CHAPTER 2

Foundations of Medical Family Therapy

FAMILIES DEALING WITH CHRONIC ILLNESS or disability find that interactions with health care professionals, HMOs, insurance providers, and government agencies are among the most stressful aspects of their situation. To help them, medical family therapists need a working knowledge of these health care and community systems. During the 1980s the field of family therapy began studying families' relationships with larger systems, as seen in the work of Lyman Wynne, Susan McDaniel, and Timothy Weber (1986) and Evan Imber-Black (1988a). The central notion for medical family therapy that emerged from that period is that the unit of assessment and treatment must include the family, the therapist, and the relevant health care system. Three models can be used to examine this complex treatment system.

The model proposed by David Reiss and Atara Kaplan de-Nour (1989) links medical staff, family, and patient within a social system that proceeds through three identifiable phases, each with its own developmental tasks: the central task of the acute phase is "assessment and support"; the central task of the chronic phase, "vigilance versus burnout; maintenance of morale, development, and rehabilitation"; and of the terminal phase, "comfort and composure." Reiss and Kaplan de-Nour describe how roles and interactions among patients, medical staff, and families change during these phases and suggest that the caregiving system's success in coping with later stages depends on success in earlier phases.

William Doherty and Macaran Baird (1983) maintained that the fundamental unit of health is the triangle of clinician, patient, and family. In John Rolland's (1987) view, the illness and its psychosocial characteristics become an additional part of the treatment systems and expand the therapeutic triangle into a therapeutic quadrangle of health care team, patient, family, and illness. By acknowledging the medical family therapist to be a distinct member of the health care team, a pentagon is created, with the therapist attending to issues involving illness, patient, family, and other members of the health care team.

A third useful conceptual approach to systems dynamics in health care is Edgar Auerswald's ecological systems approach (1968). Unlike the interdisciplinary approach, in which each provider maintains the conceptual vantage point of his or her own discipline, the ecological approach uses multiple perspectives to create entirely new approaches. Auerswald cautions that interdisciplinary discussions can lead to much "head-banging" and that by using an ecological approach providers shift their perspectives from a single discipline to the interfaces between the interdisciplinary systems and the communications between systems. In medical family therapy, the ecological approach to management of diabetes would address how the patient, the family, and the health care provider respond to the illness and treatment and how the interactions between the family and health care team affect treatment and responses.

The Biopsychosocial Model: Beyond the Biomedical Model

Modern medical training has emphasized the biomedical model, which attributes pathology to biological and molecular processes. Consumers desire this biomedical expertise but often complain that competent biomedical practitioners tend to ignore the person who has the disease. Internist George Engel noted that medical care and training reflect a cultural context and that the "biomedical model is now the dominant folk model of disease in the Western world" (Engel, 1977, p. 130). This
biomedical model, which accounts for disease by its biochemical factors without considering social or psychological dimensions, separates mind from body. It was this separation of the biological elements of disease from the psychosocial contexts in which they occur that led Engel to propose the biopsychosocial model for organizing medical care. Based on general systems theory principles attributed to Von Bertalanffy, the biopsychosocial model acknowledges the hierarchical, interdependent relationships of biological, psychological, individual, family, and community systems (see figure 2.1). The model reminds providers that they affect multiple levels of systems simultaneously. Heart bypass surgery, for example, requires attention primarily at the organ system level, but most agree that the surgery also affects the cells, the patient, and the social system of the patient.

Engel's systems-oriented work was revolutionary for mainstream medicine but was published in a nonmedical journal, Science, the most prestigious journal in American science. Engel used terminology familiar to family therapists to describe isomorphisms across the levels and urged a systemic understanding of the relationship between biological and social spheres. The biopsychosocial model was presented as a framework for understanding how psychophysiological responses to life interact with somatic factors, how a patient's understanding affects communication of symptoms and use of treatment strategies, and how communication and treatment are affected by relationships between the patient and health care providers.

Biopsychosocial theory, however, is often far apart from practice. Although most recent medical school students are exposed to the biopsychosocial model in their preclinical years, clinical training generally focuses on the biomedical aspects of disease. Psychosocial considerations are addressed only "when there is time": when the psychosocial situation is a blatant and major part of the illness, as when depression precludes a new cancer diagnosis; or when the psychosocial situation distracts from treatment.

