been raised, such as: what is considered integrated care, how does one recognize his or her current level of integration or evolve to different levels of integration (Doherty, McDaniel, & Baird 1996; Strohsal, 1998), and what does integration look like when including various mental healthcare or medical disciplines (Blount, 2003)?

So far, widely published primary IC models have typically highlighted the use of psychologists (e.g., Hegel et al., 2002; Robinson & Strosahl, 2009; Price, Beck, Nimmer, & Bensen, 2000; Robinson & Reiter, 2007; Strosahl, 1996), primary care physicians (e.g., Baird, 1998; Oakley, Moore, Burford, Fahrenwald, & Woodard, 2005), social workers (e.g., Manoleas, 2008; Williams, Shore, & Foy, 2006), psychiatrists (e.g., Judd et al., 2004), and nurses (e.g., Gerada, Barrett, Betterton, & Tighe, 2000) as the main providers of mental health care. However, no literature could be located describing a formal model utilizing medical family therapists (MedFT) in this role.

Medical Family Therapy, an emerging sub-discipline within the field of Marriage and Family Therapy (Tyndall, Hodgson, Lamson, Knight, & White, 2010), has filled a void in the healthcare system as its practitioners recognize and address physical issues and their psychosocial impacts within the context of patient relationships (Linville, Hertlein, & Lyness, 2007; McDaniel et al., 1992). This therapeutic orientation views physical illness and disability, as well as health, as simultaneously intrapersonal (i.e., how a patient views themselves in relationship to their illness) and interpersonal (i.e., how a patient views themselves in relationship to their loved ones) experiences (Doherty et al., 1994). To this end, MedFTs provide clinical services (i.e., counseling/therapy, consultation, collaboration) to patients, their families, and their medical teams that address the interaction between these various interrelated professional and personal living systems.

The following article is intended to not only introduce a framework for providing integrated behavioral health care services in a primary care setting, but also to illustrate how

MedFTs function in the role as BHPs in an integrated primary care setting. Although the framework resulting from this research is not intended to present an entire model of care, as it captures only a portion of the BHPs overall role, it is meant to begin the conversation regarding how systemically oriented professionals, such as MedFTs practice in primary care settings.

Integrated Care

Referred to by Doherty et al. (1996) as “the degree of involvement and sophistication in collaborative health care involving mental health professionals and other health professionals,” integrated care is described as a progression that is used not to presuppose the most optimal way for all clinics to function, but to describe “the strengths and limitations of a variety of options” (p. 25). For Doherty et al., the involvement of mental healthcare professionals in any way is enough to classify a system of care as integrated. What differs, however, is their degree of utilization, proximal location to biomedical providers, overall vision (e.g., belief in the utility of integrated care), case management (i.e., shared and/or combined charting for patients), and degree of direct communication between providers. From this standpoint, the authors delineated five ever-more encompassing modes of integrated care delivery, with higher levels equating to a more integrated practice structure. In terms of practice, level one facilities house providers at different sites, maintain little to no structure in terms of on-going communication regarding patients, and providers rarely, if ever, cross-refer patients to one another. A level five facility, however, not only houses both providers under the same roof, but provides communication and case management structures that allow for constant and continuous communication about and cross-referral of patients (Doherty et al.).

Blount (2003) took a somewhat different approach to categorizing the way in which biomedical and mental healthcare providers operate in regard to managing patient issues and/or concerns. Instead of utilizing a progressive model of integration (Doherty, et al., 1996), he instead opted to differentiate the way in which these providers engage in the practice of collaborative medicine, a static differentiation based on defining the “relationship between the medical and behavioral services in primary care” (Blount). Blount defined these relationships between mental health and medical services as coordinated, co-located, or integrated. These descriptions involve the location and amount of interaction/communication between biomedical and mental health providers, as well as the degree of synthesis regarding patient treatment plans. In this vein of thought, coordinated relationships are denoted by separate locations, little to no communication, and completely separate treatment plans; co-located relationships place providers in the same location, ensure more frequent communication between providers, and more frequent cross-referral of patients; and finally, an integrated relationship is defined by the housing of both providers in the same location, frequent in-person communication about patients, and a single, shared treatment plan.

Primary Care Integration

Many of the models described in contemporary literature are designed to treat particular “targeted populations” (Blount, 2003), which are patients referred by the primary care physician to the mental health care professional for a specific issue. These specific issues can be thought of as the more traditional mental health care concerns (e.g., depression, anxiety, bipolar disorder, PTSD) (Price et al., 2000; Reiss-Brennan, Briot, Daumit, & Ford, 2006; Rollman, Weinreb, Korsen, & Schulberg, 2006; Samson, Bensen, Beck, Price, & Nimmer, 1999).

Another type of care modality known as behavioral consultation has also gained prominence in collaborative literature, as well as in professional practice (Robinson & Strohsal, 2009; Robinson & Reiter, 2007; Stroshal, 1996, 2001). What this method of care involves is not only the housing of mental health care professionals in a primary care setting, but the close involvement of the BHP with issues that may not traditionally be seen as psychological in nature, and instead are considered more behaviorally based. In these systems of care, the BHP's expertise is not solely in the treatment of psychological dysfunction, but in the adherence to provider treatment regimens (Robinson & Reiter; Stroshal). What this entails is that the onsite BHP operates in several distinctly different ways than a traditional mental health care practitioner (Stroshal, 2001).

The first major difference has to do with the types of issues that elicit a referral to the BHP. No longer is a practitioner simply relegated to dealing with issues revolving around depression and anxiety, but he or she is now asked to help with "biomedical" issues regarding compliance, adherence, and any other issues that may impact patient care (Adler et al., 2009; Robinson & Reiter, 2007); the point being that issues such as depression and anxiety, while still part of the repertoire of the BHP, are not his or her sole focus (Robinson & Strohsal, 2009). The second major ideological shift regarding this typology of care has to do with the amount of time the BHP spends with the patient. Due to the fast pace of primary care, and the likelihood that a physician may see as many as 40 patients a day, the idea that a BHP and/or a physician can see and spend 50 minutes with each patient is unrealistic (Robinson & Strohsal, Reiter & Robinson, 2007). Instead, the BHP sees the patient within the span of 15-30 minutes, and usually does so within the exam room (Gunn & Blount, 2009; Robinson & Strohsal, 2009; Reiter & Robinson; Strohsal, 1996).

The third ideological shift is the way in which information is disseminated to the medical provider about the referred patient. Within the behavioral consultant model the BHP's note is often times woven into the physician's (Blount, 2003; McDaniel et al., 1996; Robinson & Reiter, 2007), as well as impromptu discussions by both providers about patients called "curb-side consultations" (Robinson & Strohsal, 2009; Strohsal, 1996). Consultations occur within the hallway or other open areas of the clinic or medical setting and exemplify an informal communication channel (although still protected by confidentiality), which delivers pertinent information in vivo regarding the patient's visit (McDaniel et al., 1996; Robinson & Strohsal, 2009; Peek, Baird, & Coleman, 2009).

In each of the studies referenced below, the integrated care model was used to address either specific mental health concerns or disease states such as depression (Reiss-Brennan et al., 2006; Rollman et al., 2006), anxiety (Price et al., 2000), substance abuse (Gerada et al., 2000), HIV (Zaller, Gillani, & Rich, 2007), diabetes (Meulepas et al., 2007), or was used to target specific populations such as Latinos (Manoleas, 2008), the elderly (Hegel et al., 2002), rural populations (Judd et al., 2004), and children (Valleley et al., 2007). While proponents of the aforementioned models utilized BHP with backgrounds other than MedFT or more generally marriage and family therapy (MFT), this does not mean that these types of models are absent from the current MFT/MedFT literature. Integrated models utilizing MedFTs/MFTs have been described for the treatment of Latino families (Willerton, Dankoski, & Martir, 2008), youths diagnosed with HIV/AIDS (Davey, Foster, Milton, & Duncan, 2009), overweight and obese pediatric/adolescent girls (Pratt et al., 2009), Hispanic and African American patients with type 2 diabetes (Phelps et al., 2009), patients with severe and persistent mental health diagnoses admitted to an inpatient setting (Anderson, Huff, & Hodgson, 2008), community based health initiatives (Doherty & Mendenhall, 2006), genetics (Rolland & Williams, 2005; Smith & Harkness, 2003), and infertility (Burns, 1999) as well.

