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ORIGINAL PAPER

A Content Analysis for the Continued Identification of Medical Family Therapy Competencies

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Abstract Medical family therapy (MedFT) is an emerging profession—where family therapy and healthcare intersect—that has had dramatic growth in the past two decades. Although identifying MedFT skills and competencies undoubtedly began with the birth of the field, the first discrete and specific sets of MedFT skills and competencies were published in 2012. In this article, we discuss the competencies from health psychology, medical social work, and the existing lists of MedFT competencies. Through a content analysis, the competencies were coded and reorganized to identify ways to capture additional skills that could be added to the current MedFT competencies and are particularly relevant to the work of MedFTs. It became apparent through this content analysis that MedFT experts must identify competencies pertaining to training in relational health, research, and unique clinical skills. Recommendations are made to further build on the current MedFT competencies by: (a) prioritizing the family, collaboration, and interprofessional communication; (b) including more competencies regarding assessment, case management, consultation, administration, research, program evaluation, training, and supervision; and (c) creating competencies for all levels of proficiency.

Keywords Competencies · Content analysis · Health psychology · Marriage and family therapy · Medical family therapy · Medical social work

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Introduction

Competency identification is an ongoing process where relevant skill sets are articulated, selected, and reviewed by educators, stakeholders, and other interested personnel (Hoge et al. 2005), typically within a specified profession. This process has typically involved an open invitation to discipline-specific experts in culminating and revising identified competencies within mental health professions (cf. France et al. 2008; National Association of Social Workers (NASW) 2005; Nelson et al. 2007). Medical family therapists (MedFTs), however, have just formally begun this process. Tyndall et al. (2012) published a list of 26 MedFT competencies in 2012 simultaneous to a set of 56 skills required for collaborative practice, published by Bischoff et al. (2012). Thus, the purpose of our article is twofold: (a) to review the processes of competency identification in MedFT and related mental health fields/specializations [i.e., Health Psychology (HP) and Medical Social Work (MDSW)], and (b) to present results from a content analysis that examined the published competencies in HP, MedFT, and MDSW in order to identify specific gaps in the existing MedFT competencies.

Competency Identification Processes

Competencies, or measurable human capabilities (Marrelli 1998), can be identified using the following strategies: defining the objectives, obtaining support, developing and implementing a plan, designing a methodology to observe competencies (e.g., focus groups, structured interviews, behavioral event interviews, surveys), identifying competencies and creating the model, applying the model, and evaluating and revising the model (Marrelli et al. 2005). The following paragraphs offer a definition of MedFT and

the strategies used by MedFT experts in identifying competencies. In addition, a snapshot is provided for the ways in which "like" fields/specializations identified their skills and published competencies (i.e., HP and MDSW). The process of understanding how competencies are considered from other fields/specializations may assist experts in MedFT to expand upon the skills/competencies that are currently published for professionals in the field.

Medical Family Therapy

MedFT has its roots in marriage and family therapy (MFT; McDaniel et al. 1992). The definition of MedFT has evolved over the past 20 years, but has always maintained its roots in a relational lens with extensive training in work with families and family dynamics. In 2007, Linville, Hertlein, and Lyness adopted and modified definitions of MedFT from McDaniel et al. (1992) and Campbell and Patterson (1995), resulting in the following definition of MedFT:

> An approach to health care from a biopsychosocial-spiritual perspective, informed by systems theory, spanning across a variety of clinical settings, where: the patient's interpersonal relationships are believed to play a key role, and collaboration exists between the family, therapist and other health care practitioners. (Linville et al. 2007, p. 86)

Later, Tyndall et al. (2010) completed a modified Delphi study with one aim of obtaining a consensus for how MedFT is defined. These authors agreed with and added to the previous definition (i.e., Linville et al. 2007) that MedFTs endorse patient agency[1] and facilitate healthy workplace dynamics (Tyndall et al. 2010).

