



Evolution of the biopsychosocial model in the practice of Family Therapy

M. Graça Pereira¹ (*Universidade do Minho, Portugal*) and
Thomas Edward Smith (*Florida State University, USA*)

(Recibido 10 de enero 2005/ Received January 10, 2005)

(Aceptado 12 de mayo 2005 / Accepted May 12, 2005)

ABSTRACT. Medical family therapy represents the maturity of the family therapy's field emphasizing the collaboration between family therapists and medical providers. This theoretical study describes the evolution of this new discipline from its conception in the biopsychosocial model, to our days, starting with biopsychosocial oriented family theories, family centered medical care and culminating with the creation of medical family therapy. Biopsychosocial oriented family theory emphasized the relationship between health and psychosocial dimensions. Family Oriented Primary Care provided the physician with the counseling skills necessary to address the patient emotional needs regarding medical problems. Finally, Medical Family Therapy applies family therapy techniques in families with specific health problems and its focus is in advocating for patients, family members and health care professionals in integrated health care. Medical family therapy as a new discipline represents the development of family therapy in the practice of biopsychosocial medicine both theoretically and in health care delivery. This paper also addresses political issues that medical family therapy has to face regarding health care in particular the use of the DSM-IV diagnosis.

KEYWORDS. Medical family therapy. Biopsychosocial model. Theoretical study.

RESUMEN. La terapia familiar médica representa el desarrollo del campo de la terapia familiar que tiene como objetivo la colaboración entre terapeutas familiares y profesionales de la salud. Este estudio teórico destaca la evolución de esta reciente disciplina

1 Correspondence: Universidade do Minho. IEP. 4710 Braga (Portugal). E-Mail: gracep@iep.uminho.pt

desde su concepción en el modelo biopsicosocial hasta la actualidad, pasando por las teorías familiares con base biopsicosocial, cuidados médicos centrados en la familia y culminando con la creación de la terapia familiar médica. Las teorías familiares con base biopsicosocial destacan la relación entre la salud y las dimensiones psicosociales. Los Cuidados Médicos Centrados en la Familia facilitan al médico las competencias de consulta necesarias para hacer frente a las necesidades emocionales del paciente con respecto a los problemas médicos. Finalmente, la Terapia Familiar Médica aplica las técnicas de la terapia familiar a familias con problemas de salud específicos, centrándose en los pacientes, familia y profesionales de la salud en la prestación de los cuidados integrados de salud. En este artículo se abordan también cuestiones políticas en las que se debate la terapia familiar médica con respecto al sistema sanitario, en particular el uso del diagnóstico basado en el *DSM-IV*.

PALABRAS CLAVE. Terapia familiar médica. Modelo biopsicosocial. Estudio teórico.

RESUMO. Terapia familiar médica representa o desenvolvimento do campo da terapia familiar tendo como foco a colaboração entre terapeutas familiares e profissionais de saúde. Este estudo teórico enfatiza a evolução desta nova disciplina desde a sua concepção no modelo biopsicossocial, até aos nossos dias, passando pelas teorias familiares com base biopsicossocial, cuidados médicos centrados na família e culminando com a criação da terapia familiar médica. As teorias familiares com base biopsicossocial enfatizaram a relação entre a saúde e as dimensões psicosociais. Os Cuidados Médicos Centrados na Família forneceram ao médico as competências de consulta necessárias para lidar com as necessidades emocionais do doente em relação aos problemas médicos. Finalmente, a Terapia Familiar Médica aplica as técnicas da terapia familiar a famílias com problemas de saúde específicos e o seu foco centra-se nos doentes, família e profissionais de saúde na prestação de cuidados de saúde integrados. Este artigo aborda também questões políticas com que a terapia familiar médica se debate em relação ao sistema de saúde em particular o uso do diagnóstico baseado no *DSM-IV*.

PALAVRAS CHAVE. Terapia familiar médica. Modelo biopsicossocial. Estudo teórico.

