

# Chapter 1

## The Beginning of Us: A Conversation Among Friends About Our MedFT Family



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From the very beginning of our (Tai, Angela, Jennifer) efforts in planning this book, we identified ideas that we wanted to convey through *Chapter 1*. Sometimes even the best laid plans lead to unanticipated routes, and sometimes those routes bring even better—more purposeful—results. This chapter, while formulated first, was the last to be written. In the name of transparency, we started our contributions to this book by writing our respective—other—chapters. As we were rounding into the halfway mark, and while at the same time experiencing several influential changes in our lives, a clearer vision for this chapter came to us. We recognized that many of you, as our readers, might be new to medical family therapy (MedFT) and would thereby need some perspective about our field’s history. While we wanted you to be informed about this history, we also wanted to offer something beyond just a history lesson—especially since the foundation of MedFT had already been described through other books and manuscripts (e.g., Doherty, McDaniel, & Hepworth, 1994; Hodgson, Lamson, Mendenhall, & Crane, 2014; McDaniel, Doherty, & Hepworth, 2014; McDaniel, Hepworth, & Doherty, 1992; Tyndall, Hodgson, Lamson, White, & Knight, 2012, 2014). In one of our many conference calls, we decided to construct an academic snapshot of MedFT (i.e., a cliff notes version) and then follow that content up with an opportunity for you to learn more about our own personal journeys that lead us to the field. Our hope is that these stories invite you into our love for MedFT and inspire you to build upon this field’s impressive history over the days and years to come.

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## An Academic Snapshot

The most current definition of MedFT that we align with was constructed in 2010 through a modified Delphi study that included contributions from many of the field's leading experts (Tyndall, Hodgson, Lamson, White, & Knight, 2010). From that effort, MedFT was defined as a field grounded in a

BPSS [biopsychosocial-spiritual] perspective and marriage and family therapy, but also informed by systems theory. The practice of MedFT spans a variety of clinical settings with a strong focus on the relationships of the patient and the collaboration between and among the health-care providers and the patient. MedFTs are endorsers of patient and family agency, and facilitators of healthy workplace dynamics. (p. 68–69)

As first introduced in our text's *Preface*, we adopted this definition because it is research informed and was developed through the input of many diverse voices, rather than constructed from our own biases regarding what MedFT represents or reflects. We anticipate that this definition will change over time to keep up with the dynamic nature of MedFT that now exists across research, training, supervision, leadership, administration, and policy—all of which are contexts that extend beyond those aligned with the clinical settings as cited in this definition.

While researchers within and outside of the field may have their own version(s) of what MedFT is or should be, its foundation is unquestioned: MedFT stemmed from many of the founders of family therapy, spanning a wide variety of disciplines. Brilliant minds from nearly seven decades ago were integrating their training in biology with family therapy (e.g., Gregory Bateson, Murray Bowen, Ludwig von Bertalanffy), and while nearly two decades would pass until more recognition was given to the ways in which physical health influences psychosocial well-being (e.g., Edgar Auerswald, Salvador Minuchin, Lyman Wynne), the systemic lens of family therapy never wavered. One of the most powerful voices that MedFTs align with is that of George Engel (1977, 1980), a visionary who took a bold risk to describe the importance of stepping out of the medical model and into a biopsychosocial (BPS) model that was grounded in systems theory. This innovative vision gave way to new energy all over the United States (and beyond), whereby MedFTs began collaborating in health-care contexts, and medical providers began to recognize the value of family therapy when integrated into the medical system (Bloch, 1984; Doherty & Baird, 1983; Hepworth & Jackson, 1985; McDaniel & Campbell, 1986; Rolland, 1984).

In 1992, McDaniel, Hepworth, and Doherty wrote the field's primer text, *Medical Family Therapy: A Biopsychosocial Approach to Families with Health Problems*. This book called attention to the need for a family-centered behavioral health model of care and opened the gates for a new field. At about that same time, a group of family nurses (Bell, Wright, & Watson, 1992) wrote a pointed article concerning the title of MedFT, particularly addressing a lack of recognition for nurses when the name was narrowed to "medical" family therapy. While the term remained, researchers have worked hard to honor nurses' contributions to the success of MedFT—both directly and indirectly (e.g., Anderson, Huff & Hodgson, 2008; Marlowe & Hodgson, 2014; Martin, White, Hodgson, Lamson, & Irons, 2014). Informed by the

invaluable contribution by Wright, Watson, and Bell (1996) called *Beliefs: The Heart of Healing in Families and Illness*, we (Angela, Jennifer, and Tai) work to train MedFTs to assess for spiritual domains of health and incorporate these into treatment plans when appropriate (Hodgson, Lamson, & Reese, 2007). Acknowledgments regarding the importance of using a biopsychosocial-spiritual (BPSS) framework in the practice of MedFT—as advanced through the pioneering work of Engel (1977, 1980) and Wright et al. (1996)—are illustrated in every chapter of this text.