Over the past two decades, MedFT has gathered increasing interest among healthcare researchers, training programs (cf. Tyndall et al. 2012, pp. 4–5), and policy makers (Shin and Jones 2014). However, training of MedFT knowledge and skills has largely occurred without continuity across developmentally similar programs. And while MedFT has its roots in MFT (McDaniel et al. 1992), the American Association for Marriage and Family Therapy (AAMFT) Core Competencies (2004) did not fully capture the nature of work that MedFTs were doing with healthcare providers, researchers, and educators and in diverse healthcare contexts. Thus, skills specific to MedFT were necessary to identify. As such, MedFT competencies were identified by researchers at two doctoral programs: the MedFT program at East Carolina University (ECU; Tyndall et al. 2012) and the doctoral faculty at the University of Nebraska-Lincoln (UNL; Bischoff et al. 2012).

In 2010, Tyndall and colleagues completed a modified Delphi study where 25 MedFT competencies were identified. The participants in the Delphi study included a sample of self -identified experts in MedFT (according to a list of inclusion criteria) from across the U.S. The competencies that were documented from the Delphi study were later edited (ECU MFT/MedFT Faculty Meeting Minutes January, 2011), sorted using the existing AAMFT Core Competency domains and subdomains (AAMFT 2004), and one competency was altered at a faculty retreat to include compassion fatigue in relation to provider self-care and burnout (ECU MFT/MedFT Faculty Meeting Minutes February, 2011).

A major point made by Tyndall et al. (2012), fitting of MFT and MedFT education, was the importance of distinguishing between levels of proficiency. MFTs and MedFTs can have training in MedFT at a Master's, post-degree certificate, doctoral, or post-doctoral level (Tyndall et al. 2012). Therefore, as MedFT competencies continue to evolve, level of proficiency will need to be attended to, a point that will be revisited later in this article.

After this study was completed, a set of collaborative practice skills for MedFTs was put forth by Bischoff et al. (2012). These researchers invited a purposive sample of thirty three experts in MedFT to complete a survey about the skills needed for successful collaborative practice. Twenty-five participants completed the study and the data were coded using qualitative data analysis methods. Fifty-six skills emerged, which were grouped into three categories: (a) skills for working in a medical setting, (b) skills for working with patients, and (c) skills for collaborating with medical providers (Bischoff et al. 2012). Within the three categories were a total of ten sub-categories.

These two lists provide the field with fodder for further conversations about what MedFTs do and guidance on how to better train future students. However, as a field, MedFT is not unique in wrestling with issues related to competency. Other behavioral health fields have sought to identify key competencies and skills and we believe there is wisdom in examining their process along with the outcomes from their resulting competencies in order to further strengthen the list of potential skills of MedFTs (particularly beyond skills related to clinical practice). Below is a brief description of the process and global competency domains from "like" fields/specializations.

Health Psychology

Experts in HP held an Executive Summit in 2007 to identify competencies for the post-doctoral specialty (France et al. 2008). The 20 invited attendees were

[1] "Active involvement in and commitment to one's own care" (McDaniel et al. 1992, p. 9).

representatives from private practice, medical centers, other areas of psychology, and HP researchers who were diverse in race, ethnicity, gender, and geographic location (France et al. 2008). Competencies were developed during the summit using the Cube Model for competency development (Rodolfa et al. 2005). Competencies were organized into six domains: Assessment, Intervention, Consultation, Research, Supervision-Training, and Management-Administration (France et al. 2008). Each domain was organized by one of two categories: knowledge-based and applied competencies (France et al. 2008). The creators of the HP competencies extended an open invitation for revision by interested parties (France et al. 2008) and a revised list was published in 2009 (Masters et al. 2009).

