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Finding the Heart of Medical Family Therapy: A Content Analysis of Medical Family Therapy Casebook Articles

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Abstract

In an effort to identify the essential ingredients of medical family therapy, a content analysis of 15 peer-reviewed case studies in medical family therapy was conducted. The case studies were published from 1996 to 2007 in *Families, Systems, & Health*. Through a qualitative content analysis, three main themes emerged that describe the essence of the practice of medical family therapy: (1) The patient's multisystemic experience of disease, (2) treatment is about caring, not just caregiving, and (3) elevating the patient as collaborator in the care team.

Keywords:

medical family therapy,
collaboration,
collaborative healthcare,
biopsychosocial-spiritual

In 1977, George Engel published an article in the journal *Science* that challenged the reductionism that was guiding medical practice at the time and that continues to exert influence on both the science and the practice of medicine today. His alternative perspective was one informed by systems theory and, when applied, encouraged providers to consider the interrelationship between biological, psychological, and social systems and functioning when working with patients.

While Engel's ideas have not been without critics (e.g., Sadler & Hulgus, 1992), they have significantly influenced the practice of both medicine and mental health care (e.g., McDaniel, Hepworth & Doherty, 1992a; Linville, Heirtlein, Prouty-Lyness, 2007). His seminal 1977 article has been cited hundreds of times in peer-reviewed articles, books, and other publications in nearly all areas of medical specialization including dentistry and chiropractic care. His biopsychosocial (BPS) model is liberally cited in publications associated with the mental health field. Unlike other models that have their day in the sun and then quickly fade, the influence of the BPS model on both practice

and science continues to grow. Evidence of this growth is the expansion of the model to include the spiritual or metaphysical dimension of human experience (e.g., Hodgson, Lamson, & Reese, 2007; Prest & Robinson, 2006; Wright, Watson, & Bell, 1996) to what is now referred to as the biopsychosocial-spiritual model (BPSS).

Family therapy has a natural connection with the BPSS model because of its common theoretical base in systems theory and its attention to family functioning. It is for this reason that McDaniel, Hepworth, and Doherty (1992a) coined the term Medical Family Therapy (MedFT) to refer to treatment based on the BPS model. In a subsequent publication, Doherty, McDaniel, and Hepworth (1994) succinctly explained that MedFT is an “. . . approach to integrating mind, body, and family in collaborative, systems-oriented treatment” (p. 32). The centerpiece of the approach is the collaborative working relationship of medical providers and family therapists (McDaniel, Hepworth, & Doherty, 1992b).

Although MedFT is a relative newcomer as a treatment approach, there is great interest in the scholarship of the approach with books and journals devoted to advancing the practice, including *Families, Systems, & Health*. There has even been some debate as to whether MedFT is a separate and distinct mental health profession (Linville et al., 2007). Many mental health providers identify themselves as medical family therapists. But, as yet, it is still unclear what this approach to treatment looks like. This research was designed to better understand the practice of MedFT.

METHOD

Sample

Fifteen Medical Family Therapy Casebook articles (hereafter referred to as Casebooks) published between 1996 and 2007 in *Families, Systems, & Health* were used as data for this study. A hallmark of the Casebook series is that they are stories from the trenches of practice. In making the original call for manuscripts for the

Medical Family Therapy Casebook series, David Seaburn, the series editor, wrote:

‘Medical Family Therapy Casebook’ is a new department that will provide a voice for therapists who practice in health care settings. They are the pioneers in the fledgling field of medical family therapy. This department is intended as a contribution to the exciting dialogue about how to apply family systems approaches in health care settings and how collaboration can be facilitated between therapists, health care providers, and families. (see introduction to Weiss & Hepworth, 1993, p. 297)

Because of the title of the series, its description, and how the articles were originally solicited, we assumed that they would reflect the realities of MedFT practice, unencumbered by theory or preconceptions, and that they would act as a window to the practice of MedFT.