As was discussed in chapter 1, family therapists have not practiced within a biopsychosocial model but have tended to operate solely within their field of comfort—the family system—and to pay only minor attention to the individual biological or physical dimensions. By neglecting the other levels of organization, they are at risk for "psychosocial fixation" (McDaniel, Campbell, and Seaburn, 1989).
We do not recommend that physicians become family therapists or that family therapists become experts on biology. Culturally we believe that biomedical treatment of disease provides the greatest success, so health care consumers expect a nephrologist, for example, to specialize in kidneys. Consumers also want family therapists who specialize in encouraging change at the interactional level. It is consistent with the biopsychosocial model to address a particular level of the system at one time but to consider other levels of the system as well. A person has the illness, and that person is embedded within a network of people who also are affected by the illness. Their families interact with larger societal organizations to assist and cope with illness in one of their members.

In Carl Whitaker and Thomas Malone’s (1953) early writings, a biopsychosocial model, although not termed such, provided the theoretical basis for the science of psychotherapy. “Any change in a part of the organism, regardless of whether the change comes in the province of the physiological, genetic, chemical, or psychological, results in changes which affect every other aspect of the total organism. The dynamic continuity between these different levels of integration means that any change in a lower level will result in corresponding changes in higher levels, and vice versa” (p. 18). Yet no single provider can have expertise at all organismic levels.

William Doherty, Macaran Baird, and Lorne Becker (1987) reviewed the ways in which the discipline of family medicine has accepted the biopsychosocial model. They suggested that family medicine is following the “split biopsychosocial model”—a transitional phase in which psychosocial issues are recognized as important but are not integrated into clinical care, and assessment and treatment of medical and psychosocial issues are separated and not coordinated or integrated. The split biopsychosocial model also describes the viewpoints of most family therapists, who consider biological and psychosocial domains as separate and distinct, with each involving different professionals. Despite the difficulties raised by attempting to move beyond clinical dualisms and having medical providers, therapists, and families work together collaboratively, the paradigm of integrated biopsychosocial treatment builds on the dreams of early family therapists to offer creative opportunities for medical family therapists.

The Contexts of Medical Care

During the past twenty years, increasing numbers of family therapists have been working in medical and private practice settings with medical colleagues. Some medical family therapists also are physicians, nurses, pastoral counselors, or medical social workers, with traditional ties to medical settings. Increasingly, people primarily trained as family therapists and psychologists are working effectively in hospital and outpatient settings in family medicine, pediatrics, internal medicine, oncology, and subspecialty areas such as transplant and dialysis units. The roles played by therapists in these contexts depend on the particular characteristics of the medical settings.

THE THREE LEVELS OF CARE: PRIMARY, SECONDARY, AND TERTIARY

Medical settings and specialties are grouped into three levels—primary, secondary, and tertiary. Primary care specialties generally provide the first link for patients and families to health care settings. Families go to a family physician, internist, pediatrician, or nurse practitioner for routine health maintenance and for initial evaluation of symptoms. Primary care specialists are trained to treat 80 to 90 percent of all medical problems (Carmichael and Carmichael, 1981; Geyman, 1981). The primary care setting includes the medical office, the community health center, and the walk-in health care facility. Many family therapists have become integral parts of family medicine training programs and private practices. Much of the literature on collaboration between family therapists and physicians reflects the experiences of these family therapists in primary care settings.

When medical problems require specialized care, such as complicated heart disease or complex fractures, patients work with cardiologists or orthopedic surgeons, the secondary care providers. Families may go directly to the specialists or be referred to them by the primary care provider. Chiropractors and acupuncturists, often considered nontraditional providers, are secondary care providers when patients are referred for specific treatments. Secondary care settings include specialty offices and hospitals.
Family therapists in private practice who receive referrals from physicians may be considered secondary care providers. We recently met an obstetrician who pays a full-time salary to a family therapist in his office. The therapist meets with all expectant couples to provide education and support, provides therapy if necessary, and leads groups for pregnancy loss, adjusting to parenthood, sibling issues, and so on. The services are so appreciated by families in the area that the obstetrician believes that the office makes money with this arrangement.

Tertiary care settings provide treatment in highly specific areas, such as pediatric cancer or kidney disease. Tertiary care settings include university teaching hospitals with units designed for care of a particular disease. Family therapists in tertiary care settings become experts in helping families cope with these diseases. They may work in kidney units in which they assist families with coping with dialysis or with deciding whether to have a transplant or have a family member become a donor. These therapists become knowledgeable about medical aspects of the disease, potential problems and coping strategies, and common individual and family responses to the disease.