Marriage and Family Therapy

The AAMFT Core Competencies (cf. AAMFT 2004) were created by a 50 member taskforce and a five member steering committee over 23 months (Hoge et al. 2005; Nelson et al. 2007). The committee reviewed competency models used in related fields, defined domains for organizational structure, and put forth and tested 273 potential competencies (Hoge et al. 2005; Nelson et al. 2007). The list of competencies was then organized into 6 domains (i.e., Admission to Treatment, Clinical Assessment and Diagnosis, Treatment Planning and Case Management, Therapeutic Interventions, Legal and Ethical, and Research and Program Evaluation) and 5 subdomains and then condensed, resulting in 126 competencies (Nelson et al. 2007; AAMFT 2004). The competencies were then sent out to other interested parties, related fields, and all AAMFT members (Nelson et al. 2007). Before the competencies were finalized they were introduced at an Educator's Summit to review and modify the competencies at that stage (Nelson et al. 2007). The taskforce planned to regularly review and modify the competencies (AAMFT 2004).

Medical Social Work

In MDSW, the NASW standards were identified by expert MDSWs to "enhance social workers' knowledge, skills, values, and methods necessary to work effectively with individuals, families (broadly defined), health care providers, and the community when practicing in health care settings" (NASW 2005, p. 8). There were 20 standards published (e.g., Ethics and Values, Health Disparities, Cultural Competence, Case Management, and Research) all of which had a narrative description and nine had specific skills in a bulleted list form following the narrative (NASW 2005). The panel of experts was listed in the preface (NASW 2005).The process of how professional standards were developed was not published in the original document.

As we reviewed the process and domains/standards from other mental health fields/specializations and reflected on the current status of competency identification in MedFT, a second aim became necessary: the need to conduct a content analysis in order identify specific gaps in the existing MedFT competencies. To meet this need, competencies from HP [American Psychological Association (APA) Division 38, 2012; Masters et al. 2009], MedFT (Bischoff et al. 2012; Tyndall et al. 2012), and the MDSW standards (NASW 2005) were compared in order to determine if there were competencies that were underrepresented in the field of MedFT, but also to highlight ways in which skills in MedFT differ from those for a HP and MDSW. While it was important to understand the process that AAMFT used to identify competencies (given that MedFT is grounded in MFT) these competencies (nor general psychology or social work competencies) were included in the content analysis, thereby ensuring the greatest likelihood for commonalities across the domains/standards.

Methods

An exploratory content analysis (cf. Bernard and Ryan 2010) was chosen in order to examine the competencies from HP, MedFT, and MDSW since the data were textual. Content analyses have been described in many ways. The steps followed for this content analysis were aligned with those of Bernard and Ryan (2010); the paraphrased steps follow:

1. Formulate the question
2. Select a set of documents to test the question
3. Create a set of codes in the research hypothesis
4. Pretest the variables on the selected texts and fix any problems
5. Apply codes to all texts
6. Create a matrix from the text and codes
7. Analyze the matrix

The first step was formulating a question (What competencies are most represented and underrepresented for MedFTs in relation to the competencies of like fields/specializations?). The second step was to identify pertinent texts. Thus, competencies were obtained for HP from Masters et al. (2009) and the APA Division 38 website (2012), for MedFT from Tyndall et al. (2012), and for MDSW from the NASW standards (2005). Two sets of HP competencies were reviewed because there were multiple editions of the HP competencies published. Also, in 2013, during the review process for this article, the Bischoff et al. 2012 article became available and thus was incorporated into the results (i.e., domains and subdomains) of this study. Given the method and organization of the analysis

