

Chapter 2

Medical Family Therapy in Family Medicine



Jennifer Hodgson, Lisa Trump, Grace Wilson, and Diego Garcia-Huidobro

The practice of family medicine is dedicated to using innovative approaches to provide holistic care for patients of all ages, addressing all organ systems and diseases (Hudon et al., 2012). In fact, primary care has become the gateway to behavioral health, expanding medical care to also include screening for and treating behavioral healthcare needs (Substance Abuse and Mental Health Services Administration [SAMHSA], 2016). The task of sorting through and differentiating between biological, psychological, social, and spiritual problems can be messy and challenging, however, because they all relate to the onset and trajectory of the illness (Hodgson, Lamson, Mendenhall, & Tyndall, 2014). Addressing one area of health (e.g., physical health) without recognition or acknowledgement of other interacting forces (e.g., mental health, spirituality) will likely result in failed interventions and frustrated patients and providers (Hatala, 2012). The great need for family medicine providers who will coordinate continued care in a comprehensive manner (i.e., with interdisciplinary teams addressing different aspects of one's health) is becoming increasingly evident (Phillips et al., 2014).

Like most medical specialties, there are opportunities in family medicine to not only collaborate with providers in independent practice settings, but also during

J. Hodgson (✉)

Department of Human Development and Family Science, East Carolina University,
Greenville, NC, USA

e-mail: hodgsonj@ecu.edu

L. Trump

Stone Arch Psychology and Health Services, Minneapolis, MN, USA

G. Wilson

Great Plains Family Medicine Residency Program, Oklahoma City, OK, USA

D. Garcia-Huidobro

Department of Family Medicine and Community Health, University of Minnesota Medical School, Minneapolis, MN, USA

© Springer International Publishing AG, part of Springer Nature 2018

T. Mendenhall et al. (eds.), *Clinical Methods in Medical Family Therapy*,

Focused Issues in Family Therapy, https://doi.org/10.1007/978-3-319-68834-3_2

their residency training years. Residency settings provide collaborators, patients, and families with unique strengths and challenges that inspire important models of integrated behavioral healthcare (IBHC) to emerge. Residents have the opportunity to practice while learning innovative and empirically supported treatments and models. However, with the benefits come the challenges as patients and collaborators struggle with continuity of care concerns related to scheduling issues (e.g., residents off-site or in the hospital for rotations) and turnovers of resident physicians every 3 years. The following case vignette provides one example of someone with MedFT knowledge and skills and illustrates how they integrated into a family medicine residency clinic. It involves a family medicine resident in her final year of training, Dr. Cheryl Robbins, and a behavioral health provider trained in MedFT, Martha Lewis, working together to support a patient and family through challenges related to Alzheimer's disease.

Clinical Vignette

[Note: This vignette is a compilation of cases that represent treatment in family medicine. All patients' names and/or identifying information have been changed to maintain confidentiality.]

Mary is a 72-year-old widowed African American mother of two who is accompanied to her appointment by her oldest daughter, Tisha (age 46), and grandson, Ronnie (age 20). Her husband died 20 years ago of lung cancer, and she has been living independently ever since. Two years ago, her grandson moved in with her to help with some minor caregiver duties and household tasks. Once living with her, he noticed that on occasion, she would display signs of memory impairment such as forgetting calendar events, conversations with family members, names of people she has met multiple times, left her car running in the driveway with the door open, and even most recently left food cooking on the stove until it set-off the smoke detector. Thankfully, Ronnie was home each time and could contain these situations safely. However, he is increasingly worried about leaving Mary alone to the point of transferring colleges so he could obtain his degree online. He never complained about caring for his grandmother but recently has shared with his family that he is starting to get irritable and resentful about his quality of life.

Mary is a patient at a family medicine clinic close to her home; she has received care from several different residents over the years. She was diagnosed with mild cognitive impairment 5 years ago but refused to come see anyone after her "favorite" doctor had graduated. Her grandson believed that this was an excuse because Mary knew her memory is getting worse and did not want anyone to diagnose her with Alzheimer's disease. One event that finally alerted Ronnie's mother to the severity of the situation was when Mary looked at one daughter and insisted she was the other. She got angry when they tried to correct her and would not go to church with the one she thought

was not supposed to take her. It scared her family and they scheduled a visit with Dr. Cheryl Robbins, a third-year family medicine resident. Dr. Robbins read Mary's chart ahead of the scheduled visit. There was a phone call message from the patient's daughter indicating the family was concerned about memory loss issues and that the patient would probably not bring it up on her own. Dr. Robbins immediately sent an internal email to Martha Lewis, one of the behavioral health providers (BHP), and requested that she attend all or some of the visit to help assess for a possible cognitive impairment and family members' concerns.

Upon entering the exam room, the family was anxiously awaiting the visit. Mary was smiling and sitting on the exam table, however, quite relaxed. She agreed to all requests by Dr. Robbins and Martha, and even agreed to have a cognitive functioning screener administered, which showed that she was in the severe cognitive impairment range. The family asked Dr. Robbins outside the exam room how they will know if Mary needs a higher level of care. They felt tremendous guilt as they promised her they would care for her in her own home until her death. However, the level of caregiving she was beginning to need was exceeding Ronnie's ability and the daughters both had full-time jobs that they could not afford to quit.

Dr. Robbins and Martha scheduled a family meeting to discuss the options with Mary and her family. They held several family meetings to develop a care plan that everyone could get behind, including signs and symptoms that would tell everyone when it was time for Mary to receive more services and where. Everything was written down for Mary so when she became confused, she could read it to understand why certain safety precautions were being taken. Dr. Robbins and Martha also met with Mary and members of her family separately to help ensure that Mary's biological, social, psychological, and spiritual needs were addressed, as well as those of the involved family members as some were also managing their own health issues (e.g., depression, irritable bowel syndrome, multiple sclerosis). Dr. Robbins and Martha communicated through the electronic health record (EHR) email system where they were able to bring one another up to date on any developments. When the time came to recommend that a care facility would be more beneficial to Mary's quality of life, Mary and her family were prepared. Thankfully, even though Dr. Robbins graduated at the end of the year and Mary transitioned to another resident, Martha stayed on her team. This was comforting to Mary and helped provide good continuity of care.

What Is Family Medicine?

The initiation of family medicine as a medical specialty shares much in common with the establishment of IBHC as a service and the development of medical family therapy (MedFT) as a field. All were designed in response to a fragmented

healthcare system. Their intent was to redesign a healthcare system that at the time was responding only to the rapid advancements in science about *parts* of the person versus understanding the *whole*. In the 1960s, researchers were getting increasingly good at honing in on specific parts of the mind and body, but the translation of this research into practice left the connections between them ignored. Subsequently, reimbursement policies were developed that lacked sensitivity to how the practice of healthcare (mind and body) would impact the patient's whole health, family, community, etc. According to Taylor (2006), "The initial promise of Family Medicine was that we would rescue a fragmented health care system, put it together again, and return it to the people" (p. 184).

It has been documented that American adults prefer to access the primary care system as an entry point for addressing their mental health needs (Kessler & Stafford, 2008; Reiss-Brennan et al., 2016; Strossahl, 1994). Since the 1970s, this desire has made primary care the nation's de facto mental healthcare system (deGruy, 1996; Regier, Goldberg, & Taube, 1978; Regier et al., 1993; Strossahl, 2005). Interestingly, researchers found that up to 70% of primary care visits have a psychosocial component (Fries et al., 1993; Gatchel & Oordt, 2003), but unfortunately many mental health disorders go undiagnosed and/or untreated (Bitar, Springer, Gee, Graff, & Schydlower, 2009; Kessler, Chiu, Demler, & Walters, 2005; Kessler & Stafford, 2008; McCann & le Roux, 2006; Reiss-Brennan et al., 2016). Mental health impairments have been shown to impact one's overall functioning (especially at home and in social relationships), and even more so than common physical disorders (Druss et al., 2009). Another population in need of behavioral healthcare are patients who seek care for medical symptoms of which up to 84% have no organic cause and typically include expensive and sometimes unnecessary testing (Kroenke & Mangelsdorff, 1989). Primary care providers are recognizing these concerns; in a 2011 national survey, 63% of urban and suburban and 71% of rural physicians working in primary care claimed that inadequate access to mental health services, and patients' inability to have the cost covered, affects their patients' health negatively (Goldstein & Holmes, 2011). Due to cost, days missed from work, and/or stigma (among other factors), patients are often forced to choose one or the other service (i.e., medical or mental health), but not both. What physicians and physician extenders have available and easily accessible are their prescription pads; not all have as extensive training in mental health issues. Many also do not have behavioral health providers on-site to provide colocated or integrated behavioral healthcare. While not all mental health disorders or patients with behavioral health issues require psychotropic intervention (Kessler et al., 2005), all patients have people outside of their healthcare team who influence their healthcare decisions in positive and/or challenging ways. Therefore, it seems logical that primary care providers need behavioral health providers, like MedFTs, who are trained to focus on relational and systemic issues, deliver research-informed interventions collaboratively, and understand the medical complexities of their patients, leading to positive biopsychosocial-spiritual (BPSS) outcomes (Engel, 1977, 1980; Wright, Watson, & Bell, 1996).

McDaniel, Doherty, and Baird are pioneers in the field of integrated healthcare. All three held jobs in family medicine at the time that they wrote about their vision for a new field: medical family therapy. They wrote numerous peer-reviewed publications and well-known textbooks explaining how to apply MedFT skills in family medicine and other primary care settings, alongside common medical concerns that MedFTs would encounter (e.g., Doherty & Baird, 1983, 1987; McDaniel, Campbell, Hepworth, & Lorenz, 2005; McDaniel, Hepworth, & Doherty, 1992; McDaniel, Doherty, & Hepworth, 2014). Others would follow and continue to write about opportunities for MedFTs in family medicine (e.g., Hodgson, Fox, & Lamson, 2014; Marlowe, Hodgson, Lamson, White, & Irons, 2012; Reitz & Sudano, 2014; Tyndall, Hodgson, Lamson, White, & Knight, 2014), and in fact, family medicine is the more commonly published collaborative partnership field with the MedFT field to date.

Treatment Teams in Family Medicine

As presented in the clinical vignette, either in outpatient or inpatient family medicine settings, teamwork is the rule rather than the exception. As family medicine providers work in ambulatory and hospitalized settings, this creates great opportunities for integrated care between primary, secondary, and tertiary care. Although beneficial for patients, this is also complex. Services to be coordinated might be dispersed, collaboration across settings of care frequently require a high amount of time and personal effort, and not all providers value or understand a need for collaboration (nor know how to delegate and work as a team). To effectively do this, MedFTs require the ability to navigate multiple styles of caring for patients as well as the willingness to take an additional step to ensure patient safety and well-being. MedFTs must also balance this task with efforts to take care of themselves.

Because family medicine is a medical specialty with a broad spectrum of care, MedFTs need to be versatile in helping patients and family members that are going through a wide variety of medical conditions. In this section, we highlight key contributors to the treatment team, in addition to behavioral health providers such as MedFTs, who are relevant in family medicine.

Family medicine providers. Although family doctors are not the only medical specialists working in primary care, these physicians are commonly found in primary care clinics. Family doctors are either medical doctors (MDs) or doctors in osteopathic medicine (DOs). During their 3-year training, family medicine *interns* and *residents* have inpatient and outpatient rotations (supervised by *preceptors*), including adult and pediatric medicine and obstetrics and gynecology, making them capable to provide care for a wide range of patients. Family medicine providers could also have *fellowship training*, which includes additional years of clinical experience focused on a specific area of interest (e.g., adolescent medicine, emergency medicine, palliative care, sports medicine, geriatrics). During residency, fam-

ily doctors oftentimes receive training in family systems, so they are more likely to have a family orientation in the care that they provide. They frequently serve as the primary care provider (PCP) for patients. PCPs are the clinicians that provide preventive and medical care for patients over time. In addition, they interact with other specialists, such as behavioral health providers, gastroenterologists, and surgeons as needed. Regardless of the setting where family medicine providers work, they collaborate with a wide range of medical providers. Other primary care medical specialists are pediatricians, who serve children and adolescents, internal medicine physicians focusing in adults and elders, obstetrics and gynecology doctors who take care of high-risk pregnancies and women's health, and psychiatrics who provide care for people with behavioral health conditions.

Nurses, physician assistants, and medical assistants. These providers are close allies of family medicine providers. They are focused in helping patients and families obtain, maintain, and recover their health. Nurses have a wide range of skills and specialties foci, such as neonatal, pediatrics, adult/gerontology, women's health, psychiatry/mental health, and community/public health. According to their training and licensing, they could be registered nurses (RNs) or nurse practitioners (NPs). RNs are nurses who have graduated from a nursing program and have met the licensing requirements of the state. Their scope of practice varies according to the local legislation but usually is centered in supporting and educating patients achieving their clinical goals. NPs have completed additional training and are capable of diagnosing and treating multiple acute and medical illnesses.

Physician assistants (PAs) are licensed healthcare professionals who practice medicine independently or, most commonly, under the collaboration and supervision of physicians. Their training is shorter compared to physicians (usually 2 or 3 years of graduate education without residency or fellowship training). PAs have a wide scope of practice, which is regulated by each state, but frequently include preventive care, diagnosing and treating common health problems, interpreting laboratory exams, prescribing medications when needed, and assisting physicians during surgery. Because of their ability to provide continuity of care, nurses and PAs frequently serve as patients' PCPs.

Medical assistants (MAs) support the work of other healthcare providers. After completing their 2-year training, MAs are responsible for taking vital signs, administering immunizations, taking X-rays, and other routine clinical and administrative duties (e.g., scheduling appointments, filling medical records, etc.), under the direct supervision of other health providers.

Behavioral health providers. Behavioral health providers in primary care may include MedFTs, "traditional" family therapists, social workers, psychologists, counselors, and psychiatric nurses. All provide mental health services and collaborate with PCPs and other clinical providers to provide comprehensive and integrated patient care. MedFTs are the ideal behavioral health providers to work in family medicine settings, as they bring unique skills to the different settings of family medicine. As shown in the vignette, MedFTs have a deep understanding of the medical conditions that patients and their families are dealing with. They know about

medications' effects (including side effects) and are trained to cross disciplinary boundaries to activate and support patients, their family members, and the health-care team to work together to improve health and well-being.

Dietitians. Registered dietitians help patients in their dietary and nutritional care. They assess nutritional requirements and eating lifestyle and help patients in setting and achieving weight and nutritional goals. Most of the time, they guide and support patients dealing with overweight/obesity and other medical conditions that require changes in a patient's diet (e.g., diabetes, malnutrition).

Pharmacists. In primary care, registered pharmacists educate patients in how to use medications, alongside what side effects and interactions with other prescriptions the said medications may have with what a patient is taking. Pharmacists also help patients to mitigate and/or cope with side effects or drug interactions (e.g., adjusting timing of dosages). In deciding which medications to prescribe, on-site pharmacists often collaborate with prescribers, particularly in complex cases. Depending in their training and scope of practice, pharmacists can also support administering immunizations and certain prescriptions.

Physical therapists. These providers help patients to improve their physical condition, such as reducing pain, and to restore and/or improve mobility and functionality. Physical therapists have different specialty areas, such as cardiovascular, pediatric, geriatric, neurological, and sports physiotherapy.

Fundamentals of Care in Family Medicine

MedFTs working in family medicine must be familiar with a myriad of content, including common problems presented within this care context, populations generally seen, and tests and procedures frequently advanced. They must also attend activity to issues of patient/family diversity and health disparities.