Introduction

The biomedical model conceptualizes disease in somatic parameters. Disease is defined in terms of any deviation from the norm of measurable biological variables. This view emphasizes reductionism (complex phenomena can be broken down to a primary cause) and mind-body dualism by separating the mental from the somatic (Engel, 1977). Such a description, does not take in consideration behavioral, psychological or social factors in the identification of disease. Engel (1977) argued that a true scientific medical model needs to involve the psychological context in which disease occurs. Fundamental to this view, is the conviction that one cannot understand a patient's illness without knowing the emotional and social context in which he or she lives. He proposed a new model -the biopsychosocial model- that takes in consideration the

biological, psychological, and social variables in the study of disease. The relationship between all the biopsychosocial factors is reciprocal rather than linear. Engel sees the world as a continuum of systems that interact at different levels. These levels are hierarchically organized from subatomic particles to atoms, molecules, organisms, individuals, couples, families, communities and so forth. Any patient can be understood to participate in that hierarchy of systems (Glenn, 1987). According to the model, any particular disease may require primary attention at a particular level but will also have an impact on other systems levels. For example, psychological factors influence biological processes that in turn may influence the social system of the patient. Based in systemic thinking, the biopsychosocial model emphasizes a comprehensive view of factors involving health, illness and health care.

Engel's biopsychosocial model gained shape at the same time that the biomedical model was starting to be questioned and General Systems Theory (Von Bertalanffy, 1968) was becoming more widespread, and seen as a good alternative to explain and understand individual behavior in context. In 1956, the idea of a family somatic approach gained more interest with the work of several family therapists at the Palo Alto's Mental Research Institute (Bateson, Haley, Jackson, Watzlawick, and Weakland) that, at the time, were concerned with the development of communication patterns associated with symptoms in schizophrenia. The next progression of the biopsychosocial model happened later, in 1969, when the specialty of Family Medicine was founded. From the beginning, Family Medicine aspired to a family perspective in health care and, as a result, endorsed the biopsychosocial model (Doherty and Campbell, 1988). The practical application of the model was called Family Centered Medical Care (Doherty and Baird, 1987) and delineated the boundaries between primary care family counseling and family therapy. Later in 1992, we assisted to a new progression of the biopsychosocial model, when McDaniel, Hepworth and Doherty coined the term Medical Family Therapy, as a specialty with the field of family therapy based on the fundamental tenet «that all human problems are biopsychosocial systems problems» (p. 26).

This theoretical study (Montero and León, 2005) provides a description and critique of the historical progression of the biopsychosocial model starting with the early biopsychosocial oriented family theories/therapy, following with family centered medical care and ending with the creation of medical family therapy as a specialty within the field of family therapy.

Biopsychosocial oriented family theories/therapy

Goldberg (1958), Garner and Weiner (1959), were the first psychoanalysts to study family influences in psychosomatic disorders. Later, Bruch (1973) included, in his psychodynamic perspective, a family oriented dimension in the study of eating disorders. However, it was with the Palo Alto's Mental Research Institute and the pursuit of the communication patterns associated with schizophrenia, that the characteristics of the biopsychosocial model really started to emerge. This trend was followed by other therapists trying to find relationships between somatic disorders and family patterns as in diabetes, anorexia, asthma, etc. In 1978, Minuchin and collaborators published

«Psychosomatic Families: Anorexia in context» presenting a circular model of psychosomatic illness that emphasized the relationship between enmeshment, rigidity, triangulation, overprotection with the development of psychosomatic illnesses. The model, proposing that family patterns and disease maintained each other, received some support from research linking children with Cohen's disease with triangulation and marital dysfunction (Wood *et al.*, 1989). In 1981, Reiss linked the family's set of beliefs to the ways the family responds and interacts with the social world. He called these shared beliefs «family paradigm». Research showed that one of the dimensions that characterizes «family paradigm»: Coordination (the degree to which family members see themselves facing the social world as a group), is an important factor in how the family handled serious illness. Later, Steinglass (1987) in his research on alcoholic families, distinguished those families who are organized around alcohol (alcoholic families), from families with an alcoholic family member (alcoholic families) in which alcohol has not invaded the family's daily roles, rules, routines and rituals. Steinglass' model takes in consideration early, middle and late phases of the family's systemic maturation identifying for each phase the developmental tasks that need to be accomplished. For each phase, the model considers specific goals for therapy taking in consideration family's and individual member's needs. The research conducted by Steinglass (1987) helped understand how some families can buffer their daily patterns from the effect of chronic illness.

