10. EXAMPLES OF CONSULTATIONS WITH ADULTS

"To find out what one is fitted to do, and to secure an opportunity to do it, is the key to happiness."

John Dewey

Many adults in the United States probably have a person in their lives that they consider to be their primary care provider. Most hope that this special person, the PCP, will see them as a whole person and provide helpful advice and support over the course of a lifetime. Most want guidance on how to maintain their health and care for health problems when they develop. Most of all, most patients hope that their PCP will provide them with good counsel when they are going through a challenging period of life.

General medicine has always been based on the belief that a collaborative, mutually respectful, life span relationship provides the best opportunity for good health care. The biopsychosocial model of general medicine (Engel, 1977) is the center piece of this philosophy. However, it is one thing to TALK about the goal of biopsychosocial care, while it is an entirely different matter to DELIVER care in this framework. Any objective review of the U.S. primary care system would conclude that biopsychosocial medicine is a much talked about, seldom delivered form of care. The integration of primary care and behavioral health services and providers is one obvious step toward resolving this conundrum. Other important developments include placing greater emphasis on holistic and complementary medicine as core components of primary care and the transformation of solo medical practices into health care teams.

The BHC, as the newest addition to the PC team, is well-equipped to support the whole-person perspective, bring fresh ideas to the idea of working in teams, and interventions that strengthen the PCP-patient relationship. Team-based services will be a particularly

important strategy for the numerous adult patients who are the survivors of adverse childhood histories, such as those we described in our introduction to Chapter 9. These patients carry the pain and suffering resulting from sexual, verbal and physical abuse experienced decades ago. They come to primary care in large numbers, and they have both medical and psychological problems. Most PCPs intuitively understand the struggle these patients face when trying to adopt healthy lifestyles and seek purposeful, meaningful lives. At the same time, the demands of primary care practice are unforgiving. Many patients with problems are seen on any given practice day, and they must generally have their full medical and psychological needs addressed in less than 10 minutes. The primary care provider perspective on this lack of fit between level of need and amount of time is quite predictable: "How can we respond when there are so many patients and we are monitored so closely and required to produce, produce, and produce!" For many PCPs, the addition of a BHC to the medical team is a "dream come true". The BHC can offer valuable assistance to these patients and their PCPs by creating programs that reduce the burden of psychosocial interventions on PCPs and enhance patient access to BHC services.

This chapter offers the reader a chance to join us for a day of BHC practice in an adult medicine team. We have a very busy schedule today, but that is nothing new. EVERY day is a busy day. For today, you will have the opportunity to shadow a BHC that provides consultations to 11 different patients. In some consultations, readers will view graphs of assessment data and learn how to use these in providing services. In conjunction with other consultations, readers will learn about practice tools (e.g., behavioral prescription pads). After a day in practice, the reader will have a much better idea of what he or she needs to learn to be a competent BHC. To this end, we have compiled Appendix C as a targeted reading list for

BHCs who want to increase their intervention skills with adults. Just as is the case for working with children and families, patient education materials are a basic part of the BHC tool kit. Instead of having the reader spends hours on end searching for the right handout, we have included a compact disc that includes a set of core patient handouts (e.g., Habit Change, Healthy Sleeping Tips, and Premature Ejaculation).

So, let your imagination take over and let's get to work. Table 10.1 describes the day (and provides an overview of this chapter). It's a busy day, with five patients in the morning and six in the afternoon. This, of course, allows the BHC time to see a few walk-in, same-day patients and perhaps conduct a class or two.

Table 10.1

Chapter 10 Overview: A Day in the Life of a BHC (Providing Care to Adults)

CHAPTER SECTION	BHC # 1442	REFERRAL REASON
Vague Pain Complaints / Domestic Violence	8:15 Maria	Neck Pain
Chronic Pain	8:45 David	Back Pain
Medical Adherence	9:15 Bud	Hypertension
Somatization	9:45 May	Dizziness
Chest Pain (Panic)	10:15Ralph	Chest Pain
Chronic Conditions	1:00 Patty	Weight gain, chronic disease management
Learning Disabilities	1:30 Penny	Dizziness, fatigue
Symptoms of Trauma and	2:00 Leslie	Fatigue, sleep disturbance,

Depression		depression
Suicidal Ideation	2:30 Jose	Thoughts of suicide, new diagnosis of diabetes
Drug and Alcohol Problems	3:00 Ed	Alcohol problems
Serious Mental Illness	3:30 Elizabeth	Hearing voices, sleep problems

VAGUE PAIN COMPLAINTS AND DOMESTIC VIOLENCE

Pain complaints are very common in primary care, and functional analysis is an excellent tool for addressing them. In a clinic where one of us practices (PR's), family practice doctors insist that 20-40% of clinic visits by women involving vague pain complaints are related to marital problems. Some of these women are victims of domestic violence, and their visit offers an opportunity to address safety issues, as well as relationship skill deficits. Maria's case example provides a demonstration of the services BHCs can offer women with vague pain complaints and marital problems.

Maria: My neck hurts.

Dr. Sims has scheduled Maria to see the BHC for neck pain and stress management, after her medical appointment was completed. When the BHC explored the neck pain, Maria began to cry and said that it started several months ago after she was laid off from her job. She and her husband were arguing more, and their youngest child was having problems in school. She has considered leaving her husband because he has been verbally abusive, but she has no place to live if she did leave. Walking and taking a shower seemed to help relieve her pain, and being with friends improved her outlook. However, she explained that her husband was jealous and that he did not like for her to see her friends. She admitted to feeling afraid of him and

explained that he had hit her early in the marriage, but had stopped after she separated from him briefly. Maria explained to the BHC that she wanted to improve her marriage and to stay with her husband, as she had young children and wanted them to have a father in the home. She was also dependent financially on her husband.

The functional analysis suggested that Marie had responded to the increased stress in her relationship by isolating herself from friends at church and in her local community. As is true for many patients in unpleasant stressful family environments, she believed that her friends would soon "get tired" of hearing talk about her stress and low life satisfaction. The net effect was that she was becoming more and more reliant on her husband to provide social support, even though he was the source of stress in the first place. This, combined with his jealousy at her being out of the house, resulted in a very perceptible pattern of withdrawal and social avoidance.

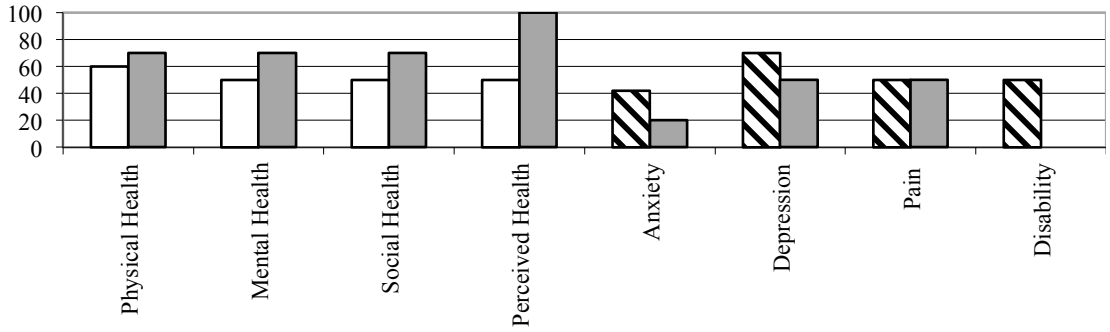
The BHC and Marie developed a plan that addressed both her pain and her desire to reduce stress and improve marital satisfaction. She agreed to resume regular attendance at her local church and to rejoin a group of women friends who took walks on a daily basis in her neighborhood. The BHC also explained the relationship between stress and pain and suggested that the pain would probably continue at some level as it was related to muscle tension in the neck and shoulders, which often increases with conflict. The BHC taught her an exercise involving diaphragmatic breathing combined with rhythmic gentle stretching of muscles in the neck, shoulders, and back. The BHC also mentioned that daily walks of 30-45 minutes would probably help her feel more relaxed and ready to solve problems at home. This made sense to her as she often felt more optimistic when she occasionally took a walk to meet her children at their school. The BHC gave her a pamphlet that described services from a domestic violence

agency in the community, explaining that they supported women in problem-solving and that she did not need to be planning to leave her husband in order to call them.

At follow-up, patient reported that she was attending her church group and had talked with her sister several times about her marriage and her life direction. She was practicing the suggested breathing exercise daily and walking to and from her children's school on weekdays. She felt better about her marriage, as her husband was staying home more and treating her more respectfully. She had not called the domestic violence agency, but wanted to know more about their services and agreed to possibly call them in the future. The BHC taught her another breathing exercise to promote relaxation and reviewed the Stress Awareness Handout (See Appendix D) with her, and they talked about Marie's values concerning friendship and ways to bring more friends into her life. The BHC explained that Dr. Sims know about her behavior change goals and her plans for the future, so that he could assess her progress and provide emotional support at each medical visit.

Figure 10.1 depicts a graph of Maria's Duke Health Profile Scores at her initial and follow-up visits with the BHC. As explained in Chapter 5, Duke Scores range from 0 to 100. Higher Scores suggest better health on Function Scales (Physical Health, Mental Health, Social Health, and Perceived Health, which are represented by white columns for the initial visit). The scoring is the opposite for Dysfunction Scales, where higher Scores suggest more severe symptoms (related to Anxiety, Depression, Pain, Disability, which are represented by stripped

columns for the initial visit). Her follow-up Scores confirmed her reported improvement.



*Note: Scores range from 0 to 100. On Physical, Mental, Social and Perceived Health Scales, higher Scores indicate better functioning. On Anxiety, Depression, Pain, and Disability Scales, higher score indicate more severe symptoms.

Figure 10.1

Maria's Duke Health Profile Scores at the Initial and Follow-up Consultations*

BHC Intervention Possibilities for Patients Reporting Pain and Domestic Violence. The interventions used with Maria are typical for patients with pain complaints and marital problems. As indicated in Table 10.2, the BHC accepted Maria's pain complaint and used it as the basis for a functional analysis. The results of functional analysis suggested a link to marital problems, and they worked together to plan interventions that might improve both. The functional analysis also suggested that pain was less troubling and marital conflict less problematic when Maria had more social outings, so the BHC supported her in efforts to improve her rate of socializing. The BHC accepted Maria's plan of staying in her marriage and, at the same time, offered her information of community services for victims of domestic violence. At follow-up, the BHC taught Maria skills to help her stay aware of her stress level and to practice relaxation skills to lower pain sensations related to muscle tension.

Table 10.2

BHC Intervention Possibilities for Patients Reporting Pain and Domestic Violence

1. Accept the pain complaint and center the functional analysis on it.
2. Look for a link between pain and marital dissatisfaction and use it to inform the plan (hopefully there are behavioral changes that have a high probability for reducing both pain and marital conflict).
3. Accept the patient's preference to stay or leave the marriage or her or his lack of a determined direction and attempt to interject information that will enhance the patient's flexibility in choosing and pursuing a direction.
4. Help the patient clarify her or his values concerning intimate relationships
5. Coach the patient about the value of using cognitive rather than emotion-focused coping strategies in addressing marital problems
6. Devise a safety plan and collaborate, as appropriate, with police, domestic violence organizations, children's protective services, shelters, etc.
7. Help the patient determine a focus for skill development (self-care, improving her or his social network, personal assertion) and suggest that the PCP support this over time.
8. Use health-related quality of life scores to evaluate patient change, and return the patient to care by the PCP when the patient reports behavior change and scores suggest improvement.
9. Co-lead classes with a representative from the local domestic violence organization

At follow-up, the BHC again evaluated Maria's functioning using the Duke, and, as both patient report and Duke Scores suggested improvement, the BHC returned the patient back to the PCP for ongoing follow up. The BHC had planted seeds that might grow overtime, including use of the domestic violence program and increased social support. The BHC briefed the referring PCP on the present and future behavior change plan, with an emphasis on having the PCP actively query the patient about progress and providing reassurance and reinforcement over time.

