Important Annual Conference details inside.
See page 23 for more information and to register.
The Pioneers of Family Therapy booklet contains brief biographical information on 25 of the innovators in the family therapy field, along with a Family Therapy Genogram, which documents the time line and history of our profession. Also included in the booklet is a DVD of the 2009 AAMFT Annual Conference plenary session by Bruce Kuehl, PhD, which addresses the founders of the MFT profession.
Features

10  The Role of MFT in Healthcare: Models of Collaboration
MFTs need to position themselves as professionals who are trained in integrated care, who know how to help change occur at the relevant systemic levels, work with more than one person in the therapy/exam room, and be trained to collaborate with healthcare teams and providers.
Jennifer Hodgson, PhD and Daniel Marlowe, PhD

15  Learning to be a Medical Family Therapist Supervisor
The growth of medical family therapy has added another dimension to MFT supervision. More mental health professionals and students are seeking additional training and skills to address the needs of the healthcare system. Further, the increasing interest in collaboration between healthcare systems means the need for more expertise in medical family therapy supervision.
Patricia Parr, PhD

18  Becoming a Medical Family Therapist: Tips for Getting Started
Information on academic programs and tips for preparing to enter this field.
Barbara Gawinski, PhD and Tziporah Rosenberg, PhD

28  HIPAA and Psychotherapists Working in Collaborative Care
An overview for psychotherapists working in medical settings of the Health Insurance Portability and Accountability Act (HIPAA).
Alicia Eggen, Kathleen McSpadden, JD and Jo Ellen Patterson, PhD

30  Family Therapists in the Primary Care Setting: What Does it Take?
The field of medical family therapy has garnered interest from many practicing MFTs wanting to know how and what is needed to expand their skills and practice in collaborative care settings. These questions are answered for you by Gene Kallenberg, MD and Zephon Lister, PhD.
Cassidy Freitas, MA

34  Checklist: MFTs in Small Practice Integrated Healthcare
Integration between MFTs and primary care providers shows great promise for our shared clients, as people treated in an integrated model attest to its positive impact on their lives. Checklists and tips provided offer quick references for working productively and positively with medical providers in your small clinic.
Martha Teater, MA

40  It All Comes Down to Medical Family Therapy
A therapist shares his experiences working in medical family therapy and what it all means.
J. Matthew Orr, PhD

LETTERS TO THE EDITOR
We encourage members' feedback on issues appearing in the Family Therapy Magazine. Letters should not exceed 250 words in length, and may be edited for grammar, style and clarity. We do not guarantee publication of every letter that is submitted. Letters may be sent to FTM@aamft.org or to Editor, Family Therapy Magazine, 112 South Alfred Street, Alexandria, VA 22314-3061.

The American Association for Marriage and Family Therapy
Dear Colleagues,

I hope your summer is going well. While you were hopefully vacationing with your families and loved ones, your Board of Directors has been busy meeting in July in Alexandria where several important actions and activities were undertaken by the Board. I am including them here in this month’s column for your information and review.

Communications Audit: An outside consultant was retained to provide the Board with a communications audit. He shared his perspective on what the AAMFT is doing well, and what it can do better. As a result, the Board will be considering several possible actions in the future as it refines its strategic direction setting. The Board is continuing its process of evaluating every aspect of the Association to ensure that the AAMFT stays on the cutting edge.

Priority Setting: The Board continued to discuss how to prioritize the many activities of the organization to best serve the members, both now and in the future. These discussions of the Board will be ongoing, and include prioritizing expectations for the Executive Director and Staff so that the focus is on current and immediate needs of the association.

Bylaws Vote: In its review, the Board has identified the need for an additional bylaw revision to address concerns in Canada and for international applicants to the AAMFT. Should the bylaws revisions regarding membership categories be approved by the membership this summer, an additional ballot with bylaw proposals will be submitted to the membership this fall.

Awards Approval: The Board reviewed and approved proposals for Award recipients for the Masters Minority Scholarships and the Divisional Contribution Award for 2011 in Fort Worth.

Board and Executive Director Evaluation: The Board took time to review its own processes and to conduct the annual performance evaluation of the Executive Director.

Additionally, the Board discussed and clarified the importance of divisional experience for AAMFT Elective offices. Such experience is invaluable for those who pursue a national Board presence, as it provides the candidate with “field” knowledge that is so important when considering the needs of our members. The Board also passed a motion to revise the Judicial Committee Procedures, which was in need of revision. The CDP Proposal Process was also examined so that divisions submitting proposals are provided with assistance in making their proposals ready for community examination.

Finally, the Chairs of the Task Forces on Governance and the AAMFT Foundation provided the Board with updates on their progress. Both Task Forces have been charged to present a preliminary report for the September Board Meeting in Fort Worth, Texas.

Rest assured that your Board of Directors hears your voices and is responding in many ways, so that practicing marriage and family therapy is always a possibility and an opportunity for you.

It is our honor as a Board to represent and serve you. We hope to see each of you in Fort Worth at our Annual Conference!

- Linda Metcalf, PhD
77% Of people report their sexual relationship is dead, comatose, or in need of a wake-up call.

“David Schnarch, our foremost expert at the intersection of sex, love, and passion, has honored us with Intimacy & Desire, which teaches people how to have tender, loving sex with eyes wide open while learning more about themselves and their partner. Schnarch shows us how conflict is essential to growth, personal development, and intimacy. A pleasure to read.”

Frank Pittman, M.D.
Author of Private Lies and Grow Up!

David Schnarch is a licensed clinical psychologist, certified sex therapist, and world-renowned expert on relationships and intimacy. He is the author of the international best-seller Passionate Marriage and Founder of Crucible 4 Points of Balance.

For more information on upcoming programs for couples, singles, and therapy professionals, or to win a free copy of Intimacy and Desire, visit www.DesireBook.com

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To win a free copy of Intimacy and Desire, visit www.DesireBook.com.
Also available in EBook Format: Intimacy and Desire and Passionate Marriage
The Chartering of a (New) Division

The AAMFT Board of Directors enthusiastically welcomes a new division of the AAMFT in Hawaii. Linda Metcalf, AAMFT President; Michael Chafin, AAMFT President Elect; Michael Bowers, Executive Director of the AAMFT; and Tracy Todd, Director of Professional and Public Affairs, met with over 90 highly motivated Hawaii members in Hilo, Kona, Kapaa, Kahului, and Honolulu. The meetings focused on clarifying facts about division leadership and management, necessary steps to creating a new division, and the relationship between the AAMFT and divisions. Energetic, committed members worked diligently to create the new division.

One of the first steps in establishing a new division was polling the interest of AAMFT members residing in Hawaii. A poll conducted by the Hawaii Steering Committee identified that 94 percent of the survey respondents were favorable to establishing a division of the AAMFT. After dealing with the necessary legal processes of establishing a new corporation (e.g., filing Articles of Incorporation, Registered Agent, Incorporators), the Initial Board forwarded their bylaws and a signed Charter Agreement to the AAMFT and the Association is happy to announce that on July 8, 2011 the AAMFT Board of Directors approved our newest division, The American Association for Marriage and Family Therapy—Hawaii Division.”

The Hawaii division of the AAMFT has its work cut out for 2011. The new Initial Board of Directors will hold their positions through the end of 2011.

I felt the excitement in the room when we met on Oahu, coming together to build a new division that is dedicated to the strengthening of marriage and family therapy in Hawaii. - JOY QUICK, SECRETARY
I am now enthusiastically looking forward to a new organization that will foster communication among members, strive for consensus in important professional decisions, and, in general, have the feel of the Hawaiian spirit of “Ohana” (a family that leaves no one behind). - BARBARA MULLEN, MFT

Initial Board of Directors
President: Sharon Liden
Past President: Vacant
Secretary: Susan Joy Quick
Treasurer: Mary Schwing
Board Member At Large: Barbara Mullen
Board Member At Large: Virginia Jones
Kauai Representative: Vacant
Maui Representative: Dan Uhrich
East Hawaii Representative: Glenn Pressel
West Hawaii Representative: Vanessa Mount
Student/Associate Representative: Miguel Velez

During the remaining months, the Initial Board will establish an Elections Committee to secure nominations for the 2012 Board of Directors. Insuring inclusivity and diversity, the Initial Board of Directors has approved bylaws that the future Board of Directors must be comprised of representatives from each of the following four Hawaii counties: Hawaii, Honolulu, Kauai and Maui.

The meetings held June 10-12 reflected a dedicated membership seeking a transparent and collaborative AAMFT-HI. Members expressed that trust and collaboration are two of the many priorities for leadership and members.

The presence of a division in Hawaii is necessary for the advancement of the profession, to market recognition of MFTs, and professional networking and development for MFTs. Collaboration defined the establishment of the Hawaii division. Members continue to work together, brainstorm, and energize one another with great ideas as they move forward.

The renewed Hawaii Division is positioned to advance the profession of marriage and family therapy and serve AAMFT members. The AAMFT wholeheartedly welcomes the new leadership and stands ready to assist with the many tasks that lie ahead.

I am very happy and satisfied with the decision from the headquarter leaders to create a new division. Our new board of directors will serve us professionally and with ethics.

- RICARDO J. SAUQUE, LMFT
2011 AWARENESS DATES

SEPTEMBER

1-30
National Alcohol and Drug Addiction Recovery Month
Substance Abuse and Mental Health Services Administration
www.recoverymonth.gov
recoverymonth@samhsa.hhs.gov

4 - 10
National Suicide Prevention Week
American Association of Suicidology
www.suicidology.org
info@suicidology.org

18
National HIV/AIDS Awareness Day
The AIDS Institute
www.theaidsinstitute.org
info@theaidsinstitute.org

21
World Alzheimer’s Day
Alzheimer’s Disease International
www.alz.co.uk/adi/wad
info@alz.co.uk

23
RAINN Day
Rape, Abuse & Incest National Network (RAINN)
www.rainn.org/get-involved/
college/rainn-day
talk@rainn.org

OCTOBER

2-8
Mental Illness Awareness Week
National Alliance on Mental Illness
www.nami.org
info@nami.org

6
National Depression Screening Day
Screening for Mental Health, Inc.
www.mentalhealthscreening.org/events/national-depression-screening-day.aspx
smhinfo@mentalhealthscreening.org

10
World Mental Health Day
World Federation for Mental Health
www.wfmh.org/00WorldMentalHealthDay.htm
wmhday@wfmh.com

The AAMFT offers a variety of consumer brochures that can be used in your office (with space on the back for your stamp or business card), or used in direct mail marketing for your practice. Please contact central@aamft.org or visit the online store at www.aamft.org/store to order brochures.

BUILD YOUR FUTURE:
The AAMFT Product Catalog

Download your copy today of the latest AAMFT Products and Services brochure.

Updated with the most current AAMFT products and services, this guide is a helpful resource as you make your library expansion considerations.

Visit www.aamft.org/store/aamft2010brochure.pdf to view the catalog. To have the catalog mailed to you, please send an email with your address to central@aamft.org.
Check out the forums and blogs in the AAMFT Community to actively participate and interact in your professional community! Here are just some of the topics that have “bubbled up” recently.

