A Revisionist Theory for the Integration of Behavioral Science into Family Medicine Departments

Johanna Shapiro, PhD
Orange, California

This article describes the common cycle of infatuation and disillusionment which occurs when the family physician meets the behavioral scientist. Some inherent problems are involved in the relationship between physicians and psychologists. For physicians, these problems are related to prior training, time pressures, perceptions of the patient role, and their attitude toward role innovation. For behavioral scientists, problems include their expectations and prior training, conceptual rigidity, psychological mindedness, their views of physician and patient, and their sense of displacement and isolation in a medical setting. Suggestions are made for future collaboration, curriculum development, problem solving, and the elimination of biases and stereotypes.

There is increasingly unanimous consensus on the part of both physicians and psychologists that a true integration of their disciplines represents one of the most important developmental tasks facing the fields of medicine and psychology today. Such an integration must occur on two levels: a content level subsuming everything that is meant by the phrase "behavioral medicine" (non-pharmacological approaches to pain and depression, psychological analysis of headaches, psychological behavior modification of obesity, and use of hypnosis in clinical practice); and on a process level, which includes an examination of the interpersonal dynamics which inevitably occur between physician and psychologist once this interdisciplinary collaboration is attempted.

This article will focus on aspects of this "process" integration, elaborate on problems encountered thus far, and point to some guideposts for constructive change. These conclusions are not based on research evidence, but on anecdotal data gathered while the author was director of the behavioral sciences program in the Department of Family Medicine at The University of California at Irvine, Medical Center, and through numerous conversations with psychologists and social workers in similar positions throughout the country. Also, although this paper discusses "physicians" and "psychologists" as though they were two distinct varieties of human being, this is an inaccurate inference. In practice, the dichotomies between the two groups are not so great as are implied in this paper, and these stereotypes are created for illustrative purposes only. Finally, there is no intention of implying that hostility is the dominant mode of interaction between the two professions. On the contrary, much initial goodwill exists, which too often becomes frustrated by some of the issues under discussion. This paper is written with the intention of preserving goodwill and of transforming it into meaningful collaboration.

Infatuation and Disillusionment

While physicians in general have not until recently been noticeably receptive to the idea that psychology deserves a prominent role in medical practice, certain medical specialties have acknowledged the relevance of psychological prin-

From the Department of Family Medicine, University of California Irvine Medical Center, Orange, California. Requests for reprints should be addressed to Dr. Johanna Shapiro, Department of Family Medicine, 101 City Drive South, Orange, CA 92668.

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ciples. Family medicine has been among the most enthusiastic in welcoming behavioral scientists into its midst.[1] An increasing number of family medicine departments throughout the country can boast at least one "behavioral scientist" (that ubiquitous term covering psychologists, psychiatrists, anthropologists, sociologists, and social workers) among their faculties. Behavioral scientists placed in this position are given vague but impressive tasks, such as "training residents in the behavioral sciences," "formulating a behavioral science curriculum," and "coordinating multidisciplinary research."

Behavioral scientists have tended to respond with a vengeance. The pioneering spirit seizes hold, and they begin to hallucinate that singlehandedly they will slay the Goliath of the modern American medical system. In the area of curriculum development in particular, behavioral scientists have been active. From family medicine departments across the nation have emerged ever thicker and more detailed behavioral science curricula,[2-4] rivaling each other in scope, breadth, depth, creativity, and ingenuity (the author has written two such masterpieces, which are kept filed for sentimental reasons).

These curricula are masterpieces of detail. They consist of classes, courses, core seminars, self-awareness groups, women's groups, noon series, videotaping sessions, audiotaping sessions, evening meetings, early morning meetings, weekend retreats. What they hope to accomplish is equally overwhelming: a thorough grasp of psychopathology, expert interviewing and communication skills, self-awareness and commitment to self-growth, awareness of community resources, to name only a few of the more easily attainable goals.