Table 1 Conceptual definitions and examples by domain and subdomain

Domain/ Subdomain	Definition	Example
Direct patient care	Behavioral health provider skills or techniques that directly affect patients, families, or systems	MDSWS11.06: An ability to advocate for changes in care that reflect the interests of the client and client system
Assessment	Competencies including assessment and diagnosis	MedFT 22: Demonstrate the ability to conduct a BPSS assessment
Intervention	Competencies including interventions and therapeutic techniques	MedFT 7: Demonstrate ability to motivate health-related behavior change
Consultation/ case management	Competencies including either consultation or case management	MDSWS08.08: Case management may include continuity of care planning
Indirect patient care	Behavioral health provider skills or techniques that indirectly affect patients, families, or systems	HPSAp9: Provide effective instruction and supervise the conduct of health related research across disciplines
Administrative	Competencies including administrative, executive, or management skills	HPMAp2: Develop behavioral health services and evaluate their effectiveness and quality
Education/ knowledge base	Competencies where the baseline education or knowledge base required of a behavioral health provider is described	MedFT 15: Understand the key historical figures, theoretical underpinnings, and empirical literature central to MedFT
Research/ evaluation	Competencies that include research or program evaluation skills	MDSWS14: Social workers shall understand research planning, methodology, evidence-based outcomes, and program evaluation
Training/ supervision	Competencies including the baseline skills necessary to train or supervise other behavioral health providers	HP2-30: Understand the role and responsibilities of an effective mentor, and have the ability to promote the development of research and teaching competencies in graduate and undergraduate students
Values	Competencies that are representative of foundational values held by the competency developers and stakeholders	HPCoAP5: Interact with fellow health care professionals in ways that facilitates improved treatment implementation based on the unique contributions that clinical health psychology can make
Values/ethics	Competencies that include values of the competency developers, ethical guidelines, theory, or epistemologies	MedFT 8: Demonstrate awareness of and sensitivity to cultural and contextual variables pertaining to health, illness, loss, and trauma
Interprofessional roles	Competencies that include definitions of provider roles or guidelines for inter- and intra-disciplinary teamwork	MedFT 9: Recognize the various disciplines involved with medical care and their role in the healthcare environment
Interprofessional communication	Competencies that include communication between providers, educators, or supervisors	MedFT 10: Facilitate communication between patients, families, and health care providers and invite coordination of services

Codes

Field	Domain	Subdomain
HP1 = Health psychology	Co = Consultation	Ap = Applied
HP2 = Division 38 health psychology research competencies	S = Supervision/training	
MedFT = Medical family therapy	M = Management/administration	
MDSW = Medical social work	S01–S20 = MDSW standards (Decimals have been used to separate MDSW Standards from specific skills listed)	

conducted by Bischoff, only the primary categories and subcategories of the collaborative care practice skills were used (i.e., Skills for working in a medical setting, Skills for working with patients, Skills for collaborating with medical providers). All competencies were taken from the original sources and put into a Microsoft Excel (2010) spreadsheet. Eight duplicate competencies between the two HP lists were identified and listed only once. The final number of competencies to be coded was 219.

In the third step, an initial coding schema was created from the lexicon used by the Interprofessional Education Collaborative Expert Panel (IPEC 2011). IPEC developed globally recognized domain titles, such as: values, interprofessional roles, interprofessional communication. However, the primary author realized that the IPEC codes alone did not capture all of the competencies from the variety of disciplines. Thus, the researcher used the lexicon from IPEC and similar or the exact same terms used in the

competency documents from MedFT, HP, and MDSW texts to create the domains and subdomains. In this stage, a total of 42 possible codes were created.

As coding began on the fourth step, a decision was made to include a second coder (who had equivalent training in research and MedFT to the primary author) to reduce the likelihood for researcher bias and increase credibility of the results. The coders reviewed the competencies and assigned codes to capture the essence of the extant competencies. It became immediately apparent that 42 codes or possible domains were too many. To reduce overlap, multiple codes were assigned to competencies that shared commonalities (e.g., administrative and executive would be assigned to the same competency).

The second half of the fourth step involved reorganizing the coded data and identifying the codes used most frequently. In order to achieve a parsimonious coding schema, three domains were chosen: direct patient care, indirect patient care, and values (see Table 1 for definitions). The domain names were chosen to represent the similarities between the subdomains (e.g., interventions and assessment both directly influence patient care). Each domain had multiple subdomains. The domain titles were chosen to simplify the layout of the coding schema and to capture as many subdomains as possible. Similar subdomains were grouped to reduce the number (e.g., supervision and training). The result was three direct patient care, four indirect patient care, and three values subdomains (see Table 2) along with definitions for each subdomain.

