THE CLINICAL ROLE OF THE MARITAL & FAMILY THERAPIST AS PERCEIVED BY PRIMARY CARE AND NON-PRIMARY CARE PHYSICIANS

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PREFACE

"O wad some Pow'r the giftie gie us,
to see oursels as others see us!"

By: Robert Burns

From: "To A Louse"

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And finally, to my wife Gretchen, who always understood, and to my daughters, Rachel and Leah, who learned to do the

same, I want to say, "It's done!", and reclaim as a family those invaluable hours we each had to temporarily sacrifice for this deeply gratifying educational experience.

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CHAPTER I

INTRODUCTION

It has long been recognized that physicians are frequently the first professionals whose help is sought by people in emotional distress (Korkes, 1957; Alexander & French, 1964). A substantial proportion of all office visits to internists, general practitioners, and other primary care physicians are for essentially psychogenic problems (Locke & Gardner, 1969; Walton, 1970). Silverman (1968), investigating admissions to the medical and surgical wards of a general hospital, found that emotional distress was often disguised by physical symptoms. He cautioned against the disregard of emotional factors even in cases where organic disease was the primary problem: "Patients in whom a diagnosis of physical disease is made have not only the emotional problems which existed prior to the onset of illness, but also psychological reactions secondarily related to the disease itself. These complicate the course of the illness." (p. 422).

Whether the physician decides to treat the psychogenic conflict, ignore it, or refer the patient for specialized help seems largely to depend upon the physician's preparation for, and perception of, his or her role in treating the

emotional and psychiatric problems of patients (Hull, 1980). Understandably then, physicians traditionally have been an important referral source to the mental health professional.

The Problem

Effective working relationships between physicians and allied health professionals, including those within the mental health discipline, are largely based upon the fulfillment of appropriate mutual expectations. Such expectations are dependent upon the clarity of roles between the interacting disciplines.

A part of the literature which will be cited in the next chapter concerns role identification and clarification by psychiatry and other mental health disciplines, notably clinical psychology and clinical social work. These studies and reports demonstrate efforts through such role identification to improve working relationships between that discipline and the physician.

Among the diverse mental health disciplines, psychiatry has established the greatest degree of role clarification with the non-psychiatric physician. This may be due partly to psychiatry's unique position within the medical profession rather than ancillary to it, and partly because psychiatry as a specialty has made considerable effort to evaluate and fulfill the needs of other medical specialties, most especially those within primary care (Green, et al., 1971; Green, et al., 1972; Fink, 1977).

With regard to marital and family therapy, however, a review of literature by this investigator reveals no studies or reports which describe how physicians perceive the clinical role of the marital & family therapist nor what criteria they would use to make patient referrals. The absence of such identifying or clarifying information may result in marital & family therapist role ambiguity as perceived by the physician and, consequently, pose serious limitations upon the potential for appropriate disciplinary interaction between physician and marital & family therapist.

The Purpose

The purpose of this study is to identify the clinical role of the marital & family therapist as perceived by a selected group of practicing physicians, and to determine the criteria which these physicians use or would predict using in making patient referrals to such a therapist. It is thereby hoped that the obtained information would ultimately contribute to improved working relationships between these two professions.

The Research Questions

To fulfill the purpose of this study just described, the following fourteen research questions will be investigated:

1. What are the clinical roles of the marital & family therapist as perceived by this study's group of primary care physicians?

2. What are the clinical roles of the marital & family therapist as perceived by this study's group of non-primary care physicians?

3. Do differences exist in the perception of the clinical roles of the marital & family therapist between this study's group of primary care physicians and non-primary care physicians?

4. Do differences exist in the perception of the clinical roles of the marital & family therapist between this study's group of primary care physicians which has made four or more patient referrals to such a therapist and those primary care physicians who have made fewer than four patient referrals?

5. Do differences exist in the perception of the clinical roles of the marital & family therapist between this study's group of non-primary care physicians which has made four or more patient referrals to such a therapist and those non-primary care physicians who have made fewer than four patient referrals?

6. Do differences exist in the perception of the clinical roles of the marital & family therapist between this study's group of physicians (primary care and non-primary care) which has made four or more referrals to such a therapist and those physicians who have made fewer than four patient referrals?

7. What are the kinds of problems with which marital & family therapists are qualified to work as perceived by this study's group of primary care physicians?

8. What are the kinds of problems with which marital & family therapists are qualified to work as perceived by this study's group of non-primary care physicians?

9. Do differences exist between this study's primary care physicians and non-primary care physicians in their perception of the kinds of problems with which marital & family therapists are qualified to work?

10. Do differences exist in the perception of the kinds of problems with which marital & family therapists are qualified to work between this study's group of primary care physicians which has made four or more patient referrals to marital & family therapists and those primary care physicians who have made fewer than four patient referrals?

11. Do differences exist in the perception of the kinds of problems with which marital & family therapists are qualified to work between this study's group of non-primary care physicians which has made four or more patient referrals to marital & family therapists and those non-primary care physicians who have made fewer than four patient referrals.

12. Do differences exist in the perception of the kinds of problems with which marital & family therapists are qualified to work between this study's group of physicians

(primary care and non-primary care) which has made four or more patient referrals to marital & family therapists and those physicians who have made fewer than four patient referrals?

13. What are the clinical roles of the marital & family therapist as perceived by this study's group of physicians (primary care and non-primary care)?

14. What are the kinds of problems with which marital & family therapists are qualified to work as perceived by this study's group of physicians (primary care and non-primary care)?

The Delimitations

The delimitations of this study are as follows:

Subject selection was restricted to include only physicians holding current staff and hospital privileges at Methodist Hospitals of Dallas (i.e., Methodist Hospital Central and Methodist Hospital Charlton).

Reliability of the instrument has not been established.

The Definition of Terms

The definition of terms applicable to this study are as follows:

Marital & Family Therapist. A marital & family therapist is an academically trained person who has earned either a Master's or a Doctoral degree (excluding the M.D. and D.O.) from a recognized institution and who:

1. is educationally qualified to treat marital and family problems; and

2. professionally identifies as a marital & family therapist, although the treatment mode which is utilized may be individual therapy as well as couple or family therapy.

Primary Care Physician. A primary care physician is an individual who has earned a Doctor of Medicine degree (M.D.) or a Doctor of Osteopathy Degree (D.O.) from a recognized medical school and whose field of specialty or practice is either General or Family Practice, Internal Medicine, Obstetrics-Gynecology, or Pediatrics. The primary care physician is generally the physician who:

1. initially evaluates the patient's various complaints or symptoms;

2. decides if, when, and to whom referral for consultation or treatment by another specialist is to be made; and

3. follows the patient's progress and provides a continuing source of medical supervision.

Non-Primary Care Physician. A non-primary care physician is an individual who has earned a Doctor of Medicine (M.D.) or a Doctor of Osteopathy degree (D.O.) from a recognized medical school and who has fulfilled the requirements of specialization within a particular and restricted category of medical practice. The non-primary

care physician provides specialized consultation or treatment services for patients usually referred by primary care physicians.

Clinical Role. Clinical role refers to what a marital & family therapist does and the professional functions that he or she performs in the evaluation or treatment of marital and family problems.

Referral Criteria. Referral criteria are to be understood as the various signs or symptoms of maladaptive functioning manifested by an individual, couple, or family which usually indicate a need for professional help.

Psychogenic. Psychogenic refers to emotional or physical distress which appears to have a mental origin.

Psychosomatic. Psychosomatic refers to the complex interaction of mind and body variables which manifests the resulting distress in specific forms of physiological disorders such as peptic ulcer, migraine headache, and asthma. No fixed or one-way cause and effect relationship between the mind and body variables is implied.

Emotional Problems, Emotional Distress. Emotional problems or emotional distress refers to individual, marital, or family difficulties in functioning which appear to have a psychogenic or psychosomatic cause.

The Assumptions

The first assumption is that the selected group of

physicians for this study is typical of the population of physicians who practice at Methodist Hospital Central and Methodist Hospital Charlton.

The second assumption is that the instrument is sufficiently sensitive and adequately comprehensive in its measurements.

The third assumption is that the subjects would respond accurately during completion of the instrument.

The fourth assumption is that working relationships between professional disciplines are affected by the way in which one discipline perceives the role of the other.

The Importance of the Study

With the growing incidence of marital and family rooted problems being brought to the attention of the physician by both patients themselves and reports in the medical and popular literature, the need for qualified mental health professionals who can provide evaluation and treatment services for marital and family problems will likely increase. The physician, and particularly the primary care practitioner, is in an instrumental position to decide if, where, and when to refer patients presenting marital and family problems. When referrals are made, physicians usually refer to psychiatrists; but the limited number of psychiatrists who treat marital and family problems could not absorb the vast number of patients who are in need of such

treatments (Lipowski, 1967; Marks, et al, 1979). As a result, this escalating need for marital and family therapy services is greater than the presently utilized resources by physicians to meet that need.

It seems uncertain whether marital & family therapists, as a generic profession composed of diverse mental health disciplines, would qualify in the view of the physician as a recognized resource for patients with troubled marriages or disturbed family relationships. Perhaps such professional recognition by physicians is lacking because the physician has little, if any, definite understanding of the appropriate clinical roles of marital & family therapists. Without role identity, any discipline would be severely disadvantaged in its potential for interaction with other disciplines that have professionally identifiable roles.

In the particular case of marital & family therapists, nothing is presently known about how physicians perceive their clinical roles or what the physician believes to be their intervention techniques. Consequently, the potential for improved working relationships and increased referral utilization of marital & family therapists by physicians has been restricted.

This study provides information about how the clinical roles of marital & family therapists are perceived by a selected group of physicians, and information concerning the

kinds of referral criteria which these physicians utilize, or predictably would utilize, with such therapists. It is hoped that the obtained information could contribute to the further development of professional role identification by marital & family therapists with the medical profession.

CHAPTER II

REVIEW OF THE RELATED LITERATURE

Introduction

Dominian (1979) stated: "At first thought, marriage may seem unconnected to the practice of medicine. But marital breakdown, which is increasingly common, is the source of an enormous amount of unhappiness and illness. Marital problems present in diverse ways to almost all doctors" (p. 424). Thus, the connection between marital status, marital functioning, and health is again emphasized, as it previously has been by others (Carter & Glick, 1970; Cohen, 1977). From a recent editorial in Lancet (March 14, 1979) comes a strikingly similar observation: "The incidence of marital breakdown continues to rise. The divorced state is associated with high mortality and probably increased morbidity. Equally worrying, though less obvious, is the morbidity associated with intact but unhappy marriages . . . Nobody has yet proved it, but many of the physical and psychological problems that present to the general practitioner may be aggravated if not actually caused by marital problems." (pp. 652-653). In the same vein, Johansen (1980) discusses the confusing mixtures of emotions and thoughts involved in the gradual process of divorce which at

times becomes "a significant stress with subsequent influence upon physical and emotional health." (p. 63).

As evidenced by such reports, conflict or unhappiness in either the process of divorce or within the marriage itself and by extension, the family, is increasingly recognized as a cause or component of both physical and emotional difficulties which are frequently presented to the physician. However, it is also well known that many physicians do not wish to become involved with their patients' marital and family problems (Redmount, 1974).

Of course, one possible alternative for the physician who prefers to avoid dealing with the complexities of such types of problems is to refer the patient(s) to a mental health professional. Shortell & Daniels (1974), in their investigation of the referral relationships between a group of internists and psychiatrists, found that only 0.9% of patients seen by these internists were referred for psychiatric help although the combined average of many of the internists revealed that "psychiatric conditions comprised 26.1 per cent of their patient load." (p. 230). Other investigators have similarly reported that primary care physicians refer approximately 1% of their emotionally troubled patients to psychiatrists (Locke & Gardner, 1969). Although this psychiatric referral rate may be considered quite low compared to the estimated higher percentage of

patients with significant emotional problems (Lipowski, 1967), even more striking is the apparent absence of professional visibility of the marital & family therapist as a referral resource in the eyes of the physician. Given the growing incidence and recognition of marital and family problems presented in various ways to the physician, it would appear that the need certainly exists for the trained marital & family therapist as a potential mental health resource for troubled patients.

Perhaps one reason that utilization of marital & family therapists as resources by physicians has been limited is because physicians may not have a clear perception of the marital & family therapist's role in evaluation and treatment of emotional problems. There is, however, considerable literature concerning the role of the psychiatrist in medical care (Lipowski, 1967; Green, et al, 1971a; Green, et al, 1971b; Shortell & Daniels, 1974; Lothstein, 1977; Noori, et al, 1979; Hull, 1979) and in medical education (Hyams, et al, 1971; Haar, et al, 1972; Fink, 1977). Similarly, other mental health disciplines have attempted to identify their roles with respect to working relationships with physicians. Lothstein (1977) describes the role of the clinical psychologist in primary care medicine, and Frangos & Chase (1976) describe a collaborative relationship between social workers and family practice residents in a general hospital.

These two studies will be reviewed later in this chapter. However, in contrast to psychiatry, psychology, and social work, no studies or reports exist in the medical literature which identify or clarify the role of marital & family therapists in collaborative relationships with, or as mental health adjuncts to, physicians.

The remainder of the review of related literature in this chapter will be divided into the following areas:

1. How physicians perceive and respond to the emotional problems of their patients;

2. The mental health referral practices and attitudes of physicians;

3. The role of psychiatry and other mental health professions with non-psychiatric physicians; and

4. Summary and implications.

How physicians perceive and respond to the emotional problems of their patients.

Hyams, et al, (1971) studied the needs and practices of primary care physicians with regard to the emotional problems of their patients. These investigators concluded that "when primary physicians attend to emotional disorders the preferred therapeutic methods and the conditions under which they are used reflect traditional medical training. Their general orientation is toward clearcut diagnoses and direct approaches to therapy as with organic diseases. The primary

physician tends to deal with the emotional problems of patients when such disturbances either interfere with the management of organic illness, directly contribute to organic illness, or when patients or their families demand that he intervene in crisis situations." (p. 44). But even when pressure to treat emotional problems is placed upon the physician, these same investigators observed: "Many physicians do not feel competent in recognizing or treating emotional disorders . . . Those physicians who have made psychotherapeutic efforts are often frustrated by an absence of direct rewards. These negative experiences may set up self-protecting mechanisms, such as denial of their patients' disturbances." (p. 44).

Another defense which the physician may consciously or unconsciously use to avoid being confronted with a patient's emotional problem is simply omission or failure to ask specific questions which might disclose or elicit such problems. Marks, et al, (1979), in their investigation of the physician's ability to detect psychiatric illness in patients, found: "The present results support the view that doctors who ask the patient about his family and what is going on at home, and who frequently use questions with a 'psychiatric' content, are very much more likely to be accurate raters of psychiatric disturbance." (p. 352). These investigators also found that "there is a substantial group

of patients whose psychiatric disturbance goes undetected by their family doctor..." (p. 352). Similarly, Mezey & Syed (1975) and Harding, et al, (1980) concluded that one reason for such widespread lack of detection was that "the majority of patients with mental disorders complain primarily of physical symptoms." (p. 239). Many of the physical symptoms were found by these investigators to have been treated symptomatically without success, and that "the need for greater awareness of psychological disturbance and for improved diagnostic skills is a general one." (p. 239).

Haar, et al, (1972) investigated physicians attitudes toward involvement with patients with emotional problems and learned from a sample of more than one thousand physicians that "84% of the doctors believed that they should become involved with the emotional problems of their patients. A similar proportion (79.9%) stated that they always, usually, or often did treat these disorders. Treatment was defined broadly to cover a variety of interventions, including handling of referrals for complete care." (p. 256). Thus, a positive attitude about involvement with patients with emotional problems may also have been associated with this physician group's referral practices.

In examining the kinds of treatment methods the physicians used with their patients' emotional problems, these same investigators (Haar, et al, 1972) found that

"primary physicians prefer to manage psychiatric patients with familiar supportive techniques such as reassurance, ventilation, and advice." (p. 261). These writers also interestingly learned that "most physicians usually preferred to refer disturbed patients" (p. 260), and that "67% felt the need for help with the management of such patients." (p. 262).

Advice and reassurance similarly have been found by other investigators (Fisher, et al, 1975) to be the most frequently used treatment techniques reported by physicians. These researchers also studied the reliance of doctors on psychoactive drugs and found that the younger physicians in their sample tended "to give tranquilizers and antidepressants to a smaller fraction of their emotionally disturbed patients. This pattern may indicate a greater feeling of confidence to personally manage the treatment of psychiatric patients ... and consequently to be less reliant on psychoactive drugs to supplement therapy." (p. 110).

Estimates vary concerning what percentage of patients seeking help from the primary care physician has significant emotional or psychiatric distress. Lipowski (1967) stated that there was evidence that "50-80% of outpatients suffer from psychic distress or psychiatric illness of sufficient severity to create a problem for the health professions." (p. 203). Locke and Gardner (1969) reported a range of 10 to 60%

of patients seeking help from general practitioners to be experiencing significant emotional conflict. Goldberg & Blackwell (1970), in a survey of British general practitioners, found that 20% of their patients experienced apparent psychological distress. Mezey & Syed (1975) reported in their study of patients referred to the medical, surgical, and gynecological clinics of a general hospital that "psychiatric disorder was found in nearly one half of medical outpatients, but in only about one third of patients referred to the other (two) clinics." (p. 133). Harding, et al, (1980), in a study of the incidence of mental disorders in primary health care in four developing countries, found "an overall frequency of 13.9%. The great majority of cases were suffering from neurotic illnesses and for most the presenting complaint was of a physical symptom, such as headache, abdominal pain, cough or weakness." (p. 231).

In a survey of 202 family physicians, Werkman, et al (1976), found that the six most common psychiatric problems of patients reported by these physicians were, respectively: (1) marital problems; (2) depression; (3) hypochondriasis; (4) alcoholism; (5) chronic illness; and (6) anxiety or tension. Interestingly, these physicians considered alcoholism and marital problems the most difficult problems to treat, while anxiety and chronic illness were considered the easiest. Perhaps the treatment of anxiety and chronic

illness are more readily compatible with the physician's training and methods of treatment, especially the prescribing of drugs, than are the problems posed by alcoholism and marital distress.