What all these models have in common, both MedFT/MFT and non-MedFT/MFT, is that they do not specifically address the continuum of diverse patient populations, diagnoses, and issues that are experienced by physicians working in a primary care environment (Robinson & Strohsal, 2009; Peek et al., 2009). This degree of model specialization may make the application of their structures particularly difficult when attempting to address the myriad of issues and populations that present in primary care as a whole (Robinson & Strohsal; Peek et al.). Keeping this in mind, the purpose of this study is twofold: (a) to describe a framework for integrated primary care that is not problem nor population specific, as well as (b) utilizing MedFTs and/or MFTs as the BHPs within an integrated primary care framework.

Method

The creation of the framework was done through the use of Ethnography of Communication (EOC), which is a methodology used in both linguistic and anthropological research (Hymes, 1972; Saville-Troike, 2003). The goal of this kind of research is a description/analysis of communicative events that "extends understandings of cultural systems to language, at the same time relating language to social organization, role-relationships, values and beliefs, and other shared patterns of knowledge. . ." (Saville-Troike, pp. 6-7). This type of description yields information not only regarding communicational patterns within certain groups (i.e., patterns that includes both verbal and non-verbal components), but also produces a broader overview concerning "ways of speaking {and acting}," which are tied to the overall culture of the group under investigation.

The analysis must be able to produce a "framework" or "schema" that is used to outline the interactional sequences constitutive of the event, which is anchored within the various cultural institutions/belief systems of the group under investigation (Hymes, 1972; Saville-

Troike, 2003). The purpose of the framework is to provide an understanding of the various components of interaction between individuals that are required for the group to function as a coherent, autonomous unit. The framework itself should allow someone not acquainted with the group to participate adequately within the group, which is achieved through an accurate description of its' members' conduct. The term describing this culturally and institutionally bound conduct, known as *communicative competence*, is defined as "knowing not only the language code [words, syntax, grammar] but also what to say to whom, and how to say it [and act] appropriately in any given situation" (Saville-Troike, 2003, p. 18). It is important to note, at this point, that while the ability of a BHP to function appropriately within any medical site requires his or her collaboration and interaction with multiple levels of the care delivery system (nurses, medical assistants, front staff, administration, etc.), the scope of this study was focused primarily on how the MedFT (i.e., BHP) engages in the patient-provider relationship. The reason for this narrow focus is the inability of a single study to describe all aspects of practice to the depth necessary given the methodology; in effect, the authors took a position of trying to describe one event in rich detail, rather than ten events in limited detail.

An everyday example of this type of description would be a person having to explain, to the member of a wedding party who has never actually attended a wedding, what they needed to do during the ceremony. The description would need to be specific enough to allow the party member to know where they needed to stand, what they needed to say and to whom, and how they needed to act, overall, in order to fit in with the rest of the wedding party. However, the description must also be flexible enough to allow for the party member to use his or her own judgment to act differently if it made sense to (e.g., if the wedding starts late, the party member should not start performing their assigned ceremonial duties simply because the wedding was supposed to start at a certain time).

It is important to mention that this particular research tradition treats language, action, and environment as mutually descriptive and constructive of the context in which the group operates. From this perspective, the participants and the site where the participants practice define and are defined by one another (Hymes, 1972; Lindolf & Taylor, 2002). Given this orientation, a description of the site and the participants is required to establish a foundation for analysis.

Site Description

One federally qualified health center (FQHC) that provides integrated primary care and utilizes MedFT/MFT master's and doctoral students, served as the site for the study. The clinic itself is a community health center owned by a single private corporation, which owns three similar clinics in a rural southeast region of the United States. In terms of where the site sits on the integrated care continuum as defined by Doherty et al. (1996), it would be considered a level four and/or five center. In practical terms, this means that the majority of medical providers work closely with BHPs, regularly collaborating on cases together, sharing a single charting system, and understanding and respecting one another's scope of practice.

Site Staff. The center's staff was comprised of five physicians; one trained in internal medicine, two in family medicine, one pediatrician, and one obstetrician. The center also employed one nurse practitioner, two nurses, and four medical assistants. Two master's level Marriage and Family Therapy students and one doctoral level Medical Family Therapy student served as the BHPs. The master's students were in the second and final year of their program, while the PhD student was in the second year of his program. Both the master's and PhD level students were part-time employees of the clinic, but rotated their working schedules so that the clinic had full-time behavioral health coverage.

Site Model. Although both master's and doctoral students provided the behavioral health services at the site, the model of integrated care utilized by both BHPs and medical providers was developed by MedFT academicians and practitioners who are experts in integrated care and who provided the on-site supervision for all BHPs. These faculty members, in conjunction with their students, implemented the model when the site was first opened in 2006, and it has remained the standard of care there for the past five years. All student BHPs received on-going, weekly live supervision by these two faculty members to oversee provision of care and fidelity to the model.

Procedure

Data collected for the analysis was obtained through the observation of and field notes regarding the MFTs/MedFTs interactions with both the patients and medical staff at the site. Prior to data collection, study participants at the site were identified utilizing the following criteria.

Inclusion Criteria

The inclusion criteria for the medical providers are as follows: (a) board certified medical practitioner, (b) current collaboration, as defined by Blount (2003) with BHPs at the site, and (c) willingness to refer patients to BHPs and see patients with BHPs. The inclusion criteria for the BHPs are as follows: (a) practicing MFT/MedFT intern, and (b) current collaboration, as defined by Blount, with the medical providers at the site. The medical providers' experience at the site ranged from one to three years, while both BHPs had been practicing at the site for almost one year. None of the providers (either medical or behavioral health) were excluded from the study based on inclusion criteria.

Data Collection

The investigator contacted the faculty site supervisors at the center, who were then asked to identify which BHPs and medical providers had been providing services the longest. Once identified, these individuals were then approached and invited to participate in the study. Upon their agreement, and after completion of an informed consent, a series of times were scheduled with the participants in order to shadow them during their time at the clinic. Prior to beginning the observational process, the investigator also obtained informed consent from both nurses and all medical assistants as well. Their inclusion in the study was essential since they would be the ones explaining the study to patients, having patients fill out the informed consent, and may be observed by entering the exam room while the research was being conducted.

Once all informed consents were obtained from the staff, the investigator observed collaborative interactions between the BHPs and medical team for a total of two weeks (20 hours total). The first week was devoted to acclimating to the medical site, as well as acclimating the provider participants to the study process; while the second week was devoted to recording the actions/experiences of the patient and provider participants through an observer-as-participant methodology (Burgess, 1984). Prior to the investigator entering the room, the medical assistant explained and gained consent from patients during their normal patient care interview. The investigator then shadowed the BHP-patient visit and listened in on the BHP’s conversation with the primary care provider following his or her patient encounter. Immediately following the patient encounter, the investigator took brief field notes. The notes themselves did not include the medical specifics regarding a patient’s visit, but instead, the way in which the BHP, patient, provider, and direct patient care staff interacted (tenor of conversation, themes of questioning, duration of encounter, ways in which topics are broached or suppressed, etc.).

Data Analysis

Although there is no specific analytical process for ethnography, EOC does provide its own framework in terms of arranging data (Saville-Troike, 2003). This specific arrangement allowed the investigator to produce a written framework that punctuated the essential elements of interaction between therapist, physician, direct care staff, and patient. This aggregate framework was achieved through the cataloguing and description of the essential features of each speech event (i.e., the interaction between the BHP and patient and BHP and provider) as defined by Hymes (1972) and Saville-Troike, which are the *genre*, *topic*, *purpose/function*, *setting* (the totality of these four initial elements is referred to as the *scene*), *key*, *participants*, *message form*, *message content*, *act sequence*, *rules for interaction*, and *norms of interpretation*.