Patients involved in abusive relationships often need help to clarify their values concerning intimate relationships and to look at the viability of their marriage or partnership in the context of these values. Values clarified this way can provide a back drop for behavior change planning and for teaching specific coping skills. Most patients benefit from learning the difference between problem-focused versus emotion-focused coping strategies, as well as the distinction between approach and avoidance oriented coping. In this case, the BHC also needed to be mindful of Maria's readiness to change in regards to her or his dysfunctional marriage and to encourage her continued contact with the clinic by matching the intervention to her level of readiness. Many patients benefit from first re-building their social supports and by focusing on building tension reduction and related self-care strategies.

Classes that help patients clarify values with respect to abusive relationships offer a way to intensify the treatment response to a large and troublesome group of primary care patients. For the most part, PCPs have trouble addressing violent, abusive and dysfunctional relationships from anything other than a moralistic, advice heavy perspective. These authority based interventions seldom have a positive impact and more than a few times have been known to drive the patient out of care altogether. In some venues, the BHC may be able to involve a

representative of the local domestic violence agency in group visits, so that a warm hand-off is possible. It is best to include pain in the name of the class, as such helps patients explain the service to a challenging partner.

The BHC also needs to address safety issues, and charting about this will allow the patient to receive support from other providers. Recent information concerning safety issues includes advising patients to stay out of the kitchen and bathroom during times of escalated conflict, as these are high risk areas. BHC also need to inquire about factors that tend to be associated with serious or lethal injury, including an increase in frequency or severity of abuse, threats of homicide or suicide by the partner, presence or availability of a firearm, and whether the abuser is aware of a victim's plan to leave.

PCP Teaching Points Concerning Patients Reporting Pain and Domestic Violence.

As suggested in Table 10.3, BHCs need to teach PCPs need to routinely ask patient's with vague pain questions about recent stressful circumstances—"So, how are things going for you day-to-day?—How is your marriage going?—Are your children well?" These help the PCP lead into an explanation of the relationship between stress and pain (and often a referral to the BHC). The purpose of this line of inquiry is not to talk the patient out of being in pain, but to increase the context for understanding suffering in the patient's life. When patients indicate marital problems, we encourage PCPs to ask one or more screening questions to help determine the likelihood of domestic violence—"Does your husband (wife) frighten you?" When a patient answers affirmatively, we recommend that the PCP encourage the patient to see the BHC on a same-day basis. We also recommend that BHCs teach PCPs to consider the possibility of domestic violence when he or she notices any of the following findings during a physical exam: any injury to face, breast, genitals, or torso; bilateral or multiple injuries; delay between

the injury event and presentation for care; explanation of injury inconsistent with injury pattern; prior use of emergency room services for trauma; chronic pain symptoms; psychological distress; evidence of rape or sexual assault; any injury in a pregnant woman, or, lastly, the presence of a partner who is overly protective, controlling, and/or refuses to leave the exam room. It is of course important for the PCP to document injuries, and most clinics have cameras available to assist with such efforts. The Family Violence Fund (www.endabuse.org) offers a good training video for PCPs on screening. Once identified, the PCP's role includes communicating concern, providing information, reviewing options, referring to the BHC, safety planning, and providing medical treatment. While many victims never leave abusing partners, their situation may improve when they talk about it. In our experience, patients that are victims of violence often do make significant changes, including leaving abusive relationships, when the PCP and BHC work together in a ping-pong fashion over a period of months or years and in collaboration with local community domestic violence programs.

Table 10.3

PCP Teaching Points Concerning Adult Patients Possibly Impacted by Domestic Violence

1. Encourage use of questions about stress, including marital stress, when patients report vague pain complaints.
2. When patients admit to marital problems, suggest use of a screening question (e.g., "Does your husband ever frighten you?") to determine the need for a same-day consultation with the BHC.
3. Provide information about the types of findings in a physical exam that need to trigger exploration of domestic violence

4. Show a film on the PCP's role in providing care to victims of domestic violence. (i.e., communicating concern, providing information, reviewing options, referring, safety planning, and providing medical treatment).
5. Stock pamphlets describing services from local domestic violence agencies in a common area so that PCPs can access them easily
6. Teach the basics of expressing concern and making safety plans.
7. Provide medical treatment and document injuries.

PATIENTS WITH CHRONIC PAIN

Patients with chronic pain have a high impact on primary care services. While they are not a large group, they are complex and difficult to serve as a group given the diversity of their medical problems and the variation in levels of psychosocial dysfunction among them. Clinical pathways (i.e., established programs that describe procedures implemented for every patient in a specific category) may improve relationships between patients with chronic pain and the providers that care for them. We provide information about a chronic pain pathway in Chapter 12. The following consultation with David occurs in a clinic with that has developed a clinical pathway for chronic pain patients, the "Pain and Quality of Life Program."

David: My back is killing me, and I need my pain medication refilled now.

Dr. Clever referred this 50-year-old man for orientation and enrollment in the Pain and Quality of Life Program. David was a new patient to the clinic and made a request for treatment of chronic back pain secondary to incomplete paraplegia and considerable spasticity. David also suffered from hypertension and diabetes. He had signed a clinical pathway agreement with Dr. Clever just prior to the consultation with the BHC. The agreement included the typical

terms for agreements that address use of opioid medications for pain, as well as additional agreements concerning participation in the program.

In the initial visit with the BHC, David explained that his goal was to be free of pain. He had tried a variety of strategies for eliminating pain and, while none seemed to help him reach his goal of being pain-free, some worked better than others to reduce the pain. The BHC explained that the pain and quality of life program was designed to help patients with chronic pain improve their quality of life. David was given a patient education handout to help him begin the on-going process of pursuing value-based behavioral change. (See the Primary Care Patient Values Plan on the compact disc in Appendix D). He chose to focus on his values concerning work and health, in particular being productive and creative. He took pride in his ability to write songs and poems. He played guitar, and most of his friends and family members enjoyed listening to him when he was willing to play.

David's initial responses to the Duke Health Profile suggested low Physical and Social Health Scores, while Mental Health was strong. The plan at the end of the initial consultation was that he would begin attending a monthly class associated with the Pain and Quality of Life Program and that failure to attend would result in his not receiving his pain medication prescription for the following month. Additionally, David agreed to plan at least two social activities weekly, as his mobility problems posed a barrier to socializing and he tended to feel worse when he was more isolated.

David did not come to the next class as planned, and someone called on his behalf several days later insisting that he would pick up David's pain prescription for him. This request was denied, and David came for an appointment with Dr. Clever later that week. At that contact, he received a tapering prescription for the month, and Dr. Clever reviewed his program

agreement and referred him for a same-day consultation with the BHC. The BHC addressed barriers to David's successful participation in the program and reviewed psychoeducational material from the missed class. Over the following twelve months, David appeared for every class on time, completed assessments promptly, participated in class discussions and exercises, and picked up his prescription at the end of class. David's Physical and Social Health Scores on the Duke inched up over the course of the year, as he had become more active in a weight training program for his upper body, more productive in his writing, and more consistent in playing music for others.

BHC Intervention Possibilities for Patients with Chronic Pain. The BHC providing care to David worked within the structure of a clinical pathway designed to help patients make the transition from a focus on pain to a focus on improving quality of life. David received many of the interventions suggested in Table 10.4 over the course of the year following his enrollment in the pathway (and without requiring much individual contact with the BHC or PCP). When David did not hold to the terms of the signed agreement, the PCP delivered a consequence specified in the pain treatment agreement. David's subsequent adherence improved dramatically. As a part of the class, the BHC obtained health-related quality of life scores and included these in chart notes. These data provided the PCP with objective measures for gauging David's response to pathway treatment over time.

Table 10.4

BHC Intervention Possibilities for Patients with Chronic Pain

1. Provide information about chronic pain treatment strategies, the impact of stress on pain, and the chronic pain cycle of avoidance (See Managing Chronic Pain handout

in compact disc in Appendix D).

2. Help patient shift from a goal of pain elimination to a goal of improving quality of life.
3. Measure health related quality of life (or other indicator of functioning, such a Healthy Days Questionnaire) at regular contacts and teach PCPs to use these to evaluate and plan treatment.
4. Encourage daily physical exercise and stretching.
5. Develop value-driven behavior change plans that the BHC and PCP can support in ping-pong visits with patient (See Primary Care Patient Values Plan on compact disc in Appendix D).
6. Work with others to create a pathway program for your clinic.
7. Refer to Community Resources, such as Yoga Classes and Fibromyalgia or Chronic Pain Support groups.
8. Suggest self-help books (See for example Jamison, 1996).

When BHCs do not have pathway programs for chronic pain, we recommend that they begin their intervention with information about the differences between acute and chronic pain treatment strategies, the impact of stress on pain, and the chronic pain cycle of avoidance. The Managing Chronic Pain handout in Appendix D provides patients with written information on these issues. BHC interventions with patients with chronic pain need to focus on activating the patient, because it is the avoidance of pain that leads to sedentary coping styles, greater muscle atrophy and uncomfortable stiffness, which can easily degenerate into a self perpetuating cycle. From an ACT perspective, the emphasis on pain elimination comes from the inability detach

from the experience of pain. Most such patients define themselves in terms of how much pain they are experiencing at any particular moment. Consequently, patients such as David will benefit from learning to monitor pain from an observer self or mindful stance. Once this skill is in place, the BHC can teach useful strategies such as pacing (which involves adjusting intensity, position and other variables in physical activity to prolong function). The BHC may also teach distraction and relaxation skills and employ interventions involving de-catastrophizing pain and de-fusing from pain. Handouts such at the Primary Care Values Plan (see Appendix D) help the BHC and patient develop value-based behavior change plans that both the BHC and PCP can support in a series of ping-pong visits. The BHC may also suggest that chronic pain patients participate in community activities, such as yoga classes and support groups for individuals with fibromyalgia and chronic pain, and as well as read books about coping with pain (See for example Jamison, 1996).

PCP Teaching Points Concerning Patients with Chronic Pain. To assist PCPs effectively treat this challenging group of patients, the BHC needs to maintain a sustained focus on training PCPs to conceptualize pain less from a bio-medical perspective and more from a psychological acceptance point of view. Surveying providers as to their experiences with treating chronic pain patients may enhance their interest in exploring new treatment approaches. Figure 10.2 contains possible survey questions. In many cases, a discussion of the results may spur development of a practice group charged with developing a pathway, along with educational programs and practice support tools.

The purpose of this survey is to further understanding of PCP experience in caring for chronic pain patients. I will ask these questions again periodically to assess the impact of

educational activities and program development activities. Thank you for completing this survey.

Below you will find a list of statements. Please rate the truth of each statement as it applies to you. Use the following rating scale to make your choices. For instance, if you believe a statement is "Always true," you would write a 5 in the blank next to that statement.

0	1	2	3	4	5
Never true	Very rarely true	Sometimes true	Often true	Almost always true	Always true

	1. My training prepared me adequately for working with chronic pain patients.
	2. I enjoy working with chronic pain patients.
	3. I have all the skills I need to work effectively with chronic pain patients.
	4. I look forward to seeing chronic pain patients.
	5. I feel that I am successful with chronic pain patients.
	6. I want to specialize in treating chronic pain.
	8. I usually have a new idea about how to help my most difficult chronic pain patients.
	8. Pain medications are very helpful to my chronic pain patients.
	9. I am able to refer my chronic pain patients to accessible, effective programs.