A new generation of MedFTs emerged with the new millennia, as did recognition for the ways in which a growing number of medical diagnoses influence relational health—biologically, psychologically, socially, and spiritually. To cite all of the work in MedFT since 2000 would not be possible, but many of these publications are referenced in the remaining chapters of this text. Some of the pivotal markers indicating a critical need for MedFT in health care include the burgeoning of accredited training programs and internship sites in MedFT (highlighted in Chapter 19), the development of MedFT core competencies (Tyndall, Hodgson, Lamson, White, & Knight, 2014), and more recently the creation of the MedFT Healthcare Continuum (Hodgson, Lamson, Mendenhall, & Tyndall, 2014). This continuum places MedFT skills and knowledge across five levels of application that range in both proficiency and intensity. It suits any context that promotes relational and BPSS health and offers a range of skills appropriate for a wide variety of health-care professionals who are invested in family-centered care and integrated behavioral health-care models.

The value of the MedFT Healthcare Continuum (Hodgson et al., 2014) is strengthened when considered in context of other historical works in our field, such as the five levels of primary care/behavioral health collaboration advanced by Doherty, McDaniel, and Baird (1996). Together, MedFTs are able to map a level of collaboration (suitable to their context, needs of patients/families, and/or unique relationships with each provider) in tandem with their MedFT knowledge and skill sets to build a successful and sustainable model of care (see Lamson, Pratt, Hodgson, & Koehler, 2014, for a detailed explanation of how Doherty et al.'s (1996) levels interface with Hodgson et al.'s (2014) continuum). Workplace opportunities for which MedFT skills and knowledge are embedded are now far reaching; these include primary, secondary, and tertiary health-care contexts, as well as a variety of others that stretch beyond the bricks and mortar of traditional health-care environments. Further, the roles and corresponding skills of MedFTs in health-care settings continue to evolve, offering greater opportunities for MedFT in research, teaching, supervision, leadership, administration, and policy. The exponential growth of MedFTs in the workforce over the past decade is a sign that this field will only continue to grow. Throughout the remaining chapters in this text, attention is given to the roles and contexts that have emerged over the past two decades (especially) and the research, knowledge, and fundamental skills needed for MedFTs situated in each unique setting/population.

As authors and editors, we take great pride in the remaining chapters of this text, as first-, second-, and third-generation MedFTs have come together to honor the

past, present, and future of this incredible field. Each of us found this field through our own serendipitous routes—whether it was through a passion to be involved in health care, via personal experiences, or both. In constructing this chapter, we wanted to share with you how we found MedFT and how it became our chosen career. Our stories represent a homage to our mentors, filled with gratitude for colleagues and students, and an invitation for professionals to join us in this amazing field.

## **Our Family Photo**

*By Angela Lamson*

My story began well before I ever identified as a MedFT. There were two pivotal narratives that had a presence in my childhood, but their influence did not really hold their value until I began my life in academia. One significant narrative relates to a legacy of strong women in my family and, not coincidentally, in my professional life. My grandmother was born with significant abnormalities in both of her hips, so much so that her pediatrician had confidence that she would not live a long life and would most certainly never bear children. This remarkable woman recently died at the age of 90 and had given birth to eight children. One of these children is my mother, another very strong woman. Through the legacy of these two women, a message was engraved onto my heart that I, too, would become a woman who exceeded in what others might not expect of me. I was the first person on both sides of my family to receive an education from a university—earning a bachelor's, master's, and Ph.D. degree.