Once the observational period had ended, the investigator reviewed his brief field and extended notes regarding the interactions that were seen. After repeated review and comparison between his notes and the arrangement provided for categorizing the data (i.e., the above categories), a framework was produced that not only described the aforementioned components, but the underlying processes as well. The framework was then sent to one of the shadowed BHPs who read it for accuracy. Her comments and changes were incorporated into the final draft. The framework resembles an action tree outlining the BHPs engagement with both patient and provider. It includes what information is pertinent, excludes information that is not, and describes the rules of conduct for each participant (Saville-Troike, 2003). Also represented are the conditions required for particular action sequences to take place within the specified encounter (e.g., condition A dictates that the BHP meet with the patient prior to the provider, whereas condition B dictates they meet with the patient together). In effect, what is being created is a frame of reference for describing how these medical provider/BHP dyads and provider/patient/BHP triads operate within an integrated primary care system.

Verification Strategies

Given that qualitative methods view information as constructed and subjective, specific to the person being studied and the researcher conducting the study, a set of essential elements must be identified and used to measure the trustworthiness of the information obtained (Lincoln & Guba, 1985). Lincoln and Guba coined concepts that delineated the elements required within a qualitative methodology to ensure the study's resulting accuracy or trustworthiness; credibility, transferability, dependability, and confirmability. These essential elements were obtained for this study through the use of member checking by the BHPs who were shadowed in order to verify that what was observed and described matched what they saw themselves doing (credibility), reflexive journaling to ensure that others could see and understand how certain conclusions and arrangements of observations were reached (transferability), an audit trail to demonstrate the avenue of data synthesis (dependability), and the culmination of the aforementioned verification techniques to establish the overall confirmability of the analysis itself and resulting schema (Lincoln & Guba).

Results

The elements that compose the framework itself are (a) function/purpose: the purpose of the visit, (b) participants: who attends the visit, (c) act sequence: what actions take place during the visit, (d) rules for interaction: what the participants should do and/or say during the visit, and (e) norms of interpretation: other implied rules about the interaction (Saville-Troike, 2003). Given that the schema in its entirety is presented as an appendix to this article, the following will deal primarily with summarizing the act sequence while weaving in rules for interaction and norms of interpretation as appropriate.

The act sequence was broken down into three major subheadings termed “Patient States,” which reference the overall reason of the patient visit. For each of the three subheadings, the BHP’s provision of care was then broken down into five different interactional phases, whose sequence and inclusion were dictated by the preceding patient state. This section presents a description of the patient states first, followed by the interactional phases, and finally, a description of how a conjoint session (one where both BHP and medical provider are present at the same) alters those phases.

Patient States

Based on the analysis, three different patient states were identified as providing the initial context for engagement between patient, BHP, and provider: (a) New Patient, (b) Return Visit- Worsening or No Change in Condition, and (c) Return Visit- Improving Condition. These states are primarily conceptualized and understood, by the BHP, in the context of the patient’s degree/length/kind of relationship with the center and their presenting medical concern. As the first state would imply, these are first time patients to the center and who initially know little if anything about integrated care, as well as the BHP’s role as a member of the healthcare team. Therefore, the initial interaction is not necessarily as contingent on the patient’s chief complaint, but focuses on joining (i.e., building rapport), educating/acclimating the patient to the integrated care model used by the healthcare team, and obtaining an initial psychosocial assessment.

The last two patient states both involve returning patients, and are further defined and clarified by the etiology and trajectory of their presenting medical condition. Understandably, those patients whose medical condition has not changed or has worsened since their last visit may present with a degree of frustration, anger, and/or anxiousness. It is also during these kinds of visits that patient/medical provider/staff relationships may become strained and acrimonious. Given the potential volatility of the patient/medical provider encounter, the BHP's overall interaction primarily focuses on joining with the patient in their frustration as a means by which to validate their experience, as well as an attempt to explore its origins. The final patient state deals again with a returning patient, but one whose medical condition has improved since their last medical visit. This last type of encounter elicits a focus by the BHP on the successes of the patient and provider dyad over the course of treatment, as well as how to maintain these successes in the future.

Interactional Phases

Couched within these varying patient states that serve as the initial point of reference for the BHP, their actual engagement with the patient can be further distilled into five phases with each phase determined by the preceding contextual condition. It is important to mention at this point that phases one through four outlined below typically only involved the BHP and patient, however, conjoint sessions (i.e., session where the BHP and medical provider meet with the patient at the same time) are also discussed.

Phase One: Patient Briefing. This phase serves as the means by which the BHP gathers an initial understanding of whether they have seen this patient before, as well as the patient's presenting medical and/or mental health issue. The information is usually obtained from the patient's medical sheet, which is placed in a holder on the exam room door. Besides the reason for the visit, the sheet also contains a detailed medication list and various biomarker information as well (e.g., blood pressure, blood glucose levels, oxygenation of blood), which, for more seasoned BHPs, serves as a way of ascertaining what medical/mental health conditions the patient may be undergoing current treatment for, along with how well the patient is or is not managing said conditions. This particular phase is a constant, regardless of whether or not the patient is new since it sets the stage for the rest of the BHP/medical provider/patient encounter.

Phase Two: Introduction. The second phase in the act sequence marks the beginning of direct patient contact, and serves as a focal point to orienting the patient to the integrated aspects of service. This phase primarily only takes place with new patients, but its inclusion is ultimately determined by whether or not the patient has had interactions with the BHP in the past (i.e., phase one will take place with returning patients who have not yet met the BHP). The BHP will typically enter the room, and introduce him or herself by name prior to their professional role, and will take a seat relative to the patient that places the BHP at eye level. A standard introduction is relayed to the patient that incorporates three overarching ideas: (a) the role of the BHP as part of the medical team, (b) the importance/purpose of the psychosocial assessment process, and (c) that the BHP is not involved because the medical provider and/or staff believe there is emergent and/or underlying psychopathology or that there is bad news to report. The aggregate aspects of the introduction serve to orient and relax the patient to the BHP's inclusion in their care, as well as build the stage for future interaction. It is this initial explanation of roles by the BHP regarding not only their role, but how they and medical provider work together that is a hallmark of a level five integrated care center (Doherty et al., 1996).

Phase Three: Elicitation of the Illness Story. This phase typically begins with the BHP inquiring as to the reason for the medical visit, and if the patient is new to the center, primarily revolves around the history of the presenting medical concern (i.e., length of diagnosis, family history, past/current treatment, psychosocial stressors accompanying illness and/or treatment history). It is important to mention at this point that the elicitation differs from the medical provider’s clinical interview in that information about psychosocial experiences in relation to the medical issue are considered central to the patient’s conceptualization and understanding. This centrality is demonstrated by the BHP not only asking the patient about their psychosocial experience, but their tying in of biological and medical information back into those psychosocial issues as well.

It is also worth mentioning that it is during this phase that the majority of psychosocial assessments take place (i.e., assessment of emergent mental health issues and/or psychosocial factors impacting physical functioning). Based on the preferences of the medical provider, the BHP may also assess for other medical/psychosocial aspects of functioning as well (e.g., medication/treatment compliance, medication side-effects, appetite, sleeping habits).

If the appointment is for a retuning visit, one where the patient’s condition has worsened, this phase primarily revolves around discovering and dealing with any accompanying anger/frustration the patient may have, as well as attempting to ascertain where and to whom that anger and/or frustration is directed. As stated earlier, these kinds of visits present the greatest possibility for acrimony between patient and medical provider/staff/BHP, and the assessment portion of this phase is oriented toward exploring and addressing this tension if it does indeed exist. Also, as a patient’s condition worsens, other mental health issues may present themselves and/or become exacerbated (e.g., a patient whose congestive heart failure continues to worsen becomes depressed), which the BHP assesses for as well. During this phase the BHP will validate the patient’s anger and/or frustration, not necessarily with the intent of amplifying or agreeing with them, but, especially if that anger is directed toward the medical staff, with the intent of letting the patient know their concerns are being taken seriously. This orients the BHP in relationship to the patient that engenders exploration of their anger and frustration in a way that is more likely to both deescalate potential conflict, and figure out a resolution to whatever the issue might be.