Snyder (1979), in discussing how the primary care physician can approach and treat the marital problems of patients, suggested the following conceptual orientations: (1) the development of a positive attitude; (2) the concept of individual responsibility; (3) a realistic expectation of change; and (4) clear and open communication. Snyder also described four common ways in which a patient's emotional distress is presented to the primary physician:

> "First they can present with subjective symptoms of emotional distress such as anxiety or depression, or with vague complaints of ... fatigue. Second, the patient can present with physical sumptoms ... Third, the patient's distress can be presented in the marital relationship in terms of overt anger, hostility, or irritability, or by distance, avoidance, lack of involvement and diminished communication between the spouses. Fourth, the patient's distress may be outside of conscious awareness and can be projected upon a third party, usually one or more children in the family." (p. 366).

Such information as just illustrated by Snyder concerning a positive and practical conceptual orientation to

the approach and management of patients' emotional problems and to increasing the doctor's awareness concerning the more common ways in which these kinds of problems are presented to the primary physician is often ignored or rejected outright because some physicians do not want to become involved with the treatment or management aspects of these problems. Although some studies indicate that the vast majority of physicians do consider themselves receptive to, or readily involved with, treatment of their patients' emotional problems (Haar, et al, 1972; Hull, 1980), other investigators report a strongly negative perception by some physicians regarding such involvements. A likely approach in the medical management of patients by these physicians and, perhaps more insidiously, the attitude which still numbers of others hold toward the treatment of emotional distress, may be very narrowly defined by and restricted to one treatment method. Halleck (1978), himself a psychiatrist, described in the following paragraph the attitudes of one such group:

> "One of the most powerful therapeutic schools is made up of professionals who hold medical degrees and who treat patients primarily with physical methods. These professionals may give the patient an opportunity to ventilate his feelings or may provide him some reassurance, but both doctor and patient usually put most of their faith in the prescribed somatic treatments. Doctors who rely primarily on physical methods

tend to be skeptical of other approaches. They often believe that insight-oriented psychotherapies are wasteful and that they may even make the patient worse. Relatively unconcerned with the influence of the patient's environment and accepting almost totally a reductionist medical model, they are not likely to work with the family in a manner which identifies its role in creating or perpetuating an illness. Nor are they likely to try to modify other stresses in the patient's environment." (p. 4).

Green, et al, (1971b), stated: "Some physicians are reluctant to involve themselves in the emotional problems of their patients ... It is important ... to help (these) physicians become more interested in handling psychiatric illnesses." (p. 1552). Similarly, Redmount (1974), describes physician resistance toward involvement with a patient's marital problems and offers a rationale for such resistance:

"Mostly, the medical professional is inclined to do very little with his patient's marriage problems. He may try to pass the matter off with some general encouragement or suggestion aimed at reassuring the patient and perhaps minimizing the matter. He does not really want to become involved in a maze of feelings and issues where he may not have the time, disposition or skills to offer effective counsel ...

> By temperament and training many physicians may have difficulty with the personal and professional requirements in marriage consultation. Physicians are accustomed to being in authority, not sharing authority with their patients ... Their focus is relatively more on the internal environment of the patient and relatively less on the patient as an element in a complex of predominantly social and psychological relationships." (pp. 489-490).

The mental health referral practices and attitudes of physicians.

Interactional problems have long existed between physicians and mental health professionals, with at least some of the problem being due to conflicting or unclear expectations concerning mutual roles (Green, et al, 1971a). This problem will be reviewed in the next section of this chapter, but the confusion and sometimes the conflict which results from unclear or inappropriate role expectations has an influence upon the physician's mental health referral practices. If a negative attitude exists toward mental health professionals, the physician will make fewer mental health referrals and be inclined either to provide more psychotherapeutic treatment him/herself or to ignore the patient's emotional problems (Hull, 1980).

Noori, et al, (1979), reports: "Most patients' psychological difficulties are not treated by the primary

care physician, and these patients are rarely referred to a psychiatrist. When treatment is provided, it is usually symptom-oriented..." (p. 31).

The resistance to refer patients with emotional or psychiatric problems to psychiatrists and other mental health professionals (Fisher, et al, 1975), may also be related to personal and family relationship factors operating upon physicians themselves and to how such physicians respond to their own problems. Kales, et al, (1978), wrote:

> "As a group physicians are highly susceptible to emotional problems, drug abuse, unstable marriages, and suicide ... The physician's typical personality discourages him from experiencing the patient's role, which he associates with feelings of helplessness and dependency, and loss of control ... The physician also resists psychiatric treatment by declaring that emotional problems are a weakness and denying such problems to himself. Physicians are unwilling to seek help to an almost phobic degree." (pp. 14-15).

This resistance to seeking help for their own personal or family problems may impart a similar resistance toward referring patients for such help.

Another possible influence upon the physician's mental health referral practices may be rooted in the experience of medical school itself, choice of specialty, and the residency

programs which follow. Attitudes in medical students and in residents have been shown to be altered by the nature of these institutional experiences (Klingfeld & Hoffman, 1979; Casareigo & Greden, 1978; Rezler, 1974; Reinhardt & Gray, 1972). Duffy (1967) found evidence of the formation of a progressively demeaning attitude toward the emotional problems of patients and toward psychological helpers, particularly psychiatrists, during medical school. However, Duffy's findings contrast with the more recent findings of Klingfeld & Hoffman (1979). These investigators studied the attitudes toward emotional problems and professional help of first- and second-year medical students and compared these with the attitudes of third- and fourth-year medical students concerning these variables. These researchers speculated that changes in medical school curricula during the past several years "might explain why third- and fourth-year students showed a more positive attitude toward obtaining help than did freshmen and sophmores." (p. 621).

It thus appears from the literature that the mental health referral practices and attitudes of physicians, particularly primary care physicians, may be influenced by a number of factors operating singularly or in combination with one another: (1) unclear role expectations regarding mental health professionals as perceived by the physician; (2) personal and family problems operating upon the physician

which may cause a negative attitude to be projected onto all psycholocical help-seeking; and (3) the experience of medical school and residency training which may inculcate negative feelings toward emotional problems and mental health care.

Two other factors which may influence the mental health attitudes and referral practices of the physician are first, the kinds of experiences the physician has had with mental health professionals and second, the availability of mental health resources, both institutional and private practitioner. Fisher, et al, (1975), found from a ranking of mental health resources used by a sample of 360 physicians belonging to the Michigan Chapter of the American Academy of General Practice that the psychiatrist in private practice was the most frequently utilized referral resource while "the least frequently used type of psychiatric resource (was) the private practitioner in other disciplines such as counseling, psychology or social work." (p. 110). Fisher (1978) in a later report based upon the just cited study showed that psychiatrists were also considered the most available mental health resource while, repeating the same pattern found in referral utilization, psychologists and social workers were considered the least available mental health resource.

Herndon & Nash (1962) surveyed the attitudes and referral practices concerning marital counseling of 514 North Carolina physicians and concluded:

> "Our data on the referral of patients show that 78 per cent of the practitioners interviewed rarely or never find it advisable to send a patient elsewhere for counsel concerning marital problems ... Even in communities where professional counseling services exist and are known to physicians, there is some reluctance about referral that seems to be based upon inadequate communication and cooperation between the physician and the counselor." (p. 140).

In an earlier survey of physicians' attitudes toward mental health problems and mental health resources, Korkes (1957) reported that 97% of a sample of more than 350 physicians agreed with either the statement that psychiatry was a great deal of help or the statement that it was of some help. The value of this finding, however, would appear to be questionable when the remaining three choices of statements concerning psychiatry are examined. These are: (1) "It's a racket"; (2) "It's mostly nonsense"; and (3) "It's an unnecessary refinement" (p. 468). The negative phrasing and derogatory tone of these statements regarding another physician specialty appear to the writer to bias the physician respondents toward marking the more favorable attitudes.

Mezey & Kellett (1971) investigated "the discrepancy between the prevalence of psychiatric disorder among medical

and surgical patients and the low rate of referral." (p. 315). These writers found that the two most frequently given responses by the physician sample against making a psychiatric referral were, respectively, "the patient's dislike of being referred" and "the disadvantage to the patient of being labeled a mental case" (p. 316). Thus the attitude of the patient may have a direct effect upon the referral practices of the patient's physician regardless of the physician's own attitude.

The role of psychiatry and other mental health professions with non-psychiatric physicians.

The term clinical role which was defined in Chapter I solely referred to the functions of a marital & family therapist. The meaning of the term "role" in the context in which it will now be used in this section of the review of literature will not be limited to only the marital & family therapist reference but will more broadly refer to what various other individuals or disciplines do in the fulfillment of their professional functions.

In the previous section of this chapter it was stated that conflicting or unclear expectations concerning mutual roles between physicians and mental health professionals could influence referral practices and interdisciplinary work relationships. Green, et al, (1971a) wrote:

"A study of the interaction of the NPP (non-psychiatric

> physician) with mental health personnel requires attention to issues of mutual expectations and of professional roles. The mental health professional with whom the NPP has most frequent contact is the psychiatrist ... Little is known about the NPP's expectations of psychiatrists. Indeed, it is the crux of our thesis that there is a paucity of information about this heterogenous NPP group, including what they expect from the psychiatrist or how they define his role." (P. 207).

These writers emphasized the need for role clarification between the psychiatrist and non-psychiatric physician and proposed, among other recommendations, that information regarding conflicting expectations, underlying assumptions, and professional role models be elicited through questionnaire surveys (p. 212).

Subsequent writers have proposed models to enhance the educational input of psychiatry in the medical school curriculum as well as hospital consultation and liaison (Fink, 1977; Fisher, 1978). Fink (1977) strongly emphasized the importance of consultations and liaison which he saw as the interface between medically-related professions. "Liaison programs represent one of the best methods for bringing psychiatry and other medical specialties into closer cooperation. It is imperative that the psychiatric

profession view the development of liaison-consultation programs as a top priority ..." (p. 128).

Lothstein (1977) proposed guidelines for the primary physician regarding the appropriate use of two mental health disciplines, clinical psychiatry and clinical psychology. His proposals were premised on the rationale that in order for primary physicians to provide comprehensive care for their patients, they periodically would need consultation with other specialists, including the mental health specialist. He stated that "to accomplish this, the primary physician must have an understanding of the mental health referral process and the background and skills of the specialists who provide (such) consultation." (p. 344).

The role of clinical psychiatry in conjunction with the primary care physician was seen by Lothstein to uniquely encompass patient evaluation for psychotropic medication or organic therapies such as electroconvulsive treatment, evaluation for hospitalization when the patient appears to be emotionally or mentally incapacitated or at risk, and consultation concerning a patient's mixed symptoms of physical and psychological disorder. In contrast, this same writer saw the role of the clinical psychologist to be unique primarily with regard to the utilization and interpretation of psychological tests which he said could help the physician make a more definitive differential diagnosis or provide

information to the physician about a patient's cognitive functioning and status.

The distinction between the roles of clinical psychiatrist and clinical psychologist began to blur when Lothstein compared the two disciplines by use of treatment methods common to each. Three of the many methods cited were family therapy, parent guidance, and marital counseling, all of which he designated as typical treatment methods utilized by both psychiatrists and psychologists. He stated that there was "considerable overlap in the (treatment) services provided by the two disciplines, which underscores the confusion many people have in distinguishing (between them)." (p. 348).

Undoubtedly, such confusion in making a distinction between the roles of these two disciplines would be compounded with the addition of the disciplines of marital & family therapy, clinical social work, and pastoral counseling which are also known to utilize these same treatment procedures of family therapy, parent guidance, and marital counseling. It is perhaps ironic that attempts by a discipline to identify or clarify its role may so readily and widely overlap with other related disciplines and result in the inability to clearly make interdisciplinary distinctions.

Frangos & Chase (1976) investigated the attitudes of thirty-nine family practice residents at the University of Utah Medical Center toward collaboration with social workers.

Much of this study examined the social work role as perceived by these residents. Frangos & Chase stated that physicians in general "have traditionally perceived social workers in instrumental roles as resource finders and arrangers of financial aid; they have not always recognized social work potential for dealing with the psychosocial aspects of patient care." (p. 66). In their study, however, these investigators found that "services ascribed to social workers (by the resident sample) covered a broad range of alternatives. Counseling was listed as the major function of the social worker, with many residents listing specific types of counseling, including family therapy, marriage counseling, group therapy, and crisis counseling. It is significant that counseling was listed as a primary function of social workers more often than resource finding." (p. 70). However, as Lothstein found in his study, Frangos & Chase similarly found that "some confusion was present among the doctors regarding the boundaries and role definition of social workers, psychologists, and psychiatrists." (p. 70).

The collaboration itself between social worker and physician was considered by Frangos & Chase to be a major influence upon the physician's perception of the social work role as being primarily psychosocial counseling rather than being primarily resource finding. In another investigation concerning social workers in university hospital settings,

Schrager (1974) similarly concluded that roles became more clearly perceived between professions given the opportunity for regular collaboration and a reasonable period of time.

Anderson, et al, (1978) described a collaborative relationship between pastoral counselors and a community mental health center. These writers suggested that mutually antagonistic misconceptions between clergy and psychiatric professionals were a widespread problem and, unless corrected, could limit the development of effective working relationships:

> "Pastoral workers have viewed psychiatric workers as anti-religious, while psychiatric workers have sought to avoid contact with what they regarded as value-laden and moralistic approaches. It appears, however, that the dichotomy between psychiatric treatment and religious-pastoral services has existed more in the minds of the two practicing groups than in the minds of those...in need of professional care." (p. 801).

According to Anderson, et al, such an undesirable dichotomy could be transformed into complementary and effective interdisciplinary efforts for patient care by liaison and collaboration between the clergy and psychiatric workers.

The roles of chaplains in community mental health settings has been described (Slaughter, et al, 1978). This

report stated that "chaplains have a direct role in patient care, counsel patients about general issues of living, and help...staff understand the role religion plays in a patient's life." (p. 797). A collaborative relationship with a psychotherapist was proposed in instances where chaplains might "help patients deal with specific problems, such as grief and loss." (p. 797). Models for such a collaborative relationship were described in this report for both inpatient and outpatient settings.

Summary and Implications.

This final section of the review of related literature will, first, summarize the main points of the chapter's previous sections and, second, conclude with implications. The summary consists of the following six paragraphs:

1. The primary care physician is often the first professional whose help is sought by people in emotional or mental distress. Such distress is frequently disguised or distorted by the patient's physical complaints. Problems with marriage, divorce, or within family living appear to be a major cause or component of the distress brought to primary care physicians. In response, the physician may choose to treat the patient's emotional problems, ignore them, or refer the patient(s) for specialized help. In some instances, the patient's emotional problems may go undetected because the physician does not ask the patient personal or family related

questions which might more directly elicit the problem during the examination or interview.

2. Most physicians perceive themselves as receptive to and active in the treatment of their patients' emotional problems. The most frequently reported treatment techniques utilized with patients by the physician include physical examination and reassurance, ventilation, and advice.

3. Estimates vary greatly with regard to the percentage of patients needing treatment for emotional and mental problems. There is uniform agreement, however, that far more patients need referral for psychological help than are actually referred by the physician. When the physician does refer to a mental health professional, the discipline most frequently chosen is psychiatry. One reason for this appears to be that physicians have a greater degree of familiarity with the clinical role of the psychiatrist than with other mental health disciplines.

4. Marital problems have been considered by physicians to be among the most frequently seen types of emotional distress, and also among those considered most difficult to treat. In contrast, anxiety symptoms have been considered by the physician to be among the easiest to treat. This may indicate that the treatment of anxiety problems is more compatible with the physician's medical training and management methods than is the treatment for marital problems.

5. The physician's attitude concerning mental health problems and mental health professionals has been shown to be influenced by a number of variables. These may include: a) the physician's own personal or family status and history; b) the experience of medical school and residency which may inculcate negative attitudes toward psychological problems and psychological helpers, although in recent years attitudinal changes in a more positive direction appear to have been made because of greater psychiatric input in the medical school curricula and in hospital training programs, consultation, and liaison; c) the physician's expectations of and previous experiences with mental health professionals; d) availability and convenience of mental health resources; e) the patient's own attitude concerning mental health services; and f) aggregate factors such as severe limitations upon the physician's evaluation or treatment time with patients, a personal disliking of involvement in a patient's emotional problems, or a feeling of possessing inadequate expertise in attempting to deal with the problems of emotional distress.

6. The clinical roles of the psychiatrist,psychologist, and social worker in primary care have been reported in the medical literature. Also, the role of the pastoral counselor in mental health settings which can be utilized for referral by physicians has been described. The clinical role of the marital & family therapist, however, has not been reported in

the medical literature although articles defining or categorizing roles and functions of marital & family therapists are available in some of the marital and family therapy literature (Gurman, 1979; Olson, 1970).

The implications of this chapter's review of related literature appear to be twofold. First, that how physicians perceive the clinical role of marital & family therapists is not known. Second, that without an understanding of the role perception which physicians have of marital & family therapists, the subsequent role clarification and the development of improved working relationships between the two professional groups, especially with regard to the development of appropriate referral criteria to marital & family therapists by physicians, will be restricted. In a study of physician referral practices previously cited in this chapter, Fisher, et al, (1975), stated:

> "It is not surprising that physicians refer primarily to individuals within the same profession since they share a common frame of reference. However, the low proportions of each group who refer to professionals in other fields suggest that other psychiatric resources are not receiving optimal utilization. It may be that the referral preference pattern is suggestive of a lack of knowledge on the parts of practicing physicians as to what services other professionals can provide." (p. 111).

CHAPTER III

METHODOLOGY

The present chapter describing the methodology which was utilized in this study has been divided into the following six sections:

1. The setting;
2. The selected group;
3. The instrument;
4. Content validation measures;
5. The collection of the data; and
6. The procedure for the statistical treatment of the data.

The Setting

The setting from which the subjects were selected and the data collected was Methodist Hospital Central. Methodist Central is a major component of Methodist Hospitals of Dallas, a nonprofit multihospital corporation accredited by the Joint Commission on Accreditation of Hospitals. Methodist Central has a licensed bed capacity for 508 inpatients and an attending medical staff of 305 physicians.

During the past few years, Methodist Central has been actively involved in a building and expansion program of its

plant facilities and services. It is among the larger of the general medical and surgical hospitals located within Dallas County, and provides additional specialized medical and emergency care services. Its medical staff and services are widely respected as attested by the fact that numerous medical schools throughout the country presently have a total of forty-five medical residents in placement within the hospital's residency programs. Residency training is offered in the specialties of General Surgery, Internal Medicine, Family Practice, Obstetrics/Gynecology, Pathology, and Anesthesiology.

In addition to these specialties in which residency placement is offered, Methodist Central has attending staff members from numerous other medical specialties. The attending staff of 305 includes 120 Primary Care physicians and 185 Non-Primary Care physicians. All members of the medical staff are expected to attend regular monthly meetings of their particular departments, as well as meetings for the entire staff which are held quarterly. Such meetings keep the staff informed of continuous new information concerning hospital services and the broader aspects of related medical practice.

