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Family Systems Medicine

What's in a Name?

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Abstract

Family Systems Medicine as an interdisciplinary field was coined in 1983 having at its core the biopsychosocial model and a "systems language". This new field is interdisciplinary and includes the contribution of family medicine, family therapy and systems theory. Family Medicine is committed to the care of the "whole" person in the context of the family, rather than the perpetuation of organ and disease based medicine. As a recent discipline, family medicine is in the process of developing an identity for itself. Family therapy is characterized by a focus on holistic and contextual language and like family medicine speaks from a nonreductionist approach providing the necessary tools to address the patient-in-context. Systems thinking allows the family physician to expand from the pure individual biomedical model to the multicausal, interactional approach allowing the physician to shift from the individual to the family as the unity of care.

This paper addresses important issues at the core of family systems medicine: collaboration between the disciplines involved, its contribution to biopsychosocial medicine, differences in focus between family systems medicine, psychosomatic medicine, behavioral medicine and health psychology and finally the evolution of the field .

Key-words: *Family Systems Medicine, Biopsychosocial Medicine*

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INTRODUCTION

Family Systems Medicine, as a field, was coined in 1983 with the publication of the journal "Family Systems Medicine". The new territory was characterized by an alliance between medicine, family therapy and systems thinking (1). The changes in medical and mental health practice, the establishment of family medicine and family therapy, and the epistemological shift from linear to systemic thinking created the conditions that culminated in the end of the schism between the medical and mental health field. Family Systems Medicine as a territory emerged as a functional related unit that emphasized the importance of the systemic paradigm in Medicine or the use of the biopsychosocial model (2). In fact, the history of Family Systems Medicine traces the evolution from an individual to a family approach in health care in the United States.

In order to understand the practice of family systems medicine, it is important to address the disciplines that gave rise to the field. We will start by looking at some of the pertinent issues in the three components of the territory labeled family systems medici-

ne, i.e., modern medicine (in particular family medicine), family therapy, and the application of the systemic paradigm to the medical field. This paper will also address the singular contribution of family systems medicine raising important questions concerning the nature and delineation of the new field's boundaries and will trace its evolution to our days.

FAMILY MEDICINE

The field of Medicine has been going through a continued evolution. The discovery of new technologies in recent years has increased the efficiency in the treatment of several diseases, and has also raised the awareness of the importance of larger levels of organization, i.e., psychological, social, community, etc., that impact and are impacted by "pure" physiologic functions. Such an enlargement of the scope of medicine, also identified as "biopsychosocial medicine" (2), has been seen as an enrichment of the practice of medicine (3, 4, 5). It was in this context that the discipline of Family Medicine was created in the late 60's to counteract the excessive emphasis on disease-based medicine associated with expensive and dehumanizing patterns of health care delivery (1). As a result, Family Medicine has been described as the specialty with the big picture (6).

The founders of the new discipline were committed to the care of the "whole" person in the context of the family, rather than the perpetuation of organ and disease based medicine. As a recent discipline, family medicine is in the process of developing an identity for itself. A large part of the literature on family medicine reflects ambivalence between the biomedical model, espoused by mainstream medicine, and the biopsychosocial model that derives from the social science paradigm (7,8,9,10,11) and reunites patient, physician, family and community. This ambivalence is probably best captured when we take in consideration the scientific nature of family medicine. The hallmark of the scientific paradigm is the experimental method that is best captured in the laboratory environment. However, human experience contains an historical component and, therefore, entities of disease and health become embedded in an interactive set of meanings, rendering the laboratory inappropriate for many of the issues pertinent to family medicine (12). To try to understand this unconventional nature of family medicine, it is necessary to analyze the two paradigms, i.e., biomedical and biopsychosocial, that seem to be at the core of the ambivalence.

Family medicine, as a discipline, has to deal with the difficult task of trying to integrate both a holistic and reductionist models. Stoller and Dozor (1988) (7), argue that the task may be too hard and, as a result, family medicine may be feeling the pressure of becoming more like modern medicine and give up its revolutionary attempt or, become more like family therapy, and expand its vision, by transcending the biomedical model within a contextually grounded practice.

How can research in family medicine, aspiring to be recognized as scientific, integrate the model of clinical epidemiology that characterizes the biomedical model, and also the systemic vision on family process, emphasized by the psychosocial model?