Including coauthors, these 15 Casebooks represented the experiences of 24 professionals (14 medical providers and 10 mental health therapists).

Data Analysis

Casebooks were qualitatively analyzed using text analysis (Silverman, 2000). The two senior investigators were well acquainted with the MedFT literature and experienced in the practice of MedFT. They have published in the area of MedFT and have contributed to the development of MedFT principles, practice, and training. In order to ensure that this previous knowledge and experience did not unduly influence the analysis of the data, a third investigator [DSF] was added who was unfamiliar with the MedFT literature and who was not a mental health therapist. Our interest was to allow the themes, concepts, and principles of MedFT to emerge from the Casebook stories rather than attempt to interpret these stories from a position of knowing based on experience and existing literature.

The third investigator [DSF] first read each Casebook article with the intent of learning what MedFT is through these case examples. While reading the Casebooks, this investigator was directed to ask the following questions:

- “What is being done here?” and “Why is this important to treatment success?”
- “What is medical family therapy?”
- “What skills, abilities, or competencies are the authors demonstrating even though they may not identify them specifically?”
- “What is the context in which medical family therapy is practiced?”

This investigator identified and extracted passages that helped to answer these questions. As this initial analysis of the data proceeded, other questions emerged such as “Who does medical family therapy?” and “Who are medical family therapists?” Questions such as these emerged because the initial data analysis exposed assumptions that the investigators were making that did not appear to be supported by the data. The investigator was directed to re-read each Casebook, continuing to identify passages that answer both the original and emerging questions.

Passages of text that appeared to contribute to an understanding of MedFT were compared with one another, organized, categorized, and labeled on a spreadsheet. This investigator then met with the other two investigators to share his observations. The other investigators asked questions about and offered comments on what was learned, the categorizations of the data, and the emerging themes from their “knowing” position. They gave particular attention to what was not found but expected based on their understanding of the literature (e.g., attention to the *spiritual* dimension of the BPSS model). [DSF] then went back to the data to determine whether this information had been overlooked in the original analysis. The goal was to ensure that nothing was missed. Once this investigator was satisfied that a comprehensive list of categories had been created,

the categorizations were given to the other two investigators who read each Casebook to verify these observations. This resulted in investigator triangulation (Creswell, 2007), which contributed to the trustworthiness of the qualitative investigation. With the list expanded, the investigators individually, and then together, worked to collapse the categories by comparing each category with all others in an attempt to identify the principles underlying the practice of MedFT. The results and conclusions were then written in manuscript form. The manuscript was given to a licensed marriage and family therapist familiar with the MedFT literature. This investigator compared the findings and conclusions, as presented in the manuscript, with three other Casebooks (Cohen, 1995; Leahy, Galbreath, Powell, & Shinn, 1994; Weiss & Hepworth, 1993) that were not included in the data analysis, because they were published prior to 1996 when the journal was known as *Family Systems Medicine*. This practitioner judged the results to be fair and accurate representations of the additional data. This analysis suggested that we had achieved data saturation, “the gold standard by which purposive sample sizes are determined in health science research (Guest, Bunce, & Johnson, 2006, p. 60).

RESULTS

The Casebooks are provider stories of working within the complex multidimensional experience of patients, family members, and providers involved in the crucible of health care. The salient theme underlying all the Casebooks is the importance of recognizing the complexity of patient experience and elevating that to a position where it is preserved within the health care system. In MedFT, the patient as a person, in all his or her complexity and wholeness, is at the center of health care. Those practicing MedFT appear to do this by (a) recognizing and respecting the patient’s multisystemic

experience of disease, (b) developing a caring relationship with the patient, and (c) elevating the patient in their role in the health care team. It is evident from the data that the practice of MedFT as described in the Casebooks is not within the exclusive practice domain of mental health providers. These results are described below.

