Original Article

The Perfect Marriage: Solution-Focused Therapy and Motivational Interviewing in Medical Family Therapy

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Abstract

Medical family therapy has many potential uses in behavioral medicine and primary care. Current research was reviewed to determine the most advantageous way to apply solution-focused therapy and motivational interviewing as a perfect marriage in medical family therapy. An extensive literature review was done in the following databases for medical family therapy: Proquest, EBSCO, Medline, and PsychInfo. The search resulted in 86 relevant articles, of which 46 of the most recent were selected for review. Medical family therapy lacks current research that supports solution-focused therapy or motivational interviewing. However, evidence supports the use of solution-focused therapy as a brief format, as well as the closely related intervention, motivational interviewing. While medical family therapy presents many hopeful possibilities in the fields of behavioral medicine, psychology, and marriage and family therapy, little evidence currently exists for the most effective implementation. This review found evidence supporting solution-focused therapy and motivational interviewing as the perfect marriage of the collaborative team approaches for the future implementation and use of specific interventions in medical family therapy.

Keywords: Brief therapy, collaboration, integrated healthcare, motivational interviewing, medical family therapy, solution-focused therapy, shared decision-making

Introduction

Medical family therapy is defined by McDaniel, Hepworth, and Doherty (1992)[1] as the "…biopsychosocial treatment of families who are dealing with medical problems. As we conceptualize it, medical family therapy works from a biopsychosocial systems model and actively encourages collaboration with other healthcare professionals." (p. 2) Medical family therapy, a subspecialty of marriage and family therapy, is a quickly rising phenomenon recognized by the fields of psychology, counseling, and behavioral medicine.[2,3] The current evidence suggests there are numerous potential benefits to including medical family therapy across settings for a diverse presentation of disorders and health issues.[2-4]

Solution-focused therapy (SFT) is a directive, brief therapeutic approach focused upon building on patient strengths and established coping skills, applying them to future and present goals around the presenting issues.[5] Motivational interviewing (MI) is a therapeutic technique that is directive-based and nonjudgmental and uses ambivalence of the patient to further explore potential barriers, how to address these barriers, and increase intrinsic motivation to support self-efficacy, and eventually lead to change in the patient.[6] Evidence exists for MI effectiveness within medical settings[7-11] and solution-focused effectiveness in the treatment of families.[11,12] Due to the overlap and similarities between the two interventions and the successful utilization of both of them in medical settings and with families, a "marriage" or combination of the two is proposed as essential to the practice of medical family therapy. The field of nursing has demonstrated success using interventions drawn from SFT and MI in patient care.[13-15]

This review begins with the description of both SFT and MI highlighting their similarities. Next, the authors present a review of the medical family therapy and its fit with SFT and MI, specifically looking at their efficacy in medical settings. A review of the literature explored the following databases for medical family therapy: Proquest, EBSCO, Medline, and PsychInfo. The search term "medical family therapy" was used with the following secondary terms: "healthcare," "collaborative care,"

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"integrated care," and "palliative care," which were implemented using the "and" function. In addition, the search included supporting articles for MI and SFT in family-centered medical conditions (using the corresponding therapeutic title with "and" with "medical family therapy"). Conditions commonly identified in medical family therapy settings utilizing SFT and MI were reviewed. This review will conclude with clinical implications for successful implementation of solution-focused and MI strategies within medical family therapy in a medical setting.

Solution Focused Therapy

According to de Shazer *et al.* (2007)[5], SFT contains several defining elements, including patients as the expert of their situations, solution talk versus problem talk, focus on exceptions to the problem, and the belief that families are resilient and resourceful. SFT believes that conflict occurs for everyone and the key to adaptive functioning is how one falls into one of the three categories: Customers with clear complaints who are ready for action, complainants who blame others, need redirection, and may become customers, and visitors who are not yet ready for treatment and it is actually best to wait.[16] The goal of SFT is to create a safe environment where families respond and cope with conflicts. Treatment focuses on the solution rather than the problem, moving patients forward toward their treatment goals as assessed by the miracle question. The stages of SFT include assessment, implementation of therapeutic techniques, and amplification, measuring progress and addressing barriers while using the patient's strengths as the foundation for progress.[17]

The assessment stage includes the miracle question, assessing the family member's vision of what the "solution" would look like allowing the therapist to better understand his or her motivation to change, discuss problem clarification, and identify the potential strengths possessed by the patient.[5] SFT focuses on the past only to determine the patient's strengths as illustrated in exceptions. The therapeutic techniques implemented are brief and fall into two categories: Development of well-focused goals and generating solutions based upon exceptions.[5] Developing well-focused goals include identification of a problem description that can lead to setting measurable goals using the patient's language and exploring what the patient has previously tried.[17] Once the problem is defined and realistic, measurable goals for solutions are established and exceptions to the problem are used as strengths from which to build. The remaining sessions of SFT focus upon identification, amplification, and measurement of progress of solutions developed through the previously mentioned processes.