Denner (1988) (8) states that the boundaries between the biomedical and the psychosocial realms are more theoretical than real, and differences between the two are not present in the practice of family medicine. He argues that the physician, who may start by addressing questions specific to symptoms, crosses the "fence" between the two realms, when asks the patient how the disease will impact his/her family life, job, etc.

If indeed the two realms interpenetrate each other, a closer look at the core of the ambivalence that prevails in the nature of family medicine, may then be traced back to

the old debate between the split body/mind. Descartes in the seventeen century, in an attempt to save the existence of the soul, postulated that mind and body were two distinct entities. Cartesian matter was subjected to the law of physics (deterministic causation) while the immaterial soul was completely free. In the way Descartes formulated his theory, any contact between mind and body was logically impossible. Mind and body were seen as two planes of being that had no contact with each other, except through the intercession of divinity. This dualism has pervaded the scientific community since then. Dimou (1987) (13) comments that apparently has more lives than cats. Although the philosophers that followed Descartes i.e., Spinoza, Putnam, and Russell have tried to solve the parallelism between body and mind, the truth is, no one satisfactory has been able to settle the argument (14). In this century, family systems medicine seems to be answering that call by trying to live up to its systemic beliefs, and give up the either/or philosophy that is at the core of the dualism between the biomedical and psychosocial realms.

The importance of this old debate has intrinsic political implications. The ambivalence facing family medicine may simply have to do with turf and control's issues (8). The biomedical model is culturally dominant and family systems medicine is viewed as subversive. In order to be "accepted" in the scientific field, family medicine research tends to focus on the biomedical aspects of disease and on the positivist model.

Society has invested physicians with great power and it is understandable why family medicine, in an attempt to keep its higher status and control, has looked upon systems theory with ambivalence. On one hand, the systemic paradigm provides a holistic view of illness, and allows the physician to treat it in the context of interpersonal processes. On the other, a more reductionist perspective feels very appealing to physicians who are required to be knowledgeable in so many different areas.

In order for family medicine to meet its own challenge, the key seems to be able to be as holistic as possible and as reductionist as necessary. The family physician has to be an expert in moving back and forth between levels of scientific explanation (15,12).

Another pertinent issue in Family Medicine centers on the meaning of the word "family" in its nomenclature. Although the American Academy of Family Practice (1980) (16) has stated that the family is the unity of care in family practice, there has been some ambivalence about the meaning of the term in the practice of family medicine. The debate seems to focus on whether the family can indeed be the unity of care.

Carmichel (1983) (17) objects to a view of "family" as an entity that literally replaces the individual. Schwenk and Huges (1983), (18) also criticize the possibility of viewing the family as a patient. Schmidt (1987) (19) states his conviction that "family physicians provide medical care for individual patients in the context of their families". In his view, "family" refers to a set of variables that have an impact on health. Family is one more epidemiological vector that plays a role in the onset and treatment of specific illness. Therefore, he believes that the physician should be concerned with those aspects of family functioning that are linked to disease or health.

Denner (1988) (8) argues that Schmidt is still embracing the biomedical model when he is concerned with what family conditions produce which mental states. In the context used by Schmidt, "family" is equivalent to the psychosocial aspects of disease that are added to the medical interview, but there seems to be no interactive phenomenon that influences the diagnosis and treatment. Ransom (1987a) (20) argues that adding a set of variables to the old biomedical model is not

practicing family systems medicine. He perceives "family" not as a set of variables influencing health care, but as an integration of family life with family medicine. He believes that "family" has more to do with how people and primary groups create the conditions for each other's co-evolution, and how physicians can make use of this fact.

In Ransom's view, "family" is more a "domain of meaning" that places the illness in the context of the patient's relationship to others. The "family" is therefore defined as a type of relationship rather than an entity subjected to treatment or correction. Ransom argues that treating the individual in the context of the family, requires that the family physician understands the biological processes of the organism and the social processes of primary groups. How far up or down, from cells to culture, the physician's focus depends on practical concerns and immediate relevance (21).

