Handbook of Cognitive-Behavioral Approaches in Primary Care
Robert A. DiTomasso, PhD, ABPP, is Professor of Psychology and Chairman of the Department of Psychology at the Philadelphia College of Osteopathic Medicine. He is a Diplomate in Clinical Psychology of the American Board of Professional Psychology, a Fellow of the Academy of Clinical Psychology, a Founding Fellow of the Academy of Cognitive Therapy, and a licensed psychologist in Pennsylvania and New Jersey. He obtained his doctoral degree from the University of Pennsylvania, and completed an internship at Temple University School of Medicine, Department of Psychiatry, Behavior Therapy Unit, and Eastern Pennsylvania Psychiatric Institute. He completed extensive postdoctoral training and supervision in cognitive therapy and primary care psychology. He previously served as Adjunct Associate Professor at the University of Pennsylvania, and as Associate Director of Behavioral Medicine at West Jersey Health System Family Practice Residency for many years. He is the coeditor of *Comparative Treatments for Anxiety Disorders* (Springer Publishing, 2002).

Barbara A. Golden, PsyD, ABPP, is an Associate Professor of Psychology and the Director of Clinical Services and Director of the Center for Brief Therapy at the Philadelphia College of Osteopathic Medicine. She received her PsyD in clinical psychology from Loyola College in Baltimore, Maryland, and completed an APA-approved internship at University of Medicine and Dentistry of New Jersey and a postdoctoral fellowship at Robert Wood Johnson Medical School. She is board certified in Clinical Psychology by the American Board of Professional Psychology. As a licensed psychologist, her clinical and scholarly work includes nonpharmacological pain management, somatization disorder, and psychology in primary care. She is a member of several professional organizations, and has published and presented on various clinical health psychology topics.

Harry J. Morris, DO, MPH, is Professor and Chair of the Department of Family Medicine at Philadelphia College of Osteopathic Medicine (PCOM). He received his DO degree from PCOM and his MPH from the Medical College of Wisconsin. He completed his internship and residency in family medicine at PCOM, and a postdoctoral fellowship in Primary Care Curriculum Development from Michigan State University. He previously directed the Family Medicine Residency at PCOM. He currently teaches communication, documentation, and physical examination skills to medical students. Dr. Morris administers the ambulatory health care system at PCOM, which includes four urban health care centers in underserved areas. He was in private practice in Pennsylvania for 11 years before becoming a Family Medicine Residency Director in Orlando, Florida. Dr. Morris is board certified in Family Medicine and Preventive Medicine/Occupational Medicine.
This book is dedicated to many people in my life, all of whom are now gone, all of whom have left this earth much too soon, all of whom I had the pleasure to spend important parts of my life, and all of whom in one or more countless ways have positively touched my life. I enjoyed the pleasure of their company and I think of them fondly and often. Through their losses, I have also come to personally realize how the toll of lifestyle, among other factors, in many instances contributed to the diseases that ultimately took their lives. These special people are: Lucy and William DiTomasso, Mary (Cammarota) and Umberto (Big Albert) Macera, Robert (Bobby DiAntonio) DiGiovannantonio, George M. Vinci, Anne (Cammarota) and John (Johnny Cheeri) Bucciero, Helen (Cammarota) and Dan Carangi, Anthony (Tony Carlo) Carangi, Joan (Barossa) Bucciero, Lena (Granny) Bongiovanni, Anthony Bongiovanni, Luigi and Antoinette DiTomasso, Esther (DiTomasso) Vecere, Rita (DiTomasso) and Mike (The Spike) Maggio, Charles (Charlie Young) DiTomasso, Buddy DiTomasso, Kate (DiTomasso) Buccella, Anthony (Rushy) DiTomasso, Frank DiTomasso, Carmela (DiGiovannantonio) Terlingo, Donato Ezzo, S.Thomas Carter, Jr., MD, and James P. Mahan, PsyD.

—RAD

For my parents, John and Kathleen Golden; my sisters, Kathleen and Carol. Being your daughter and your sister are my greatest blessings.

—BG

To my wife, Joanne, and my family.

—HM
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Contributors

**Frank Andrasik, PhD**
Distinguished University Professor  
Department of Psychology  
Senior Research Scientist  
Florida Institute for Human and Machine Cognition  
University of West Florida  
Pensacola, FL

**Stephen D. Anton, PhD**
Assistant Professor  
Department of Aging and Geriatric Research  
Department of Clinical and Health Psychology  
University of Florida  
Gainesville, FL

**Immaculate A. Antony, BSc**
Ontario Institute for Studies in Education (OISE)  
University of Toronto  
Ontario, Canada

**Michael J. Baime, MD**
Director, Penn Program for Stress Management  
Abramson Cancer Center  
University of Pennsylvania School of Medicine  
Philadelphia, PA

**Jeff Baker, PhD, ABPP**
Professor and Director  
Psychology Training Program  
Division of Rehabilitation Sciences  
University of Texas Medical Branch  
Galveston, TX

**Michael A. Becker, DO, MS, FACOFP**
Vice Chair, Associate Professor  
Department of Family Medicine  
Philadelphia College of Osteopathic Medicine  
Philadelphia, PA
Dorothy A. Borresen, PhD, APN  
Assistant Professor, University of Medicine and Dentistry  
Robert Wood Johnson Medical School  
Family Medicine Residency at Capital Health Systems  
Lawrenceville, NJ

Patrick D. Boyle, MA  
Doctoral Student, PsyD Program in Clinical Psychology  
Philadelphia College of Osteopathic Medicine  
Philadelphia, PA

Craig J. Bryan, PsyD  
Chief, Primary Care Psychology Service  
Wilford Hall Medical Center  
San Antonio, TX

Oliver Bullock, DO  
Professor, Department of Family Medicine  
Chairman of the Division of Community Medicine  
Philadelphia College of Osteopathic Medicine Healthcare Center  
Cambria Division  
Philadelphia, PA

Dawn C. Buse, PhD  
Assistant Professor, Department of Neurology  
Albert Einstein College of Medicine of Yeshiva University  
Assistant Professor, Clinical Health Psychology Doctoral Program  
Ferkauf Graduate School of Psychology of Yeshiva University  
and Director of Psychology, Montefiore Headache Center  
Bronx, NY

Stacey C. Cahn, PhD  
Assistant Professor  
Department of Psychology  
Philadelphia College of Osteopathic Medicine  
Philadelphia, PA

Raymond Carvajal, MA  
Doctoral Student, PsyD Program in Clinical Psychology  
Philadelphia College of Osteopathic Medicine  
Philadelphia, PA

