Medical Family Therapy in a Primary Care Setting: A Framework for Integration

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Abstract As the profession of marriage and family therapy (MFT), as well as the emerging sub-specialty of medical family therapy (MedFT), continue to grow and evolve within the current healthcare system, the arena of integrated primary care (IPC) presents an ideal environment for professionals who are relationally and systemically inclined. Although there has been an inundation of literature detailing collaborative systems of healthcare, several gaps still exist: (a) a lack of horizontally integrated models (i.e., models that do not target specific diseases or demographic populations), (b) a lack of model utilization regardless of disease trajectory (i.e., decline, stabilization, improvement), and (c) a lack of IPC models explicitly utilizing MedFT/MFTs as the mental health providers within the system. In lieu of these gaps, the authors present a framework for IPC, utilizing MedFTs/MFTs, that is neither population nor disease specific, as well as a model geared towards implementation regardless of disease trajectory. The framework, which was obtained using ethnography of communication, details MedFTs' interactions with front line medical providers and patients from initial contact through coordination of a shared treatment plan. Recommendations for future research studies incorporating the use of MedFTs in integrated primary care settings are extended in the context of a three world view framework (Peek in Collaborative medicine case studies: Evidence in practice. Springer, New York, pp 25–38, 2008; Peek and Heinrich in Family Syst Med 13:327–342, 1995, Integrated primary care: the future of medical and mental health collaboration. Norton, New York, pp 167–202, 1998).

Keywords Medical family therapy · Integrated care · Collaborative care · Primary care · Behavioral health · Systems consultation

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Introduction

The venue of primary care has been described 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*” (Institute of Medicine 1996, p. 31) [emphasis not added]. This definition alludes to the fact that these front line providers (primary care physicians and extenders), deal primarily with patients who present with co-morbid, and often times complex, psychosocial and biological complaints (Blount and Bayona 1994; Ostbye et al. 2005; Robinson and Reiter 2007). Due to this complexity, and the fact that many consider primary care the de facto mental health system (IOM 1996), these providers 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 their concurrent psychosocial ones as well (Adler et al. 2009; O'Connor et al. 1998; Strosahl 1996).

Role exhaustion, according to Bodenheimer (2006), has developed for primary care providers (PCPs) since many “... are expressing frustration that the knowledge and skills they are expected to master exceed the limits of human capability” (p. 3). The answer to this frustration for many physicians (e.g., Baird 1998), as well as for behavioral healthcare providers (BHP) (e.g., McDaniel et al. 1992; McDaniel 1995; Miller et al. 2009; Strosahl 2001), has been to merge mental and biological health care plans into a holistic approach to patient treatment termed integrated care (IC) (Blount 2003; McDaniel 1995; Peek 2003). In this context, physicians are able to address the biological symptoms patients present with, while mental healthcare providers (in this context called behavioral health providers: BHPs) work alongside the physician to address concurrent psychosocial issues impacting disease management.

Integrated Care

While a comprehensive discussion regarding the terminology of integrated care is beyond the scope of this article, a brief discussion of the terms related to IC practice and model development is not only relevant, but necessary. Particularly noteworthy is Peek's (2011) attempt to develop a common language for this type of care (i.e., a lexicon), which distills mental health/healthcare collaboration into nine areas of practice: (a) team composition, (b) level of collaboration/integration, (c) target population, (d) method of population identification, (e) program scale or maturity, (f) level of pt. centeredness/engagement, (g) level of office practice design and reliability, (h) business model/financing, and (i) ability to collect and use practice data. Of particular relevance to the discussion here are parameters *b* (level of collaboration) and *c* (target population). Peek and colleagues contended earlier in the literature though that innovators must also pay careful attention to the clinical, operational, and financial dimensions that drive healthcare and ultimately determine viability of integrated care models (Peek 2008; Peek and Heinrich 1995, 1998). It is also important to mention that while the term IC refers to how mental and medical health providers collaborate generally, integrated primary care (IPC) refers to this process in primary care specifically.