Common Problems Addressed in Family Medicine

The Centers for Medicaid and Medicare Service (CMS, 2013) reported that the ten most common diagnostic codes in family medicine include abdominal pain, acute respiratory infections, back and neck pain, chest pain, diabetes mellitus without complications (type 2), general medical examination, headache, hypertension, pain in the joint, pain in the limb, other forms of heart disease, and urinary tract infection/cystitis. Because family medicine physicians see patients across the lifespan with a wide variety of medical conditions, a MedFT working in this setting should be aware of basic medical diagnoses, tests, and procedures to best collaborate with providers and communicate with patients. For this chapter, we will focus on the

most common problems of diabetes mellitus, hypertension, chronic pain, and preventive care.

Diabetes mellitus. Diabetes is an endocrine chronic condition that affects the body's ability to process insulin. It is one of the most common diagnoses made by family medicine providers, affecting approximately 22 million Americans (Pippitt, Li, & Gurgle, 2016). Type 1 diabetes is an autoimmune disease that usually presents during childhood, while type 2 diabetes is caused by insulin resistance and is most common in obese patients. Uncontrolled diabetes can have a number of serious complications, including blindness, kidney failure, limb amputation, and vascular and heart disease (Pippitt et al., 2016). According to Siu (2015), family medicine providers usually follow the United States Preventive Services Task Force (USPSTF) recommendation to screen all adults age 40–70 years who are overweight or obese. They also screen other patients who have risk factors such as a close relative with type 2 diabetes, women who have had gestational diabetes, or patients from a high-risk ethnicity (American Diabetes Association [ADA], 2015). Screening is done through a finger-stick hemoglobin A1C blood test; the results of this test indicate the patient's approximate blood glucose levels over the last 3 months (Pippitt et al., 2016). The typical goal of diabetes treatment is to achieve an A1C <7.0%, while a less stringent goal of <8.0% may be appropriate for individuals if achieved without adverse events (ADA, 2016).

For patients with diabetes, experts recommend a comprehensive, collaborative approach to treatment (George, Bruijn, Will, & Howard-Thompson, 2015). Pharmacological treatment of diabetes may involve oral medications to control blood sugar, such as metformin or insulin management (George et al., 2015; Petznick, 2011). These medications sometimes have poor adherence from patients. Metformin, a frequently used oral agent for treatment of diabetes, can have uncomfortable gastrointestinal side effects for patients, and insulin frequently requires complicated dosing instructions and frequent self-monitoring of blood sugar. MedFTs can be helpful utilizing a motivational interviewing approach to improve patient adherence (Rollnick, Miller, & Butler, 2008) and helping with patient education about their medications. There are also significant lifestyle changes recommended for diabetes patients, including changes to diet, exercise, and weight management (George et al., 2015), and patients with diabetes are at a higher risk for depression (Nouwen et al., 2010). A MedFT can assist patients in their recommended lifestyle dietary changes and provide screening and brief intervention for depression as necessary.

Hypertension. Hypertension, or blood pressure greater than 140/90 mmHg, is another common chronic diagnosis in primary care. It is a major preventable contributor to diseases and death in the United States (Oza & Garcellano, 2015). About 33% of adults in the United States have hypertension. According to Piper, Evans, Burda, et al. (2014), the USPSTF recommends screening for high blood pressure in all adults ages 18 years and over, even if they have no known history of hypertension. Patients with this condition are at higher risk for myocardial infarction (heart attack), renal failure, and death (Oza & Garcellano, 2015).

Patients identified as having high blood pressure benefit from both pharmacological treatment and lifestyle changes. The goal of treatment is to achieve a blood pressure less than 150/90 mmHg in adults over age 60, and 140/90 mmHg in patients 30 to 59 years of age (Langan & Jones, 2015). One major dietary recommendation for patients with hypertension is to reduce sodium (salt) and to follow the Dietary Approaches to Stop Hypertension (DASH) diet, which gives specific recommendations for daily nutrient intake, including 27% of calories from fat, 18% of calories from protein, 30 g of fiber, and 1500 mg of sodium (Sacks et al., 2001). Other key lifestyle recommendations include moderate to vigorous activity for 40 minutes, three times per week, and tobacco cessation (Oza & Garcellano, 2015). There is some mixed evidence indicating that relaxation techniques can be successful for lowering blood pressure; transcendental meditation and biofeedback techniques may modestly lower blood pressure (Brook et al., 2013). MedFTs should familiarize themselves with relaxation and mindfulness techniques to teach patients in this population and to help them adhere with the dietary, physical activity, and pharmacological treatments.

Chronic pain. There are more than 50 million Americans who experience chronic pain (Jackman, Purvis, & Mallett, 2008). Chronic pain may include pain due to osteoarthritis, strained muscles or bulging or ruptured disks in the lower back region, digestive conditions like irritable bowel syndrome, or other known or unknown causes. Although pain can be an important indicator of acute injury, chronic pain is burdensome and difficult to manage. One major problem in treating chronic pain lies with opioid pharmacological agents; they are sometimes abused or diverted and have a high risk of overdose. According to Dowell, Haegerich, and Chou (2016), the Centers for Disease Control and Prevention (CDC) recently released new recommendations for prescription of opioid medications in the treatment of chronic pain, focusing on mitigating their risks with a patient-centered approach to care. The CDC recommends use of short-acting medications, frequent follow-ups, and use of compliance measures such as pill counts, urine drug screening, and checking state registries for patients' histories of refilling controlled medications (Dowell et al., 2016).

Experts of treating chronic pain in primary care recommend that patients should be assisted in setting realistic goals for functioning. The primary goal for treatment should not be complete resolution of the patient's pain; it should instead be improved quality of life while decreasing pain (Jackman et al., 2008). There are many non-pharmacological treatments for chronic pain that can be used in addition to (or instead of) opioids. Lifestyle changes, including tobacco cessation and weight loss, are recommended (Hayes, Naylor, & Egger, 2012). There are also benefits from exercise, physical therapy, biofeedback, cognitive behavioral therapy, and relaxation. Complementary and alternative medicine approaches such as acupuncture, massage, and mindful mediation may benefit patients as well (Jackman et al., 2008). MedFTs can be instrumental in engaging patients in self-management goals, establishing realistic expectations, and working with patients and family members on living a fulfilling life alongside their pain.

Preventive care. One major goal of primary care is to provide patients with ongoing preventive care. Family medicine providers follow the recommendations of the USPSTF, which provides guidelines for preventive medicine. Guidelines are based on age and gender, and they are targeted at improving the overall population health and preventing serious diseases and complications (USPSTF, 2016). In children, preventive care typically includes periodic well-child visits and administration of immunizations. In adults, preventive care recommendation include a variety of tests, from less invasive, such as blood pressure testing, to much more involved, such as colonoscopies, pap smears, and mammograms.

MedFTs working in primary care can help to expand this definition of preventive care to go beyond physical health, taking a more biopsychosocial-spiritual view instead. There are many behavioral health concerns that they can provide screening for, including depression, anxiety, ADHD, and others. They can also engage patients in their healthcare decision making by using techniques such as motivational interviewing to assess patient health goals and monitor progress in those areas.

Depression and anxiety. Two of the most prevalent mental health diagnoses are major depressive disorder and anxiety (which includes generalized anxiety disorder, social anxiety disorder, specific phobias, and others). Many patients experiencing symptoms of depression and anxiety will present to their physician first, rather than through the traditional mental health system (Pettersson, Miller, Payne-Murphy, & Phillips, 2014). Although recommendation from the USPSTF is to screen adult patients for depression, they add the caveat that physicians should not be screening all patients unless they have a system for follow-up in place (Siu, 2016). Many physicians feel uncomfortable addressing psychopathology in patients due to lack of knowledge about community resources and increasing time pressures. MedFTs working in primary care are instrumental in the screening and treatment of depression. For patients who screen positive, the MedFT can either provide follow-up care for patients or refer them to community health resources. Although there is not an analogous screening recommendation for anxiety disorders, generalized anxiety disorder is a prevalent concern among patients that can have implications for exacerbations of health problems such as insomnia and hypertension. MedFTs can provide screening, brief intervention, and referrals to treatment as appropriate.

Populations Served in Family Medicine

Patients served in family medicine include all ages across the lifespan, from infants to the elderly.

Children. About 70% of family medicine providers provide care for children in their practices; overall, family medicine providers spend about 10% of their time caring for children, and they are responsible for about 16–21% of all child healthcare visits (Makaroff et al., 2014). MedFTs can be helpful both for well-child visits and for childhood chronic illnesses, such as asthma, ADHD, and obesity. For well-

child visits, MedFTs may use a behavioral health screening tool such as the Pediatric Symptom Checklist (PSC), which assesses for internalizing symptoms such as depression and anxiety, attention difficulties, and externalizing symptoms such as anger outbursts and behavioral difficulties (Gardner et al., 1999). MedFTs can also help monitor child development and attainment of milestones and screen for developmental difficulties, learning disorders, or autism spectrum disorders. Finally, MedFTs can also provide parenting guidance.

For children with chronic health conditions, MedFTs can be an important part of the treatment team's intervention. The National Health Interview Survey found that 6.8% of children in the United States have asthma (CDC, 2016). Evidence has shown that behavioral intervention for asthma can be beneficial, including self-management training, such as through the development of an asthma action plan, breathing training, and exercise or physical activation programs. Systemic factors, such as parental smoking, can also be modified; if the MedFT is able to work with the patient's parents to quit smoking, there may be a beneficial effect on the child's health and symptoms. ADHD is also a common childhood illness, affecting about 11% of American children (Visser et al., 2014). The symptoms of ADHD first appear between ages 3 and 6 years old, and the average age at first diagnosis is 7 years. In addition to helping with screening and early identification of symptoms, MedFTs can provide behavioral intervention to children and their families who are facing ADHD. Pharmacological treatment of ADHD, typically stimulant medication, has a number of side effects, including poor appetite, irritability, anxiousness, and sleep problems (Felt, Biermann, Christner, Kochhar, & Van Harrison, 2014). Effective behavioral treatments include parent training, classroom management, and peer interventions.

Finally, another example of a problem increasing in the pediatric population is obesity. Growing numbers of children are presenting to their primary care doctor with weight difficulties; 12.1% children 2–5 years of age, 18.0% of children 6–11 years of age, and 18.4% of adolescents 12–19 years of age meet the diagnostic criteria for obesity (National Institute of Diabetes and Digestive and Kidney Diseases, 2012). The American Medical Association expert recommendations suggest that family medicine providers should address diet and exercise habits with families at least once a year (Rao, 2008). Further, they urge that families need to make changes together to improve children's health. MedFTs, with their solid foundation in systems theory and family therapy, as well as their experience and awareness of behavioral intervention, are particularly suited to aid physicians in these recommendations. Further, they may be able to help establish collaboration with a nutritionist, coordinating care and communication between members of the treatment team.

Adults. Family medicine providers care for adults across a wide range of health conditions, as well as services particular to women's health (which includes gynecological care and maternal/fertility treatment services). When adults are needing more specialty care (e.g., gastroenterology, endocrinology, dermatology, cardiology, specialty mental healthcare), family medicine providers refer to indicated

professionals and expand the team accordingly. Residents pursuing their family medicine specialization are trained to deliver babies, but not all may offer this service as a part of their practice. Overall, primary care systems, such as family medicine, are typically the first point of contact for adults. However, patients' type of insurance and coverage may limit their access to certain primary care systems or providers. Some insurers will permit patients to seek specialty care without a referral from their primary care provider.

Elderly. At the other end of the spectrum, family medicine providers also treat patients who are at the end of their lifespan. In addition to helping geriatric patients who have the conditions previously described, there are other considerations that may be beneficial to this population. Physicians and MedFTs can partner with geriatric patients and their families to assess their goals for maintaining functional abilities and aging in place and can connect them with community resources or assistive technology that may assist them in reaching these goals. Further, MedFTs can help family medicine providers as they aid their patients in end-of-life planning, completion of advanced directives, and entry into hospice. They also can aid in screening for cognitive decline, such as by administering the Mini-Mental Status Exam or a similar test of cognitive functioning. Although depression is common in older adults, there is often a stigma associated with therapy that is a significant barrier to traditional treatment of depression in this generation (Conner et al., 2010). For these patients, an integrated behavioral healthcare format may help them overcome stigma and be more willing to receive help for their condition.

Common Tests and Procedures in Family Medicine

Tests and procedures often advanced in family medicine vary considerably; those most common are described below.

Tests. Family medicine providers utilize many common tests (see Table 2.1) in the diagnosis and management of illnesses and diseases in their patients. The presented lab tests and interpretations are intended to be evaluated by primary care providers or other professional types with training in this area. The American Academy of Family Physicians (AAFP) recommends education in urinalysis, vaginal smears, stool microscopy, skin scraping microscopy, post-vasectomy semen analysis, blood draws for labs sent to outside laboratories, finger-stick glucose, finger-stick A1c, urine pregnancy test, rapid strep antigen, rapid influenza test, and occult blood testing of stool or emesis. Some family medicine practices have labs available in the clinic so that patients can have their needs met all in one place, whereas others have to refer patients to outside laboratories for testing. It is important that MedFTs know and understand some of the more common labs run in a primary care setting as some indicate that a patient's health is improving or deteriorating. For example, if a patient's blood pressure is higher than normal (140/90 mmHg), it is an opportunity to stop and try to identify potential causes of

Table 2.1 Common Tests and Procedures in Family Medicine

Test	Normal Limits	Purpose/Description of Test	Basic Interpretation of Abnormal Findings
<i>Vitamins</i>			
B12	200–900 pg/mL	B12 is a vitamin used in the metabolism of every cell in the body; it is particularly important in the production of red blood cells.	Deficiency may result in anemia but also could explain altered mental status and be confused with dementia.
Vitamin D	30–80 ng/mL	Vitamin D is essential for calcium absorption and bone formation.	Low levels may cause bone softening leading to fractures and increased mortality; in addition, low levels could explain depression-like symptoms.
<i>Endocrine function</i>			
TSH (thyroid-stimulating hormone), T ₃ (triiodothyronine), T ₄ (thyroxine)	TSH: 0.4 to 4.0 mIU/L T3: 100–200 ng/dL T4: 4.5–12 ug/dL	TSH is a hormone produced by the pituitary gland that stimulates the production of thyroid hormones (T ₃ and T ₄); these labs are used to measure the functioning of the thyroid gland.	High levels of TSH and low levels of T4 and T3 can explain symptoms attributed to hypothyroidism, such as fatigue, weight gain, reduced sexual drive, and difficulty with concentration and memory that could be easily attributed to depression. On the contrary, low levels of TSH and high levels of T4 and T3 can explain anxiety, mood swings, mania or hypomania, impaired concentration, irritability, and insomnia, due to hyperthyroidism and not a primarily mental health problem.
Glucose	70–100 mg/dL	Measures circulating glucose.	Low levels of blood glucose could provoke nausea, dizziness, altered vision, and disturbed mental status; if a patient is experiencing hypoglycemia, this requires urgent medical care. On the contrary, high levels of blood glucose indicate the body’s incapacity to manage healthy glucose levels; high levels indicate diabetes or other metabolic problems (e.g., glucose intolerance); extremely high levels (greater than 500 mg/dL) require urgent medical care.