The Selected Group

All members of the attending medical staff of Methodist Hospital Central are graduates of accredited medical schools

and are licensed for the independent practice of medicine by the Texas State Board of Medical Examiners. Of the total 305 attending staff members, 39.3 percent belong to a primary care specialty* and 60.7 percent to a non-primary care specialty. Four percent of the attending staff is female.

The writer was granted administrative and medical permission (see Appendix E) to attend a quarterly staff meeting and obtain the data upon which the results and conclusions of this study are based. Arrangements to distribute and collect the instrument during the quarterly meeting were kindly made by Patricia Starr, Manager for Medical Staff Services. The extraneous circumstances and activities simultaneously occurring during distribution and completion of the instrument will be described in a following section of this chapter, The Collection Of The Data.

From the total of 305 physicians comprising the attending staff, 218 physicians were present for at least some portion of the quarterly staff meeting. The instrument was distributed to most of those 218 subjects. A small percent of this total arrived late or left early and consequently did not receive the instrument. A total of 96 instruments were collected; of this number, 10 instruments were incomplete and subsequently not included in the analysis

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*General and Family Practice, Internal Medicine, Obstetrics/Gynecology, and Pediatrics

of the data. The remaining 86 instruments which were completed form the data for analysis of this study.

The selected group of 86 physician subjects who completed the instrument consisted of 35 primary care physicians and 51 non-primary care physicians. Seven percent of the selected group was female. As noted earlier in this section, the population of 305 attending staff members is composed of 39.3 percent primary care and 60.7 percent non-primary care. A strikingly similar representation was found when the selected group of 86 subjects was identified by medical specialty: 40.7 percent were in the primary care group and 59.3 percent were in the non-primary care group.

Table I below summarizes these comparisons between hospital population and selected group:

TABLE I

PRIMARY CARE AND NON-PRIMARY CARE COMPARISONS BETWEEN HOSPITAL POPULATION AND SELECTED GROUP

	Total Number	Number P.C.*	Number N.P.C.**	Percent P.C.	Percent N.P.C.	Percent Female
Hospital Population	305	120	185	39.3	60.7	4.3
Selected Group	86	35	51	40.7	59.3	6.9

The Instrument

The selected group of physician subjects completed the instrument which can be found in Appendix A. The purpose of

*Primary care physicians
**Non-primary care physicians

the instrument was twofold: first, to ascertain the clinical role of the marital & family therapist as perceived by the subject; and second, to ascertain the types of referral criteria with which marital & family therapists are qualified to work as perceived by the subject. This information was generated by questions one and two, respectively, on pages two and three of the instrument and required only checkmarks in the chosen column for completion.

The general information requested on page four of the instrument provided the data from which dichotomous subgroupings and comparisons could be made. These included primary care versus non-primary care comparisons, and comparisons between subjects who have made four or more referrals to marital & family therapists versus subjects who have made fewer or none.

Completion of the instrument took approximately five to six minutes for most subjects. Subject participation was on a voluntary basis. There were no recognized risks related to the subject's participation in this study. The subject's informed consent to participate was acknowledged by the consent form attached to the instrument (see Appendix B).

Content Validation Measures

The data gathering instrument for this study was developed by the writer upon the basis of his own clinical experience and the inherent cumulative influences of writings

of numerous theorists, educational presentations, and discussions with colleagues. Measures to establish the instrument's content validity were developed in the following three ways:

1. The writer met with a group of five marital & family therapy practitioners. This group was composed of three males and two females. The instrument was reviewed by each practitioner and verbally critiqued with special emphasis upon clarity of wording and appropriateness of questionnaire items to marital & family therapist function.

2. A panel of experts in the field of Marital & Family Therapy was selected by the writer. The panel consisted of three males and two females from four of the various disciplines which comprise the marital & family therapy field. Each member of the panel was mailed a copy of the instrument and a cover letter specifying the information needed (see Appendix C). Every member of the panel generously responded verbally and in writing to the information requested. Please see Appendix D for identification of panel members.

3. After the information generated above in steps one and two was obtained and the indicated revisions made in the instrument, a pilot study was conducted utilizing a multi-specialty group of nine practicing physicians consisting of eight males and one female. These physicians were

professionally associated in a group medical practice within a private practice clinic and were attending a business meeting of the clinic. Each of the nine physicians held staff and hospital privileges at Methodist Hospitals of Dallas. It was predicted by the writer that the extraneous circumstances in which the instrument would be pretested during the clinic business meeting would be similar to those circumstances in which the primary study would be conducted later within a staff meeting at Methodist Hospital Central.

A primary purpose of the pretesting was to determine whether ambiguities existed within the instrument as perceived by the physician. In the measures described in steps one and two above, marital & family therapy professionals assessed the clarity and appropriateness of each questionnaire item as a component contributing to the instrument's stated purpose. Since physicians, however, rather than marital & family therapists would be the target group for study, and since one professional discipline may perceive with clarity what another discipline perceives ambiguously, it was necessary for the pretesting to determine whether the physician pilot group would experience confusion in their responses to any of the items. The writer distributed the instrument to each physician and asked for verbal response to any part of the instrument which was either unclear, objectionable, or incomplete.

As a result of the three measures enacted above, modifications were made and the final version of the instrument was prepared. It was believed that the content validity of the instrument was enhanced because these measures included the following four characteristics: (1) male and female professionals assessed the instrument, thus reducing or eliminating the possible influence of sexual bias which might otherwise exist (APA Task Force on Issues of Sexual Bias in Graduate Education, 1975); (2) the instrument was assessed by both clinical practitioners of marital & family therapy and academicians in the marital & family therapy field, thereby reducing or eliminating the possibility of bias existing from the perspective of either group only (Isaac & Michael, 1971); (3) within the panel of experts, the disciplines of psychology, social work, sociology, and psychiatric nursing were represented, thereby increasing the likelihood that the diverse marital & family therapy field would be proximately reflected (Leedy, 1980); and (4) because both physicians and marital & family therapy professionals assessed the instrument, the possibility of either language bias or ambiguity within the instrument existing undetected and adversely affecting either professional group was reduced (Isaac & Michael, 1971).

The Collection Of The Data

Methodist Hospital Central conducts its quarterly staff

meetings in a large assembly area within the hospital complex. As previously stated, the writer was granted permission to attend a specific quarterly meeting. The agenda of this meeting, held in the evening, included a seated dinner and simultaneous announcements by various speakers regarding hospital and medical matters. The progression of the program was orderly and relaxed; most of the 218 physicians present informally conversed with one another during the course of the meeting. It was in this environment that the research study was conducted.

Prior to the distribution of the instrument, the President of the Medical Staff, Dr. Jerome Byers, announced that the questionnaire about to be distributed was part of a doctoral research study involving physicians' views of marital & family therapists. By choice, the writer was not identified in order to reduce the possibility of bias developing from a subject responding to the identified marital & family therapist (Bachrach, 1962; Barber, 1976). Additionally, the instrument was distributed and collected by two female program assistants who also distributed and collected other written materials during the meeting.

The extraneous variables operating within the circumstances under which the subjects completed the instrument, such as the various distractions of noise, voices, and peripheral motor activities, may proximate the surroundings

in which many physicians usually work. Disposition judgments by physicians regarding patient care and referral considerations may often be made amid innumerable extraneous distractions and interruptions.

The Procedure For The Statistical Treatment Of The Data

Tables were constructed for each of the fourteen research questions stated previously in Chapter I. Since all subjects completed identical instruments, it was possible to make subgroup comparisons for the eight out of fourteen research questions which required analysis of intergroup differences*. Each of these eight research questions was statistically treated by use of the Z test for differences between group proportions. The formula utilized was as follows (Freund, 1973, pp. 317-320):

$$Z = \frac{\frac{x_1}{n_1} - \frac{x_2}{n_2}}{\sqrt{p(1-p)\left(\frac{1}{n_1} + \frac{1}{n_2}\right)}}$$

where

(1) p signifies proportion;

(2) n_1 and n_2 are respective sizes of the two subgroups;

(3) x_1 and x_2 are number of successes** of subgroup n_1 and n_2 respectively; and where

* Research questions 3, 4, 5, 6, 9, 10, 11, and 12.

** Number of subjects from n_1 and n_2 having marked the column being compared between the two subgroups.

$$(4) \quad p = \frac{x_1 + x_2}{n_1 + n_2} \quad .$$

The data for this study is nominal in nature, and nominal data usually requires treatment by a nonparametric method such as chi-square (Siegel, 1956). However, when comparing two categories, the Z test and chi-square are equivalent statistical tests (Hopkins & Glass, 1978, p. 311). Results of the Z test yield smaller numbers than those yielded by applying the chi-square statistic and are easily interpreted for whatever level of significance is being tested (Glass & Stanley, 1970).

A one-tailed test at the 0.01 level of significance was utilized for all subgroup comparisons in research questions 3, 4, 5, 6, 9, 10, 11, and 12. Any result equal to or greater than 2.33 was considered to demonstrate a statistically significant difference at the 0.01 level between the two subgroups being compared. Calculations were made by computer analysis but were combined with numerous spot checks utilizing analysis by hand in order to reduce the possibility of computer error within a program (Isaac & Michael, 1971, p. 69).

Research questions 1, 2, 7, 8, 13, and 14 did not involve intergroup comparisons. Each of these six research questions was treated by frequency distribution utilizing descending group percentages.

Graphic representations are presented in Chapter IV in order to either simplify, to complement the findings in the tables, or to make the results more vividly interpretable. Raw data for each of the research questions is presented in table form in Appendix F*.

*Medical specialties represented in this study and number of subjects from each is also presented in Appendix F.

CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

Characteristics Of The Subjects

As previously stated, all subjects are graduates of accredited medical schools and are licensed for the practice of medicine in Texas by the State Board of Medical Examiners. Of the eighty-six subjects, 59.3 percent practice a non-primary care medical specialty and 40.7 percent practice a primary care medical specialty.

A breakdown of the eighty-six physician subjects by geographic location of medical school from which each graduated provides the following information: (1) twenty-one percent of the subjects graduated from medical schools outside the United States; (2) thirty-eight percent were graduates of medical schools within the United States but outside Texas; and (3) forty-one percent were graduated from medical schools within the State of Texas.

The subjects had a mean of 17.9 years of specialty practice after completion of residency training. The range was one year to fifty years, with a group total of 1,535 years of specialty practice.

Results

The data and its analysis for each of the fourteen

research questions upon which this study is focused is presented in tables and graphic representations throughout this chapter. As stated in Chapter III, the Z test of proportions was the statistical method utilized with those questions requiring subgroup comparisons. All tests were one-tailed and were performed at the 0.01 level of significance. Any intergroup* difference which was equal to or more than 2.33 was considered significant.

The Z test of proportions was applied to those eight of the fourteen research questions (questions 3, 4, 5, 6, 9, 10, 11, and 12) involving int group comparisons. The other six research questions not involving intergroup comparisons (questions 1, 2, 7, 8, 13 and 14) are presented to illustrate the degree of intragroup consensus concerning responses to the questionnaire items. All fourteen research questions are restated below and discussed with their respective findings so that each of these questions may be studied as a single entity. The tables and graphic representations which are presented with the questions display each group's proportion of responses in the "YES" column on pages two** and three*** of the instrument. Proportions of responses within the other columns of the instrument may be found for each group in Appendix F.

*Intergroup and subgroup comparisons are terms used interchangeably in this study.
**For questions one through six, and question thirteen.
***For questions seven through twelve, and question fourteen.

Research Question One: What are the clinical roles of the marital & family therapist as perceived by this study's group of primary care physicians?

Table 2 illustrates the respective number and corresponding proportion of "YES" responses by this group of size thirty-five primary care physician subjects to the questionnaire items on page two of the instrument. Table 3 reconstructs the item arrangement into descending proportions of "YES" responses by this same group.

The tables display that ninety percent or more of these primary care subjects perceived the clinical roles of the marital & family therapist to include six of the total fourteen questionnaire items. Among these six items, one hundred percent of the primary care group perceived the marital & family therapist role as helping people ventilate, express feelings; ninety-seven percent perceived the clinical role as providing emotional support; while ninety-four percent viewed offering practical advice and dealing with conscious problems as clinical roles. In contrast, only thirty-four percent perceived the clinical role of the marital & family therapist as managing neurotic disturbances, and a mere eleven percent of this group perceived the role as managing outpatient psychotic disturbances.

Research Question Two: What are the clinical roles of the marital & family therapist as perceived by this study's group of non-primary care physicians?

Table 2
Clinical Roles of Marital & Family Therapists
As Perceived By Primary Care Physicians

n=35

	Clinical Role Items	Number Marking Yes Column	Percent Marking Yes Column
a.	Provides emotional support	34	97
b.	Offers practical advice, guidance	33	94
c.	Manages neurotic disturbances	12	34
d.	Manages situational disturbances	30	86
e.	Manages outpatient psychotic disturbances	4	11
f.	Helps people ventilate, express feelings	35	100
g.	Teaches conflict resolution skills	32	91
h.	Deals with conscious problems	33	94
i.	Deals with unconscious problems	21	60
j.	Changes dysfunctional ways of thinking	25	71
k.	Changes patterns of family interaction	32	91
l.	Changes specific behaviors	25	71
m.	Identifies repressed conflicts	27	77
n.	Interprets underlying psychodynamics	22	63

Table 3
Descending Order of Clinical Roles of Marital & Family Therapists
As Perceived By Primary Care Physicians

n=35

	Clinical Role Items	Percent Marking Yes Column
f	Helps people ventilate, express feelings	100
a	Provides emotional support	97
b	Offers practical advice, guidance	94
h	Deals with conscious problems	94
g	Teaches conflict resolution skills	91
k	Changes patterns of family interaction	91
d	Manages situational disturbances	86
m	Identifies repressed conflicts	77
j	Changes dysfunctional ways of thinking	71
l	Changes specific behaviors	71
n	Interprets underlying psychodynamics	63
i	Deals with unconscious problems	60
c	Manages neurotic disturbances	34
e	Manages outpatient psychotic disturbances	11

Table 4 illustrates the respective number and corresponding proportion of "YES" responses by this group of size fifty-one non-primary care physician subjects to the questionnaire items on page two of the instrument. Table 5 reconstructs the item arrangement into descending proportions of "YES" responses by this same group.

The tables display that ninety percent or more of these non-primary care subjects perceived the clinical roles of the marital & family therapist to include three of the total fourteen questionnaire items. Of these three items, ninety-two percent of the group perceived the marital & family therapist role as providing emotional support and offering practical advice; ninety percent perceived the clinical role as helping people ventilate, express feelings. In contrast, less than fifty percent of this group perceived five of the fourteen items as a clinical role of the marital & family therapist. Among these five items, only thirty-one percent of the non-primary care subjects perceived interpreting underlying psychodynamics as a clinical role; twenty-six percent viewed dealing with unconscious problems to be a role; twenty-four percent considered managing neurotic disturbances as a marital & family therapist role; and a scant ten percent perceived managing outpatient psychotic disturbances as a clinical role.

Research Question Three: Do differences exist in the

Table 4
Clinical Roles of Marital & Family Therapists
As Perceived By Non-Primary Care Physicians

n=51

	Clinical Role Items	Number Marking Yes Column	Percent Marking Yes Column
a.	Provides emotional support	47	92
b.	Offers practical advice, guidance	47	92
c.	Manages neurotic disturbances	12	24
d.	Manages situational disturbances	33	65
e.	Manages outpatient psychotic disturbances	5	10
f.	Helps people ventilate, express feelings	46	90
g.	Teaches conflict resolution skills	36	71
h.	Deals with conscious problems	40	78
i.	Deals with unconscious problems	13	26
j.	Changes dysfunctional ways of thinking	17	33
k.	Changes patterns of family interaction	42	82
l.	Changes specific behaviors	28	55
m.	Identifies repressed conflicts	26	51
n.	Interprets underlying psychodynamics	16	31

Table 5
Descending Order of Clinical Roles of Marital & Family Therapists
As Perceived By Non-Primary Care Physicians

n=51

	Clinical Role Items	Percent Marking Yes Column
a	Provides emotional support	92
b	Offers practical advice, guidance	92
f	Helps people ventilate, express feelings	90
k	Changes patterns of family interaction	82
h	Deals with conscious problems	78
g	Teaches conflict resolution skills	71
d	Manages situational disturbances	65
l	Changes specific behaviors	55
m	Identifies repressed conflicts	51
j	Changes dysfunctional ways of thinking,	33
n	Interprets underlying psychodynamics	31
i	Deals with unconscious problems	26
c	Manages neurotic disturbances	24
e	Manages outpatient psychotic disturbances	10

perception of the clinical roles of the marital & family therapist between this study's group of primary care physicians and non-primary care physicians?

Table 6 compares the proportions of "YES" responses to the questionnaire items on page two of the instrument between this study's group of thirty-five primary care subjects with the group of fifty-one non-primary care subjects and then lists the corresponding Z scores. Figure 1 rearranges the questionnaire items into an ascending order which displays increasing differences of "YES" proportions between these same two groups.

Statistically significant differences between the primary care and non-primary care groups were found in five of the fourteen questionnaire items. In all five items, the primary care subjects attributed a greater proportion of "YES" responses to that particular item being a clinical role of marital & family therapists than did the non-primary care group. Among these five items, a significantly greater proportion of primary care subjects than non-primary care subjects considered the clinical role of marital & family therapists to include dealing with unconscious problems, changing dysfunctional ways of thinking, identifying repressed conflicts, and interpreting underlying psychodynamics.