Most of the examples cited throughout this book highlight family therapists in primary care settings, although examples of work in secondary and tertiary care settings also are described. Primary care settings currently provide the most common context for medical family therapy. However, more and more secondary and tertiary care settings are becoming interested in family therapists who provide medical family therapy.

A Brief History of Family Therapy in Medicine

The recent enthusiasm for the role of family dynamics and family treatment in medicine, which started in the late 1970s and began to flourish in the 1980s, historically can be considered a third wave of interest in the topic. In this century, the first wave of interest in family
care occurred in the 1920s through 1940s, and the second wave in the 1950s through 1970s, the early period of family therapy.

Donald Ransom (1981, 1983b) described the early period, beginning with the 1926 Peckham experiment, a research-oriented family club and health clinic in London, and the Pioneer Health Centre, a larger structure and community system organized in 1935 to study the reciprocal interactions of physical and social health of the family unit. Services such as health examinations, health information, and group discussions were supplemented with recreational, gymnasium, and social opportunities. Alternative birthing arrangements, in which mothers and babies could return home after forty-eight hours, and a parent-preschool educational nursery planned by Maria Montessori demonstrated the Centre’s commitment to family care and education. A number of significant family systems principles were observed during this project, including the ways in which individual and family development and adaptation to crisis resulted in predictable changes in family structure and adaptation.

In the United States, in 1937, the Macy Project began its study of the family in sickness and health care. This cooperative project of the departments of public health, medicine, and psychiatry at Cornell Medical College and social work and nursing at New York Hospital studied a group of fifteen families for two years. The project report, Patients Have Families, was written by Henry Richardson in 1945. Although the book is now out of print, its vivid formulations of the reciprocal influences of families and health are memorable. Ransom (1984) presents a widely quoted passage from Richardson’s book: “The idea of disease as an entity which is limited to one person and can be transmitted to another, fades into the background and disease becomes an integral part of the continuous process of living. The family is the unit of illness, because it is the unit of living” (p. 110).

Ransom’s (1984) attempt to have Patients Have Families reissued led to discussions with Margaret Mead, the member of the original study group responsible for research design and later organization of the family case studies. Surprised by Richardson’s (1945) sophisticated description of family processes, Ransom learned that the book drew extensively on the ideas of Mead and Gregory Bateson, who were married at the time. Ransom (1981) notes that Richardson and his team were thirty years ahead of their time. Had World War II not interrupted the project and then been followed by twenty years of emphasis on biomed-ical technology, the field of family systems medicine might have developed more rapidly.

The third and most prolific wave of development in family therapy occurred in the late 1970s and the 1980s. Within the discipline of family medicine, family physicians like David Schmidt (1978), Jack Medalie (1978), and Lynn Carmichael (1976) have tried to integrate a family systems context into practical care. The most extensive example of this work is F. J. A. Huygen’s (1982) English translation of his 1978 volume Family Medicine: The Medical Life History of Families. Huygen, a general practitioner from the Netherlands, kept detailed family case histories over decades and documented his patient’s relationships between life events, social and developmental stresses, and physical symptoms and use of medical systems. Through his understanding of family dynamics and the role of family therapists, Huygen made distinctions between family therapy and family medicine that are useful for clinical care.

Interest in the role of family theory and therapy in family medicine grew during the 1980s. In 1981, the Society of Teachers in Family Medicine sponsored a conference on “The Family in Family Medicine,” which grew to become an annual meeting of clinicians and researchers. An informal newsletter, Working Together, was edited for a couple of years in the early 1980s by Michael Glenn, a physician who promoted collaboration between physicians and family therapists. In 1982, the Ackerman Institute sponsored an important conference on “Therapy of Families with Physical Illness.” Following the conference, Don Bloch (1983), with Don Ransom, Michael Glenn, and Barry Dym, began publication of Family Systems Medicine, a journal at the “confluence of family therapy, systems theory and modern medicine.” This journal has published much of the literature on collaboration that is described in chapter 3, as well as interesting research on families and health.