However, mutual disillusionment rapidly sets in,[5] both with the elegant curriculum and with each other in general. Busy physicians sometimes feel that the behavioral scientists whom they were so proud to acquire become pushy and demanding once they achieve departmental status. At times they resent the intrusion of the behavioral scientists into what they perceive to be the more fundamental aspects of patient care. And, although they verbally acknowledge the importance of physician self-awareness and sensitivity to patients' emotional responses, behaviorally these areas frequently remain neglected.

As for the behavioral scientists, they tend to exhibit a psychological arrogance which assumes the primacy of their own specialty. Theoretical principles and research findings which they have been trained to respect are ignored by physicians seeking immediate and practical answers. Their cherished and laborious curricula are criticized as too elaborate, structurally impossible to implement, and often irrelevant. Eventually, the behavioral scientists begin to feel isolated and displaced, their skills devalued, their insights ignored, and one may begin to see them skulking along little used corridors, grumbling about the injustices inflicted on them.

What happens? What goes wrong? Actually, the sins of omission and commission are great on both sides,[6] and the fault is due largely to problems in the "process" between the two groups. This article will explore several such "process" problems: differences in communication styles; differences in theoretical models; differences in priorities; and differing views of physicians, psychologists, and patients.

Differences in Communication Styles

Problems in communication between physicians and psychologists take two forms: differences in language and similarities in language. Clearly, physicians have their own technical, highly specialized language, which is equally effective at baffling patients and psychologists. A *Merck Manual* carried to strategic encounters helps, but the effect is similar to relying on Berlitz as the vehicle for transacting sensitive diplomatic negotiations. Learning to understand, let alone use, the physician's vocabulary requires time, patience, and a flair for foreign language.

To further complicate matters, physicians are not alone in having their own form of speech. Psychologists also speak an impressive but basically unintelligible language known as "psychologese." Psychologists may flatter themselves that this is a widely known dialect; however, there are millions of people who do not read *Psychology Today*, and many of them are physicians. Concepts such as "cognitive dissonance," "operant conditioning," and terms such as "content" and "process" may not be very meaningful to many physicians. However, because physicians are high status, competent, intelligent people, many tend to

be reluctant to acknowledge their unfamiliarity with psychologese, and the basic lack of communication between the two groups may only be discovered through a laborious process of trial and error.

Paradoxically, it is the similarities of language which turn out to be even more confusing. The problem may perhaps be best understood through a loose analogy to the uneasy union between liberals and blacks during the early 1960s. Initially, the two groups approached with open arms and the assumption of a common cause. Quickly, this turned to suspicion and mutual charges of exploitation. Each felt they shared a common language and common aspirations, but in reality they often were talking about two very different things.

Similarly, the same words mean different things to behavioral scientists and physicians. For example, the term "family" can evoke triangulating, restructuring, joining, and maintaining for the structural family therapist,[7] whereas for the physician it might suggest pregnancy, vaccinations, or sexual problems. One of the most fundamental communication discrepancies occurs in the divergent use of the phrase "treating the family." To the behavioral scientist, this means seeing the family together in sessions, observing the home situation, interacting with various family members, perhaps rearranging the structure of the family, bringing into play the various theoretical concepts relevant to family dynamics. For the family physician, "treating the family" often may mean having at least two members of the same family concurrently in one's practice. This basic language discrepancy leads to a confusion about the appropriate behavior of the physician in relation to the family.

Thus, a paradox of language exists. On a theoretical level, there is no discrepancy. The words used by both groups are often identical. Both groups talk of holistic medicine, seeing the person as a totality, the integration of mind and body, and treating the entire family. Nevertheless, moving beyond the well-worn generalities, it is quickly apparent that the specifics vary significantly between the two groups.

Differences in Theoretical Models

Both psychologist and physician fulfill "helping roles" and thus may be deluded into assuming they are familiar with how the other functions in this role. However, the two groups use significantly different theoretical models for defining the nature of this helper role.

At the broadest level, physicians have been trained to accept and rely on the medical model in their understanding of disease and health. Many psychologists, on the other hand, are accustomed to models of a different sort: for example, self-actualizing models and social learning models. However, they are not used to applying these models to disease entities. Thus, all too often, the physician's model strikes the psychologist as antiquated, whereas the psychologist's model strikes the physician as irrelevant.