During a return visit where a patient's condition is improving, this phase serves the function of discovering what actions the patient has taken to help facilitate the recovery process, as well as reify the teamwork between themselves and the medical provider. The BHP may also discuss any difficulties the patient encountered during their attempt to comply with treatment, as well as any anticipated issues they might encounter as they move forward (e.g., a diabetic patient who is trying to change their eating habits, but lives with family members who still maintain an unhealthy diet).

Phase Four: Intervention. One can conceptualize phases three and four as different sides of the same interactional coin; the elicitation of the illness story itself can be considered an intervention, while the subsequent interventions that arise from it further elicit the patient's illness experience (i.e., illness story). With this idea of interdependence in mind, interventions during this phase can vary greatly depending on the patient state, the way in which the illness story is elicited, and what is shared with the MedFT once they engage the patient in conversation. BHPs may engage the patient in any number of ways during this part of the act sequence; however, four typologies of intervention were identified.

The first type of intervention, brief problem solving/supportive therapy, involves joining patients where they are emotionally regarding their psychosocial stressors, as well as exploring concrete ways they may deal with those stressors (e.g., discussing how a patient with diabetes might talk with his or her family members about not feeling supported as they attempt to make dietary/lifestyle changes). This type of intervention might also include relaxation techniques (e.g., breathing/mindfulness) and/or brief hypnotherapy depending on the patient issue (e.g., needle or blood phobia) and the skill set of the BHP. The second type of intervention, ‘planting seeds,’ has to do with issues and/or concerns the patient may relay during phase three (Elicitation of the Illness Story), which the BHP then encourages the patient to discuss during their medical visit, as well as how to discuss those issues with the provider (e.g., a patient complains of numbness in their hands after taking a new medication, but does not think to tell this to the provider). The use of psychoeducation and/or behavioral education based on the presenting concern (e.g., patient’s presenting issue is lethargy and BHP discovers patient has poor sleeping habits) is another typology of intervention incorporated into the visit by the BHP as well. The final type of intervention involves referring the patient for additional services (i.e., on site or in the community based on patient’s expressed needs and readiness). This may include applying for Medicaid, dental services, substance abuse treatment, traditional psychotherapy, etc. The referral can be either internal or external based on the need of the patient and/or the services offered by the clinic; patients who require long term psychotherapy may be referred internally to the BHP if the provider has availability, or will be referred out if their needs (e.g., night appointments) are better met in the community.

Phase Five: Relaying Information. The final identified phase begins with the BHP ending their interaction with the patient, and then relaying pertinent information gained during any or all of the previous four phases to the medical provider. Winding down the patient session may include a recap of what was discussed, any ‘seeds’ planted during the conversation, and/or confirmation of any outside referrals. Also, prior to exiting the room the BHP may ask if the patient would like them to return once the medical provider enters and the patient’s medical visit begins. This can be offered regardless of patient state, but is primarily relegated to times when anger/frustration, sadness, and/or suicidality exist.

Once the BHP ends the session and leaves the room, two modes of information relay become possible; (a) the BHP seeks out the provider and orally relays any pertinent information, or (b) the BHP attaches pertinent information to the patient information sheet. The modality of information relay is dictated by how available the medical provider is (i.e., are they in the hall between patients as opposed to in another exam room), and the importance/severity of the information obtained (e.g., issues regarding patient and/or staff safety). Of the two conditions described, severity supersedes availability, in that information regarding suicide (active or passive), planned violence against staff, and/or any type of abuse (e.g., physical, emotional, substance) is communicated directly to the medical provider regardless of their physical availability at the time. During verbal relay to the medical provider, only psychosocial information pertinent to the presenting medical issue is included in the patient summary (e.g., a diabetic patient is struggling with dietary changes due to their family's eating habits). This is not the case with emergent mental health issues (i.e., suicidality and or homicidality), which are presented 'as is.' These consultations between BHP and medical provider can last anywhere from 30 seconds to 2 minutes, and are primarily dictated by the importance/biopsychosocial complexity of the information and the temporal availability of the medical provider.

Another, more traditional, means of relaying information is the insertion of a note into the electronic health records (EHR) system. This typically takes place even if one of the other two integrated methods of exchanging information is initially used. From this standpoint, the note is very brief, detailing only that the BHP had met with patient, any safety issues (i.e., suicidality, homicidal ideation, abuse, substance abuse), and/or any outside referrals. The brevity of the note is dictated by the fact that the pertinent information, as it relates to the presenting reason for the patient's visit, has already been communicated to the medical provider and is included in his or her note. It is this in vivo informational relay system (Doherty et al., 1996) that further defines this as a level five integrated site.

Conjoint Sessions

Thus far, the phases outlined in the preceding paragraphs have involved the provision of services to the patient by BHP themselves. However, conjoint sessions (i.e., sessions where the BHP and medical provider interact with the patient together), another hallmark of a level five integrated center (Doherty et al., 1996), alters both the interactional structure for the BHP, as well as how he/she progresses through and navigates the five phases of the interactional process.

During conjoint sessions the BHP typically assumes a more observational role for the encounter, and the medical provider takes the lead during the clinical interview process. This is not always the case however, and depends primarily on the rapport between the BHP and provider, as well as the patient’s presenting concern. The BHP will take on a more active role during the conjoint clinical interview if a) the BHP and provider have a good working rapport and predominantly see patients together, and/or b) the presenting medical concern is more psychosocial or behavioral in nature (e.g., depression, anxiety, treatment adherence, adjustment to a medical diagnosis). Also, during these joint sessions the BHP typically stands while the medical provider takes the seat closest to the patient on the rolling stool. This positioning is done with the intent of allowing the medical provider unfettered access to the patient (for the physical exam) and the electronic health records system (i.e., computer) to enter biomarker information and generate patient prescriptions.

In conjoint sessions where the BHP has not had any prior contact with the patient, the introduction of the BHP and the accompanying professional description is typically done by the medical provider, although the BHP may expand upon and/or clarify any portion of the introduction. However, during conjoint sessions that began as solo interviews, (i.e., a solo session where the medical provider enters the room during the BHP's BPS assessment) while the BHP will acquiesce to the provider once he/she enters the room, the BHP adopts a more active role through the relay of pertinent information gained during their BPS assessment as the provider performs their clinical interview. Phase five, relaying of information, does not typically take place during conjoint sessions, although both BHP and medical provider may confer outside the room in order to discuss a shared treatment plan or otherwise coordinate care.

Conclusion

Although MedFTs' use and utility has been outlined in multiple venues with specific disease states and populations (Anderson et al., 2008; Davey et al., 2009; McDaniel, Harkness, & Epstein, 2001; Phelps et al., 2009; Pratt et al., 2009; Willerton, et al., 2008), no primary care model utilizing MedFTs in an integrated and/or consultant capacity, up until now, has been described in contemporary literature. With that said, the authors did not seek to offer a definitive description of integrated practice by MedFTs in a primary care setting. What the authors sought to put forward is a flexible and adaptive description of a framework of practice, which provides enough structure to impart an idea of how integration can look with MedFTs as BHPs, and enough flexibility to allow for adaptation and adjustment by those hoping to implement these ideas at their own sites. In attempting to produce a framework of adequate descriptive and adaptive value, the authors, utilizing ethnography of communication, developed an interactional framework outlining MedFTs' actions in the provision of integrated primary care services to a non-targeted, non-specific patient population (Peek, Baird, & Coleman, 2009). Through construction of the schema, three different patient states were identified as providing the initial pretext to the MedFTs' visit with the patient; (a) new patient, (b) returning patient- no change or worsening condition, and (c) returning patient- improving condition.

Further analysis yielded five distinct phases that comprised the overall act sequence (i.e., the MedFT's visit with the patient and/or provider), and whose order and inclusion was determined by the preceding patient condition; (a) Patient Briefing, (b) Introduction, (c) Elicitation of the Illness story, (d) Intervention, and (e) Relaying of Information. Of the five phases, phase four (Intervention) yielded four different subclassifications of interventions utilized by MedFTs during the provision of services; (a) brief problem solving/supportive therapy, (b) planting seeds, (c) psycho and/or behavioral education, and (d) outside referral. As these conditions and phases were constructed in relation to one another, implicit rules for interaction between the MedFT and patient/MedFT and provider were noted as well, along with normative interpretative standards required for adequate functioning within the MedFT as BHP role.