The new coding schema was used to apply codes in step five. See Table 1 for the coding schema, conceptual definitions, and examples of competencies by domain and subdomain. The two coders began this step by reviewing the name and definition for each domain and subdomain together to ensure that there was consistency in their understanding of each term and the framework before assigning codes. Then, each coder was independently provided with an Excel worksheet that included the names of all domains and subdomains. The coders independently assigned domain and subdomain codes to each of the competencies. Competencies were assigned multiple codes if the competency fit into multiple domains and subdomains. Upon completion, the coders achieved consensus via one of three routes: (a) both researchers agreed on the decision and moved on, (b) the primary researcher accepted the other coder's take on the competency and added that subdomain to the list, or (c) the researchers disagreed on the coding and then went back to discuss their perspective by reviewing the definitions as outlined in Table 1. The coders had an initial agreement rate [agreed upon codes/total codes as described in (a) above] of 71.89 and 70.05 % for domain and subdomain codes, respectively on all codes from all competency lists with the exception of the Bischoff categories and subcategories which were reviewed at a later date and with 100 % consensus between two researchers who were part of the original research process. The discussion surrounding differences in coding were addressed by revisiting the definitions of each subdomain and by recognizing that codes may fit in more than one domain. In these instances, the primary and secondary coder discussed their reviews; by which the primary author agreed that the secondary's code was a more accurate representation of the domain or subdomain, or in the few instances when there was greater difficulty in assigning a code a more intensive conversation was needed to reach a decision. Full agreement was reached on all of the decisions after researchers had the opportunity to re-review the domains, subdomains, or codes in context. A third researcher then reviewed all of the analyses (with the coders) to ensure that the codes were assigned as accurately as possible. Results on Steps 6 and 7 are reported in the following findings section.

Table 2 Number and percent of competencies by domain and subdomain

Domain	N	Percent	Subdomain	N	Percent
Direct Patient Care	75	34.25	Assessment	27	12.33
			Intervention	27	12.33
			Consultation/Case Management	22	10.05
Indirect Patient Care	101	46.12	Administrative	19	8.68
			Education/Knowledge Base	41	18.72
			Research/Evaluation	36	16.44
			Training/Supervision	9	4.11
Values	69	31.51	Values/Ethics	38	17.35
			Interprofessional Roles	24	10.96
			Interprofessional Communication	14	6.39
Totals	245	111.88*		257	117.36*

* Multiple competencies were assigned more than one code which resulted in totals > 100 %

Findings

For step six of the content analysis, the results are reported in Tables 2 and 3. The numbers and percentages (of total codes) of competencies fitting in each domain and subdomain are reported in Table 2. Since competencies

Table 3 Competency distribution

Direct patient care

	Assessment	Intervention	Case management/consultation
HP1	AsK1–3; AsAp1–9; IK1	IK1–2; IAp1–6	CoK2; CoAp1–3, 6
HP2			
MedFT	22	2, 3–4, 6–7	25
CCP		2.3	
MDSW	S06.0–S06.11	S07.0–S07.11, S10, S11.6	S08.0–S08.13, S20.1, S20.9

Indirect patient care

	Administrative	Education/knowledge base	Research/evaluation	Training/supervision
HP1	SK4; SAp2; MK1, 4; MAp1–2	AsAp9; IK1–2; CoK1; RK1–4; SK1, SAp3; MK1	IAp3–4; CoAp3; RK5; RAp1–5; MK3, MAp2	SAp5–9
HP2		1–7, 27–28	10–11, 13–19, 21–26	29–30
MedFT		13–18, 23	21	
CCP		2.1, 2.2		
MDSW	S13.0–S13.10, S20.1, S20.10	S05.1–S05.11, S18, S20.6	S05.10, S14, S15.0–S15.7, S20.3, S20.5	S19, S20.3