Figure 10.2

PCP Experiences with Treating Patients with Chronic Pain

As many PCPs did not receive training for treating chronic pain in medical school, they will be open to the ideas suggested in Table 10.5. Many want to avoid or stop prescribing opioids for chronic pain because the evidence for the long term effectiveness of narcotic regimes is very scant and inconclusive. Nevertheless, PCPs may struggle delivering a coherent explanation for shifting from medications to behavior change, and the BHC can help with this. Some patients are prone to thinking that the PCP sees their pain as "all in the head," and the BHC can also help PCPs better engage these patients by teaching them to include statements such as the following in their standard explanation to patients, "We do not think that pain is in the head of our patients at this clinic. We know that pain is in the mind and the body, and we take a holistic approach." Most PCPs will also welcome presentations on behavioral techniques and use of quality of life measures to evaluate treatment and will use handouts, such as Managing Chronic Pain (available in Appendix D). While many PCPs use some type of medication agreement when prescribing longer term narcotic regimes, they will benefit from behaviorally sound strategies for responding to violations of the agreement. To support PCPs in shifting the focus of care from eliminating pain to improving functioning, BHCs may provide brief presentations on designing plans that help patients improve rates of socializing and exercising.

Table 10.5

PCP Teaching Points Concerning Patients with Chronic Pain

1. After surveying PCPs concerning their experiences with treating patients with chronic pain, ask them to consider forming a committee to explore a clinical pathway.

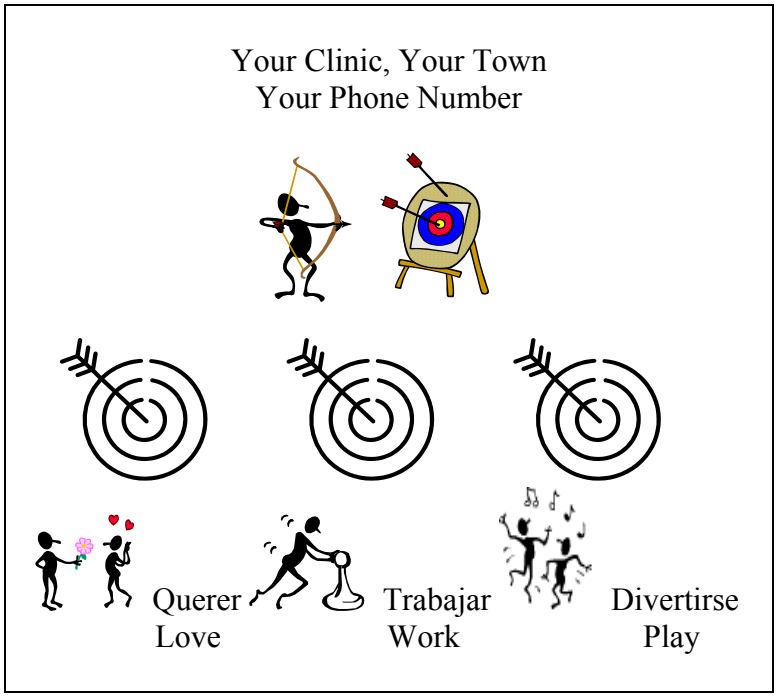
2. Teach PCPs to use patient education handouts promoting behavioral strategies for coping with pain (e.g., the Managing Chronic Pain handout in Appendix D).
3. Support consistent use of a pain agreement with chronic pain patients who use medications.
4. Help PCPs use language emphasizing that all pain is "real" and that pain is best understood as a body-mind experience.
5. Encourage PCPs to consistently include increasing rates of socializing, exercising and stretching in care plans with chronic pain patients.
6. Encourage PCPs to identify patients who are at risk for developing chronic pain.
7. Teach PCPs to use strategies for preventing onset of chronic pain (e.g., use of a behavioral health prescription pad focused on functioning in lieu of a medication prescription pad).
8. Encourage use of BHC services for patients who voice strong fears of pain and report use of sedentary strategies 2-4 weeks after an acute injury.

It is of paramount importance that BHCs also teach PCPs about the opportunity to prevent chronic pain syndrome when treating patients with acute pain complaints. This involves teaching PCPs to detect patients at risk for development of chronic pain and ways to intervene meaningfully with them within weeks, rather than years, after an acute injury. Risk factors include job dissatisfaction, the ability to make as much money not working as when employed, history of or current symptoms of depression, a tendency toward somatization, a history of substance abuse, prior pain complaints, over-reliance on sedentary strategies for coping, and (when the injury occurred at work) failure of the employer to express concern

about the patient's recovery in the weeks immediately following the injury. For acute pain patients with even moderate risk status, the PCP must be able to explain the difference between strategies for treating acute pain and chronic pain, to explain that pain is a normal part of the recovery process, to emphasize acceptance of the fact that pain may be present over time, to explain the concept of pacing, to encourage return to normal social activities as soon as possible, and to insist on some type of stretching and physical exercise regime on a daily basis.

A behavioral health prescription paid such as the one in Figure 10.3 can help the provider curb the urge to prescribe medications and to instead prescribe behavior change. This tool involves the Bull's Eye concept first developed by Tobias Lundgren of the University of Upsala in Sweden. This tool supports behavior change plans based on valued directions in the areas of love, work and play. When using the pad, the PCP can explain that recovery from an injury requires one to take stock of what's really important in life and to carefully plan ways to pursue them. The PCP will also need to explain the difference between values and goals. Values (as globally constructed, abstract concepts) provide direction for behavior change, while goals (as specific attainable targets) provide an immediate target for changing behavior. Further, the PCP can explain that the bull's eye represents a person's value in each of the three areas. He or she can draw a line from the bull's eye to the side and write down a few words representing what the patient reports as valued life ends (e.g., kindness for the love bull's eye or dependability for the work bull's eye). The PCP needs to point out that most people only sometimes behave in ways that represent their values, but that keeping one's values in mind helps one come closer over time. The PCP can also explain that an injury or illness causing pain may make it difficult for one to think about values and personal meaning as the basis for making daily choices. Then, the PCP can invite the patient to form a goal in one or two areas

(depending on time) that he or she believes would help them come closer to living in accordance with the bull's eye value over the next few weeks. For example, a patient might agree to spend 15 minutes reading to her children in the evening (goal) in order to come closer to being a mother that puts her children first (value). It is also useful for the PCP to ask the patient to throw the dart or shoot the arrow into the target and make a dot with a pencil to show how close their behavior has been to the value for one or more areas (love, work, or play) over the past week, and then to encourage the patient by suggesting, "I am thinking that your arrow will land closer to the bull's eye at our follow up visit. Let's see what happens." We have evaluated patient response to using this approach with their PCPs, and many patients indicate that they like talking with their PCPs about their values. While we are suggesting this prescription pad for the purpose of teaching PCPs to prevent onset of chronic pain with high risk patients, it is also useful with patients with numerous other types of problems, such as difficulties with managing chronic disease.



Robinson & Reiter, 2015. *Behavioral Consultation and Primary Care: A Guide for Integrating Services*, Chapter 10

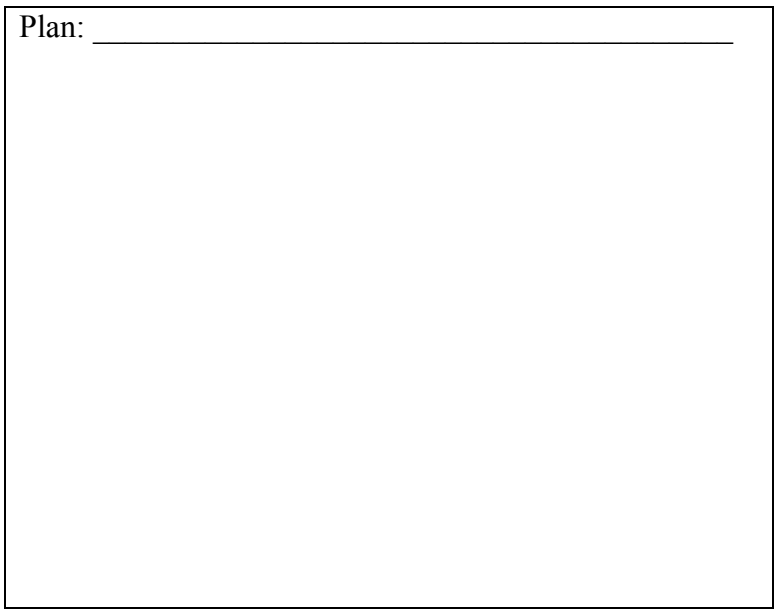


Figure 10.3

A Bull's Eye Behavioral Health Prescription Pad

Note: Appendix D offers a different prescription pad (the ACT Behavioral Health Prescription Pad), along with directions for use.

MEDICAL ADHERENCE

Patients are most likely to adhere to plans that reflect their personal preferences, involve skills they can perform independently and with confidence, are supported by their family members or friends, and that fit within their perspective on health. Ann Fadiman's book, The Spirit Catches You and You Fall Down: A Hmong Child, her American Doctors, and the Collision of Two Cultures, (1997) provide an excellent demonstration of the tenacity that human beings are capable of demonstrating in interactions with medical providers. Ultimately, it is the patient that chooses what advice to heed, what procedures to tolerate, and what medical treatments to consume. Bud's case example demonstrates the important role the BHC can play in helping patients identify and overcome obstacles to medical adherence.

Bud: I don't like taking pills.

Dr. Mason referred this 47-year-old man for a consultation concerning hypertension, worry, and stress management. Bud explained that his worries were about his health and that they started two months ago when he was diagnosed with hypertension. Bud has made numerous behavior changes since the diagnosis, including starting a walking program and quitting smoking and drinking. He reported walking fourteen laps six out of seven days weekly. He had lost twenty-five pounds, and people were complimenting him, as he had been overweight. Bud confessed that he had stopped taking the blood pressure medication when his prescription ran out after the first fourteen days. He explained that he took his blood pressure often and that it was usually normal.

In the initial consultation, the BHC helped Bud explore his worries and his values. His worries included health, dying and not being available to his children, and a fear of becoming manic, as his father had. The BHC provided information about bipolar disorder, and patient seemed somewhat reassured. As a part of the intervention, the BHC used the Acceptance and Commitment Therapy (ACT) Behavioral Prescription Pad (see Appendix D) and explained that durable behavior change often requires that a person learn to experience feeling discouraged and/or afraid and worried—like pulling your hair out (see two upper figures on pad). Additionally, the person needs to learn to experience these unwanted feelings while engaging in daily behaviors that are consistent with valued directions, which are suggested by figures on the bottom half of the page (e.g., walking at the track, avoiding salt, etc). The BHC taught Bud a technique for observing his thoughts and feelings (i.e., mentally placing them one-by-one onto the sides of imagined railroad cars) and suggested that he use this technique during the first few laps of his walk and then switch to singing a few of his favorite songs and noticing aspects of

nature that appealed to his senses. He agreed to this modification to his walking program and to follow-up with the BHC in two weeks. He also agreed to have his blood pressure checked after the visit and to the BHC informing the PCP about his walking program and desire to control his blood pressure without medication. Bud agreed to learn progressive muscle relaxation in his planned follow-up visit with the BHC.