(continued)

Table 2.1 (continued)

Test	Normal Limits	Purpose/Description of Test	Basic Interpretation of Abnormal Findings
Hemoglobin A1c (A1c)	<5.7%	Evaluates how much hemoglobin (molecule in the red blood cells) has been glycosylated (“covered with sugar”); it is a measure of average blood glucose in the last 3 months.	Chronic hyperglycemia is related to stroke, coronary artery disease, neuropathy, renal failure, and increased mortality; for patients with diabetes, treatment goals could be having A1cs under 6.5 or 7%, depending on the patient; higher levels require treatment adjustment to improve diabetes control.
<i>Liver function</i>			
Albumin	3.4–5.4 g/dL	In general, this panel of lab tests measure how the liver and their associated organs (e.g., gallbladder, bile ducts) are working.	In asymptomatic patients, high levels of these tests could reflect damage to the liver or its associated organs.
ALP (alkaline phosphatase)	44–147 IU/L		
ALT (alanine aminotransferase)	10–40 IU/L		
AST (aspartate aminotransferase)	10–34 IU/L		
Total bilirubin	0.3–1.9 mg/dL		
<i>Kidney function</i>			
BUN (blood urea nitrogen)	6–20 mg/dL	These lab tests evaluate how well the kidney is eliminating these molecules.	High levels of creatinine might explain acute or chronic kidney failure but also high intensity exercise or other medical conditions; high BUN levels result in mental status changes including disorientation and confusion that require acute medical care.
Creatinine	0.6–1.3 mg/dL		
<i>CBC (complete blood count)</i>			
RBC (red blood cell) count	Male: 4.7–6.1 million cells/mcL Female: 4.2–5.4 million cells/mcL	RBCs carry oxygen to the body organs; these tests evaluate the counts of red blood cells (RBC), the % of red blood cells in the blood sample (hematocrit), and the amount of hemoglobin (molecule inside the RBC that carries the oxygen).	Low levels of these exams could be related to anemia (which has many causes); symptoms of this condition include profound fatigue, loss of mental acuity, and reduced ability to perform simple tasks like reading; high levels are rare and could be explained by dehydration, living at a high-altitude location, or bone marrow diseases.
Hematocrit	Male: 40.7–50.3% Female: 36.1–44.3%		
Hemoglobin	Male: 13.8–17.2 gm/dL Female: 12.1–15.1 gm/dL		

(continued)

Table 2.1 (continued)

Test	Normal Limits	Purpose/Description of Test	Basic Interpretation of Abnormal Findings
WBC (white blood cell) count	4500–10,000 cells/ mcL	WBC are the body’s defense against infection(s); common types of WBCs are leukocytes and lymphocytes.	Low levels (leukopenia or lymphopenia) could be explained by viral and other infections (including HIV), bone marrow diseases, cancer, autoimmune disorders, or as medication side effects; high levels of WBC (leukocytosis or lymphocytosis) can be explained by an active infection, drug reactions, bone marrow diseases (e.g., leukemia), and other immune disorders; as a CBC is ordered by a provider, MedFTs could encourage patients to follow-up with their PCP.
Platelet count	150,000–450,000/ dL	Platelets play an important role in the blood clot formation.	Extremely low platelet levels (thrombocytopenia) produce excessive bleeding (internal and external) and could be explained by multiple reasons that require an evaluation by the provider who ordered the test; high levels are very uncommon.

this dysregulation (e.g., being in a hurry, having smoked a cigarette, having drunk coffee). If blood pressure remains high in several opportunities, the client could have hypertension and should be referred to his/her PCP for a diagnosis. If the client has been diagnosed with hypertension, this could be an opportunity to address stress management, lifestyle changes, and medication adherence and/or hold a family conference to expand support.

Procedures. Most family medicine providers perform at least some outpatient procedures in their offices. In the AAFP’s 2015 Member Census, family medicine providers most commonly reported performing skin procedures such as biopsies (74.7%), musculoskeletal injections (68.4%), spirometry (35.7%), endometrial sampling (31.1%), X-ray (26.1%), and colposcopy (16.5%). Although MedFTs do not participate in the performance of these procedures, they can play an important role with patient care in this area. Informed consent for treatment requires patients’ understanding of a procedure, alongside its anticipated benefits and potential risks. The MedFT can assist doctors in ensuring that patients have an understanding of their procedure in a way that matches the patient’s level of health literacy. MedFTs can also help patients who are anxious about treatments and procedures by assisting them in relaxation and mindfulness exercises as they are waiting for their procedure to be performed.

Sensitivity to Diversity and Health Disparities

Primary care is designed to meet the needs of all populations, including those who are underserved, by providing them with a medical home where they can have many of their needs met in one location. According to the 2015 AAFP Member Census, 59% of family physicians accept Medicaid (AAFP Member Census, 2015). At a national level, the Family Medicine for America's Health Project is a collaborative effort of multiple organizations, including the AAFP and the Society for Teachers of Family Medicine (STFM), designed to improve practice models and payment so that more patients can have their healthcare needs met through primary care (Kozakowski et al., 2016).

Despite these efforts, significant health disparities still exist. Members of marginalized groups including ethnic minorities, lesbian, gay, bisexual, transgender, and queer (LGBTQ) populations, migrant and seasonal farm workers, and low socioeconomic status patients frequently experience poorer health outcomes and numerous barriers to care compared to more privileged populations (Purnell et al., 2016). Access to mental healthcare is even more fragmented (Cook et al., 2014). Despite changes in education standards, biases still exist among healthcare providers that exacerbate these problems (Blair et al., 2013; Chapman, Kaatz, & Carnes, 2013). Experts have recommended various solutions for these problems, including programs that impact social determinants of health (Thornton et al., 2016) and integrated care (Sanchez, Ybarra, Chapa, & Martinez, 2016; Vander Wielen et al., 2015). Emerging evidence suggests that integrated healthcare helps reduce healthcare disparities for Latinos (Bridges et al., 2014), people with severe mental illnesses (Kelly, Davis, & Brekke, 2015), underserved urban (Wrenn, Kasiah, & Syed, 2015), and rural populations (Ranson, Terry, Glenister, Adam, & Wright, 2016).

MedFTs can help family medicine physicians in their efforts to address problems with diversity and health disparities. In a general way, integrated care reduces the stigma of behavioral healthcare and increases access by providing services in the primary care office (Sanchez et al., 2016; Vander Wielen et al., 2015). MedFTs can also assist providers in delivering culturally appropriate care. One way to do this is through Galanti's (2014) four Cs—that is, inquiring about what the patient calls their illness, what are their concerns about it, what do they believe caused it, and what do they believe will cure it. Conversations like these can help providers understand patients' culturally bound health beliefs. They can also reveal areas of poor health literacy. Although healthcare providers often fail to recognize poor health literacy, it is a serious problem with implications for patient morbidity (Caplan, Wolfe, Michaud, Quinzanos, & Hirsh, 2014) and mortality (Bostock & Steptoe, 2012). MedFTs working in integrated behavioral healthcare are the perfect people to help bridge gaps in health literacy, because they have both the experience of working in a healthcare setting as well as the lack of a medical degree; they are adept at helping translate medical jargon into terms a layperson can easily understand.

Table 2.2 MedFTs in Family Medicine: Basic Knowledge and Skills

MedFT Healthcare Continuum Level	Level 1	Level 2	Level 3
Knowledge	<p>Somewhat familiar with family medicine as a medical specialty and its background and collaboration with MedFTs, as well as unique and overlapping skills/roles, and the team’s overall structure.</p> <p>Limited knowledge about BPSS impacts of a few common population health conditions seen at family medicine clinics.</p> <p>Rarely engages professional members, patients, and support system members collaboratively.</p> <p>Basic understanding regarding strategies for a healthy lifestyle when living with someone with a health condition.</p> <p>If conducting research and/or policy/advocacy work, on rare occasions will collaborate with other disciplines related to family medicine and consider relational and/or BPSS aspects of health and well-being.</p>	<p>Can recognize the disease processes and differentiate between some of the more common ones and other comorbid BPSS health conditions and impacts.</p> <p>Familiar with benefits of couple and family engagement in health-related adjustments and/or lifestyle maintenance but tends to refer more than provide this service.</p> <p>Knowledgeable about how to use the electronic health record system or other forms of secured communication to collaborate with various team members.</p> <p>Is an occasional contributor to discussions about research design and policy/advocacy work that include relational and/or BPSS aspects of health and well-being.</p>	<p>Working knowledge of specific team members (e.g., allopathic and osteopathic physicians, nurse practitioners, physicians assistants, nurses, medical office assistants, phlebotomists, pharmacists, nutritionists, physical therapists, other behavioral health disciplines, etc.) and medical terminology with regard to medications and EHR charting (e.g., prn, qd, BGL, TSH), as well as common comorbid conditions to family medicine illnesses (e.g., hypertension, hyperlipidemia, diabetes mellitus, cardiopulmonary obstructive pulmonary disease).</p> <p>Broad range of knowledge about research-informed family therapy and BPSS interventions; able to and usually will conduct couple and family therapy and incorporate BPSS health factors into treatment with minimal need to refer out due to limited expertise.</p> <p>When work permits, is knowledgeable and consistency committed to conducting research and constructing policy/advocacy work that identifies and intervenes on behalf of individuals, couples, families, and healthcare teams toward the advancement of BPSS health and well-being.</p>

(continued)

Table 2.2 (continued)

MedFT Healthcare Continuum Level	Level 1	Level 2	Level 3
Skills	<p>Able to recognize at a basic level the BPSS dimensions of health and apply a BPSS lens to practice, research, and/or policy/advocacy work.</p> <p>Can discuss (and psycho-educate) basic relationships between biological processes, personal well-being, and interpersonal functioning.</p> <p>Demonstrates minimal collaborative skills with family medicine and other related healthcare providers; prefers to work independently, but, when care is complex enough, will contact /refer to other providers about additional services.</p>	<p>Knowledgeable about how to apply systemic interventions in practice and does it occasionally; capable of assessing patients and support system members present for background health issues such as family history and risk-related factors.</p> <p>Demonstrates adequate and occasional collaborative skills through (a) written and verbal communication mediums that are understandable to all team members and (b) coordination of referrals to specialty behavioral health providers and communication with the patient’s primary care provider.</p> <p>Conducts separate treatment plan from other providers involved in the patient’s care; goals and interventions can overlap with—or be informed by—a family medicine team, but BPSS goals and collaboration with the team is not consistently done.</p>	<p>Able to and usually will integrate respective team members’ expertise and counsel into treatment planning.</p> <p>When done can successfully conduct a systemic assessment of a patient and family with competencies in assessing for BPSS aspects of family medicine illnesses and/or comorbid diseases and resources within the family.</p> <p>Usually engages other professionals within and outside of the practice who are actively involved in the patient’s care.</p> <p>Skilled with standardized measures to track patients’ individual and relational strengths and challenges (e.g., PHQ9, GAD7, Relationship Dynamics Scale).</p> <p>Attends and contributes to team meetings to help shape BPSS treatment plans for patients.</p>

Family Medicine Across the MedFT Healthcare Continuum

The family medicine setting lends itself well to all applications of MedFT across the healthcare continuum (see Tables 2.2 and 2.3; Hodgson et al., 2014). In fact, many of the pioneers of MedFT have illustrated in their texts the versatility of MedFT in primary care, particularly in family medicine (Hodgson, Lamson, Mendenhall, & Crane, 2014; McDaniel et al., 1992, 2014). However, regardless of one’s amount and quality of training or one’s ability to execute MedFT in a particular setting, MedFTs have to respect the workflow, reimbursement, and transformation

processes common to integration of behavioral health into a healthcare context (Cohen et al., 2015; Hodgson et al., 2014; McDaniel et al., 1992, 2014). These operational, systemic factors will have an impact on the care provided. This section aims to highlight, using the case example at the beginning of this chapter, the various ways that MedFTs may be assimilated into family medicine settings.

Depending on one’s job duties, MedFTs at *Levels 1 and 2* of the continuum may have the ability to function as clinician, researcher, and/or policy advocate who executes components of a relational and BPSS framework (Engel, 1977, 1980; Wright et al., 1996). At these levels, the MedFT may have the skills to practice at a more advanced level but may not have the “green light” of the system to do so.

Table 2.3 MedFTs in Family Medicine: Advanced Knowledge and Skills

MedFT Healthcare Continuum Level	Level 4	Level 5
Knowledge	<p>Consistently applied understanding of the more commonly treated health conditions and BPSS impacts in family medicine.</p> <p>Knowledgeable about benefits and risks of associated treatments of the more commonly seen biological and mental health conditions across the lifespan in family medicine (e.g., diabetes mellitus, hypertension, COPD, asthma, depression, anxiety).</p> <p>Understands how to collaborate with other disciplines to implement evidence-based BPSS and family therapy protocols in traditional and integrated behavioral healthcare contexts.</p> <p>Identifies self as a MedFT.</p> <p>Knowledgeable about designing and advocating for policies that govern BPSS-oriented inpatient and outpatient family medicine care services.</p>	<p>Understands and educates others about treatment and care sequences for unique and/or challenging topics in family medicine practice (e.g., delirium, medication interaction effects, comorbidities); can consult proficiently with professionals about BPSS topics from other fields.</p> <p>Proficient at explaining evidence-based treatments regarding most mental health disorders and their role(s) in the family; has background to provide psychoeducation to patients and families about a variety of symptoms, medications, and behavioral health management.</p> <p>Very knowledgeable about BPSS research designs and execution, policies, and advocacy needs as relevant to family medicine care.</p> <p>Proficient in developing a curriculum on integrated behavioral healthcare, BPSS applications, MedFT, etc. to mental health and other health professionals.</p> <p>Understands leadership and supervision strategies for building integrated behavioral healthcare teams in outpatient and inpatient family medicine settings.</p>

(continued)

Table 2.3 (continued)

MedFT Healthcare Continuum Level	Level 4	Level 5
Skills	<p>Able to deliver seminars and workshops to a variety of professional types (e.g., mental health, biomedical) about the BPSS complexities of a variety of commonly reported health and wellness topics found in family medicine settings.</p> <p>Can apply several BPSS interventions in care (including most types of brief interventions); can administer mood- and disease-specific assessment tools as the family medicine context requires.</p> <p>Consistently collaborates with key family medicine team members (e.g., primary care providers, nurses, medical assistants, behavioral health providers, pharmacists, dieticians); initiates and facilitates team visits with multiple providers when working with patients and families.</p> <p>Can independently and collaboratively construct research and program evaluation studies that study the impact of BPSS interventions with a variety of diagnoses and patient/family units of care.</p>	<p>Proficient in nearly all aspects of commonly seen presenting problems in a family medicine setting; able to synthesize and conduct research and clinical work; engages in community-oriented projects outside of the family medicine.</p> <p>Goes beyond intervention routine for this population; can integrate specific models of integrated behavioral healthcare into routine practice (e.g., PCBH, Chronic Care Model).</p> <p>Works proficiently as a MedFT and collaborates with other providers from a variety of disciplines.</p> <p>Leads, supervises, and/or studies success of the implementation and dissemination of BPSS curriculum on integrated behavioral healthcare, BPSS applications, MedFT, etc.</p> <p>Leads and explains at a high level of skill evidence-based treatments regarding most commonly seen family medicine presenting problems and their impact(s) on family systems; has background to provide psychoeducation to patients and families about a variety of symptoms, medications, and behavioral health management techniques that facilitate managing chronic illnesses well, returning to optimal health, or managing one’s health successfully.</p>

Contemporary MedFTs in family medicine settings are more commonly in roles where they provide both integrated behavioral healthcare (IBHC) services and traditional psychotherapy services, as well as teaching and research. Their expertise is in working relationally and applying the BPSS framework, but at *Levels 1 and 2*, this expertise is often sought after for “special” cases or situations rather than as a routine service. For example, the case example presented at the beginning of this chapter started with how the family medicine resident contacted the MedFT to request that she join her in the patient’s next visit (*Levels 1 and 2*). At this point, it is hopeful that Dr. Robbins will continue to work along with the MedFT throughout

the duration of the case, but many *Level 1 and 2* engagements end at the initial consult phase with little or no coordination of services or treatment plans, and no BPSS interventions or family therapy provided. Consulting with the MedFT is rare to occasional in its occurrence. Then, when the MedFT incorporated the family into the treatment in a hallway consult during the visit, this began to showcase more of the MedFT's BPSS and relational skills. However, Martha moved beyond *Level 2* when she incorporated the family into the treatment plan versus being strictly in a consulting role.