Rolland (1984, 1987) provided a psychosocial typology of chronic illness. His purpose was to show how family beliefs shaped the way families adapt to chronic and life threatening diseases, constituting what he denominated the «family-illness paradigm». The typology takes in consideration disease onset (acute *vs.* gradual), course (progressive *vs.* constant *vs.* relapsing), outcome (fatal *vs.* short life span or sudden death *vs.* no effect on longevity), and incapacitation (none *vs.* mild, moderate *vs.* severe); three major phases in the natural history of chronic disease (initial crisis, chronic and terminal), and components of family functioning. Probably one of the most important contributions of the «family illness paradigm» was the importance ascribed to beliefs concerning health and illness. Rolland emphasized in particular ethnicity, race, and religion as major determinants of the family's belief's system. According to his typology, when confronted with illness, families with a particular psychosocial profile will face different challenges than another family with different psychosocial characteristics. Rolland also related illness typology with life cycle explaining how chronic illness can create more or less stress on the family depending on whether it occurs «out of phase» i.e., before late adulthood or after late adulthood when it is more or less expected. Rolland's contribution is very important for the family therapist working in medical settings who is trying to help a family cope with chronic illness.

Another contribution, emphasizing the great potential of the biopsychosocial model, came from theories that emerged from the study of schizophrenia. Leff and Vaughn (1985), described how expressed emotion (intrusiveness of a parent toward a mentally ill family member) was a strong indicator of relapse and rehospitalization. Wynne (1989) emphasized the complex contribution of biopsychosocial systems applied to schizophrenia such as genetics, developmental variables, intrapsychic processes and

responsiveness of the therapeutic system that interface with the family system and the identified patient. Some of these insights led to the application of a family perspective to several other medical illnesses.

Other useful models/theories that contributed to the development of the biopsychosocial model were the Family Adjustment and Adaptation Response (FAAR) model (McCubin and Patterson, 1982; Patterson, 1988) that examine families adaptation to chronic illness in light of their resources; the Family Adaptation to Medical Stressors (FAMS) model (Koch, 1983) that studied the impact of a medical stressor upon: a) the family system, b) individual members, and c) family interactions associated with adaptation to the stressor; and finally the family FIRO model (Doherty and Colangelo, 1984) that is an application of Will Schutz's Fundamental Interpersonal Relations Orientation model to family development and family therapy that postulates a relationship between family dynamics and health behavior.

At the same time that family theory/therapy was developing a growing interest in health issues and how they related with psychosocial dimensions, family medicine was concerned with how some families utilize the resources of their physician (Preachey, 1963), mortality rate of widowed spouses (Klein, Dean, and Bogdanoff, 1968; Kreitman, 1964; Parkes, 1972), the influence of psychosocial factors on the development of angina pectoris, hypertension and blood cholesterol level (Medalie *et al.*, 1973), and the implications of stress on the immune system (Meyer and Haggerty, 1962). As a result, the two disciplines of Family Medicine and Family Therapy saw each other as natural allies (Doherty and Baird, 1983). Such partnership based on the biopsychosocial model, became even more visible with the creation of Family-Centered Medical care (Doherty and Baird, 1987) that later, became Family Oriented Primary Care (McDaniel, Campbell, and Seaburn, 1990).

Family-centered medical care

Doherty and Baird in their book «Family Therapy and Family Medicine» (1983), used for the first time the term «Family-Centered Medical Care» to refer to the levels of physician involvement with families. The model intended for physicians and medical students, describes five levels of progressive involvement with families based on the seriousness of the problem and the physician's level of knowledge and skill. At level one, Minimal emphasis on family, physicians deals with families for medical-legal reasons. Communication with family is not viewed as part of the physicians' role. At level two, Ongoing medical information and advice, physicians engage families in a collaborative way by eliciting relevant diagnostic and treatment information, refer the family for therapy if family dysfunction interferes with medical treatment, and are aware of the patient-family-physician relationship. In level three, Feeling and Support, physicians are aware of family development and reaction to stress, and their own feelings towards patient and family. The physician addresses emotional and medical needs of the family. At level four, Systemic Assessment and Planned Interventions, physicians are knowledgeable in Systems theory. They assess the family's level of

functioning, avoid coalitions, reframe the family's definition of the problem and help the family to develop alternative ways of coping with the difficulty. Levels two through four, focus on family patterns directly involved with the medical problem(s) and have been called «Family Oriented Primary Care» (McDaniel *et al.*, 1990). Level five, Family Therapy, requires specific therapy skills that go beyond primary care residency training.