A number of texts for family physicians have emphasized how families can be used in medical care. In Family Therapy and Family Medicine (1983), Doherty and Baird, a family therapist and a family physician, identified how family therapy concepts could be used by family physicians to care for common family problems. Janet Christie-Seeley (1984), a family physician, edited an extensive text, Working with the Family in Primary Care, that includes family theory and clinical applications for the primary care physician. Other texts such as Henao and Grose (1985), Crouch and Roberts (1987), and Sawa (1985) present
conceptualizations, techniques, and examples that integrate family systems concepts into medical care. Susan McDaniel, Thomas Campbell, and David Seaburn's (1990) book is a practical, skill-based manual for primary care professionals. The volume and sophistication of these writings fed enthusiasm for this field.

An ongoing debate in the field of family systems medicine examines the appropriate roles of the physician and the family therapist doing counseling or therapy. William Doherty and Macaran Baird (1983) provided a clear distinction between family therapy and primary care family counseling for primary care physicians. Their book documents how primary care physicians inevitably become part of a triangle with the family, whether or not they choose to meet with family groups. Thus physicians are encouraged to think and practice in terms of families by including families in routine health care decisions and management plans. In Janet Christie-Seely's text (1984), she and Yves Talbot contrasted "working with families," in which there is no contract for emotional change, to family therapy, in which families request change. If change does occur in the medical setting, the impetus for change should come from within the family.

Doherty and Baird’s recommended skills for primary care physicians were further clarified in their edited casebook, Family-Centered Medical Care (1987). The book demonstrated the growth of interest in family systems medicine, for its cases were submitted by many physicians and therapists who were in collaborative and solo practices. Doherty and Baird organized the clinical cases within a framework of levels describing physician involvement with families (see table 2.1). These levels have become a useful means for distinguishing skills for general family physicians and family therapists. The levels represent different degrees of interest and training in family skills and allow physicians to choose how to interact with families and obtain pertinent skills.

- **Level 1: Minimal emphasis on the family.** At this baseline level families are considered as necessary only for medical or legal reasons. No special communication skills are deemed necessary for the caregiver.
- **Level 2: Ongoing medical information and advice.** At this level participants understand the triangular nature of patient-family-provider relations and exercise skills in communicating with families, primarily about medical issues. Affective communication is not a deliberate focus of the family conference.
- **Level 3: Feelings and support.** This level requires participants to have knowledge of normal family development and responses to stress. As at level 2, the physician meets with families, provides information and medical advice, but also responds to emotional needs of family members. Support, encouragement of alternative responses, and facilitating referrals to therapists when necessary are skills required in level 3 involvement, but no intervention occurs.
- **Level 4: Systematic assessment and planned intervention.** This requires participants to have training and supervision in family assessment and intervention skills. The physician engages members in a counseling session, avoids coalitions, reframes difficulties, and encourages mutually advantageous problem solving. These brief, limited interventions focus on family patterns directly related to the medical problem. Working in this level, the physician monitors progress and refers the family to a family therapist if problems are not amenable to primary care treatment. McDaniel, Campbell, and Seaburn's volume, Family-Oriented Primary Care: A Manual for Medical Providers (1990), articulates the specific skills and concepts needed to practice medicine at levels 1 through 4.
- **Level 5: Family therapy.** Providing therapy requires extensive training and supervision beyond primary care residency training. Involvement with families at this level requires the ability to handle intense emotional responses elicited by the work. Just as some primary care physicians choose to obtain special expertise, perhaps through fellowship training in cardiology or infectious disease, others will obtain advance training in family therapy, perhaps by attending a postdegree program. Most family medicine residency training programs promote the distinctions between therapy and counseling in curricula. A small number of family physicians do proceed with advanced family therapy training. In recent years, Macaran Baird (personal communication, 1990), a family physician and family therapist, has abandoned trying to combine the roles of family therapist and family physician with the same families, but other family physician-
TABLE 2.1 (continued)

Level Four: Systematic Assessment and Planned Intervention

Knowledge base: Family systems

Personal development: Awareness of one's own participation in systems, including the therapeutic triangle, the medical system, one's own family system, and larger community systems.