Another difficulty with the prevailing model employed by physicians is that insofar as it considers psychological dysfunction, its emphasis is heavily psychoanalytic. Behavioral scientists, on the other hand, tend to be trained in a more eclectic fashion with resultant clashes in interpretation of etiology and treatment of psychological disorders. When discussing a patient, physicians may exhibit a tendency to label, rather than to observe behavior. This process serves a protective function: the physician is protected once he or she can distinguish the patient as schizophrenic, for example, and him or herself as "not-schizophrenic." The psychoanalytic emphasis also means that for the physician, pathology is located in the individual, rather than in the social and environmental context.[8] Thus, developing a mutual understanding of psychological dysfunction is often difficult.

Training and situational factors influence the physicians' theoretical model to be crisis oriented. As a rule, residents in particular invest less time in the long-term management of a patient than in solving an immediate problem. Most psychosocial consults become crisis oriented, and present the following question: "What do I do right now?" Yet psychologists' models often include the concept of client intervention and growth over time, and are strained by expectations to produce instantaneous solutions. Residents need immediate responses from attending physicians because often a medical crisis thus can be averted. However, from a psychological viewpoint many of the problems encountered in a family practice context are more enduring: the management of obesity, dyspareunia associated with a poor sexual relationship, depression, anxiety neurosis, problems with one's children. These cannot be solved easily in a

ten-minute consultation.

The physicians' model also trains them to adopt a problem solving orientation; patients present them with problems, and (if they are lucky) physicians solve them. They tend to be made helpless by situations which they cannot solve. Physicians are often uncomfortable with the idea that "just talking" can help alleviate negative feelings. It is a common physician assumption that the patient expects concrete action. Yet even the most action oriented psychologist quickly learns to adjust to the value of "just talking" to establish rapport, to clarify understanding, to allow identification of emotions and catharsis to occur.

Differences in Priorities

Different concepts of the appropriate physician role lead to a very different ordering of priorities. All family medicine residents find themselves laboring under tremendous time pressures. There is not enough time for their patients, for reading, for attending conferences, for their spouses, families, and friends, for eating and sleeping. There is certainly not enough time for behavioral science. This is an unsolvable dilemma, and one any smart behavioral scientist will get used to. However, "lack of time" is often a rationalization for a conviction that psychological skills are secondary rather than integral to the practice of medicine. In this view, these skills are desirable rather than essential to know. Many residents adopt the attitude that effective communication with patients or knowing how to intervene in a dysfunctional family system are valuable but not necessary skills for the family physician. Thus they become relegated to that immense and hopelessly backlogged category of "things I would like to do when I have more time," including taking the kids to Disneyland and learning how to surf. In a pinch, the resident values "medical" knowledge above "psychological" knowledge, and this fundamental bias influences all subsequent interactions with behavioral science material.

Like physicians, behavioral scientists tend to be convinced of the primacy of their subject matter: What is life without psychology? In this formulation, behavioral science is seen as an "ethical imperative" in family medicine.[9] This is a concept that smacks somewhat of self-righteousness. It is easy for the behavioral scientist to fall into the role of "good guy,"—"I'm the one that cares about people, I'm sensitive, humanistic." In this view, medicine is conceptualized as the problem, and behavioral science the solution. This simplistic interpretation of the situation is likely to end in mutual antagonism and hostility.

The behavioral scientist and the physician bring different sets of priorities to the actual practice of family medicine as well. For example, they understand communication interactions differently. Looking at the same videotape, psychologists tend to focus on the process, and to a lesser extent, the observed psychopathology. Physicians will tend to look at the medical information elicited. Closeted in the same room, with the same patient, the two professionals will observe different things, and will consider different things to be important. Psychologists bring a certain "psychological-mindedness" to their work; that is, they are trained to be sensitive to process, to analyze the interaction patterns between human beings, to pay attention to group dynamics, to power struggles, to implicit meanings. Physicians, by contrast, have their own specialized area of medical competencies. Yet often little attempt is made at reconciling these divergent hierarchies.