At follow-up, patient's Duke Health Profile Scores suggested improvement, and all Function Scales were in the normal range. He reported that he was now walking nineteen laps on six out of seven days weekly and was spending the first part of his walk watching his worries and then switching to singing. He reported that he worried less at work and that he was more playful there, as he had been before his diagnosis. He reported that people at his job and in his family noticed this change. He wanted to talk about the way his parents treated him as an adolescent and his current struggle with his 18-year-old daughter. The BHC linked this discussion to a review of value driven behavior change, and Bud left with a plan of spending several hours weekly alone with his daughter in the service of promoting her ability to make decisions independently. As planned, the BHC taught Bud a 5-minute version of progressive muscle relaxation (using the handout on the compact disc in Appendix D). He agreed to follow-up with his PCP and to re-contact the BHC for support of behavior change if the need arose in the next six months.

BHC Intervention Possibilities for Patients with Medical Adherence Problems. The case example illustrates commonly used interventions for behavioral treatment of hypertension (e.g., start of an exercise program, mastery of relaxation skills, support of dietary changes recommended by the PCP), as well as important interventions for addressing medical adherence. BHCs need to understand a patient's perspective on health and the role of medical

treatments to preserve health. The BHC must use this information to facilitate better communication between the patient and PCP. The BHC told Dr. Mason about Bud's having stopped the medicine and starting the exercise program. As Bud was monitoring his blood pressure and new his program was working, Dr. Mason was pleased and the BHC conveyed this to Bud at his follow-up. Since Bud's new health promoting behaviors were still not "habits" and could reverse over time, the BHC asked that he follow-up with Dr. Mason in four to six weeks. While the BHC did offer to help with any bumps in the road, the planned follow-up was with the PCP. This is an important element of clinical practice with patients like Bud, who can easily get confused about the role of the BHC versus the PCP over time. In addition to the interventions suggested in Table 10.6, we suggest strategies for addressing medical adherence in a case example involving an older adult in Chapter 11.

Table 10.6

BHC Intervention Possibilities for Patients with Medical Adherence Problems

1. Attempt to understand patient's perspective on his or her illness, what caused it, the personal meaning of the condition for the person, and the treatments that make sense, given the unique world view of that specific patient.
2. Discuss values concerning health and concerns about dying.
3. Relate information to PCP and consider ways to strengthen the relationship between the patient and the PCP.
4. Help patient anticipate obstacles to maintaining newly established behaviors.
5. Make plan for patient to follow-up with his or her PCP.

PCP Teaching Points. The best adherence comes from a strong patient-PCP relationship where both parties work diligently toward a common understanding of the patient's problem and an acceptable and effective attempt at solution. PCPs benefit from learning to ask questions that solicit information about the patient's view of a medical problem and the acceptability of medical treatments. Questions like this include: "Why do you think this (illness) happened to you? What do you think you should do to address it at this time? What are the things you can think of that would get in the way of you following through with this treatment? Can you name some of these obstacles?" Patients are more likely to comply with treatments that are consistent with their values. When a patient's relationship with a PCP is at its beginning and there is a diagnosis of a disease, such as hypertension, the PCP may not know the patient well enough to anticipate a potential adherence problem. A consultation with the BHC can help the PCP better understand the patient's world view and link the treatment to important patient-centric values. Patients like Bud are a delight to PCPs because of their willingness to make behavior changes. PCPs will readily accept these changes as being a "done deal", not appreciating that new habits are unstable for six to eighteen months and that continued vigilance and reinforcement will be needed. This, of course, may be done through formats other than direct patient contact (e.g., brief letters of support, calls from a nurse, nursing assistant, or BHC), as suggested in Table 10.7.

Table 10.7

PCP Teaching Points Concerning Patients with Medical Adherence Problems

1. Encourage discussion of patient world view as it relates to a newly diagnosed health problem, along with their beliefs about viable treatments.

2. Encourage PCPs to see adherence as the result of a collaborative process and a good relationship.
3. Encourage PCPs to provide long term support to healthy behavior changes, using a variety of methods (e.g., nursing assistant phone calls, letters, etc.).

SOMATIZATION

Some patients have learning histories that prepare them to be hypervigilant to even normal variations in bodily functions. When stress increases in their lives, they experience more physiological arousal (like we all do). Unlike the "normal" patient under stress, the somatisizing patient is exquisitely sensitive to signs of physiological arousal, and attaches (fuses) to provocative, negative thoughts about their meaning. For example, a somatisizing patient might interpret GI distress as a sign that a cancer is growing in the bowel; dizziness as a sign of a rare neurological disorder. Patients with a somatic focus seek medical care on more frequent basis even during the good times. During stressful periods, their medical visits can skyrocket to the point of frustrating and angering the PCP. Patients with somatization are renowned for their ability to elicit numerous, expensive and usually benign specialty tests and procedures. When the specialty test comes back negative, the PCP assumes the patient will drop the issue, while the patient concludes that the medical establishment has missed a diagnosis. (After all, why would the doctor refer me for a test in the first place if he or she didn't secretly think that I have some type of life threatening problem?)

In general, PCPs find patients with somatization to be among the most difficult in a general practice. The case example of May demonstrates the dramatic impact the BHC can have on interrupting this ever expanding pattern of health care seeking.

May: I have problems with dizziness, and I want to be sure that I don't have . . .

Dr. West referred this 37-year-old married, mother for a consultation concerning dizziness and weight loss. May explained that her problems with dizziness began in her twenties and agreed with the idea that stress made this problem worse. She also indicated a recurring fear that her dizziness was a sign of a brain aneurysm, explaining that this concern began after her father died of a brain aneurysm five years ago. May wanted to believe Dr. West's reassurances, but was troubled by her doubts and her continued dizziness. May had struggled with her weight since having children and had started a walking program and engaging in dietary changes.

The BHC focused on the relationship anxiety/worry, shallow-breathing and a myriad of physical symptoms including light headedness and dizziness. The more worried and anxious a person gets, the more there is a tendency to breathe rapidly and with a "shallow breath". Over time, this pattern can result in chronic problems with dizziness and light-headedness. The BHC taught May diaphragmatic breathing (using the Diaphragmatic Breathing Tips handout on the Compact Disc in Appendix D) and suggested that she practice it in the mornings by breathing in her thoughts of poor health and breathing out thoughts about poor health for a few minutes. Then, the same breathing pattern would be used to increase her skills for being present, even when having troubling thoughts about her health. The BHC instructed May was to say "here" to herself as she breathed in slowly and "now" as she breathed out slowly. The cues of here and now might help her be present in the moment, where she was capable of changing her behavior and sustaining her efforts to eat well, exercise, and express love toward her husband and children—all activities of great importance to May.

Possible BHC Interventions Concerning Patients Who Somatisize. The case of May illustrates the potential for single BHC interventions to strengthen gains made by somatisizing patients during periods of relatively better functioning. The BHC taught her a skill that furthered her ability to function well with her long-standing pattern of worry. Additionally, the BHC supported the weight control behavior changes she had been making with support from her PCP. Subsequent feedback from the PCP indicated that May was reporting significantly less periods of dizziness and did not seem as bothered by these symptoms when they did occur.

There are additional possibilities for intervening with patients that somatisize, including those in Table 10.8. With chronically somatisizing patients, it is often best to schedule regular follow-up appointments to reduce anxiety patients may have about being seen in a timely manner if they detect signs of a new medical problem. During periods of high stress, the PCP and BHC may want to see the somatically focused patient in a ping-pong fashion. These patients generally respond well to a biopsychosocial approach and are often open to improving stress management skills. Some patients with somatization may have symptoms of panic, as May did. Diaphragmatic breathing techniques and other relaxation exercises (see for example the CALM Exercise handout in the compact disc in Appendix D) are often helpful. Traditional cognitive restructuring strategies have also been used in the treatment of somatization. In this approach, one would list out the negative health related beliefs as examples of cognitive distortions, weight the evidence pro and con, and then help the patient develop a more balanced interpretation of the physical symptom. In the ACT approach, the same process would trigger the use of mindfulness and acceptance strategies designed to help the patient learn to detach from negative health-related thoughts. Most patients who demonstrate a somatic focus do so because their learning history has reinforced this pattern, as was the case for the patient in this

consultation example. The BHC needs to normalize the patient's worry and to express genuine compassion for the patient's experience—in this case the sudden loss of her father. At the same time, the BHC needs to encourage somatisizing patients to make choices about immediate and longer term life directions based upon personal values.

Table 10.8

Possible BHC Interventions Concerning Patients Who Somatisize

1. Encourage a plan of regular, scheduled, brief follow-up visits with the PCP or a series of ping-pong visits with the PCP and BHC.
2. Explain the stress, coping and vulnerability model to patient and possibly suggest a series of BHC consultation visits to learn stress reduction techniques.
3. Clarify values about health and encourage adoption of healthy lifestyle behaviors.
4. Teach relaxation, mindfulness and acceptance strategies to help patient detach from health related worries.
5. Consider use of a cognitive restructuring skill training to help patient learn to identify and balance distorted interpretations.

PCP Teaching Points. Some PCPs struggle with these patients, while others work skillfully with them. We've noticed that providers (like Dr. West) that focus on developing a trusting relationship often have the best outcomes. This is why most of the teaching points in Table 10.9 concern ways to develop this type of relationship. These providers tend to understand the patient's perspective and that allows them to help the patient develop a mindful or accepting perspective on the problem. In teaching providers how to do this, we have found

that it helps to change the usual spatial configuration of the exam room. If the patient and provider sit side-by-side and look at the problem (in front of them) together, both may be more able to let it be there and not let the problem come between them. The PCP is less likely to get into a struggle with the patient who requests additional procedures and specialty consultations that are not warranted by medical findings. Many of the complaints made by somatizing patients cannot be solved or eradicated. However, they can be watched regularly, caringly, and confidently, especially when the patient and provider pursue this collaboratively.

Table 10.9

PCP Teaching Points Concerning Patients Who Somatisize

1. Encourage PCPs to schedule regular follow-ups with patients and to use a structured approach to monitoring various complaints.
2. Encourage PCPs to sit beside patients rather than across from them to support adoption of a more empathetic and less conflicted view of the patient's concerns.
3. Help PCPs develop ways of explaining that not all symptoms indicate disease and that most symptoms of concern increase with stress. Reinforce the importance of learning stress reduction techniques.
4. Help PCP's express compassion for patient's on-going vulnerability and see it as an understandable position for patient to take (given unique personal history).

CHEST PAIN (PANIC)

Many primary care patients present with medical complaints (e.g., shortness of breath, chest pain, rapid heart beat, dizziness, numbness or tingling, trembling, excessive sweating,

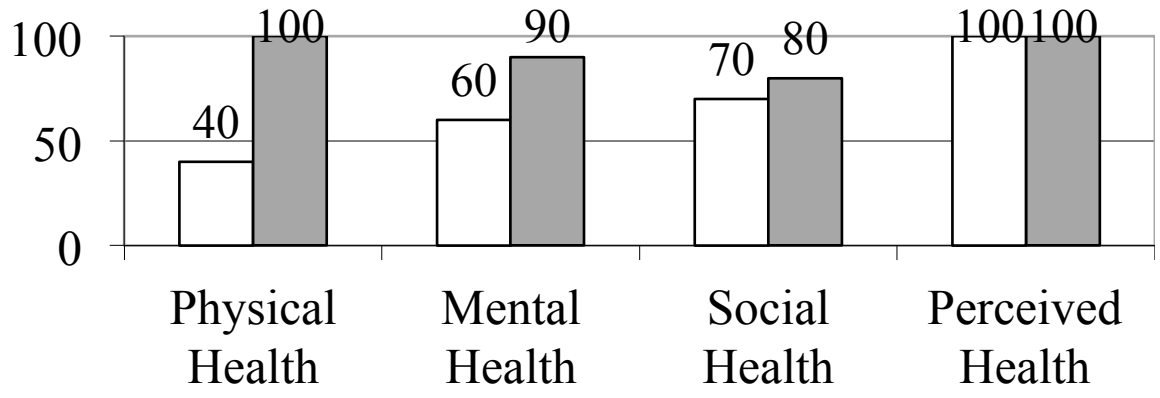
etc.) that may be related to panic attacks rather than any dangerous medical condition. Behavioral treatments for panic are perhaps more effective than behavioral treatments for most conditions and indeed more effective than most medical treatments (see Barlow, O'Leary, & Craske, 1992). The case example of Ralph shows the important role the BHC can play early in the course of a developing panic disorder to help suppress the disorder and forestall unnecessary medical tests and procedures.