Skills:
1. Engaging family members, including reluctant ones, in a planned family conference or a series of conferences.
2. Structuring a conference with even a poorly communicating family in such a way that all members have a chance to express themselves.
3. Systematically assessing the family's level of functioning.
4. Supporting individual members while avoiding coalitions.
5. Refining the family's definition of their problem in a way that makes problem solving more achievable.
6. Helping the family members view their difficulty as one that requires new forms of collaborative effort.
7. Helping family members generate alternative, mutually acceptable ways to cope with their difficulty.
8. Helping the family balance their coping efforts by clarifying their various roles in a way that allows support without sacrificing anyone's autonomy.
9. Identifying family dysfunction that lies beyond primary care treatment and orchestrating a referral by educating the family and the therapist about what to expect from one another.

Knowledge base: Family systems and patterns whereby dysfunctional families interact with professionals and other health care systems.

Personal development: Ability to handle intense emotions in families and self and to maintain one's balance in the face of strong pressure from family members or other professionals.

Skills:
The following is not an exhaustive list of family therapy skills but rather a list of several key skills that distinguish level five involvement from primary care involvement with families.
1. Interviewing families or family members who are quite difficult to engage.
2. Efficiently generating and testing hypotheses about the family's difficulties and interaction patterns.
3. Escalating conflict in the family in order to break a family impasse.
4. Temporarily siding with one family member against another.
5. Constructively dealing with a family's strong resistance to change.
6. Negotiating collaborative relationships with other professionals and other systems who are working with the family, even when those groups are at odds with each other.

Level Five: Family Therapy

Knowledge base: Family systems

Personal development: Awareness of one's own family interaction with professionals and other health care systems.

Skills:
1. Interviewing families or family members who are quite difficult to engage.
2. Efficiently generating and testing hypotheses about the family's difficulties and interaction patterns.
3. Escalating conflict in the family in order to break a family impasse.
4. Temporarily siding with one family member against another.
5. Constructively dealing with a family's strong resistance to change.
6. Negotiating collaborative relationships with other professionals and other systems who are working with the family, even when those groups are at odds with each other.

The Knowledge Base of Medical Family Therapy

The fundamental tenet of medical family therapy is that all human problems are biopsychosocial systems problems: there are no psychosocial problems without biological features and no biomedical problems without psychosocial features. All therapeutic issues involve complex systems dynamics at biological, psychological, interpersonal, institutional, and community levels. We have added the term systems to Engel's (1977) biopsychosocial model to go beyond using that model simply as a framework for arranging biological, psychological, and social levels hierarchically and to help explain the interactions across the levels of the multiple social systems involved in health and illness (Doherty, Baird, and Becker, 1987). We emphasize that family therapists apply their sophistication in social systems analysis to biopsychosocial assessment and treatment.

To reduce the complexity of these issues to manageable levels, it is necessary to create areas of focus in professional work. Thus, health professionals often refer to "medical illness" or "physical illness" as distinguished from "mental illness" or "psychosocial problems." Similarly, professionals make distinctions between family problems, psychological problems, physical problems, and community problems. Some professionals concentrate nearly exclusively on the biomedical dimension and others on the psychosocial dimension, while a growing subset is working at areas of overlap between these two traditional domains. As practical as these distinctions may be for everyday discourse, physical and psychosocial problems do not exist as discrete, bounded domains of reality. Professionals in these fields are dealing with biopsychosocial systems issues in research and practice whether they are aware of these systems issues or not.

Expertise in all aspects of the biopsychosocial systems domain is beyond the ability of individuals and specific professional groups. Given our cultural bias toward believing in a mind-body split, it is not surprising that most health professionals specialize in either the biomedical side or the psychosocial side of the divide. To work in the overlap area stretches health professionals beyond their traditional training and requires a degree of interprofessional collaboration that runs counter to the trend toward autonomy of professional groups, an autonomy newly won and especially treasured by nonphysician mental health professionals.

Contemporary medicine provides a good example of collaboration within its own ranks. Neurologists, for example, know that they cannot practice medicine without closely collaborating with neurosurgeons, radiologists, and other medical specialists. Psychotherapists and family therapists, on the other hand, often treat clients in relative isolation from other professionals. They may consult with therapist colleagues and may collaborate with a psychiatrist for medication purposes, but most therapists, outside of mental hospital settings and occasional cotherapy arrangements, do not work in collaborative teams on cases with other professionals. Because therapists tend to collaborate only with other mental health professionals, rather than with medical professionals, it is relatively easy for therapists to remain narrowly focused on a psychosocial conceptual framework and practice. When the culture splits the mind and the body, professionals tend to line up on either side of the gap—and mistrust the other side.