**UNREALISTIC MEDIA IMAGES OF WOMEN**
Amy Harman responded to a forum on the way women are used in advertising and said, “I have done a lot of work with girls and women suffering from eating disorders and images in the media definitely play a part (even though it’s not the sole cause). I think it’s important to be critical consumers and take active steps to encourage the media to portray women in a more realistic and less sexualized manner. We’re all affected when women don’t get the respect they deserve in the media.”

**ADVICE FOR BEGINNING THERAPISTS**
David Moultrup provided some suggestions to an early-career therapist looking for advice: “Don’t expect yourself to be able to go directly into private practice from a Masters program. The only people who may be at all ready to do that are those who have had a previous health career, and even then I think it’s questionable. It’s too isolated, and there’s still too much to learn. Give yourself the opportunity to be involved in case conferences, supervision, and casual exchange of ideas in an ongoing way that can only happen in a bigger system.”

**Great Ways to Keep Up with AAMFT Happenings:**
Every second and last Thursday of the month, check your email for the AAMFT eNews, providing news from the Association, interesting popular press stories, podcasts, and much more.

LIKE the AAMFT on Facebook and get daily notes and insights from the Association.

Sign up for the AAMFT’s Twitter feed!
In 2006, Congress authorized hiring of MFTs and LPCs in behavioral health jobs at the federal Department of Veterans Affairs (VA), the nation’s largest source of mental health jobs. Last September, VA issued profession-specific Job Standards, and to date has posted about 147 MFT and 7 LPC jobs.

Unfortunately, the MFT and the LPC job standards pose the problem that candidates must hold a degree from an MFT program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) or from an LPC program accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP). The problem results because COAMFTE and CACREP accreditation was not widespread in the past, so thousands of MFTs and LPCs with decades of experience are barred from applying for VA jobs.

Because VA has declined to reconsider these standards, the AAMFT—along with the National Board for Certified Counselors, California Association of Marriage and Family Therapists, American Counseling Association, and the American Mental Health Counselors Association—recently submitted a formal Statement to the US House Committee on Veterans Affairs, noting that these VA job standards bar roughly half of all MFTs and LPCs from eligibility at a time when VA has a groundswell of veterans with mental health problems such as Post Traumatic Stress Disorder.

Our Statement also notes that VA’s MFT and LPC jobs posted to date have been mainly in Readjustment Centers, popularly called Vet Centers, which help veterans readjust to civilian life. While these Vet Centers provide valuable services, they are not mental health facilities. In general, VA continues not to recognize that MFTs and LPCs are clinicians, as shown both by the few jobs posted for VA clinical facilities and by June 14 VA testimony to the cited House committee, in which MFTs and LPCs were collectively and incorrectly termed “family counselors.”

We at the AAMFT are continuing to educate Congress and the VA about MFTs’ clinical skills, and will exhibit at a national VA mental health conference in August, to be attended by more than 1,000 VA mental health staff.

As part of the process VA used to develop its MFT and LPC Job Standards, VA agreed to petition the federal Office of Personnel Management (OPM) to develop federal Government-wide job standards for MFTs and for LPCs. At present, there are no such Government-wide job standards. This creates problems—especially within the Department of Defense—for hiring MFTs and LPCs, as well as for promotional and inter-agency transfer opportunities. For example, MFTs are typically hired by the military in jobs titled “Consulting Psychologist” or “Social Worker,” although those titles are inaccurate.

The AAMFT recently learned that OPM, the only federal agency that can develop Government-wide profession-specific job standards, and only upon petition of a federal agency, has rejected VA’s request for Government-wide MFT and LPC job standards. We and our allies are working to determine the basis of OPM’s decision and have contacted staff of the House Oversight and Government Reform committee, which has jurisdiction over such matters.
Military MFT Collaborative

The AAMFT has been working on efforts to increase the number of MFTs who work as providers within the military. Last year, officials from the Army created the Marriage and Family Counseling Collaborative (MFCC). Both AAMFT members and staff have been actively participating as leaders of this Collaborative.

On July 13-14, the leadership of this Collaborative met in Alexandria, VA, to work on planning a more permanent structure for the Collaborative, as well as future projects for the MFCC. The AAMFT Clinical Members and staff, along with representatives from government agencies and other mental health professions, attended this important meeting. The leadership agreed to change the name of the Collaborative to the “Alliance of Military and Veteran Family Behavioral Health Providers.” This new name will more accurately reflect the restated purpose of the Alliance, which is, “to optimize the preparedness of behavioral health providers working to enhance the resilience, recovery and reintegration of Service members, Veterans, and their Family members and communities throughout the military, post-military, and family life cycle.”

Future activities of this Alliance will involve the development and dissemination of additional materials to MFTs and other behavioral health providers working with military and veteran families. The Alliance will also work on efforts to collaborate with government agencies on the development of resources to aid MFTs and other providers of behavioral health services to military and veteran families.

Division Advocacy

Below are some recent developments concerning MFT state advocacy for 2011.

MAINE: Earlier this year, the Maine Division succeeded in passing legislation that will allow MFTs to work as state employees under an MFT job title. In addition to this achievement, the Division succeeded in enacting legislation that would allow MFTs to work as providers in the public schools. This law requires the state government to allow MFTs to work as qualified evaluators. Both bills were sponsored by Representative Mark Eves, who previously served as MEAMFT President. Congratulations to the Division on these accomplishments.

TEXAS: In April, the Division filed legislation that would allow MFTs to serve as school providers. The MFTs in the schools legislation passed the Texas legislature and was signed into law by Governor Rick Perry on June 17th. Congratulations to the Division on the passage of this important legislation.

2-Day Level I Training presented by
JOHN & JULIE GOTTMAN
Bridging the Couple Chasm
Gottman Couples Therapy: A Research-Based Approach
Colorado Association for Marriage & Family Therapy ANNUAL CONFERENCE
SEPT. 16 & 17, 2011 — DENVER — REGISTER EARLY AND SAVE!
www.coamft.org 303-792-3966 A NOT-TO-BE-MISSED EVENT!
THE ROLE OF MFT IN HEALTHCARE:

Models of Collaboration

JENNIFER HODGSON, PHD       DANIEL MARLOWE, PHD
THERE HAS BEEN AN EXPLOSION OF RESEARCH AND OPPORTUNITIES in healthcare for family therapists in the past 10 years! We have an opportunity, now more than ever, to apply systems concepts and family therapy approaches to patients receiving medical care and their family/support systems. The challenges we have are actual (e.g., insurance, such as Medicare) but not insurmountable. We need to position ourselves as professionals who are trained in integrated care, who know how to help change occur at the relevant systemic levels, work with more than one person in the therapy/exam room, be cost and clinically effective at it, and trained to collaborate with healthcare teams and providers. To ensure our place in this movement, we must be working now to train ourselves and the next generation of marriage and family therapists (MFTs) to do this work.

To be prepared means knowing and doing the necessary research on clinical, operational, and financial sustainability models. These three worlds in healthcare need to be considered simultaneously when entering into any healthcare setting (Peek, 2008; Peek & Heinrich, 1995, 1998). Family therapists may need to learn a new language, models of collaboration, and how to provide clinical care outside the box (literally outside the four walls of our office and in under 20 minutes). The 2010 AAMFT Annual Conference hosted a well-attended track in medical family therapy that introduced a tool kit to family therapists seeking this kind of training and re-training. The 2011 Collaborative Family Healthcare Conference, to be held in Philadelphia, PA, October 27-29th, is critical for cutting edge training and information necessary for family therapists who want to expand their skill set to be seen as competent, central players in the integrated care movement. (See www.CFHA.net for more information about this and other training opportunities.)

Why is this Important?

Despite mental health providers’ (MHP) efforts to de-stigmatize psychotherapy services, most American adults prefer to have their behavioral health needs met by their primary care provider (Kessler & Stafford, 2008; Reiss-Brennan, 2010; Strosahl, 1994). With as many as 70 percent of primary care visits having a psychosocial component (Fries, Koop, & Beadle, 1993; Gatchel & Oortd, 2003), and up to 84 percent of the most common primary care symptoms found to have no known organic cause (Kroenke & Mangelsdorff, 1989), there is a place for mental health in medical settings, such as primary care; now known as the defacto mental health system (e.g., DeGruy, 1996).

Projects where mental health and medical care have intersected have demonstrated better health outcomes (e.g., Goodie et al., 2009; Roy-Byrne et al., 2005), more efficient use of resources (e.g., Guck et al., 2007; Reiss-Brennan et al., 2010), and increased patient satisfaction (e.g., Chen et al., 2006; Runyan et al., 2003). Russ Crane at Brigham Young University has been providing MFTs with research to help argue the case that what we do makes us competitive in the healthcare marketplace (Crane, 2011). Combining his work with what is known about being an effective collaborator and encouraging family therapy academic institutions and continuing education opportunities that better prepare family therapists to be specialists in integrated care will strengthen our place in the collaborative care movement. Other mental health disciplines are devoting more and more research, training opportunities, financial backing, and attention to policy and advocacy around this issue. Together with their efforts, we can build an even more comprehensive primary care medical home.

The National Committee for Quality Assurance (NCQA) credentials primary care centers as medical homes. A medical home is an approach to providing comprehensive primary care that facilitates partnerships between patients, physicians, and families. The latest iteration of NCQA standards acknowledged behavioral health as a critical service within these homes, something that was not overtly noted in the
What is Collaborative Care?
There are three methods of collaborating with healthcare providers: 1) Co-ordinated; 2) Co-located; or 3) Integrated (Blount, 2003) that span across five levels of systemic collaboration (Doherty, McDaniel, & Baird, 1996). The type of model chosen is often dependent upon providers’ comfort level, type and quality of training in integrated care, and reimbursement mechanisms.

Co-ordinated. These can be thought of as traditional relationships between mental health (MHP) and medical providers (MP). The MHP is housed off-site from the medical practice, and is referred patients by the MP, who present with overt mental health issues (e.g., anxiety, depression, PTSD). Communication about the referral is typically the referral itself (either a phone call or fax), and is usually the extent of communication between providers, unless emergent psychosocial issues present themselves (i.e., suicidality and/or homicidality). Treatment plans remain separate and are rarely shared (Blount, 2003).

Co-located. The MHP moves in-house, and while still referred patients for typical MH issues, communication, aside from the clinical note, also takes place during meetings and/or patient briefings. Treatment plans, although remaining separate, reach a higher degree of complementation because of shared access to the patient’s medical chart and increased provider communication (Blount, 2003).

Integrated. MHPs are in-house and referred patients for both traditional and brief consults around mental health and behavioral health issues relevant to the treatment plan (McDaniel et al., 1996; McDaniel, Hepworth, & Doherty, 1992). Providers often have consistent and ongoing conversations regarding referred patients, and the MH provider may even see patients during their medical visit with the MP (McDaniel et al.; Stroshal, 1996). Treatment plans are highly intertwined, and both providers may construct a shared treatment plan/note (Blount, 2003).

The Language of Collaboration
It can be intimidating to learn a new professional language, and some may even consider talking about psychopathology tantamount to renouncing our systemic mindset. However, as we extend ourselves to learn about and use a healthcare provider’s language, a very subtle transition occurs—they often start to use some of our language. Ever listen to a person speak English when their first language was something else? Even after years of speaking that second language, they still carry fundamental imprints of the first—an accent and their inner dialogue. What this means, at least from a metaphorical standpoint, is that how we make sense of the world relationally, our systemic language as family therapists, is not lost because we attempt to learn the language most often used in medical environments. Instead, it is strengthened by our ability to be bilingual and facilitative of a positive MP-patient relationship.