A second narrative was passed onto me from my father, a man of many talents in home and commercial building. He took me and my siblings to job sites when we were children, and I remember how he once shared the incredible importance of the foundation for any home or building. He felt strongly that a structure was not sound if the foundation was not first attended to. While I may not have given much thought to my dad's lesson as a child, his words have had a powerful narrative for me as a professional, a wife, and a mother. I have translated his words over time and began to see their connection to my self-of-therapist. I soon realized that if my own foundation (beliefs, values, biases) was not well attended to, the structure of what I do (in any role) was not likely to be sound. I felt so connected to this lesson from my father that I co-wrote a pedagogical chapter about how MedFTs are able to evaluate the role of their own foundation (also considering the ways in which BPSS factors influence our outlook on life and relationships) in relation to the development of their theory of change. This work is called the *Building Your Home Project* (Lamson & Meadors, 2007) and is shared annually with my marriage and family therapy (MFT) and MedFT students.

These two narratives set my purpose into motion, heavily influencing my career (in which I advocate for marginalized groups, champion health care, train students for a better health-care workforce, and lead investigations on research and grants for underserved populations). To describe my steps toward MedFT, I should share two key experiences that occurred during my master's program. If either of these two had not occurred, I am fairly certain that my present-day career would be much different. First, in the early fall of my first year as a Human Development and Family Studies master's student, I met Jennifer Bernasek (now Jennifer Hodgson). We met while working as waitresses at a restaurant near the campus. Later that year, we had offices near one another and found ourselves talking about the family therapy program. It is interesting how some things never change (my office is now two doors down from Jennifer, and we still talk daily about our ongoing research, grants, training programs, and policy-oriented initiatives).

My other pivotal experience during this time was having the opportunity to help care for a centenarian. She was in great health but longed for a friend to read to and talk with her. While visiting this young woman, I was asked to help feed dinner to her 70+ year-old son-in-law who had been an esteemed physician earlier in his career. He had diagnosed himself with Alzheimer's disease, and his BPSs struggle was evident. I went on to conduct my dissertation research on the role(s) of Alzheimer's disease in the life of caregivers under the mentorship of Dr. Harvey Joanning. The people I have described were placed in my life so purposefully—all of whom have shaped who I have become as a MedFT trainer, researcher, supervisor, clinician, and advocate.

In 1998, during my last year of my Ph.D. program, I was at an American Association for Marriage and Family Therapy (AAMFT) annual conference in Dallas, TX, and had decided to go to the showcase for accredited programs to learn about potential job opportunities. I remembered standing in front of a display for a program that was well-known to do some MedFT training when I felt a hand on my elbow. That hand belonged to Dr. Mel Markowski, who gently guided me over to the East Carolina University (ECU) display. He then shared his vision with me for a future MedFT doctoral program at ECU. He says that he remembers me literally jumping up and down with excitement. While I do not remember the jumping, I do recall my heart skipping a few beats. I was 25 years old at the time and somehow in a discussion about creating a Ph.D. program at a university that had only a dozen or so doctoral programs on campus. Another subtle issue was that it would be the first of its kind in the nation. Drs. Mel Markowski and David Dosser were brave enough to hire me for the job, whereupon it became my duty to find another courageous soul to come on board to create this program. Mel and I began a large recruitment campaign—but serendipity took over when Jennifer Hodgson reentered my life.

From 2000 to 2003, Jennifer and I worked tirelessly along with many other colleagues and administrators to create the Ph.D. program, all the while working toward tenure. We received permission to start the program 4 months after I became a mother. We took in our first doctoral students in the fall of 2005 and graduated our first cohort in 2008. Due to a series of unfortunate events, our first Ph.D. program director had to step down from his role, which meant another big change in my life.

I simultaneously became the program director for our master's program, program director for our doctoral program, and clinic director of our ECU Family Therapy Clinic—while still maintaining a teaching and research workload. With the incredible support and investment from Jennifer and our MFT team, we went on to earn accreditation with the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) for the doctoral program (as the first medical family therapy Ph.D. program).

Thinking back on my life with Jennifer (at ECU) over the past 17 years is similar to what life is like when growing up with a sibling. Our children have literally grown up together, and she and I have collaborated on so many projects that people sometimes call us by one another's name (that happened early on in our careers, and we have actually received mail with "Angela Hodgson" and "Jennifer Lamson" on the envelopes). From the start, Jennifer and I worked hard to introduce one another to people that we knew had a heart for BPSS and relational health. We sought out a community that would afford us a sense of belonging—something that she and I call "matched energy."