If family medicine focuses on patients and their contexts, technically speaking, "family" or the context, becomes the patient (22). In 1993, at the 25th anniversary conference of the Society of Teachers of Family Medicine, Ransom summarized the meaning of the focus on "family", in Family Medicine, by including two more meanings besides "family as context": "family as history" and "family as access to meaning". "Family as history" differs from "family as context", in the sense that instead of referring to the family in which the patient lives, the concern is with the family that "lives in" the patient. Therefore, the meaning of "family" is also grasped through family of origin work and attachment theory that can inform the doctor/patient relationship and the plan of care, in terms of transmission of family rules or patterns of behavior. The third meaning of family, "family as access to meaning" refers to the contribution of the patient's context and history as providing access to understand the patient's world. As such, it draws on communication between patient and family and patient and physician, and emphasizes the symbolic interaction perspective in which reality is constructed between doctor/patient encounter and patient and family.

This interest for the patient in context, with an history and an emphasis on the search for meaning is at the core of the field of Family Systems Medicine.

The next component to be addressed, within the territory of Family Systems Medicine, is the contribution of family therapy.

FAMILY THERAPY

Family therapy has taken the systemic paradigm farther than most other disciplines (23). Therefore it is no surprise that family systems medicine uses family therapy as a technology or a vehicle to address the psychosocial aspects of medicine. This new definition of medicine, as a biopsychosocial entity, has required family medicine to learn a new language, i.e., a language of context and contingency (24). Family therapy is characterized by a focus on holistic and contextual language and, in that regard, Bloch (1983a) (1) its role within family medicine can be compared to what family therapy has been to psychiatry. Both disciplines speak from nonreductionist approaches and, in this sense, have been described as a reform movement (25, 26). In terms of the field of family systems medicine, the pertinent question becomes: how much do physicians benefit from a collaboration with family therapy, and how much do family therapist benefit from a collaboration with family physicians?

As mentioned before, family therapy can provide family medicine with the tools necessary to address the patient-in-context. Family therapy can provide family medicine with the techniques to change patterns of human behavior and to improve the quality of life of those involved (27). By the same token, family medicine can provide family therapy a

working dialogue with another discipline that family therapy lacks. In fact, Steinglass (1993) (28) Shields and colaborators (1994) (29) argue that family therapy, in an attempt to institutionalize itself, has focused on its unique contribution to the mental health field, and in the process, has isolated itself in the mental health field running the risk of being marginalized. Family medicine, being a pragmatic discipline that places high regard on concrete reality, may provide family therapy with a fresh new perspective, a development of its technological base and a varied clinical practice. The field of family therapy has recently gone through an "epistemological shift". Probably one of the biggest contributions of family therapy, to the general field of Family Systems Medicine, is the idea that one cannot observe or describe without modifying and being modified by the subject of the observation or description (30). This philosophy of knowledge has been called Constructivism (31, 32). In another words, individuals do not discover "reality" rather, they invent it (33). Reality is evident through the constructed meanings that shape and organize experience. Therefore, reality is not objectively described but is agreed through social interaction. With this shift, from the cybernetics of the observed systems to the cybernetics of the observing systems, the distinction between observer and observed has been erased (30). As a result, therapy becomes a collaborative and cooperative endeavor between therapist and clients.

When applied to the medical field, the constructivist epistemology in family therapy, points out that one of the most powerful interventions available to the physician, is the physician itself. Unfortunately, as Balint (1972) (34) has noted, physicians poorly understand dosages, therapeutic limits and side effects of such an intervention.

Abell (1986) (12) argues that another consequence of this epistemological shift is the importance of eliciting the patient's perception of the problem. The cooperation between physician and patient is crucial in the process of diagnosis and treatment. The separation of the doctor into an objective and a subjective self becomes illusory (35). A search on the part of the physician, to look for something clinically objective is seen as a limitation to the healing process (36).

Another contribution of Family Therapy to the medical field is the introduction of emotions in the doctor-patient relationship. Since family therapy is seen as a collaborative effort between therapist and client, by the same token, disagreement and conflict between doctor and patient may be seen not as an enemy, but as an opportunity for change and growth in the healing process (36). In this view, the notion of patients' compliance, for example, takes another meaning.

Family therapy also contributes to the medical field by reducing medical costs (37). This situation derives, directly, from the change in patient-doctor relationship and is related with health care delivery. The relationship between physician and patient may provide many of the answers that expensive medical tests cannot (36). This idea of cost efficiency is considered one of the assets of the collaboration between family physicians and family therapists and is at the core of the field of Family Systems Medicine.

Last but not least, Systems Theory provides the common language to both family medicine and family therapy and serves as a link between the two disciplines.