It is worth mentioning that the unique and substantive contributions of this study are fourfold; (a) to outline how the provision of integrated primary care services to non-specific and non-targeted populations might look (Peek et al., 2009), (b) to describe a method of integrated care that is health rather than disease focused, (c) to describe how a MedFT might specifically function in a role providing those services, and (d) while other studies have discussed broad models of and/or principals regarding integrated care (e.g., Baird, 1998; Gerada et al., 2000; Judd et al., 2004; Manoleas, 2008; Robinson & Strosahl, 2009; Robinson & Reiter, 2007; Strosahl, 1996; Williams et al., 2006), none have broken down the interactional sequence of events from initial patient contact to coordination of treatment to this degree of specificity. In terms of these unique contributions, this study, to the exclusion of all formally published models, emphasizes the need for the BHP to be involved in all cases regardless of disease trajectory. What this involvement ensures is that beneficial health behaviors are reinforced while potential detractors are mediated long before they become issues. In this way, the framework emphasizes health rather than disease, in emphasizing the involvement of the BHP in all visits and not only those where a problem exists.

Again, the point in constructing this framework, as well as choosing this particular methodology to do so, is not meant to presuppose, as Doherty et al. (1996) warned against, that this framework, or the interactional sequence it outlines is the optimal way for all integrated primary care programs to function. This framework is only meant to provide one way of organizing mental health services in integrated settings, and is presented in the hopes of eliciting a broader conversation by the MedFT, marriage and family therapy (MFT), and medical communities about what is useful and what is not, in regard to working as a MedFT/MFT in an integrated primary care setting. Specific topics of discussion related to this broad conversation may include, but are not limited to: (a) how common factors of non-targeted integrated models incorporating MedFT/MFTs might be applied across primary, secondary, and tertiary care systems, (b) the measurement of the efficacy and effectiveness of these types of non-targeted models, and (c) what unique characteristics are found in a non-targeted model utilizing MedFT/MFTs when compared with other non-targeted models utilizing BHPs from other mental health disciplines. Another hope inherent in this work is that through studying and describing the actual practice of MedFT/MFTs in these venues, competencies can later be developed in regard to the training of student professionals who hope to work in this area (Tyndall et al., 2010).

Limitations

As with any study, time and logistics place constraints on both researchers and participants in ways that can affect the findings. With that said, this study has several limitations that, while not detracting from the veracity of the claims or credibility of the ideas presented, must be acknowledged and mentioned. First and foremost, the investigator functioned as a mental health care provider at the site under investigation, and helped train the MedFTs he shadowed during the data collection process. While this may be seen as a strength of the study, whereby his prior knowledge and relationship with the participants helped to create a more natural and less intrusive observational process (Saville-Troike, 2003), it can also be construed as a limitation in that the investigator might have been less likely to report what actually happened and instead opt to report what he believed should have taken place given that prior knowledge. Secondly, a limitation exists in that only the MedFTs' actions were observed in relation to the patient and/or provider, and not with the overall medical system (e.g., front desk staff, nurses, medical assistants, social workers). However, the goal of this research was not to describe an entire model of care, but to describe, to the greatest degree possible, one way of providing integrated direct care services by BHPs with MedFTs as those providers.

Also worth mentioning are the methodological constraints placed on the primary investigator in terms of his existing at the site as a BHP prior to his role as an investigator. The PI was placed in the position of knowing that certain events transpire regarding how the BHPs operate within the medical system, but was unable to report on these instances since he did not specifically observe the BHPs engaging in that practice during his observations. These specific issues revolve around the BHPs' interaction with nurses in terms of receiving patient briefings during phase one, as well as how visits might look similar or different if a patient's family member/s are present for the medical visit itself. While these issues can be construed as limitations, they are only fodder for needing additional studies to expand the framework surrounding integrated care encounters.

Future Research

As stated previously, this study presents only one piece of the entire BHP role in providing integrated care at the site under investigation, and if the entirety of that role is to be accurately replicated across clinics, further research must be done to outline how a MedFT, or any other mental health discipline, operates within the entire medical context where he/she exists (Linville et al., 2007). Studies must now be conducted that can be used to describe, to the greatest degree possible, how this interaction looks at all levels of the care delivery system (i.e., the BHP's interaction with nurses, social workers, admin staff, family members), and continue to describe this model in its entirety through an aggregate of research endeavors utilizing similar methodologies. As this particular model of care becomes more apparent through these investigations, verification of this model, and the professional competencies required to function appropriately within this environment, will become paramount. To this end, investigations regarding the matching and comparing of practices across sites and providers, and thusly the competencies related to that practice, can be actualized through the use of other qualitative and quantitative analytic techniques.

Once we have accurately defined, verified, and manualized the essential characteristics and practices of how a MedFT or non-MedFT BHP operates similarly and differently in this capacity, we can then begin to investigate the benefits of the systems developed for this purpose. Studies exploring the effectiveness and efficacy of these models against standard, non-integrated treatment modalities (Peek et al., 2009; Robinson & Strosahl, 2009) will be needed. Specifically, the focus of these studies should be on that of changes in biomarker (e.g., blood pressure, weight, blood glucose levels), psychosocial (e.g., depression, anxiety, distress), and/or practice related (e.g., provider burnout, competency in handling psychosocial issues, staff morale) variables. In summary, this model of integration, as with any model of practice, must first be studied, defined, and replicated across clinics in its entirety before its utility can be scientifically examined.

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CHAPTER 6: DISCUSSION

Chapters three and five, the theoretical and research articles, presented in this dissertation will offer contributions to both the science and practice of medical family therapy (MedFT) and integrated care in general. However, chapters one, two, and four add further depth to their arguments, and as such, are essential components of this dissertation as a whole. The contributions of each chapter to this overall ecological argument are as follows.

Chapter one presented an initial discussion that introduced the concepts of integrated care and MedFT, which then set the stage for the literature review presented in chapter two. The literature review was written to define and discuss primary care, integrated care, different ways of defining that concept, and also to further define and discuss the sub-specialty of MedFT, closing with a discussion regarding the theoretical basis used to guide the dissertation in general. The third chapter (the theoretical article), capitalized on the definition of MedFT and the theoretical discussion presented in the second chapter as a means by which to help clarify that definition in a way that presented MedFT as a specialization within the field of marriage and family therapy (MFT), and not as a separate profession. Chapter four (the methodological chapter), although not directly connected to the preceding chapters, described the way in which the research study was carried out. Chapter five (the research article) further clarified the theoretical discussion presented in the third chapter through the presentation of a framework of integrated primary care that is flexible enough to be adequately applied across all populations regardless of disease.

Another, perhaps less explicit conclusion regarding this dissertation, is the idea that the relational and systemic epistemology that drives the field of MFT will be seen as a unique and innovative force in the arena of both integrated and traditional care environments. What follows is a discussion about the potential implications of both articles (chapters three and five), as well as an aggregate description of both the ideology and philosophical foundation that drives MedFT, and how that philosophy translates into clinical practice.

Article One

As a profession develops it begins as an idea informed by action, a difference in the way a group of individuals not only think about how they perform their professional role, but how that difference is simultaneously actualized through real world application; a recursive relationship whereby both thought and action mutually inform and sustain one another. From this standpoint, one can draw a distinction between the ‘traditionalists,’ those that adhere to classical ways of practice, and the ‘innovators,’ those professionals who embrace that difference. As these differences continue to proliferate through time, and are further enforced by the creation of societal institutions that clarify and back those dissimilarities (e.g., national organizations, federal and state regulatory boards, academic training programs), those distinctions become more apparent. Essentially, these different governmental and societal institutions, rules, and regulatory structures lend credibility to the legitimacy of the profession itself, as well as its differentiation from other professions within the same field.