Motivational Interviewing

Many of the techniques and premises of SFT are similar to the work of Miller and Rollnick (2002)[18] in MI. The premise of MI is that resistance is not strong-armed, but addressed and utilized through collaboration, evocation, and respect for the patient's autonomy.[18] MI implements clinician directness toward enhancing intrinsic motivation by exploring patient's values, and assessing current ways for health behaviors to change to be more consistent with his or her values. Similar to SFT, MI includes the exploration of what has or is working and a rating of symptoms and confidence in their ability to address the symptoms. Similar to scaling questions in SFT, MI contains an element that implements readiness to change measurement where clinicians ask patients how confident and ready they are to change, asking the patient to rate his or her response on a scale of 1 to 10.[10] The outcome dictates the direction the therapist will go, which appears to be a brief and effective manner of addressing resistance and identifying ways patients and families may be struggling as well as motivating change toward treatment goals.[10,19]

MI implements similar techniques as those used in SFT, differing primarily by the capitalization of ambivalence in the patient and the emphasis on increased intrinsic motivation.[18] Miller and Rollnick (2002)[18] emphasize on the importance of leading the patients to their own reasons and identified benefits of change. By leading the patient to advocate for his or her own change, intrinsic motivation is enhanced, leading to amelioration of barriers to beginning or sustaining change. The spirit of MI includes collaboration, evocation, and autonomy. Collaboration is the focus of the shared decision-making, empowering the patient's involvement and voice in the therapeutic process. Evocation focuses on clinicians implementing attending skills, such as open-ended questions, affirmations, reflections, and summarizations, to draw on the patient's values, goals, and attitudes. Supporting patient autonomy effectively encourages self-efficacy throughout the therapeutic process for the patient, and in this case, his or her families, through supporting patient decision-making and avoiding challenging or encouraging resistance in the patient. MI approaches resistance uniquely, generally seen as an indicator that the provider should use a different approach, with the goal of leading the patient to argue for change and develop confidence to change.

Current research also indicates the effectiveness of multidisciplinary training and implementation of MI across settings for various mental health and medical occurrences.[9,10] A recent meta-analysis described rating outcomes of effectiveness for different providers and practitioners (i.e. nurses, BA students, MA/PhD level practitioners), along with group, individual, manualized versus non-manualized, and various settings for implementation of MI techniques.[9] The meta-analysis focused upon eight broad health outcomes, with psychological well-being and treatment engagement of depressed patients a focus of their analysis. Moderators for the analysis included comparison group, patient distress, MI type (i.e. "pure" MI or motivational enhancement therapy [MET]), role of MI in patient treatment (additive, adjunct, primary), who delivered MI, and delivery mode.[9]

Overall utility for MI in treating emotional and psychological well-being resulted in increased treatment motivation and engagement in patients at significant ($g = 0.19$, $P < 0.001$) and

moderate ($g = 0.21$, $P < 0.001$) levels of distress.[9] MI ($g = 0.43$, $P = 0.04$) was also an effective prelude to therapy. Last, and perhaps the most interesting, MI did not demonstrate significant treatment effects in 13 studies comparing treatment administrators composed of bachelor's level ($g = 0.19$, $P = 0.36$), nurse ($g = 0.1$, $P = 0.35$), or student ($g = 0.23$, $P = 0.15$). But significant improvements were observed from doctoral and master's level (aggregate) practitioners with MI ($g = 0.39$, $P < 0.001$).[9] Based upon these findings, medical family therapists' education attainment is well suited to prepare them to be the primary individuals to implement MI when working with families in medical settings.

The similarities in interventions and objectives between SFT and MI strategies have been proven to fit well within the medical setting.[9,10] As such, medical family therapists who are trained in the biopsychosocial-spiritual systems model, including SFT and MI can promote collaboration for the benefit of their patients.[1] Prior to describing MI and SFT effectiveness in working with families in medical settings, discussing what exactly medical family therapy is seems essential to promote an in-depth understanding of the main points of this text.

Medical Family Therapy

Focus and attention on medical family therapy has increased as a result of managed care and the desire and need for integration of care and services in medical settings. Additionally, the recognition of the importance of the patient's family system as essential to best medical outcomes has promoted medical family therapy as a profession. This growth reflects the necessity of a systemic approach to healthcare. Research supports the effective treatment of these conditions such as chronic pain, eating disorders, and depression by family-based interventions.[20-24] The effectiveness of these practitioners and interventions demonstrates an enormous need in the current healthcare system and supports the continued integration of medical care with mental health interventions such as SFT and MI. Medical family therapists are the answer to this need.