Patient's Multisystemic Experience of Disease

The Casebooks are stories of providers seeing, understanding, and working within the complexity of patients' experience of disease and treatment. Patient experience is complex because it is multisystemic, requiring simultaneous intervention in the multiple systems of patient experience. Casebook authors recognize this. But, for them, this recognition is more personal than academic; more felt than conceptualized; more from the perspective of the patient than from the perspective of the provider.

Providers of MedFT recognize that the BPSS perspective is the patient's perspective. The patient's experience of disease (or whatever it is that prompts them to seek care) exists within the biological, social, psychological, and spiritual systems. Seeing it from this perspective allows them to anticipate what the patient needs within the various systems of functioning. For these providers, successful patient care includes simultaneous work within and between these multiple systems. This difference in perspective and perspective taking is subtle, but appears to be foundational to the practices being described in the Casebooks. It is what makes patient care personal rather than purely professional. It is what allows the BPSS model to be operationalized in a way that makes a difference in patient care.

The importance of observing from the perspective of the patient was most evident in examples of patient care provided by physicians. Physicians told of how experiences with patients challenged them to reconsider their perspective by seeing the disease experience from the perspective of the patient and by recognizing

that the traditional models of care (biomedical) did not support multisystemic intervention. Two examples from the data illustrate this theme. First, Munshower (2004), a physician, explained that she

... learned early in my medical training that patients were not just the 'hypertensive in Room 1' or the 'gall bladder in Room 2' but instead were unique individuals with their own family circumstances that impacted one way or another on their health care. (p. 497)

However, once she began facing the realities of providing care "... I found that I had to work within time constraints that made it difficult to provide the full breadth of family oriented medicine" (p. 497). Out of this frustration in addressing patient suffering on multiple levels, she began looking for ways of increasing family involvement in treatment. She found that the multifamily educational group would allow her to address the impact of disease at multiple levels while at the same time allowing her to concentrate on treating the medical condition.

The second example is from Radomsky (1996), a physician, who poignantly described how complexities of patient experiences with disease challenged her own perspective and led her to change how she was treating patients. Radomsky, like others, described the difference between using the BPSS model as a mere conceptual model and coming to see that the patient's experience exists in the biological, psychological, social, and spiritual systems. For the patient, these cannot be separated. As she described below, this perspective taking would not be possible without time to just be with patients in a way that allowed her to see through their eyes.

Certainly, in my early years in practice, the idea that I translated the meaning of my patient's symptoms into the right diagnosis and treated them in the most up-

to-date fashion was central to my sense of being a good doctor ... I would have described my work as congruent with the biopsychosocial model ... It was with patients with labels that are not easily understood, for example, fibromyalgia ... that challenged my security with the notion that the doctor is a 'doer and fixer.' ... I would have defended my approach as patient-centered, but at times my behavior likely was otherwise ... Over time I began to notice that sometimes I was just *with* these patients ... these moments were often, what I sensed to be a powerful experience for the patient (pp. 497–498).

Reflective Practitioner

As evidenced by the quote above, those practicing MedFT take a reflective, rather than an objective, stance in relation to the patient. As the provider allows herself to just be with the patient, she allows her perspective to change so that she is able to see and acknowledge the patient's biopsychosocial- spiritual experience of disease and that she is part of that experience. When this happens, intervention in each systemic area becomes a priority. The provider increases her impact on the patient through her participation in the patient's multisystemic experience. Providers acknowledge that they learn and are changed as a result of their interactions with patients as Clabby and Howarth (2007) illustrated by concluding that "Henry taught us much about trust, the human will, and the capacity for change (p. 464)."

Treatment Is About Caring, Not Just Care Giving (or It's All About Relationships With Patients)

The Casebook data suggests that MedFT isn't so much about a collection of techniques, strategies, and interventions as it is about the willingness of the provider to care about their patient

as a person. As the quote above from Radomsky (1996) demonstrated, the provider's willingness to see the experience of disease from the perspective of the patient appears to go hand-in-hand with a willingness to be in a caring relationship with the patient. This changes the nature of treatment. Providers are no longer treating a disease, but a person with a disease. They are no longer intervening in just one system, but in multiple systems simultaneously. Radomsky (1996) explained: "Increasingly I see being a family physician as a balance between DOING FOR my patient and BEING WITH my patient. Over time, I've come to appreciate the partnership aspect of the doctor-patient relationship" (p. 502).