The Ecology of Collaboration
The ecology of collaboration includes understanding and respecting the context of a medical practice and its organizational hierarchy.

Context. When an MHP is hired to provide integrated care, he or she will need to learn how to assimilate into the medical culture. For example, how to provide MH services in smaller time segments (i.e., 5-15 minutes), with healthcare providers coming in and out of the exam room. They will need to learn to document in electronic health record systems and read medical notes. In some locations, they will need to dress
in ways that protect them from airborne or surface contact pathogens. These are a few things to keep in mind, but there are more to learn.

**Organizational Hierarchy.** We must remember that the responsibility for the medical needs of the patient falls on the MP. If, while talking with a patient, he or she voices a concern, the MHP should encourage that patient to talk with the MP, and/or be present during the medical visit and help the patient with that conversation. The MHP does not serve as an advocate for the patient, but helps promote the patient’s own advocacy through their relationship with the MP and team (McDaniel et al., 1992). MH providers also need to be aware of the levels of bureaucracy that exist in every healthcare organization (e.g., administrators, lead providers, office managers) that need to be consulted with each time a new treatment protocol is designed or MHP is hired.

**Training Opportunities**
There are training opportunities at the post degree, degree, and continuing education levels. Noted earlier are the AAMFT and CFHA annual conferences that also provide opportunities for training in this area. In addition, there are summer week-long institutes (e.g., University of Rochester, New York and Chicago Center for Family Health), master’s level programs/tracks within programs (e.g., East Carolina University, University of Rochester, Seattle Pacific University, Nova Southeastern University, Drexel University), and doctoral programs in medical family therapy (East Carolina University and University of Nebraska, Lincoln) that are hotbeds for training, research, and leadership preparation in this area. For more information about training, please contact the lead author for an extensive list of training opportunities.

**Conclusion**
While systems thinking has put our field on the map, it is our advancement in how to apply it in conjunction with a biopsychosocial model (Engel, 1977, 1980) and brief models of therapy that create opportunities for us to fill a niche in healthcare. Advocacy, research, and training are the three ways that we can continue to strengthen our field and keep generations of family therapists competitive at the intersection of mental health and medical care. Joining with our mental health colleagues who have other professional licenses will allow us to collaborate with the healthcare setting more effectively, but no one will advocate for us better than ourselves.

Like any pioneer, this is not easy work, but then again you chose family therapy as your profession because you believed that change happens at the individual, couple, family levels, and beyond. You are a pioneer already, travelling the path of more resistance, at times, because you believe in what you do for change to occur. Healthcare needs family therapists who are trained in collaborative practice. The train is leaving the station. Join us in making a difference and applying our skills in healthcare settings.
Jennifer Hodgson, PhD, LMFT, is an associate professor in the Departments of Child Development and Family Relations and Family Medicine at East Carolina University. She received her doctoral degree from Iowa State University, specializing in marriage and family therapy, and completed a fellowship in medical family therapy at the University of Rochester, NY. She co-authored the nation’s first doctoral program in medical family therapy. She is a Clinical Member of the AAMFT, an AAMFT Approved Supervisor, COAMFTE Commissioner, and a long-time member of the Collaborative Family Healthcare Association. She is president of the Collaborative Family Healthcare Association and has published in several journals and has given several presentations locally and nationally on collaborative and integrated care. She serves as a reviewer for several journals and as a co-editor for the “Collaboration in Action” department in the journal of Families, Systems, and Health.

Daniel Marlowe, PhD, is a recent graduate of the Medical Family Therapy Program at East Carolina University, and completed his doctoral internship at Duke University Medical Center’s Cancer Patient Support Program, a collaborative care program that provides psychosocial care to cancer patients and their families. Throughout his graduate education he has helped design, implement, and practiced in collaborative care programs at a federally qualified health center (FQHC), state psychiatric hospital, family medicine residency program, and major university medical center. He has presented on collaborative and integrated care at state and national conferences, and recently was appointed the director of behavioral science and community medicine for the Duke/SR-AHEC Family Medicine residency program.

References


Learning to be a Medical Family Therapist Supervisor  Patricia Parr, PhD

In the last 15 years, there has been a greater understanding about the dynamics of supervision and an accumulating knowledge base of literature and research. This is particularly the case with marriage and family therapists (MFTs) because of the continued emphasis placed upon the training of MFT supervisors by the AAMFT. Current MFT students and those in the field know they want and need MFT supervision. And, those who choose to become MFT supervisors know they need to be trained to offer these services.

The growth of Medical Family Therapy has added another dimension to marriage and family supervision. More mental health professionals and students are seeking additional training and clinical skills to address the burgeoning needs of the healthcare system. In addition, the increasing interest in collaboration between healthcare systems means the need for more expertise in medical family therapy supervision. Medical family therapy books, such as the seminal, Medical Family Therapy (McDaniel, Hepworth, & Doherty, 1992), journal articles, certificate programs, and intensive workshops do address many of these additional training needs. However, most of the literature focuses on the trainee, rather than the trainer/supervisor.
There are some articles that address basic skills needed by medical family therapy supervisors, such as the one written by Edwards and Patterson (2006), which is focused on the primary care setting. Two skills from their list stand out as essential for initiating a medical family therapy supervision relationship: moving from a systems perspective to a biological/health issues perspective and being attuned to the trainee’s self-of-therapist issues. Be informed about the medical implications of your supervisee’s clients. Don’t minimize the influence of health issues for couples and families.

If your supervisee has a case in which an acute or chronic illness is a factor, assess their knowledge of this illness, find ways to help them and yourself explore the multiple dimensions of the illness (diagnosis, prognosis, medicines, and treatments). Many organizations have program specific information about different diseases. Additionally, they often welcome mental health professionals to attend one of their support groups for patients. Examples, such as the American Heart Association (americanheart.org), the National Kidney Foundation (kidney.org), and the National Multiple Sclerosis Society (nationalmssociety.org) are just a few. Reliable web sites, such as the National Institutes of Health (nih.gov) can also be very informative.

Although I did not know it at the time, my first medical family therapy case would open up a whole new vista of what I could do to help families. A young couple, in their early 30s and recently married, sought therapy to deal with communication problems. When they walked through the door, my eyes told me something else was going on with them. Clancy was gaunt and didn’t look like he had an ounce of fat on him. Sara was vibrant and healthy looking. She was tan, while he had a grayish hue to his skin. They proceeded to share their problem, which from Sara’s perspective was that Clancy was spending huge amounts of time getting “stoned” and no longer seemed invested in their marriage. Clancy’s story was that “pot” relaxed him, and since he had lost his job, he was having a difficult time getting motivated to do anything, even talk to Sara. They both shared that they were strongly committed to each other. However, it didn’t take long for my ears to confirm what my eyes had seen. Clancy was dealing with a serious health issue. His kidneys were failing and he was on dialysis three days a week.

When asked to talk more about how Clancy’s medical issue was impacting the couple, they both immediately minimized its impact. Later, as I was discussing this couple in supervision, I wondered aloud if perhaps Clancy’s drug use was directly related to his illness and learning more about his illness might be the first step I should take in the therapy process. My supervisor encouraged me to stay in the “here and now” with the couple. She said if the illness was a problem, I would eventually find this out. Reflecting on this case, I think that isomorphism was at work. My supervisor and my clients were both denying the impact of illness on the relationship. Navigating my supervisor’s directions and trusting my instincts was a delicate dance. Fortunately, Clancy and Sara began to discuss the illness and I was able to help them understand how it was impacting their relationship. As therapy progressed, Clancy invited Sara and I to go with him to dialysis. We both agreed, although Sara was fearful. She did not know what to expect. This visit became a turning point for them, and for me. This couple was able to begin the journey of accepting Clancy’s illness as part of their relationship. And, what I learned about couple resilience, kidney failure, and dialysis will always be there to draw upon for other couples and supervisees.

Be knowledgeable about how your own experiences influence your understanding of illness. Discuss your supervisee’s self-of-therapist experiences and feelings about illness in general, as well as specific illnesses they or others in their family have experienced.

Currently, I supervise a number of students at various developmental levels. I supervise novice therapists encountering their first client experiences, doctoral students who are licensed and working in the field, and psychiatric residents who have medical degrees and some experience working with individual patients. Each one of my supervisees has thoughts and feelings about the healthcare system, medical professionals, and varied amounts of
knowledge about disease and illness. All of them bring to their client relationships preconceived ideas about physical health. It is important that I know as much about their perceptions of health and illness as I expect them to know about their clients’ health experiences. A good starting point is discussing each supervisee’s personal genogram as related to health issues. I may request supervisees research different diseases and share this information with me. I encourage them to attend disease specific support groups, or schedule a trip to a local hospital or emergency room to observe the medical system at work. I do not expect that all supervisees become as versed in medical knowledge as physicians. I do expect that all of my supervisees will become comfortable with medical terms and jargon applicable to their clients. Modeling comfort with medical topics helps supervisees become comfortable doing the same with their clients. I also strongly encourage learning directly from the clients their narratives of health and illness. These rich details are vital to understanding each client/family.

As I assess my supervisees, I am often amazed to discover how much they do not know. Most of my supervisees are young and healthy. Most have no personal experience with health issues. And most seem to initially distance from knowing too much about a family’s health issues. Usually, my supervision case load includes one or two supervisees whose clients are dealing with multiple sclerosis (MS). Often, clients with MS look physically healthy and supervisees underestimate the chronicity of this disease. Diabetes is another example. Clients with diabetes may also appear to be physically healthy. However, if a diabetic client experiences a drop in blood sugar while in therapy and begins to go into diabetic shock, as one of my supervisee’s clients did, it is critical that the supervisee knows what to do. Fortunately, the supervisee did know about this client’s condition and was able to act promptly. Additionally, the therapist discovered how responsive and nurturing the client’s spouse was during this event.

The therapist’s perception of a non-involved spouse was quickly replaced by a deeper appreciation of this couple’s dynamics around illness. This case illustrates the importance of knowing about medical conditions the client is dealing with, but also how the system is organized around this medical issue.

We promote our supervisees’ efforts to discuss past and current mental health issues, obtain releases and talk to other mental health workers about their clients. We should also encourage our supervisees to put the same effort into knowing about their client’s medical history and collaborating with medical professionals that are involved in their client’s care. Be persistent with supervisee’s so that they complete medical histories, as well as psychological histories for each family member. Require that family genograms include significant transgenerational illness patterns. Model how to make contact with medical professionals. School your supervisees to expect that medical professionals may communicate in different modes and styles. It should be an essential part of our role as medical family therapy supervisors to address the whole supervisee, as well as model for our supervisees how to do the same with their clients.