SYSTEMS THEORY

The systems perspective in science has been developing for the past hundred years. Systems theory (38) offers the medical context, the importance of including other levels of analysis beyond the individual and the understanding of how symptoms, illness and interpersonal relationships are embedded

in a contextual system.

Systems thinking is the tool that allows the family physician to expand from the pure individual biomedical model to the multicausal, interactional approach epitomized in the practice of biopsychosocial medicine (39). The systems approach allows the physician to shift from the individual to the family as the unity of care.

In medical practice, not all presenting problems can be adequately explained in pathophysiological terms. The importance of the relationship between family dynamics and individual illness has been documented in the literature (40, 41, 42, 43, 44, 45). The physician who is oblivious to this influence may inadequately diagnosed or create a treatment plan that, due to a lack of understanding, is likely to be less effective (46).

Systems theory also provides the physician with a basis to understand patient's response to symptoms by identifying behaviors, such as roles, rules, rituals and routines in the patient's life incorporating them in the patient's diagnosis and treatment (44). Based on systems theory, Barnhill (1979) (47) and Epstein and collaborators (1978) (48) have described family organization in healthy and unhealthy family systems. Minuchin (1978) (49) as well, has written extensively of families that maintain psychosomatic symptoms.

When addressing systems theory, it is necessary to keep in mind that epistemologically speaking, there is an observer and a reality that can be observed. This paradigm appeals to physicians because concrete problems are easily assessed and treated and is the basis for the family assessments instruments: McMaster model (48); the Practice model (50), and the Apgar model (51) that are often included in family medicine books.

Let's now focus on a series of reflections concerning the nature of the field. Dymn (1983) (52) describes Family Systems Medicine as a network field drawing its technological base from apparently different practices of knowledge: medicine, nursing, social work, family therapy, public health, rehabilitation counseling and many others. If that is so, *What makes the field of Family Systems Medicine unique to justify a new nomenclature*? Or in another words, what does family systems medicine provide that psychosomatic medicine, behavioral medicine or health psychology do not?

Schwartz and Weiss's (1978) (53) define Behavioral Medicine, as an "interdisciplinary field concerned with the development and integration of behavioral and biomedical science, knowledge and techniques relevant to health and illness and the application of this knowledge and these techniques to prevention, diagnosis, treatment and rehabilitation" (pg.250). Pomerlau and Brady, (1979) (54) include in their definition of behavioral medicine, techniques of behavior therapy and behavior modification that serve as tools of evaluation, prevention, management, and treatment of physical disease or physiological definition. Jeffery (1989) (55) describes the emphasis of behavioral medicine on the alteration of maladaptive behavior patterns that constitute unhealthy lifestyle. All the definitions found in the literature stress the interdisciplinary of behavioral medicine and focus on the individual behavior associated with medical disorders.

Psychosomatic Medicine, on the other hand, focuses on etiology and pathogenesis of physical disease, rather than intervention (53, 56). The field is heavily influenced by psychodynamic theory. If there is not much consensus within the field of Behavioral Medicine regarding its definition, within the field of Psychosomatic Medicine, the disagreement exists even at the nomenclature level. Webb (1988) (57) states that the field is also referred as "liaison psychiatry", "consultation psychiatry" or "psychiatric medicine". For reasons that go beyond the focus of this paper, the interest in psychosomatic medicine started to decline and by 1970, the field

was in need of a more scientific base and tools to treat and prevent disease (58). Behavioral Psychology filled many of these gaps when it became a big component of Behavioral Medicine.

In 1978, the American Psychological Association created the division of Health Psychology. Matarazzo (1982) (59) the first president, defined health psychology as the aggregate of the specific educational, scientific, and professional contributions of psychology to 1) promotion and maintenance of health; 2) prevention and treatment of illness; 3) etiologic factors of disease and 4) the improvement of the health care system. Health Psychology as a result has, as its core, the biopsychosocial model.

Family Systems Medicine, on the other hand, is concerned with the family as the most important context to understand the patient's illness (60). As Mauksch (2002) (61) has said, family systems medicine´s goal is interstitial healthcare, i.e., takes in consideration the space between diseases, patients, family members, providers, researchers and health policy bridging all these spaces.