Ralph: There's something wrong with my heart.

Ms. Montemayor, R.N., referred this 31-year-old Dr. Fine patient for a consultation concerning chest pain, shortness of breath, anxiety, and vomiting. In the initial consultation, Ralph described having an episode involving these symptoms, along with shaking and rapid heart beat, a week earlier. During the episode, Ralph feared that he was having a heart attack and sought urgent care. Ralph received a prescription for Lorazapam, and had experienced three similar episodes in the past week even while using the medication. Ralph had missed five days of work since the initial episode. He worked as an insurance agent and usually enjoyed going out with his girlfriend and being active in his church. Current stressors involved his desire to forgive his mother's shortcomings during his childhood and forge a relationship with her, as well as trying to bring his older brothers into the process of repairing family relationships.

At the initial consultation, the BHC taught him the square breathing technique as a form of mindfulness training. This technique involves instructing the patient to imagine breathing slowly while imagining proceeding around the four sides of a square and counting slowly from one to four during the breath activity for each side. Side one is inhaling deeply; side two is holding the breath; side three is exhaling slowly and completely; side four is again holding the

breath. During a practice period, patients should go around the square 10 or more times. Ralph was instructed to "just notice" any sensations, thoughts, memories or feelings in a non-judgmental way during the breathing practice. The BHC also explained the impact of stress on breathing and the impact of shallow breathing on physiological functioning. The BHC encouraged him to begin a daily exercise program to reduce stress and suggested that he take a vacation from trying to solve his family of origin problems and consider what he might do to build a sociological family in his present community. He agreed to come for follow-up in one week. Figure 10.4 displays Ralph's Duke Health Profile Scores, which suggested significant problems with both physical and mental health at the initial consultation and normal functioning at the follow-up visit.



*Note: Scores range from 0 to 100. On Physical, Mental, Social and Perceived Health Scales, higher Scores indicate better functioning. On Anxiety, Depression, Pain, and Disability Scales, higher Scores indicate more severe symptoms.

Figure 10.4

Ralph's Initial and Follow-up Function Scale Scores on the Duke Health Profile

At the follow-up, Ralph reported that he had practiced the breathing-mindfulness exercise and had started a walking program. He had returned to work full time and had

proposed marriage to his girlfriend of twelve months. Ralph had stopped trying to get his brothers to relate to his mother, but had continued his relationship activities with her. He reported no episodes of chest pain or shortness of breath over the prior week. The BHC recommended that he follow-up with Dr. Fine in one month to discuss his progress with maintaining his walking program, breathing practice, and efforts to develop good family relationships.

Possible BHC Interventions Concerning Chest Pain and Other Symptoms of Panic. Ralph's case example demonstrates the potential of early behavioral interventions with patients experiencing symptoms of panic. As a rule of thumb, earlier interventions mean less intensive treatment. Patients with symptoms of panic experience a great deal of relief when given a plausible explanation for their distressing symptoms. It is important that the BHC take adequate time in providing this information and allowing the patient time to ask questions. At times, it is useful to help the patient experience symptoms in the consult visit, as suggested in Table 10.10, so that he or she can use coping strategies while the BHC is available for immediate coaching. The BHC helped Ralph develop a behavior change plan to reduce stress, including starting an exercise program and reducing exposure to stressful family interactions. The BHC may see these patients for one or more follow-ups, and then plan specific follow-up with the PCP. As with Ralph, it is important that the BHC chart specific recommendations to the PCP concerning the follow-up visit (e.g., I recommend that Dr. Fine support Ralph in continuing his walking program, practicing square breathing, and developing good relationships with his family members). As many of these patients have somewhat sensitive nervous systems, the BHC may help the patient anticipate and plan for future episodes of physical symptoms. Specifically, the BHC might suggest that the patient intensify exercise, engage in targeted problem solving

efforts, share relaxing activities with a good friend, or work with the PCP on these basic coping skills if symptoms become troubling in the future.

Table 10.10

Possible BHC Interventions Concerning Chest Pain and Other Symptoms of Panic

1. Educate the patient concerning the stress-coping-vulnerability model and the impact of shallow breathing on physiology (See compact disc in Appendix D for handout on Stress Awareness).
2. Teach diaphragmatic breathing instruction and/or mindfulness strategies supported by patient education handouts (See compact disc in Appendix D for handouts on the Calm Exercise, Progressive Muscle Relaxation, and Diaphragmatic Breathing Tips).
3. Expose the patient to symptoms and assist with application of new strategies.
4. Help the patient plan possible solutions to current stressful life circumstances.
5. Anticipate and plan for reoccurrence of panic symptoms.
6. Plan for patient to follow-up with the PCP and provide the PCP with specific recommendations for follow-up activities.

PCP Teaching Points for Patients with Chest Pain and Other Symptoms of Panic

It is not uncommon for patients like Ralph to receive prescriptions for benzodiazepines and for a nurse to be the first point of contact. Given this, the BHC is wise to offer a presentation on diagnosis and treatment of panic to nursing staff, along with the PCPs, as suggested in Table 10.11. PCPs will often prescribe benzodiazepines prior to referring patients

with panic to the BHC, but we strongly recommend that the BHC be involved at the time the medicine is prescribed. This strategy can short circuit the tendency of panic patients and prescribing providers to over utilize anxiolytic medicines, which the research shows are contraindicated in the long term treatment of panic. In addition, benzodiazepines have potential for abuse, dependence and addiction. The BHC needs to assure that PCPs understand this potential and that they can distinguish between addiction to and physical dependence on benzodiazepines. Patients with substance abuse problems use benzodiazepines most often to augment the high received from another drug or to offset the adverse effects of other drugs. Pharmacologic dependence is a predictable adaptation of a body system to a drug to which it becomes accustomed, and it may occur in patients taking therapeutic doses of benzodiazepines. Symptoms of dependence occur with abrupt discontinuation of the medication, and the PCP may control these through dose tapering, medication switching, and/or medication augmentation. PCPs also need to understand the phenomenon of rebound, which is different from withdrawal. Rebound is the relative worsening of anxiety/panic symptoms at the point of discontinuation of anxiolytic medicine, regardless of the tapering schedule. When schedules allow, ask the PCP to remain in the room to observe BHC efforts to educate the patient concerning the stress-coping-vulnerability model, the role of medicines in treatment and core strategies for combating panic inducing thoughts, sensations and memories.

Table 10.11

PCP Teaching Points Concerning Patients with Symptoms of Panic

1. Help nursing staff and PCPs learn about behavioral treatment for symptoms related

to panic through presentations at meetings.

2. Encourage PCPs to bring the BHC into the exam room with patients with panic symptoms prior to prescribing any medications, so that a solo behavioral intervention is an option.
3. Teach PCPs to promote lifestyle behaviors (e.g., engaging in daily cardiovascular exercise and relaxation activities) that enhance the patient's ability to prevent future episodes of troubling symptoms.
4. Plan a venue for discussing concerns about addiction, dependence, and rebound issues associated with use of benzodiazepines

PATIENTS WITH CHRONIC CONDITIONS

The pace of primary care makes treatment of chronic medical conditions difficult. Unlike patients with acute conditions, patients with chronic conditions need to develop strong relationships with their PCPs to succeed in making stable changes to multiple behaviors associated with effective self-management. While the addition of BHC services can enhance outcomes for this large and growing group, changes in the way medical care is delivered to this group are also needed. Patients with chronic medical conditions can benefit from a set of new approaches often referred to as chronic disease management programs, which include such strategies as the use of registries and the provision of services in group medical appointments (See Chapter 12). However, the first step with this group of patients is to engage them in the process of self-management of their medical condition. The case example of Patty demonstrates the important role the BHC can play in fostering this engagement.

Patty: I'm gaining weight, and my health just isn't very good**.**

Dr. Forester referred this 54-year-old married mother for a consultation concerning weight gain and diabetes. Patty had lived with diabetes for 29 years, and her current level of control was generally good. However, Duke Health Profile Scores at the initial consult suggested she perceived her physical and mental health to be poor. A functional analysis suggested that Patty began overeating about a year prior to the consult when she left her job as a nursing assistant. She was forced to leave because of on-going vision problems related to diabetic complications. Patty had gained eighty pounds since leaving her job. A surgery on her eyes had been successful, and she could return to work now if she lost weight. She had started controlling portion size, but was not exercising due to back pain and a sore on her foot. In the past she had lost a great deal of weight on three different occasions but always seemed to gain it back over time.

The BHC explored Patty's motivation for change. She wanted help with developing a weight loss program. She had the prerequisite skills for making dietary changes and wanted to focus on starting an exercise program. The BHC asked Patty what would be different in her life if she lost weight, and she indicated that she would go back to work and would have a social life again. Patty agreed to a plan calling for her to walk to and from the mail box five to ten times daily and to invite her friends over to play cards with her two or three times per week. Patty returned two weeks later, and her Duke Scores suggested improvement in Social Health. She beamed when the BHC shared this good news with her, and she indicated that she was walking more, her foot sore was healing, and she was playing cards on a regular basis. The follow-up plan included having Patty maintain her dietary, exercise and social activities and quarterly check-ins with the BHC for strategic adjustments to her plan. The PCP was advised to

actively query Patty about these three behavior change goals at each diabetes exam and to reinforce their important role in her long term management of the disease.

BHC Interventions. The consultation with Patty demonstrates the potential for a BHC to fine tune programs started by the patient and PCP by further engaging the patient in the process of behavior change. The BHC helped Patty focus on her long-term goals of working and seeing her friends more often, and this perspective helped to dignify the process of losing weight. Her success in implementing the plan to increase social activities probably enhanced her sense of self-efficacy for other behavior changes. The BHC also offered to remain in contact with Patty as an auxiliary care team member focusing on maintaining behavior change. The BHC can be available for quarterly check-ins when a clinic does not have programs such as registries and/or group visits for patients with chronic diseases. Table 10.12 summarizes interventions BHCs may offer to patients like Patty who struggling to live well with chronic conditions.

Table 10.12

Possible BHC Interventions for Patients Living with Chronic Conditions

1. Use value-based behavior change and motivational interviewing strategies.
2. Focus on small, specific behavior change goals to help build self-efficacy for making more widespread behavior changes.
3. Employ a team-member versus coach perspective.
4. Offer quarterly consults (particularly when registry and/or group visit services are not available at the clinic).
5. Promote development of registries and group care clinics.

Patients with chronic conditions often experience discouragement and symptoms of depression, along with medical problems. The BHC can help the patient generate hope for a better future by taking a specific step that is feasible and that fits with their world view. Factors listed in Table 10.13 are important to the process of engagement needed to improve outcomes for patients living with chronic conditions. Patty believed she could loose weight, and she needed a medical provider to affirm this ability and help her continue in the direction she had already started. She needed problem solving and affirmation, not information and not admonition. The BHC took the role of being a player on patient's team rather than a coach giving instructions, and the BHC suggested this perspective to the PCP. This is not an easy thing to do, as most providers experience a certain level of irritation with patients who, in the past, have failed to follow medical advice concerning strategies for coping with chronic conditions.