Attitudes Toward Physicians

Physicians' Self-Perception

Family practice residents perceive themselves as humanistic, holistic people, possessed of good interpersonal skills. In fact, research suggests this to be a fairly accurate perception relative to physicians in other specialties. Residents often conclude that they have chosen this specialty because of innate personality characteristics. Physicians whose only exposure to psychological principles is psychodynamic do not readily accept the social learning concept of situation-specificity of behavior.[10] To them skills connote the palpitation of an organ or the interpretation of an x-ray film, rather than the phrasing of a question or interpreting the non-verbal language of the body. According to this point of view, individuals are each endowed with a fixed amount of human interaction abilities: those with great ability cannot be improved; those with little ability cannot be helped. This attitude leads to the mistaken conclusion that skills of accurate empathy, a nonjudgmental attitude, and effective communication are unteachable. In point of fact, there is good evidence that such intangible personal qualities can be

learned.[11,12]

The assumption of the fixed nature of people also reinforces that idea that the internal processes of the physician are unimportant in understanding patient dynamics. Physicians struggling with the pressures of a residency tend to be somewhat resistant to introspection. Residents are quick to identify hysteria, depression, and seductive behavior in patients, but it is much more difficult to switch the focus from the patient to themselves. Physicians are trained to analyze, interpret, and problem-solve. But these skills are almost exclusively directed outward, and it is the rare resident who does not mistrust self-analysis. There is often the mistaken belief that once personal problems are examined and shared, the entire superstructure of the individual's life will collapse. Physicians still suffer from the burden of infallibility. Despite the holistic health movement, in many communities the physician is still seen as next to God. While not necessarily accepting this identification, physicians tend to emphasize their competence, their ability to control their own and others' environments, their effectiveness. Negative feedback becomes a personal challenge, and it is sometimes difficult to go beyond a defensive reaction. Thus, while there is readiness to interpret the patient, there is relative unawareness of self, and considerable suspicion of the process necessary to achieve such awareness. For physicians, self-growth may be simultaneously perceived as threatening and unimportant. Self-understanding does not play a major role in their image of themselves as doctors, and there is not common acceptance that self-understanding can be a professional asset.

Of course this attitude is anathema to any self-respecting psychologist. The maintenance and development of one's own mental health is usually considered by psychologists to be of critical professional, as well as personal, importance. Most clinicians acknowledge the necessity of working on their own problems so that they can be "clear" to focus on the problems of their clients.[13] Psychologists are eager to apply this practice to physicians, and are unprepared for the resistance they meet. They also tend to conveniently forget how difficult, how threatening, and at times how painful it was for each one of them to learn the skills of introspection, and to appreciate its hard-won rewards.

Psychologists' View of Physicians

Psychologists may sometimes hold grandiose ideas about the physician's potential, and enthusiastically urge a variety of new and frequently untried roles on the physician: group facilitator, family therapist, educator, consultant, marriage counselor, behavior modificationist, all-purpose change agent. The physician, of course, cannot play chameleon so easily. The physician is aware of the limitations of his or her role, the constraints of the system, the restrictions of the larger culture. The behavioral scientist tends to be insensitive to these limitations, and thus imposes unrealistic expectations on the physician.

More commonly, psychologists bring to their involvement in a medical setting a covert antagonism toward the medical profession. Partly this may be a reaction resulting from entering a high status profession with what has suddenly become a low status degree. Partly it may be due to an instinctive identification with the patient. Observe any newly arrived behavioral scientist in a medical setting and pay attention to how many medical horror stories he suddenly begins to dredge up. It is an easy, although dangerous, choice for the behavioral scientists to ally themselves with the patient rather than with the physician. In this model, the physician is conceptualized, albeit covertly, as the enemy. Patient and psychologist join to defeat and outwit the physician. Not only does this bias seriously distort one's skills of impartial observation and accurate empathy, but in the long run it is highly detrimental to effective physician education.