Deborah Chiumento, PsyD  
Postdoctoral Fellow  
Clinical Coordinator, “A Healthier You”  
Department of Psychology  
Philadelphia College of Osteopathic Medicine  
Philadelphia, PA

Andrea L. Cincotta, MS  
Research Coordinator  
Penn Program For Stress Management  
University of Pennsylvania Health System  
Philadelphia, PA
Contributors

Carla Cirilli, MA
Doctoral Student
Psyd, Program in Clinical Psychology
Philadelphia College of Osteopathic Medicine
Philadelphia, PA

Travis A. Cos, PhD
Department of Psychiatry
University of Rochester Medical Center
Rochester, NY

Michael J. Dolan, PsyD, CAC
Licensed Psychologist, Adjunct Faculty
Department of Psychology
Philadelphia College of Osteopathic Medicine
Philadelphia, PA

Rebecca Egner, BS
University of Pennsylvania
Philadelphia PA

Stephanie H. Felgoise, PhD, ABPP
Professor, Vice Chair
Department of Psychology
Director, PsyD Program in Clinical Psychology
Philadelphia College of Osteopathic Medicine
Philadelphia, PA

Amelia G. Findiesen, MS, NCC
Doctoral Student, PsyD Program in Clinical Psychology
Philadelphia College of Osteopathic Medicine
Philadelphia, PA

Larry H. Finkelstein, DO
Associate Professor of Family Medicine
Director of Extended Care Services and Education
Philadelphia College of Osteopathic Medicine
Philadelphia, PA

Arthur Freeman, EdD, ScD, ABPP
Visiting Professor, Department of Psychology
Governors State University
Chicago, IL

Robert J. Gatchel, PhD, ABPP
Professor and Chairman
Department of Psychology
College of Science, The University of Texas at Arlington
Arlington, TX
Scott Glassman, MSEd
Doctoral Student, PsyD Program in Clinical Psychology
Philadelphia College of Osteopathic Medicine
Philadelphia, PA

Elizabeth A. Gosch, PhD, ABPP
Associate Professor
Department of Psychology
Philadelphia College of Osteopathic Medicine
Philadelphia, PA

Kimberly A. Hand, MSc
Graduate Student, Department of Applied Physiology and Kinesiology
University of Florida
Gainesville, FL

Erica A. Henninger, PsyD, MBA
Psychotherapist and Director of Bariatric Behavioral Health
Family Health Psychology Center
Darby, PA

Jenna L. Jebitsch, MS
Doctoral Student, PsyD Program in Clinical Psychology
Philadelphia College of Osteopathic Medicine
Philadelphia, PA

Jeanne R. Kestel, MS
Doctoral Student, PsyD Program in Clinical Psychology
Argosy University
Chicago, IL

Samuel Knapp, EdD
Director of Professional Affairs
Pennsylvania Psychological Association
Harrisburg, PA

Anu Kotay, PhD
Director of Behavioral Science, Family Medicine Residency
Robert Wood Johnson Medical School
New Brunswick, NJ

Stuart L. Kurlansik, PhD
Faculty, West Jersey–Memorial Family Practice Residency at Virtua
The Tatem-Brown Family Practice Center
Voorhees, NJ

Paul Lehrer, PhD
Professor of Psychiatry
University of Medicine and Dentistry of New Jersey
Robert Wood Johnson Medical School
Piscataway, NJ
Contributors

Richard Levine, MD
Faculty, West Jersey–Memorial Family Practice Residency at Virtua
The Tatem-Brown Family Practice Center
Voorhees, NJ

Eileen Lightner, MA, MS, LPC
Doctoral Candidate, PsyD Program in Clinical Psychology
Philadelphia College of Osteopathic Medicine
Philadelphia, PA

Meghan L. Marsac, PhD
Psychology Fellow, Center for Injury Research and Prevention
The Children’s Hospital of Philadelphia
Philadelphia, PA

Roger K. McFillin, PsyD
Department of Psychology
Philadelphia College of Osteopathic Medicine
Philadelphia, PA

Eugene Mochan, PhD, DO
Associate Dean, Primary Care
Philadelphia College of Osteopathic Medicine
Philadelphia, PA

Margaret Nam, BA
Graduate Student, Department of Psychology
Philadelphia College of Osteopathic Medicine
Philadelphia, PA

Arthur M. Nezu, PhD, ABPP
Professor of Psychology, Medicine, and Public Health
Drexel University
Philadelphia, PA

Christine Maguth Nezu, PhD, ABPP
Professor of Psychology and Medicine
Drexel University
Philadelphia, PA

Philip J. Pellegrino, PsyD
Department of Psychology
Philadelphia College of Osteopathic Medicine
Philadelphia, PA

Michael G. Perri, PhD
Interim Dean, College of Public Health and Health Professions
Department of Clinical and Health Psychology
University of Florida
Gainesville, FL
Contributors

Maurice F. Prout, PhD, ABPP  
Professor and Director, Respecialization Program  
Widener University, Institute for Graduate Clinical Psychology  
Chester, PA

J. Russell Ramsay, PhD  
Assistant Professor of Psychology in Psychiatry  
University of Pennsylvania School of Medicine  
Adult ADHD Treatment & Research Program and Center for Cognitive Therapy  
Philadelphia, PA

Paul M. Robins, PhD  
Director of Clinical Services  
Codirector, Internship Training Program  
Department of Psychology  
The Children’s Hospital of Philadelphia and  
Associate Professor of Psychology  
University of Pennsylvania School of Medicine  
Philadelphia, PA

Bradley Rosenfield, PsyD  
Assistant Professor  
Department of Psychology  
Philadelphia College of Osteopathic Medicine  
Philadelphia, PA

M. David Rudd, PhD, ABPP  
Professor and Chair  
Department of Psychology  
Texas Tech University  
Lubbock, TX

Nancy Breen Ruddy, PhD  
Director of Behavioral Science  
Mountainside Family Practice Residency  
Mountainside Hospital  
Mountain Lakes, NJ

Laura Russo-Innamorato, MS  
Doctoral Candidate  
PsyD Program in Clinical Psychology  
Philadelphia College of Osteopathic Medicine  
Philadelphia, PA

Jesús A. Salas, PsyD, ACT  
Clinical Psychologist, Clinical Assistant Professor  
Philadelphia College of Osteopathic Medicine  
Department of Psychology  
Philadelphia, PA
Contributors

Marsha S. Singer, PhD
Clinical Assistant Professor
Department of Psychology
Philadelphia College of Osteopathic Medicine
Philadelphia, PA