Table 10.13

Engaging Patients Living with Chronic Conditions

1. Explore and validate patient reactions and expectations (desired service, belief about what PCP has to offer).
2. Form a working alliance using the collaborative set (e.g., We are facing this together; what can we do to improve your sense of health?)
3. Encourage attendance at all medical appointments (classes and other formats, registries).
4. Obtain on-going assessment of patient satisfaction with medical care.

BHCs can also help patients living with chronic conditions by supporting system changes that promote on-going collaboration between patients and providers. These might include the development of registries and related "tickler" systems that trigger appropriate follow-up with patients, whether by phone, mail, or in-person contacts in visits with providers or in classes. Group medical appointments can be used to medical/behavioral care to a group of patients that share some similarity, such as having diabetes or having multiple health problems and being over the age of seventy. These programs address elements critical to engaging patients in self-care, including the availability of on-going support, respecting and incorporating patient expectations, and an emphasis on consumer satisfaction. In fact, many patients living with chronic conditions would probably prefer a group appointment because of the longer appointment time and opportunity to receive social support and advice from other patients with the same type of problem.

PCP Teaching Points. The BHC can empower the PCP in efforts to work with this large group of patients by helping the PCP to experience frustration and irritation with this group while acting in ways that are consistent with promoting their health. It is not easy to believe that a patient who has coped poorly with diabetes for ten years can change at any moment, yet this may be a prerequisite for helping some patients change. As suggested in Table 10.14, the BHC may consider developing a series of lunch hour workshops describing strategies from Acceptance and Commitment therapy and exercises for empowering acceptance and committed action with even the most frustrating patients. Additionally, the BHC may teach PCPs to use health-related quality of life measures and motivational interviewing (MI) strategies with this group of patients. (See Burke, Arkowitz, & Menchola, 2003 for evidence concerning MI.) Providing PCPs with information about group medical appointments and registries may also be

helpful, as these approaches may help relieve the burden of care on PCPs while improving patient satisfaction overall.

Table 10.14

PCP Teaching Points Concerning Patients Living with Chronic Conditions

1. Help PCPs to allow feelings of frustration in response to patients who struggle with self-management, while acting in ways that promote behavioral change (i.e., expressing confidence in the patient's ability to change).
2. Suggest PCPs experiment with use of behavioral prescription pads (e.g., see Figure 10.3) to plan self-management goals with patients.
3. Teach PCPs to use health-related quality of life as the principal disease management outcome and to tie this goal to motivational interviewing strategies.
4. Encourage PCPs to experiment with newer formats for delivering medical care to patients with chronic diseases (e.g., group visits and/or registries).

LEARNING DISABILITIES

Numerous adults function with impairments stemming from learning disabilities and ADHD. In some cases, these disabilities may not have been diagnosed in childhood, and, in others, they will have been. Either way, it is important that the PCP know that a patient has this type of impairment, so that the process of providing medical care can be adapted to fit the individual's limitations. Penny's case example demonstrates how the BHC can help PCPs improve outcomes for this sizeable group of adults.

Penny: I am scared to death of loosing my job.

Dr. Monroe referred this 60-year-old married mother for a consultation concerning dizziness, fatigue, and chest pain. He had prescribed atenolol and, while this was helpful, it made her feel sleepy. She was married with adult children living out of the house and was working full time.

At the initial consultation, Penny's Duke Health Profile Scores suggested poor physical and mental health. A functional analysis of her symptoms suggested that these developed in the context of increasing problems at her job and conflicts with her two adult children. Penny explained that she had a learning disability, and that she was being required to change from her familiar job on an assembly line to working as a shipping clerk. She worried that she would be unable to keep her figures straight and that it wouldn't be long until she had trouble with the "big cheese." Penny liked the idea of the BHC writing a letter to her employer recommending that she remain in her current position.

The BHC also taught patient a breathing exercise named the Courage Breath to help her manage job and family stress better. The Courage Breath involves teaching diaphragmatic breathing and then helping the patient to integrate an inhalation and exhalation with three movements of the shoulders. The first is that of lifting the shoulders toward the ears on the inhalation; the second is bringing the shoulders back (squeezing the shoulder blades together) on the exhalation, and the third is bringing the shoulders down as the exhalation is completed. This exercise opens the chest so that diaphragmatic breathing can occur more easily. The BHC can teach this exercise quickly, and it is particularly useful for a person who breathes in a shallow manner and who is currently struggling with an interpersonal situation that requires him or her to be courageous. . The BHC needs to model this exercise and then provide feedback after watching the patient. Most often, patients find this exercise relaxing and their

facial expressions become more pleasant. When this happens, it is helpful for the BHC to point this out to the patient and ask the patient how he or she thinks this might affect the way that people respond to him or her. The BHC recommended that Penny practice this exercise on an hourly basis for several breathing cycles and routinely prior to a planned entry into interpersonally challenging situations.

When Penny returned, her Duke Scores suggested improvements in Mental and Social Health. She had practiced the Courage Breath exercise and had cut her atenolol dosage. She was pleased with this, as she was no longer sleepy from the atenolol and enjoyed her work day more. Her employer had agreed to allow her to continue in her present position for the time being. While she no longer had problems with dizziness, she noted that she still had some problems with fatigue. The BHC provided information about the impact of exercise on energy, and patient indicated that she would like to resume walking during her lunch hour to see if this improved her energy in the afternoons. The BHC also provided patient with information about the Americans with Disabilities Act.

BHC Interventions for Patients with Learning Disabilities. Penny's case illustrates how patients with learning disabilities and other impairments such as ADHD may have more difficulties adapting to changes in both their work and home situations. When these patients are referred, the BHC often needs to help the patient acquire new coping skills. Skills may focus specifically on coping with the learning disability (e.g., a plan for developing cashier skills) and/or reducing the stress and anxiety associated with a specific situation. Interventions may also address development of general self-care skills and developing healthy lifestyle behaviors. Penny's request for a letter is not unusual. BHCs often receive these types of requests, as this is a service that PCPs often provide. We both routinely write letters for patients during the

confines of our visit. This is often helpful to the patient, and it only requires a few minutes of BHC time. Patients with disabilities may not know their rights, and the BHC may provide useful information about this, as suggested in Table 10.15.

Table 10.15

BHC Interventions for Patients with Learning Disabilities

1. Support adaptations required to ensure continued employment, even in the midst of job redesigns.
2. Teach problem solving, particularly regarding relationship issues.
3. Provide resource information (e.g., Americans with Disabilities Act, programs offering assistance with development of personal financial management skills).
4. BHC consultation services in series of 1-3 visits every 3 to 5 years may improve outcomes for this relatively large group.

PCP Teaching Points Concerning Patients with Learning Disabilities. As suggested in Table 10.16, the BHC can teach PCPs to ask new patients about their education and to follow-up on any indication of problems with questions such as, "Did you attend special classes?" This only takes seconds, and it can help the PCP adjust his or her care to accommodate the patient's disability. For example, a patient with a learning disability may benefit from having all instructions written rather than spoken. It is also helpful for the BHC to stock copies of screeners that PCPs can use in diagnosing common problems such as ADHD (See for example the ADHD Symptom Checklist Adult Version—Self Report and the ADHD Symptom Checklist Adult Version—Observer Report, both of which are easily accessed and free on the

internet). As these types of disabilities may predispose patients to more stress in adulthood, the PCP needs to make an effort to develop a working relationship that encourages more frequent contact (perhaps with the BHC as well as the PCP), particularly when life stresses challenge the patient's coping skills.

Table 10.16

PCP Teaching Points Concerning Patients with Learning Disabilities

1. Suggest that PCPs routinely ask new patients about their education.
2. Stock copies of screeners (such as the ADHD Symptom Checklist (Adult Version—Self Report) and ADHD Symptom Checklist (Adult Version—Observer Report) for PCP use.
3. Encourage PCPs to provide a regular pattern of more frequent visits over time to promote better risk monitoring.
4. Let PCPs know that the BHC can provide patients with information about the Americans with Disabilities Act.

SYMPTOMS OF DEPRESSION AND TRAUMATIC STRESS

Many PCPs practice under the assumption that depression, and to some extent trauma, is a biological condition that requires medication to suppress various symptoms, such as fatigue, sadness, sleep disturbance, loss of appetite, etc. Many patients with symptoms of depression and secondary trauma report numerous psychosocial problems which may in fact be "driving" the symptoms. Simply prescribing medicines to suppress symptoms is an empty exercise, if the underlying psychosocial concerns are not adequately addressed. When the

medication is withdrawn in such situations, the patient is at high risk for relapse. Leslie's case example demonstrates the impact the BHC can have on sorting out what needs to be suppressed, accepted, and changed and, in so doing, broaden the PCP perspective on treating traumatized and depressed patients.

Leslie: I can't stop myself from thinking about it, and I'm so tired . . .

Dr. Mason referred this 25-year-old married mother of one for a consultation concerning fatigue, loss of appetite, sleep disturbance, and flashbacks. Leslie was six months pregnant with her second child, and her rate of weight gain was slower than expected. Her Duke Scores at the initial visit suggested poor physical and mental health. In the functional analysis, the BHC learned that Leslie's symptoms had started several months prior when she attended her father's trial concerning sexual molestation of a child. This experience had triggered painful memories about abuse Leslie experienced from her father as a child. She was disgusted by these memories, avoided anything that brought them up for her, and still was plagued by gnawing details that even woke her from sleep. Leslie had withdrawn from her husband (described as a nice guy that didn't know about her father) and couldn't even tolerate his effort to take her hand. Patient's childhood had been traumatic in other ways. For example, she had lived in several foster homes before being returned to her mother's home in late adolescence. Leslie worked as a child welfare advocate, and this was the light in her life at the time of the consult. At work, she felt competent, and she enjoyed the 45-minute walk that she took at lunch.

The BHC acknowledged Leslie's strengths (e.g., a career focused on promoting child safety and health, a pattern of regular exercise, the ability to pull back when she needed to) and normalized the experience of intrusive images. The BHC explained that the patient's mind ". . .

was trying to make sure she remembered . . . .” and that the best way to help one’s mind when it is caught in a repetitive loop is to allow it to spin rather than to try to stop the thoughts and feelings. The BHC suggested she focus on the thoughts, feeling, and bodily sensations triggered by memories of the sexual abuse during the first five or ten minutes of her daily walk before turning on her CD player, as was her habit. Leslie agreed to consider this and to ask her husband to stop initiating touch with her for two weeks. She would explain to him that she needed to pull back to work on personal issues and that she wanted to be the one to initiate any touching for the next two weeks. Leslie agreed to bring her husband to the planned follow-up consultation in two weeks, if he was willing and it made sense for him to come.

At follow-up, patient’s Mental Health score on the Duke had improved significantly, and her Physical Health score also moved in the desired direction. Leslie reported that she had talked with her husband about her memories and the distress they caused her. His response was caring and supportive beyond what she could have imagined. While he was very angry with her father, he was kind and considerate to Leslie. She had began to initiate touch with him after the talk, and she now felt calm when he took her hand and comforted when he held her in bed. She had not focused on thoughts of the abuse during her walks, but reported that they were less troubling for her none the less. The BHC suggested writing in a journal as a possible strategy for becoming more familiar with the content of intrusive thoughts and images. Leslie responded very positively to this suggestion. The BHC described sensate focus exercises to patient, and she planned to talk with her husband about these. She planned to see Dr. Mason for her prenatal check-up in two weeks. If she was not continuing to improve, she agreed to stop by to see the BHC while in the clinic for that visit. Leslie did not return for follow-up with the BHC.