The importance of this caring doctor-patient relationship is a common theme emerging from the Casebooks. It appears that the centerpiece of MedFT is the relationship between the provider and the patient that is developed as the provider cares about the patient's multisystemic experience. Relationships with other providers are important only to the degree that they serve to strengthen the relationship of the provider with the patient. For example, Berkley explained that which is evident throughout the Casebooks: "Although it is common to think of collaboration as an endeavor between professionals, often times the most important collaborators are the patients themselves" (Berkley, 2000, p. 499).

Caring about the patient opens the door to caring about others in the patient's social network. Providers begin to see the importance of family meetings (Knishkowsky & Herman, 1998; Munshower, 2004; Prest, Fitzgibbons, & Krier, 1996; Souza, 2002) and other opportunities to include family members in treatment (Berkley, 2000; Edwards & Turnage, 2003; Lowe, 2007; Riccelli, 2003; Thomasgard, Boreman, & Metz, 2004). While including family members in treatment accomplishes the purposes of the treatment, it is obvious that providers of MedFT care about the impact of the disease on family and significant others (Edwards & Turnage, 2003;

Knishokowy & Herman, 1998; Munshower, 2004; Prest et al., 1996; Souza, 2002; Thomasgard et al., 2004). The focus is not on the individual, but on the functioning of the system in which the patient resides.

Elevating the Patient as Collaborator in the Care Team

It appears that a result of allowing oneself to see the complexity of the patient's experience and of caring about the patient is a natural desire to prioritize the patient's voice and to empower the patient in their role as collaborator in the care team. Analysis of the Casebooks revealed that providers do this by (a) eliciting the patient's story, (b) advocating for the patient, and (c) expanding the care team.

Eliciting the Patient's Story

Casebook authors recognized that the traditional treatment approach values providers' opinions over those of patients (see Souza, 2002). The result of this approach is that patients often feel marginalized and disempowered in their own treatment. Radomsky (1996) explained: "My patients on occasion clearly challenged me with the fact that my approach sometimes devalued the patient's perspective." (p. 497; see also Lowe, 2007; Souza, 2002).

Practicing MedFT means (a) recognizing how patients are marginalized and (b) seeking to elicit patient stories about their functioning in biological, psychological, social, and spiritual systems in a way that these stories will influence treatment. This requires time—which is often very precious—and a willingness to ask questions about patients' experience in each system of functioning. Casebook authors suggest that this must be done with explicit questioning about functioning within each system. Clabby and Howarth (2007) asked their patient, Henry, what advice he would give to providers. He responded:

Any doctor ... can develop a conversation about the person's life. You almost have

to delve into the person's life to a certain degree. That would help you understand the illness. No? It would help patients not complain as much. I'm—I work as a plumber ... and work with heating and systems. If a system goes down, you change a nozzle. You have to look at the whole system. In medicine, you deal with a person's mind too. It seems to me that is pretty important. (p. 464)

Failure to ask patients about their experience in each system perpetuates the status quo which preferences the one-dimensional experience within the biological system. But, asking questions to elicit patient stories allows providers to understand the complexity of patient experience of both disease and treatment and to work within the multiple systems of the patient's experience. Clinicians who elicit patient perspectives have information available that might otherwise be hidden and that can be used in diagnosis and in gaining patient investment in the care plan (see Navon, 2005). Fogarty (2001) explained that:

Spending a few moments with all patients and more time with more complex patients can yield important insights. Seemingly paradoxical behaviors may become better understood and the physician is more likely to avoid the pitfalls that affected previous physician-patient relationships. (p. 226)