Family-Oriented Primary Care is aimed at helping the physician understand the illness in terms of the person, the family, the patient-physician relationship, and the social context (McDaniel *et al.*, 1990). Probably one of the major contributions of Family Oriented Primary Care is the importance attributed to the patient-doctor relationship. This includes taking in consideration the physician's interaction with the patient that may contribute to patient's noncompliance. The physician is therefore seen as part of the system and a change in his/her behavior may facilitate change throughout the system.

Family Oriented Primary Care provides the physician with the counseling skills necessary to address the patient emotional needs regarding medical problems. Family Oriented Primary Care is concerned with family counseling skills and not family therapy skills. In order to be proficient in family counseling skills, the physician needs to have a basic knowledge of family dynamics and family assessment, well-developed interviewing skills, and be able to support the patient/family (Doherty and Baird, 1983). The goals of family counseling are to provide education, prevention, support and challenge (Doherty and Baird, 1983). According to the authors, counseling is the appropriate treatment for most of the psychosocial problems that physicians face in medical practice. When should family oriented primary care give raise to family therapy? According to Doherty and Baird (1983), when there is «a family's resistance to changing its interactional patterns» (p. 115). In another words, family therapy starts when counseling fails and, at that point, the physician has the option to refer. The model that we have discussed seems to avoid nicely the issues of turf between physicians and therapists. However, the line between counseling and therapy is imprecise. If the physician uses "therapy techniques" while counseling, will the family change? Is the difference in the skills or in the way the problem is conceptualized? The distinction between levels 2, 3, and 4 seem somewhat forced.

Christie-Seeley (1984) proposed a similar model to Doherty and Baird's that focused on «working with families in primary care». She contrasted her model from family therapy, because a contract for change was not the goal. In her model, both counseling and therapy belong to therapists. The physician needs to see the family as a system and «working with the family» means that physicians work in a collaborative relationship with families with a focus on promoting health. Although family-oriented primary care and Christie-Seely's models denote the growth of interest, on the part of physicians in the biopsychosocial model, they still separate the «psycho» from the «social» falling short from a true biopsychosocial approach. Indeed, there is no mention of how the social aspects of family illness are taken in consideration in these models. References to culture and community are absent in the description of the family physician' role.

Another separation seems to exist between «soma and «psyche». Family Oriented Primary Care seems concerned with the role of the family physician when psychosocial

problems are present, but seems to skip the role of family physicians with traditional biomedical problems. Christie-Seely avoids this entire discussion by having therapists take care of counseling and therapy and having physicians concentrate on health issues. For this reason, like in the epigraph to this chapter, Herman (1989) has proposed a transitional framework that would apply the biopsychosocial model selectively in the practice of Family Oriented Primary Care. Doherty, Baird, and Becker (1987) have called it the split biopsychosocial model. The split model allows the physician, confronted with a common cold, to «skip» the patient's psychosocial context in order to be effective. Again such a model implies a dichotomy between the «psyche» and «soma» as if physicians first rule out any biomedical problems and, only after, address the psychosocial aspects of illness.

Is there a difference between the split model and the biopsychosocial model originally proposed by Engel? Engel's article «The need for a New Medical Model: A challenge for Biomedicine» (1977), states that «It is the doctor's not the patient's responsibility to establish the nature of the problem and to decide whether or not it is best handled in a medical framework» (p. 133). One wonders if the biopsychosocial model proposed by Engel is indeed a «split» model. And, if that is the case, he failed to address how, when, and with what problems does the physician make a decision to handle the problem in the traditional biomedical framework versus the biopsychosocial. Engel's model, although clearly a systemic one, fails to emphasize the quality of interaction between systems. The physician is the only one responsible to treat the patient's illness instead of a joint responsibility influenced by other systems.