At my first Collaborative Family Healthcare Association (CFHA; then the Collaborative Family Healthcare Coalition) conference, Jennifer introduced me to her mentor, Dr. Susan McDaniel, who then introduced me to her colleagues Drs. William (Bill) Doherty, Mac Baird, Don Bloch, Bill Gunn, Jeri Hepworth, John Rolland, and Dave Seaburn. They then introduced me to their colleagues, all of whom have been essential mentors to me over the years. I have learned more from my conversations with these champions than I can ever describe, but I must particularly punctuate my gratitude to Bill Doherty. He has given his time to me so selflessly, and the life lessons and lessons as a professional that he has passed onto me are priceless. His legacy is one of a kind.

Part of meeting incredible mentors, like Bill, is meeting their amazing mentees. While attending a conference in North Carolina in 2002, I had the chance to meet a doc intern who was at Wake Forest University School of Medicine. This intern had so much energy for MedFT that any attendee at that conference had no choice but to want to be on the MedFT innovation train with him. Tai Mendenhall was the name of that intern. He quickly became part of my professional family; another sibling was in the mix. Jennifer, Tai, and I went on to present at many conferences with one another for years, but had not really published together until more recently. When we decided to make a commitment to do this, we decided to "go big or go home." We worked on a special issue of medical family therapy in the journal of *Contemporary Family Therapy* and are now finishing our second book together. We see ourselves as a generation of MedFTs who are grateful to all of the founding fathers and mothers who were influential in developing MedFT and have made it our vision to grow the potential opportunities for the next generation. While MedFT began as a subdiscipline often most closely aligned to family therapy, it is now recognized as a field that has made its mark in training, research, practice, supervision, and policy initiatives.

When I think about why I chose MedFT to begin with, it was because I believed that health, illness, loss, and trauma occur in the context of families. No matter if it

was my work with children and their families who experienced Hurricane Floyd; couples who had experienced a miscarriage or stillbirth; providers struggling with compassion fatigue who worked in pediatrics, the NICU or PICU; families facing a chronic illness; or the couples receiving integrated behavioral health care in a family medicine clinic on a military base, I recognized that biological, psychological, social, and spiritual health are interwoven and have the capacity to change the trajectory of a life and, thus, a system. I have learned a lot of lessons throughout the past two decades, especially—such as my belief that everyone seeks a sense of belonging (so find a community that strengthens you!). Equally important is that if you are in a position to be a champion or an ambassador, then fulfill that role to the best of your ability.

Our charge as MedFTs is not an easy one. We have a country and world that faces incredible health disparities and treatments that come with an extraordinary expense to their families and communities. MedFTs are relational health experts and, as such, must push to tear down silos across health care. We must provide best practices for families, conduct ethical and responsible research that makes an impact on the lives of families and health care, offer training that is current and relevant to the domestic and global health-care needs of patients and populations, and construct policy briefs that make a real difference in the delivery of health care. My hope is that this book triggers for each reader the possibility of growing the future of MedFT.

### ***By Jennifer Hodgson***

Like Angela, I too was a first-generation college student. The first in my family to achieve my bachelor's to doctoral degrees. I was the only person on both sides to have a master's and doctoral degree until a maternal cousin achieved her doctorate in veterinary medicine a decade later. I felt tremendous pressure to complete college, but the kind of pressure that excited me to keep going. Secretly, I wanted to be a physician. I liked the idea of helping people to feel better and live healthier lives. However, I did not have a role model for a career in health care, so it seemed out of reach. I was a natural musician and loved computers, so I thought one of those career paths would be my lane. However, my heart always found its way back to helping people and being around others during their times of greatest struggle. It would be the marriage of my admiration for health care and compassion for people in need that would lead me to medical family therapy. However, it would take several life events to help to carve that pathway.

It was a graduate student who was teaching my "Introduction to Psychology" course at the University of Akron who inspired me to be an academician. She looked like she was having so much fun teaching that I wanted to do that as well. From that day, forward, I could not get enough of what the field of psychology had to offer. Everything was new to me, and everything was a missing puzzle piece. I loved research, statistics, writing, presenting, and learning from the faculty who I cherish

today (Richard Haude, Charlie Waehler, and Linda Subich). They took a chance on me. And while they were grooming me for a career in psychology, they could tell I saw things a bit differently. Dr. Subich shared in a quiet moment how there was a field called marriage and family therapy (MFT) that she thought would fit my philosophy of health a bit better. I met with the program director for the MFT program later that week and, within 10 minutes, knew I had found my professional home. My grounding in psychology was critical to my success, and I am forever grateful for that beginning.