Medical family therapists operate in the biomedical-psychosocial overlap area of professional activity and must acquire knowledge that is generally inaccessible in their psychosocial systems training. To acquire this knowledge, they must learn from the work of other health professionals, biomedical scientists, and social scientists. Furthermore, since knowledge changes rapidly in the biopsychosocial area, medical family therapists must collaborate with physicians and other health professionals who practice different skills and read different kinds of professional literature.

MAJOR CHRONIC ILLNESSES AND DISABILITIES

Medical family therapists need to have an adequate working knowledge of the major chronic illnesses and disabilities and the re-
sources to learn more basic biomedical facts when faced with specific cases. For therapists to work meaningfully with family medical problems, they need to be as informed as motivated patients are about their diseases.

The basic list of diseases and disease complexes is not long; it includes diabetes, heart disease, hypertension, lung diseases such as asthma and emphysema, the major cancers, plus the most common degenerative diseases such as multiple sclerosis and the muscular dystrophies. Beyond these and several common disabilities such as cervical spinal cord injuries, the therapist should read and consult with medical and nursing colleagues about the particular problems displayed in specific cases.

In addition to understanding common medical problems, the medical family therapist should be informed about the major treatments and their psychosocial implications. For example, a medical family therapist needs to know the following:

- Hypertension generally has no symptoms, and certain antihypertensive medications cause erectile dysfunction.
- Juvenile-onset diabetes involves the failure of the pancreas to produce insulin, and the patient requires lifelong insulin shots and careful attention to diet. Noninsulin-dependent diabetes, with onset generally in adulthood, may or may not require supplementary insulin injections and often can be controlled by weight loss and diet.
- Multiple sclerosis often involves repeating periods of relapse and remission and emotional lability that may be independent of the patient’s social situation at the moment.

Medical family therapists are not expected to have expert knowledge about these common diseases but must know enough to be able to work realistically with patients and families experiencing them. They can obtain instruction from three overlapping sources—physicians and nurses; medical encyclopedias and continuing education articles intended for primary care health professionals; and patients and families, many of whom become quite knowledgeable about their health problems. For example, a woman with multiple sclerosis taught her therapist an important fact about the disease when she said, “These tears are my disease talking; I’m actually doing pretty well today.” Similarly, reading about genetic predispositions to breast cancer can disabuse a therapist of a simplistic belief that such cancers are caused mainly by a “cancer-prone personality.”

RESEARCH IN BEHAVIORAL MEDICINE AND OTHER SOCIAL SCIENCES

Behavioral medicine has produced a significant body of research knowledge about health and illness since emerging as a specialty in psychology in the 1970s. Also called health psychology in some circles, this field—in combination with other traditional disciplines, such as social epidemiology, medical sociology, medical anthropology, and nursing—offers bedrock information and perspectives for medical family therapy. Little of this material is available in traditional family therapy education or training. The following areas are particularly relevant to medical family therapy:

- Social support and health. In a review for the journal Science, James House, Karl Landis, and Debra Umberson (1988) propose that there is now enough research evidence to assert with confidence that social relationships are a central factor in health and mortality. In fact, the authors concluded that poor social support is a stronger predictor of mortality than cigarette smoking.
- Health behaviors. Behavioral medicine and other researchers have explored the strong relationships between health and diet, exercise, and cigarette smoking (Gentry, 1984). Two behavior-related diseases, heart disease and cancer, currently account for 75 percent of all deaths in the United States. The federal government estimates that half of all premature mortality in the United States stems from unhealthy behaviors (U.S. Department of Health, Education, and Welfare, 1979).
- Cooperation with medical regimens. Lack of patient “compliance” with medication and other prescribed regimens is a major cause of illness and mortality. The National Heart, Lung, and Blood Institute (1982) estimates that most patients are not taking
enough of their prescribed medication to achieve blood pressure control. Behavioral medicine researchers have examined this issue in depth from psychological and behavioral perspectives.

- Gender issues in health. Perhaps because women researchers have been active contributors to the behavioral medicine literature, a rich body of work has examined gender aspects of health, illness, and health behaviors (Blechman and Brownell, 1988). Women have special health issues and concerns about reproductive health, breast cancer, alcoholism, cigarette smoking, care for ill family members, and treatment within the health care system.