Research Question Four: Do differences exist in the perception of the clinical roles of the marital & family

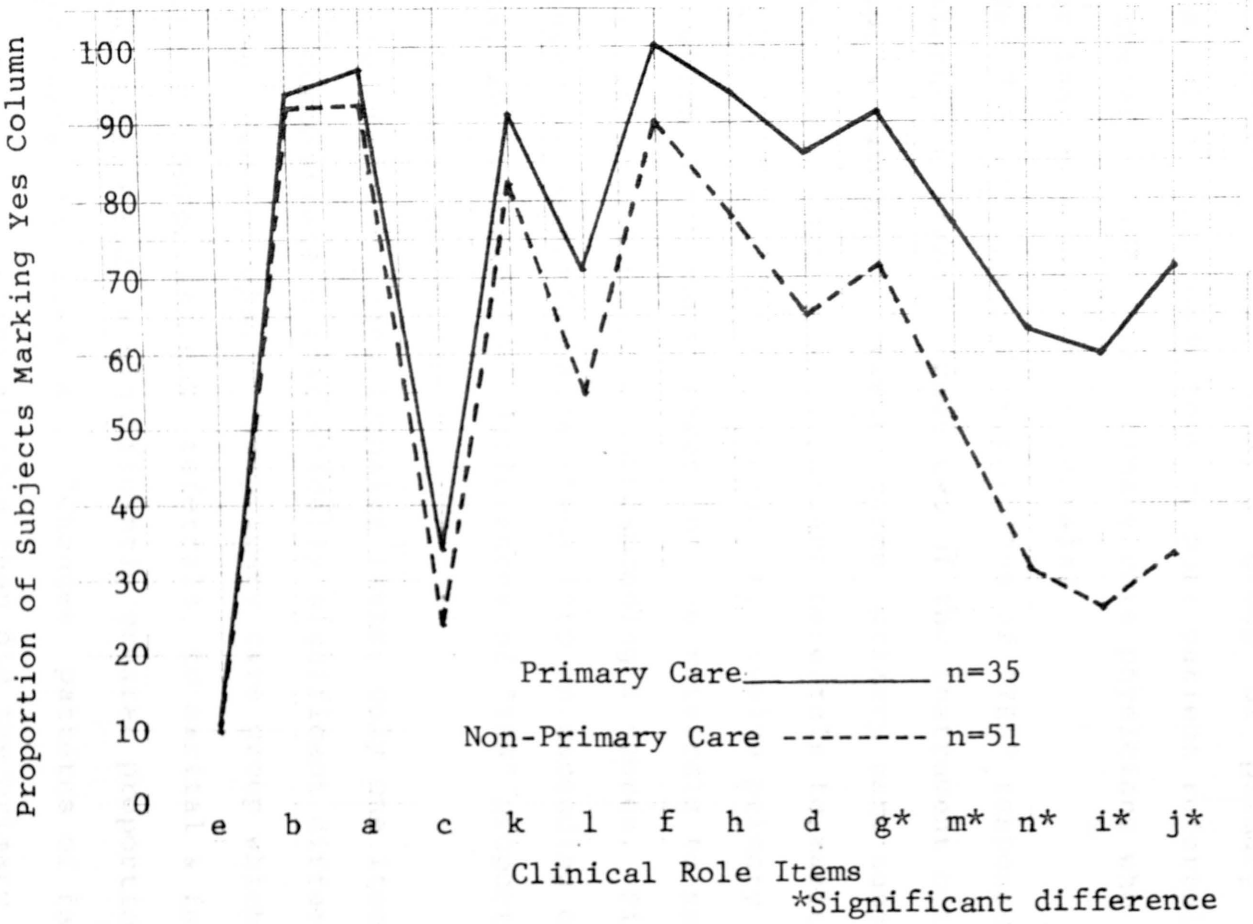
Table 6
Comparative Perceptions of Clinical Roles
Of Marital & Family Therapists By
Primary Care and Non-Primary Care Physicians

P.C.: n=35
N.P.C.: n=51

	Clinical Role Items	Percent Marking Yes column		
		P.C.	N.P.C.	Z Score
a.	Provides emotional support	97	92	.9707
b.	Offers practical advice, guidance	94	92	.3807
c.	Manages neurotic disturbances	34	24	1.0925
d.	Manages situational disturbances	86	65	2.1624
e.	Manages outpatient psychotic disturbances	11	10	.2418
f.	Helps people ventilate, express feelings	100	90	1.9087
g.	Teaches conflict resolution skills	91	71	2.3339*
h.	Deals with conscious problems	94	78	2.0164
i.	Deals with unconscious problems	60	26	3.2157*
j.	Changes dysfunctional ways of thinking	71	33	3.4721*
k.	Changes patterns of family interaction	91	82	1.1933
l.	Changes specific behaviors	71	55	1.5483
m.	Identifies repressed conflicts	77	51	2.4510*
n.	Interprets underlying psychodynamics	63	31	2.8884*

*Significant difference

Figure 1
Comparative Perceptions Of Clinical Roles Of Marital & Family Therapists By Primary Care and Non-Primary Care Physicians



therapist between this study's group of primary care physicians which has made four or more patient referrals to such a therapist and those primary care physicians who have made fewer than four patient referrals?

Table 7 compares the proportions of "YES" responses to the questionnaire items on page two of the instrument between this study's group of twenty-three primary care subjects which has made four or more patient referrals to marital & family therapists with the group of twelve primary care subjects which has made fewer or no referrals to such a therapist; it then lists the corresponding Z scores. Figure 2 rearranges the questionnaire items into an ascending order which displays increasing differences of "YES" proportions between these same two groups.

Of the fourteen questionnaire items, only one item was found to demonstrate a statistically significant difference between the two groups. The primary care group which had made four or more patient referrals to marital & family therapists attributed a significantly greater proportion of "YES" responses to item k., "Changes patterns of family interaction", as a clinical role than did the primary care group which made fewer than four patient referrals.

Research Question Five: Do differences exist in the perception of the clinical roles of the marital & family therapist between this study's group of non-primary care

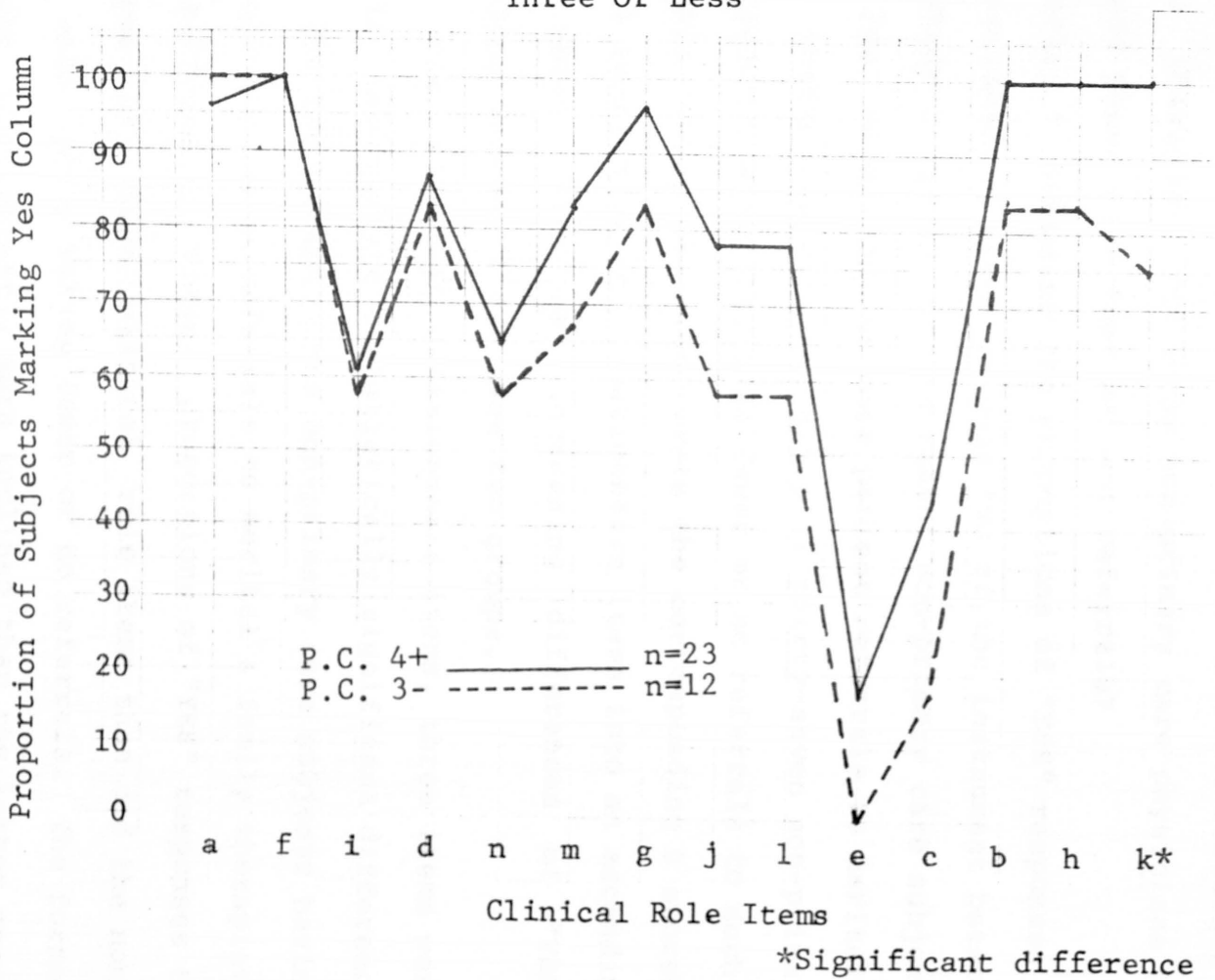
Table 7
Comparative Perceptions of Clinical Roles Of Marital & Family Therapists By Primary Care Physicians Making Four or More Referrals and Primary Care Physicians Making Three Or Less

P.C.4+: n=23
P.C.3-: n=12

	Clinical Role Items	Percent Marking Yes column		
		P.C. 4+	P.C. 3-	Z Score
a.	Provides emotional support	96	100	-.7329
b.	Offers practical advice, guidance	100	83	2.0163
c.	Manages neurotic disturbances	44	17	1.5862
d.	Manages situational disturbances	87	83	.2907
e.	Manages outpatient psychotic disturbances	17	0	1.5350
f.	Helps people ventilate, express feelings	100	100	0.0
g.	Teaches conflict resolution skills	96	83	1.2357
h.	Deals with conscious problems	100	83	2.0163
i.	Deals with unconscious problems	61	58	.1454
j.	Changes dysfunctional ways of thinking	78	58	1.2387
k.	Changes patterns of family interaction	100	75	2.5078*
l.	Changes specific behaviors	78	58	1.2387
m.	Identifies repressed conflicts	83	67	1.0661
n.	Interprets underlying psychodynamics	65	58	.4001

*Significant difference

Figure 2
Comparative Perceptions Of Clinical Roles Of Marital & Family Therapists By Primary Care Physicians Making Four Or More Referrals and Primary Care Physicians Making Three Or Less



*Significant difference

physicians which has made four or more patient referrals to such a therapist and those non-primary care physicians who have made fewer than four patient referrals?

Table 8 compares the proportions of "YES" responses to the questionnaire items on page two of the instrument between this study's group of fourteen non-primary care subjects which has made four or more patient referrals to marital & family therapists with the group of thirty-seven non-primary care subjects which has made fewer or no referrals to such a therapist; Table 8 also lists the corresponding Z scores. Figure 3 rearranges the questionnaire items into an ascending order which displays increasing differences of "YES" proportions between these same two groups.

Of the fourteen questionnaire items, three items were found to demonstrate a statistically significant difference between the two groups. The non-primary care subjects having made four or more referrals to marital & family therapists had significantly higher proportions of "YES" responses to all three of these clinical role items than did the non-primary care group making fewer or no referrals. The former group was significantly more inclined than the latter group to perceive managing neurotic disturbances, dealing with unconscious problems, and interpreting underlying psychodynamics as a clinical role of the marital & family therapist.

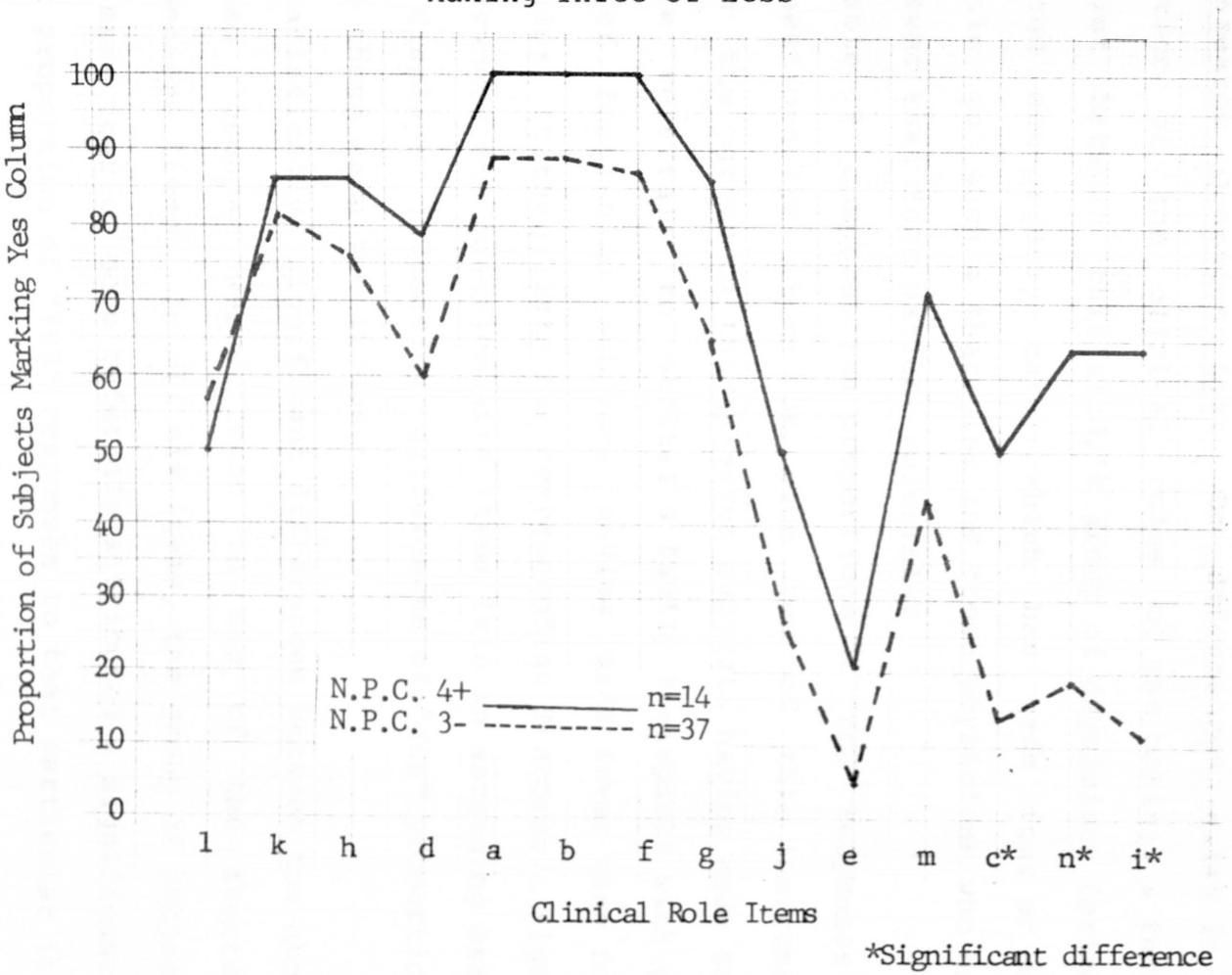
Table 8
Comparative Perceptions of Clinical Roles Of Marital & Family Therapists By Non-Primary Care Physicians Making Four or More Referrals and Non-Primary Care Physicians Making Three Or Less

N.P.C. 4+: n=14
N.P.C. 3-: n=37

	Clinical Role Items	Percent Marking Yes column		
		N.P.C. 4+	N.P.C. 3-	Z Score
a.	Provides emotional support	100	89	1.2815
b.	Offers practical advice, guidance	100	89	1.2815
c.	Manages neurotic disturbances	50	14	2.7413*
d.	Manages situational disturbances	79	60	1.2746
e.	Manages outpatient psychotic disturbances	21	5	1.7173
f.	Helps people ventilate, express feelings	100	87	1.4483
g.	Teaches conflict resolution skills	86	65	1.4583
h.	Deals with conscious problems	86	76	.7778
i.	Deals with unconscious problems	64	11	3.9105*
j.	Changes dysfunctional ways of thinking	50	27	1.5531
k.	Changes patterns of family interaction	86	81	.3873
l.	Changes specific behaviors	50	57	-.4328
m.	Identifies repressed conflicts	71	43	1.7969
n.	Interprets underlying psychodynamics	64	19	3.1160*

*Significant difference

Figure 3
Comparative Perceptions Of Clinical Roles of Marital & Family Therapists By Non-Primary Care Physicians Making Four Or More Referrals and Non-Primary Care Physicians Making Three Or Less



*Significant difference

Research Question Six: Do differences exist in the perception of the clinical roles of the marital & family therapist between this study's group of physicians (primary care and non-primary care) which has made four or more referrals to such a therapist and those physicians who have made fewer than four patient referrals?

Table 9 compares the proportions of "YES" responses to the questionnaire items on page two of this instrument between the group of thirty-seven subjects having made four or more referrals to marital & family therapists with the group of forty-nine subjects having made fewer than four referrals; it then lists the corresponding Z scores. Figure 4 rearranges the questionnaire items into an ascending order which displays increasing differences of "YES" proportions between these same two groups.

Statistically significant differences between the above mentioned groups were found in six of the fourteen questionnaire items. In all six items, the group of subjects having made four or more referrals attributed a significantly greater proportion of "YES" responses to that particular item being a clinical role of marital & family therapists than did the group having made fewer than four patient referrals to such a therapist. Among these six items were included managing neurotic disturbances, dealing with unconscious problems, and interpreting underlying psychodynamics.