Behavioral scientists often are guilty of cherishing insensitive and inaccurate stereotypes about physicians: physicians care only about money and status, physicians have computers for brains, physicians are obsessive-compulsive. They assume physicians to be unaware, controlling, suffering from a god-complex, and mechanical and technical rather than warm and compassionate.[14] Of course, these stereotypes need to be challenged and debunked.

View of Psychologists

Physicians tend to regard the psychologist as a jack-of-all-trades, someone to call on in a crisis situation, at best a kind of magician who works an incomprehensible but useful magic, at worst a bumbler without any real skills relevant to the

practice of medicine. Unconsciously, many physicians view the psychologist as a kind of glorified assistant. In practice, this means that physicians often expect easy availability and instant access to their psychologists.

Meanwhile, the psychologist has joined the department with the deluded notion that he or she is there to train and teach physicians about the subtleties of psychological principles. Further, most PhD social scientists perceive themselves as experts, as specialists in a few clearly defined subspecialties—ie, behavior therapists, family therapists, researchers on the etiology and treatment of obesity. However, they must function in an environment where a psychologist is a psychologist is a psychologist. They are seen as interchangeable with one another, and as the resource person to consult regarding any "mental" matters. These may range from intervening with a hysterical patient to modification of smoking to treatment of depression to management of heroin addicts to compliance and adherence problems for hypertensive or diabetic patients. The list is endless, and the behavioral scientist is forced to develop short-order expertise which he may mistrust as shallow and superficial.

Finally, psychologists see themselves as professionals with a solid base in theory and research. Yet this perception is challenged in a family medicine setting. Residents are looking for a how-to, technique oriented approach. They have no time, and often not the interest, to explore flaws in the methodology of research designs or delve into theoretical rationales. Thus, behavioral scientists find themselves viewed somewhat as a conjurer with a bag of tricks, and woe to them if the tricks do not work. A grasp of the limitations of research encourages a tolerance for partial success and even failure. Psychologists are well aware in clinical practice of how many variables remain beyond their control, and how often outcome is influenced by extraneous factors. Residents tend to be uninterested in these qualifications and limitations on the power of psychology to change people.

Attitudes Toward Patients

There is a tendency among physicians and especially among residents to want to maintain a clear distinction between themselves and their patients. In this view, patients are ordinary people who get sick. Physicians are skilled, highly trained people who help other less skilled people get well. These roles can be construed rigidly, so that physicians sometimes have difficulty perceiving themselves as sick or in need of help. Similarly, they have difficulty accepting that patients can be helpers too. Physicians often reassure themselves with this too-clear role dichotomization. This kind of distancing, while often a good coping mechanism, tends to define the patient exclusively as other than self.

While the physician protects himself by distancing from the patient, the behavioral scientist finds it easy to identify with the patient, often having been one himself. Precisely because of this ready alliance with the patient, psychologists may place an unrealistic emphasis on the patients' strengths: and may push their ability to be self-reliant and self-determining beyond the limits of practicality. Thus, there is often quite a large discrepancy between the behavioral scientist's view of the patient and the physician's view of the patient. The physician is used to an authoritarian role which the patient often reinforces. The egalitarian model naively offered by the behavioral scientist is difficult to relate to.

A further problem is the antipathy some residents experience toward patients with psychological problems. Often, there is a feeling the physicians should not have to deal with these kinds of patients. These patients do not have real diseases, the argument goes; they are malingering, there is nothing that can be done for them anyway, they make the physician feel depressed, there are specialists who enjoy dealing with these kinds of people. The omnipresent danger of a competent, high-status physician experiencing contempt for patients who have "allowed" themselves to become sick is most acute with patients suffering from psychological dysfunction. These are the patients the physician is most apt to dismiss with a consultation to the nutritionist, a prescription of Elavil, or advice to see a psychiatrist.

Guideposts for Change

The above problems confronting physicians and behavioral scientists have been discussed at some length because they are subtle and not easily amenable to change. Most deceptive is the apparent ease with which the two disciplines fit to-

gether. It is easy to dismiss conflict entirely, to flatter the flexibility of physicians and nonphysicians alike. However, failure to acknowledge the above problems will result neither in resolution nor even amelioration.