Level of Collaboration or Integration

This parameter by Peek (2011) is a combination of source works that not only define how mental health and medical providers work together (Blount 2003), but also how closely

intertwined their organizational cultures/professional relationships are (Doherty et al. 1996). Blount originally defined these relationships between mental health and medical services as coordinated, co-located, or integrated, which involved the location and amount of interaction/communication between medical and mental health providers, as well as the degree of synthesis regarding patient treatment plans. The synthesis of these works by Peek presents coordinated relationships as denoted by separate locations, little to no communication between providers, and completely separate treatment plans for patients; co-located relationships as placing providers in the same location, ensuring more frequent communication, more frequent cross-referral of patients, and some shared organizational culture; and finally, an integrated relationship as housing both providers in the same location, frequent in-person communication about patients, shared treatment plans, and a cohesive organizational culture.

Target Population

Many models described in contemporary literature are designed to treat particular *targeted populations* (Blount 2003; Peek 2011), which are patients referred by the primary care physician to the mental health professional for a specific mental health or behavioral issue (e.g., Peek 2011; Strosahl 1996, 2001) (i.e., vertical integration). In each of the studies referenced below, the IC model was used to address 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 et al. 2007), diabetes (Meulepas et al. 2007; Phelps et al. 2009), genetic disease (Rolland and Williams 2005; Smith and Harkness 2003), infertility (Burns 1999), or was used to target specific populations such as Latinos (Manoleas 2008; Willerton et al. 2008), the elderly (Hegel et al. 2002), rural populations (Judd et al. 2004), and children (Pratt et al. 2009; Valleley et al. 2007). In these systems of care, the BHP's expertise is not solely in the treatment of psychological distress, but in the adherence to and improved completion of treatment regimens.

What all these models have in common is that they do not specifically address the continuum of diverse patient populations, diagnoses, and issues that are experienced by providers working in a primary care environment (Peek et al. 2009; Peek 2011; Robinson and Reiter 2007; Robinson and Strosahl 2009) (i.e., horizontal integration). Keeping this gap in mind then, the purpose of this study was twofold: (a) to describe a horizontally integrated care framework for BHP PCP collaboration, and (b) to describe a system of care utilizing MedFTs/MFTs as the BHPs within that horizontal framework.

Methods

The creation of the framework was achieved 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 2003, pp. 6–7). This type of description yields information not only regarding communicational patterns within certain groups (i.e., patterns that include 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 purpose of this methodology is 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). This framework subsequently provides an understanding of the various components of interaction between individuals that are required for a group to function as a coherent, autonomous unit. The descriptive adequacy of this framework is such that someone not acquainted with the group under investigation would be able 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) engaged 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 new 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 his/her 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). 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 provided IPC and utilized MedFT/MFT master’s and doctoral students, served as the site for the study. The clinic itself was a community health center owned by a single private corporation, which owned three similar clinics in a rural southeast region of the United States.

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 from a local, research university served as the site 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 3-year 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 6 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 MedFTs/MFTs 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 were as follows: (a) board certified medical practitioner, (b) current collaboration with BHPs at the site, and (c) willingness to refer patients to BHPs and see patients with BHPs. The inclusion criteria for the BHPs were as follows: (a) practicing MFT/MedFT intern, and (b) current collaboration with the medical providers at the site. The medical providers' experience at the site ranged from 1 to 3 years, while both BHPs had been practicing at the site for almost 1 year. None of the providers (either medical or behavioral health) were excluded from the study based on inclusion criteria.

Data Collection

Once all informed consents were obtained from front-line clinical staff (i.e., nurses, medical assistants, physicians, BHPs), the investigator observed collaborative interactions between the BHPs and medical team for a total of 2 weeks (20 h total). The first week was devoted to acclimating to the medical site as well as acclimating the provider participants to the study process; 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 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 BHP, physician, direct care staff, and patient. The 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 (2003), which are: *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 categorical arrangement of the data provided by the methodology (i.e., the above categories) (Saville-Troike 2003), a framework resembling an action tree outlining the BHPs engagement with both patients and medical staff emerged. Represented in this interactional tree are the conditions required for particular action sequences that take place within a 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). The framework was then sent to one of the BHPs who read it for accuracy and verification of the results, with her comments and changes incorporated into the final draft.