Clancy and Sara were the starting point of my awareness of the interconnections of illness and the entire family. But others, like Mike and Susan, convinced me of the powerful layered effect of illness, the patient, the family, and the therapist. Mike and Susan were a couple in their 80s, and by Susan’s report, had a good marriage but needed to talk about their adult children. Their concerns centered on one of their three children, Jim. Jim had been diagnosed with MS in his early twenties. Jim was bed ridden; his wife had left him. Mike and Susan had assumed his primary care. They were exhausted and terrified of what would happen to Jim if something happened to them. This case was different for me. I had experience with MS. My adult son was also diagnosed with MS when he was in his twenties. In some ways, this couple’s concerns were a good fit with my knowledge and understanding of MS. I knew a great deal about MS and its many related health issues. But, this couple also represented to me where my husband and I might be in our later years. The supervisor for this case was more attuned to medical issues, he also knew more about me, and my personal story. I knew that I did not want to burden this overly gracious care-giving couple with my own issues. They needed to be supported, not supportive. What I learned from my supervisor for this case was how valuable it is to have a supervisor that can be nonjudgmental and allow one to share their own stories of illness in supervision. This gave me the extra time and space to separate myself from my story and attend to their story.

There has been an opening created for medical family therapists and supervisors evolving from necessity. As more individuals become trained as medical family therapists, and as we become more aware of illness being a family story, let us who supervise in this field be prepared for the job of providing appropriate services.

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References
THE TERM “MEDICAL FAMILY THERAPY” HAS BEEN AROUND FOR DECADES NOW.
Susan McDaniel, Jeri Hepworth, and Bill Doherty coined the phrase in 1992: “[W]e introduce the term medical family therapy to refer to biopsychosocial treatment of individuals and families who are dealing with medical problems” (p. 2). They explained that this approach was more than just adding family therapy to traditional healthcare. It was a way of relating, and understanding relationships, differently; it called for breaking down silos of professional skills and allegiances, and building up partnerships based on mutual respect and shared goals for families. Today, the practice of medical family therapy and collaborative care is booming, and more and more MFT graduates are aiming to provide this kind of integrated care. But how do you do it? And where? And what does it take to become a “medical family therapist”? In this article, we take a look at the current climate of primary healthcare, the role of family therapists in that climate, and guidelines for joining the growing community of providers who wouldn't practice any other way.
Integrating family-oriented behavioral health professionals—family therapists, psychologists, psychiatrists, and social workers—into primary care settings expands the capabilities of primary care physicians. It makes perfect sense, and its success is reflected in the tremendous growth of medical family therapy and collaborative care practices. Why? Because professionals of all disciplines, as well as policymakers and third-party payors, see that interdisciplinary teams result in better care, better job satisfaction for the professionals, and, most importantly, better health for individuals and families. The “one stop shop” of the Patient-Centered Medical Home (AAFP, AAP, ACP, AOA, 2007) is quickly becoming the gold standard of primary care, one critical piece of that model being a whole-person, biopsychosocial orientation.

George Engel’s (1977) biopsychosocial model derives from general systems theory (Wynne, 2003) and demands that we are attend to health and wellness at each level (from the micro to the macro), including of course, the family and social/cultural systems. Unfortunately, not all family therapy training programs prepare graduates to work with the physical concerns of their patient families. Close to 1 out of 2 adult Americans has at least one chronic illness (Wu, 2000), so most MFTs work with people who are struggling with health and illness conditions in addition to their psychological and relationship concerns.

Despite a growing interest in and need for this type of practice, graduates from MFT training programs often complete their education with limited coursework and clinical training, unless they trained at one of the few programs with an explicit focus on medical family therapy (i.e., East Carolina University, University of Rochester). So how would an interested graduate of a less specialized program embark on this important work? It comes down to three main areas of focus: do your homework, network with like-minded others, and develop competencies.

**Do Your Homework**

Getting prepared for work in a medical setting as a family therapist is fascinating. Each encounter, be it with a patient, support staff, or medical professional, draws on several levels of knowledge, awareness, and fluency. Start with some good primers on the subject of collaborative care and the integration of systemic therapies and traditional healthcare. *Medical Family Therapy* (McDaniel, Hepworth, & Doherty, 1992) and *Family Therapy and Family Medicine* (Doherty & Baird, 1984) are two seminal works that set the stage for family-oriented care in the medical setting. *Models of Collaboration* (Seaburn, Lorenz, Gunn, Gawinski, & Mauksch, 2003) is an excellent guide with useful strategies and suggestions for forming working relationships with others in a collaborative setting. While these texts offer solid background information.
and guidelines for practice, preparedness should also be informed by the growing body of literature dedicated to evidence-based practice, training models, and case studies in collaborative care. The journals *Families, Systems, and Health* and *Annals of Behavioral Medicine* routinely features these types of articles. For those seeking collaboration in a tertiary care or specialty setting (i.e., bariatrics, cardiology, endocrinology, oncology), journals catering specifically to those specialties may also have pieces on “behavioral” or psychosocial medicine.”

**Network**
Establishing yourself as a medical family therapist is all about relationships. Organizations such as the Collaborative Family Healthcare Association (http://cfha.site-ym.com) and the Society for Teachers of Family Medicine (www.stfm.org) provide a home for family medicine professionals of all disciplines who are devoted to more integrated models of care and training. They also offer specialized conferences, meetings, journals, and trainings for those hoping to learn the requisite skills as integrative practitioners. These organizations also provide online forums, listserves, and small group memberships to allow for more exchange among members with common clinical and training interests.

The most esteemed and oldest models of medical family therapy and collaborative care exist in institutions where a physician or family therapist (or both) pioneered something new. The University of Rochester Medical Center (URMC) is the embodiment of this pioneering energy, having been the birthplace of the biopsychosocial model (Engel, 1977) and an early partnership between family therapy and family medicine (McDaniel, Campbell, Hepworth, & Lorenz, 2005). The URMC Institute for the Family offers a week-long Medical Family Therapy Intensive that highlights not only how the field has evolved but also cutting edge applications of integrative practice (www.urmc.rochester.edu/psychiatry/institute-for-the-family/family-therapy/mfti.cfm). Experiences like this where family therapists learn alongside physicians, nurses, and other mental health professionals help to create stimulating professional relationships and networking possibilities among others interested in this type of care.

**Developing Competencies**
The Commission on Accreditation of Marriage and Family Therapy Education’s (COAMFTE) core competencies establish the base skills needed for an MFT to practice independently and effectively. As the field of medical family therapy is still in its relative infancy (Linville, Hertlein, & Lyness, 2007), discussions continue around the set of core knowledge, skills, and attitudes for the medical family therapist. While it can be argued that all of the core competencies of an effective family therapist apply to the practice of medical family therapy, it is also true that collaborative practice and working with patients with health problems demands an additional skill set, including emotional responses to medical illness, common caregiver reactions, and collaborative skills with medical providers, to name a few. Developing skills as a medical family therapist
Establishing yourself as a medical family therapist is all about relationships.

can also be facilitated by consultation and supervision with a more seasoned medical family therapist either in your practice or elsewhere.

**Becoming a Medical Family Therapist**

Becoming a medical family therapist can occur in two distinct environments: well-established programs and settings with the “right ingredients.” In the first, the idea of integration is well established. The practitioners, educators, and trainees all buy into the importance of attending to all aspects of a family’s health and well-being. The practice walks the talk; medical professionals and family therapists work side by side, share space, patients, and often charts. They value the experience of a highly skilled team with diverse expertise when it comes to providing healthcare.

Environments with the “right ingredients” have possibility, but also need to be assembled and developed. The “right ingredients” include a physician or nurse practitioner champion (someone who’s willing to push the envelope a bit and who has the respect and resources to do it), a culture of teams (recognition that good care requires a variety of professionals from a variety of disciplines), and a physical space that can accommodate the addition of psychosocial or behavioral services (though many a visit by a fully integrated medical family therapist is successfully conducted in an exam room).

Medical family therapists can also work from an off-site office if they make use of these principles in working with families, their health concerns, and their health professionals. The skill set transcends physical practice setting, although collaboration with other healthcare professionals, especially off-site, will require a more concerted and intentional effort.

Once you’ve found the right setting, getting the job, so to speak, is about knowing what you know, and marketing yourself as a primary care mental health provider. A systems-trained, relationally-oriented therapist who both understands the effect of illness on families and can bring together potentially divergent perspectives is likely to be a good fit and an asset to any integrative and

**Establishing yourself as a medical family therapist is all about relationships.**
interdisciplinary healthcare team. Focused training through either a specialized medical family therapy degree, a certificate program, or a post degree coursework or conference can help to develop additional skills as well as foster a solid identity and competencies as a medical family therapist.

Conclusion
Those new to the field are entering at an exciting time. Opportunities to treat families in collaborative primary and specialty care settings are growing, as is the demand for well-trained, versatile, team- and family-oriented mental health practitioners. And those not-so-new-to-the-field, who began the movement toward integrated care, are not merely seeing the fruits of their labor. They are training the next generation of medical family therapists, vital members of the healthcare teams of the present and future.

We use the term “patient” synonymously with “client” given its universal use in healthcare settings.

Training Opportunities:
University of Rochester Medical Center
(Post-degree certificate: www.urmc.rochester.edu/psychiatry/institute-for-the-family/family-therapy/)

University of Nebraska-Lincoln
(PhD: http://cehs.unl.edu/cyaf/grad/mftPhD.shtml)
(Post-degree certificate: www.unl.edu/gradstudies/prospective/programs/Cert_MedicalFamilyTherapy.shtml)

Drexel University
(Post-degree certificate: www.drexel.edu/catalog/certificates/medical-family-therapy.html)

Northern Illinois University
(Post-degree certificate: www.niu.edu/strategicplan/summary/postmasterscert.shtml)

East Carolina University
(PhD: www.ecu.edu/che/cdfr/phdmft.htm)

Seattle Pacific University
(Post-degree certificate: www.spu.edu/depts/spfc/mdft/)

Mercer University
(Post-degree certificate: http://medicine.mercer.edu)

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References


The AAMFT Annual Conference is just around the corner. See details below and register before August 22nd to save up to $100! For more information about this year’s program, or to register online, visit www.aamft.org/fortworth.

**PLENARY DESCRIPTIONS**

**Thursday afternoon**

**The Anthropology of Marriage**

Meredith F. Small, PhD, Professor of Anthropology at Cornell University, and author of books including, What’s Love Got to do with it? The Evolution of Human Mating, Our Babies Ourselves: How Biology and Culture Shape the Way we Parent, and The Culture of Our Discontent: Beyond the Medical Model of Mental Illness.

**Friday morning**

**Technology in Family and Social Relations**

Keith N. Hampton, PhD, Assistant Professor in the Anneberg School for Communications at the University of Pennsylvania; principle author of Social Networking Sites and Our Lives, a project of the Pew Research Center’s Internet & American Life Project; and Past-Chair of the American Sociological Association’s Section on Communication and Information Technologies.

**Saturday morning**

**The Neuroscience of Relationships**

Louis Cozolino, PhD, Professor of Psychology at Pepperdine University; Adjunct Clinical Professor of Psychiatry at UCLA; and author of The Neuroscience of Psychotherapy, The Making of a Therapist, The Neuroscience of Human Relationships, and The Healthy Aging Brain.

**Saturday afternoon**

**The Science of Attraction and Desire in Long-term Couples**

Patricia Love, EdD, licensed marriage and family therapist; co-founder of Austin Family Institute; and author of books including Hot Monogamy: Essential Steps to More Passionate, Intimate Lovemaking, The Truth About Love: The Highs, the Lows, and How You can Make It Last Forever, and How to Improve Your Marriage Without Talking About It.
SESSIONS

Thursday, September 22, 2011

9:00 AM - 3:30 PM, Lunch break (on your own) from 12:00 p.m. – 1:30 p.m.