While MedFTs at *Levels 1 and 2* have a complementary skill set to other members of the team, they should also have a working knowledge of the pharmaceuticals more commonly being prescribed by the team and a familiarity with non-family medicine diagnoses that may exacerbate or be a consequence of treatments for family medicine conditions (e.g., polypharmacy effects due to metabolism changes in aging adults). These skills should be executed more frequently and advanced across the entire continuum as the MedFT becomes more fully integrated. As he or she becomes more integrated, he or she then moves beyond a siloed "mental health or discipline-specific" role into one where he or she is a member of the team where expertise among all members, including the patient and his/her support system member, is shared and respected collectively. Additionally, with regard to research and policy/advocacy, MedFTs operating at *Levels 1 or 2* may rarely to occasionally be asked or inspired to add to a study or policy addendum that taps into BPSS interactional dynamics. They may also advocate or be consulted with on occasion regarding relational and BPSS factors that influence the family medicine setting's clinical, operational, financial, and training/education policies and protocols. One example of this would be the modification of a policy on how information may be documented and exchanged between the healthcare team members and which members of the patient's support system should be routinely invited to visits.

In the case example presented for this chapter, the MedFT functions at a *Level 3* when she applies her MedFT knowledge and skills through BPSS and relational interventions. While not all MedFTs will have relational and BPSS research or policy/advocacy opportunities in family medicine settings, this level of MedFT has skills and experience necessary for participating in opportunities related to each and is able to contribute effectively. In relation to the chapter's case example, something appears to be embedded in the procedures of the system, where providers of different disciplines know about and refer to one another. At a *Level 3*, collaboration usually continues past the referral point and how frequently it occurs may depend upon the complexity of the case and how much the providers value it. The fact that Martha was called in advance of Dr. Robbins meeting with the patient and her family, and not just in response to a crisis, demonstrated a *Level 3* application of MedFT clinical and collaborative knowledge and skills. She also responded to and included the patient's family in treatment, acknowledging that they are important to the success of managing the patient's BPSS health. Those living and interacting with the patient outside of the healthcare context are able to separate out sudden versus gradual changes that may point to different diagnoses. For example, a urinary tract infection in an older adult may rapidly lead to mental status changes and get treated as a

purely mental health issue although a biomedical intervention is the critical first step. This is why it is important that providers remain BPSS aware of patient's health and well-being and family/support system members be permitted to participate in treatment and contribute to providers' understanding of the problem.

MedFTs at *Levels 4 and 5* highlight consistent and then proficient application of MedFT knowledge and skills. At these levels, the clinician, like Martha, will identify as a MedFT professionally. She will be seen as part of the healthcare team versus exclusively as a colocated specialty care provider. An example of this advanced level of skill would be when she led the family interventions sessions to help the family plan for future declines in cognitive functioning. The *Level 5* skills were also evident with this case when Martha led the team in developing a treatment plan that would be best for the family unit, not just the patient. It permitted the opportunity for the providers to address the guilt expressed by the family members over needing to consider a care facility at some point in the future. The team also recognized the cultural components of the system and did not exclude the kin from the treatment plan but incorporated them into it. Team members had access to each other's notes, and everyone shared responsibility for encouraging the team's overall goals with the patient and her family versus only the goals aligned for the patient's best interests. Also at their sessions, incorporation of the family's spirituality into the plan was also recognized as a vital need. Martha as a *Level 5* MedFT also displayed skills in alternating between integrated behavioral healthcare and traditional psychotherapy services, being able to blend them well and maintain a BPSS and relational perspective throughout.

Research-Informed Practices

For a MedFT in a primary care setting, there are numerous opportunities for intervening in patient care. Interactions between a MedFT and a patient may occur in the form of a patient introduction, same-day responses to referrals, brief assessments or point of care interventions (i.e., under 30 minutes), short-term psychotherapy (e.g., 4 to 6 sessions; Vogel, Kirkpatrick, Collings, Cederna-Meko, & Grey, 2012), or as interprofessional collaboration with other healthcare providers (McDaniel et al., 2014). Research has emphasized the importance of brevity and cost-effectiveness in these behavioral interventions, recognizing that there are unique limits, focuses, and constraints for this particular kind of work (Polaha, Volkmer, & Valleley, 2007). These interventions are often educational, cognitive- and/or behaviorally based, and solution-focused (Vogel et al., 2012); they are not intended to dig deep into one's past as a professional in a traditional therapy context would. Rather, they are meant to empower and equip a patient to traverse forward in accord with the design set within their treatment team. The following section will review several individual, family, and community research-informed practices commonly used by MedFTs in family medicine.

Individual Approaches

Cognitive behavioral therapy. Cognitive behavioral therapy (CBT) represents a way to help patients restructure their maladaptive preconceptions and corresponding behaviors, which often interfere with or impede successful compliance with treatments. CBT has been found to be effective for treating common concerns in primary care such as chronic fatigue (Meng, Friedberg, & Castora-Binkley, 2014), depression (Kessler et al., 2009; Linde et al., 2015), anxiety and other stress-related problems (Craske et al., 2006; Ejeby et al., 2014), and somatic physical symptoms (Escobar et al., 2007). Beyond primary care, CBT has been shown successful in treating mild to moderate dementia and general mental functioning (Robinson et al., 2010; van Ravesteijn, Lucassen, Bor, van Wheel, & Speckens, 2013) and disordered eating (Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000). Research has demonstrated that helping patients in primary care settings emotionally process their experiences (i.e., integrate their thoughts and feelings) via CBT predicted improved outcomes (Godfrey, Chalder, Ridsdale, Seed, & Ogden, 2007). The effects of CBT have been shown at completion of therapy and at 6-month follow-up (Escobar et al., 2007).

Interpersonal psychotherapy. Interpersonal psychotherapy (IPT) is another well-documented, empirically based clinical intervention commonly used in primary care. IPT is designed to focus on the patient's current interpersonal relationships while addressing primary areas of concern (e.g., grief, role transitions, role disputes, interpersonal deficits; Kindaichi & Mebane, 2011; Markowitz & Weissman, 2004). The goal of this particular approach is to intervene by considering significant life changes that may precipitate negative symptoms (e.g., grief and loss) and addressing identifiable triggers of the patient's health concern(s). In primary care, IPT is an effective approach to treating depression and postpartum depression (van Schaik et al., 2006). Beyond primary care, IPT has been found successful in treating depression and postpartum depression, (Markowitz & Weissman, 2004; O'Hara, Stuart, Gorman, & Wenzel, 2000), disordered eating (Wilfley et al., 2002), posttraumatic stress disorder (Markowitz et al., 2015), multisomatoform disorder (Sattel et al., 2012), and anxiety (Stangier, Schramm, Heidenreich, Berger, & Clark, 2011). IPT has been found to be ineffective in treating dysthymic disorder in primary care (Browne et al., 2002).

Motivational interviewing. Motivational interviewing (MI; Miller, 1983) is a collaborative, patient-centered approach focused on assessing patients' readiness for change and empowering patients to move toward change. This approach reaffirms patients' freedom of choice and self-efficacy and avoids provider-driven treatment plans that often fail to consider patients' ambivalence toward making a change. The overarching goal of MI is behavior change through collaboration between patient and MedFT, supporting patient autonomy and drawing out the patient's concerns and ideas for solutions (Anstiss, 2009).

The original description of MI (Miller, 1983) was based on implicit principles derived from intuitive practices (e.g., alcohol addiction, smoking cessation) and was elaborated upon by Miller and Rollnick (1991). Since then, hundreds of studies, including meta-analyses, have been conducted evaluating the effectiveness of this approach. One meta-analysis by Lundahl et al. (2013) reported MI to have a significant positive impact on cholesterol levels, blood pressure, HIV viral load, weight, physical strength, quality of life (e.g., worrying, pain, adjustment to illnesses), self-monitoring activities (e.g., blood sugar levels), reducing sedentary behavior, and increasing confidence and engagement in treatment. MI has also been found to significantly increase medical adherence for older adults (mean age of 75 years) in primary care when compared to a control group that received an advice approach (Moral et al., 2015). MI is also a good approach when working with problems that are often found to be comorbid in patients (e.g., alcohol dependence, drug abuse, eating disorders; Britt, Hudson, & Blampied, 2004; Vanbuskirk & Wetherell, 2014).

Psychoeducation. The use of psychoeducation in primary care can be a helpful strategy to deliver information about topics like sleep hygiene, smoking cessation, lifestyle habits, medication management, and mental health (Substance Abuse and Mental Health Services Administration, 2009). The main components of psychoeducation include therapeutic interaction, clarification, and enhancing coping competence (Bäumli, Froböse, Kraemer, Rentrop, & Pitschel-Walz, 2006). Psychoeducation may be offered in a one-on-one conversation between a MedFT and patient or via multi-person visits or group classes. In research to date, psychoeducation has been shown to be helpful in patients' positive adjustment to receiving a breast cancer diagnosis (Dastan & Buzlu, 2012). Findings from systematic reviews and meta-analyses have suggested that for adult patients with major depressive disorder, psychoeducation is an effective approach in improving clinical course, treatment adherence, and psychosocial functioning (Donker, Griffiths, Cuijpers, & Christensen, 2009; Tursi, Baes, Camacho, Tofoli, & Juruena, 2013). Research has also shown that a significant percentage of parents who received psychoeducation about nutrition, family meals, and physical activity have reduced the amount of screen time and sugary drinks consumed by their children (Stovitz et al., 2014).

Family Approaches

Families are important for health. Research has consistently linked better family relationships to positive health (e.g., Campbell, 2003; Chesla, 2010; Garcia-Huidobro & Marsalis, 2012; Hartmann, Bzner, Wild, Eisler, & Herzog, 2010; Martire, Lustig, Schulz, Miller, & Helgeson, 2004; Martire, Schulz, Helgeson, Small, & Saghafi, 2010; Shields, Finley, & Chawla, 2012). Interventions that have integrated a family approach can be grouped in two broad types: family therapy and family-based interventions. Family therapy approaches are structured interventions that have focused in improving family relationships and consequentially mental

health outcomes including depressive, anxiety, eating, and substance use disorders. Although these approaches require specific training, it is important that MedFTs are familiar with them, as certain communities might not have access to providers who can deliver effective family therapy interventions. Family-based interventions use the relational principles of family therapy and aim at improving physical health outcomes (McDaniel et al., 2005). These have been more commonly implemented in primary care settings, targeting patients with a wide array of physical health conditions. In the following sections, research on these two family-focused approaches is reviewed.

Family therapy approaches. Traditional family therapy approaches, such as structural, strategic, narrative, and systemic family therapy, among others, have focused on relational outcomes. Yet, few of them are supported with empirical research (Sprenkle, 2002). In this section, we review the evidence-based family therapy approaches for mental health problems commonly seen in primary care across the lifespan. As practicing these techniques requires specific training, it is unlikely that MedFTs will use all of these therapy styles; however, it is important to be familiar with them, as some primary care patients might benefit from specific types of interventions.

Frequent mental health problems in *children* are related to problematic behaviors. Parent-child interaction therapy has shown positive effects in preschool- and school-aged children with attention-deficit hyperactivity disorder (Matos, Bauermeister, & Bernal, 2009; Nixon, 2001) and children with oppositional defiant disorder (Nixon, Sweeney, Erickson, & Touyz, 2004). This approach aims to enhance positive parent-child interactions and subsequently improve parent-child relationship quality. For example, MedFTs often provide direct coaching to assist parents in practicing skills while interacting with their children in the therapy session.

Common mental health problems for adolescents that are seen in family medicine settings include depression, anxiety, conduct problems, substance use, and suicide ideation. Multidimensional family therapy, solution-focused family therapy, attachment-based family therapy, functional family therapy, family cognitive behavioral therapy, and Maudsley family therapy are evidence-based approaches to treat adolescent depression, anxiety, bipolar disorder, suicide ideation, substance use, conduct problems, and eating disorders and improve overall family functioning (Ewing, Diamond, & Levy, 2015; Liddle, Dakof, Turner, Henderson, & Greenbaum, 2008; Liddle, Rowe, Dakof, Henderson, & Greenbaum, 2009; Lock, Agras, Bryson, & Kraemer, 2005; Santisteban et al., 2003; Wood, Piacentini, Southam-Gerow, Chu, & Sigman, 2006; Storch et al., 2007; Waldron & Turner, 2008; Wood, Piacentini, Southam-Gerow, Chu, & Sigman, 2006). Multidimensional family therapy is a comprehensive intervention that provides individual and joint care to parents and adolescents. This approach is focused in helping adolescents and their parents develop effective coping and problem-solving skills as a way to improve their relationships as a protective factor for substance abuse. Research studies have provided strong evidence for its effectiveness and cost-effectiveness at improving substance

abuse among other significant outcomes (e.g., education, delinquency, and crime; Liddle et al., 2008; Liddle et al., 2009).

Solution-focused family therapy posits that troublesome adolescent behaviors originate in negative family interactions; therefore, improving family functioning will help to improve adolescents' behaviors. Under this approach, MedFTs join the family to diagnose patterns of family interactions and then help restructure their dynamics. After receiving this treatment, youth have reported improved conduct problems, substance use, and family functioning (Gingerich & Peterson, 2013; Santisteban et al., 2003).

Attachment-based family therapy aims to repair attachment injuries that predispose adolescents to experience depression, anxiety, and suicide ideation, by rebuilding secure relationships (Ewing et al., 2015). It assumes that symptoms can be triggered, exacerbated, or reduced by family relations. This approach has shown significant effects reducing all mental health outcomes while also improving family support (Ewing et al., 2015).

Functional family therapy is focused in family adaptation and overall functionality. It is a strength-based model of care that targets family engagement, motivation, relational assessment, behavioral changes, and generalization of the behaviors changed in the family to other contexts. This short-term treatment has shown effectiveness helping families with adolescents overcome depression, substance abuse, HIV risk behaviors, and behavioral problems (Sexton & Turner, 2010; Waldron & Turner, 2008).

Family cognitive behavioral therapy shares the same principles of individual CBT that is focused on thoughts (cognitions), emotions, and behaviors. As a family therapy approach, it extends its strategies to other family members and relationships. Research has shown positive effects at improving multiple anxiety disorders in youth, including generalized anxiety disorder, social phobia, and obsessive-compulsive disorder (Storch et al., 2007; Wood et al., 2006).

Finally, the Maudsley approach was developed to help families with a member experiencing eating disorders. This approach combines multiple family therapy techniques with guidance on healthy eating behaviors and strategies to gain weight. Multiple randomized trials support the effectiveness of this approach to treat anorexia and bulimia nervosa, including short (10 sessions) and long (20 sessions) treatment (Lock et al., 2005), and these were conducted conjoint or separated from the family (Eisler, Simic, Russell, & Dare, 2007; Loeb et al., 2007).

Among *adults*, frequent mental health problems seen in primary care include mood and anxiety disorders and substance use. Emotionally focused therapy (EFT) and cognitive behavioral couples therapy (CBCT) are the family therapy approaches that have been studied the most. EFT aims at helping couples improve their attachment and, thereby, their relationship. It is centered on helping patients develop a secure emotional attachment with their partner. CBCT includes a focus on substance use behaviors and the couple's relationship. Both of these approaches improve relationship satisfaction and dyadic distress (Fals-Stewart, Birchler, & Kelley, 2006). EFT also contributes improving depressive symptoms and distress caused by chronic illnesses (Dessaulles, Johnson, & Denton, 2003; Wiebe &

Johnson, 2016); CBCT has shown robust findings improving mood and substance use disorders (Fischer, Baucom, & Cohen, 2016; Schumm, O'Farrell, Kahler, Murphy, & Muchowski, 2014).