Telling these stories appears to engender hope and greater responsibility for treatment in both the patient and the provider (see Navon, 2005). Radomsky (1996) acknowledged that when she began to ask patients more specifically about their experience, that it often had surprising and empowering results:

Sometimes patients expressed ideas about their problems that produced a shift away from the perceived hopelessness of their situation ... I've noticed that

when I'm more willing to take the risk of being with my patients and being respectful of my patients' healing process, I'm less exhausted. The more I take on that risk, the more I hear my patients' sense of their own strength and their own healing journey. (pp. 498, 502)

The Casebooks are replete with examples of providers, regardless of discipline, eliciting information about patient experience in each systemic area. This appears to be a key ingredient to the practice of MedFT: Acumen in asking about patient experience in multiple systemic areas, regardless of the emphasis of one's own disciplinary expertise. Yet, some Casebooks also suggest that eliciting a patient's biopsychosocial- spiritual experience can be facilitated by collaborating in multidisciplinary teams (see Edwards & Turnage, 2003; Harkness & Nofziger, 1998; Munshower, 2004; Prest et al., 1996; Souza, 2002) with each team member bringing their disciplinary expertise to bear in eliciting information about the system in which they have particular expertise.

Advocating for the Patient

The patients represented in the Casebooks appeared to have entered the health care system unable to contribute sufficiently as a partner in their own care team. It appeared that prior to the application of MedFT, they were disempowered and left to the mercy of their health or mental health care providers. While there may be many reasons for this disempowerment, some that are identified in the Casebooks include the following:

- The medical system (and mental health care system) is unfamiliar to most patients. It is a system with its own structure and rules of interaction. It is a system that discourages and even prevents patients from navigating the system alone. (Souza, 2002; Lowe, 2007).
- The system values professional opinion over personal experience. (Navon, 2005; Souza, 2002)
- Patients are often experiencing physical, emotional, or psychological pain. Pain and the distress that accompanies it, by its very nature, are disempowering, especially when it is accompanied by uncertainty about the cause of the pain or what to do about it (Clabby & Howarth, 2007; Edwards & Turnage, 2003; Fogarty, 2001; Harkness & Nofziger, 1998).
- They often enter the system alone. Without their familiar support system, they often lack the power to act on their own behalf (Munshower, 2004; Prest et al., 1996; Souza, 2002).

Providers practicing MedFT recognize this power imbalance and act as advocates for their patients. At times this includes giving voice to patient experiences, concerns, wishes, and desires to others who might not be willing or able to hear the patient themselves. Souza (2002), a physician, provided a dramatic example of being a patient advocate in a case in which her patient was intubated and sedated and literally unable to express her wishes and desires about her care. In this instance, the family physician had to become an advocate for the patient and the patient's family. She had a meeting with the family members and actively engaged the primary physician (i.e., the surgeon) in taking a course of action contrary to his wishes and training—something that the patient and the family members were not able to do by themselves. Ultimately through the provider's advocacy, the patient's voice was elevated and contributed to decision making about her own care. Souza wrote:

The surgeon told me it made a great difference having the primary care doctor involved in such an important issue. He felt it allowed him to place more confidence in the family's decision, knowing I had been involved in her care on a con-

tinuing basis and that I agreed with the family. (p. 451)

Lowe (2007), a mental health therapist, advocated for a family whose voice was lost in a morass of multiple care providers, none of whom were coordinating care with each other. Coordinating the care provided by these multiple helpers empowered the family to take an active role in their treatment. From the article:

The Lopez family did not realize that they had a say in determining which, and how many 'helpful' people would be involved in their lives. This conversation helped them develop a sense of agency; a family's active commitment to, and involvement in their own care. (p. 230)

In the role of advocate, providers use their privileged role in the medical system to ensure that the patient's voice is being heard. The primary effect is that patients have greater say in their health care and feel a sense of agency and hope (see Riccelli, 2003).