Values

	Values/ethics	Interprofessional roles	Interprofessional communication
HP1	AsAp7; RK5; SAp1, 7, 9	IK1; CoK1; CoAp6; RK4; RAp6; SK1–3; SAp4; MK2; MAp3–4	IK1; CoAp2, 4–6; RK4; MAp4
HP2			
MedFT	1, 5, 8, 12, 14–16, 20, 24	9, 19, 26	10–11
CCP	1.1–1.4	3.3	3.1, 3.2
MDSW	S01–S05; S05.6–S05.9, S05.11; S09, S11.1, S12, S16–17, S20.0, S20.4, S20.7, S20.8	S05.1, S11.0–S11.2, S11.4–S11.5, S11.8, S20.2	S01, S11.0, S11.3, S11.7

Codes

Field	Domain	Subdomain
HP1 = Health psychology	As = Assessment	K = Knowledge
HP2 = Division 38 health psychology research competencies	I = Intervention	Ap = Applied
MedFT = Medical family therapy	Co = Consultation	
CCP = Collab. care practice	R = Research	
MDSW = Medical social work	S = Supervision/training	
	M = Management/administration	
	S01–S20 = MDSW Standards (Decimals have been used to separate MDSW (Standards from specific skills listed)	

(n = 219) were assigned one or more codes, the total number of domain (n = 3) and subdomain (n = 10) codes was 245 and 257, respectively (therefore, 26 competencies were assigned into more than one domain and 38 were assigned into more than one subdomain). The number of competencies per domain was: 75 for direct patient care, 101 for indirect patient care, and 69 for values. The education/knowledge base, research/evaluation, and values/ethics subdomains had the greatest number of competencies and fewer competencies were represented in training/supervision.

While Table 2 showcases the culmination of where competencies align via a more global perspective, Table 3 includes a coded guide for the competencies by domain and subdomain per each field/specialty's competencies (e.g., As = Assessment and I = Intervention). Thus, this table reflects the rigor and alignment of specific competencies from each of the independent documents as they map across

the three domains. For the sake of readability, individual codes were devised for each set of competencies using the domain and subdomains from HP1 (i.e., Masters et al. 2009), the number from HP2 (i.e., APA Division 38, 2012), the competency number from MedFT (i.e., Tyndall et al. 2012) a collaborative care practice category and subcategory number from Bischoff et al. (2012) (i.e., CCP1.1–CCP3.3), and the standard number from MDSW (decimals were added to denote the bulleted items within a standard; i.e., NASW 2005). While readers are able to go back and view the wording of specific competencies that are embedded in this table from the cited independent documents, the purpose of Table 3 is really to punctuate the prevalence of competencies in each of these domains. Through this table, it is clearer to see where the competencies are concentrated and to also see where gaps exist in each domain for each field/specialty. In this Table, the number of competencies within each domain/subdomain is not as relevant as recognizing where competencies have clustered or been identified. Through Table 3, professionals can look at competencies both within their field and in comparison to "like fields." As such, an observer can determine (a) where an expertise or concentration lies in each of the domains and subdomains within and across fields, and (b) whether revision is needed within a field to better capture expertise in other domains or subdomains (e.g., MedFTs may notice that competencies are well represented in "education/knowledge base" but relatively absent in "administration," "research," and "training/supervision," even though many MedFTs would likely agree that competencies are necessary in each of these areas. This Table was not created to encourage a "we do that, too" attitude, but rather to ensure that these fields/specialties are accountable to what students or professionals should receive in their training in order to gain or work toward competency.

Through the use of Table 3 and in accordance with the analyses needed at step seven (Bernard and Ryan 2010), the results from the content analysis were reviewed in relation to the research question (i.e., What competencies are most represented and underrepresented for MedFTs in relation to the competencies of like fields/specializations?). Based on the analysis at this step, it became apparent that there are multiple skills that MedFTs possess. For example, MedFTs had a stronger representation of competencies in intervention, their knowledge base that indirectly influences patient care (e.g., education in clinical, operational, and financial elements of the healthcare system, and key historical and theoretical underpinnings of MedFT), values and ethics, interprofessional roles, and interprofessional communication than in other subdomains. For MedFT, more competencies sorted into the values/ethics subdomain than any other subdomain.