100 - Approved Supervisor Refresher Course
101 - Neuro-Ecology®
102 - Trauma of Sexual Addiction
103 - Better Understanding of Emotion
104 - Personal Model of MFT Supervision
105 - Cognitive-Behavioral Therapy
106 - Single Session Therapy
107 - Client-Focused Research
108 - Helping Couples After Combat Trauma
109 - High Conflict Marriages
110 - Domestic Violence Focused Treatment
111 - Technology as a Major Ingredient
112 - Metaframework for MFT Supervision
113 - Power of Play
114 - Healing Attachment Injuries
115 - Addiction & Emotions
116 - Intimate Couple Relationships

Friday, September 23, 2011

Morning Workshops
10:45 AM - 12:45 PM

200 - Addicted Women & Trauma
201 - Supervisory Practices in Asian Context
202 - Internal Family Systems Therapy
203 - Therapeutic Suicide Assessment
204 - Co-creating the Supervisory Relationship
205 - Hormonal Disorders
206 - ADD and ADHD
207 - Perinatal Mood Disorders
208 - Trauma and Military Couples
209 - Eating Disorders
210 - Building Collaborative Clinicians
211 - Developing Scholarly MFT Articles
212 - Sitting with ORCA
213 - Family Centered Treatment
214 - Moving Couples beyond “Fight-or-Flight”
215 - Effective Online Therapy
216 - Autistic Spectrum Disorders
217 - Same-Sex Couple Development
Afternoon Workshops
2:15 PM - 4:15 PM
300 - Treatment of Complex Trauma
301 - Creating Therapeutic Alliance
302 - Principles for Satisfying Couple Sex
303 - Neurocybernetics and Siblings
304 - Structuring the Supervision Process
305 - Bridging MFT and Medicine
306 - Systemic and Physiological Change
307 - Attachment and the Divine Triangle
308 - Bicultural Couples in the Military
309 - Pornography Addiction
310 - MFT’s in Schools
311 - A.R.E. Moments in the Couple Dialogue
312 - Mental Health Finance and Delivery Systems
313 - ADHD
314 - Crying and Therapists’ Perceptions
315 - Stress Response and Couples
316 - Suicidal Adolescents
317 - Restoration Couples Therapy
318 - The Resilient Therapist

Saturday, September 24, 2011

Morning Workshops
10:45 AM - 12:45 PM
400 - EFT and Couples with Autistic Kids
401 - Relationships and Neuroscience
402 - In-Home Therapy for At-Risk Families
403 - Working with Children and Families
404 - Mentorship within MFT Supervision
405 - Therapeutic Approach to The Birds & The Bees
406 - Intense Emotions in Affair Recovery
407 - Law Enforcement Culture
408 - The Military Couple
409 - Physiology at Work in Therapy
410 - Relationship Education into MFT
411 - Integrating the Johnson & Gottman Models
412 - LGB Affirmative Therapists
413 - Grief & the Impact on the Couple Relationship
414 - Impact of Adult ADHD on Marriage
415 - Depression and Relationship Distress
416 - Sibling Violence
417 - Brain Rewiring Therapy
418 - Attraction and Therapist-Client Relationship

Afternoon Workshops
2:15 PM - 4:15 PM
500 - Relationship Trauma of Inpatients
501 - Conversations with a Sex Therapist
502 - Internet-Related Problems in Couples
503 - Mind-Mapping in Couples Therapy
504 - Ethical and Legal Issues in MFT Supervision
505 - Queer Science
506 - Increasing Bonding in Families Utilizing BSFT
507 - MFT in Collaborative Divorce
508 - Veteran PTSD and Relationships
509 - Trauma Therapy and Parent-Child Therapy
510 - How do I Touch Thee
511 - Psychobiology of Relationship Competence
512 - Readiness in MFT Training Programs
513 - MFT Students Mentoring Youth
514 - Twin Territories of Story Development

Board Dinner and Award Presentation
Friday, September 23, 2011
8:30 p.m. – 12:00 a.m.

Denim and Diamonds Dance & Western Fair
Friday, September 23, 2011
9:30 p.m. – 12:00 a.m.

Register before August 22nd to save up to $100! For more information about this year’s program, or to register online, visit www.aamft.org/fortworth.
AAMFT ANNUAL CONFERENCE REGISTRATION FORM

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Pre-Conference Institutes
(Thursday, September 22, 9:00 a.m. – 3:30 p.m)
On/Before August 22 After August 22
With Full Conference          □ $115              □ $125
W/O Full Conference           □ $150              □ $200

Full Conference (Thursday, September 23, 4:00 p.m. –
Sunday September 25, 12:30 p.m.)
On/Before August 22 After August 22
AAMFT Clinical, Affiliate,   □ $290              □ $390
and In Process Members
AAMFT Associate Members      □ $210              □ $310
Non-Members                  □ $390              □ $490
AAMFT Student Members       □ $190              □ $240
Non-Member Students          □ $290              □ $340

One Day Attendance Only (members and non-members)
Day             On/Before August 22 After August 22
Friday           □ $175              □ $275
Saturday         □ $175              □ $275
Sunday           □ $175              □ $275

Continuing Education Certificate
□ Yes ($10)        □ No ($0)

Board Dinner, Award Presentation and Dance (Friday, September 23)
(Specify number of tickets) _____ Tickets (x) $50 _____ TOTAL_____

Conference Workshop Choices
Thursday Pre-Conference Institute, September 22 (Please note that
there is an extra fee for the Pre-Conference Institute)
100 Series 1st Choice_________________   2nd Choice________________

Friday Workshops, September 23rd
200 Series 1st Choice_________________   2nd Choice________________
300 Series 1st Choice_________________   2nd Choice________________

Saturday Workshops, September 24th
400 Series 1st Choice_________________   2nd Choice________________
500 Series 1st Choice_________________   2nd Choice________________

Sunday Morning Seminar September 25th
600 Series 1st Choice_________________   2nd Choice________________

Payment Information
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Under the Americans with Disabilities Act (ADA), do you require auxiliary aids or services? Specify special assistance required:
________________________________________________________________________________ ___________________________________________________________________________

Do you have a dietary restriction for the BOD dinner?
□ No             □ Yes, Please explain: ___________________________________________________________

If you would like to pre-order your session recordings, the AAMFT is offering the following options:
AUDIO:  All of the recorded sessions on CD:                □ Members $109              □ Non-Members $139
DVD: of the Plenary Sessions Only:                       □ Members $79               □ Non-Members $109
Both: the Plenary and all other recorded sessions:       □ Members $139             □ Non-Members $169

How did you hear about the 2011 AAMFT Annual Conference? Please check one.
□ E-mail from the AAMFT             □ The brochure             □ Non-AAMFT Publication □ AAMFT Web site
□ AAMFT Magazine or Journal         □ My local division       □ My state licensure/certification board
□ Previous Conference               □ Word of Mouth
Do you see your practice specialty or area of experience listed below?
Send a brief article description or outline to ftm@aamft.org and the editorial team will consider your topic for publishing.

2011
November/December - Therapeutic Power

2012
January/February - Empirically-supported Treatments
March/April - How to Start and Run a Practice
May/June - Managing Your Practice in the Electronic Age

Topics are subject to change. Please see most recent updates online at www.aamft.org/imis15/content/FTM/FTM_upcoming_issues.aspx.
When psychotherapists provide collaborative care within a primary care setting, sharing and coordinating patient care between physicians, nurses, and other healthcare providers is a regular occurrence. However, psychotherapists must be aware of the implications of compliance with the Health Insurance Portability and Accountability Act (HIPAA) in such settings. Generally, HIPAA governs the protection and maintenance of patients’ health information. HIPAA protects the privacy of a patient’s identifiable health information, also known as Protected Health Information (PHI) and regulates disclosure and use of a patient’s PHI. Marriage and family therapists (MFTs) should familiarize themselves with the disclosure of PHI, as regulated by HIPAA, as it relates to working in a collaborative setting. The major areas of HIPAA relevant to MFTs practicing in a medical setting include psychotherapy notes, patient confidentiality as it relates to collaborative communication, and release of records.

Psychotherapy Notes
Under HIPAA, psychotherapy notes are defined and protected from normal release to the client, the courts, and anyone else (see HIPAA privacy rule 45 CFR 164.524(a)(1)(i), 45 CFR 164.501). This distinction is sufficiently important that MFTs should familiarize themselves with the language of the federal regulation. “Psychotherapy notes means notes recorded (in any medium) by a healthcare provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record” (see 45 CFR 164.501).

Therapists working in collaboration with physicians in a primary care setting should distinguish between psychotherapy notes, which are kept separate from the medical record, and progress notes kept with the client’s medical record. Psychotherapy notes include the therapist’s own impressions, hypotheses, personal reactions, doubts, possible interpretations, supervisory recommendations, and so on. Any sensitive information, either current or historical, that is gathered and used to formulate a diagnosis and does not impact the patient’s current care on an immediate basis should be omitted from the progress notes that become part of the patient’s medical record consultation report and included in the psychotherapy notes. In other words, only the information pertinent to a patient’s immediate care should be included in the progress note. 45 CFR 164.524(a)(1) gives individuals nearly unlimited access to their own medical records, but specifically excludes psychotherapy notes as described above.

Progress Notes
Progress notes are kept with the rest of a client’s medical record and may, under certain circumstances, be open to disclosure to the client and other interested parties, including the referring physician, another mental health clinician within the same system (if appropriate consent has been obtained), or an attorney representing the client or, perhaps more importantly,
an opposing attorney in a legal proceeding. Progress notes should be kept to a minimum, while including the following essential information: counseling session start and stop times, medication prescription and monitoring (if any), modalities and frequencies of treatment furnished, results of clinical tests, and a summary of the following: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date (45 CFR 164.501).

When writing the progress note, it is important that the MFT keep in mind that often the patient’s primary care physician referred them for psychological services with the goal of establishing a concrete diagnosis and establishing a treatment plan as a means of resolving the presenting problem. The progress note should delineate specific treatment goals and any interventions directly related to the established goals. When working in a collaborative setting with medical professionals, it is also important to both document and communicate with the treating physician whose responsibility it will be to deliver the interventions related to the care delivery and progress of the patient.

Confidentiality and Communication
Under HIPAA, “[a] covered entity is permitted to use or disclose protected health information as follows: (i) To the individual; (ii) For treatment, payment, or healthcare operations, as permitted by and in compliance with §164.506.” Be that as it may, when a therapist does disclose PHI, they “must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request” (45 CFR 164.502[b]). However, this ‘minimum necessary’ requirement does not apply to “[d]isclosures or requests by a healthcare provider for treatment” (45 CFR 164.502[b][2][i]). Prior to providing any services, MFTs in a collaborative setting should take the time to explain to their patients that information the patients share may be disclosed to other medical staff in the setting, specifically their primary care physician, insofar as the information relates to the patient’s care and treatment. Patients should also be informed about how their healthcare information can be shared with other providers. More specifically, patients should be made aware that as little identifiable information as possible will be shared with others on the treatment team and only the information relevant to their current care will be disclosed.