Although they have contributed substantially to the understanding of individual behavioral factors in health and illness, social scientists from behavioral medicine have paid less attention to family issues.

FAMILY AND HEALTH RESEARCH

A substantial body of research about families and health now exists. In their book surveying this literature, Doherty and Campbell (1988) used the Family Health and Illness Cycle (figure 2.2) as a model for organizing this research. The cycle delineates the phases of a family’s experience with a health problem, beginning with family health promotion and risk reduction and moving clockwise to adaptation to illness or recovery:

1. Family health promotion and risk reduction. There is now widespread consensus that most health behavior patterns are learned in and sustained by families. Cigarette smokers tend to marry other smokers (Sutton, 1980) and to smoke similar numbers of cigarettes as their spouses (Venters et al., 1984). Adolescents tend to smoke if their same-sex parent smokes (U.S. Department of Health, Education, and Welfare, 1976).

2. Family vulnerability and disease onset or relapse. The most widely used measurement of psychosocial stress, the Holmes and Rahe Social Readjustment Scale (Holmes and Rahe, 1967) contains a weighted list of fifty stressful events that require life readjustment by individuals. No fewer than ten of the fifteen most stressful events are family events, such as divorce, death of a spouse, and major change in health of a family member. Biopsychosocial research has begun to discover biological markers for family stress. Kiecolt-Glaser and colleagues (1987) have found that lower marital satisfaction is associated with poor immune system responses. And John Gottman and Lynn Katz (1989) showed that children’s stress hormone levels (specifically, cortisol levels) were calibrated to the level of marital distress in their parents. Thus, increasing evidence shows that family-related stress leads to physiological changes that are associated with increased illness.

3. Family illness appraisal. In the family sciences, more and more attention has been paid to families’ beliefs about health events. In Doherty and Campbell’s (1988) words, families tend to have their own “epidemiology” based on their experience with cer-
tain illnesses, their relationship with health care professionals, and their level of education about health issues. Family health activities such as visiting a physician tend to flow from complex consultative processes in which family members share their beliefs and expectations about a family member's symptoms (Litman, 1974).

4. Family acute response. This research investigates families' reactions to the immediate onset of a disease or disability, such as a heart attack, a diagnosis of cancer, or a cervical spinal cord injury. Families at this stage of a serious illness tend to become more cohesive immediately following a potentially fatal episode of a family member (Steinglass et al., 1982). This is a time in which medical family therapists occasionally become involved with the family, especially if the therapist is working directly in a medical setting where the acute reaction is occurring.

5. Family adaptation to illness or recovery. Medical family therapists are most apt to become involved with a family at this phase. Many families handle the acute phase of an illness well but find the chronic, readjustment phase more problematic. A large body of research has examined how families cope with realigned roles, new interaction patterns, changed social support, and the ongoing stressors of family life (Doherty and Campbell, 1988). Understanding the constraints and opportunities faced by families with chronic illness is a cornerstone of medical family therapy.

The pioneering contribution to family systems and medical issues was Minuchin, Rosman, and Baker's (1978) psychosomatic family model. This model is based on structural family therapy theory and clinical and research observations of families of children with uncontrolled childhood diabetes for whom organic explanations had been ruled out. Minuchin's team proposed that these psychosomatic families were characterized by patterns of enmeshment, overprotection, rigidity, poor conflict resolution, and triangulation of the child. Although this model has sometimes been misunderstood to imply that family patterns cause disease, the psychosomatic family model posits a circular process whereby family patterns and disease mutually maintain each other (Wood et al., 1989). This model was given initial research support in a study by Minuchin et al. (1978), which showed a link between family interaction and blood glucose levels in certain diabetic children. Although there were methodological problems with this original study, Wood et al. (1989) later found support for some elements of the psychosomatic family model, particularly triangulation and marital dysfunction, in accounting for disease activity in children with Crohn's disease.

A second area of pertinent theory comes from the work of David Reiss, Peter Steinglass, Jane Jacobs, and colleagues at George Washington University. With theory and research that began with mental illness, alcoholism, and the hospital environment, these scholars have shown how families organize around health problems. David Reiss (1981) and Reiss, Sandra Gonzalez, and Norman Kramer (1986) have described how the family's paradigm for coordination is an important factor in its ability to handle serious illness and relationships with the health care system. Coordination refers to the family's level of readiness to experience themselves as a single unity, especially in times of stress. Peter Steinglass's model of the alcoholic family (Steinglass et al., 1987) has proved useful in conceptualizing how families with other chronic illnesses can fail to buffer their daily routines and rituals from the illness, thereby allowing the illness to become an organizing principle of the family system.