Although both Biopsychosocial-Oriented Family Theories and Family-Oriented Primary Care emphasize the importance of the biopsychosocial model, none of them seem to address the broad social aspect of the model. It is as if Engel's translation of «social» refers simply to the application of systems theory i.e., how other systems, besides the biological, are affected by the patient's problem. The broader impact of «social» in terms of culture, community, race, gender, and class are simply not present in these models. Family-Oriented Primary Care in particular, is an important mile stone in the practice of biopsychosocial medicine, family oriented physicians still deal with the psychosocial the same way as they deal with any other medical specialty i.e., only when they cannot solve the problem in medical terms, they will inquire in the psychosocial arena. Engel's more recent version of the biopsychosocial model (1987) emphasizes the doctor's knowledge of communication skills in order to practice scientific medicine. One starts to wonder what happen to the paradigmatic dimension of the biopsychosocial model in the Kuhnian sense, as originally described. The biopsychosocial model also failed to address the spiritual experience of the patient and its impact on the healing process (Henao, 1985).

It seems that putting the biopsychosocial model in practice, in family oriented primary care, is very complex and so far the «split model» seems to function as a possible working transitional model, between the traditional biomedical and the biopsychosocial. Unfortunately it reflects the old mind/body dualism that Family Systems Medicine tries so hard to overcome. But why is it so hard to apply the biopsychosocial model? Miller (1983) believes that in order for the biopsychosocial model to get a

chance of surviving, the current health care system needs to change. Concerns regarding the cost of a broad redefined primary care, setting up of interdisciplinary models in which hospital-university-community are connected, and hierarchical disputes between the disciplines and the providers involved, need to be accounted for the difficulty.

At the present, family oriented primary care seems to be more concerned with the type of problems that can be helped with counseling skills and those that would require a referral to a mental health specialist (McDaniel *et al.*, 1990), showing no signs of discomfort with the adoption of the «split» biopsychosocial model.

Recently, in 1992, McDaniel, Hepworth, and Doherty added the term «systems» to Engel's (1977) biopsychosocial model with the intent «to go beyond using the model as framework for arranging the hierarchical levels of biological, psychological, and social levels to help explain the interactions across the levels of the multiple social systems involved in health and illness» (p. 26). The systems analysis of family therapy to the biopsychosocial assessment and treatment of individuals and families who are dealing with medical problems has been called Medical family therapy. Medical Family Therapy refers to the application, by family therapists, of the biopsychosocial model of assessment and treatment to families experiencing health problems (Bell, Wright, and Watson, 1992).

Medical Family Therapy

The network of family therapists working in medical settings started in 1991, as a meeting of six interested therapists at the Family in Family Medicine Conference, sponsored by the Society of Teachers of Family Medicine (STFM). The network of medical family therapists participated, for the first time, in the 1994 conference «Collaborative Family Health Care: Opportunities and Directions» that focused on models of collaboration, training issues, research and health policy and since then has been represented in the five annual conferences that the Family Health Care Association has organized. Medical family therapists work in the overlap of the biomedical-psychosocial continuum and since expertise in all the biological, psychological and social aspects of illness by one individual is not possible, professional collaboration is a necessity. Collaborating with medical providers is therefore an integral part of the practice of medical family therapy (McDaniel *et al.*, 1992). Kleiman, Eisenberg, and Good (1978) have distinguished between illness and disease. Illness is the patient's experience of disease. Disease is the biomedical aspect of the illness. In this sense, the goal of medical family therapy is to attend to the patient's illness. McDaniel *et al.* (1992) propose the following general goals for Medical Family Therapy:

- Promotion of Personal Agency, the sense that one can make personal choices in dealing with illness and with the health care system.
- Communion, the quality of nurturing relationships that support an ill person.

McDaniel *et al.* (1992) proposed seven sets of techniques in medical family therapy: a) recognize the biological dimension; b) solicit the illness story; c) respect defenses,