Although parenting interventions are not necessarily family therapy interventions, these types of interventions aim to improve parents' parenting skills and parent-child relationships. These interventions are structured and can be effectively delivered in primary care settings by family educators, social workers, and MedFTs in either individual or group formats. A recent literature review of parenting interventions delivered in primary care identified that Incredible Years and Triple P are the programs with that most evidence supporting feasibility and effectiveness (Cluxton-Keller, Riley, Noazin, & Umoren, 2015; Leslie et al., 2016). Given the longitudinal relationship between primary care providers and parents, MedFTs could have a significant impact in helping parents to raise their children in positive and healthy ways, leading to short- and long- term health and well-being. Children of parents who took part in parenting interventions are less likely to exhibit behavioral, substance use, and other mental health problems and are more likely to be healthier (Svetaz, Garcia-Huidobro, & Allen, 2014).

Family-based approaches. Family-based interventions are grounded in family therapy principles, but oftentimes these are less structured and include components of multiple approaches (Campbell, 2003). These types of interventions include separate or joint sessions, family meetings, home visits, multi-family groups, or a combination of these interventions (McDaniel et al., 2005). These interventions are frequently interdisciplinary, as when Dr. Robbins and Martha met with Mary's family in several family meetings. Even though for research purposes these interventions have structured manuals and protocols, these interventions are flexible and can be adapted according to the circumstances of the environments where they are being implemented. For example, García-Huidobro, Bittner, Brahm, and Puschel (2011) implemented a family-based intervention to improve the metabolic control of patients with type 2 diabetes. This intervention advanced a family approach to diabetes care and included components such as having medical assistants ask how the family were helping them with their condition, pharmacists discussing with patients and their families about the use of the medications, and providers extending family consultations in home visits to discuss in-depth strategies and increase family involvement in the patient's care. These last components were conducted by physicians, nurses, psychologists, or social workers who were trained in principles of family therapy, how to conduct family assessments and support family relationships (but they were not asked to follow a scripted intervention for each meeting). As with this example, many family-based interventions are focused at strengthening family relationships and promoting involvement in patients' care. Training is required for MedFTs to deliver these interventions effectively.

Research in support of family-based interventions, especially those focused on physical health outcomes, is growing. In the last decades, multiple systematic reviews have been published reporting the benefit of including family members in preventive or therapeutic interventions (Campbell, 2003; Chesla, 2010;

Hartmann et al., 2010; Martire et al., 2004, 2010; Shields et al., 2012). In preventive care, family-based interventions are useful at increasing healthy eating and physical activity and preventing overweight/obesity, high blood pressure, dyslipidemia, smoking, and overall cardiovascular risk (Garcia-Huidobro & Marsalis, 2012). In addition to improving relationship outcomes (Martire et al., 2010), family-based interventions are also useful at improving the management of multiple medical conditions such as arthritis and chronic pain (Hartmann et al., 2010; Martire et al., 2010), type 1 and type 2 diabetes control (Baig, Benitez, Quinn, & Burnet, 2015; Torenholt, Schwennesen, & Willaing, 2014), anti-HIV medication management (Hartmann et al., 2010), cardiovascular disease and stroke (Hartmann et al., 2010; Sher et al., 2014), and improved coping with cancer (Hartmann et al., 2010; Shields et al., 2012). Involving spouses only or a diverse group of family members seems to produce similar results (Hartmann et al., 2010). Effects on family members' health have been observed in interventions targeting cardiovascular disease, cancer, and arthritis, but there is less evidence supporting these extended effects (Hartmann et al., 2010; Martire et al., 2010). With all these encouraging results, family medicine clinics are a prime location for the work of MedFTs.

Community Approaches

Integrated primary care services go beyond the clinic or healthcare networks. Integrated behavioral healthcare includes collaborating with community agencies, faith organizations, among other groups that also have an impact in patient health (McDaniel et al., 2014). MedFTs working in primary care settings with the required skills to successfully interact with members of the community can be tremendous assets to collaborate maximizing the resources that would help patients and their local communities become happier and healthier.

Research in this area is also growing and oftentimes has been conducted under the principles of community-based participatory research (CBPR; Minkler & Wallerstein, 2011), which emphasize the participation of the community in all phases of the research projects. Community Partners in Care (CPIC) was the first randomized study that compared "traditional" research methods with CBPR methods (Wells et al., 2013). This study focused on improving mental health in Los Angeles, CA, using community engagement and planning or resources for services. After 6 months of intervention, participants in the community engagement group achieved better outcomes, including better health-related quality of life, reduced behavioral health hospitalizations, and increased depression visits among users of primary care.

Beck et al. (2014) developed a collaborative intervention between primary care clinics and community organizations called Keeping Infants Nourished and Developing [KIND]. In this partnership, pediatricians and community collaborators developed processes to link food-insecure families of infants with supple-

mentary formula, educational materials, and other resources (e.g., community referrals, food banks, and job training programs). After 14 months, recipients were more likely to have undergone lead testing and developmental screening procedures and to have received well-infant visits. Another example is presented by Ariza et al. (2013), where they linked pediatric primary care with community services focused in obesity via the Promoting Health Project [PHP]. Although this project was centered in processes related to partnership success, authors reported that this coordination required many unanticipated resources that ended up affecting patients' results.

Allen et al. (2013) present how a partnership between academics and community organizations (including primary care clinics) was developed using a paralleling community-academic partnership development with Erikson's stages of human development. As a way to reconcile the research interests of the academic partner in tobacco use prevention, alongside needs within parenting programs for immigrant Latino families, they developed a parenting curriculum using the academic and community expertise that led them to secure funding to conduct a large randomized study over 5 years (Allen et al., 2012). This intervention blended core Latino cultural values such as *respeto* (respect), *familismo* (importance of family relationships), and *personalismo* (importance of individual relationships) with evidence-based parenting education. As a product, the intervention had similar or higher attendance than other parenting programs, while improving parent-child relationships (Allen et al., 2017).

The population health approach, originally developed by the Canadian Institute for Advanced Research in the 1990s, aims to improve the health status of an entire population or subpopulations. This alternate approach was developed to oppose current standard (i.e., individualistic) approaches to care. Its primary focus is to reduce health inequities among population groups by recognizing and addressing factors and conditions that have a strong influence on our health, known as *determinants of health* (Sox, 2013). Examples of determinants of health include employment/working conditions, health services, education, income, and social environments (Richmond & Ross, 2008). This approach is based on the understanding that the health of populations as a whole is correlated with factors that fall outside the health system and which are not routinely addressed (Public Health Agency of Canada [PHAC], 2013). The population health approach calls for innovative and interrelated strategies that recognize the connections between the social, economic, and environmental health determinants. The focus, then, is on developing and implementing policies and actions to improve the health and well-being of those populations. Benefits of a population health approach extend beyond improved population health outcomes but also include a more wholly integrated health system.

Dr. Jeffrey Brenner, founder of the Camden Coalition of Healthcare Providers, has been recognized for his work in the field of population health. He has identified the term, *hotspotting*, as the strategic reallocation of resources to a small subset of high-needs, high-cost patients (Camden Coalition of Healthcare Providers [CCHP], 2016). These patients are known as *super-utilizers*—those

that account for much of the cost in the healthcare system. As these patients' chronic conditions worsen over time, they require more complex and expensive treatments. Hotspotting uses data to identify these super-utilizers and focuses efforts on understanding the problem, reallocating resources, and intervening. Multidisciplinary, coordinated care attends to both the medical and nonmedical needs that affect health (e.g., housing, mental health, substance abuse), providing a more holistic approach to patient care (CCHP, 2016). Considering a family medicine practice through the lens of a population health approach—including hotspotting to address the impact of super-utilizers on the health of the larger population—could be an advantageous way for MedFTs to focus in their integrated behavioral healthcare in a culturally relevant way.

In sum, MedFTs can support healthcare integration beyond their work in traditional clinical settings. However, they need to be aware that this work requires additional skills outlined in higher levels of the MedFT healthcare continuum (Table 2.3).

Conclusion

Family medicine has a long-standing relationship with family therapy and has been a place where integrated behavioral healthcare has gotten its footing. Given the exponential opportunities for family therapists to hold positions as administrators, clinicians, researchers, and faculty in family medicine settings, it is imperative that there are working models and resources to help provide the necessary training. When it comes down to it, we are all focused on health. While family therapists do not make diagnoses rooted in the physical body, they understand that all diagnoses, whether mental or medical, have psychosocial implications. There is a place at the table for relationally trained behavioral health providers. There is evidence that supports that approaching health from a relational perspective leads to positive health outcomes. Therefore, as clinical, operational, and financial models for integrated behavioral healthcare are becoming sustainable services in settings like family medicine, there will be an increase in demand for trained MedFT clinicians and researchers.

Reflection Questions

1. If you were given the opportunity to integrate into a family medicine setting, what strengths do you already possess that you believe would be transferable? What areas would be notable ones for future growth—and where could you get this training locally, regionally, and/or nationally?
2. What reimbursement mechanisms exist in your state that permit family therapists to bill for services in a family medicine setting? What reimbursement mechanisms exist but are not available to family therapists currently?
3. What are the top three things you know to recommend for patients who are developing health goals in each of the following areas: (a) sleep hygiene, (b) stress management, (c) physical activity, and (d) healthy eating?

Glossary of Important Terms for Care in Family Medicine

Attending physician In medical residency training, the attending physician is a faculty member responsible for the training of residents and supervision of patient care. At times the term “preceptor” may be used to describe an attending physician who is providing specific teaching and supervision during a focused period of time (such as a clinic session).

Collaborative care A model of healthcare delivery that requires collaborative efforts from people of different disciplines.

Colocated care A model of care where behavioral health providers are working in the same facility as physical health providers, but there is limited collaboration in their care.

Community-based participatory research (CBPR) An approach to research (and accompanying methodologies) that emphasize the co-ownership of the investigative process between professionals and community members; these efforts are carrying out within the contexts and processes of flat professional hierarchies.

Fellowship training Additional years of clinical experience focused on a specific area of interest, such as adolescent medicine, emergency medicine, palliative care, sports medicine, geriatrics, or others.

Healthcare disparities Systematic differences in the provision of healthcare; groups from marginalized populations tend to have less access to care and poorer health outcomes.

Hotspotting An innovative approach to managing healthcare disparities; it involves strategic reallocation of resources to a small subset of high-needs, high-cost patients.

Integrated behavioral healthcare A model of healthcare delivery that embeds behavioral healthcare providers within the traditional healthcare environment. At varying levels of integration, teams of providers share access to patients, electronic records, and physical space, and they collaborate and coordinate on plans for treatment.

Primary care Full-spectrum healthcare; primary care providers often serve as the patient’s “medical home” by managing chronic conditions, treating acute concerns, and coordinating treatment from various specialists.

Primary care provider The clinician who provides preventive and medical care for patients over time; this includes physicians, nurses, and physician assistants.

Residency Medical training that takes places after the completion of medical school but before independent practice. Most family medicine residency programs are 3 years long; a few require 4 years of training.

Resident A person who has graduated from medical school and is pursuing further training in a particular specialty area and may be referred to as an “intern” during the first year of training. The resident’s year of training is designated as PGY1 (program year 1), PGY2, etc. “Chief resident” is a senior leadership position with varying responsibilities based on the specific program but frequently includes some additional organizational and teaching responsibilities.

Silo A term that refers to the traditional separation between behavioral health and biomedical treatment.

Secondary care Specialist care focusing on a specific body system, disease, or condition (e.g., medical family therapist, endocrinologist, cardiologist, etc.).

Tertiary care Higher-level specialty care within the hospital requiring highly specialized equipment and expertise or complex treatments or procedures (e.g., burn units, neonatal intensive care unit).

Additional Resources

Literature

- Blount, A. (2003). Integrated primary care: Organizing the evidence. *Families, Systems, & Health, 21*, 121–133. <https://doi.org/10.1037/1091-7527.21.2.121>.
- Crane, D., & Christenson, J. D. (2014). A summary report of cost-effectiveness: Recognizing the value of family therapy in health care. In J. Hodgson, A. Lamson, T. Mendenhall, and D. Crane (Eds.), *Medical family therapy: Advanced applications* (pp. 419–436). New York, NY: Springer.
- Hodgson, J., Lamson, A., Mendenhall, T., & Crane, D. (Eds.). (2014). *Medical family therapy: Advanced applications*. New York, NY: Springer.
- Marlowe, D., Hodgson, J., Lamson, J., White, M., & Irons, T. (2012). Medical family therapy in a primary care setting: A framework for integration. *Contemporary Family Therapy, 34*, 244–258. <https://doi.org/10.1007/s10591-012-9195-5>.
- McDaniel, S. H., Doherty, W. J., & Hepworth, J. (2014). *Medical family therapy and integrated care*. Washington, DC: American Psychological Association.
- McDaniel, S., Campbell, T. L., Hepworth, J., & Lorenz, A. (2005). *Family-oriented primary care*. New York, NY: Springer.
- Peek, C. J. (2008). Planning care in the clinical, operational, and financial worlds. In R. Kessler and D. Stafford (Eds.), *Collaborative medicine case studies* (pp. 25–38). New York, NY: Springer.