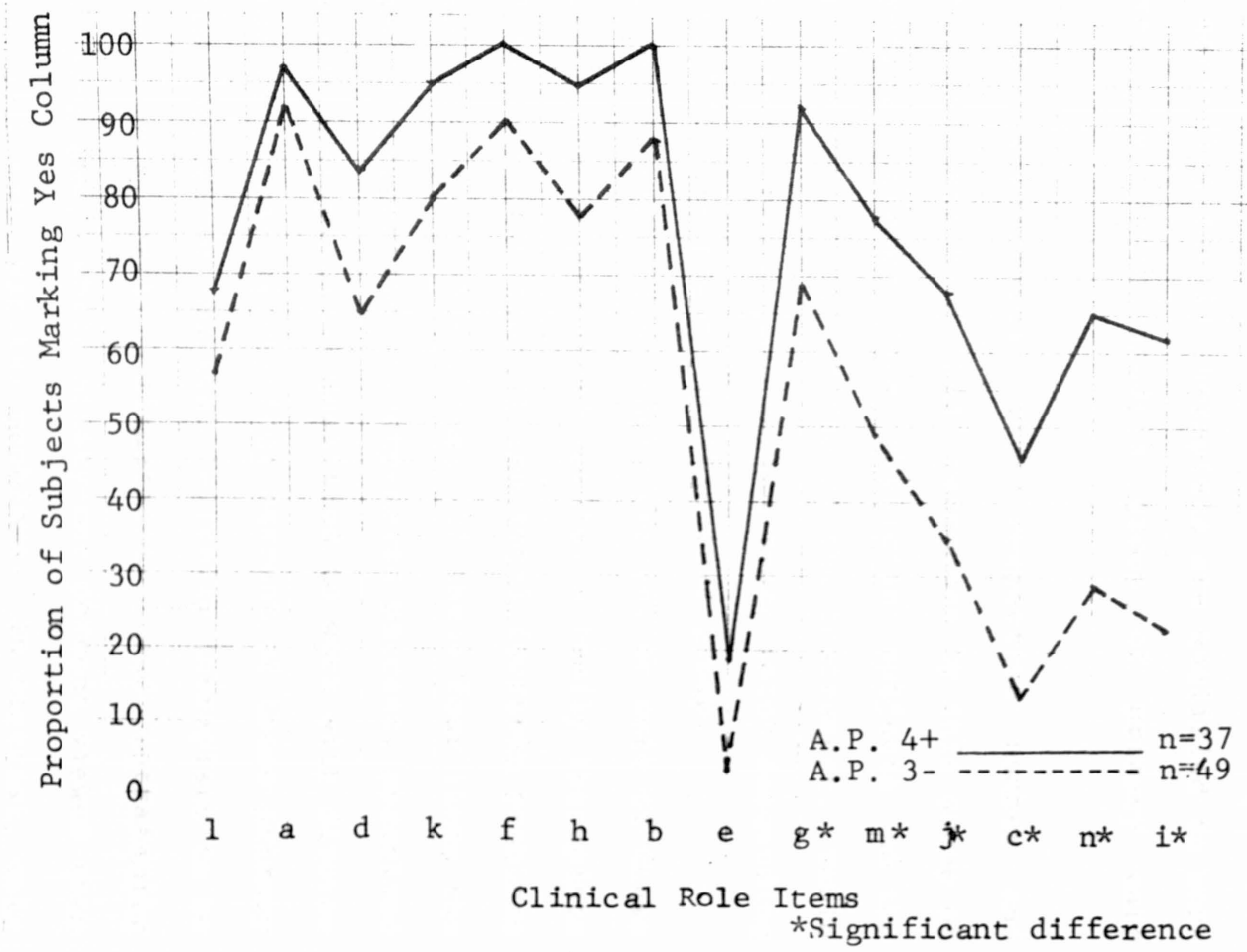
Table 9
Comparative Perceptions of Clinical Roles Of Marital & Family Therapists By All Physicians Making Four or More Referrals and All Physicians Making Three Or Less

A.P. 4+: n=37
A.P. 3-: n=49

	Clinical Role Items	Percent Marking Yes column		
		A.P. 4+	A.P. 3-	Z Score
a.	Provides emotional support	97	92	1.0714
b.	Offers practical advice, guidance	100	88	2.2069
c.	Manages neurotic disturbances	46	14	3.2408*
d.	Manages situational disturbances	84	65	1.9167
e.	Manages outpatient psychotic disturbances	19	4	2.2255
f.	Helps people ventilate, express feelings	100	90	2.0021
g.	Teaches conflict resolution skills	92	69	2.5399*
h.	Deals with conscious problems	95	78	2.1846
i.	Deals with unconscious problems	62	23	3.7294*
j.	Changes dysfunctional ways of thinking	68	35	3.0195*
k.	Changes patterns of family interaction	95	80	1.9880
l.	Changes specific behaviors	68	57	.9843
m.	Identifies repressed conflicts	78	49	2.7758*
n.	Interprets underlying psychodynamics	65	29	3.3556*

*Significant difference

Figure 4
Comparative Perceptions Of Clinical Roles of Marital & Family Therapists By All Physicians Making Four Or More Referrals and All Physicians Making Three Or Less



Research Question Seven: What are the kinds of problems with which marital & family therapists are qualified to work as perceived by this study's group of primary care physicians?

Table 10 illustrates the respective number and corresponding proportion of "YES" responses by this group of size thirty-five primary care physician subjects to the questionnaire items on page three of the instrument. Table 11 reconstructs the item arrangement into descending proportions of "YES" responses by this same group.

The tables display that ninety percent or more of these primary care subjects perceived marital & family therapists as qualified to work with four of the total fourteen problems listed in these questionnaire items. Of these four items the group's highest proportion, ninety-seven percent, perceived marital & family therapists as qualified to work with divorce or separation problems; ninety-four percent of these primary care subjects perceived marital & family therapists to be qualified to work with situational and intrafamily relationship problems, while ninety-one percent viewed them qualified to work with marital problems. In contrast, only thirty-seven percent considered marital & family therapists qualified to work with depressive problems (although a comparatively higher sixty percent of this primary care group rated such therapists as qualified to work with anxiety

Table 10
Referral Qualifications of Marital & Family Therapists
As Perceived By Primary Care Physicians
n=35

	Referral Criteria Items	Number Marking Yes Column	Percent Marking Yes Column
a.	Parent-child conflicts	31	89
b.	Marital problems	32	91
c.	Depressive problems	13	37
d.	Anxiety problems	21	60
e.	Sexual problems	23	66
f.	Psychosomatic problems	12	34
g.	Sexual trauma	18	51
h.	Divorce or separation problems	34	97
i.	Emotional problems secondary to disease	20	57
j.	Situational problems	33	94
k.	Hypochondriacal problems	20	57
l.	Paranoid and delusional problems	5	14
m.	Intrafamily relationship problems	33	94
n.	Undesired pregnancy	28	80

Table 11
Descending Order of Referral Qualifications
Of Marital & Family Therapists
As Perceived By Primary Care Physicians

	Referral Criteria Items	n=35 Percent Marking Yes Column
h.	Divorce or separation problems	97
j.	Situational problems	94
m.	Intrafamily relationship problems	94
b.	Marital problems	91
a.	Parent-child conflicts	89
n.	Undesired pregnancy	80
e.	Sexual problems	66
d.	Anxiety problems	60
i.	Emotional problems secondary to disease	57
k.	Hypochondriacal problems	57
g.	Sexual trauma	51
c.	Depressive problems	37
f.	Psychosomatic problems	34
l.	Paranoid and delusional problems	14

problems). Thirty-four percent viewed them qualified to work with psychosomatic problems, and only a slight fourteen percent of this primary care group judged the marital & family therapist to be qualified to work with paranoid and delusional problems not requiring hospitalization.

Research Question Eight: What are the kinds of problems with which marital & family therapists are qualified to work as perceived by this study's group of non-primary care physicians?

Table 12 illustrates the respective number and corresponding proportion of "YES" responses by this group of size fifty-one non-primary care physician subjects to the questionnaire items on page three of the instrument. Table 13 reconstructs the item arrangement into descending proportions of "YES" responses by this same group.

Unlike the subjects in the primary care group, there were no items toward which ninety percent or more of these non-primary care subjects perceived marital & family therapists as qualified to work. Tables 12 and 13 display that eighty percent or more of these subjects considered marital & family therapists to be qualified to work with five of the total fourteen problems listed in the questionnaire items. Of these five items the group's highest proportion, eighty-eight percent, perceived marital & family therapists as qualified to work with intrafamily relationship problems;

Table 12
Referral Qualifications Of Marital & Family Therapists
As Perceived By Non-Primary Care Physicians
n=51

	Referral Criteria Items	Number Marking Yes Column	Percent Marking Yes Column
a.	Parent-child conflicts	42	82
b.	Marital problems	40	78
c.	Depressive problems	8	16
d.	Anxiety problems	18	35
e.	Sexual problems	22	43
f.	Psychosomatic problems	7	14
g.	Sexual trauma	17	33
h.	Divorce or separation problems	42	82
i.	Emotional problems secondary to disease	30	59
j.	Situational problems	41	80
k.	Hypochondriacal problems	21	41
l.	Paranoid and delusional problems	3	6
m.	Intrafamily relationship problems	45	88
n.	Undesired pregnancy	42	82

Table 13
Descending Order of Referral Qualifications
Of Marital & Family Therapists
As Perceived By Non-Primary Care Physicians

n=51

	Referral Criteria Items	Percent Marking Yes Column
m.	Intrafamily relationship problems	88
a.	Parent-child conflicts	82
h.	Divorce or separation problems	82
n.	Undesired pregnancy	82
j.	Situational problems	80
b.	Marital problems	78
i.	Emotional problems secondary to disease	59
e.	Sexual problems	43
k.	Hypochondriacal problems	41
d.	Anxiety problems	35
g.	Sexual trauma	33
c.	Depressive problems	16
f.	Psychosomatic problems	14
l.	Paranoid and delusional problems	6

eighty-two percent perceived marital & family therapists to be qualified to work with parent-child conflicts, divorce or separation problems, and undesired pregnancy, while eighty percent of this group believed them qualified to work with situational problems. In contrast, less than fifty percent of these non-primary care subjects perceived marital & family therapists as qualified to work with seven of the fourteen problems listed in the questionnaire items. Among these seven items, only thirty-five percent of the subjects viewed marital & family therapists as qualified to work with anxiety problems; sixteen percent considered them qualified to work with depressive problems. An even smaller proportion, fourteen percent, perceived them to be qualified to work with psychosomatic problems, and a mere six percent viewed marital & family therapists qualified to work with paranoid and delusional problems not requiring hospitalization.

Research Question Nine: Do differences exist between this study's primary care physicians and non-primary care physicians in their perception of the kinds of problems with which marital & family therapists are qualified to work?

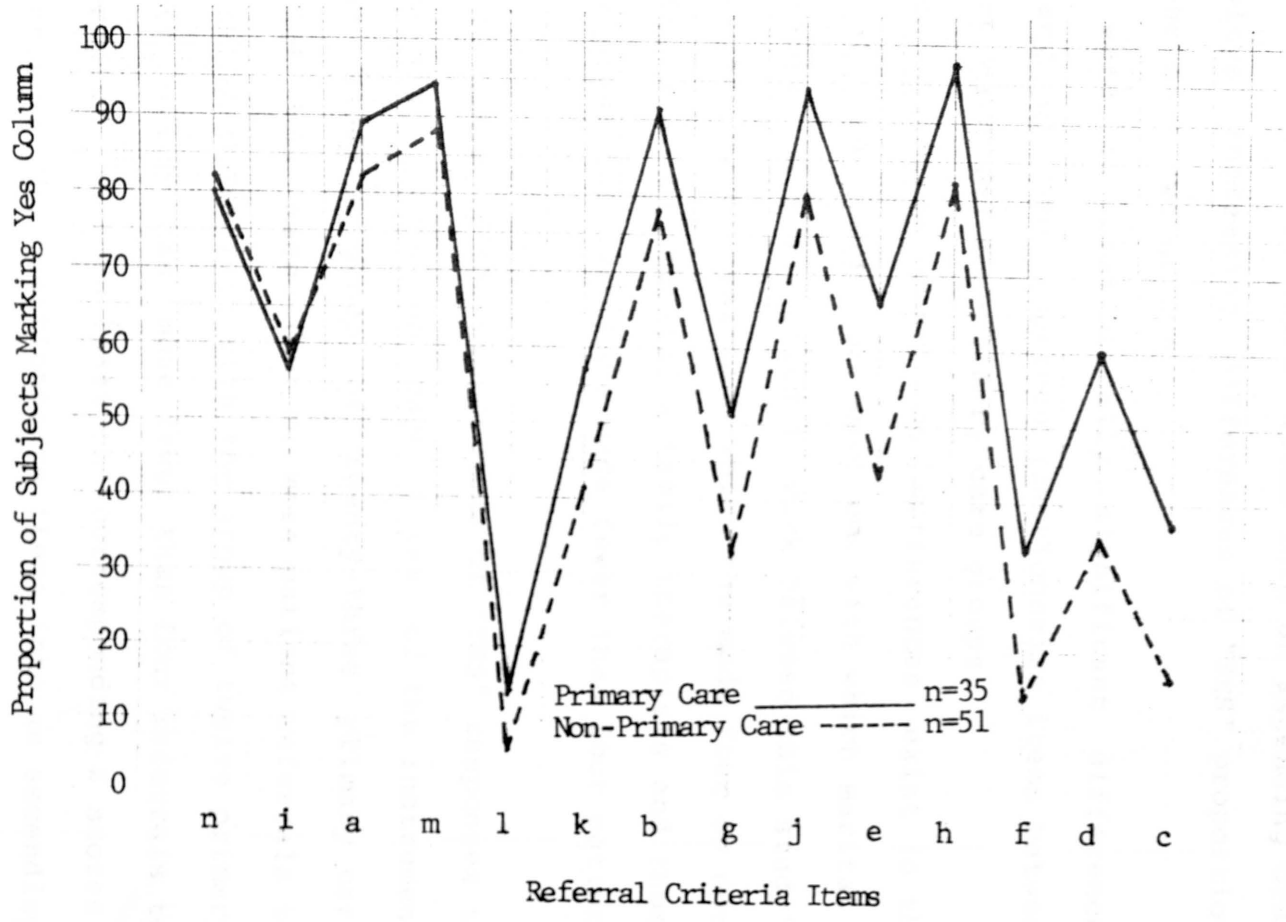
Table 14 compares the proportion of "YES" responses to the questionnaire items on page three of the instrument between this study's group of thirty-five primary care subjects with the group of fifty-one non-primary care subjects and then lists the corresponding Z scores. Figure 5

Table 14
Comparative Perceptions of Referral Qualifications
Of Marital & Family Therapists By
Primary Care and Non-Primary Care Physicians

P.C.: n=35
N.P.C.: n=51

Referral Criteria Items		Percent Marking Yes column		
		P.C.	N.P.C.	Z Score
a.	Parent-child conflicts	89	82	.7909
b.	Marital problems	91	78	1.6039
c.	Depressive problems	37	16	2.2754
d.	Anxiety problems	60	35	2.2609
e.	Sexual problems	66	43	2.0594
f.	Psychosomatic problems	34	14	2.2578
g.	Sexual trauma	51	33	1.6781
h.	Divorce or separation problems	97	82	2.1020
i.	Emotional problems secondary to disease	57	59	-.1552
j.	Situational problems	94	80	1.8267
k.	Hypochondriacal problems	57	41	1.4564
l.	Paranoid and delusional problems	14	6	1.3180
m.	Intrafamily relationship problems	94	88	.9490
n.	Undesired pregnancy	80	82	-.2755

Figure 5
Comparative Perceptions Of Referral Qualifications Of
Marital & Family Therapists By Primary Care and
Non-Primary Care Physicians



rearranges the questionnaire items into an ascending order which displays increasing differences of "YES" proportions between these same two groups.

There were no statistically significant differences found in any of the fourteen questionnaire items between these primary care and non-primary care groups.

Research Question Ten: Do differences exist in the perception of the kinds of problems with which marital & family therapists are qualified to work between this study's group of primary care physicians which has made four or more patient referrals to marital & family therapists and those primary care physicians who have made fewer than four patient referrals?

Table 15 compares the proportions of "YES" responses to the questionnaire items on page three of the instrument between this study's group of twenty-three primary care subjects which has made four or more patient referrals to marital & family therapists with the group of twelve primary care subjects which has made fewer than four referrals to such a therapist; it then lists the corresponding Z scores. Figure 6 rearranges the questionnaire items into an ascending order which displays increasing differences of "YES" proportions between these same two groups. None of the differences were found to be significant at the 0.01 level.

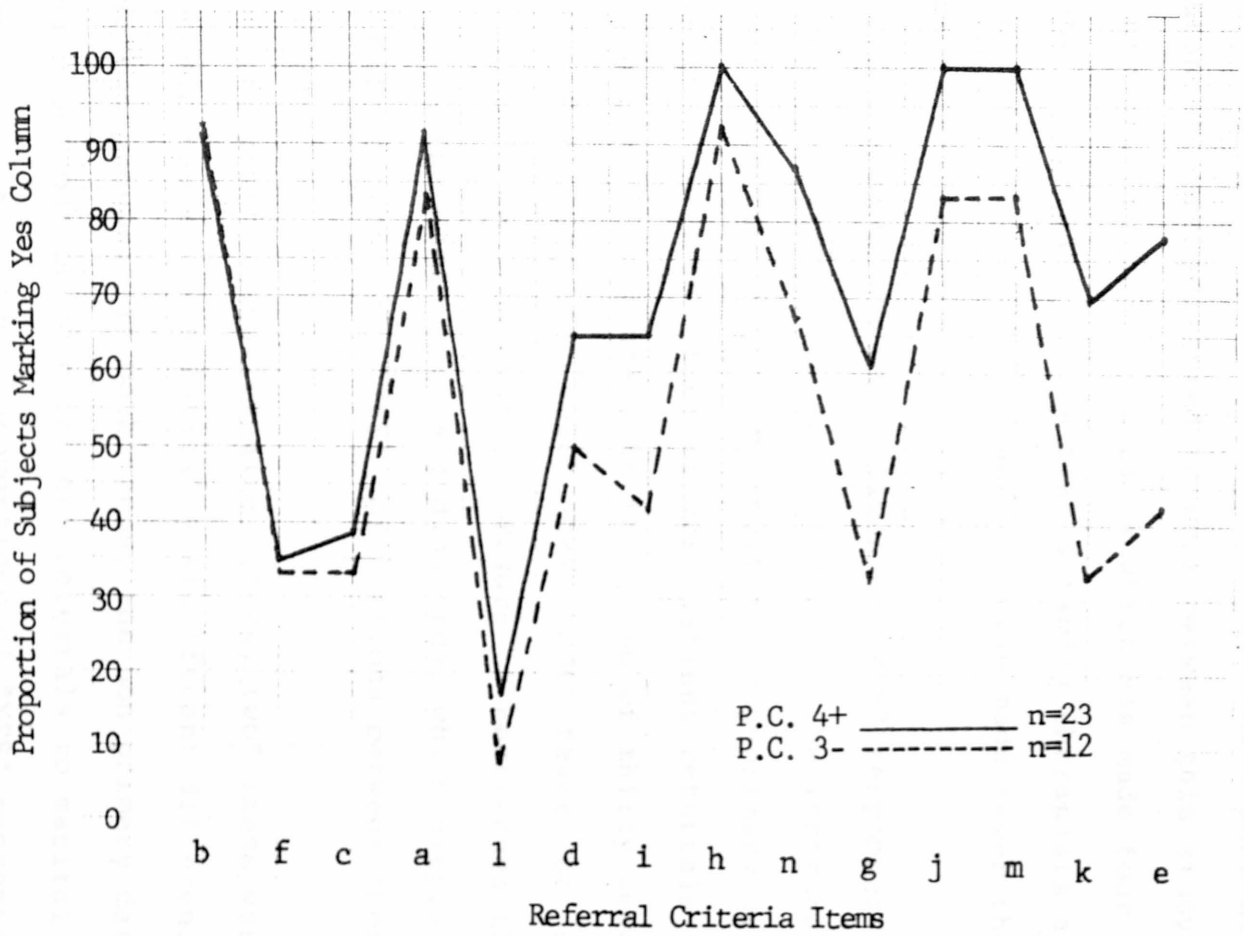
Research Question Eleven: Do differences exist in the

Table 15
Comparative Perceptions of Referral Qualifications
Of Marital & Family Therapists By Primary Care
Physicians Making Four or More Referrals and
Primary Care Physicians Making Three Or Less

P.C. 4+: n=23
P.C. 3-: n=12

	Referral Criteria Items	Percent Marking Yes column		
		P.C. 4+	P.C. 3-	Z Score
a.	Parent-child conflicts	91	83	.7035
b.	Marital problems	91	92	-.0363
c.	Depressive problems	39	33	.3369
d.	Anxiety problems	65	50	.8723
e.	Sexual problems	78	42	2.1649
f.	Psychosomatic problems	35	33	.0857
g.	Sexual trauma	61	33	1.5471
h.	Divorce or separation problems	100	92	1.4046
i.	Emotional problems secondary to disease	65	42	1.3364
j.	Situational problems	100	83	2.0163
k.	Hypochondriacal problems	70	33	2.0560
l.	Paranoid and delusional problems	17	8	.7269
m.	Intrafamily relationship problems	100	83	2.0163
n.	Undesired pregnancy	87	67	1.4244

Figure 6
Comparative Perceptions Of Referral Qualifications Of Marital & Family Therapists By Primary Care Physicians Making Four Or More Referrals and Primary Care Physicians Making Three Or Less



perception of the kinds of problems with which marital & family therapists are qualified to work between this study's group of non-primary care physicians which has made four or more patient referrals to marital & family therapists and those non-primary care physicians who have made fewer than four patient referrals?