Less discernible, however, are the intra-professional distinctions. Practitioners, although adhering to the same underlying and foundational premises over time, may apply those ideas in specific venues differently. This change in appearance can, if left unaddressed, lead to confusion as to how these practitioners still maintain fidelity to their discipline. It is at this juncture that questions may emerge regarding whether or not a new profession must be formed. This uncertainty cannot be clarified through conversation about practice alone, but must be complimented by conversation and investigation regarding how those foundational ideas lead directly to the specifics and particularities of practice and vice versa; how one's thoughts regarding their work remain the same, while the actual practice of that work may look markedly different. If these two conversations can be held simultaneously, a picture can begin to emerge that portrays those professionals as applying these foundational concepts in new and emerging areas, depicting them as ideological innovators instead of defectors. The creation of that picture, or at least the first brush stroke, is the aim of this first article.

What drives MedFT is a relational framework that serves as the basis for both professional thought and practice, and helps to facilitate the conceptual connection of ideas that are typically thought to exist as opposites (e.g., health/disease, compliance/resistance, healthy/unhealthy) (Flemons, 2002; Keeney, 1983). From this standpoint, MedFT, whether as a theoretical construct or as a designation of a clinical practitioner, embraces a modus operandi of understanding the benefit or utility of any position; especially those considered to be 'opposing' (treatment compliant vs. treatment resistant). What this means is that the definition of a patient as 'resistant' to treatment, whatever that treatment might be, will be dependent on who is doing the defining, the etiology of the disease, the trajectory of the disease process, etc., (essentially the entire context within which the patient exists), and says little if anything about the patient themselves. The implication of such an orientation, one that emphasizes that decisions made make sense if we set out to understand and appreciate the context within which they are made, has serious and far reaching implications for practice at the clinical level and collaboration with other professional groups.

From a clinical standpoint, such an orientation will allow the practitioner to become interested in why a decision was made instead of attributing it to an a priori state that may or may not necessarily be the case, a state that is usually pathology oriented (i.e., some degree or type of psychopathology). This will typically lead to acrimony between a patient and their medical provider for a number of reasons, but more importantly, will lead to a breakdown in communication, trust, and a productive working relationship for each. This is typically where the behavioral health provider first enters the picture, and from a non-systemic or linear orientation, is then left with the untenable position of siding either with the patient or the provider; invariably alienating one side of the dyad and doing little to help restore the kind of relationship that both had prior to the impasse. In order to connect these two disparate concepts, and thusly the patient/provider dyad, a MedFT utilizes their knowledge of both the frame of reference of the medical provider (i.e., training that emphasizes the eradication of disease and a desire to alleviate physical dysfunction) and the patient (i.e., their conceptualization of the problem), in order to facilitate a conversation that presents both participants as working toward the same end by different means.

Utilizing this type of framework, and this particular example, a MedFT may conceptualize a patient’s refusal of treatment as the means by which to fully embrace life, a life likely shortened by a lack of treatment, but one devoid of the complications (physical, emotional, religious, etc.) that treatment might entail- an embracement of quality (e.g., a patient refuses chemotherapy that might extend life by six months, but a treatment whose sides effects will confine him/her to bed for that time). At the same time, the MedFT will also able to conceptualize the provider’s insistence on treatment not as the dismissal of the patient’s right to agency, but instead the desire to help the patient embrace life as well, albeit it from a different perspective- one of quantity. At this juncture, the MedFT will have successfully connected both the provider and patient in their desire to embrace life with the difference being in how one goes about doing so. Moving forward from this conceptual connection, the MedFT is then able to help facilitate a conversation with both patient and provider, either together or separate, which alludes to this shared goal and is able to begin the task of coordinating efforts accordingly. In this way the MedFT will have escaped this classically zero sum position, and will have oriented him or herself to play neither and both sides simultaneously. In taking this relational position, one that does not declare a patient ‘crazy’ for refusing treatment and a provider ‘insensitive’ for pushing treatment, neither side is pathologized and both positions are seen as reasonable given the context within which they were made; this is the advantage of a relational orientation.

The notability of this orientation is not necessarily in the orientation itself, but the venue in which it is applied. As a whole, the profession of MFT was born from this relational and systemic approach, and it is this unique way of addressing issues that has acted as the keystone of practice for the better part of sixty years. If one confuses MedFT as a new profession that has discovered an ‘innovative’ way of addressing issues, rather than a young profession applying half-century old ideas in new areas, then those adopting this notion will attempt to reformulate ideas rather than explore how established ones are applied in non-traditional settings- essentially re-inventing the conceptual wheel. However, if one embraces the legacy of the professionals whose theoretical and clinical work bore the ideas that we as MedFTs (and MFTS) adhere to, that time will be best spent formulating new configurations and models whose applicability is directly related to the unique issues that arise in medical contexts. What we are discussing here is the innovation of a profession or the defection from it; two conceptual sides, although relationally connected, as our profession would argue, but sides that many would find hard to reconcile.

Article Two

As we attempt to discuss and describe what the practical work of behavioral health providers (BHPs), and in this case MedFTs, look like in new environments, one must always be mindful that descriptions of adequate specificity will be of particular importance. The purpose of this study was not to present the most appropriate way of practicing integrated care, but to further the discussion surrounding how the concept of integration might look and be practiced between a behavioral health and primary care provider with their patient. The ideas, constructs, theories, frameworks, and models presented in these works will hopefully spark new ideas and applications by those who find utility in the information presented; in essence, allowing the reader to 'pick up' where the author 'left off.' This relational approach to research, whereby the work of one group serves as the basis for the work of another, requires that a study's scope be narrow enough to hold little ambiguity regarding the process it is used to describe and enough flexibility in the presentation of that description to allow for an adaptable application of those ideas by others. These two underlying premises regarding applied research relate directly back to the way in which the second article was conceptualized, carried out, and its findings presented.

History of the Model. Prior to discussing the implications of the framework presented in article two, the history of the entire model's presence at the site is worth briefly discussing to add further context and clarity. The model itself began as a traditional care delivery system where the BHP was referred patients by the provider for traditional psychotherapy for classic mental health issues; in this capacity, there existed little to no collaboration between BHP and medical providers toward the development of shared treatment plans. As the BHPs became more acclimated to the site and the providers more acclimated to their presence, the service itself began to expand to incorporate consultation by the BHPs. This expansion of service was directly related to the BHPs' ability to connect with medical providers and staff in terms of learning about their challenges in working with patients. The consultation process itself was developed out of an attempt to mediate these challenges, as well as the preference of the medical staff in terms of what questions to ask and when to engage patients. Ultimately medical providers, and to a greater extent their patients, determine the type and degree of integration utilized in each visit. Depending on provider/patient preference, BHPs may engage in full to no integration in terms of shared visits, treatment plans, and/or charting practices. New providers entering the site are educated both formally (e.g., a formal introduction by the BHP about their role) and informally (e.g., watching how other medical providers utilize the BHPs), and are encouraged to utilize BHPs in a way that is most appropriate for and aligned with their own administration of care.

Implications for Integrated Care. The framework central to the second article serves as the basis for generating a model of integrated primary care that is neither population nor disease state specific. The reason for describing these findings in this way is two-fold. Firstly, in order to produce a framework that possesses the necessary descriptive power to find immediate clinical applicability and relevance, only one aspect of the MedFTs overall clinical role could be properly described given the methodological and programmatic constraints inherent in the study process. Also, if one keeps in mind that a framework is conceptualized as an underlying structure (Oxford English Dictionary, 2008), one that gives form to a model but is only a piece of the model itself, a study laying out a framework may describe the action of practitioners, but cannot describe the process of connection between actions that culminate in the overall methodology of practice, namely, the model, of which the framework is only a part.