Expanding the Care Team To Empower the Patient

The Casebooks suggest that a key ingredient to the practice of MedFT is expanding the care team to include the patient, relevant people in the patient's natural social systems (e.g., family members), and other professionals who can help address the various dimensions of the patient's biological, psychological, social, and spiritual experience of disease. Doing so helps to elevate the patient as a collaborator in the care team.

All but two of the authors explicitly noted the benefit of helping patients rally their immediate and extended family members to provide support during times of distress and illness. For example, Clabby and Howarth (2007) wrote that "Dr. Howarth recognized that Henry's family needed to be involved directly

in his care. He held two family meetings" (p. 459). Lowe (2007) explained "... the first step was to try to reinvolve as many of the Lopez" extended family as I could" (p. 230). Harkness and Nofziger (1998) wrote: "With his permission, we discussed plans for contacting his girlfriend and involving her more directly in his care ... His girlfriend would have to be involved since she was his only support outside of the [clinic]" (p. 446).

Unique skills and relationships allowed for these meetings between doctors, patients, patient families, specialists, therapists, and other professionals to be successful. For example, Dr. Howarth "made efforts to simplify Henry's complex treatment plan, and to help Henry and his family understand it" (Clabby & Howarth, 2007, p. 459). In several cases, this social system was able to be engaged fairly easily (Berkley, 2000; Munshower, 2004; Riccelli, 2003; Souza, 2002; Thomasgard et al., 2004). In other cases, there was reluctance on the part of the patient to expand the care team to include family members (Edwards & Turnage, 2003; Harkness & Nofziger, 1998; Lowe, 2007; Prest et al., 1996). In these cases, unique skills were needed to expand the care team to include members of the social system and great effort was exerted to do so.

Munshower (2004) provided an example of expanding the social system to include other families who were also dealing with the same medical condition, diabetes. He did this through psychoeducational family groups. He reported that the increased knowledge that patients and family members gained through participation in the groups changed their relationship with the disease. He also reported that these groups also expanded patient support systems.

I had not expected that the group would prove to be an effective vehicle for addressing individual concerns or for demonstrating that, for all our amassed knowledge, diabetes means different

things to each individual who has it ... I also had not anticipated how strong the influence of the patients would be on each other—stronger even than medical information provided. (p. 499)

As patients' support systems are expanded, new resources become available and patients become empowered.

Expanding the health care team also includes accessing other professionals both within and outside of the health care system who can assist in working in a balanced effort across the multiple systems that make up the patient's experience. For example, in Prest et al. (1996), Dr. Fitzgibbons' patient was a woman, Mary, whose 18-year old son, Randy, was in a car accident that resulted in a serious head injury. Randy became her patient as well. The stress of the interaction between the patients' medical conditions and family relationships resulted in an exacerbation of Mary's symptoms. To work simultaneously within the multiple systems of her patients' experience Dr. Fitzgibbon's:

... requested a family meeting ... [and] invited Ms. Krier [the medical social worker] and [Dr. Prest, the mental health therapist] to attend ... in order to assist with facilitating this process, and to support her as the professional whose job it was to deliver the bad news (regarding Randy's deterioration over time since the accident). (p. 388)

As the health care team is expanded, collaborative relationships among providers communicate that the care team is working to facilitate relief of distress in multiple systems of a patient's experience. This helps patients feel heard and cared for, which empowers patients and increases patient agency. For example, Scott Edwards (a mental health therapist) and Jim Turnage (a physician) described how their pre-existing relationship encouraged patient trust and engagement in treatment. They explained that Mr. Hurley was initially reluc-

tant to be seen by Dr. Edwards, but that this reluctance was overcome by helping him see that these two providers had a strong working relationship. Similar to other cases, relationship capital pertaining to the working relationship among providers can be transferred to the relationship with the patient. These authors go on to explain that the visibility of their working relationship helped the patient see that they cared about him and that his biopsychosocial experience was important in his medical treatment. "Mr. Harley was appreciative of our communication about him, which delivered a message that he was an important patient and that we were working as a team devoted to giving him the best possible care" (Edwards & Turnage, 2003, p. 239).