Patients experience multiple interworking systems, which include biological, psychological, social, and spiritual components (BPSS), all of which have the potential to influence the family system, and provide essential sources of coping and support.[1,21,25,26] Bischoff *et al.* (2011)[2] highlighted three areas of family-centered care needs; "recognition and respect of a patient's multisystemic experience of a disease, developing a caring relationship with the patient, and elevating the patient in their role of the healthcare team" (p. 186-7). These needs corroborate with the fit of SFT[7,27] and MI[10] for treating patients in medical family therapy settings. SFT allows for autonomy of the patient and his or her family, as well as providing a family-centered approach that focuses on reaching solutions rather than engaging in problem-saturated talk. Medical family therapist can work collaboratively and in conjunction with the medical providers and with patients in medical settings promoting adherence to treatment recommendations. SFT and MI are excellent interventions to elevate the patients in their role of the healthcare team. MI specifically achieves this by focusing on autonomy, increasing intrinsic motivation, and enhancing patient self-efficacy.[10,13] Autonomy is bolstered in healthcare settings by including the patients and their families in decision-making processes, delivering information with tact and care, and asking the patient permission to discuss certain issues. This leads to empowerment of the patients and their family, enhanced rapport and validation of their status as valued individuals in the process. Rather than speaking *at* them, the clinician is speaking *with* them and expressing empathy for the patients.[10]

MI in healthcare settings is present-focused, leading to a directive style that empowers and validates the patients and their families, capitalizing on strengths and change talk (i.e. identifying statements indicating steps taken and desires to change), and providing empathetic responses to new-found abilities and strengths within the context of their therapy.[6,10] SFT focuses on capitalizing on these patient strengths by involving the patients and their families in the decision-making process through exploring and advocating for patient goals and aspirations within the therapeutic process.[5] SFT is present-focused; validating the current presence of the patients and their families, and building upon their strengths and successes, ultimately leading them to feel more involved in the shared decision-making process.[5,19] Empathy is an important aspect of both MI and SFT that is enhanced by the present focus that builds upon strengths and goals of the patient leading to fully involved and autonomous patients participating in the healthcare team.

Clinical Implications

Some examples of current implementation of SFT and MI include the field of nursing's implementation of SFT as a modality of care into diabetes, cancer, and other common and chronic presenting problems in medical settings. SFT contains a degree of overlap in principles and desired outcomes for treatment as demonstrated by current implementation with other medical providers (i.e. nurses, nurse practitioners, behavioral health consultants, and other mental health clinicians in healthcare settings). Nurses, for example, aim to improve trust, promote positive patient orientations and perceived control in managing their illness, emphasize and bolster patient strengths, and develop health-directed goals. As previously noted, research supports SFT principles previously used in in-patient settings as resulting in less behavioral conflicts, decreased length of stay, increased levels of collaboration between nursing and other medical staff, and decreased readmission rates.[20,28,29] MI has also been successfully used by nurses for improving treatment adherence and self-monitoring when necessary.[14] Furthermore, medical family therapists receive extensive training in counseling and de-escalation techniques and have demonstrated lower dropout rates and recidivism, and were more cost-effective than medical doctors, nurses, or psychologists in providing family interventions.[30]

MI is useful in healthcare settings in establishing brief, effective rapport and trust with patients, and can be a critical aspect of the stages needed for nurses to establish a present, solution-focused approach to patient care. Implementing MI techniques and interventions with previously developed SFT nursing models will only amplify the patient- and solution-focused approach. Due to the past success, buy-in, and familiarity with the SFT by nurses, this type of therapy may lend itself well to medical family therapists making the collaborative transition easier to accomplish between medical family therapists and traditional members of the medical team. Another important clinical implication, as suggested by Anderson, Huff, and Hodgson (2008),[20] is medical family therapists are dedicated to two "metagoals" consistent with those of medical ethics and practices: Agency (commitment to and involvement in one's own care) and communion (emotional bonds, which may be adversely effected by chronic and long-term illness). These underlying premises of care and goals lend themselves well to a collaborative team, and their utilization can bolster professional integration of services based upon delivery models and general aims of service. Currently, a shortage in the evidence for an SFT and MI blended approach to treating families in a medical family therapy setting exists in the literature reviewed, indicating it to be a recommended area for future research and programmatic development based upon the proven utility and success of both of these interventions for better medical outcomes using medical family therapy.

Conclusions

The potential for increased acceptance and amplified reimbursement abilities may be possible through the implementation of MI and SFT by medical family therapists. In this review, the authors have highlighted the literature utilizing the components of MI and SFT that have been proven to be effective in marriage and family therapy, medical settings, and by medical professionals. Future research efforts should focus on establishing cost-effectiveness and the ability for SFT and MI to fit into the already established and fiscally supported millieu channels in medical settings. Results of these findings can be applied to future developments in medical family therapy training programs. While only a handful of medical family therapy programs currently exist in the United States, the evidence supports it to be an area of need and an under-utilized service by the medical and mental health systems.

This review found evidence supporting SFT and MI as the perfect marriage of the collaborative approach for the future implementation and use of specific interventions in medical family therapy. SFT provides a wide range of coping skills and behaviors to assist families with the maladaptive nature of many of the potential presenting problems that can arise in a medical setting. MI is an effective skill used by therapists and medical professionals to evoke motivation on the part of the patient and his or her family. As with many other emerging collaborative endeavors, being able to motivate and educate policy makers, physicians, mental health professionals, and the public of the current need for medical family therapy is essential. If consistent with previous positive evidence for SFT, marriage and family therapy interventions, and MI, future clinical trials may demonstrate the ability to increase clinical effectiveness and comprehensive, family-centered care for patients resulting in better medical outcomes consistent with the BPSS approach of medical family therapy.[1]

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