Table 16 compares the proportions of "YES" responses to the questionnaire items on page three of the instrument between this study's group of fourteen non-primary care subjects which has made four or more patient referrals to marital & family therapists with the group of thirty-seven non-primary care subjects which has made fewer or no referrals to such a therapist. Figure 7 rearranges the questionnaire items into an ascending order which displays increasing differences of "YES" proportions between these same two groups.

Of the fourteen questionnaire items, two* items were found to demonstrate a statistically significant difference between the two groups. In both items, the non-primary care group having made four or more patient referrals to marital & family therapists had higher proportions of "YES" responses than the non-primary care group making fewer than four referrals. The former group perceived marital & family

*A third item, item e., also may be considered to demonstrate a statistically significant difference, but it was omitted from analysis due to the small sizes of the cells being compared.

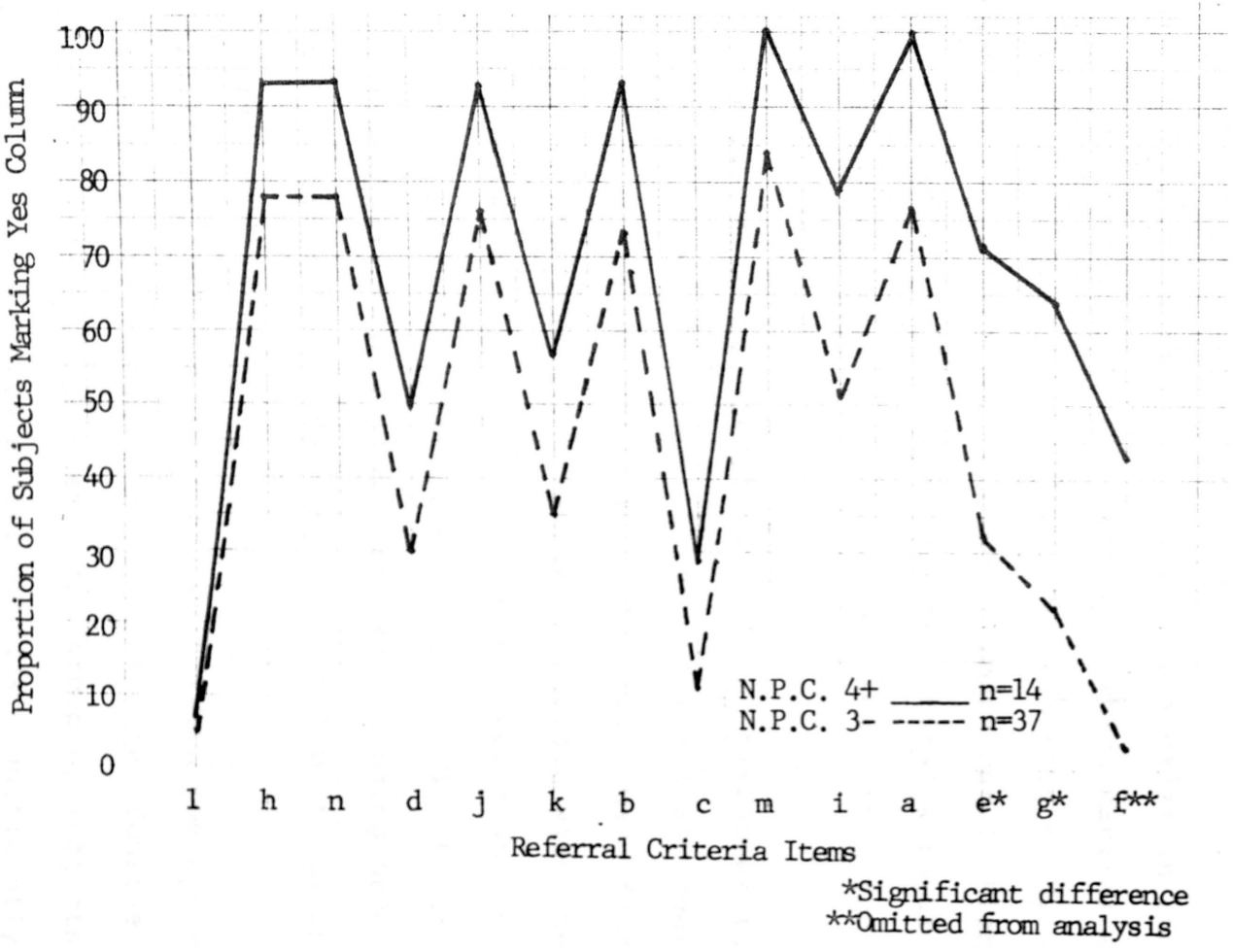
Table 16
Comparative Perceptions of Referral Qualifications Of Marital & Family Therapists By Non-Primary Care Physicians Making Four or More Referrals and Non-Primary Care Physicians Making Three Or Less

N.P.C. 4+: n=14
N.P.C. 3-: n=37

Referral Criteria Items		Percent Marking Yes column		
		N.P.C. 4+	N.P.C. 3-	Z Score
a.	Parent-child conflicts	100	76	2.0335
b.	Marital problems	93	73	1.5407
c.	Depressive problems	29	11	1.5564
d.	Anxiety problems	50	30	1.3518
e.	Sexual problems	71	32	2.5093*
f.	Psychosomatic problems	43	3	3.7188**
g.	Sexual trauma	64	22	2.8844*
h.	Divorce or separation problems	93	78	1.2104
i.	Emotional problems secondary to disease	79	51	1.7627
j.	Situational problems	93	76	1.3792
k.	Hypochondriacal problems	57	35	1.4251
l.	Paranoid and delusional problems	7	5	.2353
m.	Intrafamily relationship problems	100	84	1.6040
n.	Undesired pregnancy	93	78	1.2104

*Significant difference
**Omitted from analysis

Figure 7
Comparative Perceptions of Referral Qualifications Of Marital & Family Therapists By Non-Primary Care Physicians Making Four Or More Referrals and Non-Primary Care Physicians Making Three Or Less



*Significant difference
**Omitted from analysis

therapists to be more qualified to work with sexual problems and sexual trauma than did the latter group.

Research Question Twelve: Do differences exist in the perception of the kinds of problems with which marital & family therapists are qualified to work between this study's group of physicians (primary care and non-primary care) which has made four or more patient referrals to marital & family therapists and those physicians who have made fewer than four patient referrals?

Table 17 compares the proportions of "YES" responses to the questionnaire items on page three of the instrument between the group of thirty-seven subjects having made four or more referrals to marital & family therapists with the group of forty-nine subjects having made fewer than four referrals; it then lists the corresponding Z scores. Figure 8 rearranges the questionnaire items into an ascending order which displays increasing differences of "YES" proportions between these same two groups.

Statistically significant differences between the above mentioned groups were found in six of the fourteen questionnaire items. In all six items, the group of subjects having made four or more referrals attributed a significantly greater proportion of "YES" responses to marital & family therapists being qualified to work with that particular item than did the group having made fewer than four patient

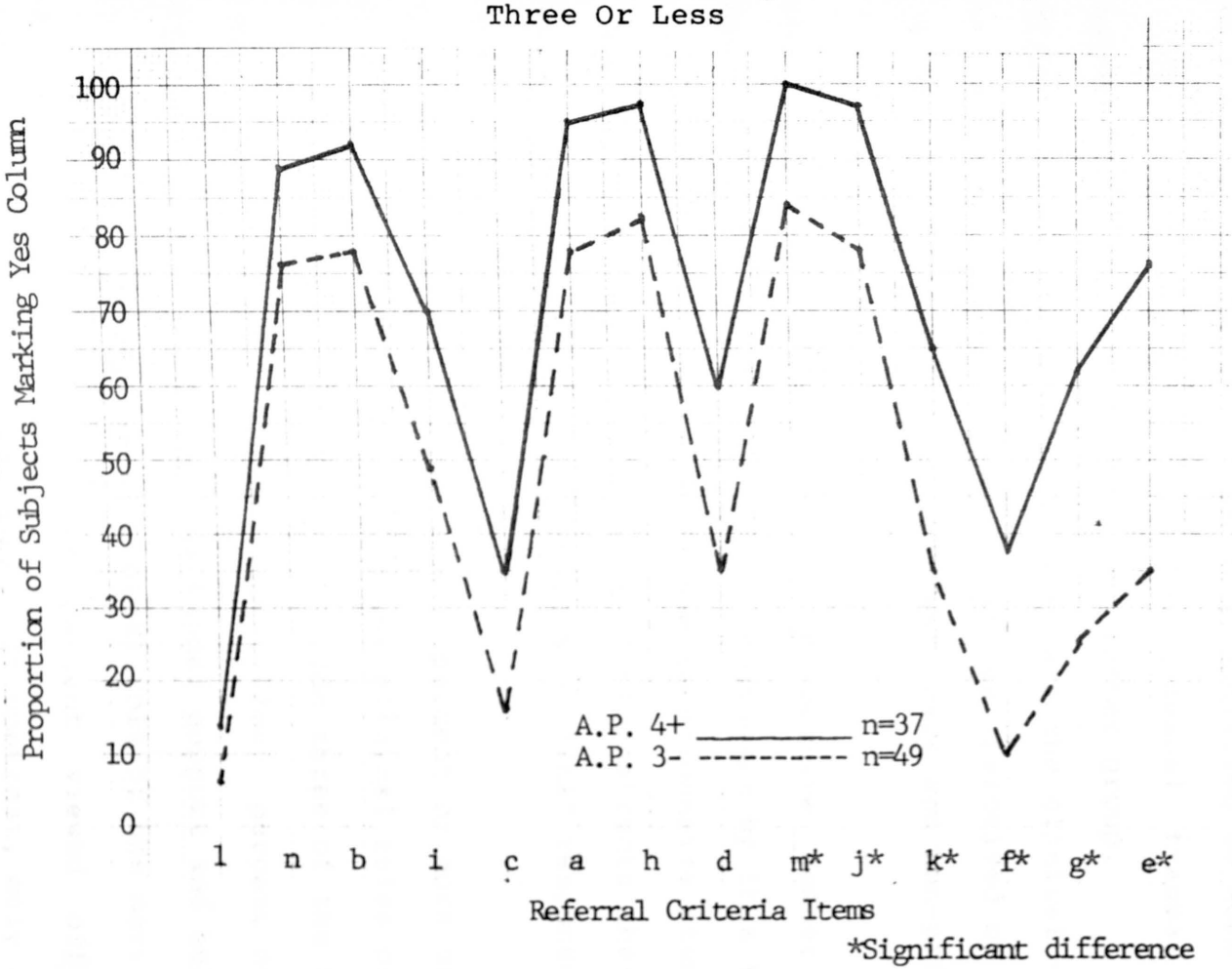
Table 17
Comparative Perceptions of Referral Qualifications
Of Marital & Family Therapists By All
Physicians Making Four or More Referrals and
All Physicians Making Three Or Less

A.P.4+: n=37
A.P.3-: n=49

	Referral Criteria Items	Percent Marking Yes column		
		A.P. 4+	A.P. 3-	Z Score
a.	Parent-child conflicts	95	78	2.1846
b.	Marital problems	92	78	1.7836
c.	Depressive problems	35	16	2.0102
d.	Anxiety problems	60	35	2.2841
e.	Sexual problems	76	35	3.7673*
f.	Psychosomatic problems	38	10	3.0582*
g.	Sexual trauma	62	25	3.5209*
h.	Divorce or separation problems	97	82	2.2437
i.	Emotional problems secondary to disease	70	49	1.9815
j.	Situational problems	97	78	2.6165*
k.	Hypochondriacal problems	65	35	2.7736*
l.	Paranoid and delusional problems	14	6	1.1683
m.	Intrafamily relationship problems	100	84	2.5808*
n.	Undesired pregnancy	89	76	1.6140

*Significant difference

Figure 8
Comparative Perceptions of Referral Qualifications Of Marital & Family Therapists By All Physicians Making Four Or More Referrals and All Physicians Making Three Or Less



referrals to such a therapist. The former group considered marital & family therapists to be more qualified to work with such criteria as sexual problems, sexual trauma, and hypochondriacal problems than did the latter group.

Research Question Thirteen: What are the clinical roles of the marital & family therapist as perceived by this study's group of physicians (primary care and non-primary care)?

Table 18 illustrates the respective number and corresponding proportion of "YES" responses by this total group of eighty-six subjects to the questionnaire items on page two of the instrument. Table 19 reconstructs the item arrangement into descending proportions of "YES" responses by this same group.

The tables display that ninety percent or more of the subjects in this study perceived the clinical roles of the marital & family therapist to include three of the total fourteen questionnaire items. Ninety-four percent of the subjects perceived providing emotional support and helping people express feelings as a clinical role of the marital & family therapist. Ninety-three percent viewed offering practical advice as a clinical role. In contrast, only forty percent of this group considered that dealing with unconscious problems was a marital & family therapist role. A lesser proportion, twenty-eight percent, perceived managing

Table 18
Clinical Roles Of Marital & Family Therapists
As Perceived By All Physicians

n=86

	Clinical Role Items	Number Marking Yes Column	Percent Marking Yes Column
a.	Provides emotional support	81	94
b.	Offers practical advice, guidance	80	93
c.	Manages neurotic disturbances	24	28
d.	Manages situational disturbances	63	73
e.	Manages outpatient psychotic disturbances	9	11
f.	Helps people ventilate, express feelings	81	94
g.	Teaches conflict resolution skills	68	79
h.	Deals with conscious problems	73	85
i.	Deals with unconscious problems	34	40
j.	Changes dysfunctional ways of thinking	42	49
k.	Changes patterns of family interaction	74	86
l.	Changes specific behaviors	53	62
m.	Identifies repressed conflicts	53	62
n.	Interprets underlying psychodynamics	38	44

Table 19
Descending Order Of
Clinical Roles Of Marital & Family Therapists
As Perceived By All Physicians

n=86

	Clinical Role Items	Percent Marking Yes Column
a.	Provides emotional support	94
f.	Helps people ventilate, express feelings	94
b.	Offers practical advice, guidance	93
k.	Changes patterns of family interaction	86
h.	Deals with conscious problems	85
g.	Teaches conflict resolution skills	79
d.	Manages situational disturbances	73
l.	Changes specific behaviors	62
m.	Identifies repressed conflicts	62
j.	Changes dysfunctional ways of thinking	49
n.	Interprets underlying psychodynamics	44
i.	Deals with unconscious problems	40
c.	Manages neurotic disturbances	28
e.	Manages outpatient psychotic disturbances	11

neurotic disturbances to be a clinical role. The smallest proportion of subjects, eleven percent, perceived managing outpatient psychotic disturbances as a marital & family therapist role.

Research Question Fourteen: What are the kinds of problems with which marital & family therapists are qualified to work as perceived by this study's group of physicians (primary care and non-primary care)?

Table 20 illustrates the respective number and corresponding proportion of "YES" responses by this total group of eighty-six subjects to the questionnaire items on page three of the instrument. Table 21 reconstructs the item arrangement into descending proportions of "YES" responses by this same group.

Out of the fourteen questionnaire items, only item m., "Intrafamily relationship problems", was perceived by ninety percent or more of the subjects as a criteria with which marital & family therapists are qualified to work. Five other items were perceived by eighty percent or more of these subjects as criteria with which marital & family therapists are qualified to work. Among these items, eighty-eight percent considered marital & family therapists qualified to work with divorce or separation problems, eighty-five percent with parent-child conflicts, and eighty-four percent with marital problems. In contrast, only twenty-four percent of

Table 20
Referral Qualifications Of Marital & Family Therapists
As Perceived By All Physicians

n=86

	Referral Criteria Items	Number Marking Yes Column	Percent Marking Yes Column
a.	Parent-child conflicts	73	85
b.	Marital problems	72	84
c.	Depressive problems	21	24
d.	Anxiety problems	39	45
e.	Sexual problems	45	52
f.	Psychosomatic problems	19	22
g.	Sexual trauma	35	41
h.	Divorce or separation problems	76	88
i.	Emotional problems secondary to disease	50	58
j.	Situational problems	74	86
k.	Hypochondriacal problems	41	48
l.	Paranoid and delusional problems	8	9
m.	Intrafamily relationship problems	78	91
n.	Undesired pregnancy	70	81

Table 21
Descending Order Of
Referral Qualifications Of Marital & Family Therapists
As Perceived By All Physicians

n=86

	Referral Criteria Items	Percent Marking Yes Column
m.	Intrafamily relationship problems	91
h.	Divorce or separation problems	88
j.	Situational problems	86
a.	Parent-child conflicts	85
b.	Marital problems	84
n.	Undesired pregnancy	81
i.	Emotional problems secondary to disease	58
e.	Sexual problems	52
k.	Hypochondriacal problems	48
d.	Anxiety problems	45
g.	Sexual trauma	41
c.	Depressive problems	24
f.	Psychosomatic problems	22
l.	Paranoid and delusional problems	9

this total group considered marital & family therapists qualified to work with depressive problems; a lesser twenty-two percent considered such therapists to be qualified to work with psychosomatic problems, and a very slight nine percent perceived the marital & family therapist qualified to work with paranoid and delusional problems not requiring hospitalization.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This chapter has been divided into the following four sections: (1) Summary; (2) Limitations; (3) Conclusions; and (4) Recommendations. To avoid redundancy*, the fourteen research questions have not been restated but instead have been incorporated piecemeal within the Conclusions section.