Clint C. Stankiewicz, PsyD
Department of Psychology
Philadelphia College of Osteopathic Medicine
Phillipsburg, NJ

Rebecca K. Stern, PhD
Research Assistant
Widener University
Chester, PA

Takako Suzuki, PhD
Assistant Professor
Department of Psychology
Philadelphia College of Osteopathic Medicine
Philadelphia, PA

Brenda B. Toner, PhD
Center for Addiction and Mental Health
Toronto, Ontario, Canada

Adam G. Tsai, MD, MS
Assistant Professor of Medicine
University of Colorado
Denver, CO

Kenneth J. Veit, DO, MBA
Senior Vice President for Academic Affairs and Dean
Philadelphia College of Osteopathic Medicine
Philadelphia, PA

Ivette Velez, MS
Department of Psychology
Philadelphia College of Osteopathic Medicine
Philadelphia, PA

Thomas A. Wadden, PhD
Professor of Psychology in Psychiatry
and Director, Center for Weight and Eating Disorders
University of Pennsylvania School of Medicine
Philadelphia, PA

Mark A. Watling, MD, FRCPC
Assistant Professor
Department of Psychiatry and Behavioural Neurosciences
McMaster University
St. Joseph’s Healthcare
Hamilton, Ontario, Canada
Beverly White, PsyD
Assistant Professor
Department of Psychology
Philadelphia College of Osteopathic Medicine
Philadelphia, PA

Laura Young, MD, PhD
Clinical Associate Faculty
Department of Medicine
Division of Endocrinology, Diabetes and Metabolism
University of Pennsylvania School of Medicine
Philadelphia, PA

Bruce S. Zahn, EdD, ABPP
Professor
Director of Clinical Training
PsyD Program in Clinical Psychology
Department of Psychology
Philadelphia College of Osteopathic Medicine
Philadelphia, PA

David L. Zehrung, PhD
Director, Counseling and Psychological Services
Greencastle Family Practice, P.C.
Greencastle, PA
Foreword

The premise that mental health and physical health factors affect each other has become widely accepted in our society. By and large, psychotherapists and medical practitioners alike have come to appreciate the ways in which stress, maladaptive attitudes, negative behavioral and lifestyle habits, and physiological pathology interact, typically in vicious cycles, often leading patients to present with problems that are neither quickly nor easily assessed or treated. Similarly, there has been a rising awareness that by coordinating care between psychotherapists and primary care physicians, patients can receive more powerful interventions, and their adherence to treatment and ongoing self-care can be enhanced. The results of such professional collaboration promise better outcomes and maintenance for patients, reduced costs in the long run (for individual patients and for society as a whole), and improved understanding of the etiology, development, and maintenance of health and mental health problems, thus leading to potentially fruitful treatment research directions.

The Handbook of Cognitive-Behavioral Approaches in Primary Care is an impressive volume that clearly and comprehensively describes theory, research, and practice on issues pertinent to the mind-body connection, from the level of individual patients to the macro-levels of professional systems and societal access to empirically supported treatments. The editors and authors have a wealth of professional experience as prime movers in the growing trend toward integrative medical and mental health care, and they expertly bring this knowledge to bear in spelling out the issues and problems that need to be addressed so as to maximize the availability and utility of this model.

As interested readers, we learn that there has been a convergence between the rise of the biopsychosocial model in health care, the growing body of data supporting cognitive-behavioral therapies as being at the forefront of “best practices” in the treatment of a wide range of disorders and populations, and the emergence of the overlapping fields of health psychology and behavioral medicine. We also learn some things that may be surprising even to seasoned clinicians, such as the fact that mental health difficulties are among the most common presenting problems in primary health care and about 70% of psychotropic medication prescriptions come from primary care physicians. Nevertheless, there is often a significant disjunction between primary care practitioners and mental health therapists, even when they are fundamentally in agreement that it would be advantageous for patients to avail themselves of both types of care. Appropriate referrals to therapists may be difficult for primary care practitioners to make, and patient follow-through is notoriously poor. Primary care practitioners and cognitive-behavioral therapists have different exigencies (e.g., in terms of time allotments, billing regulations, ethical guidelines on boundaries) and a contrasting nomenclature, thus leading to suboptimal collaboration. However, as the Handbook of Cognitive-Behavioral Approaches in Primary Care so clearly details, creating a workable environment and system for better coordination of care can produce
markedly improved results for patients and enhanced professional satisfaction for clinicians.

The breadth and depth of this text is astounding. It would be more than sufficient if the book focused only on the major problems encountered in primary care to which cognitive-behavioral methods could be applied in a facilitative manner. Indeed, we learn about the ways in which integrative care can better address such health concerns as hypertension, diabetes, asthma, obesity, headaches, insomnia, chronic pain, and irritable bowel syndrome, as well as behavioral problems such as substance abuse, eating disorders, and suicidality, among others. However, the volume goes well beyond this, tackling such highly relevant issues as patient problems in adherence to medical advice (owing to misunderstandings, memory problems, fears of medical procedures, negative beliefs, and the like), preparing patients to be in an optimal state of mind for medical interventions (a sort of “mental prehab”), and cultural considerations pertinent to the practitioners’ sensitivity to the patients’ ethnic and familial norms that may affect the patients’ receptivity to treatment.

The editors and authors offer extremely helpful guidelines on how to improve collaboration, coordination, and integration of care so as to approach the goal of providing treatments to the “whole person” in the most effective, efficient, and empirically supported ways. They repeatedly make the point that the primary practitioner’s office and the cognitive-behavioral therapist’s office do not have to be separate worlds—they can be brought together via improved appreciation for what the other venue has to offer its patients, and via improved communication between their disciplines regardless of whether or not they are located in the same physical space. In the same way that health and mental health professionals can become more culturally aware and sensitive when treating patients from a variety of ethnic backgrounds, they also can become better partners if they understand each other’s professional “culture,” such that timely teamwork is enhanced in a way that adds value to the other’s practice. Significantly, the *Handbook of Cognitive-Behavioral Approaches in Primary Care* includes a chapter on the training of primary care residents in cognitive-behavioral methods. Although it is true that they will likely have far too many patients and too little time to apply such methods as guided discovery and motivational interviewing techniques, these future frontline physicians will be better positioned to recognize problems such as patient denial, low adherence, eating disorders, and substance-use disorders, and also will be better oriented to work in tandem with their colleagues doing cognitive-behavioral therapy so as to bring comprehensive care to their patients.