Electronic Resources

- Collaborative Families and Health Blog. <http://www.cfha.net/blogpost/753286/Families-and-Health>
- Integrated Behavioral Health Project (2007). <http://www.ibhp.org/>
- Society of Teachers of Family Medicine (resource section). <http://www.stfm.org/Resources>
- Substance Abuse and Mental Health Services Administration (2016). *What is Integrated Care?* <http://www.integration.samhsa.gov/about-us/what-is-integrated-care>

Measures/Instruments

- Brief Pain Inventory. <https://www.mdanderson.org/education-and-research/departments-programs-and-labs/departments-and-divisions/symptom-research/symptom-assessment-tools/brief-pain-inventory.html>
- CAGE Assessment. <http://www.tobaccofreemaine.org/channels/providers/documents/CAGE.pdf>
- Edinburgh Postnatal Depression Scale (EPDS). <http://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf>
- Generalized Anxiety Disorder 7-item (GAD-7) scale. <http://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf>
- Healthy Living Questionnaire. http://www.integration.samhsa.gov/clinical-practice/Healthy_Living_Questionnaire2011.pdf
- Kessler 6 Assessment of Mood. <http://www.integration.samhsa.gov/images/res/K6%20Questions.pdf>
- Patient Health Questionnaire (PHQ-9). http://www.cqaimh.org/pdf/tool_phq9.pdf
- Patient Satisfaction Questionnaire. http://www.rand.org/health/surveys_tools/psq.html
- Patient Stress Questionnaire. http://www.integration.samhsa.gov/Patient_Stress_Questionnaire.pdf
- Primary Care-PTSD Screen. http://www.mirecc.va.gov/docs/visn6/2_primary_care_ptsd_screen.pdf
- Quality of Life Scale (QOLS). https://www.theacpa.org/uploads/documents/Life_Scale_3.pdf
- Suicide Behaviors Questionnaire (SBQ-R). <http://www.integration.samhsa.gov/images/res/SBQ.pdf>
- Vanderbilt Assessment Scale. <http://www.nichq.org/childrens-health/adhd/resources/vanderbilt-assessment-scales>

Organizations/Associations

- American Academy of Family Physicians. www.aafp.org
- American Association for Marriage and Family Therapy. www.aamft.org
- Collaborative Family Healthcare Association. www.cfha.net
- Society of Teachers of Family Medicine. www.stfm.org

References¹

- Agras, W. S., Walsh, B. T., Fairburn, C. G., Wilson, G. T., & Kraemer, H. C. (2000). A multicenter comparison of cognitive-behavioral therapy and interpersonal psychotherapy for bulimia nervosa. *Archives of General Psychiatry*, *57*, 459–466. <https://doi.org/10.1001/archpsyc.57.5.459>
- Allen, M., Svetaz, M. V., Hurtado, G. A., Linares, R., Garcia-Huidobro, D., & Hurtado, M. (2013). The developmental stages of a community-university partnership: The experience of padres informados/jovenes preparados. *Progress in Community Health Partnerships: Research, Education, and Action*, *7*, 271–279. <https://doi.org/10.1353/cpr.2013.0029>
- Allen, M. L., Garcia-Huidobro, D., Bastian, T., Hurtado, G. A., Linares, R., & Svetaz, M. V. (2017). Reconciling research and community priorities in a multisite participatory trial (mPaT): Application to padres informados/jovenes preparados. *Family Practice*, *34*, 347–352.
- Allen, M. L., Garcia-Huidobro, D., Hurtado, G. A., Allen, R., Davey, C. S., Forster, J. L., ... Trebs, L. (2012). Immigrant family skills-building to prevent tobacco use in Latino youth: Study protocol for a community-based participatory randomized controlled trial. *Trials*, *13*, 242–252. <https://doi.org/10.1186/1745-6215-13-242>
- American Academy of Family Physicians (2015). *Member census*. Retrieved from <http://www.aafp.org/about/the-aafp/family-medicine-facts/table-13.html>
- American Diabetes Association. (2015). Classification and diagnosis of diabetes. *Diabetes Care*, *38*, S8–S16. <https://doi.org/10.2337/dc15-S005>
- American Diabetes Association. (2016). Standards of medical care in diabetes. *Diabetes Care*, *39*, S1–S106. <https://doi.org/10.2337/diaclin.34.1.3>
- Anstiss, T. (2009). Motivational interviewing in primary care. *Journal of Clinical Psychology in Medical Settings*, *16*, 87–93. <https://doi.org/10.1007/s10880-009-9155-x>
- Ariza, A. J., Hartman, J., Grodecki, J., Clavier, A., Ghaey, K., Elsner, M., ... Binns, H. J. (2013). Linking pediatric primary care obesity management to community programs. *Journal of Health Care for the Poor and Underserved*, *24*, 158–167. <https://doi.org/10.1353/hpu.2013.0112>
- Baig, A. A., Benitez, A., Quinn, M. T., & Burnet, D. L. (2015). Family interventions to improve diabetes outcomes for adults. *Annals of the New York Academy of Sciences*, *1353*, 89–112. <https://doi.org/10.1111/nyas.12844>
- Bäumli, J., Froböse, T., Kraemer, S., Rentrop, M., & Pitschel-Walz, G. (2006). Psychoeducation: A basic psychotherapeutic intervention for patients with schizophrenia and their families. *Schizophrenia Bulletin*, *32*(Suppl 1), s1–s9. <https://doi.org/10.1093/schbul/sbl017>
- Beck, A. F., Henize, A. W., Kahn, R. S., Reiber, K. L., Young, J. J., & Klein, M. D. (2014). Forging a pediatric primary care–community partnership to support food-insecure families. *Pediatrics*, *134*, e564–e571. <https://doi.org/10.1542/peds.2013-3845>
- Bitar, G. W., Springer, P., Gee, R., Graff, C., & Schydlower, M. (2009). Barriers and facilitators of adolescent behavioral health in primary care: Perceptions of primary care providers. *Families, Systems, and Health*, *27*, 346–361. <https://doi.org/10.1037/a0018076>
- Blair, I. V., Havranek, E. P., Price, D. W., Hanratty, R., Fairclough, D. L., Farley, T., ... Steiner, J. F. (2013). An assessment of biases against Latinos and African Americans among primary care providers and community members. *American Journal of Public Health*, *103*, 92–98. <https://doi.org/10.2105/AJPH.2012.300812>
- *Blount, A. (2003). Integrated primary care: Organizing the evidence. *Families, Systems, & Health*, *21*, 121–133. <https://doi.org/10.1037/1091-7527.21.2.121>
- Bostock, S., & Steptoe, A. (2012). Association between low functional health literacy and mortality in older adults: Longitudinal cohort study. *British Journal of Medicine*, *344*, 1–10. <https://doi.org/10.1136/bmj.e1602>

¹Note: References that are prefaced with an asterisk are recommended readings

- Bridges, A. J., Andrews, A. R., Villalobos, B. T., Pastrana, F. A., Cavell, T. A., & Gomez, D. (2014). Does integrated behavioral health care reduce mental health disparities for Latinos? Initial findings. *Journal of Latino/a Psychology, 2*, 37–53. <https://doi.org/10.1037/lat0000009>
- Britt, E., Hudson, S. M., & Blampied, N. M. (2004). Motivational interviewing in health settings: A review. *Patient Education and Counseling, 53*, 147–155. [https://doi.org/10.1016/S0738-3991\(03\)00141-1](https://doi.org/10.1016/S0738-3991(03)00141-1)
- Brook, R. D., Appel, L. J., Rubenfire, M., Ogedegbe, G., Bisognano, J. D., Elliot, W. J., ... Rajagopalan, S. (2013). Beyond medications and diet: Alternative approaches to lowering blood pressure: A scientific statement from the American Heart Association. *Hypertension, 61*, 1360–1383. <https://doi.org/10.1161/HYP.0b013e318293645f>
- Browne, G., Steiner, M., Roberts, J., Gafni, A., Byrne, C., Dunn, E., ... Kraemer, J. (2002). Sertraline and/or interpersonal psychotherapy for patients with dysthymic disorder in primary care: 6-month comparison with longitudinal 2-year follow-up of effectiveness and costs. *Journal of Affective Disorders, 68*, 317–330. [https://doi.org/10.1016/S0165-0327\(01\)00343-3](https://doi.org/10.1016/S0165-0327(01)00343-3)
- Camden Coalition of Healthcare Providers. (2016). *Healthcare hotspotting: A project of the Camden Coalition of Healthcare Providers*. Retrieved from <http://hotspotting.camdenhealth.org/>
- Campbell, T. L. (2003). The effectiveness of family interventions for physical disorders. *Journal of Marriage and Family Therapy, 29*, 263–281. <https://doi.org/10.1111/j.1752-0606.2003.tb01204.x>
- Caplan, L., Wolfe, F., Michaud, K., Quinzanos, I., & Hirsh, J. M. (2014). Strong association of health literacy with functional status among rheumatoid arthritis patients: A cross-sectional study. *Arthritis Care & Research, 66*, 508–514. <https://doi.org/10.1002/acr.22165>
- Centers for Disease Control & Prevention (CDC). (2016). *Most recent asthma data*. Retrieved from http://www.cdc.gov/asthma/most_recent_data.htm
- Centers for Medicare & Medicaid Services (CMS). (2013). *Common codes for family practice*. Retrieved from <http://www.roadto10.org/specialty-references/common-codes-family-practice/>
- Chapman, E. N., Kaatz, A., & Carnes, M. (2013). Physicians and implicit bias: How doctors may unwittingly perpetuate health care disparities. *Journal of General Internal Medicine, 28*, 1504–1510. <https://doi.org/10.1007/s11606-013-2441-1>
- Chesla, C. (2010). Do family interventions improve health? *Journal of Family Nursing, 16*, 355–377. <https://doi.org/10.1177/1074840710383145>
- Cluxton-Keller, F., Riley, A. W., Noazin, S., & Umoren, M. V. (2015). Clinical effectiveness of family therapeutic interventions embedded in general pediatric primary care settings for parental mental health: A systematic review and meta-analysis. *Clinical Child and Family Psychology Review, 18*, 395–412. <https://doi.org/10.1007/s10567-015-0190-x>
- Cohen, D. J., Balasubramanian, B. A., Davis, M., Hall, J., Gunn, R., Stange, K. C., ... Miller, B. F. (2015). Understanding care integration from the ground up: Five organizing constructs that shape integrated practices. *Journal of the American Board of Family Medicine, 28*(Suppl 1), S7–S20. <https://doi.org/10.3122/jabfm.2015.S1.150050>
- Conner, K. O., Copeland, V. C., Grote, N. K., Koeske, G., Rosen, D., Reynolds, C. F., & Brown, C. (2010). Mental health treatment seeking among older adults with depression: The impact of stigma and race. *American Journal of Geriatric Psychiatry, 18*, 531–543. <https://doi.org/10.1097/JGP.0b013e3181cc0366>
- Cook, B. L., Zuvekas, S. H., Carson, N., Wayne, G. F., Vesper, A., & McGuire, T. J. (2014). Assessing racial/ethnic disparities in treatment across episodes of mental health care. *Health Services Research, 49*, 206–229. <https://doi.org/10.1111/1475-6773.12095>
- Crane, D., & Christenson, J. D. (2012). A summary report of the cost-effectiveness of the profession and practice of marriage and family therapy. *Contemporary Family Therapy, 34*, 204–216. <https://doi.org/10.1007/s10591-012-9187-5>
- *Crane, D., & Christenson, J. D. (2014). A summary report of cost-effectiveness: Recognizing the value of family therapy in health care. In J. Hodgson, A. Lamson, T. Mendenhall, and D. Crane. (Eds.), *Medical family therapy: Advanced applications* (pp. 419–436). New York, NY: Springer.

- Craske, M. G., Roy-Byrne, P., Stein, M. B., Sullivan, G., Hazlett-Stevens, H., Bystritsky, A., & Sherbourne, C. (2006). CBT intensity and outcome for panic disorder in a primary care setting. *Behavior Therapy, 37*, 112–119. <https://doi.org/10.1016/j.beth.2005.05.003>
- Dastan, N. B., & Buzlu, S. (2012). Psychoeducation intervention to improve adjustment to cancer among Turkish stage I-II breast cancer patients: A randomized controlled trial. *Asian Pacific Journal of Cancer Prevention, 13*, 5313–5318. <https://doi.org/10.7314/apjcp.2012.13.10.5313>
- deGruy, F. (1996). Mental health care in the primary care setting. In M. S. Donaldson, K. D. Yordy, K. N. Lohr, and N. A. Vanselow (Eds.), *Primary care: America's health in a new era* (pp. 285–311). Washington, D.C: Institute of Medicine.
- Dessaules, A., Johnson, S. M., & Denton, W. H. (2003). Emotion-focused therapy for couples in the treatment of depression: A pilot study. *American Journal of Family Therapy, 31*, 345–353. <https://doi.org/10.1080/01926180390232266>
- Doherty, W. J., & Baird, M. A. (1983). *Family therapy and family medicine: Toward the primary care of families*. New York, NY: Guilford Press.
- Doherty, W. J., & Baird, M. A. (1987). *Family centered medical care: A clinical casebook*. New York, NY: Guilford Press.
- Donker, T., Griffiths, K. M., Cuijpers, P., & Christensen, H. (2009). Psychoeducation for depression, anxiety, and psychological distress: A meta-analysis. *BMC Medicine, 7*, 79–88. <https://doi.org/10.1186/1741-7015-7-79>
- Dowell, D., Haegerich, T. M., & Chou, R. (2016). CDC guideline for prescribing opioids for chronic pain – United States, 2016. *Recommendations and reports, 65*, 1–49. [10.15585/mmwr.mm6501e1er](https://doi.org/10.15585/mmwr.mm6501e1er)
- Druss, B. G., Hwang, I., Petukhova, M., Sampson, N. A., Wang, P. S., & Kessler, R. C. (2009). Impairment in role functioning in mental and chronic medical disorders in the United States: Results from the national comorbidity survey replication. *Molecular Psychiatry, 14*, 728–737. <https://doi.org/10.1038/mp.2008.13>
- Eisler, I., Simic, M., Russell, G. F. M., & Dare, C. (2007). A randomized controlled treatment trial of two forms of family therapy in adolescent anorexia nervosa: A five-year follow-up. *Journal of Child Psychology and Psychiatry, 48*, 552–560. <https://doi.org/10.1111/j.1469-7610.2007.01726.x>
- Ejebj, K., Savitskij, R., Ost, L., Ekbom, A., Brandt, L., Ramnero, J., ... Backlund, L. G. (2014). Randomized controlled trial of transdiagnostic group treatments for primary care patients with common mental disorders. *Family Practice, 31*, 273–280. <https://doi.org/10.1093/fampra/cmu006>
- Endevelt, R., Peled, R., Azrad, A., Kowen, G., Valinsky, L., & Heymann, A. D. (2015). Diabetes prevention program in a Mediterranean environment: Individual or group therapy? An effectiveness evaluation. *Primary Care Diabetes, 9*, 89–95. <https://doi.org/10.1016/j.pcd.2014.07.005>
- *Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196*, 129–136. <https://doi.org/10.1016/b978-0-409-95009-0.50006-1>
- *Engel, G. L. (1980). The clinical application of the biopsychosocial model. *American Journal of Family Medicine, 137*, 535–544. <https://doi.org/10.1176/ajp.137.5.535>
- Escobar, J. I., Gara, M. A., Diaz-Martinez, A. M., Interian, A., Warman, M., ... Rodgers, D. (2007). Effectiveness of a time-limited cognitive behavior therapy-type intervention among primary care patients with medically unexplained symptoms. *Annals of Family Medicine, 5*, 328–335. <https://doi.org/10.1370/afm.702>
- Ewing, E. S. K., Diamond, G., & Levy, S. (2015). Attachment-based family therapy for depressed and suicidal adolescents: Theory, clinical model and empirical support. *Attachment & Human Development, 17*, 136–156. <https://doi.org/10.1080/14616734.2015.1006384>
- Fals-Stewart, W., Birchler, G. R., & Kelley, M. L. (2006). Learning sobriety together: A randomized clinical trial examining behavioral couples therapy with alcoholic female patients. *Journal of Consulting and Clinical Psychology, 74*, 579–591. <https://doi.org/10.1037/0022-006x.74.3.579>
- Felt, B. T., Biermann, B., Christner, J. G., Kochhar, P., & Van Harrison, R. (2014). Diagnosis and management of ADHD in children. *American Family Physician, 90*, 456–464. Retrieved from <http://www.aafp.org/journals/afp.html>