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 and Guba 1985). Lincoln and Guba (1985) 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 framework (Lincoln and Guba 1985).

Results

The elements that composed the framework are (a) function/purpose: the purpose of the visit, (b) participants: who attended the visit, (c) act sequence: what actions took 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). The following description 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 (i.e., 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 were primarily understood in context of the patient's degree/length/kind of relationship with the center and his/her presenting medical concern. As the first state would imply, these were first time patients to the center who initially knew little if anything about IC, as well as the BHP's role as a member of the healthcare team. Therefore, the initial interaction was not necessarily as contingent on the patient's chief complaint, but focused on joining (i.e., building rapport), educating/acclimating the patient to the IC model used by the healthcare team, and obtaining an initial psychosocial assessment.

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

Interactional Phases

Couched within these varying patient states, the BHP's actual engagement with the patient was further distilled into five phases with the specifics of 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 served as the means by which the BHP gathered 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 was usually obtained from the patient's medical

sheet, which was placed in a holder on the exam room door. Besides the reason for the visit, the sheet also contained a detailed medication list and various biomarker information as well (e.g., blood pressure, blood glucose levels, oxygenation of blood), which, for more experienced BHPs, served as a way of ascertaining what medical/mental health conditions the patient may be undergoing current treatment for, along with how well the patient was or was not managing said conditions. This particular phase was a constant, regardless of whether or not the patient was new since it set the stage for the rest of the BHP/medical provider/patient encounter.

Phase Two: Introduction

The second phase in the act sequence marked the beginning of direct patient contact, and served as a focal point to orienting the patient to the integrated aspects of service. This phase primarily only took place with new patients, but its inclusion was ultimately determined by whether or not the patient had interactions with the BHP in the past (i.e., phase one took place with returning patients who have not yet met the BHP). The BHP typically entered the room and introduced him or herself by name prior to his/her professional role. A standard introduction was relayed to the patient that incorporated 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 was not involved because the medical provider and/or staff believed there was emergent and/or underlying psychopathology or that there was bad news to report. The aggregate aspects of the introduction served to orient and relax the patient to the BHP's inclusion in his/her care, as well as built the stage for future interaction..

Phase Three: Elicitation of the Illness Story

This phase typically began with the BHP inquiring as to the reason for the medical visit, and if the patient was new to the center, primarily revolved 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 differed from the medical provider's clinical interview in that information about psychosocial experiences in relation to the medical issue were considered central to the patient's conceptualization and understanding. This centrality was demonstrated by the BHP's tying in of biological and medical information back into the stated psychosocial issues. It is also worth mentioning that it was during this phase that the majority of psychosocial assessment took 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 also assessed for other medical/psychosocial aspects of functioning as well (e.g., medication/treatment compliance, medication side-effects, appetite, sleeping habits).

If the appointment was for a retuning visit, one where the patient's condition had worsened, this phase primarily revolved around discovering and dealing with any accompanying anger/frustration the patient may have had, as well as attempting to ascertain where and to whom that anger and/or frustration was directed. As stated earlier, these kinds of visits presented the greatest possibility for acrimony between patient and medical provider/staff/BHP, and the assessment portion of this phase was oriented toward exploring and addressing this tension if it indeed existed. Also, as a patient's condition worsened, other mental health issues might have developed and/or become exacerbated

(e.g., a patient whose congestive heart failure continued to worsen became depressed), which the BHP assessed for as well. During this phase, the BHP validated the patient's anger and/or frustration, not with the intent of amplifying or agreeing with them, but, especially if that anger was directed towards the medical staff, with the intent of letting the patient know his/her concerns were being taken seriously.

During a return visit where a patient's condition was improving, this phase served the function of discovering what actions the patient had taken to help facilitate the recovery process, as well as reified the teamwork between themselves and the medical provider/team. The BHP also discussed any difficulties the patient encountered during his/her 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 his/her 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 BHP once they initiated conversation with the patient; however, four general typologies of intervention were identified.