Summary

The physician, being in a position of both healer and authority figure, is frequently the first professional whose help is sought by people in emotional distress. As evidenced by reports in the medical literature, physicians are seeing a rising incidence of symptoms rooted in marital and family problems, including those problems associated with the divorce process. Such problems are often disguised behind the physical complaints that are presented to the doctor. If the emotionally laden factors underlying these complaints are detected, the physician may choose to either treat the patient**, ignore the distress, or refer the patient to a mental health specialist for further help.

*The research questions have been stated in Chapters I and IV.

**The term patient is used in both the singular and plural sense.

When physicians do choose to refer the patient for further help, the mental health professional most often selected is the psychiatrist. One possible reason appears to be that psychiatry, as a specialty within the medical profession rather than ancillary to it, has gained a greater degree of role identification and clarification with physicians than have other mental health disciplines. Through medical school curricula, hospital liaison, and extensive writings in the medical literature, the psychiatrist's role in the treatment of emotional distress has been not only described but often demonstrated to the non-psychiatric physician.

In contrast to the psychiatric profession's effective efforts toward the development of an acceptable professional role identity with and within the medical profession, marital & family therapists, as a discipline, have not developed comparable efforts at role definition with physicians. It has been the central purpose of this study to: (1) examine the clinical roles of the marital & family therapist as perceived by a selected group of practicing physicians; and (2) determine the kinds of referral criteria, or patient problems, with which this selected group considers marital & family therapists qualified to work. It is hoped that such information would contribute to the further development of professional role identification by marital & family therapists with the medical profession.

The research design for this descriptive study involved the following five components: (1) development of an instrument to ascertain the perceptions of physicians toward marital & family therapists; (2) establishment of validating measures for the instrument; (3) selection of the eighty-six primary care and non-primary care physician subjects; (4) collection of the data; and (5) statistical analysis of the data utilizing the Z test for differences between proportions and testing at the 0.01 level of significance. The findings have been presented in tables and graphic representations which accompany the discussion sections for each of the fourteen research questions. The predominant perceptions of marital & family therapists by this study's physicians, and various significant differences between the proportions of the subgroups concerning these perceptions, were reported.

Limitations

The data for this study was collected from only one hospital and was limited to physician subjects holding staff and hospital privileges at that facility. The results that have been found and the conclusions that are reached, therefore, may be applicable only to that particular setting and group, and may not be generalizable to other hospital settings and physician groups.

Conclusions

The results of the data for this study are interpreted

in the following ways:

1. Both primary care and non-primary care subjects perceived the clinical roles of the marital & family therapist as largely supportive or directive in nature. The greater proportions of each of these two subgroups saw the intervention techniques of marital & family therapists to be providing emotional support, offering practical advice, and helping people ventilate. These findings almost exactly duplicate the findings of previous studies mentioned in Chapter II with regard to the psychotherapeutic techniques that doctors attribute to themselves in responding to their patients' emotional distress. It thus appears that those techniques which physicians themselves are most likely to use for psychotherapeutic purposes are the same as those which they attribute to marital & family therapists.

2. The smallest proportions of both primary care and non-primary care subjects perceived the clinical roles of marital & family therapists to be managing outpatient psychotic disturbances, neurotic disturbances, and dealing with the more general reference of unconsciously based problems. It would appear from these low proportions that, in marked contrast to interventions which provide emotional support, guidance, and help people express their feelings, the physician does not believe that the clinical role of the marital & family therapist includes provision of what may be

considered more intense or in-depth psychotherapy. It may be concluded that, to the physician, the treatment of these latter type problems (outpatient psychosis, the neuroses, and unconsciously-rooted problems) requires either greater expertise than the marital & family therapist possesses, or that the treatment of such problems may require medication management which, likewise, is perceived to be outside the treatment domain of marital & family therapists.

3. When comparative perceptions of marital & family therapist clinical roles are made between the primary care group and the non-primary care group, primary care subjects had higher proportions of their members who marked the "YES" column to each of the fourteen clinical role items on page two of the instrument. Five of these differences between proportions were statistically significant. This may imply that primary care physicians tend to regard marital & family therapists as possessing a greater degree and wider variety of clinical skills than do non-primary care physicians. A further inference may be made that a reason for such broader appreciation of the marital & family therapist role is because primary care physicians may similarly have a broader focus pertaining to assessment of their patients' complaints than does the more specialized non-primary care physician who works with a comparatively narrower range of patient problems.

4. When the perceptions of the clinical roles of marital & family therapists are compared between the group of subjects making four or more patient referrals to such therapists and the group of subjects making fewer or no referrals, the former group demonstrates statistically higher "YES" proportions than the latter group in their ratings of six of the fourteen clinical role items on page two of the instrument. The more frequently referring subjects had greater proportions of their group than the less frequently referring subjects who viewed marital & family therapists performing clinical roles which included dealing with unconscious problems, changing dysfunctional ways of thinking, identifying repressed conflicts, and interpreting underlying psychodynamics. It may be concluded from these results that physicians who have a higher patient referral rate to marital & family therapists tend to view such therapists as possessing a greater degree and variety of clinical skills, especially those skills associated with more intensive psychotherapeutic treatment, than do physicians who have lower referral rates*.

*Further support for this conclusion was indicated by a comparative analysis of the perceptions of thirteen subjects who had made twenty-five or more patient referrals to marital & family therapists with the perceptions of subjects having made three or less. It was found that the differences between these two groups in the "YES" proportions of all clinical role items were even greater than the differences found between the two groups reported above.

5. Both primary care subjects and non-primary care subjects demonstrated similar views concerning the kinds of patient problems, or referral criteria, with which marital & family therapists are qualified to work. The largest proportions of each of these two groups viewed marital & family therapists as qualified to work with intrafamily relationship problems, divorce or separation problems, and situational problems involving interpersonal conflicts or status changes. From these affirmative high proportions, it may be concluded that the physician, whether primary care or non-primary care specialist, considers marital & family therapists qualified to work with problems which can be largely defined by their relationship or situational variables. Such problems and their attendant variables may be considered by the physician to be treatable by the supportive or directive interventions previously noted in Conclusion one and to which the largest proportion of subjects in this study ascribed as clinical roles of the marital & family therapist. Thus a rationale appears to exist for the kinds of clinical roles which the physician subjects most identified with marital & family therapists and the kinds of patient problems with which they perceived such therapists as qualified to work.

6. As stated in Conclusion five above, primary care and non-primary care subjects had similar perceptions of the

kinds of patient problems with which marital & family therapists were believed qualified to work. The similarity of their perceptions also applied to those patient problems with which these two groups considered marital & family therapists least qualified to work. The smallest proportion of subjects in both groups rated marital & family therapists qualified to work with psychosomatic problems, depressive problems, and paranoid or delusional problems not requiring hospitalization. These low proportions may indicate that the physician, whether primary care or non-primary care specialist, tends to perceive marital & family therapists as unqualified to work with patient problems which, while having their relationship and situational components, also may be defined by an interaction of psychophysiological, biochemical, and intrapsychic variables. Such variables may appear to the physician to require treatment by medically trained specialists and, consequently, be inappropriate for treatment by those intervention techniques noted in Conclusion one which were most ascribed by the physician subjects to marital & family therapists.

7. When comparative perceptions of patient problems (referral criteria) with which marital & family therapists are qualified to work are made between the primary care group and the non-primary care group, primary care subjects have higher proportions of their members who marked the "YES"

column in twelve of the fourteen items on page three of the instrument. None of these differences between group proportions, however, was statistically significant. It may be concluded, therefore, that primary care physicians generally tend to credit marital & family therapists as more qualified to work with a wider variety of patient problems than do non-primary care physicians, but that the differences between the views of these two groups may not be great enough to be significant when tested at the 0.01 level.

8. When the perceptions concerning the kinds of problems with which marital & family therapists are qualified to work are compared between the group of subjects making four or more patient referrals to such therapists and the group of subjects making fewer or no referrals, the former group demonstrates larger "YES" proportions than the latter group in their ratings of all fourteen referral criteria items on page three of the instrument. Six of these fourteen differences between group proportions were statistically significant. The more frequently referring subjects had greater proportions of their group than did the less frequently referring subjects who considered marital & family therapists qualified to work with such referral criteria as sexual problems (dysfunctions), sexual trauma, and hypochondriacal problems. It may be concluded from these findings that physicians who have a higher patient referral rate to marital & family therapists tend to view such therapists as

more qualified to work with a wider variety of patient problems than do physicians who have lower referral rates*.

9. Within the primary care group, no significant differences were found between the subgroup of subjects making four or more referrals to marital & family therapists and the subgroup making three or less in the perceptions toward any of the fourteen clinical role items or any of the fourteen referral criteria items in the instrument on pages two and three, respectively. However, the more frequently referring primary care subjects had larger proportions of their subgroup which marked the "YES" columns for twenty-five of the combined twenty-eight clinical role and referral criteria items than did the subgroup of less frequently referring primary care subjects. Although not demonstrating statistically significant differences, the former subgroup generally perceived marital & family therapists in more varied clinical roles and as being more qualified to work with a wider variety of patient problems than did the latter subgroup. These findings may indicate that, while proportional differences exist between the more frequently referring and the less frequently referring primary care

*Further support for this conclusion was indicated by a comparative analysis of the perceptions of thirteen subjects who had made twenty-five or more patient referrals to marital & family therapists with the perceptions of subjects having made three or less. It was found that the differences between these two groups in the "YES" proportions of all referral criteria items were even greater than the differences found between the two groups reported above.

physicians concerning their perceptions of the marital & family therapist clinical role and referral criteria, such differences may not be as great as the differences which exist when the physician group as a whole (primary and non-primary care specialties) is analyzed using the same parameters*.

10. When the perceptions of non-primary care subjects making four or more referrals to marital & family therapists are compared with the perceptions of non-primary care subjects making three or less, the former subgroup had larger proportions of its members marking the "YES" columns in twenty-seven of the combined twenty-eight clinical role and referral criteria items**. Five of these proportional differences between the two non-primary care subgroups were statistically significant. Significantly greater proportions of the more frequently referring subjects than the less frequently referring subjects perceived the clinical roles of marital & family therapists to include managing neurotic disturbances, dealing with unconscious problems, and interpreting underlying psychodynamics; these same subjects also had higher proportions that rated marital & family therapists as qualified to work with patient problems involving sexual dysfunction and sexual trauma. It may be

*See Conclusions four and eight for supportive evidence.
**Clinical role and referral criteria items may be found in the instrument on pages two and three, respectively.

concluded from these findings that, unlike the comparatively smaller proportional differences between the higher referring and lower referring primary care subgroups reported in Conclusion nine above, relatively greater proportional differences exist between the higher referring and lower referring non-primary care subgroups in their perceptions of the marital & family therapist clinical role and referral criteria qualifications. Such proportional differences may imply that non-primary care physicians who have had greater referral experience with marital & family therapists tend to credit these therapists with performing more in-depth psychotherapeutic functions than do non-primary care physicians who have had little or no referral experience with marital & family therapists.

Recommendations

Upon the basis of this study, the following four recommendations are made: (1) that further study be conducted with practicing physicians in other hospitals or clinics and in other geographical locations in order to determine whether the findings and conclusions of the present study appear to be generalizable; (2) that research be conducted with marital & family therapists to determine how uniformly such therapists perceive their own clinical roles and the kinds of patient (client) problems with which they consider themselves qualified to work; (3) that efforts be made by the Marital &

Family Therapy profession to identify its professional role in working relationships with physicians, and that such information be directed to the medical literature; and (4) that research investigating how members from other professions who are potentially likely to interact with marital & family therapists, most particularly family law attorneys and ministers, be conducted to determine how these professionals perceive the clinical roles of such therapists.

APPENDICES

APPENDIX A

MARITAL & FAMILY THERAPIST
ROLE AND REFERRAL CRITERIA
SURVEYOR

Purpose

The purpose of this research is to learn more about how marital & family therapists are perceived by physicians. The information obtained from the questionnaire will be used as data for analysis within a doctoral dissertation. Your participation in this study is most sincerely appreciated.

Definition of Marital & Family Therapist

For this study, the definition of a marital & family therapist is an academically trained person who has earned either a Master's or a Doctoral degree (excluding the M.D. and D.O.) from a recognized institution and who:

1. is educationally qualified to treat marital and family problems;
2. identifies him/herself as a marital & family therapist, although the treatment mode may be individual therapy as well as couple or family therapy.

About the Questionnaire

Please complete the attached questionnaire regardless of whether you have had any working familiarity with a marital & family therapist. If you have not, please mark your responses to the questions on the basis of your best prediction or judgment.

Questionnaire

1. For each of the fourteen items listed below, please mark the column of your choice with regard to whether you believe or don't believe that particular item to be a clinical role performed by marital & family therapists.

		YES Is a clinical role of M&F therapists	NOT SURE	NO Is not a clinical role of M&F therapists
a.	Provides emotional support			
b.	Offers practical advice, guidance			
c.	Manages neurotic disturbances			
d.	Manages situational disturbances			
e.	Manages outpatient psychotic disturbances			
f.	Helps people ventilate, express feelings			
g.	Teaches conflict resolution skills			
h.	Deals with conscious problems			
i.	Deals with unconscious problems			
j.	Changes dysfunctional ways of thinking			
k.	Changes patterns of family interaction			
l.	Changes specific behaviors			
m.	Identifies repressed conflicts			
n.	Interprets underlying psychodynamics			

2. For each of the fourteen items below, please mark the column of your choice with regard to whether you believe or don't believe Marital & Family Therapists to be qualified to work with that particular problem.

	YES are qualified	NO not qualified	Cannot Determine
a. Parent-child conflicts (child behavior problems, overbearing parent, etc.)			
b. Marital problems (incompatibility, infidelity, etc.)			
c. Depressive problems (despair, withdrawal, etc.)			
d. Anxiety problems (fearfulness, emotional insecurity, etc.)			
e. Sexual problems (impotence, frigidity, etc.)			
f. Psychosomatic problems (ulcer, headaches, etc.)			
g. Sexual trauma (rape, incest, etc.)			
h. Divorce or separation problems (adjustment difficulties)			
i. Emotional problems secondary to disease (diabetes, cancer, etc.)			
j. Situational problems (interpersonal conflicts, status changes, etc.)			
k. Hypochondriacal problems (complaints that are mental in origin)			
l. Paranoid and delusional problems (not requiring hospitalization)			
m. Intrafamily relationship problems (poor communication, personality clashes, etc.)			
n. Undesired pregnancy (emotional problems adjusting to the pregnancy)			

General Information
(Please complete this final segment of the questionnaire)

I. What medical school did you attend?_____

2. Year graduated_____

3. What is your present specialty?_____

4. How many years have you practiced this specialty?_____

5. Your sex_____

6. In general, do you work with the emotional problems of your patients?_____

7. Approximately how many referrals would you estimate you make per year to psychiatrists? _____

8. Have you ever made a referral to a marital & family therapist?

_____

9. If you answered yes to question #8, approximately how many referrals to marital & family therapists would you estimate you have made?_____

I0. Of this sum total above, how many of these would you estimate you have made during the past twelve months?_____

II. Are resources or practitioners available to you for referral of marital & family problems?_____

Sincerest thanks.

APPENDIX B

I UNDERSTAND THAT THE RETURN OF MY QUESTIONNAIRE CONSTITUTES MY INFORMED CONSENT TO ACT AS A SUBJECT IN THIS RESEARCH.

NO MEDICAL SERVICES OR COMPENSATION IS PROVIDED TO SUBJECTS BY THE UNIVERSITY AS A RESULT OF INJURY FROM PARTICIPATION IN RESEARCH.

YOU MAY STOP YOUR PARTICIPATION IN THIS RESEARCH AT ANYTIME SIMPLY BY WITHDRAWING AND/OR NOT RETURNING THE QUESTIONNAIRE.

APPENDIX C

PHYSICIANS AND SURGEONS CLINIC

1511 NORTH BECKLEY DALLAS, TEXAS 75203

TELEPHONE (214) • 942-6131

PEDIATRICS
Ben W. Denny, M.D.
F.A.A.P.
W. Robin Mers, M.D.

GENERAL SURGERY AND DIAGNOSIS
John G. Martin, M.D., P.A.
D.A.B.S., F.A.C.S.
Larry A. Arnspiger, M.D.
D.A.B.S., F.A.C.S.

INTERNAL MEDICINE AND DIAGNOSIS
W.A. Godfrey, Jr., M.D.
D.A.B.IM., F.A.C.P.
Norman W. Krouskop, Jr., M.D.
D.A.B.IM.
Debra L. Patterson, M.D.

INTERNAL MEDICINE AND ONCOLOGY
Joseph R. Mussell, M.D.
D.A.B.IM. & Medical Oncology

INTERNAL MEDICINE AND CARDIOLOGY
Sanford Reich, M.D., P.A.
D.A.B.IM.

INTERNAL MEDICINE AND GASTROENTEROLOGY
S.S. Safavi, M.D., P.A.
D.A.B.IM.

GENERAL MEDICINE
Arnott DeLange, M.D.
Lindsey T. Elder, M.D.
William W. Kempe, M.D.
Jan T. Howard, M.D.

OBSTETRICS AND GYNECOLOGY
Harwin B. Jamison, M.D., P.A.
D.A.B.O.G., F.A.C.O.G.
Harry W. G. Khouw, M.D.
D.A.B.O.G.

OBSTETRICS-GYNECOLOGY AND GYNECOLOGIC ONCOLOGY
D.J. Choi, M.D.
D.A.B.O.G., F.A.C.O.G.