During my master's program, the faculty member who recruited me into the program, Anthony Health, left his position to join a family medicine residency program as their director of behavioral medicine. I was curious about his new job and why he would leave family therapy to pursue it. He offered me the opportunity to shadow him one day in his new role, and I was smitten. It was like someone had turned the light on; I could see how all the parts of my academic past fit together neatly. I had already known I wanted a Ph.D., so that I could teach in a university setting, but now I knew what I wanted to focus on. However, it was not until I was applying to doctoral programs that I learned about Bill Doherty and his research in MedFT at the University of Minnesota. While life events directed me to Iowa State University for my doctoral studies, I was determined to find a way to get training in MedFT.

As a doctoral student, I was encouraged by my faculty to follow my passion. Chuck Cole, Linda Enders, and Harvey Joanning encouraged me to identify ways to get MedFT training even though it was not available at Iowa State University. So, I shadowed a behavioral medicine provider in a family medicine residency program in Des Moines, IA. It was there I received opportunities to guest lecture the residents and affirm my interests. I learned that if I wanted to be a MedFT, then I would need to get intensive training. I learned of a summer institute at the University of Rochester run by Susan McDaniel, Dave Seaburn, Pieter Leroux, and Tom Campbell (to name a few). I contacted Dave to see if they offered scholarships, and he said sadly they did not. So instead, I saved my graduate assistantship pennies and bought a ticket the following summer. It was transformative, and I knew that I would return there for more training. Later that year, I applied for their doctoral internship in MedFT and trained under Barbara Gawinski, Dave Seaburn, Susan McDaniel, Nancy Ruddy, Cleve Shields, and countless others. After I completed my internship, I applied for their newly established postdoctoral fellowship in MedFT and worked under Susan McDaniel's supervision. I will forever be grateful to her and to the whole Rochester team.

My first academic job after completing my postdoctoral fellowship was at Nova Southeastern University (NSU). There, I helped teach courses toward a certificate in families, systems, and health to their master's and doctoral family therapy students. During that time, I coedited the CFHA newsletter with Don Block. Don was a family psychiatrist and major innovator in the field of family therapy. He was a founding member of CFHA. He took me under his wing and taught me so much about the organization and the numerous opportunities that would lie ahead for MedFTs. Many of my former students at NSU are now major players in MedFT. I loved my

experience at NSU and all my colleagues there. However, the next step in my career path would take everything I had learned thus far and apply it in full force.

One day out of the blue, Angela Lamson called me and shared with me how Dr. Mel Markowski, a professor at East Carolina University, had a vision to start the first doctoral program in MedFT. (Please read, above, how we met in Angela's section. I love that story.) She asked me to apply for their open position because she wanted someone to help her with this task. However, being a loyalist, I told Angela I could not leave NSU as I had only been there a year and a half. A month later, Mel Markowski called himself and asked me again to consider applying. He further described his vision for the doctoral program, and I realized that it was the opportunity I needed professionally. Shortly after arriving in August of 2000, Angela and I started writing the doctoral program proposal. By 2005 we were taking in our first cohort of doctoral students. The administration at ECU took a chance on two junior faculty, and it has paid off with a nationally awarded and well-established accredited program with 24 graduates to date!

During my time at ECU, I had the privilege of retaining relationships with many of my mentors. I became more involved in the Collaborative Family Healthcare Association (CFHA) where I have met so many pivotal innovators in integrated behavioral health care, too many to name here. One year after having my third baby, I received a call from Frank deGruy, stating that they wanted to nominate me to serve as president of CFHA. This was such a tremendous honor. However, I only agreed to do it because Randall Reitz was the executive director at the time, and I knew we would be a great team (and we were). Many of my most cherished relationships have formed through my work with CFHA and at the American Association for Marriage and Family Therapy (AAMFT) conferences. These communities have afforded me the opportunities to collaborate with Tai Mendenhall and Angela Lamson along a professional journey together to advance our shared passion for MedFT.