The first type of intervention, brief problem solving/supportive therapy, involved joining patients where they were emotionally regarding their psychosocial stressors, as well as exploring concrete ways they might 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 also included 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*, had to do with issues and/or concerns the patient relayed during phase three (Elicitation of the Illness Story), which the BHP then encouraged the patient to discuss during his/her medical visit, as well as how to discuss those issues with the provider (e.g., a patient complains of numbness in his/her 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) was another typology of intervention incorporated into the visit by the BHP as well. The final type of intervention involved referring the patient for additional services (i.e., on site or in the community based on patient's expressed needs and readiness). This included applying for Medicaid, dental services, substance abuse treatment, traditional psychotherapy, etc. The referral was either internal or external based on the need of the patient and/or the services offered by the clinic; patients who required long term psychotherapy were referred internally to the BHP if the provider had availability, or were referred out if their needs (e.g., night appointments) were better met in the community.

Phase Five: Relaying Information

The final identified phase began with the BHP ending his/her 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 included 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 asked if the patient would like them to return once the medical provider entered and the patient's medical visit began. This was offered regardless of patient state, but was primarily relegated to times when anger/frustration, sadness, and/or suicidality existed.

Once the BHP ended the session and left the room, two modes of information relay became possible: (a) the BHP sought out the provider and verbally relayed any pertinent information, or (b) the BHP attached pertinent information to the patient information sheet. The modality of relay was dictated by the availability of the provider (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 superseded availability, in that information regarding suicide (active or passive), planned violence against staff, and/or any type of abuse (e.g., physical, emotional, substance) was communicated directly to the medical provider regardless of his/her physical availability at the time. During verbal relay to the medical provider, only psychosocial information pertinent to the presenting medical issue was included in the patient summary (e.g., a diabetic patient is struggling with dietary changes due to his/her family's eating habits). This was not the case with emergent mental health issues (i.e., suicidality and or homicidality), which were presented *as is*. These consultations between BHP and medical provider lasted anywhere from 30 s to 2 min, and were primarily dictated by the importance/biopsychosocial complexity of the information and the availability of the medical provider.

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

Conjoint Sessions

During conjoint sessions the BHP typically assumed a more observational role for the encounter, and the medical provider took the lead during the clinical interview process. This was not always the case however, and depended primarily on the rapport between the BHP and provider, as well as the patient's presenting concern. The BHP took on a more active role during the conjoint clinical interview if (a) the BHP and provider had a good working rapport and predominantly saw patients together, and/or (b) the presenting medical concern was 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 stood while the medical provider took the seat closest to the patient on the rolling stool. This positioning was 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 had no prior contact with the patient, the introduction of the BHP and the accompanying professional description was typically done by the medical provider, although the BHP expanded upon and/or clarified any portion of the

introduction. However, during conjoint sessions that began as solo interviews, (i.e., a solo session where the medical provider entered the room during the BHP's BPS assessment) while the BHP acquiesced to the provider once he/she entered the room, the BHP adopted a more active role through the relay of pertinent information gained during his/her biopsy-chosocial assessment as the provider performed his/her clinical interview. Phase five, relaying of information, did not typically take place during conjoint sessions, although both BHP and medical provider might confer outside the room in order to discuss a shared treatment plan or otherwise coordinate care.

Conclusion

Although MedFTs' utility has been outlined in multiple venues with specific disease states and populations (Anderson et al. 2008; Davey et al. 2009; McDaniel et al. 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 with a non-targeted population, up until now, has been described in contemporary literature. It is worth mentioning that the unique and substantive contributions of this study are threefold; (a) an outline of how the provision of horizontally IPC services might look (Peek et al. 2009; Peek 2011), (b) a description of how a MedFT might specifically function in providing those services, and (c) while other researchers 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 and Strosahl 2009; Robinson and 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.