Keeping in mind these two points, the framework presented in the second article produces a description with enough specificity that those looking to use the ideas presented in it can do so easily. The initial three patient states (i.e., New Patient, Returning Patient-Worsening or No Change in Condition, Returning Patient-Improving Condition), which serve to give context to the nature of both the medical and behavioral health provider's interaction with patient, are general enough that they can describe the vast majority of patients that present not only in primary care, but any care setting in general. One can make the argument that disease, regardless of etiology, has only three trajectories: (a) improvement, (b) stasis, and (c) decompensation, and as such, the 'global' nature of these states not only refers to the overall patient experience, but the generalizability of these states to the patient population as a whole. The next five phases outline in the framework (i.e., Patient Briefing, Introduction, Elicitation of the Illness Story, Intervention, Relaying of Information), which describe the actual clinical contact between the triad of the patient/BHP/medical provider, form a description of how the BHP first learns about the patient, how they introduce themselves, how they elicit conversation from the patient regarding their concerns, how they (as the BHP) mediate those concerns if able, and finally, how collaboration takes place between the BHP and medical provider. Being that the order, appearance, and application of phases is couched within the context provided by the preceding 'patient state,' the framework, at its core, is relationally driven in that each aspect of it (e.g., global state, phase, rules for interaction) informs and is informed by the preceding and proceeding pieces. Although a quantitative difference, whose veracity cannot be proven at this point for reasons to be discussed later in this section, cannot be attributed to this fundamental relational orientation, a qualitative difference emerges that speaks to the importance of context as the driving force behind action, a point outlined in the first article.

Implications for MedFT. Given that MedFTs are called BHPs within the framework, and the political nature of research, questions can be raised as to the 'MedFTness' of what is presented here; specifically, what makes this a ‘MedFT’ framework as opposed to a social work, psychiatry, psychology, etc. driven one. While an excellent question, one that is definitely of great importance as it pertains to furthering the sub-specialty of MedFT, it is nonetheless a question that cannot be answered given the state of contemporary integrated care literature. Every model formally described is geared toward working with targeted populations, a basis of work that generalizes across disease and professional designation, and as such, no model exists in the literature to serve as the basis of comparison for the one presented in article two. A comparison can only take place if the nature of the starting point is the same between the things being compared. An example of this relationship would be in comparing a targeted model and non-targeted model; the basis of comparison (i.e., targeted vs. non-targeted) is derived from the starting point of there being a population to serve. In this particular instance the question of ‘what kind of population’ can successfully be answered only due to the fact that both models start off as a serving a ‘population,’ a construct whose specific nature then acts as the point of comparison.

What this logic bares out, at least as it pertains to the initial question, is that until another framework emerges that offers a description of a similar method of practice, whether utilizing MedFTs or not, with the same population (i.e., non-targeted), the act of comparison for the ‘MedFTness’ of this framework is an impossibility. The impracticality of this exists in the premise that any comparison between this framework and another will invariably be flawed in its initial presentation. What this argument presents in practical terms, is that fleshing out professional differences between models requires that the models be doing the same thing with the same types of people, which means that the framework in article two cannot be compared with contemporary literature because nothing exists describing work with this non-targeted population. If we continue to follow this logic to its end, since a description of what something ‘is’ at the same time elicits a description of what it ‘is not’ (Keeney, 1983; Flemons, 1991), we, at this point, are only left with one half of this conceptual dyad, which in turn ensures that any attempt at comparison will invariably fall short in its credibility.

Although the lack of another framework in contemporary literature leaves us with an inability at direct comparison, it does afford us another method of making a statement regarding the unique ‘MedFTness’ of this framework, which is achieved through a comparison with integrated care literature as a whole. Since there does exist formal models for integration utilizing other professional bodies (e.g., social work, psychology, psychiatry), what makes this framework inherently MedFT is the very fact that MedFTs were the ones acting as the BHPs at the site with a non-specific diagnosis population. This claim will and can only be challenged once another comparable framework finds its place into the contemporary professional zeitgeist, which in turn will allow for closer examination and further revision of what makes the framework presented here inherently MedFT.

Connection

Where these two articles find connection is in the notion of praxis, a construct defined by the Oxford English Dictionary (2009) as “Conscious, willed action. . . that through which theory or philosophy is transformed into practical social activity.” Praxis can be considered the point where the theoretical and conceptual world and the ‘real’ world work of MedFT meet, and it is through this meeting that professional definition is then negotiated; in therapeutic terms, praxis is also defined by Keeney and Ross (1985) as practical strategy, or where “the primary purpose revolves around practical advice and strategy for organizing one’s action” (p.13). Praxis highlights the connection between theory and practice in that any theory outlines a series of constructs, as well as the processes between constructs that connects them. This description of process then serves as the guide for action by the practitioner, which in turn further describes, clarifies, and modifies the theory. In this way, action defines theory as theory defines action, each informing and informed by the other concurrently.

What this concept lends to these two articles specifically, is that the definition of what MedFT is or is not, while negotiated at levels of theoretical and philosophical abstraction, also becomes negotiated directly in the sites where MedFTs, as clinicians, practice, by the way they practice. Their relationally oriented training serves as the basis for their action at these sites, which then further informs their understanding of that relational orientation; a recursive relationship that connects both theory and practice in a way that makes each the foundation for the other. Given that connection, the first article can be seen as describing the orientation of the MedFT who engaged in clinical practice as found in the second article, and the second article aids in further clarifying the theoretical discussion presented in the first. In order to then adequately close this feedback loop, a third, comparative, article would be necessary that examines the relationship of this framework with that of another utilizing a different mental health discipline. It is this future research study that will provide the basis for further clarification of the theory and practice of MedFT through its relationship to other disciplines, which serves not only to compare and further define, but also connect research with theory and practice. It is through this idea of connection, an idea that presents the research, theoretical, and clinical spheres of professional discourse as interrelated, which ensures MedFTs are mindful of theory, discerning in practice, and always critical of both through careful examination, the very epitome of both the scientist-practitioner and scholar-practitioner models (Belar & Perry, 1992; Korman, 1973).

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APPENDIX A

Framework

FUNCTION/PURPOSE: To assess patient's psychosocial functioning, along with how said functioning impacts/is impacted by presenting biological concerns.

PARTICIPANTS:

P1- Patient
P2- MedFT
P3- Medical Provider

ACT SEQUENCE:

Condition A: New Patient

Phase One- "Patient Briefing"

P2- gathers an overview of P1 presenting concern

P2 either retrieves patient encounter sheet from exam room door, which provides a description of the presenting concern and other information (e.g., initial or return visit, medication list, weight, height, age), or accesses information through EHR on nearby computer.

Phase Two- "Introduction"

P2- Enters room, greets P1 and takes seat at P1's eye level

P2- introduces self and presents service as standard of care for all patients while emphasizing that P2's inclusion is not indicative of any concerns by P3 or staff (i.e., P2 is not speaking with P1 because they are 'crazy' or to cushion impending 'bad' news).

Phase Three- "Elicitation of Illness Story"

P2- asks P1 about presenting concerns as they relate to medical visit

P2's elicitation encompasses both biological and psychosocial aspects

P1- relays illness story

Phase Four- "Intervention"

Based on nature of illness story, P2 engages P1 in brief intervention based on presenting needs.

Phase Five- "Relaying of Information"

P2- makes transition from sitting/leaning to standing- readying exit

P2- thanks P1 for participating in their exchange and if able, gives P1 timeframe for when P3 will enter room.

P2- exits room and either seeks out P3 for "curbside" consultation regarding P1, or places pertinent information on sticky note and places it on encounter sheet in exam room door.

Condition B: Return Visit- Worsening or No Change in Condition

Phase One, Two, and Three are the same with the exception of no introduction by P2 during Phase Two

Phase Four- "Intervention

P2- joins P1 in frustration over condition then assesses P1's level of satisfaction with P3 and medical staff

P2- engages P1 in conversation about difficulties of treatment (compliance/adherence) or relationship with P3

If compliance/adherence or relationship issues between P1 and P3 are found, P2 focuses encounter to specifically address these.

Phase Five- "Relaying of Information"

P2- thanks P1 for participating in their exchange and also inquires about returning for P1's encounter with P3

P1- either agrees or denies, which P2 then honors

P2- depending on if discord between P1 and P3 exists, and the extent, P2 will seek out P3 for "curbside" consultation; if little or no discord exists, P2 will leave information on sticky note on patient information sheet.

Condition C: Return Visit- Improving Condition

Phase One, Two, and Three are the same with the exception of no introduction by P2 during Phase Two

Phase Four- "Intervention"

P2- encourages and reinforces life choices made by P1 and treatment choices by P3

P2- engages P1 in conversation regarding strategies used to comply with treatment, as well as strategies that will be used in the future, and discusses any difficulties P1 may be encountering or expected to encounter.