In my career thus far, I have been able to thrive as a researcher, educator, administrator, supervisor, and clinician. I have held major officer positions at the state and national levels and have become passionate about policy reform to help advance parity among the mental health professions and health professions. I am particularly interested in policies that advance integrated behavioral health care and family-centered models of care. My research and funding portfolio is rich with studies and grants showing my interest in advancing the biopsychosocial and spiritual health of individuals, couples, families, and communities. In some ways, I feel like I am just getting started despite having achieved full professor in 2012 and accomplishing many of my professional goals. I think it is because I love what I do and who I work with (Mel Markowski [retired], David Dosser [retired], Angela Lamson, Damon Rappleyea, Andy Brimhall, Kit Didericksen, Jake Jensen, Erin Roberts, and countless other colleagues, administrators, and students all across the ECU campus). ECU gives me the support I need as a woman, mother, academician, and innovator. While I never know where life will take me next, I am forever grateful to all those who have taught me so much about following your passion and living your dream.

## *By Tai Mendenhall*

People often ask me why I chose medical family therapy (MedFT) as my career path. Sometimes they pose these queries in ways that are straightforwardly “academic.” They are sensitive to larger trends about how behavioral health care—broadly defined—is becoming more visible and integrated into U.S. health systems and are interested in what drew me in. Other times people ask me about MedFT with what sounds like an almost aghast curiosity: “Why do you want to work in a hospital?”, “Don’t you see horrible things there?”, and “Aren’t the hours really bad?”

Accordingly, my answers are sometimes straightforward and professional (e.g., I highlight the merits of integrated care and how research supports it as an effective way to treat this, that, or the other thing). Other times my answers are more personal. I talk about my “calling” to work in a medical environment and about wanting to contribute to a larger mosaic of healing and care within teams of interdisciplinary colleagues working with and alongside patients and families. I talk about growing up watching my father—a research surgeon—perform operations at any hour of the day or night, and discussing in graphic detail a myriad of things over dinner that others might consider unpleasant. I maintain that working long hours is natural for me because I watched all of my parents and grandparents do it. I joke about how my doctoral internship in a psychiatry residency aligned well with my innate tendencies to be a workaholic, or reflect about how health care is so welcoming to those who get bored with routines or a 40-hour week. But in truth, it was for all of these reasons—and many others—that I chose MedFT. Or maybe it chose me.

I began my master’s degree in marriage and family therapy (MFT) with an indefatigable want to connect the dots between my clients’ (we call them “patients” in medical environments) and their families’ lives. Having learned all about systems thinking during my undergraduate days, I saw family therapy’s inclination to advance treatment in ways that embrace this complexity as a natural next step. When I first began to see patients and families in clinical work, I was drawn most to the especially difficult cases (other students and colleagues called them the “tough families,” the “heart-sink” patients, etc.). Being—as I have always been—an adrenaline junky (e.g., motorcycles, bridge jumping), many said students and colleagues did not find this surprising. But the draw was not something grounded in any kind of personal excitement or voyeuristic appeal; it was a natural extension of the very systems thinking that drew me to MFT in the first place.

“Difficult” cases are, by their nature, systemically complex. I thereby found, early on, where the limits and boundaries of my baseline MFT training were. Collaborating with social workers, probation officers, school teachers, addictions counselors, physicians (of all stripes), psychiatrists, psychologists, and others directly involved in the lives of my patients and their families served to humble my heretofore espoused notions that MFT was the “best” way to care for people. I came to understand, instead, how MFT fits into a complex constellation of many other fields that are also very good at what they do. And, more importantly, I came to value—cherish, even—the work that we can do together.

With these understandings, though, grew a frustration with the limited scope of my training at the time. I wanted to learn more about “medicine” in a broad sense and about how to purposefully integrate and collaborate within and across interdisciplinary teams. I thereby knew that my doctoral training could not simply be more-of-the-same in MFT—but at the time, I did not know how it could be anything else. And just as I was beginning to change course so that I could pursue medical school (with the intent, afterward, to connect MFT with biomedical care), I learned about a burgeoning idea—a “subspecialty” at the time—called medical family therapy.

I chose my Ph.D. program so that I could work with Dr. William (Bill) Doherty in Minnesota. He, along with colleagues Drs. Susan McDaniel and Jeri Hepworth, was pioneering MedFT as a way to engage families struggling with health problems. They were bridging disciplines that had heretofore not talked to each other very much. I could not have possibly been at a better place at a better time.