It stands to reason that expanding the health care team would also include those with expertise in the spiritual systems of patient experience. Some reference was made to issues within the spiritual system in 5 of the 13 Casebooks (Clabby & Howarth, 2007; Knishkowsky & Herman, 1998; Prest et al., 1996; Riccelli, 2003; Souza, 2002). Two Casebooks provided evidence that the treatment team was expanded to include religious or spiritual leaders (Prest et al., 1996; Souza, 2002).

DISCUSSION

This qualitative analysis of the articles in the Medical Family Therapy Casebook series revealed an approach to health care that places the biopsychosocial-spiritual experience of the patient at the center of health care. The heart of this approach is recognizing that the patient's experience is biopsychosocial-spiritual. Those practicing in this way value patient experience in each system (i.e., biological, psychological, social, and spiritual) and seek to structure the care team environment so that they can work within and between each of these systems simultaneously for the patient's well-being. In this way, the approach takes the BPSS

model out of the conceptual and into the applied realm. This, we believe, is the essence of the paradigm shift that is inherent in MedFT and that redefines how medical care and mental health care are practiced and the relationships that exist between the provider and the patient.

Recognizing that the patient's experience of disease is biopsychosocial-spiritual, naturally leads providers to consider how they might intervene, or at least provide support, in each of these systems. This often leads to attempts to expand the care team to include other professionals with expertise in those other systems. In some Casebooks, collaborative relationships among providers existed previous to the relationship with the patient. In others, these relationships were formed in response to a desire to expand the care team to meet patient needs in multiple systems. But, no Casebook presented the relationship among providers as the centerpiece of the approach (see McDaniel et al., 1992b). Rather, these relationships were a by-product of addressing patient experience in multiple systems. In the Casebooks, the collaborative relationship between the provider (or provider team) and the patient was always pre-eminent.

None of this, however, devalues the importance of relationships among providers. The literature emphasizes the importance of these relationships (e.g., Blount, 2003; Katon, 1995; McDaniel et al., 1992b; McDaniel, Campbell, & Seaburn, 1995; Seaburn, Lorenz, Gunn, Gawinski, & Mauksch, 1996), and our results also point to their importance. It may be that the approach is most effective and efficient—and eminently more enjoyable—when it is practiced in a context of pre-existing collaborative relationships with other providers also taking the same approach to health care. This hypothesis is backed by suggestive evidence from research (see Blount, 2003, for a discussion of findings from Katon, 1995) and narrative reports of provider experience (e.g., McDaniel et al., 1992b). Readers may want to look to

other literature for information on the importance of collaborative relationships among providers. Future research about the importance of these relationships to treatment outcomes and patient and provider satisfaction may also be helpful. But, our research suggests that in doing so, one should not lose sight of the centrality of collaborating with patients in their own health care.

We cannot overstate the importance of the relationship between the provider and patient to the approach described in the Casebooks. It is clearly the most important collaborative relationship. Based on the results of this study, we hypothesize that the relationship between the patient and provider (or provider team) is the curative factor of MedFT.

As evidence that this is truly a relationship in every sense of the word, prominent throughout the Casebooks were descriptions of how providers were changed, for the better, by allowing themselves to care *about*, not just *for*, their patients. This has important treatment implications. First, it may increase providers' investment in patient outcomes within each system of functioning. Second, it may increase patients' investment in their care because they see that their providers care about their experience, value their perspective, and listen to their concerns and opinions. Third, it may expand the definition of what can be considered a successful treatment outcome to include improved functioning in psychological, social, and spiritual systems. Additional research may help to elucidate these and other potential impacts.