Once patients have been informed that their therapist and healthcare provider will be communicating about their care and working together to provide the best treatment possible through collaboration, fluidity of care is possible. When doctors and therapists are able to work together within the regulations of HIPAA, patient care can be streamlined. When communicating with other members in the collaborative setting, individual releases are not necessary. However, it is often considered good practice to reference by date and by source the original referral in any written communications.

Release of Records
Before releasing any PHI, the MFT collaborating with a patient’s primary care physician should take the precaution of discussing such release of records with the patient and should secure written authorization to do so. Client records must be secured so that they are not readily available to anyone not on the treatment team.

When an MFT receives a request by a patient for the release of confidential medical records, including the release of the progress notes that make up one part of the record, he or she is required to document the request for release as part of the patient file (see 45 CFR 164.524). It is important to recognize that marriage and family therapists working in collaborative health settings must use sensitivity and precision when documenting a patient’s current state and their progress in treatment. This is essential given that HIPAA grants patients a right to access their medical files, including progress notes, which become part of the patient’s medical record.

Electronic Medical Records
In recent years, it has become increasingly common to keep patient health information in the form of Electronic Medical Records (EMRs). The use of EMRs raises new challenges that will need to be resolved to ensure proper protection of PHI. It is important to note that HIPAA ensures the same standards of privacy for both paper and electronic records. HIPAA’s Security Rule establishes standards to ensure that electronic health information is protected (45 CFR Parts 160, 164). The Security Rule requires appropriate administrative (how to comply), physical (access to protected information), and technical (access to networks and protecting electronic communication) safeguards to ensure the confidentiality, integrity, and security of electronic protected health information. This movement toward electronic maintenance of critical, private, and protected patient health information presents exciting opportunities to promote continuity of care and link documentation between providers.

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Labor Pains
As with much of my clinical work these days, writing this article has just become more challenging. The wonderful and very distracting acrobatic routine that is currently taking place in my womb has just emotionally pulled me away from whatever task I was about to complete. With every drop-kick and twirl, this little life reminds me that she will soon be meeting the outside world.

Arriving into my third trimester of pregnancy, I am also reminded of the excitement and evolution that took place in me while learning how to thrive as a family therapist in primary care. I knew I was interested in medical family therapy, due to my own interest in medicine for a portion of my undergraduate years. Fortunately, as a marriage and family therapist (MFT) trainee, I had the opportunity to work at the University of California, San Diego’s department of Family Medicine following my first year of graduate school.

At this point you might be wondering, what in the world do pregnancy and childbirth have to do with family therapists working in primary care settings? Quite a bit, as it turns out. The personal traits I hope to utilize during the upcoming delivery of my child are similar to those I found most useful as a family therapist in primary care.

For example, I know what my ideal birth plan would look like and have no problem asserting these wishes. I also know that being flexible and adaptive (especially in the case of an unforeseen crisis) is going to be vital. A variety of key players will all be present on this day (such as my physician, my doula, the nurses, my husband, my family, my baby, and I) and in order to get an optimal experience, I must understand the dynamics of being a team player. I am also aware of the medical setting’s pace and language, and this knowledge will come in handy when communicating with the medical team assisting in my delivery. Interestingly, I have found that being assertive, flexible and adaptive, a team player, an effective communicator, and familiar with the dynamics of the medical setting, are all necessary skills that eased my transition into the world of integrated care.

Argument for Integration
The goal of integrated or collaborative care is to improve access, screening, and treatment of mental health, psychosocial, and substance abuse problems through primary care settings (PCS). To accomplish this goal, behavioral health clinicians (BHC) have become a core part of the primary care team (Hunter & Goodie, 2010). A variety of mental health clinicians work as BHCs, including, but not limited to, MFTs, psychologists,
social workers, and counselors. MFTs, often referred to as MedFTs in primary care settings, are particularly well-suited for this position because our training emphasizes two content areas that are underdeveloped within many healthcare environments: 1) a systemic relational perspective of illness and the illness experience; and 2) the inclusion of the relational system around the patient.

The field of MedFT has garnered continued interest from many practicing MFTs wanting to know how and what is needed to expand their skills and practice in collaborative care settings. These questions were posed to Gene Kallenberg, MD, chief of UCSD Family Medicine, and Zephon Lister, PhD, LMFT, director of the Collaborative Care Program at UCSD Family Medicine. Their answers are provided as a guide for understanding the requisites that would lead to a successful expansion of MFTs into PCS.

Requisite I: Personality

What do you look for in terms of personality, when interviewing and hiring an MFT into your setting?

GK: The MFT needs to be an up-front, straightforward, straight-shooting communicator. Any personality artifice is going to serve as a detractor and a barrier to communicating with physicians who are usually moving at light speed. A term I often use with medical students is “respectfully assertive.” They need to be respectful, but in order to get things done they must be a little bold. The wallflower is not going to make it. You are trying to effect culture change, and while there should be a certain level of respect for the way things are, the MFT certainly can work to re-prioritize behavioral health needs as higher up on the food chain. This is part of the magic that will occur with collaboration.

ZL: I want someone that can remain calm under pressure. There are a lot of high intensity emotions and unexpected events that transpire in healthcare settings, and one of the more subtle but important roles we play is bringing a calming atmosphere to the environment. Everyone is running on high emotions and significant time restrictions, but if we can come in and manage these situations effectively, then that is crucial. The human factor is very important as well, and I am looking for a clinician who can connect with not only the patients, but the medical providers and staff as well.

In addition to the personality characteristics mentioned above, other traits and qualities identified in the literature include:

Flexible and Adaptive. The pace and issues addressed in primary care are rapid and ever changing. MFTs entering this world have to be open to adjusting how they think about mental health intervention and treatment.

Team Player. MFTs must be comfortable collaborating with professionals in other disciplines. They must recognize that many physicians are used to working solo or being the team leader, and may not be accustomed to having another provider present during their patient visits (Runyon, 2009).
Effective Communicator. The MFT should be articulate and concise in his or her means of communication when discussing cases and ongoing treatment. MFTs can gain credibility by effectively communicating their roles and providing rationale for their presence (Hunter et al., 2009).

Assertiveness. The MFT should also be comfortable taking initiative, providing succinct and thorough recommendations and following up with physicians when necessary. MFTs must be confident and assertive in a world where time limits and constraints are many, and providers are bound by these constrictions in their capacity to collaborate with each other.

Requisite II: Clinical Skills

What clinical skills do you find important when hiring an MFT?

GK: Knowing what you’re doing clinically is the same measure by which doctors assess each other’s abilities. A huge part of good clinical care is assiduous follow-up. We all know that medicine is 95 percent perspiration and 5 percent inspiration; if you do the right thing and follow up, you are going to keep yourself and the patient out of trouble. When hiring an MFT, I want to know if they have ever worked in a primary care shop. I want to see letters speaking to their clinical qualities, and I want to see if they can demonstrate how they would use their clinical skills in a difficult case. Do they have special knowledge areas? How much pharmacology do they know? How much experience do they have with behavioral change and medical co-morbidities? These are all markers of skill sets we would find highly valuable in practice.

ZL: When you only have 10-15 minutes, you need someone who has good conceptualization and diagnostic skills. You also need someone who is knowledgeable and comfortable with brief interventions and remote follow-up for patient care. I need someone who can come in and offer the patient something in those 15 minutes that would be meaningful, practical, and doable. You also need to be able to convey to the PCP what you did and what the PCP can do to reinforce and follow-up on your intervention.

Additional skills highlighted in the literature include:

Familiarity with PCS Culture. A successful MFT will benefit from having past experience working in the primary care environment, and will thus be familiar with the dynamics and hierarchy that exist within the PCS.

Further, having a working knowledge of disease and psychopharmacology is necessary to ensure understanding and communication with medical care providers (O’Donohue, 2009).

Competent Case Conceptualization. The MFT should be able to quickly identify a problem and conceptualize a case. Further, it is important that the MFT focus on and respond to referral questions, which demonstrates respect for the referring provider’s concerns (Robinson & Reiter, 2006).

Structured Assessment Skills. The MFT should be up-to-date with evidenced-based assessment tools that can have immediate translatability into patient care.

Clear and Concise Clinical Notes: Primary care physicians will need to rely on chart notes at their next visit with a patient, so the MFT’s note should be clear, concise, consistent with verbal recommendations, and use language that the primary care provider will understand (Robinson & Reiter, 2006).

Familiarity with Evidence-Based Treatments. Theories such as Cognitive-Behavioral Therapy, Acceptance and Commitment Therapy, and Motivational Interviewing, that are evidence-based, concrete, functionality focused, and rely on brief interventions and patient self-management, are the most compatible with the primary care needs.

A Biopsychosocial Approach: The stress diathesis model is a key component to the reasoning behind Integrative Care. The MFT should be able to communicate how physical factors, behaviors, thoughts, environment, and interactions with others impact symptoms and functional impairment to patients and physicians (Hunter & Goodie, 2010).

Requisite III: Consultation Skills

Consultation is a key component of collaborative care. How can an MFT demonstrate that they would make a strong consultant in the PCS?

GK: I want someone who can connect the dots. I’ve found that at times the therapist is working with a patient on an issue that differs from the referral. This
happened to me with a therapist and I contacted the therapist saying, “I sent the patient to see you for _____, so why is it that you are working on _____?” The therapist wrote back a very clear message saying, “Well we started talking about _____, and it quickly became clear that _____ was a major issue and related to the referring issue.” This therapist was able to connect the dots for me.

When an MFT does a consultation, it would be neat to see some sort of evidence that they read my notes. Did they review the problem list and medication list and the last couple of office visit notes to see how things go and what the flavor of things were? This tells me they are really getting to know the patient.

ZL: The clinician needs to almost be bilingual. They need to be familiar with the behavioral health language and the medical language, so that when they talk to the physician they are able to convey behavioral health concepts in the medical tongue. Say I’m using motivational interviewing. Instead of talking to the physician about how the patient was in the pre-contemplative phase and I think we moved them to the contemplative phase, I might let him or her know that we discussed the barriers to adherence, addressed these barriers, and the patient is now feeling more motivated to follow through with the physician's recommendations.

Additional skills include:

Translatable Clinical Skills. MFTs should be able to give conscious, focused responses to questions regarding how to address the behavioral health needs of a patient (Robinson & Strosahl, 2009).

“Curb-Side” Consultations. The MFT must be willing to make him or herself available for “curb-side” consults or crisis interventions (Robinson & Reiter, 2006). The MFT will certainly at some point be asked to assist with a difficult patient situation, and it is not always the case that the timing will be convenient.

Additional Insights

GK: Maybe not every practice is interested in teaching and research, but because we are an academic center, we are really interested in the missions of teaching and research. Teaching is probably the most broadly applicable, because you have to teach me. You have to teach the physician and all of the staff what it’s like to take care of the whole patient. On the research side, it’s imperative to try and understand the population burdens in our practice, and to study how we can capture everyone that is behaviorally or mentally hurting out there.

I think that these partnerships are just waiting to happen, and I think the systems that we practice in put up so many barriers that the natural ability of behavioral folks and primary care people to talk together is being obstructed. If we can just tear down these barriers by co-location and collaboration, this will allow for the natural process to go. We all know as primary care physicians that 60 to 80 percent of our patients have behavioral health issues going on, and that it’s substantially affecting what we consider to be the medical problems. Any primary care physician that cannot see this integration as huge and potentially wonderful for their patients, and their practice, probably should be practicing something other than primary care.