The goals of these four fields are very similar although they all take, in our view, different emphasis and varying degrees of interdisciplinary. Psychosomatic medicine continues to be very close to medicine, behavioral medicine and health psychology are very close to psychology and family systems medicine to family therapy and family medicine.

Table 1 summarizes the different focus of all four fields according to our perspective.

If Family Systems Medicine's focus is unique, does it represent a new paradigm?

The biopsychosocial model introduced by Engel (1977) (2) represented a shift in the way medical care was conceptualized. The traditional idea that the patient is his/her disease was transcended and the limitations

Table 1

Psychosomatic Medicine	**Behavioral Medicine**	**Health Psychology**	**Family Systems Medicine**
Etiology and pathogenesis of disease — the relationship between psychological and physiological	Mind-body issues centered on the promotion of health in the individual	Promotion and maintenance of health; prevention and treatment of illness; causes and detection of illness and improvement of the health care systems and health policy	Family as the most important context within which illness occurs
"Intrapsychic level": emphasis on the biological systems	*"Individual level": emphasis on the psychological systems*	*"Systems level": emphasis on the individual level, health care system and policy*	*"Systems level": emphasis on family level and health care delivery*

of such conceptualization acknowledged. Family Systems Medicine personifies a new model that deals with the patient as a person with a family. Ransom (1992) (62) captures this idea better when he states that "family systems medicine employs a new language in which to converse about patients and their care" (pg. 307). Following Kuhn's (1962) (63) definition of a paradigm shift or "scientific revolution", it makes sense to accept that the introduction of the biopsychosocial model in medicine created a new language in the medical field, one of uncertainty and context that went beyond what was previously accepted, i. e., the biomedical model. In this regard, Family Systems Medicine constitutes a paradigm shift in the way traditional medical care was delivered by depicting patients not as simple biological organisms that physicians work upon, but as active units in the healing process.

If the biopsychosocial model is at the core of Family Systems Medicine (64) conferring it a status of a "new paradigm", it is nonetheless a confusing "new paradigm". On one hand, Family Systems Medicine tries to be "Constructivist" especially when describes the doctor-patient relationship, when emphasizes the importance of the patient's perception of illness, when welcomes a collaborative relationship between patient and physician, in the diagnosis and treatment plan, and when perceives doctor-patient encounters as the base for the construction of reality. On the other hand, by making use of General Systems Theory, assumes that symptoms are sometimes necessary and therefore serve certain functions within the family. If family therapists carry too zealously the view that symptoms are purposive and may be necessary in the context of medicine, it may risk any possible collaboration between family therapists and family physicians (27). Taken to the extreme this would mean that therapists would relate to "ghosts" instead of real people and therefore the potential within the field of Family Systems Medicine for an adversarial role between the components of family therapy and family medicine would be widely open. Such opposition would destroy any base for the practice of medical family therapy.

Unfortunately, how much of General Systems Theory should therapists make use when they collaborate with family physicians has not been dosaged yet.

Another important issue to be considered is collaboration: *Can there be collaboration between Family Medicine and Family Therapy* if historically and ideologically speaking the "medical discourse" has been privileged over the "therapeutic discourse"? Can there be an egalitarian partnership?

Antonovosky (1992) (65) describes the relationships between physicians and therapists as the former keeping a foot in the traditional biomedical model while being open to the contribution of the psychosocial components of the biopsychosocial model. He appropriately has called this process "watering down the paradigm" so that it becomes more palatable for physicians. Does this mean that, in order to collaborate with physicians, medical family therapists need to compromise the premises of biopsychosocial medicine?

But, if on one hand, Family Medicine may still debate its allegiance to the biomedical model, it also seems to show a true genuine affection for the use of constructivist/narrative practice (66, 67, 68, 69, 70) that epitomizes collaboration between physician and patient. But once again, such a tendency taken to heart would jeopardize the traditional diagnose of "psychiatric problems" as defined by DSM-IV. In the light of a constructivist epistemology, such problems, as have been described before (71), become collective illusions rather than biological or social units that can be cured. On the long run, the only possible answer to this question may be provided by family systems research suppor-

ting the effectiveness of the biopsychosocial model. That in itself, will grant credibility to the "therapeutic discourse" placing it on an equal partnership with the "medical discourse".