A third theoretical contribution is John Rolland's (1984, 1988) psychosocial model of illness type and family life cycle. In his 1984 paper in Family Systems Medicine, Rolland made the case for a typology of illness that would facilitate the examination of individual and family dynamics in chronic disease—in other words, a psychosocial typology of chronic illness. His proposed typology used four categories—onset, course, outcome, and degree of incapacitation. For the purposes of a medical family therapist, these dimensions directly affect the family's everyday experiences and are likely to be more important than the particular pathophysiology of specific diseases. For example, both Parkinson's disease and rheumatoid arthritis have a gradual onset, have a progressive course, are nonfatal, and are incapacitating. Families with these illnesses will have a different set of challenges than families who have members with illnesses showing a different psychosocial profile,
such as ulcerative colitis, which is a relapsing disease that does not follow a constant progressive course. Rolland (1988) integrates this illness typology with phases of the family life cycle, showing how the interaction between the characteristics of an illness and the family's developmental needs can derail a family from its natural course. For example, a parent's cervical spinal cord injury can make it difficult for a young adult child to leave home physically and emotionally.

The biospsychosocial approach to schizophrenia and other mental illnesses offers a fourth relevant theoretical contribution to medical family therapy. Family systems researchers have embraced concepts such as genetic vulnerability, stimulus overload, family communication effects, and expressed emotion. Expressed emotion, which refers to negative criticism and intrusiveness by a parent toward a mentally ill family member, is a particularly strong predictor of relapse and rehospitalization after treatment for schizophrenia (Leff and Vaughn, 1985). Because of their genuine biospsychosocial orientation, family systems theories emerging from the study of schizophrenia offer great potential for being adapted to other medical illness. Lyman Wynne (1989, pp. 507–508) indicates the complexity of this biospsychosocial systems model as applied to schizophrenia:

What we see clinically in schizophrenic illness is not the simple consequence of an ultimate "etiology" but, rather, that the precursors, onset, and later course are part of a complex developmental, epigenetic process ... that involves multiple systems levels—genetic and non-genetic biologic factors, rearing and developmental variables, both intrafamilial and extrafamilial; variations in the fit, integration, and developmental time of intrapsychic processes; and the responsiveness of the therapeutic systems that interface with the family systems and the identified patient.

A fifth theory useful for medical family therapy is the family adjustment and adaptation response (FAAR) model (McCubbin and Patterson, 1982; Patterson, 1988), which combines family stress theory and family systems theory. Applied to medical problems, the FAAR model builds on the adjustment and adaptation phase of the family health and illness cycle and examines families' efforts to manage the demands of chronic illness and disabilities in light of their resources, coping patterns, and beliefs. The outcome of this coping process is a level adjustment or adaptation. The FAAR model has been operationalized by a number of self-report instruments and has been applied successfully in research on how families cope with chronic and handicapping medical conditions (Patterson, 1989).

Finally, the Family FIRO Model, an extension of Schutz's fundamental interpersonal relations orientations model (Doherty, Colangelo, and Hovander, 1991) was originally developed by Doherty and Colangelo (1984) for family therapy and later applied to the family dynamics of health behaviors and chronic illness. The model offers three core dimensions of family interaction—inclusion (structure, connectedness, and shared meaning), control (power and influence), and intimacy (close personal exchanges). Publications on cigarette smoking (Doherty and Whitehead, 1986; Whitehead and Doherty, 1989), obesity (Doherty and Harkaway, 1990), and chronic illness (Doherty and Campbell, 1988) have postulated that health behaviors and disorders can serve as ways for family members to be included or excluded from each other's lives, to create battlegrounds for control, and to open or close opportunities for intimacy.

Conclusion

In sum, an important body of literature provides the knowledge base for medical family therapy, but is not routinely included in the training of family therapists in the early 1990s. This knowledge base is extensive and better grounded empirically than most of the traditional literature in family therapy. Practicing medical family therapy, then, involves more than "parachuting" into the medical domain with one's existing knowledge. It involves grappling with new and exciting research and theory and in the process expanding the paradigm for treatment.