ZL: Something that is often not taken into consideration is diversity. What I mean by diversity, is the qualities that a person brings in that help them more readily resonate with the clinical population. For example, familiarity with the cultural aspects of the population that they are working with, or knowledge regarding a unique dimension of the population, is a level of experience in diversity that is often not screened for. This becomes very important because the MFT is trying to reduce the stigma of mental health and hoping to engage the individual in a service that they would probably otherwise not access. When the patient and MFT are able to connect, it helps bring down the level of anxiety that people have about new things.

It may be overwhelming at first glance, but I can personally attest to the fact that working within the primary care setting has been incredibly rewarding. It has allowed me the opportunity to make a truly positive impact on the health of individuals and their families seeking medical and mental healthcare in one setting. Transitions are rarely easy, as I am sure to find true as I enter motherhood. Nevertheless, if we are willing to trust in our abilities and effectively collaborate with others, we will have the opportunity to not only survive, but thrive in these enriching transitions.

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References


CHECKLIST: MFTs in Small Practice Integrated Healthcare

MARTHA TEATER, MA

Integration between marriage and family therapists (MFTs) and primary care providers (PCPs) shows great promise for our shared clients. People treated in an integrated model attest to its positive impact on their lives.

I am an MFT and have worked in medical settings with PCPs for over 25 years. I currently work in a primary care medical clinic that also has an opiate addiction program and a free clinic for indigent people.

I’ve seen the power of medical and mental health providers working closely together, as our clients benefit tremendously from this integrated approach.
What is Integrated Care?
At its most basic, integrated healthcare includes behavioral and physical health specialists working together for the good of those we serve.

Alexander Blount (1998) notes, “It’s a service that combines medical and behavioral health services to more fully address the spectrum of problems that patients bring to their primary medical care providers. It allows patients to feel that, for almost any problem, they have come to the right place.”

MFTs in Primary Care
There are many compelling reasons for MFTs to work more closely with PCPs. The primary care setting is often the first and most trusted place people go with mental health issues. People like to get their mental health needs taken care of by their PCP. Seeking medical care for mental health needs helps people feel less of a stigma; they are not going to see a “shrink.” Having mental health needs treated by a PCP may be more cost effective, as health insurance may more readily cover medical needs than mental health needs. While MFTs are gaining ground in the fight for insurance parity, many current policies lag behind in covering mental healthcare by MFTs and other mental health professionals.

Also:

- Referral out of the primary care office reduces follow-up, so working in the same office increases the likelihood that the client will obtain mental health care
- The client isn’t the only one who benefits—the PCP’s awareness of mental health issues increases with the presence of an MFT onsite. Our proximity and involvement keeps psychological issues front and center in the mind of the PCP.
- It’s hard to think of any examples of medical problems that don’t have an effect on individual mental health and family functioning.

PCPs are Already Providing Mental Health Care. Research shows that 80 percent of patients want to get mental healthcare through their PCPs. Almost half of all substance abuse and mental health treatment is provided through a PCP only. Almost 70 percent of all psychotropic meds are prescribed by PCPs. Nearly 70 percent of all healthcare visits have a primarily psychosocial basis. Ninety percent of the most common complaints in PCP setting have no organic cause.
WHAT DO PCPS WANT FROM MFTS?

I’m often surprised to hear that MFTs haven’t cracked the code on what PCPs want from us. PCPs really do want feedback, and they value our insight and expertise. Perhaps that knowledge will make us bolder in opening up dialogue with our professional peers across disciplines.

PCPs are often quite open in sharing what they would like from MFTs. Following are some of the requests for help that I hear most often when working in a medical setting.

- **Diagnosis**: Are there any mental health diagnoses that may complicate care? PCPs welcome our input about diagnoses and how those issues may impact medical care. Many have limited training in mental health diagnosis, and while they may have a DSM-IV on the bookshelf, it isn’t their area of expertise. With a more obscure diagnosis, I have even copied information from the DSM-IV to send to the PCP so he or she can gain a more thorough understanding of the diagnosis and its ramifications.

- **Support systems**: Who does the patient depend on? Who does the patient respect? PCPs can use these relationships to improve compliance and increase patient motivation. PCPs will often get permission from a patient to include the family in the care of that patient.

- **Assessment of the patient’s level of commitment to wellness**: Are there ways of enhancing motivation? Some PCPs are becoming more aware of motivational interviewing techniques, but we can certainly help in this area.

- **Educating patients about their conditions and treatment**: Could the MFT enhance and support the information that the PCP gives the patient? People are often anxious or intimidated when talking with the PCP in the exam room, and may not fully grasp the information the PCP is sharing about disease, treatment, and prognosis. MFTs can guide patients to appropriate sources of support and education.

- **Informing the PCP of patient changes**: Is there a change in the patient’s life that could affect his or her care? When the patient is not doing well because of a change in mood or circumstances, the MFT may share this to help the PCP make informed treatment decisions.

- **Recommendations on medication management**: Does the MFT think the patient may benefit from a change in medications or an adjustment in the dose? Keeping an open line of communication between the patient, the MFT, and the PCP will help medication changes be made more effectively.

- **Help the patient develop a support system**: Could the MFT help the patient connect with sources of support? Improving the patient’s level of social support and involvement in activities or support groups often make the patient more compliant with medical care.

- **Information**: What is happening in therapy? Most PCPs report that referrals to MFTs result in no feedback on the treatment plan or progress made. PCPs want to know the effectiveness of their referrals to MFTs. The PCP would like to know if the person is going to therapy, what the diagnosis is, and the expected course of treatment. I routinely obtain a signed release of information that allows me to coordinate care with the PCP. I don’t call PCPs very often, and when I do, I keep it brief and to the point. With a signed release, I send the PCP copies of my progress notes. This is an easy way to improve coordination of care, but very few MFTs share any information with the PCP.
WHAT DO MFTS WANT FROM PCPS?

- **Diagnosis:** What does the PCP think could be going on with the client’s mental health? The PCP can greatly assist the MFT in developing a diagnosis. The person may have seen the PCP for several visits over some time, giving the PCP more history with the client.

- **Medical conditions:** What medical issues are impacting the client? The PCP can shed light on the medical conditions the person has, and on how those physical challenges may impact mental health.

- **Medications:** What medications is the client taking, and how might they impact the client? The PCP is able to explain medications that the person is on, articulate what the medications are intended to do, and describe any potential side effects.

- **Specialty referral:** Does the PCP think referral to a medical specialist is indicated? PCPs are gatekeepers of the client’s care. In some cases the PCP is the person to make a referral to another specialist and can best manage that referral.

- **Physical changes:** Is there a change in the client’s medical condition that may impact the progress in therapy? It’s helpful to know when a medical challenge is happening with a client so we can better assist the person in dealing with those changes.

**Brief Screening Tools**

As MFTs, we are well aware of the abundance of screening tools used in our profession. Consider working up a list of brief tools for the medical providers with whom you work. If you are working in an environment that has thus far not been very integrated, you can help everyone on staff become acclimated to look for mental health issues. The following checklist can be used as a starter to help everyone on the healthcare team discern a possible mental health diagnosis.

*Martha Teater working in her clinic with doctor and patient.*
PCP CHECKLIST

- **Panic Disorder** “Do you have anxiety or panic attacks?” If the person isn’t sure, you can elaborate by describing this as “a sudden rush of fear and nervousness that makes your heart pound and makes you afraid you’re going to die or go crazy.”

- **Agoraphobia** “Have you had to limit where you can go because of your anxiety?”

- **Substance Abuse** “Do you continue to use in spite of the consequences?” The person may not initially be able to identify consequences, but with some questioning, providers can uncover consequences such as family discord, physical problems, legal issues, or financial costs related to using substances.

  **CAGE**
  - Cut down: “Have you ever felt the need to cut down on your use?”
  - Annoyance: “Have you ever been annoyed by someone’s concern about your use?”
  - Guilt: “Have you ever felt guilty about your drinking or drug use?”
  - Eye-opener: “Have you ever felt the need for a drink or a drug in the morning?”

  A positive response to two or more items implies a high likelihood of a substance use problem.

- **AUDIT (Alcohol Use Disorders Identification Test)** This is a well-validated instrument that is a highly effective tool to assess alcohol problems.

- **Depression** “Are you depressed?” A study of terminally ill patients revealed that this simple question alone had incredible sensitivity and specificity in diagnosing major depression.

- **SIGECAPS**
  - Sleep change
  - Interest deficit
  - Guilt (worthless, hopeless)
  - Energy deficit
  - Concentration deficit
  - Appetite change
  - Psychomotor retardation or agitation
  - Suicidality

- **PHQ-9** We routinely screen clients for depression using the PHQ-9. It is quick, easy to administer, and simple to score. We record the score in the chart so we can document changes over time. We also use the scores to help us assess treatment outcomes.

- **ZUNG SELF-RATING DEPRESSION SCALE** The Zung self-rating depression scale is a 20-question scale that has well-documented validity and specificity in identifying depression.

- **BIPOLAR DISORDER** “Have you had periods of feeling so happy or energetic that your friends told you that you were talking too fast or that you were too hyper?”

- **DIGFAST**
  - Distractibility
  - Indiscretion (excessive involvement in pleasurable activities)
  - Grandiosity
  - Flight of ideas
  - Activity increase
  - Sleep deficit
  - Talkative, pressured speech

- **Bipolar Spectrum Diagnostic Scale** Diagnosing bipolar disorder can be challenging; this tool is an objective way to get at the subtleties of making this diagnosis.

- **DYSTHYMIA** “When is the last time you felt good?” Dysthymia is a chronic depression lasting at least two years. The average duration of dysthymia prior to diagnosis is 16 years.

Integrated healthcare is an effective, powerful way to manage the care of our clients. By working with our peers in primary medical care, we can dramatically enhance the wellbeing of our shared clients. MFTs have a unique systems orientation that fits well in an integrated care model.
Martha Teater, MA, LMFT, is director of mental health for Mountaintop Healthcare and Good Samaritan Clinic, nonprofit primary care clinics in North Carolina. She is involved with the American Red Cross as a disaster mental health manager. A Clinical Member of the AAMFT, Martha wrote “Compassion Fatigue in Katrina’s Wake” in the March/April 2007 edition of Family Therapy Magazine.

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It All Comes Down to Medical Family Therapy

J. Matthew Orr, PhD
It was my first day at my new practicum site placement—a family medicine residency program during my doctoral coursework—settling into my cubby and excited to finally discover what this medical family therapy (MedFT) thing was all about. Since the beginning of my training in marriage and family therapy (MFT), I knew I wanted to practice MedFT. That is not to say that I had any idea what this meant, other than that I had always been convinced that minds and bodies and the relational context in which they exist are inextricably woven in a dance with no beginning and no end, moving in circular patterns and in step with whatever music life is projecting. Poetic for sure, but what does that look like in the real world? I was about to find out when one of the nurses handed me the chart of my first patient and I opened it to find a beautiful picture of his colon staring up at me! So, that was it. I had met the patient’s colon before I had met the patient. For me, MedFT now looked like the colon of a 48-year-old man.