- Fischer, M. S., Baucom, D. H., & Cohen, M. J. (2016). Cognitive-behavioral couple therapies: Review of the evidence for the treatment of relationship distress, psychopathology, and chronic health conditions. *Family Process*, 55, 423–442. <https://doi.org/10.1111/famp.12227>
- Fries, J., Koop, E., Beadle, D., Cooper, P., England, M., Greaves, J., Sokoilov, J., Wright, D., & the Health Project Consortium. (1993). Reducing health care costs by reducing the need and demand for medical services. *New England Journal of Medicine*, 329, 321–325. <https://doi.org/10.1056/NEJM199307293290506>
- Galanti, G. A. (2014). *Caring for patients from different cultures* (2nd ed.). Philadelphia, PA: University of Pennsylvania Press.
- Garcia-Huidobro, D., Bittner, M., Brahm, P., & Puschel, K. (2011). Family intervention to control type 2 diabetes: A controlled clinical trial. *Family Practice*, 28, 4–11. <https://doi.org/10.1093/fampra/cmq069>
- Garcia-Huidobro, D., & Marsalis, S. (2012). *Family interventions for the primary prevention of cardiovascular disease*. Presentation at the annual conference for the Collaborative Family Healthcare Association, Austin.
- Gardner, W., Murphy, M., Childs, G., Kelleher, K., Pagano, M., Jellinek, M., ... Sturner, R. (1999). The PSC-17: A brief pediatric symptom checklist with psychosocial problem subscales. A report from PROS and ASPN. *Ambulatory Child Health*, 5, 225–236. Retrieved from [http://onlineibrary.wiley.com/journal/10.1111/\(ISSN\)1467-0658/issues](http://onlineibrary.wiley.com/journal/10.1111/(ISSN)1467-0658/issues)
- Gatchel, R., & Oordt, M. (2003). *Clinical health psychology and primary care: Practical advice and clinical guidance for successful collaboration*. Washington, DC, US: American Psychological Association.
- George, C. M., Bruijn, L. L., Will, K., & Howard-Thompson, A. (2015). Management of blood glucose with noninsulin therapies in type 2 diabetes. *American Family Physician*, 92, 27–34. Retrieved from <http://www.aafp.org/journals/afp.html>
- Gingerich, W. J., & Peterson, L. T. (2013). Effectiveness of solution-focused brief therapy: A systematic qualitative review of controlled outcome studies. *Research on Social Work Practice*, 23, 266–283. <https://doi.org/10.1177/1049731512470859>
- Godfrey, E., Chalder, T., Ridsdale, L., Seed, P., & Ogden, J. (2007). Investigating the ‘active ingredients’ of cognitive behaviour therapy and counselling for patients with chronic fatigue in primary care: Developing a new process measure to assess treatment fidelity and predict outcome. *British Journal of Clinical Psychology*, 46, 253–272. <https://doi.org/10.1348/014466506X147420>
- Goldstein, D., & Holmes, J. (2011). Health and wellness survey: 2011 physicians’ daily life poll. Retrieved from <http://www.rwjf.org/content/dam/web-assets/2011/11/2011-physicians--daily-life-report>
- Hartmann, M., Bzner, E., Wild, B., Eisler, I., & Herzog, W. (2010). Effects of interventions involving the family in the treatment of adult patients with chronic physical diseases: A meta-analysis. *Psychotherapy and Psychosomatics*, 79, 136–148. <https://doi.org/10.1159/000286958>
- Hatala, A. R. (2012). The status of the “biopsychosocial” model in health psychology: Towards an integrated approach and a critique of cultural conceptions. *Open Journal of Medical Psychology*, 1, 51–62. <https://doi.org/10.4236/ojmp.2012.14009>
- Hayes, C., Naylor, R., & Egger, G. (2012). Understanding chronic pain in a lifestyle context: The emergence of a whole-person approach. *American Journal of Lifestyle Medicine*, 6, 421–428. <https://doi.org/10.1177/1559827612439282>
- Hodgson, J., Fox, M., & Lamson, A. (2014). Family therapists in primary care settings: Opportunities for integration through advocacy. In J. Hodgson, A. Lamson, T. Mendenhall, and D. Crane (Eds.), *Medical family therapy: Advanced applications* (pp. 357–380). New York, NY: Springer.
- *Hodgson, J., Lamson, A., Mendenhall, T., & Crane, D. (Eds.). (2014). *Medical family therapy: Advanced applications*. New York, NY: Springer. <https://doi.org/10.1007/978-3-319-03482-9>
- Hodgson, J., Lamson, A., Mendenhall, T., & Tyndall, L. (2014). Introduction to medical family therapy: Advanced applications. In J. Hodgson, A. Lamson, T. Mendenhall, and D. Crane (Eds.), *Medical family therapy: Advanced applications* (pp. 1–9). New York, NY: Springer.

- Huang, L., Yang, L., Shen, X., & Yan, S. (2016). Relationship between glycated hemoglobin A1c and cognitive function in nondemented elderly patients with type 2 diabetes. *Metabolic Brain Disorders*, *31*, 347–353. <https://doi.org/10.1007/s11011-015-9756-z>
- Hudon, C., Fortin, M., Haggerty, J., Loignon, C., Lambert, M., & Poitras, M. E. (2012). Patient-centered care in chronic disease management: A thematic analysis of the literature in family medicine. *Patient Education and Counseling*, *88*, 170–176. <https://doi.org/10.1016/j.pec.2012.01.009>
- Jackman, R. P., Purvis, J. M., & Mallett, B. S. (2008). Chronic nonmalignant pain in primary care. *American Family Physician*, *78*, 1155–1162. Retrieved from <http://www.aafp.org/journals/afp.html>
- Kelly, E. L., Davis, L., & Brekke, J. S. (2015). PBRN findings: Integrated care for individuals with serious mental illness. *Psychiatric Services*, *66*, 1253–1253. <https://doi.org/10.1176/appi.ps.201500075>
- Kessler, R., Chiu, W., Demler, O., & Walters, E. (2005). Prevalence, severity, and comorbidity of 12-Month DSM-IV disorders in the National Comorbidity Survey replication. *Archives of General Psychiatry*, *62*, 617–627. <https://doi.org/10.1001/archpsyc.62.6.617>
- Kessler, R., & Stafford, D. (2008). Primary care is the de facto mental health system. In R. Kessler and D. Stafford (Eds.), *Collaborative medicine case studies* (pp. 9-21). New York, NY: Springer.
- Kessler, D., Lewis, G., Kaur, S., Wiles, N., King, M., Weich, S., ... Peters, T. J. (2009). Therapist-delivered internet psychotherapy for depression in primary care: A randomised controlled trial. *The Lancet*, *374*, 628–634. [https://doi.org/10.1016/S0140-6736\(09\)61257-5](https://doi.org/10.1016/S0140-6736(09)61257-5)
- Kindaichi, M. M., & Mebane, S. (2011). Considerations for treating depression in adolescent and college-enrolled females. In P. K. Lundberg-Love, K. L. Nadal, and M. A. Paludi (Eds.), *Women and mental disorders* (pp. 93–109). Santa Barbara, CA: Praeger.
- Kozakowski, S. M., Becher, K., Hinkle, T., Blackwelder, R., Knight, C., Bentley, A., & Pugno, P. A. (2016). Responses to medical students' frequently asked questions about family medicine. *American Family Physician*, *93*, 1–8. Retrieved from <http://www.aafp.org/journals/afp.html>
- Kroenke, K., & Mangelsdorff, D. (1989). Common symptoms in ambulatory care: Incidence, evaluation, therapy and outcome. *American Journal of Medicine*, *86*, 262–266. [https://doi.org/10.1016/0002-9343\(89\)90293-3](https://doi.org/10.1016/0002-9343(89)90293-3)
- Langan, R., & Jones, K. (2015). Common questions about the initial management of hypertension. *American Family Physician*, *91*, 172–177. Retrieved from <http://www.aafp.org/journals/afp.html>
- Leslie, L. K., Mehus, C. J., Hawkins, J. D., Boat, T., McCabe, M. A., Barkin, S., ... Beardslee, W. (2016). Primary health care: Potential home for family-focused preventive interventions. *American Journal of Preventive Medicine*, *51*(4 Suppl 2), S106–S118.
- Liddle, H. A., Dakof, G. A., Turner, R. M., Henderson, C. E., & Greenbaum, P. E. (2008). Treating adolescent drug abuse: A randomized trial comparing multidimensional family therapy and cognitive behavior therapy. *Addiction*, *103*, 1660–1670. <https://doi.org/10.1111/j.1360-0443.2008.02274.x>
- Liddle, H. A., Rowe, C. L., Dakof, G. A., Henderson, C. E., & Greenbaum, P. E. (2009). Multidimensional family therapy for young adolescent substance abuse: Twelve-month outcomes of a randomized controlled trial. *Journal of Consulting and Clinical Psychology*, *77*, 12–25. <https://doi.org/10.1037/a0014160>
- Linde, K., Rucker, G., Sigterman, K., Jamil, S., Meissner, K., Schneider, A., & Kriston, L. (2015). Comparative effectiveness of psychological treatments for depressive disorders in primary care: Network meta-analysis. *BMC Family Practice*, *16*, 1–14. <https://doi.org/10.1186/s12875-015-0314-x>
- Lock, J., Agras, W. S., Bryson, S., & Kraemer, H. C. (2005). A comparison of short- and long term family therapy for adolescent anorexia nervosa. *Journal of the American Academy of Child and Adolescent Psychiatry*, *44*, 632–639. <https://doi.org/10.1097/01.chi.0000161647.82775.0a>
- Loeb, K. L., Walsh, T., Lock, J., le Grange, D., Jones, J., Marcus, S., et al. (2007). Open trial of family-based treatment for full and partial anorexia nervosa in adolescence: Evidence of suc-

- cessful dissemination. *Journal of the American Academy of Child and Adolescent Psychiatry*, 46, 792–800. <https://doi.org/10.1097/chi.0b013e318058a98e>
- Lundahl, B., Moleni, T., Burke, B. L., Butters, R., Tollefson, D., Butler, C., & Rollnick, S. (2013). Motivational interviewing in medical care settings: A systematic review and meta-analysis of randomized controlled trials. *Patient Education and Counseling*, 93, 157–168. <https://doi.org/10.1016/j.pec.2013.07.012>
- Makaroff, L. A., Xierali, I. M., Petterson, S. M., Shipman, S. A., Puffer, J. C., & Basexmore, A. W. (2014). Factors influencing family physicians' contribution to the child health care workforce. *Annals of Family Medicine*, 12, 427–431. <https://doi.org/10.1370/afm.1689>
- Markowitz, J. C., Petkova, E., Neria, Y., Van Meter, P. E., Zhao, Y., Hembree, E., ... Marshall, R. D. (2015). Is exposure necessary? A randomized clinical trial of interpersonal psychotherapy for PTSD. *American Journal of Psychiatry*, 172, 430–440. <https://doi.org/10.1176/appi.ajp.2014.14070908>
- Markowitz, J. C., & Weissman, M. M. (2004). Interpersonal psychotherapy: Principles and applications. *World Psychiatry*, 3, 136–139. Retrieved from [http://onlinelibrary.wiley.com/journal/10.1002/\(ISSN\)2051-5545](http://onlinelibrary.wiley.com/journal/10.1002/(ISSN)2051-5545)
- *Marlowe, D., Hodgson, J., Lamson, J., White, M., & Irons, T. (2012). Medical family therapy in a primary care setting: A framework for integration. *Contemporary Family Therapy*, 34, 244–258. <https://doi.org/10.1007/s10591-012-9195-5>
- Martire, L., Schulz, R., Helgeson, V., Small, B., & Saghafi, E. (2010). Review and meta-analysis of couple-oriented interventions for chronic illness. *Annals of Behavioral Medicine*, 40, 325–342. <https://doi.org/10.1007/s12160-010-9216-2>
- Martire, L. M., Lustig, A. P., Schulz, R., Miller, G. E., & Helgeson, V. S. (2004). Is it beneficial to involve a family member? A meta-analysis of psychosocial interventions for chronic illness. *Health Psychology*, 23, 599–611. <https://doi.org/10.1037/0278-6133.23.6.599>
- Matos, M., Bauermeister, J. J., & Bernal, G. (2009). Parent-child interaction therapy for Puerto Rican preschool children with ADHD and behavior problems: A pilot efficacy study. *Family Process*, 48, 232–252. <https://doi.org/10.1111/j.1545-5300.2009.01279.x>
- McCann, C. M., & le Roux, P. (2006). Individual, family, and group therapy for adolescents. *Adolescent Medicine Clinics*, 17, 217–231. <https://doi.org/10.1016/j.admecli.2005.09.003>
- *McDaniel, S., Campbell, T. L., Hepworth, J., & Lorenz, A. (2005). *Family-oriented primary care*. New York, NY: Springer.
- *McDaniel, S. H., Doherty, W. J., & Hepworth, J. (2014). *Medical family therapy and integrated care* (2nd ed.). Washington, DC: American Psychological Association.
- McDaniel, S. H., Hepworth, J., & Doherty, W. J. (1992). *Medical family therapy: A biopsychosocial approach to families with health problems*. New York, NY: Basic Books.
- Meng, H., Friedberg, F., & Castora-Binkley, M. (2014). Cost-effectiveness of chronic fatigue self-management versus usual care: A pilot randomized controlled trial. *BMC Family Practice*, 15, 184–192. <https://doi.org/10.1186/s12875-014-0184-7>
- Miller, W. R. (1983). Motivational interviewing with problem drinkers. *Behavioural Psychotherapy*, 11, 147–172. <https://doi.org/10.1017/S0141347300006583>
- Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York, NY: Guilford Press.
- Minkler, M., & Wallerstein, N. (Eds.). (2011). *Community-based participatory research for health: From process to outcomes*. San Francisco: John Wiley & Sons.
- Moral, R. R., de Torres, L., Angel, P., Ortega, L. P., Larumbe, M. C., Villalobos, A. R., ... Rejano, J. M. P. (2015). Effectiveness of motivational interviewing to improve therapeutic adherence in patients over 65 years old with chronic diseases: A cluster randomized clinical trial in primary care. *Patient Education and Counseling*, 98, 977–983. <https://doi.org/10.1016/j.pec.2015.03.008>
- National Institute of Diabetes and Digestive and Kidney Disease. (2012). *Overweight & obesity statistics*. Retrieved from <https://www.niddk.nih.gov/health-information/health-statistics/overweight-obesity>