There were also cases where MedFT competencies were underrepresented. For example, MedFT competencies were not as prevalent in areas of assessment, care management or continuity of care, even though MedFTs at all levels of proficiency are trained in how to assess and manage continuity in patient care from an initial intake onward through levels of collaboration (Doherty et al. 1996; Hodgson et al. 2014). Furthermore, while there are courses that promote administration, training, and supervision in MedFT (e.g., ECU), competencies pertaining to these areas were not represented in the initial MedFT competencies. Additionally, there was only one competency that was coded into the research/evaluation subdomain, yet a significant amount of research has been published in the past 10 years by MedFTs. In fact, 57 authors came together to publish on MedFT training, administration, and research in 2014 (Hodgson et al. 2014).

Discussion

Various methods have been used to identify competencies across these three fields/specializations. In terms of process, three observations may be made in consideration of the guidelines proposed by Marrelli et al. (2005). (1) Representatives of these fields have been able to define their goals, obtain support, plan (typically at a summit), identify competencies, and create and apply a model. (2) Competency developers from all fields would benefit by using more systematic methodologies or by providing more detailed descriptions of the methodologies already used (i.e., levels of proficiency). (3) The competency development processes for MedFT and MDSW have yet to include evaluation and revision of the competency models, although an invitation to experts in MedFT was extended in 2013 such that a review could take place in 2014 (L. Tyndall, personal communication, March 6, 2013).

The need for updating and re-examining the competencies in fields of specialization was highlighted in a recent poll of professional psychologists, who estimated the "half-life" of professional knowledge (Neimeyer et al. 2012). In a Delphi poll of practitioners in the specialties and proficiencies of Clinical Health Psychology, respondents predicted an increasing profusion of knowledge, as well as rapid obsolescence.[2] Neimeyer et al. (2012) thereby urged attention toward identifying and documenting ongoing professional competencies.

In reviewing the initial research question, several themes emerged during this content analysis. First, a number of MedFT competencies are omitted or underrepresented from the currently published competencies. Second, the MedFT competencies identified by Tyndall et al.

[2] "Discrepancy between job needs and professional capabilities as a result of change, innovation, or knowledge growth within a field" (Neimeyer et al. 2012, p. 365).

(2012) and Bischoff et al. (2012) should be considered "essential" for developing and existing MedFT programs, due to the use of MedFT experts as participants and a research based approach to competency identification. Third, an organizational schema would help a reader to identify growth areas as the MedFT competencies continue to evolve.

The areas where further attention is needed in the current MedFT competencies are clear. Based on this examination, there are seven subdomains that appear to be underrepresented in the MedFT competencies. These seven subdomains are: (a) assessment and diagnosis, (b) case management/consultation, (c) completing administrative duties, (d) conducting research studies and program evaluations, (e) training, (f) supervising, and (g) communicating with other professionals. The organizational schema was useful in making more apparent the need for punctuating the skill set for MedFTs.

Some of the gaps in MedFT competencies were filled once the third level of Bischoff et al. (2012) analysis (i.e., those embedded in the sub-categories) was taken into consideration. At that level, skill sets became more specific and included two skills that were more reflective of assessment and diagnosis [e.g., Assess and diagnose mental disorders using the current DSM and ICD (p. 203)], and several appeared to be related to case management/consultation [e.g., "Actively collaborate with health care providers as a member of the care team" (p. 204)]. In addition, several skills pertained to communicating with other professionals [e.g., "Communicate with medical providers in an efficient and clear manner" (p. 204)]. However, skills pertaining to administrative duties, conducting research studies and program evaluations, training, and supervising were still underrepresented. Those who participate on panels that identify competencies may have been especially focused on competencies that are required for professional practice, and less on those required for teaching, research, and administration. In a commentary on two initiatives identifying competencies for the practice of professional psychology, Schaeffer et al. (2013) noted that articulation of competencies by those who educate and train professionals may differ from those emphasized by licensing boards who are charged with protecting the public.