Phase Five is the same as in *Condition A.*

RULES FOR INTERACTION:

Phase One-Phase Four:

If P2 accompanies P3 during medical visit P2 takes on a more observational role, which includes offering pertinent information when appropriate (i.e., psychosocial, behavioral, adherence), but medical visit is primarily run by P3; the introduction of P2 to P1 will be done by P3.

If P2 is interacting with P1 when P3 enters room, P3 will ask P2 if they should "move on" to the next patient and return when P2 is finished; this decision is made by both P2 and P1, and is based on patient load of P3.

If P3 enters room during P2 and P1 interaction and stays, P2 will transition to standing/leaning position to allow P1 access to the seat and computer in the room. P2 will then adopt a more observational positioning during remainder of encounter

Phase Five:

Information presented to P3 during curbside consultation and/or placed on sticky note deals primarily with psychosocial issues as they relate to presenting medical concern.

Consultations should not last more than 30 seconds to 2 minutes based on relevance/importance of information.

If emergent issues are present (i.e., suicidal ideation, abuse, neglect, substance abuse) this requires immediate consultation.

NORMS OF INTERPRETATION:

The introduction by P2 during Phase Two combines elements of educating the patient about the psychosocial assessment process, role of the therapist as part of the medical team, services offered by the therapist (i.e., consultation and/or traditional psychotherapy), and humor

During Phase Three the elicitation primarily encompasses history of presenting medical concern (i.e., length of dx, family hx, past/current tx, psychosocial stressors accompanying illness and/or tx history)

Based on P3's preference, Phase Three may also include other assessments (e.g., medication side effects, sleep, diet)

Interventions during Phase Four can include the following: brief problem solving/supportive therapy, "planting seeds" (i.e., encouraging P1 to bring up certain issues during medical visit), psychoeducation, and/or psychosocial referral (i.e., social work referral for concrete services, referral to either P2 or outside provider for traditional psychotherapy)

During Phase Four/Condition B "joining" does not entail agreeing with P1's frustration, particularly if it involves denigrating P3 or medical staff. Joining entails acknowledging P1's frustration while at the same time exploring possible reasons for relational discord.

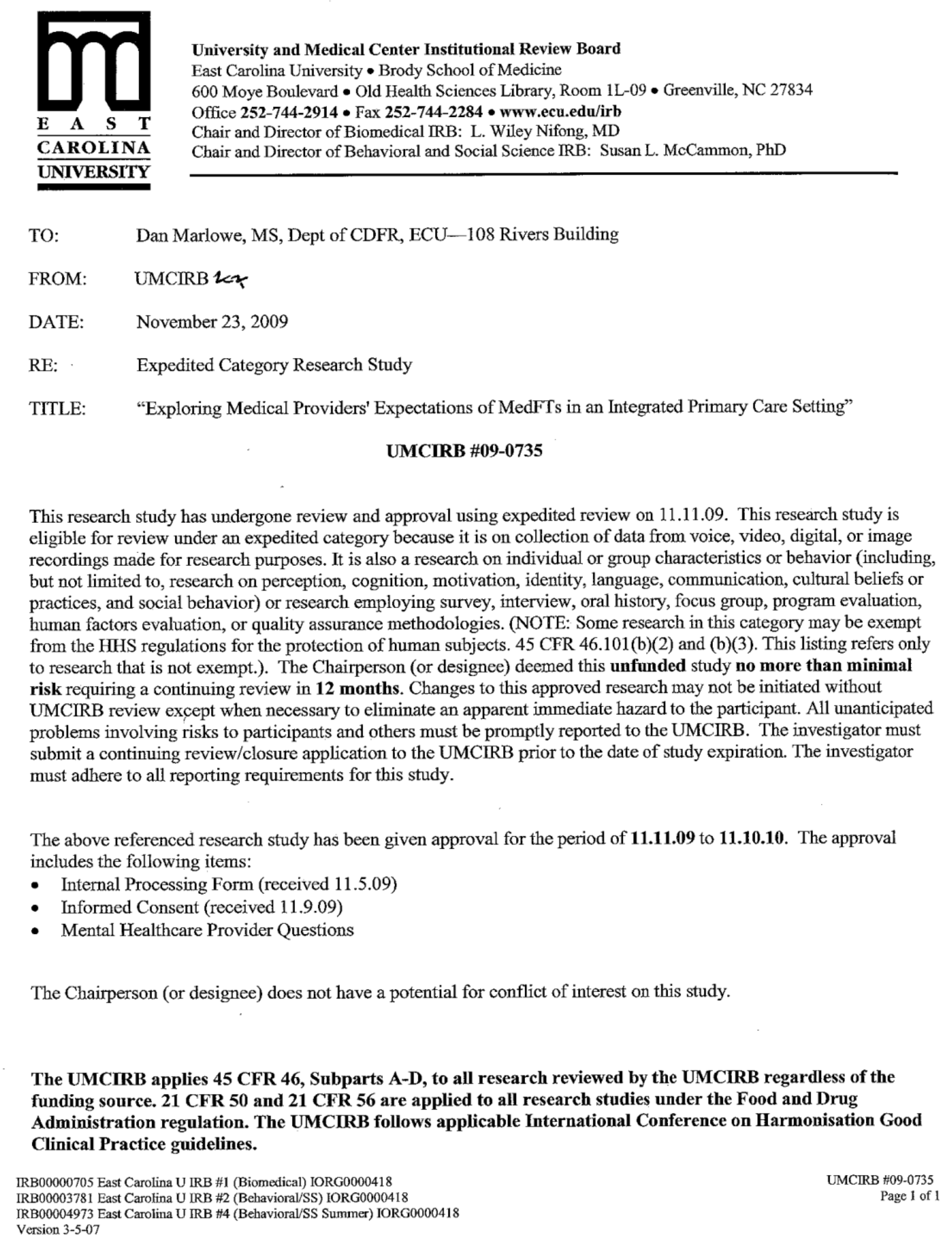
If P2 either returns for medical visit after meeting with P1 or remains in exam room after P3 enters, their role may also include relaying pertinent information from their initial session to P3 during clinical interview.

If P2 and P3 conduct conjoint session Phase Five may or may not take place based on amount of information shared during session; if Phase Five does occur it is typically done outside the exam room, and revolves around coordination of services (e.g., P3 prescribes an antidepressant for P1 and P2 conducts traditional psychotherapy)

Based on degree of rapport between P2 and P3 and nature of the presenting issue, P2 may take a larger role during conjoint sessions.

APPENDIX B

Institutional Review Board Approval Form



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

TO: Dan Marlowe, MS, Dept of CDFR, ECU—108 Rivers Building

FROM: UMCIRB

DATE: November 23, 2009

RE: Expedited Category Research Study

TITLE: "Exploring Medical Providers' Expectations of MedFTs in an Integrated Primary Care Setting"

UMCIRB #09-0735

This research study has undergone review and approval using expedited review on 11.11.09. This research study is eligible for review under an expedited category because it is on collection of data from voice, video, digital, or image recordings made for research purposes. It is also a research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. (NOTE: Some research in this category may be exempt from the HHS regulations for the protection of human subjects. 45 CFR 46.101(b)(2) and (b)(3). This listing refers only to research that is not exempt.). The Chairperson (or designee) deemed this **unfunded** study **no more than minimal risk** requiring a continuing review in **12 months**. Changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must submit a continuing review/closure application to the UMCIRB prior to the date of study expiration. The investigator must adhere to all reporting requirements for this study.

The above referenced research study has been given approval for the period of **11.11.09** to **11.10.10**. The approval includes the following items:

- Internal Processing Form (received 11.5.09)
- Informed Consent (received 11.9.09)
- Mental Healthcare Provider Questions

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

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

IRB00000705 East Carolina U IRB #1 (Biomedical) IORG0000418
IRB00003781 East Carolina U IRB #2 (Behavioral/SS) IORG0000418
IRB00004973 East Carolina U IRB #4 (Behavioral/SS Summer) IORG0000418
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