That experience was over 13 years ago, so one might ask how I would now describe MedFT. My response is that I do not like the question, “What is medical family therapy (MedFT)?” I and my MedFT colleagues usually answer this question with something to the effect of, “Working with patients and their families to successfully adapt to the physical, psychological, emotional, and spiritual challenges of acute and chronic illness.” This is true of course; we MedFT-ers do this kind of work and train others to do it, as well. However, it did not take me long working in a primary healthcare setting to realize that I had practiced MedFT even if I was not intentional about it. I have always collaborated with physicians, especially family practitioners, pediatricians, and psychiatrists, and I have always tried to learn as much about a person’s illness and potential impact on mind and body, even when I was not working in a typical medical setting. I do not mean to oversimplify or minimize the distinctness and specialty of the MedFT field that I am so passionate about; quite the opposite.

I believe that we must consider MedFT as much more than a movement in healthcare. We must champion it as a standard of care for all our clients and patients who have bodies that house their minds. How can we be systemically- and relationally-minded as MFTs and not consider both mind and body and then even spirit? If the answer is that we cannot, or at least that we should not, then the more appropriate question is, “What is not MedFT?” The answer is simply, “Nothing.” The reality is that it all comes down to what we call “medical family therapy,” and what we actually may be referring to when we use this term—systemic behavioral healthcare integrated into medical healthcare. As several of the pioneers in the field of MedFT, McDaniel, Hepworth, and Doherty (1992) urged nearly 20 years ago:

We now know that human life is a seamless cloth spun from biological, psychological, social, and cultural threads; that patients and families come with bodies as well as minds, feelings, interaction patterns, and belief systems; that there are no biological problems without psychosocial implications, and no psychosocial problems without biological implications. Like it or not, therapists are dealing with biological problems, and physicians are dealing with psychosocial problems. The only choice is whether to do integrated treatment well or do it poorly (p. 1-2).
The only choice is whether to do integrated treatment well or do it poorly. This statement is as true now as it was when it was written. To the extent that all people of have minds and bodies, we are always providing integrated care! This applies to all types of behavioral healthcare providers, such as psychologists, social workers, and counselors, as well as to physicians, nurses, and other medical providers. Of course, I am focusing primarily on MFTs here. So how do MFTs do integrative treatment well? What does it look like?

For a number of clinicians being a MedFT, or being integrated, means sitting on the doctor's spiny stool while the patient sits on white crunchy paper (okay, we often get chairs now) in an exam room in an outpatient primary care clinic to discuss depressive symptoms or increasing physical activity to control weight or blood sugar. For others, it may mean going into the home or the hospital room of a patient who is receiving palliative care to support the patient and her family as they make end-of-life decisions. For some, it may mean sitting with a patient and/or patient family in a well-furnished oncology clinic, where the pleasantness and comfort of the surroundings would be much more appreciated if the conversation within those surroundings were not so grim. In the end, much of what happens between clinician and patient-family looks and sounds like most typical therapy sessions, albeit often in 5-15 minute chunks of time and in more (or less) sterile surroundings...and with the added flurry of medical jargon, endless acronyms, and graphic stories of bowel habits, wound openings, and the oft-dreaded, “Let me show you this!”

To be fair, we cannot expect that all clinicians would be comfortable working with those presenting issues or in those settings if they were simply parachuted in them today with no training or previous exposure. We cannot expect that an MFT working in her office with a patient who is grieving over a divorce and happens to have been taking an antidepressant medication for the last four weeks is going to consider herself “doing” MedFT. However, we might expect that during the course of discussing the patient’s emotional well-being, that it is possible that she, intentionally or unintentionally, elicits information about the patient’s sleeping and eating habits, a drop in physical activity, and an increase in her blood pressure, which has been compounding her frustration with herself and her feelings of helplessness about her situation. How might the MFT handle this information? Does she address it directly? Does she defer to the patient’s primary care clinician? Does she approach it systemically hoping that addressing change on one level will impact change on other levels?

This is one hypothetical example; however, if we consider how many of our own patients or clients are taking medications of any kind, those numbers alone should alert us to the ubiquity of medical problems and patients’ often silent and unknowing demand that we understand them, at least enough to talk about them. There are differences between typical MFT practice and what we consider MedFT. The difference is not so much in models or methods. For example, I have found that my training and experience with common MFT methods, such as reframes, paradoxical interventions, and solution-oriented therapy, are extremely useful in the context of MedFT. The difference to me seems to be two elements: 1) understanding the medical culture and how to most effectively collaborate with physicians in one’s own community, including any medical setting in which a clinician may work; and 2) developing and maintaining functional knowledge of the illness and the treatment the patient is receiving. The MFT who applies these elements to her clinical approach will be well on her way to integrating treatment well.

These days there are numerous certificate and degree-granting MedFT programs (see Gawinski and Rosenberg in this issue) that can help train clinicians to develop and hone these essential elements in the care they provide, as well as to how to work in a variety of healthcare settings and with a variety of problem types. For now, it is my hope that on the pages that comprise this issue of FTM, interested MFTs will find valuable insights and ideas in regard to growing and evolving toward a standard of integrative treatment in a special area of interest or in general.

It is not reasonable to expect that any of us is going to have expert knowledge of each and every illness that our patients experience; any physician will tell you that is not possible. We simply need to know enough to understand and appreciate what their experiences have been and we can often get there by simply asking them to explain what they are experiencing and to teach us about their illnesses.

J. Matthew Orr, PhD, is an AAMFT Clinical Member and Approved Supervisor. He is an associate professor and director of Behavioral Medicine in the Department of Family and Preventive Medicine at the University of South Carolina School of Medicine. Orr practices as an LMFT at the University Special Clinics where he specializes in working with families of children with ADHD, ODD, and anxiety. He has taught on the topic of ADHD and ODD at the AAMFT Institutes for Advanced Clinical Training.

Reference
**Announcements**

**CALL FOR PRESENTATION PROPOSALS.** The International Family Therapy Association (IFTA) is holding their 20th World Family Therapy Congress AND 25th Anniversary Celebration March 21-24, 2012 at the Wall Center Sheraton in Vancouver, British Columbia, Canada. The Congress theme is “Couples Therapy: Advancing the Profession.” Submittal deadline is August 30, 2011. For information about how to submit your presentation proposal, go to www.ifta-congress.org/abstractsubmissions.html.

**Earn CE credit Online!** The AAMFT Online CE Testing Center offers you the opportunity to earn CE contact hours for reading the *Journal of Marital and Family Therapy* and other quality publications from the AAMFT. Visit www.aamft.org/OnlineCE.asp for more information.

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**Be sure to check out the AAMFT eNews, every second and last Thursday of the month. Many issues feature an interview podcast with prominent and informative experts on the family and relationships.**

This month’s newsletters showcase Dr. Meredith Small, discussing the anthropology of marriage and family, and Dr. Keith N. Hampton talks about technology in family and social relations. Both will be plenary speakers at the AAMFT 2011 Annual Conference in Ft. Worth, TX.

If you miss any issue of eNews, go to www.aamft.org/Community and click on the AAMFT eNews tab at the top.

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**calendar**

**SEPTEMBER 16-17**

The Colorado Division of the AAMFT will hold its annual conference at the Colorado Convention Center. For more information, visit the Colorado Division website at www.coamft.org.mft.org.

16-17 The Idaho Division of the AAMFT will hold its annual conference at Boise State University. For more information, visit the Idaho Division website at www.idamft.org or telephone 208-424-0468.
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**POLICY AND ADVOCACY:** AAMFT is the primary advocate for the profession, and the primary force for advancing the practice of marriage and family therapy. Our staff and leaders meet regularly with legislators and policy-makers to persuade them that family therapy works and that family therapists should be accepted throughout the health care system. To view the latest legislation updates and to learn how you can take action, please login as a member at www.aamft.org and click on the Legislation and Policy link.

**THERAPISTLOCATOR.NET:** This free online therapist directory is a public service of the AAMFT. Clinical Members receive a free listing that they can personalize with practice and biographical information and their photograph. The AAMFT regularly advertises this service to the media and the public. Visit www.therapistlocator.net to learn about this valuable service.

**JOB CONNECTION:** Search for the ideal job or internship, or find the perfect employee with the AAMFT’s Job Connection. Anyone can post a job, but searching the listings is an exclusive AAMFT member benefit.

**FAMILYTHERAPYRESOURCES.NET:** This online resource includes AAMFT publications, events and articles, tapes from AAMFT conferences, and books by AAMFT members. AAMFT members can view and print out complete magazine articles for free. Members are also invited to add their books and products to the list of resources at no charge. For further information, visit www.FamilyTherapyResources.net.

**CONTINUING EDUCATION:** The AAMFT offers several opportunities for MFTs to earn continuing education credit, including an Annual Conference in the fall, as well as yearly Institutes for Advanced Clinical Training. AAMFT members also can earn continuing education online. AAMFT members receive discounts on all continuing education opportunities. For more information, visit www.aamft.org.

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**LEGAL CONSULTATION:** AAMFT Clinical members who need consultation on legal matters relating to their professional practice of marriage and family therapy can consult with the AAMFT legal representative free of charge. To make an appointment to seek legal consultation please call (703) 253-0471, email legalconsult@aamft.org, or visit www.aamft.org and click on Legal and Ethics Information.

**FREE ETHICAL PRACTICE INFORMATION:** The AAMFT offers comprehensive ethical advice and resources based on the AAMFT Code of Ethics. Marriage and family therapists can obtain FREE informational ethical advisory opinions, plus training and resources to protect and inform you about how to maintain an ethical practice. To reach this benefit visit www.aamft.org and follow the Legal and Ethics Information link.

**DIVISION MEMBERSHIP:** The AAMFT divisions advocate for members at the state and local level and offer a variety of networking opportunities. Access the division directory and find out how you can get involved at www.aamft.org.

**ONLINE NETWORKING DIRECTORY:** AAMFT members have exclusive access to the membership directory located at www.aamft.org. Use the directory to make referrals, develop a peer supervision group, locate students to supervise, or find the perfect supervisor for your internship.

**PUBLICATIONS:** AAMFT members receive free subscriptions to the Family Therapy Magazine, AAMFT’s bimonthly publication, as well as the quarterly Journal of Marriage and Family Therapy (JMFT).

**DISCOUNTED WEB HOSTING:** from TherapySites.com (www.therapysites.com/AAMFT). This web hosting company provides therapist websites that bundle all the tools you need into one all-inclusive package. The service is designed to give you everything you need to make your online presence a profitable investment for your practice including: Personalized domain name, integrated email service, easy-to-use editing tools, website hosting, unlimited pages, HIPAA compliant technology, client forms, appointment requests, website statistics and many other services.

**DISCOUNTED CREDIT CARD PROCESSING:** The AAMFT has collaborated with First National Merchant Solutions to help provide additional cost savings for members. Some of the benefits of the program include: Discounted group rates on Visa, MasterCard and Discover transactions, dedicated account management team, additional merchant processing services, including debit card acceptance, an interest-bearing account, and check verification/guarantee services, free online statements and account access and much more. An additional benefit of this service is an account management system that allows you to set up automatic client billing, the ability to obtain insurance pre-authorizations and setting up recurring payments.
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