Unique Contributions by MedFTs

The foundational orientation of family therapy, and subsequently medical family therapy, is the importance and centrality of relationships/systems in all aspects of a person's experience (Doherty et al. 1994; Linville et al. 2007; Tyndall et al. 2010). It is this relational lens that is unique to systemic thinking, and is the defining feature of a MedFT practicing as a BHP in an IPC setting as opposed to another mental health profession. This relational focus manifested for MedFTs in two main ways: (a) how they discussed problems/solutions, and (b) how they managed patient/provider relationships.

In terms of discussing problems and subsequent solutions, what was observed in this study was that the MedFTs maintained a relational focus, whether that focus was on patient/family/social supports or the patient/provider relationship itself. What this meant is that a patient's *non-compliance* was discussed not only as internal motivation, but was broadened to include how family/friends or even the PCP might help or hinder the patient in achieving his/her intended goals (e.g., how a diabetic patient's spouse might help with taking insulin regularly). This expansion was seen even when the patient's condition was improved, which allowed for the MedFT to punctuate and amplify how the patient himself/herself achieved success, as well as discussion of relationships that were particularly useful for the patient in this respect. This strength-based perspective, while not necessarily unique to MedFT, is unique in that the MedFTs framed those strengths in the context of both the patients' and their relationships. Perhaps the most unique contribution of the MedFT was observed in times where disagreement manifested between patient and provider. In these instances the MedFT, much like their MFT counterparts with couples, positioned

themselves in a way as to not side with either party. Instead, the MedFT took a position of equifinality when re-framing disagreements, where patient and provider were attempting to achieve the same result through different means.

Recommendations for MedFTs

Even though conducting psychotherapy in IPC settings in particular, must be brief and outcome/functionality focused (Strosahl 2005), the systemic/relational foundations of family therapy should remain evident in the way the MedFT functions in an IPC setting. Family therapy has traditionally been brief, outcome oriented, and strength based due to its relational focus and attention to context—not in spite of it. With that being said, although many other intra- individually oriented psychotherapeutic models are more widely studied in the arena of primary care (e.g., Acceptance and Commitment Therapy, Motivational Interviewing, mindfulness, CBT), we recommend that the techniques stemming from these models be augmented by the relational lens of the MedFT in ways previously discussed. Also, postmodern (e.g., solution focused, narrative) and cybernetic (e.g., solution oriented, strategic, ericksonian) informed modalities of therapy (and their constituent techniques) are uniquely suited for IPC work, as they mirror closely many of the aforementioned IPC behavioral health modalities while still maintaining a relational focus.

Limitations

This study has several limitations that must be acknowledged. First and foremost, the investigator functioned as a BHP at the site under investigation, and helped train the MedFTs/MFTs 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.

Building on the first limitation, the PI was placed in the position of knowing that certain events transpired regarding how the BHPs operated within the medical system, but was unable to report on these instances since he did not specifically observe these interactions during the observation period. These specific issues revolved around the BHPs' interaction with nurses in terms of receiving patient briefings during phase one, as well as how visits looked similar or different if a patient's family member/s were 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. Finally, 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, the interactional sequences between BHPs who are MedFTs and primary care providers who are engaged in an IPC model.

Future Research

As stated previously, this study presents only one piece of the entire BHP role in providing IPC 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 integration looks at all levels of the care delivery system (i.e., the BHP's interaction with nurses, social workers, admin staff, family members), through an aggregate of research endeavors utilizing similar methodologies in accordance with the three world view (Peek 2008; Peek and Heinrich 1995, 1998).

Once we have accurately defined, verified, and manualized the essential characteristics and practices of how a MedFT or non-MedFT BHP operates in this generalist capacity, we can then begin exploring the effectiveness and efficacy of these models against standard, non-integrated treatment modalities and measuring clinical, operational, and financial outcomes to demonstrate effectiveness at more than the patient-outcome level (Peek et al. 2009). 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, relational distress/dynamics), and/or practice related (e.g., provider burnout/compassion fatigue, workflow/time, screening protocols, staff morale/turnover) variables. These types of studies are critical for MedFTs, as well as all other mental health professions who are trying to demonstrate that they are viable and sustainable in an IPC setting.

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