Alongside his mentorship, Bill got me into a family medicine residency housed within Regions Hospital and Ramsey Family Physicians Clinic in Saint Paul, MN. It was through this work that I met—and had the privilege to train with—local leaders in integrated health care. Rosanne Kassekert, LICSW, Milt Cornwall, MD, and Pete Harper, MD, pushed me so far out of my comfort zone that I often did not know where I was—but, at the same, I knew that this was exactly where I needed to be. Through the Collaborative Family Healthcare Association (CFHA), Bill introduced me to Drs. Susan McDaniel and Jeri Hepworth. He also introduced me to Drs. Mac Baird, C.J. Peek, Sandy Blount, Rusty Kallenberg, Frank deGruy, and others—all who were working together to promote efforts in the respective fields they represent (e.g., family medicine, family therapy, psychology) to do the same. I was excited, inspired, and honored to join their cause.

As a new and, honestly, hyper-engaged member of CFHA, I soon—and finally—met Drs. Jennifer Hodgson and Angela Lamson. They were a couple of years ahead of me in terms of their doctoral training and early career steps, but I nevertheless felt close to them as like-minded colleagues who were (are) advancing MedFT as the next generation of scholars, clinicians, and supervisors trained by some of MedFT’s most influential founders. By the time I completed the internship requirements of my doctoral program at Wake Forest University’s School of Medicine (with Dr. Wayne Denton), our collegiality had evolved into close friendships.

Over the next several years, Angela, Jennifer, and I worked hard together in advancing MedFT’s visibility and scope. We (I, as a new faculty member at the University of Minnesota’s Medical School, and they, as pioneers of East Carolina University’s first-ever doctoral program in MedFT) presented together at almost every annual conference for CFHA, the American Association for Marriage and Family Therapy (AAMFT), and other local and national forums. We trained students and colleagues about ways to effectively prepare for MedFT through didactic content (e.g., clinical methods/strategies, psychopharmacology, health-care administration, payment policies, health maintenance organizations, medical terminology). We shared wisdom—often learned the hard way—about how to enter medical

contexts as a behavioral health provider without being a bull-in-a-china-shop about it. We began describing MedFT's applications in and beyond the arenas of family medicine (i.e., as its most established "home"). All of this then led to our leading a special issue for the journal *Contemporary Family Therapy*. This effort enabled us to connect formally with colleagues all over the country to bring MedFT to light across contemporary training, research, policy, and financial foci. In 2014 we—with colleague Dr. Russell Crane—extended this effort with a textbook entitled *Medical Family Therapy: Advanced Applications*.

Now—with one of CFHA's most visible and beloved physician leaders and MedFT advocates, Dr. Mac Baird—we have constructed *Clinical Methods in Medical Family Therapy*. This new text highlights MedFT's ever-growing presence, reach, and contributions across a myriad of primary, secondary, tertiary, and other care settings. We see it as a landmark confirmation of how the work we are doing in integrated behavioral health care is helping to ease suffering, advance agency, enhance communion, and empower patients and families in our care.

## Closing Thoughts

By reading about our journeys into MedFT, we hope it is clear that our stories are still far from over. We (Angela, Jennifer, and Tai) see ourselves as continuing to advance what our mentors first put into motion. These professional paths are ones that have been less traveled. It has taken inner passion, grit, and resilience to stay on a course that continues to tear down the silos between biological, psychological, social, and spiritual health and health care. Our paths were made possible through a community of mentors willing to serve as both champions for the next generation of learners and ambassadors for their own patients who received relational and BPSS health care.

It is up to us to continue this legacy. As such, we offer through this book a series of chapters that describe ways that MedFT functions across primary, secondary, tertiary, and other care contexts. Our authors first introduce the uniqueness of each setting and present a clinical vignette that represents the unique population(s) they serve. They then describe treatment teams and possible collaborators, fundamental knowledge and skills, and research-informed practices associated with that context. They present the MedFT Healthcare Continuum to depict ways in which MedFTs can function across a range of foci (breadth) and sophistication (depth). At the conclusion of each chapter, our authors offer pointed reflection questions and specific clinical measures/instruments, resources, and organizational links to further prepare MedFTs for their upcoming work and contributions.

Finally, it is important to note that many of the contributing authors in this book were (or are) our own students. As MedFT's newest generation, they are charging into uncharted territories in health care that are defined by ever-changing political and organizational uncertainties. We are confident that they will continue to grow and innovate in this work long after we are gone. This, to be sure, is one of the most

rewarding things about what we are doing. All of us believe in MedFT’s vision, and we are contributing to it in ways that are collectively greater than what any one of us—or any single generation of us—could. It is an honor and a privilege to be a part of this movement.

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