remove blame; d) maintain communication; e) attend to developmental issues; f) increase a sense of agency in patient/family; g) leave the door open for future contact. Except for techniques a), b), and d) that address, respectively, the biological aspects of illness, perception of disease, and how to keep communication open throughout the family care network, the authors do not provide a rationale why the remaining techniques are specific to medical family therapy. In technique b), soliciting the illness story, the authors propose the use of a genogram to gather the family's beliefs concerning health/illness, that in itself, is a common technique used in traditional family therapy to gather information regarding multigenerational family patterns. The same happens with technique c), respect defenses and remove blame, that emphasize the need to provide support, positive connotation, reframing, externalization of the illness, removal of blame, and normalization of negative feelings. In technique e), attend to developmental issues, physicians take in consideration the development stage the family is in when illness struck, and emphasizes the need for support to a family in the process of meeting new physical, emotional, and financial needs. Techniques f) and g), focusing on increasing a sense of agency and leaving the door open for future contact, emphasize the therapist as a facilitator in decision-making, and as a provider of follow-up. None of these techniques seem to be described in a unique way when compared to its use in traditional family therapy. The major difference between medical family therapy techniques and traditional family therapy techniques seems to be the focus of the presenting problem. Medical family therapy typically begins during an illness crisis and, as a result, the techniques focus on health/illness issues while traditional family therapy techniques focus on a variety of presenting problems.

McDaniel *et al.* (1990) in their book «Medical Family Therapy» illustrate these specific techniques with smoking, obesity, pregnancy loss, infertility, chronic illness, dying/grieving families, and somatization issues. Probably, one of the most important aspects in the practice of medical family therapy is the process in which the physical symptom is related to psychosocial issues, without the family feeling abandoned/insulted. Griffith and Griffith (1992), and Griffith *et al.* (1992) proposed the use of reflecting team consultations when dealing with somatic symptoms with no organic cause. Their research supported clinical observations that reflecting team's consultations had a positive therapeutic effect in initial sessions. Sokel, Devane, and Bentovim (1991) proposed the use of relaxation/self-hypnosis techniques for control of abdominal pain in children, especially those who needed to gain some sense of control from their families. Green and Sattin (1985) described the use of paradox for anxiety-related somatic complains with impatient patients and suggested that the efficacy of the technique could be generalized to outpatient patients.

In a search for other techniques used for specific problems, McDaniel *et al.* (1992) reveal how family therapy has been successfully employed in families with specific health problems. It is beyond the purpose of this paper to describe them all but in all studies, the focus of medical family therapy is in advocating for patients, family members and health care professionals in integrated health care. As we have described previously, medical family therapy pays attention to the role that medical illness plays in the patient's life and in the interpersonal dynamics of the family system (McDaniel *et al.*

1992; Pereira and Smith, 2004). As a result, terms such as somatic fixation no longer makes sense since a problem is neither physical or emotional but integrates both components.

Identity of the field regarding health care

Medical family therapy has become increasingly popular and the department of family Medicine in conjunction with the University of Rochester School of medicine now offers a two-year fellowship in medical family therapy and a medical family therapy institute. But this friendship with the medical model creates some problems. After all, the field of family therapy was born in direct opposition to the medical model in the late 1950s. The question that medical family therapy poses is an important one: joining the medical system means not being marginalized from the health care system and become mainstreamed. However there is a risk, in the process, of losing its identity compromising the fundamental principles of the field. The major problems that medical family therapy has to solve are the diagnosis' assignment and the third-party payments that are related to it (Bartlett, 2002). In her paper titled "The politics of identity", based on an interview to several family therapists, they seem divided regarding the first issue. Some believe that a diagnosis shifts the control from the client to the diagnosis emphasizing patients' symptomatology. This view is reductionist and in itself is what family therapy has rebelled against from the beginning. As a result, medical family therapy would have to be "problem focused" instead of deconstructing the patient's reality and help them create a different one not dominated by the problem. The diagnosis in this sense would crystallize a particular reality limiting the options the patient and those working to help him/her have. Others, however, believe that a diagnosis needs to be used when the language of a particular system requires it and that a diagnosis can be informative for clients and allow them to get supported treatment. This issue is not completely solved and I believe is an ongoing discussion that family therapy has to come to grips with.

The use of new relational diagnosis that addresses the patient's context in relation to the medical illness has tried to answer the gap around the diagnosis' issue with the GARF -Global Assessment for Relational Functioning-, (Denton, 2002). The GARF was included in appendix B of DSM-IV. Ross and Doherty (2001) found that lower GARF scores were associated with more severe levels of client problems and improved with client' reported improvement. According to Wyne (Shields and Watson, 2002), a consistent diagnostic formulation based on GARF three dimensions (organization, communication/problem solving, and emotional climate) would be a good start for family therapists to speak a common language that would guide interventions. This would also help with the issue of third-party payments since the need to give an individual diagnosis, in order to be reimbursed, when the problem is relational would also be overcome.