Absorbing the evidence-based principles and experiential wisdom these pages have to offer will be a gratifying experience, whether the reader zeroes in on one or more particular chapters of interest or is determined to read the entire book (and I enthusiastically recommend the latter choice). Many of the chapters include illustrative case examples that exemplify the use of cognitive-behavioral assessment methods, case formulations, and interventions to ameliorate the wide range of clinical problems already noted. As previously stated, these chapters also address cultural considerations, such that practitioners and therapists can adjust their approaches when necessary and appropriate to enhance their partnership with patients from different ethnic backgrounds. Especially useful are the sections on “clinical pearls of wisdom” that summarize so many of the chapters. This will surely be a text to which to refer again and again.

The *Handbook of Cognitive-Behavioral Approaches in Primary Care* makes a compelling case for integrative models of health care and mental health care being the wave of
Foreword

the future, promising significant advantages for all parties. Nonetheless, as with any major “merger,” there are formidable challenges in trying to move forward in an organized manner, with well-defined roles and new lines of communication. The new “team” has to learn to work collaboratively and synergistically with the least amount of delay and a minimum of growing pains. The editors and authors of this seminal text do a masterful job in explicating the conceptual and technical details involved, thus guiding this vitally important, soon-to-be burgeoning field in the right direction.

Cory F. Newman, PhD, ABPP
Director
Center for Cognitive Therapy
University of Pennsylvania
School of Medicine
Our goal in this handbook is to present a comprehensive, up-to-date summary of the integration and applications of cognitive-behaviorally oriented approaches to common issues and problems confronted by practitioners in primary care medical settings. As academics and practitioners ourselves, we have experienced the multitude of issues and problems described in this volume. Each of us has been fortunate enough to have spent her/his career in multidisciplinary medical settings integrating our services on the frontline in a variety of service delivery units, as well as training advanced doctoral students, medical students, family medicine interns, family medicine residents, nurse practitioners, and physician assistants.

Before joining the Department of Psychology at Philadelphia College of Osteopathic Medicine full time in 1998, Robert A. DiTomasso had served for roughly 20 years as Associate Director of Behavioral Medicine at West Jersey Health System Family Practice Residency and its outpatient medical service, the Tatam-Brown Family Practice Center. This program, originally affiliated with the University of Pennsylvania School of Medicine, and later, the University of Medicine and Dentistry of New Jersey, provided rich and priceless opportunities for working side by side on a daily basis with 5 attending family physicians and about 24 residents. Before joining this residency, DiTomasso had completed an internship at the Behavior Therapy Unit at Temple University’s Department of Psychiatry/Eastern Pennsylvania Psychiatric Institute, under the direction and supervision of Joseph Wolpe, MD, the father of behavior therapy, and L. Michael Ascher, PhD. The melding of these two experiences—behavior therapy and primary care—was critical in shaping ideas and concepts about the important role of mental health practitioners in primary care. Barbara A. Golden completed her postdoctoral training in Clinical Health Psychology at the University of Medicine and Dentistry of New Jersey/Robert Wood Johnson Medical School. She worked closely with primary care physicians and specialists in the areas of pain management, somatization disorders, and HIV/AIDS. At the Philadelphia College of Osteopathic Medicine (PCOM), this work was continued and expanded by creating, implementing, and overseeing the training of the clinical psychology students from our APA-accredited PsyD program in the area of integrated health care in PCOM’s neighborhood health care centers. In these multidisciplinary settings, students have marvelous educational opportunities to complete practica and internship (APPIC) experiences working with chronically ill underserved medical patients. Harry J. Morris worked in family medicine as a solo practitioner for many years. Prior to coming to PCOM, he was the Residency Director for Florida Hospital East Orlando. Since coming to PCOM 14 years ago, he has been the Chair of the Department of Family Medicine and oversees the health care centers. His background in family medicine, public health, and spirituality provides a unique blend for the delivery of health care in these urban settings, as well as training family medicine residents and clinical psychology interns.

There is little doubt that the marriage between psychology and family medicine at PCOM has served as the impetus for this book. We hope to provide practitioners
and scholars with the unique and important benefits made possible by integrating cognitive-behavioral models into the delivery of primary medical care. In Part I, General Considerations, chapter 1, with our colleague Deborah Chiumento, postdoctoral fellow in clinical health psychology and Clinical Coordinator of the "A Healthier You" project at PCOM, we describe the importance of three major events influencing primary care: the birth of the biopsychosocial model, the emergence of behavioral medicine and health psychology, and the cognitive-behavioral revolution in psychotherapy. In chapter 2, with Sam Knapp and Ken Veit, we elucidate the roles and functions of the cognitive-behavioral clinician in primary care, with an emphasis on ethical issues. Borresen and Ruddy, in chapter 3, present a comprehensive overview and analysis of the importance of collaboration between mental health providers and primary care physicians. In chapter 4, Cos, DiTomasso, Cirilli, and Finkelstein examine critical issues in the process of conducting patient-centered and consultee-centered consultation in primary care. In chapter 5, DiTomasso, Cahn, Cirilli, and Mochan argue for the absolute importance of incorporating empirically based models and their applications into primary care practice. In chapter 6, Kurlansik and Levine, seasoned educators of family medicine residents, examine their methods and strategies for educating and training family practice residents in cognitive-behavioral approaches and biopsychosocial medicine, with a keen eye focused on cognitive-behavioral clinicians seeking to function effectively as teachers of family medicine. In chapter 7, Felgoise, Becker, and Jebitsch, based on their work with chronically ill medical patients, offer a unique perspective on the role of spirituality in primary care, a frequently neglected topic.

In Part II, Cognitive-Behavioral Techniques, a variety of important cognitive-behavioral strategies are reviewed. In chapter 8, Suzuki, White, and Velez present their ideas on the importance of cultural competence and psychoeducation in working with primary care patients. In chapter 9, Young, Cincotta, and Baime summarize their work on mindfulness from their experience at the University of Pennsylvania’s Stress Management Program. In chapter 10, Art Nezu and Christine Maguth Nezu, based on years of work in mind-body medicine and problem-solving therapy at Hahnemann University’s (now Drexel’s) Department of Clinical and Health Psychology, contribute their comprehensive and useful model of conceptualizing patient problems in primary care. In chapter 11, Zahn, Zehrung, and Russo-Innamorato offer a detailed review of common cognitive assessment and treatment strategies of relevance to the primary care setting. Next, in chapter 12, Gosch, DiTomasso, and Findiesen describe the behavioral model of assessment and treatment and its relevance in working with primary care patients. Finally, in chapter 13, Jeff Baker, based on his work at the University of Texas Medical Branch at Galveston, undertakes the important topic of how to best prepare primary care patients for stressful medical procedures.