- Nixon, R. D. V. (2001). Changes in hyperactivity and temperament in behaviourally disturbed preschoolers after Parent-Child Interaction Therapy (PCIT). *Behaviour Change*, *18*, 168–176. <https://doi.org/10.1375/behc.18.3.168>
- Nixon, R. D. V., Sweeney, L., Erickson, D. B., & Touyz, S. W. (2004). Parent-child interaction therapy: One- and two- year follow-up of standard and abbreviated treatments for oppositional preschoolers. *Journal of Abnormal Child Psychology*, *32*, 263–271. <https://doi.org/10.1023/b:jacp.0000026140.60558.05>
- Nouwen, A., Winkley, K., Twisk, J., Lloyd, C. E., Peyrot, M., Ismail, K., & Pouwer, F. (2010). Type 2 diabetes mellitus as a risk factor for the onset of depression: A systematic review and meta-analysis. *Diabetologia*, *53*, 2480–2486. <https://doi.org/10.1007/s00125-010-1874-x>
- O'Hara, M. W., Stuart, S., Gorman, L. L., & Wenzel, A. (2000). Efficacy of interpersonal psychotherapy for postpartum depression. *Archives of General Psychiatry*, *57*, 1039–1045. <https://doi.org/10.1001/archpsyc.57.11.1039>
- Oza, R., & Garcellano, M. (2015). Nonpharmacologic management of hypertension: What works? *American Family Physician*, *91*, 772–776. Retrieved from <http://www.aafp.org/journals/afp.html>
- *Peek, C. J. (2008). Planning care in the clinical, operational, and financial worlds. In R. Kessler and D. Stafford (Eds.), *Collaborative medicine case studies* (pp. 25–38). New York, NY: Springer.
- *Pettersson, S., Miller, B. F., Payne-Murphy, J. C., & Phillips, R. L. (2014). Mental health treatment in the primary care setting: Patterns and pathways. *Families, Systems, & Health*, *32*, 157–166. <https://doi.org/10.1037/fsh0000036>
- Petznick, A. (2011). Insulin management of type 2 diabetes mellitus. *American Family Physician*, *84*, 183–190. Retrieved from <http://www.aafp.org/journals/afp.html>
- Phillips, R. L., Brungardt, S., Lesko, S. E., Kittle, N., Marker, J. E., Tuggy, M., ... Krug, N. (2014). The future role of the family physician in the United States: A rigorous exercise in definition. *Annals of Family Medicine*, *12*, 250–255. <https://doi.org/10.1370/afm.1651>
- Piper, M. A., Evans, C. V., Burda, B. U., et al. (2014). *Screening for high blood pressure in adults: A systematic evidence review for the U.S. preventive services task force, Evidence synthesis no. 121. AHRQ publication no. 13–05194-EF-1*. Rockville: Agency for Healthcare Research and Quality.
- Pippitt, K., Li, M., & Gurgle, H. E. (2016). Diabetes mellitus: Screening and diagnosis. *American Family Physician*, *93*, 103–109. Retrieved from <http://www.aafp.org/journals/afp.html>
- Polaha, J., Volkmer, A., & Valleley, R. J. (2007). A call-in service to address parent concerns about child behavior in rural primary care. *Families, Systems, & Health*, *25*, 333–343. <https://doi.org/10.1037/1091-7527.25.3.333>
- Public Health Agency of Canada. (2013). *What is the population health approach?* Retrieved from <http://www.phac-aspc.gc.ca/ph-sp/approach/approche/appr-eng.php>
- Purnell, T. S., Calhoun, E. A., Golden, S. H., Halladay, J. R., Krok-Schoen, J. L., Appelhans, B. M., & Cooper, L. A. (2016). Achieving health equity: Closing the gaps in health care disparities, interventions, and research. *Health Affairs*, *35*, 1410–1415. <https://doi.org/10.1377/hlthaff.2016.0158>
- Ranson, N. E., Terry, D. R., Glenister, K., Adam, B. R., & Wright, J. (2016). Integrated and consumer-directed care: A necessary paradigm shift for rural chronic ill health. *Australian Journal of Primary Health*, *22*, 176–180. <https://doi.org/10.1071/PY15056>
- Rao, G. (2008). Childhood obesity: Highlights of AMA expert committee recommendations. *American Family Physician*, *78*, 56–63. Retrieved from <http://www.aafp.org/journals/afp.html>
- Regier, D., Goldberg, I., & Taube, C. (1978). The de facto US mental health services system. *Archives of General Psychiatry*, *35*, 685–693. <https://doi.org/10.1001/archpsyc.1978.01770300027002>
- Regier, D., Narrow, W., Rae, D., Manderscheid, R., Locke, B., & Goodwin, F. (1993). The de facto US mental and addictive disorders service system: Epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*, *50*, 85–94. <https://doi.org/10.1001/archpsyc.1993.01820140007001>

- *Reiss-Brennan, B., Brunisholz, K. D., Dredge, C., Briot, P., Grazier, K., Wilcox, A., ... James, B. (2016). Association of integrated team-based care with health care quality, utilization, and cost. *Journal of the American Medical Association*, *316*, 826–834. <https://doi.org/10.1001/jama.2016.11232>
- Reitz, R., & Sudano, L. (2014). The medical family therapist as transdisciplinary trainer. In J. Hodgson, A. Lamson, T. Mendenhall, and D. Crane (Eds.), *Medical family therapy: Advanced applications* (pp. 177–195). New York, NY: Springer.
- Richmond, C. A. M., & Ross, N. A. (2008). The determinants of first nation and inuit health: A critical population health approach. *Health & Place*, *15*, 403–411. <https://doi.org/10.1016/j.healthplace.2008.07.004>
- Robinson, L., Iliffe, S., Brayne, C., Goodman, C., Rait, G., Manthorpe, J., ... Moniz-Cook, E. (2010). Primary care and dementia: 2 long-term care at home: Psychosocial interventions, information provision, career support and case management. *International Journal of Geriatric Psychiatry*, *25*, 657–664. <https://doi.org/10.1002/gps.2405>
- Rollnick, S., Miller, W. R., & Butler, C. C. (2008). *Motivational interviewing in health care: Helping patients change behavior*. New York, NY: Guilford.
- Sacks, F. M., Svetkey, L. P., Vollmer, W. M., Appel, L. J., Bray, G. A., Harsha, D., ... Cutler, J. A. (2001). Effects on blood pressure of reduced dietary sodium and the Dietary Approaches to Stop Hypertension (DASH) diet. *New England Journal of Medicine*, *344*, 3–10. <https://doi.org/10.1056/NEJM200101043440101>
- *Sanchez, K., Ybarra, R., Chapa, T., & Martinez, O. N. (2016). Eliminating behavioral health disparities and improving outcomes for racial and ethnic minority populations. *Psychiatric Services*, *67*, 13–15. <https://doi.org/10.1176/appi.ps.201400581>
- Santisteban, D. A., Coatsworth, J. D., Perez-Vidal, A., Kurtines, W. M., Schwartz, S., LaPerriere, A., & Szapocznik, J. (2003). The efficacy of Brief Strategic Family Therapy in modifying Hispanic adolescent behavior problems and substance use. *Journal of Family Psychology*, *17*, 121–133. <https://doi.org/10.1037/0893-3200.17.1.121>
- Sattel, H., Lahmann, C., Gundel, H., Guthrie, E., Kruse, J., Noll-Hussong, M., ... Henningsen, P. (2012). Brief psychodynamic interpersonal psychotherapy for patients with multisomatoform disorder: Randomised controlled trial. *British Journal of Psychiatry*, *200*, 60–67. <https://doi.org/10.1192/bjp.bp.111.093526>
- Schumm, J. A., O'Farrell, T. J., Kahler, C. W., Murphy, M. M., & Muchowski, P. (2014). A randomized clinical trial of behavioral couples therapy versus individually based treatment for women with alcohol dependence. *Journal of Consulting and Clinical Psychology*, *82*, 993–1004. <https://doi.org/10.1037/a0037497>
- Sexton, T., & Turner, C. W. (2010). The effectiveness of functional family therapy for youth with behavioral problems in a community practice setting. *Journal of Family Psychology*, *24*, 339–348. <https://doi.org/10.1037/a0019406>
- Sher, T., Braun, L., Domas, A., Bellg, A., Baucom, D. H., & Houle, T. T. (2014). The Partners for Life Program: A couples approach to cardiac risk reduction. *Family Process*, *53*, 131–149. <https://doi.org/10.1111/famp.12061>
- *Shields, C. G., Finley, M. A., Chawla, N., & Meadors, P. (2012). Couple and family interventions in health problems. *Journal of Marital and Family Therapy*, *38*, 265–280. <https://doi.org/10.1111/j.1752-0606.2011.00269.x>
- Siu, A. L. (2015). Screening for abnormal blood glucose and type 2 diabetes mellitus: U.S. Preventive Services Task Force recommendation statement. *Annals of Intern Medicine*, *163*, 861–868. <https://doi.org/10.7326/M15-2345>
- Siu, A. L. (2016). Screening for depression in adults: US Preventive Services Task Force recommendation statement. *Journal of the American Medical Association*, *315*, 380–387. <https://doi.org/10.1001/jama.2015.18392>
- Smock, S. A., Trepper, T. S., Wetchler, J. L., McCollum, E. E., Ray, R., & Pierce, K. (2008). Solution-focused group therapy for level 1 substance abusers. *Journal of Marital and Family Therapy*, *34*, 107–120. <https://doi.org/10.1111/j.1752-0606.2008.00056.x>

- Sox, H. C. (2013). Resolving the tension between population health and individual health care. *Journal of the American Medical Association*, *310*, 1933–1934. <https://doi.org/10.1001/jama.2013.281998>
- Sprenkle, D. H. (2002). *Effectiveness research in marriage and family therapy*. Alexandria, VA: American Association for Marriage and Family Therapy.
- Stangier, U., Schramm, E., Heidenreich, T., Berger, M., & Clark, D. M. (2011). Cognitive therapy vs. interpersonal psychotherapy in social anxiety disorder: A randomized controlled trial. *Archives of General Psychiatry*, *68*, 692–700. <https://doi.org/10.1001/archgenpsychiatry.2011.67>
- Storch, E. A., Geffken, G. R., Merlo, L. J., Mann, G., Duke, D., Munson, M., ... Goodman, W. K. (2007). Family-based cognitive-behavioral therapy for pediatric obsessive-compulsive disorder: Comparison of intensive and weekly approaches. *Journal of the American Academy of Child and Adolescent Psychiatry*, *46*, 469–478. <https://doi.org/10.1097/chi.0b013e31803062e7>
- Stovitz, S. D., Berge, J. M., Wetzsteon, R. J., Sherwood, N. E., Hannan, P. J., & Himes, J. H. (2014). Stage 1 treatment of pediatric overweight and obesity: A pilot and feasibility randomized controlled trial. *Childhood Obesity*, *10*, 50–57. <https://doi.org/10.1089/chi.2013.0107>
- Strosahl, K. (1994). New dimensions in behavioral health/primary care integration. *HMO Practice*, *8*, 176–179. [https://doi.org/10.1016/S1077-7229\(05\)80084-7](https://doi.org/10.1016/S1077-7229(05)80084-7)
- Strosahl, K. (2005). Training behavioral health and primary care providers for integrated care: A core competencies approach. In W. T. O'Donohue, M. R. Byrd, N. A. Cummings, and D. A. Henderson (Eds.), *Behavioral integrative care: Treatments that work in the primary care setting* (pp. 15–52). New York, NY: Brunner-Routledge.
- Substance Abuse and Mental Health Services Administration. (2009). *Illness management and recovery: The evidence*. Retrieved from <http://store.samhsa.gov/shin/content/SMA09-4463/TheEvidence-IMR.pdf>
- Svetaz, M. V., Garcia-Huidobro, D., & Allen, M. (2014). Parents and family matter: Strategies for developing family-centered adolescent care within primary care practices. *Primary Care: Clinics in Office Practice*, *41*, 489–506. <https://doi.org/10.1016/j.pop.2014.05.004>
- Taylor, R. B. (2006). The promise of family medicine: History, leadership, and the age of aquarius. *Journal of the American Board of Family Medicine*, *19*, 183–190. <https://doi.org/10.3122/jabfm.19.2.183>
- Thornton, R. L. J., Glover, C. M., Cene, C. W., Glik, D. C., Henderson, J. A., & Williams, D. R. (2016). Evaluating strategies for reducing health disparities by addressing the social determinants of health. *Health Affairs*, *35*, 1416–1423. <https://doi.org/10.1377/hlthaff.2015.1357>
- Torenholt, R., Schwennesen, N., & Willaing, I. (2014). Lost in translation – The role of family in interventions among adults with diabetes: A systematic review. *Diabetic Medicine*, *31*, 15–23. <https://doi.org/10.1111/dme.12290>
- Tursi, M. F., Baes, C. V., Camacho, F. R., Tofoli, S. M., & Juruena, M. F. (2013). Effectiveness of psychoeducation for depression: A systematic review. *Australian & New Zealand Journal of Psychiatry*, *47*, 1019–1031. <https://doi.org/10.1177/0004867413491154>
- *Tyndall, L., Hodgson, J., Lamson, A., White, M., Knight, S. (2014). Medical family therapy: Charting a course in competencies. In J. Hodgson, A. Lamson, T. Mendenhall, and D. Crane (Eds.), *Medical family therapy: Advanced applications* (pp. 33–53). New York, NY: Springer.
- U.S. Centers for Disease Control. (2010). *National ambulatory medical care survey: General/family practice* [fact sheet]. Retrieved from https://www.cdc.gov/nchs/data/ahcd/namcs_2010_factsheet_general_family_practice.pdf
- U.S. Preventive Services Task Force. (2016). *About the USPSTF*. Retrieved from <http://www.uspreventiveservicestaskforce.org/Page/Name/about-the-uspstf>
- van Ravesteijn, H., Lucassen, P., Bor, H., van Weel, C., & Speckens, A. (2013). Mindfulness based cognitive therapy for patients with medically unexplained symptoms: A randomized controlled trial. *Psychotherapy and Psychosomatics*, *82*, 299–310. <https://doi.org/10.1159/000348588>
- van Schaik, A., van Marwijk, H., Adèr, H., van Dyck, R., de Haan, M., Penninx, B., ... Beekman, A. (2006). Interpersonal psychotherapy for elderly patients in primary care. *American Journal of Geriatric Psychiatry*, *14*, 777–786. <https://doi.org/10.1097/01.JGP.0000199341.25431.4b>

- Vanbuskirk, K. A., & Wetherell, J. L. (2014). Motivational interviewing with primary care populations: A systematic review and meta-analysis. *Journal of Behavioral Medicine*, *37*, 768–780. <https://doi.org/10.1007/s10865-013-9527-4>
- Vander Wielen, L. M., Gilchrist, E. C., Nowels, M. A., Petterson, S. M., Rust, G., & Miller, B. F. (2015). Not near enough: Racial and ethnic disparities in access to nearby behavioral health care and primary care. *Journal of Health Care for the Poor & Underserved*, *26*, 1032–1047. <https://doi.org/10.1353/hpu.2015.0083>
- Visser, S. N., Danielson, M. L., Bitsko, R. H., Holbrook, J. R., Kogan, M. D., Ghandour, R. M., ... Blumberg, S. J. (2014). Trends in the parent-report of health care provider-diagnosed and medicated attention-deficit/hyperactivity disorder, United States, 2003–2011. *Journal of the American Academy of Child & Adolescent Psychiatry*, *53*, 34–46. <https://doi.org/10.1016/j.jaac.2013.09.001>
- Vogel, M. E., Kirkpatrick, H. A., Collings, A. S., Cederna-Meko, C., & Grey, M. J. (2012). Integrated care: Maturing the relationship between psychology and primary care. *Professional Psychology: Research and Practice*, *43*, 271–280. <https://doi.org/10.1037/a0029204>
- Waldron, H. B., & Turner, C. W. (2008). Evidence-based psychosocial treatments for adolescent substance abuse. *Journal of Clinical Child and Adolescent Psychology*, *37*, 238–261. <https://doi.org/10.1080/15374410701820133>
- Wells, K. B., Jones, L., Chung, B., Dixon, E. L., Tang, L., Gilmore, J., ... Ramos, E. (2013). Community-partnered cluster-randomized comparative effectiveness trial of community engagement and planning or resources for services to address depression disparities. *Journal of General Internal Medicine*, *28*, 1268–1278. <https://doi.org/10.1007/s11606-013-2484-3>
- Wiebe, S. A., & Johnson, S. M. (2016). A review of the research in emotionally focused therapy for couples. *Family Process*, *55*, 390–407. <https://doi.org/10.1111/famp.12229>
- Wilfley, D. E., Welch, R. R., Stein, R. I., Spurrell, E. B., Cohen, L. R., Saelens, B. E., ... Matt, G. E. (2002). A randomized comparison of group cognitive-behavioral therapy and group interpersonal psychotherapy for the treatment of overweight individuals with binge-eating disorder. *Archives of General Psychiatry*, *59*, 713–721. <https://doi.org/10.1001/archpsyc.59.8.713>
- Wood, J. J., Piacentini, J. C., Southam-Gerow, M., Chu, B. C., & Sigman, M. (2006). Family cognitive behavioral therapy for child anxiety disorders. *Journal of the American Academy of Child and Adolescent Psychiatry*, *45*, 314–321. <https://doi.org/10.1097/01.chi.0000196425.88341.b0>
- Wrenn, G., Kasiah, F., & Syed, I. (2015). Using a self-service kiosk to identify behavioral health needs in a primary care clinic serving an urban, underserved population. *Journal of Innovation in Health Informatics*, *22*, 323–328. [10.14236/jhi.v22i3.134](https://doi.org/10.14236/jhi.v22i3.134)
- Wright, L. M., Watson, W. L., & Bell, J. M. (1996). *Beliefs: The heart of healing in families and illness*. New York, NY: Basic Books.