The use of the DSM-IV in medical family therapy is therefore a hot topic. Wyne (Shields and Watson, 2002) summarizes this issue when he says that family therapists should be primarily skilled in making family systems diagnosis but also be able to take a stock of individual and larger systems issues i.e. that problems should be considered on more than one system level: the individual in its biological and psychological

functioning, the social/family and the culture just like Engel have initially proposed when he talked about the biopsychosocial model.

Conclusion

The new discipline of medical family therapy is the application of family therapy to medical problems. Except for the inclusion of biological aspects of disease, there seems to be no difference between traditional techniques of family therapy and medical family therapy's techniques. Medical family therapy functions as a "metaframework" through which several approaches to family therapy can be woven. In its essence, medical family therapy represents the development of family therapy emphasizing the interdisciplinary of the field in the practice of biopsychosocial medicine both theoretically and in health care delivery. Medical family therapy has allowed a very interesting debate in the field of family therapy. For some there is no conflict with the medical model since the latter created an opportunity to practice within a multi-perspective approach. For others the politics of diagnosis need to be further discussed. The inclusion of relational diagnosis (GARF) in the actual DSM-IV is the beginning of what family therapy intends to develop and further discuss. For now, outcome research in medical family therapy is helping to build the bridge between the medical and the systems approach providing answer regarding intervention that will help both the patient, the family and the health care system.

References

- Bartlett, C.V. (2002). The politics of identity: Thoughts on the future of the medical model and family therapy. *Family Therapy Magazine: Diagnosis and Treatment*, 1, 10-17.
- Bell, J. M., Wright, L., and Watson, W. L. (1992). The medical map is not the territory or «medical family therapy»: Watch your language! *Family Systems Medicine*, 10, 35-39.
- Bruch, H. (1973). *Eating disorders: Obesity, anorexia, and the person within*. New York: Basic Books.
- Christie-Seely, J. (Ed.) (1984). *Working with the family in primary care: A systems approach to health and illness*. New York: Praeger.
- Denton, W. (2002). Relational diagnosis and the DSM-IV. *Family Therapy Magazine: Diagnosis and Treatment*, 1, 18-19.
- Doherty, W. J. and Baird, M. A. (1983). *Family therapy and family medicine: Toward the primary care of families*. New York: Guilford Press.
- Doherty, W. J. and Baird, M.A. (Eds.) (1987). *Family centered medical care: A clinical case book*. New York: Guilford.
- Doherty, W. J., Baird, M. A., and Becker, L. (1987). Family medicine and the biopsychosocial model: The road toward integration. *Marriage and Family Review*, 10, 51-70.
- Doherty, W. J. and Campbell, T. L. (1988). *Families and health*. Beverly Hills, CA: Sage.
- Doherty, W. J., and Colangelo, N. (1984). The family FIRO model: A modest proposal for organizing family treatment. *Journal of Marital and Family Therapy*, 10, 19-29.
- Engel, G. L. (1977). The need of a new medical model: A challenge for biomedicine. *Science*, 196, 129-136.