Part III, Common Behavioral Problems in Primary Care, opens with chapter 14, in which DiTomasso, Chiumento, Singer, and Bullock describe the challenges of assessing and treating nonadherent patients in primary care. Anton, Hand, and Perri, in chapter 15, address critical issues related to behavioral lifestyle habits, including smoking and physical activity. In chapter 16, Freeman, Lightner, and Golden address the common cold of mental health—depression in primary care. Salas, Henninger, Stern, and Prout, in chapter 17, provide a thorough and eye-opening account of the role of anxiety in clinical presentations and its treatment in the outpatient medical setting. Rudd and Bryan, in chapter 18, present a useful model of understanding suicidality in primary care, coupled with a variety of clinically helpful strategies for
dealing with this challenging issue. In chapter 19, Dolan and Nam offer a practical perspective on identifying and handling substance abuse issues in primary care. Golden, Stankiewicz, and Kestel, in chapter 20, describe the common, complex, and challenging issues presented by somatoform patients. In chapter 21, Watling offers a complete analysis and clinically helpful recommendations for handling the problem of medical phobias that interfere with medical treatment. Robins and Marsac, in chapter 22, tackle the common behavioral pediatric problems presented in the primary care setting. In the final chapter in this section, Cahn and McFillin provide a thoughtful treatment of the complexities of assessing and handling eating-disordered patients.

In Part IV, Common Medical Problems in Primary Care, DiTomasso, Chiumento, and Morris begin with the assessment and treatment of the hypertensive patient in chapter 24. In chapter 25, Kotay and Lehrer of UMDNJ discuss the issue of asthma. In chapter 26, DiTomasso, Boyle, Finkelstein, and Morris address the complicated and challenging problems presented by diabetic patients in primary care. In chapter 27, Tsai, Carvajal, Egner, and Wadden present an academically stimulating review of their well-known work from the University of Pennsylvania on obesity, with implications for primary care clinicians. Golden, Gatchel, and Glassman offer valuable insights in assessing and treating chronic pain in primary care in chapter 28. In chapter 29, Buse and Andrasik provide a thoughtful piece on the headache patient, and in chapter 30, where irritable bowel syndrome is discussed, Toner and Antony offer clinical considerations about the assessment and treatment of this challenging problem.

In chapter 31, Rosenfield, Ramsay, Cahn, and Pellegrino provide a thorough approach to the assessment and treatment of the insomnia patient. Finally, in chapter 32, we offer our insights and conclusions about the future of cognitive-behavioral approaches in primary care.
Acknowledgments

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My deepest appreciation goes to my coeditors. Bob has had the desire to write this book for many years. With his experience and mentorship, I have learned much of what I know about cognitive-behavioral therapy and primary care medicine. Harry welcomed the practice of providing psychological services into our health care centers at a time when this multidisciplinary approach was considered “a new way” of doing business. We share a common vision of providing comprehensive health services to urban, underserved persons, and have taught and supervised countless numbers of students. I am most grateful to the Sisters of St. Joseph, Chestnut Hill, PA, and to the Society of Jesus, the Jesuits, who gave me the foundation to become an empathetic psychologist and a knowledgeable teacher, and, in addition, a mission to serve the most vulnerable persons in our society. I am grateful for my dear friend, Thomasina Farley, SSJ, and my aunt, Mary J. Golden, SSJ, without whose constant encouragement
I would never have completed my doctorate. My deepest thanks also go to my colleagues and my students at PCOM, especially Amelia Findiesen, Jeanne Kestel, and Margaret Nam, who remind me of the reasons why I chose to be a teacher. Finally, for all the patients struggling with physical and mental illnesses, I am in awe of their perseverance and strength to overcome many hardships (BG).

I recognize and thank many individuals. My patients have taught me that medical care and caring for the patient are separate and equally important concepts. My family medicine colleagues have shown me how to deliver quality health care and train the next generation of physicians. The Psychology Department has shown me how to implement comprehensive care of the mind and the body. A special thanks also goes to Linda Monger for her dedicated assistance to me over these many years (HM).
Handbook of Cognitive-Behavioral Approaches in Primary Care
Part I

General Considerations
Introduction

Over the past 25 years, we have witnessed a rather dramatic rise in the number of mental health practitioners in medical settings. The primary care setting is no exception, as shown by the call to integrate the biopsychosocial model into patient care. The American Psychological Association calls for strategies to promote collaboration and multidisciplinary practice in health care settings (Bray, 2009). There is little doubt that cognitive-behavioral approaches play a central role in the assessment and treatment of primary care patients. The cognitive-behavioral approach has quickly established itself as the treatment of choice for many of the common problems of patients presenting for care (Sperry, 2008). This phenomenon has likely occurred from the confluence of a number of factors. First, over the past century, the traditional medical model has been sorely lacking in its ability to fully explain, predict, and treat medical patients. This biomedical approach has been found to be inadequate due to its almost exclusive focus on the biological, to the exclusion of other relevant factors. Engel (1977) argued for the adoption of a more comprehensive model that attended to the multifaceted nature of medical problems. This biopsychosocial model has received increasing attention over the
past 30 years, serving as a basis for spawning clinical research that addresses the interplay between physical, psychological, and social factors in medical patients and their problems. Second, the average life span of patients has improved, due in large part to dramatic advances in medical technology. On the whole, people are living longer, and are thereby confronting rather unique medical challenges (Seime, Clark, & Whiteside, 2003). Quality of life is, therefore, often compromised and undermines the potential for living a fully functional life. Third, there has been a growing appreciation of the fact that lifestyle habits play a major role in the onset, development, maintenance, and exacerbation of medical problems. For instance, rigorous vaccination protocols have all but eliminated the demise of patients from infectious diseases that were commonly observed in the last century. Broadly speaking, today the culprit is found among the “behavioral pathogens” (Matarazzo, 1984) that set the stage and fuel the rates of morbidity and mortality commonly seen in medical practice. Simply put, factors such as poor diet, minimal physical activity, significant stressors, the abuse of substances, unsafe sex practices, limited coping ability, inadequate emotional support, and nonadherence to medical advice may combine to place patients at great risk for health problems. Fourth, the rise in popularity of primary care medicine, especially family medicine, places the physician in the central role of partnering with patients in the coordination of their health care needs. The basic tenets of primary care medicine (Taylor, 2003), such as continuity of care, comprehensiveness of care, attention to psychosocial issues, and the role of patient education have placed emphasis on the assessment and treatment of the “whole patient,” as opposed to disease states. The training of family physicians is a case in point. Allopathic and osteopathic medical education accreditors, including the American Board of Family Practice and the American Board of Osteopathic Medicine, mandate that all interns and residents have exposure and training in the psychological aspects of medical care. Fifth, the emphasis on evidence-based medicine and the rise in popularity of empirically based treatments, as reported in the Cochrane Evidence Based database, has sensitized physicians to the scientifically supported efficacies of cognitive-behavioral therapies. Today, primary care physicians (PCPs) are more aware of the clinical outcomes associated with the cognitive-behavioral approach for problems for which efficacy has been demonstrated. The cognitive-behavioral therapy (CBT) revolution in the field of psychotherapy, the rise of behavioral medicine/health psychology, the application of the CBT approach to medical patients and the crises they experience (DiTomasso, Martin, & Kovnat, 2002), and the popularity of empirically supported approaches has done much to reinforce the view that cognitive-behavioral assessment and treatment protocols have much to offer in the primary care setting. CBT practitioners must rise to the challenge and meet the demands for the care of patients. Given the common medical and psychosocial problems seen in primary care, as well as the literature demonstrating efficacy for treating these problems, the CBT model is a perfect fit. The functional analysis of behavior, cognitive-behavioral case conceptualization, the development and selection of empirically based treatment plans, and the willingness to work side by side with physician colleagues will help to address the needs and enhance the health care of primary care patients.
Theoretical Issues

