

# ADRIAN MARTIN, M.S.

---

Psychotherapy for Individuals, Couples, & Families

## Medical Family Therapy

Many practicing therapists are aware that family systems theory provides a highly developed approach to analyzing and working with circular interaction processes, relational triangles, boundaries, and the beliefs that occur within the complicated structure and interaction among family members. Medical family therapy (MedFT) is the application of systems theory in the form of a biopsychosocial systems approach to conducting psychotherapy with patients and their families who experience physical health problems, including illness, trauma, or disability. As such, MedFT addresses the systemic interactions among patients, their families, their doctors, surgeons, nurses, and other allied healthcare workers. By becoming an integral part of that structure, a medical family therapist is able to work with those processes to help the patient through the course of their illness.

The biopsychosocial, or BPS model was developed by psychiatrist George Engel in the late 70s as a reaction to the splitting of patient problems into either biological or psychosocial issues, that had tended to become the established norm through the biomedical approach generally taken by the healthcare industry. The result of this dualism is that physicians tended to deal with biological problems and psychotherapists got to work on the psychosocial problems. The BPS model is a general framework that creates an awareness of the importance of the biological, psychological, social, cultural, and (more recently) spiritual system levels of a patient's presenting problem. These system levels are thought to interact synergistically to produce the symptoms about which the patient and/or family are concerned. In essence the presenting complaint is explored from each of these dimensions, and the model requires that the healthcare team address the effects of these dimensions on the patient's level of functioning.

The BPS model suggests that solely biological or solely psychosocial problems do not really exist and therefore physicians are in-fact treating medical problems that have psychosocial components and psychotherapists need to actively consider the biological elements to their client work. Often physicians are unable to address psychosocial issues unless there is enough time available within the biomedical model of the 10 – 20 minute consultation, or these issues are particularly prominent and perhaps are seen as being causal. Few psychotherapists receive specialized training in organic based problems or the effects of disease processes such as adolescent onset diabetes, or congenital health problems that necessitate intensive medical resources and long-term care.

The two disciplines have traditionally used very different languages, for example the conventions around the terms client and patient, and the language of the biomedical model is often beyond the comprehension of the layperson. There has also been a traditional difference in approach to directing the patient, with the biomedical model being highly directive, building physician and patient expectations towards fast results once the problem is identified, while the psychosocial "arts" have developed a process orientation that has traditionally focused on the potential existence and development of client efficacy over a loosely defined time period.

The BPS model identifies a clear need for detailed multidisciplinary collaborative care in order to best serve the patient's interests. Collaboration is the central component of MedFT and taking this approach without collaboration has been likened to doing marital therapy without one spouse. I know many therapists that contact their patient's physicians to obtain further information or to inform the physician of an area of concern regarding their patient, but MedFT provides a more formal arena for integrated collaboration by taking a systemic approach.

The level of collaboration can vary greatly depending on the setting in which the therapist works and the availability and commitment to the process of the medical providers. Therapists working in a primary care or specialist medical setting are more likely to have easier access to physicians than those working in private practice; however, even if you don't work out of a physician's office or in a hospital, it is still possible to develop effective collaborative relationships. Ideally a high degree of consultation should occur between the providers, so even if the family is receiving treatment from the family therapist and the physician in different settings, which is very common, there is free communication between those providers before and after sessions, so that the family's progress can be monitored from all aspects of the BPS model, and treatment may be coordinated.

In an ideal world, sessions may be conducted with the family and both the physician and family therapist in the same room, for part or all of the session, taking a co-therapy approach. This is particularly effective at the start of MedFT treatment as it helps cement the concept of everyone working together as an integrated team, and eases the process of treatment planning and role division. In any case, it is important to establish who is going to take responsibility for which areas of treatment and to guide the family as to which providers are offering specialist skills and knowledge.

One potential hazard with collaborative healthcare is that the therapist may become yet another "expert" who teams with the physicians and other medical providers in driving the patient's treatment, and potentially the helpless patient grows to feel even more disempowered. This may promote mind / body dualism as the patient seeing "his doctors" as being in-charge, treating the pathology in his body without regard for the existential experience of his disease process and so decreasing the sense of being viewed as a whole person. The therapist is mindful of entering into a dyad with the physician to the exclusion of the patient and MedFT actively discourages this through promoting the patient's involvement and developing the paths of communication. The patient and the patient's family take center-stage to the treatment plan and are actively encouraged to operate as consultants on the treatment plan. Patient and family concerns are openly articulated through encouraged communication and the therapist may serve as an interface between patients and families, and their care givers, to help process through potential boundaries to patient care.

Illness naturally causes stress to the patient and the patient's family and social structure. Pre-existing conflicts and difficulties are often exacerbated when there is severe or chronic illness. These are often areas of premorbid functioning that are readily addressed in family therapy, and may have been dormant or denied for years, only becoming evident in the face of physical health stressors. It seems highly beneficial to help patients through difficulties such as increased marital discord and decreased family cohesion that often results from the illness process, not only to improve the existential quality of life for the patient and the family, but because these very difficulties may in fact impede the patient's progression towards health. Relational conflict reduces the potential for support and research has indicated a lack of social support as being a greater risk factor to ill health than cigarette smoking. Decreased family cohesion may limit the ability for patients to maintain medication compliance, or for families to agree on, and facilitate, the best treatment course for the patient.

So the predominant goal of medical family therapy is to assist the patient and their close relations through the course of acute and traumatic, or chronic and potentially terminal health issues. This is achieved through the development and promotion of agency and communion. Agency includes concepts such as self-efficacy and the ability to cope well enough with the symptoms of the illness and other life stressors, whereas communion is an acknowledgement of the family cohesion, communication and emotional bonds that become strained through the illness process.

The treatment plan may include enhancing the day-to-day functioning of both the patient and their family, improving their ability to cope with symptoms (both chronic and acute), improving communication with the healthcare providers, developing acceptance of incurable health problems, and increasing the ability to make necessary lifestyle changes such as diet and exercise regimens.

Following more traditional therapeutic lines, the therapist may assist the family develop meaning out of the current illness and the family's illness history, helping to remove blame, acknowledge defenses, and facilitate grieving and acceptance around loss of health. It is also important to promote the family strengths and resources that may become eroded through the illness process and this may include acknowledging and maintaining family traditions and rituals as well as providing psycho-education where appropriate.

Overall, medical family therapy assists clinicians to avoid the risk of the somatic or psychosocial fixations that can reduce a complex problem to just a medical problem, or just a psychosocial issue, and helps promote biomedical interventions that make psychosocial sense, and also guides the psychotherapist to continue to refer the patient to their physician when they have a new or different symptom.

Adrian Martin, MS, LMFT, LMHP trained as a Medical Family Therapist in the post-graduate program at UNMC's Department of Family Medicine. He works part-time in a hospital setting and has a private practice in the Paxton Building in Downtown Omaha, NE.

For more information visit [www.adrianmartin.info](http://www.adrianmartin.info)