

SPECIAL ISSUE

Introduction to the Special Issue on Primary Care

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The prevalence of chronic illness in the population is increasing each decade, and many people coping with long-term illness develop symptoms of anxiety and depression. Although primary care physicians receive some training in Behavioral Science and Psychiatry, they do not have the time to manage all the patients who are emotionally symptomatic. This article discusses the rationale for incorporating behavioral/mental health providers in primary care practice.

The Integration of Biofeedback Mental and Behavioral Health Services Into Primary Care

This special issue is devoted to the exposition of information regarding integration of mental and behavioral health services into primary care. During the past few decades, epidemiological studies have identified increased prevalence of chronic illness, most of which is managed by primary care physicians. Chronic illnesses, such as hypertension, heart disease, diabetes, and asthma are associated with a high comorbidity of anxiety and depressive disorders. Most patients with chronic illness complicated by emotional disorders are diagnosed and totally managed in primary care (Utz, 2003).

Whether or not patients with chronic illness have diagnosable emotional illness, every patient has an emotional response to an illness, receiving bad news, or hearing that their illness is going to require time off from work, loss of functioning, or daily self-management. Exacerbations of illness need medical intervention but also require psychological adjustment to worsening disability or to the need for the patient to add components to an already complicated regimen.

Problems in Prevailing Practice Models

Primary care physicians receive training and instruction in behavior and psychology during their residency. They learn the criteria for diagnosis of psychiatric disorders, in addition to the multitude of relatively simple or highly complex manifestations of physical illness. Despite this knowledge base, physicians do not use that information to manage the stress-related disorders effectively or according to evidence-based treatment paradigms (Kroenke,

Jackson, & Chamberlin, 1997; Kroenke & Swindle, 2000). Eliciting physical symptoms from patients takes up all their time, with only a few minutes to explore emotional reactions or frank psychiatric illness. When a stress-related condition or emotional disorder is diagnosed, providing patients with handouts and books can be helpful, but learning from written materials is difficult without support from a knowledgeable individual. Similarly, maintaining motivation for exercise without a trainer or learning a healthy nutrition plan without a nutritionist presents multiple challenges to patients faced with new diagnoses. This is not to say that the physician's few minutes of teaching is worthless. A brief intervention does produce results (Calfas, Salis, Oldenburg, & French, 1997); however, these results may be limited to short-term behavior change. Patients may try the new behavior, but need follow-up to hone skills and receive reinforcement. It is daunting to consider that if every suggestion meant a return office visit within 2 weeks, the already beleaguered primary care system would become nonfunctional.

Physicians intellectually accept worry and sadness as normal patient reactions to bad news. However, they are reluctant to explore these areas further because of discomfort with the topic and lack of available resources to offer the patient, in addition to the time pressures of the practice. Since most patients find it more difficult to reveal and talk about their worry, anxiety, sadness, or depression, more time is necessary to create a comfort zone and to bring feelings into the medical conversation. In addition, we must consider that the language of primary care is pain, bloating, aching, and insomnia, which are often disguises for worry, anxiety, depression, or family and work problems. Therefore, patients come to their primary care physician and speak the official language of the medical practice – "I hurt here (stomach, neck)" – instead of saying "my spirit is confused, my emotions are distressing me" (Moss, 2002).

The Appeal of Complementary Medicine

What is the attraction of patients to complementary medicine (CM)? What is the rationale for expenditure of large amounts of money on self-care, such as herbal products, Reiki, or megavitamins? The basic premise of

most CM therapies is that mind, body, and spirit are integrated in health and illness. Patients perceive that the CM provider is not only focused on physical symptoms but on feelings and spiritual life. So the patients' feelings about their illness, the effects of the illness on family, or work will be addressed. The CM provider is more likely to emphasize quality of life rather than focusing solely on cure (Verhoef & Best, 2003).

Integration of Mental and Behavioral Health Services into Primary Care

Mental/behavioral health providers (MBHP) who are located in the primary care clinic can offer services that the physician does not have time or expertise to offer. A team approach is best for patients with emotional illness, difficulty coping with stress or comorbid emotional disorders that accompany medical problems (Yuen, Gerdes, & Waldforger, 1999). Presence of the mental health provider in the primary care office is an obvious validation statement; in contrast to the referral process, which separates the patient from the primary care provider.

What can the MBHP offer to the practice? People with chronic illness need techniques to deal with significant behavioral self-care demands. Let's recall that the major medical illnesses have a behavioral component that has contributed to the etiology of the illness and, therefore, behavior change must be part of the recovery (McGinnis & Foege, 1993). People with chronic illness need tools to motivate themselves to change and skills training to modify behavior. Mental and emotional illnesses can be harbingers of physical illness or may follow years of medical illness (McGrady, 2003).

Patients identified as difficult by primary care physicians are those who have vague, ill-defined complaints; they often are frustrated about the lack of answers provided by physicians regarding their physical complaints. Although emotional illness or symptoms might have an important influence on physical symptoms, patients and sometimes their health care providers do not acknowledge the relationship between mind and body (Barsky & Borus, 1999). Even subclinical anxiety or depression can worsen physical discomfort and decrease quality of life. Yet, the primary care physician who recommends psychological or psychiatric services to these patients will rarely be successful. Studies of treatment of mental illness in the population have shown that the intervention paradigm follows evidence-based standards only 14% of the time (Wang, Berglund, & Kessler, 2000). By recommending psychological counseling, the physician is perceived to abandon patients or to have run out of options. On the contrary,

when the therapist is located within the same practice, the message is different. The patient is told: "my colleague, Dr. Smith, will see you to help you manage the stress of your illness." Another option is to refer the patient to one of the wellness or stress-management groups in the practice. The presence of the MBHP becomes commonplace in the practice and, therefore, the acceptability of referrals increases.

The Special Issue on Primary Care

The articles in this special issue address various aspects of behavioral mental health in primary care. The article by Dr. Doug Post discusses the essential aspects of good communication between doctor and patient and methods of improving dialogue to maximize the available time in the appointment.

The contribution by Dr. Kathy Farmer describes an intervention that allows patients with chronic headaches to be active in the management of their headaches, while continuing to take medication as necessary. Integration of this treatment into any primary care office where many patients with headaches are seen has the potential to improve outcome for patients with migraine without increasing office visits.

Dr. C. J. Peek's article on integration is an excellent description of models of integrated care. Several salient aspects of the collaborative model of primary care and mental health professionals are discussed.

The article by Dr. Richard Gevirtz proposes an approach to integrating behavioral health and medical care, by "embedding" a biofeedback/applied psychophysiology practitioner in the primary care setting, and conducting a two-stage physician education program to optimize the use of behavioral health in the medical setting.

The article by Lynch and McGrady discusses ways of identifying patients in family medicine who are at high risk for illness and subsequent high medical utilization. A brief intervention is described that can be conducted within a primary care setting to decrease the risk for these patients.

Finally, the article by Dr. William Isler focuses on the integration of primary care and behavioral health by using two illustrative examples. For patients with insomnia, a four session protocol was implemented with positive results. The second example describes the implementation of group appointments for patients with diabetes.

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