A number of theoretical models and issues are important to examine when considering the role of CBT clinicians in primary care. Three main areas are relevant here: Taylor’s Tenets of Family Medicine, Engel’s Biopsychosocial Model, and the Cognitive-Behavioral Model of Behavior and Psychopathology.

There are a number of important tenets of family medicine that must be considered in understanding the unique characteristics of primary care. By embracing these concepts, practitioners will appreciate the context within which primary medical care is embedded, but more importantly, will foster a more effective partnership among PCPs, cognitive-behavioral practitioners, and patients. Taylor (2003) elucidated several important tenets of primary care. Perhaps most important is the construct of continuity of care, the idea that patients have their medical care provided by one physician over the course of the life cycle. Continuity of care has profound implications for a number of reasons. Having a consistent medical practitioner who is thoroughly familiar with the patient’s history, as well as the unique and idiosyncratic aspects of the patient’s medical and psychosocial history, can make a dramatic difference in the quality of patient care. The importance of continuity has far-reaching implications in enhancing the accuracy of problem identification and in fostering the formation of a more effective physician-patient relationship. Continuity is especially relevant in the psychological realm. Having care provided by a physician in a continuous manner over an extended period of time provides a physician with a thorough level of familiarity with the unique and idiosyncratic manner in which the patient adjusts to change. The physician sees how the patient handles the daily stressors associated with living in today’s world, and specifically within the community and family environment. Likewise, knowledge about the patient’s history, when the patient is likely to become symptomatic, family medical and psychiatric history, the role of stressors in the family, the availability of family support, the implicit trust in the physician, and the like are critical factors that can affect the course of care. When continuity does not exist, such as instances in which patients seek primary care from an emergency room, the treating physician is missing the entire picture. Incomplete information results in incomplete assessments and has a significant impact on the validity of diagnoses. Often the patient receives incomplete treatments and treatments aimed at the wrong targets. The consequence may be unnecessary diagnostic tests, patient discomfort and inconvenience, increased patient expense, unnecessary physician time and effort, and waste of precious health care dollars.

Comprehensiveness of care refers to the importance of considering the totality of the patient’s experience. In this sense, there is a commitment to understanding and treating the “whole” patient, not just focusing exclusively on one aspect, such as biological functioning. This construct places emphasis on the many advantages of having a thorough understanding of all of the factors that are likely to impinge upon the patient’s care. Failure to attend to the total view leaves significant areas ignored in patient assessment and treatment that serve to undermine effective care. Unfortunately, in some instances, physicians may miss an obvious factor
that is associated with the onset, exacerbation, and maintenance of a problem. Failure to consider all relevant factors may thus occur, resulting in ineffective treatments or placing patients at undue risks. A balanced view of patient problems that respects the multifaceted causal nature of problems is indicated. For instance, in the diagnostic realm, ignoring important psychosocial patient information in the patient's life is just as serious as overlooking the possibility of a physical, albeit rarer, cause of a problem. Partnering with patients by incorporating their self-observation and monitoring into the assessment process (DiTomasso & Colameco, 1982), as well as maintaining a scientifically skeptical and empirically based attitude coupled with the respect for physical or organic causes of patient problems (Colameco & DiTomasso, 1982), is critical.

The emphasis that PCPs place on the psychosocial aspects of patient care is also of obvious importance. The implicit assumption communicated to patients is simply that patients are welcome to discuss the psychological and social aspects of their lives and their impact on physical and mental functioning. By addressing physical and mental (mind-body) problems in a broad, concurrent, and simultaneous fashion, medical practitioners emphasize the interplay of these factors in explaining patient problems and in ultimately solving them.

PCPs also place a premium on educating patients about their health. The impact of patient education is such that it provides a basis for the patients' understanding their conditions, factors creating them and influencing them, and why specific treatments are offered. Although patient education may not be a powerful treatment in and of itself, it does appear to provide a mechanism for patients to integrate and accept the treatment package. It may be necessary, although not sufficient, for fostering patient change. For example, in the psychological area, patient psychoeducation may serve a variety of useful functions—explanatory, motivational, and practical—in fostering the patient's adoption of the treatment package to orient the patient to the components of the treatment protocol and facilitate treatment assimilation (DiTomasso, Freeman, Carvajal, & Zahn, 2010).

Finally, the emphasis on evidence-based approaches in medicine provides another vehicle for considering the value of CBT approaches and making these strategies relevant to the primary care setting. Primary care has embraced the integration of the different facets of patients, including cognitive, physical, affective, behavioral, and motivational components, and how these unite to provide a thorough understanding and formulation of patient problems and the search for effective interventions.

**Biopsychosocial Model**

The term *biopsychosocial* stems from George Engel, who, in 1977, introduced the biopsychosocial model of disease in a now-classic article entitled “The Need for a New Medical Model: A Challenge for Biomedicine.” This model is based on the interplay of the biological, the psychological, and the social aspects of a person’s disease (Engel, 1977). In describing this model, Campbell and Rohrbaugh (2006, pp. 10–11) stated:

*In the biopsychosocial model, the biological system emphasizes the anatomical, structural, and molecular substrates of disease and their effects on the patient’s biological*
functioning; the psychological system addresses the contributions of developmental factors, motivation, and personality on the patient’s experiences of and reactions to illness; and the social system examines the cultural, environmental, and familial influences on the expression of, as well as the patient’s experiences of, illness.