- Garner, A. and Weiner, C. (1959). *The mother-child interaction in psychosomatic disorders*. Urbana: University of Illinois Press.
- Glenn, M. L. (1987). *Collaborative health care: A family oriented model*. New York: Praeger Press.
- Goldberg, E. M. (1958). *Family influences of psychosomatic illness*. London: Tavistock.
- Green, G. and Sattin, D. (1985). A paradoxical treatment format for anxiety-related complaints: Four case studies. *Family Systems Medicine*, 3, 197-204.
- Griffith, J. and Griffith M. (1992). Speaking the unspeakable: Use of the reflecting position in therapies for somatic symptoms. *Family Systems Medicine*, 10, 41-51.
- Griffith, J., Griffith, M., Krejman, N., McLain, M. Mittal, D., Rains, J., and Yingle, C. (1992). Reflecting team consultations and their impact upon family therapy for somatic symptoms as coded by structural analysis of social behaviour (SASB). *Family Systems Medicine*, 10, 53-58.
- Henao, S. (1985). A Systems approach to family medicine. In S. Henao and N. Grose (Eds.), *Principles of family systems in family medicine* (pp. 25-39). New York: Brunnel/Mazel.
- Herman, J. (1989). The need for a transitional model: A challenge for biopsychosocial medicine? *Family Systems Medicine*, 7, 106-111.
- Kleiman, A., Einsberg, M., and Good, B. (1978). Culture, illness, and care: Clinical lessons from anthropological and cross-cultural research. *Annals of Internal Medicine*, 88, 251-258.
- Klein, R., Dean, A., and Bogdanoff, M. (1968). The impact of illness upon the spouse. *Journal of Chronic Disease*, 20, 241-252.
- Koch, A. Y. (1983). Family adaptation to medical stressors. *Family Systems Medicine*, 1, 78-87.
- Kreitman, N. (1964). The patient's spouse. *British Journal of Psychiatry*, 110, 159-167.
- Leff, J. and Vaughn, C. (1985). *Expressed emotion in families*. New York: Guildford.
- McCubbin, H. I. and Patterson, J. M. (1982). Family adaptation to crises. In H. I. McCubbin, A. Cauble, and J. Patterson (Eds.), *Family stress, coping and social support* (pp.26-47). Springfield, IL: Charles C. Thomas.
- McDaniel, S. H., Campbell, T. L., and Seaburn, D. (1990). *Family oriented primary care: A manual for medical providers*. New York: Springer-Verlag.
- McDaniel, S. H., Hepworth, J., and Doherty, W. J. (1992). *Medical family therapy*. New York: Guildford.
- Medalie, J. M., Snyder, M., Groen, J., Neufeild, H.N., Goldbourd, and V., Riss, E. (1973). Angina pectoris among 10,000 men: Five year incidence and univariate analysis. *American Journal of Medicine*, 55, 583-594.
- Meyer, R. J. and Haggerty, R. J. (1962) Streptococcal infections in families: Factors altering individual susceptibility. *Pediatrics*, 29, 539-549.
- Miller, R. S. (Ed.) (1983). *Primary health care: More than medicine*. Englewood Cliffs, NJ: Prentice Hall.
- Montero, I. and León, O.G. (2005). Sistema de clasificación del método en los informes de investigación en Psicología. *International Journal of Clinical and Health Psychology*, 5, 115-127.
- Parkes, C. M. (1972). *Bereavement: Studies of grief in adult life*. New York: International University Press.
- Patterson, J. M. (1988). Families experiencing stress. Applying the FAAR model to health related issues for intervention and research. *Family Systems Medicine*, 6, 202-237.
- Pereira, M.G. and Smith, T. (2004). Collaborative family health care in an hospital setting: A pilot study on physician and therapists' perceptions. *International Journal of Clinical and Health Psychology*, 4, 639-650.

- Preachey, R. (1963). Family patterns of stress. *General Practitioner*, 27, 82-89.
- Rolland, J. (1984). Toward a psychosocial typology of chronic and life threatening illness. *Family Systems Medicine*, 2, 245-262.
- Rolland, J. (1987). Family illness paradigms: Evolution and significance. *Family Systems Medicine*, 5, 482-503.
- Ross, N.M. and Doherty, W.J. (2001). Validity of the global assessment of relational functioning (GARF) when used by community-based therapists. *American Journal of Family Therapy*, 29, 239-253.
- Shields, C. and Watson, B. (2002). A conversation with Dr. Lyman Wynne: The role of diagnosis in family therapy. *Family Therapy Magazine: Diagnosis and Treatment*, 1, 18-25.
- Sokel, B., Devane, S., and Bentovim, A. (1991). Getting better with honor: Individualize relaxation/self-hypnosis techniques for control of recalcitrant abdominal pain in children. *Family Systems Medicine*, 9, 83-91.
- Steinglass, P. (1987). *The alcoholic family*. New York: Basic Books.
- Von Bertalanffy, L. (1968). *General Systems Theory*. New York: George Braziller.
- Wood, B., Watkins, J., Boyle, J., Nogueira, J., Zimand, E., and Carroll, L. (1989). The psychosomatic family model: An empirical and theoretical analysis. *Family Process*, 28, 399-417.
- Wynne, L. C. (1989). Family systems and schizophrenia: Implications for family medicine. In C.N. Ramsey (Ed.), *Family systems in medicine* (pp. 1-4). New York: Guildford.