Casebook authors were self-reflective. It is impossible to know, based on these data, if this characteristic is unique to those who wrote Casebooks or if it is a general characteristic of those who practice MedFT. But, it appears that this intangible characteristic is a necessary ingredient to the practice described in the Casebooks to deal with the tension that exists when caring for patients in the context of a treatment system that values objectivity and the applica-

tion of the biomedical model. The traditional approach appears to deal with this tension by creating a bifurcation between the objective provider part and the subjective human part, allowing the provider part to interact with the patient. As a consequence, both patients and providers may feel dehumanized. But, Casebook authors reflected both on their impact on the patients' multisystemic experience and on their patients' impact on them. It appears that the wholeness of the patient was allowed to interact with the wholeness of the provider for the benefit of both. Allowing themselves to care about patients' experience in multiple systems challenged providers to acknowledge their own humanity and to interact with their patients subjectively. This leads to the development of a caring relationship between provider and patient and facilitates the elevation of the patient to the role of collaborator in the health care team.

Our content analysis suggests that the approach described in the Casebooks is not within the exclusive practice domain of either mental health therapists or medical providers. If we can call what is being described in the Casebooks *Medical Family Therapy*—as the name of the series suggests—we can find nothing in the data to suggest that MedFT is either a psychotherapy or medical treatment. Instead, it appears that MedFT is an approach to health care in which providers, regardless of profession, recognize and respect the patient's multisystemic experience of disease, develop caring relationships with patients, and elevate patients in their role in the health care team. Because of this, it is not the location of the service or the profession of the provider that determines whether or not MedFT is being practiced. Rather, it is the attitude and approach toward the patient and treatment that determines MedFT.

A limitation of this study, however, is that we do not know if the Casebooks reflect the practice of MedFT, as the title of the series suggests. The term *Medical Family Therapy* was

rarely used in the text of the Casebooks, yet this was the title of the series. While it is possible that there has been an evolution in the term *Medical Family Therapy* since the series was initiated, the Casebooks do not reflect an evolution in the practice being described in them. We do not know if this was because the majority of the Casebook authors were medical providers who did not think that this term characterized what they did or if it was for some other reason. It might be helpful, in future studies, to ask medical providers, who practice in this way, if they would consider what they do Medical Family Therapy. Our data suggest that the practice described in the Casebooks is consistent across provider, regardless of discipline, and we could find nothing unique about what mental health providers did, or what medical providers did, except those things that would be expected to be their expertise from their disciplinary training. Medical providers provided medical care and mental health providers provided psychotherapy, but each approached their interactions with patients and with each other similarly. So, while the study illuminates what is at the heart of MedFT, it doesn't necessarily help us distinguish MedFT from other constructs.

Perhaps this could be answered best by knowing what it means to be a *medical family therapist*? We have carefully chosen to avoid using this designation in this report, in part, because it is not used in the Casebooks. Often this title is used to refer to a mental health therapist who is practicing MedFT (e.g., Bischof, Lieser, Taratuta, & Fox, 2003; Grauf-Grounds & Sellers, 2006; Prouty-Lyness, 2003) and some have even argued that MedFT is a profession within the marriage and family therapy discipline (e.g., Linville et al., 2007). It may be that it would be more appropriate to label what is reflected in the Casebooks as "collaborative care." This would allow MedFT to be distinguished as a profession within the disciplinary home of mental health care but it would also raise questions about how the practice of

MedFT differs from the practice of collaborative care.

We recommend that this be a topic of further study and discussion. What these data suggest is that for the mental health therapist, while the practice of MedFT includes psychotherapy, it is more than that. So much of the work of mental health therapists practicing in this way occurs outside of the provider-patient interaction that it would be difficult to see it as a psychotherapy treatment. Likewise, for the medical provider, while the practice of MedFT includes biomedical treatment, it is much more than that. It may be worthwhile for future investigations to explore the role-specific activities of both mental health therapists and medical providers in the practice of MedFT.

Clearly, additional attention must be given to clarifying what MedFT is. This is important so that the term can be used consistently. Operationalizing this term and distinguishing it from others (e.g., collaborative care) is necessary for research on both the practice and the profession to proceed in a way that advances the field for the benefit of patients and providers.

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