This revolutionary view of patients strayed from the traditional unidimensional approach of viewing health and illness, and focused on incorporating and viewing biological, psychological, and social aspects of the person and how these factors influenced, precipitated, interacted with, and maintained illness. Not unexpectedly, this novel viewpoint of health and illness (and even wellness) represented a major paradigm shift and, as a result, was met with resistance from the medical community. The social and psychological aspects of a patient’s life, unlike the physical biological markers, emerged from the “soft” sciences and were not accorded the same respect or potency in explaining, let alone affecting, patients. Consequently, they were not previously considered or, if so, were minimized, at best. Over the past two decades, volumes of research have attested to the importance of these factors in fully understanding and treating patient problems in the medical setting.

The biopsychosocial approach assesses functioning within the behavioral, emotional, affective, biological, psychological, and social realms. Physiological, behavioral, and cognitive mechanisms may link to an individual’s health (Richman et al., 2005), and positive emotions may correspond with a healthy lifestyle to the extent that assessing patients on all domains of this model may more accurately measure functioning and risk and protective factors. For example, with hypertensive patients, assessment on the social domain (such as social support) may yield clues about their support network, a well-known buffer to stress and possible key to facilitating adherence to medical regimens. Evidence suggests that individuals who have strong social supports typically manage their hypertension better than those without social support (Marzari et al., 2005).

An explanation of each of the domains and their impact will underscore the importance of this model for the cognitive-behavioral clinician in primary care. The biological component encompasses all physical and demographic factors related to the patient. Assessment on this domain specifically addresses the age, sex, race, physical appearance, symptoms, health status, physical examination, vital signs, laboratory data, medications, drugs, psychophysiological data, constitutional factors, genetics, and history of injury, disease, and surgery. The biological domain captures the unique physical portrait of the patient undergoing assessment and warrants exploration of factors such as genetics, medications, substances, and physical conditions. This area, although critically important, represents only one piece of the puzzle.

The psychological component encompasses all those things that are related to the psychological functioning of the patient. Assessment on this domain includes any history of psychological problems (including type, nature, duration, and severity), psychological vulnerabilities, disruptions in psychological development from childhood, and psychosocial stressors and coping mechanisms. Cognitive aspects of the patient are assessed here as well, including thoughts, attitudes, beliefs, and assumptions, as well as behaviors and emotions that may be related to illness. These data form the basis for a functional analysis of behavior as a
basis for determining, for instance, whether any behaviors are serving a specific purpose, such as escape, avoidance, or secondary gain.

The social component of the biopsychosocial model focuses the clinician’s attention toward the role of family, friends, significant others, social issues, education, work, housing, income, access to health care services, and legal problems. Especially relevant in this domain is the strength or lack of close interpersonal relationships, the patient’s social support network.

Engel’s (1977) view of the inadequacy of the traditional medical model opened the way for a new understanding of patients. He emphasized the consequences of failing to factor in other important domains of the patient’s life and functioning, and argued for a fuller, richer, comprehensive, and more useful understanding of patients from assessment and treatment perspectives. In the field of psychology, the rise in popularity of learning-based approaches added significantly to the development of empirically based assessment and treatment alternatives.

Learning-Based Models

The development and extension of learning-based approaches to psychotherapy and behavior change have dramatically impacted the course of medical care. The implicit assumptions of these approaches, including operant-based, classically conditioned-based cognitive models and, more recently, the influx of mindfulness-based models, have been quite influential. The most central tenet of these approaches is the critical role of learning in developing, maintaining, extinction of, generalizing, and modifying behavior. The implicit ideas are that behavior is learned to a great extent and, therefore, can be unlearned; maladaptive behavior can be replaced with adaptive behavior; behavior can be replaced by learning and engaging in positive incompatible behaviors; new behaviors can be shaped gradually through reinforcement; and, finally, that laws of learning are powerful models for understanding, predicting, and controlling behaviors. The central role of cognitive factors, including automatic thoughts, implicit assumptions, and underlying conditional and unconditional beliefs and their inherent relationships to behaviors and feelings is also of paramount importance. These models have placed great emphasis on behavior broadly defined as the problem, and moved away from models presuming the importance of some underlying cause. The focus on history of the patient as a learning blueprint provides clues to formulating models that explain the development of problems, their maintenance, and ultimately their treatment. Finally, these models have spawned unique and widely applicable and useful methods of assessment, case formulation models, and specific empirically based treatment strategies. Perhaps no other models in the history of psychology and mental health have provided as much empirical evidence to support the application of psychological principles to the assessment and treatment of patient problems commonly encountered in primary care. More recently, there has been great emphasis on transporting efficacious treatments into the community at large and testing their effectiveness in clinical settings.

In sum, the melding of primary care, the biopsychosocial model, and learning-based approaches have much to offer in enhancing the care of patients in medical settings. However, there are many practical and logistical issues that affect the application of these theories and principles in the practical everyday world of the
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PCP. In the next section, we describe these issues and strategies for overcoming them.