RADIOLOGY
Donald L. Oberlin, M.D.

INDIVIDUAL AND FAMILY COUNSELING
Edward L. Coben, M.S.W., A.C.S.W.

ADMINISTRATION
Esther Zett, Business Manager

November 6, I980

Dear

Many thanks for your willingness to help in establishing content validity for the enclosed instrument. I have also included copies of three sections from my dissertation prospectus which describe the purpose of the study (p.I0) and explain how I plan to divide the twenty-eight items into two groups (Group I will be Supportive or Directive Treatment; Group II will be Intrapsychic Treatment).

The input I basically need is:

1. Your assessment whether each of the I4 items of question #I on page 2 of the instrument is a clinical role/function of marital and family therapists;
2. Your assessment whether each of the I4 items of question #2 on page 3 of the instrument is a criteria utilized for referrals to marital and family therapists; and
3. Your assessment concerning the placement of each of the 28 items into either Group I (Supportive or Directive Treatment) or Group II (Intrapsychic Treatment). The placement will be for purposes of statistical analysis.

Your generous help in validating this instrument is most deeply appreciated. Should you have any questions in your assessment, please call me at 942-6I3I or at home if more convenient, 369-7I80.

Most sincerely,

Edward L. Coben, M.S.W., S.P.

ELC:lc
Encls.

APPENDIX D

Panel of Experts

This panel was composed of three men and two women with educational and experiential backgrounds which appear to approximate the diverse field of Marital & Family Therapy. They generously gave of their time in the critique and final development of the instrument. A brief sketch of credentials for each is given below:

Martin Sundel, M.S.W., Ph.D., University of Michigan. Completed post-doctoral fellowship at the Laboratory of Community Psychiatry, Harvard Medical School. Major fields: Psychology and Social Work. Primary theoretical orientation in behavior modification. Numerous professional publications. Formerly Senior Research Associate at The Urban Institute, Washington, D.C., and currently the Roy Dulak Professor, Graduate School of Social Work, University of Texas at Arlington.

Edward J. Rydman, Ph.D., Ohio State University. Major fields: Psychology and Marital & Family Therapy. Formerly was National Executive Director of the American Association for Marital & Family Therapy (AAMFT). Locally and nationally recognized as an authority in the field of Marital & Family Therapy. Several professional publications. Currently a full time practitioner of marital & family therapy.

Coleen Shannon, Ph.D., Texas Woman's University. Major field: Sociology. Primary theoretical orientation in family systems and behavior modification. Several professional publications. Currently Associate Professor, Graduate School of Social Work, University of Texas at Arlington.

Robert P. Stewart, M.S.S.W., University of Texas (Austin). Major field: Clinical Social Work. Primary theoretical orientation in family systems, especially the functioning of healthy families. Former State Chapter President, National Association of Social Workers. Currently Chief of Clinical Social Work, Timberlawn Psychiatric Hospital.

Paula Sigman, R.N., Ph.D., Texas Woman's University. Major fields: Medical and Psychiatric Nursing. Primary theoretical orientation in psychoanalytic psychotherapy. University and graduate teaching; formerly with nursing administration, Methodist Hospitals of Dallas.

APPENDIX E

METHODIST HOSPITALS of Dallas

Edward L. Coben, MSW, SP
Physicians and Surgeons Clinic
1511 North Beckley
Dallas, Texas 75203

Dear Mr. Coben:

In reply to our recent discussion concerning your request to conduct a questionnaire survey of physicians' perceptions of marital and family therapists, I am pleased to inform you that administrative and medical staff approval for this doctoral dissertation has been granted.

Dr. Jerome Byers, president of the medical staff, and I have reviewed your questionnaire and research design utilizing the hospital's medical staff as subjects and invite you to proceed with your study as outlined.

We look forward with interest to your sharing the finding of your study with us.

Sincerely,

Patricia Starr
Manager, Medical Staff Services
METHODIST HOSPITALS OF DALLAS

/*

Methodist Central Hospital
Post Office Box 225999
Dallas, Texas 75265
(214) 944-8181

McAllen Methodist Hospital
701 South Main Street
McAllen, Texas 78501
(512) 687-7611

Charlton Methodist Hospital
Post Office Box 225357
Dallas, Texas 75265
(214) 296-2511

Southeastern Methodist Hospital
9202 Elam Road
Dallas, Texas 75217
(214) 398-1531

TEXAS WOMAN'S UNIVERSITY
Box 23717 TWU Station
Denton, Texas 76204

HUMAN SUBJECTS REVIEW COMMITTEE

Name of Investigator: Edward L. Coben Center: Denton

Address: Methodist Hospital Date: February 4, 1981

301 W. Colorado Blvd.

Dallas, TX 75208

Dear Edward L. Coben,

Your study entitled The Clinical Role of & Referral Criteria to Marital & Family Therapists as Perceived by a Selected Group of Practicing Primary Care Physicians has been reviewed by a committee of the Human Subjects Review Committee and it appears to meet our requirements in regard to protection of the individual's rights.

Please be reminded that both the University and the Department of Health, Education, and Welfare regulations typically require that signatures indicating informed consent be obtained from all human subjects in your studies. These are to be filed with the Human Subjects Review Committee. Any exception to this requirement is noted below. Furthermore, according to DHEW regulations, another review by the Committee is required if your project changes.

Any special provisions pertaining to your study are noted below:

_____ Add to informed consent form: No medical service or compensation is provided to subjects by the University as a result of injury from participation in research.

_____ Add to informed consent form: I UNDERSTAND THAT THE RETURN OF MY QUESTIONNAIRE CONSTITUTES MY INFORMED CONSENT TO ACT AS A SUBJECT IN THIS RESEARCH.

__X__ The filing of signatures of subjects with the Human Subjects Review Committee is not required.

_____ Other:

_____ No special provisions apply.

cc: Graduate School
Project Director
Director of School or
Chairman of Department

Sincerely,

Marilyn Hinson

Chairman, Human Subjects
Review Committee

at Denton

APPENDIX F

Research Question One
Clinical Roles As Perceived By Primary Care Physicians
n=35

Item	Yes		Not Sure		No	
	#	%*	#	%	#	%
1a	34	97	0	0	1	3
1b	33	94	2	6	0	0
1c	12	34	13	37	10	29
1d	30	86	4	11	1	3
1e	4	11	6	17	25	71
1f	35	100	0	0	0	0
1g	32	91	3	9	0	0
1h	33	94	1	3	1	3
1i	21	60	7	20	7	20
1j	25	71	4	11	6	17
1k	32	91	3	9	0	0
1l	25	71	5	14	5	14
1m	27	77	4	11	4	11
1n	22	63	5	14	8	23

*Percent totals may not always equal 100 due to rounding.

Research Question Two
Clinical Roles As Perceived By Non-Primary Care Physicians
n=51

Item	Yes		Not Sure		No	
	#	%*	#	%	#	%
1a	47	92	2	4	2	4
1b	47	92	3	6	1	2
1c	12	24	7	14	32	63
1d	33	65	9	18	9	18
1e	5	10	3	6	43	84
1f	46	90	2	4	3	6
1g	36	71	9	18	6	12
1h	40	78	8	16	3	6
1i	13	26	9	18	29	57
1j	17	33	20	39	14	28
1k	42	82	4	8	5	10
1l	28	55	11	22	12	24
1m	26	51	9	18	16	31
1n	16	31	5	10	30	59

*Percent totals may not always equal I00 due to rounding.

Research Question Three
Comparative Perceptions of Clinical Roles By Primary Care (P.C.) and Non-Primary Care (N.P.C.) Physicians

P.C.:n=35
N.P.C.:n=51

Item	%* Yes		% Not Sure		% No	
	P.C.	N.P.C.	P.C.	N.P.C.	P.C.	N.P.C.
1a	97	92	0	4	3	4
1b	94	92	6	6	0	2
1c	34	24	37	14	29	63
1d	86	65	11	18	3	18
1e	11	10	17	6	71	84
1f	100	90	0	4	0	6
1g	91	71	9	18	0	12
1h	94	78	3	16	3	6
1i	60	26	20	18	20	57
1j	71	33	11	39	17	27
1k	91	82	9	8	0	10
1l	71	55	14	22	14	24
1m	77	51	11	18	11	31
1n	63	31	14	10	23	59

*Percent totals may not always equal I00 due to rounding.

Research Question Four
Comparative Perceptions of Clinical Roles By Primary Care Physicians Making Four or More Referrals (P.C.4+) and Primary Care Physicians Making Three or Less (P.C.3-)

P.C.4+:n=23
P.C.3-:n=12

Item	%* Yes		% Not Sure		% No	
	P.C.4+	P.C.3-	P.C.4+	P.C.3-	P.C.4+	P.C.3-
1a	96	I00	0	0	4	0
1b	100	83	0	17	0	0
1c	44	17	35	42	22	42
1d	87	83	13	8	0	8
1e	17	0	13	25	70	75
1f	100	100	0	0	0	0
1g	96	83	4	17	0	0
1h	100	83	0	8	0	8
1i	61	58	17	25	22	17
1j	78	58	9	17	13	25
1k	100	75	0	25	0	0
1l	78	58	13	17	9	25
1m	83	67	9	17	9	17
1n	65	58	9	25	26	17

*Percent totals may not always equal I00 due to rounding.

Research Question Five

Comparative Perceptions of Clinical Roles By Non-Primary Care Physicians Making Four or More Referrals (N.P.C.4+) and Non-Primary Care Physicians Making Three or Less (N.P.C.3-)

N.P.C.4+:n=14
N.P.C.3-:n=37

Item	%* Yes		% Not Sure		% No	
	N.P.C.4+	N.P.C.3-	N.P.C.4+	N.P.C.3-	N.P.C.4+	N.P.C.3-
1a	100	89	0	5	0	5
1b	100	89	0	8	0	3
1c	50	14	7	16	43	70
1d	79	60	7	22	14	19
1e	21	5	7	5	71	89
1f	100	87	0	5	0	8
1g	86	65	0	24	14	11
1h	86	76	14	16	0	8
1i	64	11	7	22	29	68
1j	50	27	21	46	29	27
1k	86	81	7	8	7	11
1l	50	57	21	22	29	22
1m	71	43	7	22	21	35
1n	64	19	7	11	29	70

*Percent totals may not always equal I00 due to rounding.

Research Question Six

Comparative Perceptions of Clinical Roles By All Physicians Making Four or More Referrals (A.P.4+) and All Physicians Making Three or Less (A.P.3-)

A.P.4+:n=37
A.P.3-:n=49

Item	%* Yes		% Not Sure		% No	
	A.P.4+	A.P.3-	A.P.4+	A.P.3-	A.P.4+	A.P.3-
1a	97	92	0	4	3	4
1b	100	88	0	10	0	2
1c	46	14	24	22	30	63
1d	84	65	11	18	5	16
1e	19	4	11	10	70	86
1f	100	90	0	4	0	6
1g	92	69	3	22	5	8
1h	95	78	5	14	0	8
1i	62	23	14	22	24	55
1j	68	35	14	39	19	27
1k	95	80	3	12	3	8
1l	68	57	16	20	16	22
1m	78	49	8	20	14	31
1n	65	29	8	14	27	57

*Percent totals may not always equal I00 due to rounding.

Research Question Seven
Referral Criteria As Perceived By Primary Care Physicians
n=35

Item	Yes		No		Cannot Determine	
	#	%*	#	%	#	%
2a	31	89	2	6	2	6
2b	32	91	0	0	3	9
2c	13	37	16	46	6	17
2d	21	60	8	23	6	17
2e	23	66	5	14	7	20
2f	12	34	13	37	10	29
2g	18	51	12	34	5	14
2h	34	97	0	0	1	3
2i	20	57	10	29	5	14
2j	33	94	1	3	1	3
2k	20	57	9	26	6	17
21	5	14	22	63	8	23
2m	33	94	0	0	2	6
2n	28	80	3	9	4	11

*Percent totals may not always equal I00 due to rounding.

Research Question Eight
Referral Criteria As Perceived By Non-Primary Care Physicians
n=51

Item	Yes		No		Cannot Determine	
	#	%*	#	%	#	%
2a	42	82	4	8	5	10
2b	40	78	4	8	7	14
2c	8	16	28	55	15	29
2d	18	35	20	39	13	25
2e	22	43	16	31	13	25
2f	7	14	30	59	14	27
2g	17	33	22	43	12	24
2h	42	82	3	6	6	12
2i	30	59	10	20	11	22
2j	41	80	3	6	7	14
2k	21	41	18	35	12	24
2l	3	6	32	63	16	31
2m	45	88	1	2	5	10
2n	42	82	3	6	6	12

*Percent totals may not always equal I00 due to rounding.

Research Question Nine
Comparative Perceptions of Referral Criteria By Primary Care (P.C.) and Non-Primary Care (N.P.C.) Physicians

P.C.:n=35
N.P.C.:n=51

Item	%* Yes		% No		% Cannot Determine	
	P.C.	N.P.C.	P.C.	N.P.C.	P.C.	N.P.C.
2a	89	82	6	8	6	10
2b	91	78	0	8	9	14
2c	37	16	46	55	17	29
2d	60	35	23	39	17	25
2e	66	43	14	31	20	25
2f	34	14	37	59	29	27
2g	51	33	34	43	14	24
2h	97	82	0	6	3	12
2i	57	59	29	20	14	22
2j	94	80	3	6	3	14
2k	57	41	26	35	17	24
2l	14	6	63	63	23	31
2m	94	88	0	2	6	10
2n	80	82	9	6	11	12

*Percent totals may not always equal I00 due to rounding.

Research Question Ten

Comparative Perceptions of Referral Criteria By Primary Care Physicians Making Four or More Referrals (P.C.4+) and Primary Care Physicians Making Three or Less (P.C.3-)

P.C.4+: n=23

P.C.3-: n=12

Item	%* Yes		% No		% Cannot Determine	
	P.C. 4+	P.C. 3-	P.C. 4+	P.C. 3-	P.C. 4+	P.C. 3-
2a	91	83	4	8	4	8
2b	91	92	0	0	9	8
2c	39	33	39	58	22	8
2d	65	50	22	25	13	25
2e	78	42	9	25	13	33
2f	35	33	30	50	35	17
2g	61	33	30	42	9	25
2h	100	92	0	0	0	8
2i	65	42	26	33	9	25
2j	100	83	0	8	0	8
2k	70	33	17	42	13	25
21	17	8	57	75	26	17
2m	100	83	0	0	0	17
2n	87	67	9	8	4	25

*Percent totals may not always equal 100 due to rounding.

Research Question Eleven

Comparative Perceptions of Referral Criteria By Non-Primary Care Physicians Making Four or More Referrals (N.P.C. 4+) and Non-Primary Care Physicians Making Three or Less (N.P.C. 3-)

N.P.C. 4+: n=14
N.P.C. 3-: n=37

Item	%* Yes		% No		% Cannot Determine	
	N.P.C. 4+	N.P.C. 3-	N.P.C. 4+	N.P.C. 3-	N.P.C. 4+	N.P.C. 3-
2a	100	76	0	11	0	14
2b	93	73	0	11	7	16
2c	29	11	50	57	21	32
2d	50	30	36	41	14	30
2e	71	32	14	38	14	30
2f	43	3	43	65	14	32
2g	64	22	36	46	0	32
2h	93	78	7	5	0	16
2i	79	51	14	22	7	27
2j	93	76	0	8	7	16
2k	57	35	36	35	7	30
21	7	5	57	65	36	30
2m	100	84	0	3	0	14
2n	93	78	7	5	0	16

*Percent totals may not always equal 100 due to rounding.

Research Question Twelve

Comparative Perceptions of Referral Criteria By All Physicians Making Four or More Referrals (A.P.4+) and All Physicians Making Three or Less (A.P.3-)

A.P.4+:n=37
A.P.3-:n=49

Item	%* Yes		% No		% Cannot Determine	
	A.P.4+	A.P.3-	A.P.4+	A.P.3-	A.P.4+	A.P.3-
2a	95	78	3	10	3	12
2b	92	78	0	8	8	14
2c	35	16	43	57	22	27
2d	60	35	27	37	14	29
2e	76	35	11	35	14	31
2f	38	10	35	61	27	29
2g	62	25	32	45	5	31
2h	97	82	3	4	0	14
2i	70	49	22	24	8	27
2j	97	78	0	8	3	14
2k	65	35	24	37	11	29
2l	14	6	57	67	30	27
2m	100	84	0	2	0	14
2n	89	76	8	6	3	18

*Percent totals may not always equal I00 due to rounding.

Research Question Thirteen
Clinical Roles As Perceived By All Physicians

n=86

Item	Yes		Not Sure		No	
	#	%*	#	%	#	%
1a	81	94	2	2	3	3
1b	80	93	5	6	1	1
1c	24	28	20	23	42	49
1d	63	73	13	15	10	12
1e	9	11	9	10	68	79
1f	81	94	2	2	3	3
1g	68	79	12	14	6	7
1h	73	85	9	10	4	5
1i	34	40	16	19	36	42
1j	42	49	24	28	20	23
1k	74	86	7	8	5	6
1l	53	62	16	19	17	20
1m	53	62	13	15	20	23
1n	38	44	10	12	38	44

*Percent totals may not always equal 100 due to rounding.

Research Question Fourteen
Referral Criteria As Perceived By All Physicians
n=86

Item	Yes		No		Cannot Determine	
	#	%*	#	%	#	%
2a	73	85	6	7	7	8
2b	72	84	4	5	10	12
2c	21	24	44	51	21	24
2d	39	45	28	33	19	22
2e	45	52	21	24	20	23
2f	19	22	43	50	24	28
2g	35	41	34	40	17	20
2h	76	88	3	3	7	8
2i	50	58	20	23	16	19
2j	74	86	4	5	8	9
2k	41	48	27	31	18	21
21	8	9	54	63	24	28
2m	78	91	1	1	7	8
2n	70	81	6	7	10	12

*Percent totals may not always equal 100 due to rounding.

Primary and Non-Primary Care Specialties

Represented In This Study of 86 Subjects

Primary Care specialties and numbers of subjects (total, 35):

General and Family Practice, 18

Obstetrics/Gynecology, 8

Internal Medicine, 5

Pediatrics, 4

Non-Primary Care specialties and numbers of subjects (total, 51):

Surgery, 16

Pulmonary Medicine, 5

Cardiology, 4

Urology, 3

Ophthalmology, 3

Pathology, 3

Endocrinology, 3

Psychiatry, 3

ENT, 3

Anesthesiology, 2

Radiology, 2

Neurology, 2

Industrial Medicine, 1

Allergy, 1

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