Change must proceed on two fronts. The first, most obvious, and not to be ignored is structural change on the part of both groups. On the one hand, physicians must be prepared to deal with the psychological sciences in a serious fashion. This means moving beyond the lip service paid to psychosocial homilies toward the implementation of structural and organizational changes. It means possibly including a month of behavioral science rotation, just as one would include a month on pediatrics. It means shortening clinic to allow for supervisory time with the behavioral scientist. Most simply, but most importantly, it means providing space in the curriculum for formalized psychosocial training. This means not only the odd half hour of free time turned over to behavioral sciences, but official accommodation to reasonable educational needs.

The behavioral scientist, on the other hand, must remember that he is functioning in a medical setting, not a graduate school. Medical departments have their own organization, their own priorities; insensitivity to this reality can be a time-consuming mistake. Behavioral scientists must be flexible enough to adapt to this new environment. They must remember that they are not training mini-psychotherapists but physicians.[15] They must realize that residents are overburdened, stressed, and juggling several life roles, and that they must not make unreasonable demands. They must be prepared to adopt the problem solving, crisis oriented working mode in which residents tend to feel most comfortable, and adapt it to their own ends: to become adept at moving backwards from practice to theory; to become skilled at inserting tiny gems of theoretical insight between great chunks of "how-to" crisis consultations. They need to take their own discipline seriously, to assert that they exist not simply to provide frills, but to help physicians develop a crucial professional expertise in treating families.[16] This means time in the program for residents to develop an understanding of family dynamics and time to develop skill at using family interventions to promote growth and positive change.

In terms of curriculum development per se, the behavioral science curriculum in family medicine departments should be designed to meet the following criteria:

1. It should stress one-to-one feedback, rather than group learning.
2. It should provide a broad range of electives for those residents with an interest in the behavioral sciences.
3. It should be practical, non-theoretical, and intervention oriented.
4. It should emphasize feedback and the use of audio and videotapes.
5. It should address the common problems found in family practice, such as obesity, depression, sexual problems, "crocks," and drug and alcohol abuse.
6. It should be designed with extreme flexibility in mind, so that it is able to be adapted to fill any available time slot. Behavioral scientists should never reject even a half-hour of usable time simply because they cannot accommodate to it within their conceptual framework.
7. It should be pragmatic: something is better than nothing at all!

In terms of attitudes toward physicians and patients, for the behavioral scientist it is important to remember that not only is the patient a person, but that the physician is a person, too. Thus, physicians need to be approached with compassion and respect. Physicians, on the other hand, need to identify more with the patient role, to practice being helpless and dependent, and to be willing to expand their self-concept to include a multitude of professional roles.

Most importantly, physician and behavioral scientist need to learn to understand each other's worldview better. For the behavioral scientist, this may mean endless hours of attending clinic sessions, not as a teacher but as a learner, experiencing firsthand the frustrations, the decisions, the joys of the family physician. For the family physician, it may mean an opportunity to actually engage in therapy with a family; a requirement of time to develop self-understanding and the awareness that this kind of insight is critical to the effective practice of medicine. It may mean an opportunity for discussion, for experiential exercises as a means of reaching consensus on priorities, so that physicians and psychologists may agree on the ideal practice of medicine. It may mean the humility for both groups to let go of their conviction of

moral and/or professional superiority. It may mean developing ways of reducing the mutual anxiety and defensiveness that exist in both parties, such as role reversal exercises. It may mean identifying and then breaking down the stereotypes each group holds about patients, physicians, and psychologists. It means arriving at a consensus about the kind of role innovation possible and desirable given the limits of the medical system. It means strengthening psychological-mindedness in the medical community, strengthening the value of attending to emotional responses, nonverbal communications, mixed messages, and feeling states. Above all, it means continued and intense dialogue, on all issues, from all angles, aimed finally at the development of a truly common and meaningful language.

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