**Practical and Logistical Issues**

There are a number of unique issues that the cognitive-behavioral clinician will confront in working with primary care patients. Practical and logistical issues are those that relate to the day-to-day operations of the medical environment and that impact the delivery and collaborative implementation of service. Whether working onsite with physicians or outside of the medical center independently, a number of considerations must be addressed. Otherwise, care will be compromised and the providers are likely to experience significant frustrations with each other. These include issues related to time constraints, schedules, turn-around of information, and resistance. To ensure success in this regard, the therapist must, for all intents and purposes, become a student of primary care and fully embrace the model, understanding and accepting its basic tenets and its underpinnings. An appreciation of the role of the PCP and filtering what the therapist does through the lens of the physician will help make whatever is offered to the physician most practical and applicable. The medical environment is a time-oriented setting, in which typically there are large numbers of patients being seen in limited time slots. Although mental health clinicians are accustomed to having the luxury of a 50-minute hour in which to provide service, most physicians spend about 15 minutes or even less with patients. Likewise, the sheer volume of patients in a typical primary care practice for which a physician is responsible dwarfs the usual patient panel of the mental health clinician. These factors usually place physicians under a great deal of pressure to balance multiple priorities simultaneously, with limited time to spend talking with other providers. Considering the typical schedules of most therapists, arranging time to collaborate may present a significant challenge. Likewise, what time is available is typically limited, placing further constraints on the situation. In consulting with physicians, this means avoiding overelaborate, highly theoretical, and overly detailed explanations of the patient’s problem (e.g., a theoretical aspect of an aspect of a patient’s problem) that may be completely unnecessary and not well received by the physicians. A consideration of what the physician needs to know versus does not necessarily need to know will streamline an already time-pressured encounter and will be appreciated by the physician. Seizing available opportunities to discuss a patient on the fly and openly accepting one’s role as a consultant are helpful. A related time issue is office staff, who may see it as their role to buffer the physician from undue distractions and to keep the schedule flowing. Coordinating office space and differences in the manner in which services are billed may also be problems. Many physicians are frustrated by the lack of flow of information back to them about their patients, as well as the timing of the response when they do receive information. These issues necessitate educating physicians about unique confidentiality issues in psychotherapy and obtaining permission from patients as a prerequisite for treatment at the outset to share relevant information. Patients may not initially appreciate the mind-body connection and the value and importance of integrating care. Failure to include the physician may seriously compromise care and create mixed messages when the physician and therapist
are not on the same page, so to speak. Dealing with resistant physicians who may not appreciate the role of the therapist is another matter. It is often valuable to use medical metaphors as a means of explaining problems and situations to physicians. For example, the use of standardized psychological tests, such as the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and the Beck Anxiety Scale (Beck, Epstein, Brown, & Steer, 1988), may be likened to screening blood work. To deal with a physician who views a serious suicidal threat as an attention-getting device, the seriousness of hopelessness and suicidal intent as cardinal indicators may be likened to crushing substernal chest pain and shortness of breath as impending signs of a heart attack. Forgiving positive relationships with physicians, educating them about your role, collaborating with them, respecting their role as coordinator of patient care, and demonstrating the value of your services are critical for success. There are also a number of clinical and professional issues to consider.

Clinical and Professional Issues

Clinical issues relate to specific assessment, diagnostic, and treatment issues that arise in collaboration with physicians. The therapist would be wise to consider a number of unique considerations in patients presenting in primary care settings. First, most patients presenting in primary care are seeking care from their physician as a result of physical symptoms that they are experiencing. Their illness representations are frequently physical, as opposed to psychological. Coupled with this fact is that many problems are presented to physicians in an undifferentiated state, requiring the therapist to anticipate what a symptom could represent and to be prepared for early detection. A proportion of patients will, as a result, resist the idea of a psychological interpretation as a cause of a problem. It takes a great deal of skill and coordination between the physician and therapist to present an explanation that the patient will accept. This may involve framing the patient's problem in terms that the patient will accept, such as initially referring to the patient's problem as stress, as opposed to depression. A patient may be more willing to accept stress management as a treatment, as opposed to psychotherapy. Of course, the timing of a referral is also important (Belar & Deardorff, 1995). Physicians who espouse a true biopsychosocial model help patients entertain the interrelationship of these factors early on and may be more likely to accept the involvement of a therapist, unlike the patient who would naturally assume that a referral means the problem is only in their head. The primary care therapist must also be cognizant of the fact that the types of problems often seen in primary care patients are directly related to the setting in which they are seeking care. For example, one may be more likely to encounter medical phobias in the primary care setting than in a typical mental health population.

Other important clinically related problems confronted by the therapist may include issues related to differential diagnosis, inappropriate treatment for problem, specific assessment and diagnostic and treatment issues that arise, recommendation and use of nonempirically based treatments, poor quality of information originally obtained by the physician, lack of a thorough biopsychosocial conceptualization of the patient's problem, failure to appropriately address nonadherence issues, and improper handling of problematic, difficult cases. The therapist must
also appreciate that some clinical problems are more common than others in primary care settings, and these base rates must be considered in diagnostic decisions. A thorough understanding of common presenting problems and their clinical and typical manifestations, including depression, anxiety, and substance abuse, should be considered. Physical symptoms may be signs of a depressive equivalent or mask an underlying psychological diagnosis. Likewise, physicians often think of patients as sick versus not sick or emergent versus nonemergent, which allows them to quickly ascertain the necessity for responding quickly to a patient problem. These issues warrant great skill on the part of the therapist in negotiating a win-win solution while allowing the physician to save face, and ultimately providing optimal care to the patient.

Professional challenges confronted by therapists may stem from role-related issues (therapist versus physician), differing models of patient care, role status, or confusion (e.g., a physician expecting a recommendation for a psychotropic medicine from the therapist), expecting the therapist to do something outside of his/her prescribed role and unique norms in medical settings. Regarding the latter, violation of norms may alienate the physician from the therapist. For example, the therapist should avoid telling patients that their physician needs to order a particular test, such as an MRI. These types of matters are more appropriately handled by the physician.

Ethical Issues

There are a number of special ethical considerations in medical settings, and the astute clinician will make him/herself aware of such before embarking on practice. These issues reflect problematic ethical concerns and dilemmas that are raised in collaboration (e.g., confidentiality, informed consent, charting, appropriateness of information for the chart, competence issues, and boundary violations). These issues are discussed in more depth elsewhere in this book, and should be carefully considered to avoid unethical practice.

Recommendations for Effective Practice

To function effectively in collaborating with PCPs, there are a number of important recommendations for effective practice. Therapists should consider the following:

1. Understand and learn as much as possible about the primary care model of medical care. A thorough appreciation of the tenets of primary care, as well as the role of the PCP, will enhance the likelihood of successful handling of the patient.
2. Respect the mores, norms, and customs of practicing within a medical environment, and find the common ground between medicine and mental health practice with a commitment to collaboration and consultation.
3. Embrace the biopsychosocial and learning-based cognitive-behavioral model of assessment and intervention, with an emphasis on empirically based and tested approaches.
4. Educate physicians about the biopsychosocial model of patient care and the cognitive-behavioral approach and its relevance for assessing, conceptualizing, and treating common problems in primary care.

5. Educate physicians about the role of the cognitive-behavioral therapist, the assessment and treatment model, and the effectiveness of this approach in helping patients.

6. Emphasize an empirically based approach to practice that is commonly accepted in medical circles today, emphasizing the outcomes associated with this approach. Educate physicians about the CBT approach as a psychosocial model of empiricism.

7. Respond to physicians and keep them informed in a timely manner, sharing the case conceptualization and treatment plan with the physician and patient.

8. Provide assistance that is practical, understandable, applicable, useful, and easily adopted in the primary care setting.

9. Use medical metaphors to communicate the rationale of assessment and treatment procedures.

10. Avoid turf wars and emphasize the common ground between physician and therapist, which is the welfare of the patient. Coordinate the care of the patient with the physician and reinforce the role of the physician as the coordinator of patient care.

References


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