Other important questions that remain to be answer by Family Systems Medicine are: How useful are the DSM (IV) codes in primary care? When different professionals talk about a depressed patient do they mean the same thing? How can confidentiality be ensured when so many professionals are involved? What type of training should family physicians receive to help them deal with the psychosocial aspects of disease? What training should family therapists and other psychosocial providers receive in order to be prepared to deal with the biomedical aspects of illnesses?

For now, the territory of Family Systems Medicine raises questions for which has not been able to provide full answers.

EVOLUTION OF FAMILY SYSTEMS MEDICINE

In 1993, an informal group of 15 colleagues from the fields of family medicine and family therapy came together to discuss the possibility of developing a new paradigm for health care. Don Block, editor of Family Systems Medicine convened the meeting. The compartmentalized delivery system with several specialties and referrals was cumbersome, cost-driven and was not able to respond to the varying needs of disadvantaged populations. This group task question was: *What should a modern health care delivery system look like at the clinical level?* As a result of this meeting, " a decision was taken to form an organization that would serve as a network for those interested in this new paradigm, dubbed the collaborative family health care model" (72).

The "Collaborative Family Health Care Association" is now a mature organization having sponsored four biennial conferences and stands for an ecosystemic perspective that puts a great premium on integration of multiple health care disciplines involved in the care of the patient and views the patient and provider as co-constructors of the health care event. According to the authors, the three key elements in this paradigm are:

1) the use of teams that include psychosocial, biomedical and nursing providers working in concert;
2) giving equal conceptual importance to the bio, psycho and social aspects of treatment (biopsychosocial model);
3) including the family as crucial element in patients treatment.

In 1996, "Family Systems Medicine" changed editorship from Don Bloch to Susan McDaniel and Thomas Campbell who, at that time, changed the journal title to "Family, Systems and Health in an attempt to broaden the health care constituencies that contribute to the journal" (73) and, in our view, reinforcing the interdisciplinary nature of the field.

Since the creation of "Family Health Care Association", new methods that include policy makers and create dialogue between biomedical, psychosocial and nursing disciplines have not stopped. More and more collaborative family health care is taking place in several communities in U.S. and England (74), becoming a reality showing the importance of interstitial practice.

In Portugal, family systems medicine is giving their first steps with the creation, in 1996, of " Group of Family Studies" (GEF) that include family physicians, therapists, nurses and other psychosocial providers that use a systemic approach in their practice. The association was created due to the initiative of a group of family physicians. In 1997, the group edits the first issue of a journal called "Familiarmente" that since then has become a network between the members publishing articles and news on famili-

es with the purpose of teaching "how to think family and how to use the systems approach" (75). In Portugal, some health care centers and a few hospitals employ, on their staff, psychologists. However, there is a big asymmetry within the country and almost all psychologists work in big cities. Very few family therapists work in these settings but some psychologists do have a family therapy background.

As the population ages in the 21st century and more chronic diseases develop, more ethical decisions concerning genetics, new technology and life style will become a concern. The great contribution of family systems medicine is its change agent that allows the development of compelling goals and strategies to effect meaningful change in the health care delivery and in patient advocacy.

Resumo

A Medicina familiar Sistémica como uma área interdisciplinar foi criada em 1983, tendo como base o modelo biopsicossocial e uma "linguagem sistémica". Esta nova área é interdisciplinar e inclui a contribuição da medicina familiar, terapia familiar e teoria de sistemas.

A medicina familiar dedica-se ao cuidar da pessoa "como um todo" no contexto da família e não na perpetuação duma medicina centrada nos órgãos e doença. Como disciplina ainda recente, a medicina familiar está no processo de desenvolver uma identidade para si mesma. A terapia familiar caracteriza-se por um foco numa linguagem holística e contextual e, tal como a medicina familiar, possui uma abordagem não reduccionista fornecendo as ferramentas necessárias para lidar com o paciente-em-contexto. O pensamento sistémico permite ao médico de família expandir do modelo puramente biomédico para uma abordagem multicausal, interacional, permitindo-lhe passar do indivíduo para a família como unidade de cuidados. Este artigo aborda questões fundamentais centrais da medicina familiar sistémica: colaboração entre as disciplinas envolvidas, contribuição para a medicina biopsicossocial, diferenças em termos de foco entre a medicina familiar sistémica, a medicina psicossomática, a medicina comportamental e a psicologia da saúde bem como a evolução desta nova área de intervenção.

***Palavras-chave**: Medicina Familiar Sistémica, Medicina Biopsicossocial*

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