Feedback from Dr. Mason revealed that Leslie was continuing to improve and that weight gain was now occurring at a normal rate.

BHC Interventions for Patients with Symptoms of Depression and Traumatic Stress. The BHC identified Leslie's strengths and helped her re-direct her control efforts from thoughts and feelings to her actions (walking) and interactions (talking with her husband). As indicated in Table 10.17, behavior change plans of this type are basic interventions, and the BHC may use a variety of patient education materials to support this type of intervention. At follow-up, the BHC planted the idea that intrusive thoughts and feelings might return in the future and suggested a strategy for Leslie to use if such did occur. With Leslie, the BHC also offered to work with her husband, and this offer may have felt helpful, even though it did not occur. Marital dissatisfaction is common among depressed women. In fact, it is the single factor that best predicts relapse of depression symptoms in women.

A variety of interventions are helpful to patients with fatigue, sleep problems, concentration problems, sadness, and anxiety, and the BHC's job is to match the intervention to the results of the functional analysis. Often, the BHC consulting with a patient with multiple symptoms of depression will use behavioral activation strategies. With more anxious patients, the BHC may lean toward interventions involving relaxation training and exposure. Most patients benefit from instruction in problem-solving, and many will agree to bring a family member to a consult when the BHC suggests this. Generic classes that aim to improve skills for reducing stress and improve quality of life can provide a means for more intensive skill training for this group (See Chapter 12 for a discussion of generic classes). We encourage BHCs to think about prevention opportunities and to encourage PCPs to refer patients to the BHC for

relapse prevention planning. Books listed in Appendix C contain useful material for BHCs concerning intervention development for this large group of primary care patients.

Table 10.17

Possible BHC Interventions for Patients with Other Symptoms of Depression and Traumatic Stress

1. Identify patient strengths (at present; at time of a past trauma) and activities or times of the day when patient feels best.
2. Teach patient to be present in the moment and to choose to engage in activities that promote desired affective states (e.g., feeling calm, content).
3. Direct patient focus on controlling events to external (e.g., going for a walk, calling a friend) rather than internal events (e.g., avoiding recall of traumatic experiences, suppressing depressing thoughts).
4. Use patient education materials to support behavior change (e.g., the Change Plan Worksheet on the compact disc in Appendix D).
5. Suggest planned exposure to avoided thoughts and feelings as an option (but don't require it).
6. Address specific symptoms that trouble patient, such as sleep, using patient education handouts (e.g., Beating Insomnia and/or Healthy Sleeping Tips on compact disc in Appendix D).
7. Offer to include members of the patient's family in the behavior change process.
8. Use a ping-pong strategy (i.e., appointments alternating from PCP to BHC to PCP) to increase the time frame and coordination of the intervention.

9. Develop and place a relapse prevention plan in the medical chart. Recommend that the PCP support patient in implementing the plan for at least 6-12 months after remission in symptoms.
10. Offer a drop-in class series supported by materials, such as Living Life Well: New Strategies for Hard Times (Robinson, 1996).
11. Suggest community resources (e.g., group programs based on leisure activities, exercise, or spirituality).

PCP Teaching Points for Patients with Symptoms of Depression and Traumatic Stress. The BHC can improve diagnosis and treatment of patients with symptoms of depression and trauma by encouraging PCPs to take a biopsychosocial approach and to use behavioral interventions as the foundation for treatment, as suggested in Table 10.18. PCPs struggle with employing approaches like the Diagnostic and Statistical Manual for Psychiatric Disorders for many reasons, including the reality that the rule-out process often requires more time than a PCP has for his entire visit with the patient. Additionally, the PCP—being a medical provider—must give priority to medical conditions, such as hypertension and diabetes. In an effort to provide psychiatric services, PCPs may resort to catch-all diagnoses, like depression and anxiety, which sound like psychiatric diagnoses. The busy PCP can make this type of diagnosis and start a treatment (usually pharmacological) in less than 10 minutes. However, this very approach leads to many unnecessary medication starts and stops, as about half of all patients prescribed anti-depressants stop the medicine within the first month. One of us authors (PR) participated in two large clinical trials where PCPs were asked to identify and refer patients with probable major depression and who were willing to take an anti-depressant. When

the research assistant conducted a follow-up structured psychiatric interviews with referred patients, only 50% of them met criteria for major depression. These findings suggest that half of the patients PCPs diagnose with major depression actually have sub-threshold conditions that most likely would respond to brief behavioral interventions.

An alternative to this costly approach to diagnosis and treatment involves the BHC teaching PCPs to use a "watchful waiting" strategy with patients reporting less severe depression-like and anxiety-like symptoms. The PCP can refer these patients to the BHC for assessment and a targeted behavioral intervention to improve one or more specific troubling symptoms (e.g., poor sleep, flashbacks, fatigue, etc.). The patient can come for follow-up with the BHC (or PCP) within the next month for follow-up assessment, including evaluation of the impact of behavioral treatment on symptoms. We both use the PHQ-9 (as a supplement to the Duke Health Profile) to assist PCPs with implementing the "watchful waiting" strategy (See Chapter 6 for more information on the PHQ-9). Patients who are not improving and/or are experiencing more difficulties with functioning at the one-month follow-up might then be candidates for a combination of medicine and behavioral intervention. This strategy is consistent with a biopsychosocial approach to treatment of depression, anxiety and trauma, where the basic treatment is behavioral and medication plays a specific, time limited role in controlling symptoms that are interfering with the more basic goal of behavior change.

Introducing the idea of "watchful waiting" provides an opportunity for the BHC to teach PCPs to amend their standard intervention with these patients to include an orientation to the biopsychosocial model (See Robinson, Wischman, & Del Vento, 1996 for patient education materials that support this orientation). As a part of this re-training, BHCs may encourage PCPs to forgo efforts to make a definitive psychiatric diagnosis, and instead to identify target

symptoms (e.g., fatigue, poor sleep, weight gain, chest pain, etc.) or skill deficits (e.g., stress-reduction, self-management of diseases, etc.) that will be further assessed and targeted by the BHC. The BHC should develop a battery of specific outcome indicators (e.g., health related quality of life, PHQ-9 total score and impairment score) that will be used to plan and evaluate the effects of treatment. PCPs need to learn that symptoms of depression and anxiety rarely occur in the absence of psychosocial stress and that even physical trauma always is experienced by a living, thinking, feeling being.

The BHC also needs to teach PCPs that patients who experience trauma, whether in childhood or adulthood, are more likely to experience somatic pain and often present with pain related concerns. PCPs need to encourage a holistic approach to care for these patients and to involve the BHC as an auxiliary provider. Many PCPs were trained in the biomedical model and view depression as an illness rather than the result of a habitual and ineffective way of responding to life challenges. The BHC can help PCPs teach the depression management skills listed in Table 10.17, including development of relapse prevention plans. A relapse prevention plan usually includes: (1) identification of a way the patient will assess their own functioning on an on-going basis (usually weekly), (2) a plan for maintaining gains made in a series of consultations visits (such as exercising 30 minutes daily, engaging in two social activities weekly, eating breakfast), and (3) a plan for accessing support if planned assessment indicates a drop in functioning on two consecutive weeks (such as a visit with the PCP or BHC).

Table 10.18

PCP Teaching Points for Patients with Symptoms of Depression and Traumatic Stress

1. Teach PCPs to educate patients in the biopsychosocial model of depression and

traumatic stress and to employ the "watchful waiting" strategy.

2. Teach PCPs to curb urges to diagnose "illness" and instead use available time to identify specific stressors and encourage stability in functioning.
3. Teach PCPs to identify symptoms of anxiety and depression that trouble the patient and/or interfere with patient functioning and to state these as the reason(s) for referring to the BHC.
4. Teach PCPs to conduct quick efficient values assessments (e.g., by asking, "What is important to you in terms of being a wife?" and perhaps hearing, "Good communication."), and to help patients plan activities that are consistent with stated values (Take a 20 minutes talking-walk with husband every day).
5. Teach PCPs to use a BHC consult visit to generate objective information to use in deciding whether to start a medication (thus creating a baseline against which to measure treatment, whether a decision to start or wait and watch).
6. Teach PCPs to refer improved patients to the BHC for development of a relapse prevention plan one month prior to the start of a taper from anti-depressant medication.
7. Teach PCPs to develop and support relapse prevention plans, particularly for patients with recurrent problems with depression and anxiety.

SUICIDAL IDEATION

Most people who commit suicide make a visit to a primary care clinic within months of dying, and often within days. Men with medical problems, particularly when they have no wife, and adolescents, particularly males who are using alcohol and have been rejected by a

girlfriend, are probably among the most at risk primary care patients. Jose's case example shows how many patients reveal thoughts of suicide to a PCP just prior to an attempt and the role the BHC can play in helping the patient, PCP, as well as the entire clinic.

Jose's Wife: He wants to kill himself.

P. A. Avondale referred this 42-year-old, Hispanic man for a consultation concerning thoughts of suicide. Jose's wife brought him to the clinic requesting help after he told her that he wanted to die so badly that he thought he shouldn't even go into the kitchen because he might stab himself. Jose had seen P. A. Avondale one week prior to the date of his same-day referral to the BHC, and he had received a prescription for an SSRI at that visit.

At the initial BHC assessment, Jose's Duke Scores suggested mild depression and concerns about his physical health (i.e., a score of 50 on the Perceived Health scale). He explained that his thoughts of suicide had started about ten days prior when he was diagnosed with diabetes. As recommended, Jose was checking his blood sugar, making dietary changes, and attempting to exercise more. He cried, as he explained that he was unable to keep thoughts of suicide out of his mind, and what was even more disturbing was that these thoughts were getting more and more frequent and compelling. He felt overwhelmed by worries about his ability to care for his wife and their children. He felt that he had failed his family by having failed to maintain good health. Jose explained that he had always worked in the fields and worried if he would be able to continue. Other stresses included the recent loss of his father who had suffered from numerous health problems. Jose loved music and found prayer helpful. He denied using alcohol or drugs.

The BHC explained to Jose that the more we try to stop ourselves from thinking of something (e.g., a red apple) or feeling something (e.g., fear or sadness about having a chronic

disease), the more we tend to have the avoided thought or feeling pervade our awareness. The BHC used her arms to depict an imaginary time line going from birth (the left hand) to death (the right hand) and asked Jose to point to the place where he thought he was at that moment on the time line. He said he wasn't sure, but thought he might be close to death. She explained that being diagnosed with a chronic disease requires a person to be courageous and to look at that time line multiple times throughout the day. Further, she explained that it is by developing the courage to look at the time line four or five times a day (and feel the fear and sadness, etc.) that the person with a chronic disease is most able to consistently make decisions that support health. Many people don't want to feel bad and don't look at the line. Then, they have trouble staying aware the choices that would help them live longer with better health. The BHC also suggested the following metaphor to Jose.

> "Imagine that there is a pot of beans cooking on the stove, and the temperature is a little high. The beans start boiling and there's quite a bit of steam. Let's say you don't like steam, so you put a lid on the pot. What happens? Right, the steam builds up and soon you have a mess on the stove and you probably like that even less than the steam. Well, you could still put the lid back on, but then you'd probably soon have a bigger mess on the stove and perhaps a burned pan as well. If you really don't like steam though, you have to find a way to live with it so that you can leave the lid off long (who knows—the heat could die down!). That's what I want you to try with your thoughts of suicide and your fears about not being able to take care of your family. Keep the lid off of your mind and let them bubble up. Notice when you start to put the lid on, try to take a slow deep breath and remember that painful thoughts, like steam, tend to come and go (unless you try to control it by putting the lid on)".