To the second observation noted above, it is important to determine whether competencies should be aligned with a level of proficiency (e.g., master's vs. post-graduate or doctoral levels). As the identification of competencies continues, the following questions should be considered: What requisite skills do educators expect trainees to exhibit at a Master's level? After completing a post degree certificate program? At a doctoral level? Or, at a post-doctoral level? For example, the skills that one would expect to gain in a doctoral program might include proficiency in conducting research, teaching, and supervising, among others. At this point, only one competency included in the current list of MedFT competencies (Tyndall et al. 2012) is designated as a doctoral level competency. The list of collaborative practice skills identified by Bischoff et al. (2012) did not distinguish between levels of proficiency. Schaeffer et al. (2013) advocated for competency assessment procedures at the academic, practicum, internship, postdoctoral, and licensure levels. They recommended that educators and regulators agree upon core competencies in order to establish "a consistent and seamless means of assessing competency from training through licensure" (p. 97). Perhaps future editions of the MedFT competencies can include a column for levels of proficiency.

A final thought on the issue of proficiency: MedFTs do not do everything that HPs and MDSWs do, nor should they. MedFTs should exhibit at least baseline proficiency as ethical diagnosticians, researchers, clinicians, and collaborators with diverse populations toward enhanced biopsychosocial-spiritual health through a relational and/or systemic lens. Future research on actual MedFT behavior in collaborative/integrated care practice, research, or training settings can also identify which competencies are regularly exhibited by MedFTs and which clearly distinguish them from other "like" professionals.

Finally, in relation to the review of MedFT competencies for the future, it will be important to keep the following in mind:

- Prioritize the family. MedFTs are distinct from other professions for multiple reasons, the first of which is the family focus (cf. Doherty et al. 1994).
- Say more about administrative capabilities, research (e.g., Bischoff et al. 2011), program evaluation, policy, training, and supervision (e.g., Edwards and Patterson 2006).
- Explore the role of collaboration and communication between and within disciplines to ensure that competencies are consistent with skills described in past MedFT literature (e.g., Marlowe 2012; Seaburn et al. 1996) as well as with current trends in healthcare practice, policy, and financial reimbursement.
- Capture skills necessary for treatment across the lifespan. MedFTs treat families with infants, as well as dying family members. The skills required to meet patients in the family life cycle differ based on practice setting and presenting problem and must also be reflected through MedFT research, training, and policy.
- Identify competencies pertaining to cultural awareness and humility that are unique to MedFT beyond what MFTs would need in practice, training, and research.

The organizational schema used in the content analysis was useful for the purpose of identifying the areas where

MedFT capabilities are underrepresented. The schema can be used to target topic areas for the next step of MedFT competency development. Additionally, an organizational schema will be useful as MedFT competencies evolve.

Strengths and Limitations

In terms of methodology, the content analysis was useful given the research question, textual data, and need for organization of current MedFT competencies. As in most qualitative studies, the coding process was subjective and may vary if completed by other coders. The use of a second coder, however, adds credibility to this methodology. This review of the pertinent competency-focused literature is an essential step in developing competencies, though not an end-all (Marrelli et al. 2005).

Throughout the coding process, it became apparent that language was important. The primary reason competencies were assigned more than one code was the language used to describe the competency. While the competency developers may not have had the goal of creating competencies with only one facet, some of the competencies were lengthy, multifaceted, and unclear. This may be a point of interest as MedFT competencies evolve.

Conclusion

It will be important for MedFTs to continue to identify what makes them unique and accurately represent that in their competencies. The areas of growth identified in this article are the inclusion of the family, clearer direct and indirect patient care competencies, punctuating the relational lens from which MedFTs work, and the prioritizing of collaboration and interprofessional communication through a systematic process (e.g., Delphi method, survey research, focus groups, or observation studies). Now that areas of further growth have been identified the organizational schema can be used to structure qualitative surveys of practicing MedFTs and those they collaborate with, whereby gaps in cataloging the MedFT competencies will hopefully be closed.

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