Additionally, the BHC suggested that Jose take daily walks at a moderate pace with his wife and talk about his values concerning their relationship. Jose agreed to return for follow-up in one week and to call the clinic or the 24-hour crisis line number should he become worried about acting on his thoughts of suicide.

At follow-up two weeks later, patient's Duke Scores suggested a high level of health-related quality of life. He was walking with his wife almost daily, and his children were joining them on walks some of the time. His family enjoyed talking about their values, and they all wanted to help him look at his personal time line and make good choices. He was using the timeline metaphor at daily choice points related to his diabetes and the pot of beans metaphor to help him look at his uncomfortable thoughts and feelings. He proudly reported that he had taught these skills to his mother, who was also diabetic and who had originally encouraged him to "just not think" about his new diagnosis. At work, he was singing and talking with others and even felt comfortable eating his new food selections with his co-workers. He had accepted an invitation to dinner at a friend's house and brought food for himself, but was pleasantly surprised to find that the friend had anticipated his needs. He agreed to follow-up with his P. A. and to return for an additional BHC consultation if needed in the future.

Possible BHC Interventions with Suicidal Ideation. The consultation with Jose and his wife provides a good example of a patient overwhelmed by a new diagnosis of a chronic disease. While it is difficult to predict which patients might be so disturbed as to consider suicide as an alternative to living with such a diagnosis, the proportion of patients who find such a visit with their PCP highly distressing is significant. Rarely does anyone in primary care see a patient who has made up his or her mind to complete suicide. Most patients who seek care are ambivalent about dying and troubled by problems for which they see no solution. Most

often, thoughts of suicide function as a form of avoidance based problem solving behavior. In a functional analysis of suicidal thoughts, the BHC can quickly come to understand when the thoughts started, what happens just before and after they occur, etc. Other questions can help establish level of risk (e.g., use of drugs and alcohol, availability of fire arms, etc.). The BHC will often be able to help the suicidal patient formulate a plan to solve the problem that provoked the suicidal thoughts. In the case of Jose, the problem was that of fearing that he would fail to meet his responsibilities as a father and husband if he had diabetes. In a brief intervention, he came to see that it was not an either/or (either good health and good provider for family or bad health and inadequate provider) situation. When unsure about safety issues, the BHC can shorten the return visit to as little as a day if need be. In addition, the BHC can coordinate the safety plan with the PCP and assume a more central role in care of the patient. Some counties will be able to send a mental health professional to the clinic when transportation cannot be safely arranged for the patient, while others prefer that transportation be arranged through 9-1-1 services. The resources and methods for accessing these services vary from state to state and often from county to county within a state, and the BHC needs to be aware of back-up services and ways to access transportation as well.

Consistent with possible interventions with suicidal patients listed in Table 10.19, the BHC assessed the level of risk for Jose, focused on completing a functional analysis of the suicidal thoughts, developed a coping plan for suicidal thoughts and developed a behavior change plan consistent with remaining alive and successfully managing diabetes.

Table 10.19

BHC Interventions for Patients with Thoughts of Suicide

1. Assess level of risk and plan accordingly.
2. Conduct functional analysis concerning suicidal thoughts with particular emphasis on their emotional avoidance problem solving function (i.e., what problems would you solve if you in fact killed yourself? How effective do you think suicide would be here as a way of solving these problems?).
3. Ask patient what keeps him or her from acting on suicidal thoughts (and this will often promote talk about what the patient values, e.g., children, religious convictions, belief in ability to always find a solution) and reinforce this as a significant deterrent.
4. Address the problem(s) that patient has been unable to solve and which he or she wants to avoid (through suicide) with skill-training and a specific plan.
5. Come down on the side of life in interactions and focus on behavior changes that implicitly affirm being alive.

PCP Teaching Points Concerning Patients with Thoughts of Suicide. When a patient expresses suicidal ideation, the PCP must invariably slow down the patient flow to address the crisis. The BHC needs to let PCPs know of his or her ability to help with this type of situation so that the PCP's schedule is not over-whelmed. However, the BHC's schedule also needs to remains accessible, as it is easy to spend an entire morning or afternoon placing an acutely suicidal patient in the appropriate community program. It is important to make sure that the clinic has a strong triage plan for addressing emergencies (We discuss this at length in Chapter 13). While many PCPs will be comfortable with using BHC services in suicidal emergencies,

an occasional provider may think that a psychiatric opinion is needed. This may be problematic, as psychiatric services are usually difficult to access. If a BHC encounters this, it is probably a good idea to take the provider to lunch (after the emergency!) to explore his or her thinking and to provide assurance that the BHC is fully capable of addressing the needs of a suicidal patient. PCPs may also benefit from the BHC providing specific training on the issue of suicidal behavior, so that it is "demystified". The current cognitive and behavioral models of suicidal behavior provide a much more operable framework for addressing suicidal behavior, rather than treating it as a symptom of mental illness (See Strosahl & Chiles, 2005 for more information). Additional training can help PCPs use questions to help highlight patient's beliefs and values that are inconsistent with suicide or to reveal problem solving strategies that don't necessarily require killing oneself, as suggested in Table 10.20. The reading list in Appendix C includes our favorite resource book on suicidal behavior (Chiles & Strosahl, 2005), and we recommend that you read the chapter by Robinson (2005) concerning the relative risk status of patients who have lost loved ones to suicide, as this group is large relative to the number of patients who complete suicide and is a good target for preventive efforts.

Table 10.20

PCP Teaching Points Concerning Patients with Thoughts of Suicide

1. Involve PCPs in reviewing the clinic triage plan for psychiatric emergencies.
2. Encourage PCPs to use the BHC to help save his or her schedule by involving the BHC early in a visit with a suicidal patient.
3. Teach PCPs to use the BHC to assess risk level and to involve resources external to the clinic as appropriate.

4. Teach PCPs to recognize that most people do not want to die, but simply face problems that overwhelm them and that asking questions that shift the focus to these problems may be helpful (e.g., "What problem, if solved or even somewhat solved, would tip the balance toward your wanting to live?").
5. Teach PCPs that few patients attempt suicide while many have thoughts about it.
6. Teach PCPs to implement a problem solving focused, value based approach to suicidal behavior, rather than a "mental illness" approach.
7. Present information on the prevalence of survivors of suicide (meaning primary care patients who have lost a loved one to suicide) in primary care and explain their health risks (e.g., problems with intimacy, mood, and apprehension; under-achievement in relation to life goals).

DRUG AND ALCOHOL PROBLEMS

Drug and alcohol problems are generally under recognized and under treated in primary care settings. Patients with substance problems, particularly those with chronic problems, are among the least liked patients in primary care setting. While this is not surprising, it is regrettable because there are now a variety of effective, brief alcohol and drug abuse screening tools for primary care use. In addition, studies have consistently found that brief interventions delivered by primary care providers have a significant impact on subsequent alcohol and drug abuse patterns in primary care patients. While there is tremendous potential for helping patients in the initial stages of problematic use, the BHC is also likely to receive referrals for many patients whose lives were derailed by substance abuse long ago. These range from the young pregnant woman who is trying to stay free of methamphetamine while pregnant to the older

man with multiple health and psychosocial problems. The case example of Ed demonstrates ways the BHC can help strengthen a patient's commitment to health and active participation in health care.

Ed: I haven't had anything to drink in two weeks, and it's kind of hard.

P. A. Jones referred this 42-year-old, Native American man for consultation to both assess motivation to reduce or stop drug and alcohol abuse and to find stable housing. Patient had a long history of alcohol and drug abuse and had recently been released from jail. He had come to the clinic as a new patient, seeking treatment for a serious burn on his hand. Patient reported numerous chronic health conditions and his P.A. was attempting to obtain records and start medications as needed. Patient had been hit by a car several years ago, resulting in serious facial injuries and loss of vision in one eye.

At the initial consult, Ed's Duke Scores suggested some problems with physical health and social health, while mental health was a relative strength. When the BHC explored health issues, he explained that he had a plate and screws in his head and similar orthopedic hardware in his arm and shoulder. He had not used drugs or alcohol for two weeks, as he had been in jail. He wanted to continue to be straight and sober now that he was out and living temporarily with his brother. In the past, he had benefited from attending AA meetings in another city. He had no way to get to local AA meetings, but agreed that this would be helpful. Winter holidays were approaching, and he felt like he might relapse because his favorite recreational activity was partying, and he didn't know much about partying without using psychoactive substances to excess.

The BHC used the Bull's Eye prescription pad (See Figure 10.3) with Ed, taught him an exercise to help him be mindful of urges to use, and provided him with resource information.

The BHC asked Ed about his values concerning love, and he said he wanted to be a playful person that was liked by his nieces and nephews and someone that could stay out of trouble. He was proud when he told the children traditional Native American stories and taught them the traditional ways. In the past, he had been one of the best huckleberry pickers in his family. When asked to make an X on the bull's eye in terms of how close his activities of the past week came to the bull's eye of being the playful uncle and teacher of tradition, Ed made a mark outside the target. The BHC helped him make a plan to bring his behavior closer to his values over the next week. Specifically, Ed planned to avoid drugs and alcohol and tell a story every night to his brother's children.

The BHC told Ed about the WAVE metaphor (Marlatt, 2001), and the following passage provides a summary of the BHC's conversation with Ed.

> "Ed, I want you to think about the ocean shore and to imagine that you have become a surfer. A surfer has a board and watches the waves. In fact, a good surfer usually watches the ocean for fifteen minutes before going in. That is because surfers can't see currents under the surface that impact wave patterns; they just need to wait and watch for waves to emerge. Now, Ed, think for a moment about waves at the ocean. What's true about every wave? . . . Right, they start out there somewhere and they end at the shore. So, now tell me how waves differ? Right, some are small, some medium, some large. I want you to spend some time everyday thinking about urges as waves; notice the difference between one urge and another. Remember your board because it's what helps you watch or ride the surf. And, Ed, do you think a surfer would ever go out and start to swat the waves with his board? No, probably not, because he'd just get pulled under. A board is for riding the waves, watching the urges. Good luck, Ed, be a surfer".

The BHC also provided Ed with information about resources in the community, including a number to call to get a sponsor that could possibly provide transportation to meetings and other numbers concerning both dry and wet (i.e., alcohol permitted) housing. Finally, the BHC explained to Ed that the clinic was taking a team approach and that she would be a member of the team of people trying to help him get closer to the Bull's Eye.

Possible BHC Interventions with Patients with Drug and Alcohol Problems. Ed's case illustrates many of the possible interventions listed in Table 10.21 that a BHC can provide to patients with drug and alcohol problems. The BHC helped Ed develop a plan that increased his sense of purpose and meaning (and hopefully also helped him maintain his temporary housing situation with his brother). Use of the behavioral prescription pad resulted in a written copy of the plan which is very helpful to patients withdrawing from drugs and alcohol. The metaphor gave Ed a tool to use in his attempts to cope with urges to drink. The BHC also provided a 1-800 number that Ed could dial from a pay phone to find a sponsor, as well as numbers for emergency housing. With patients just entering into risky drinking patterns, brief interventions are very helpful. To improve detection of these patients, passive screening activities, such as exam room posters may be helpful.

Table 10.21

BHC Intervention Possibilities for Adult Patients with Drug and Alcohol Problems

1. Assess readiness for change and provide a brief intervention that matches patient's level of readiness.
2. Provide the patient with a written copy of the plan that results from the visit.
3. Look for interventions that increase patient's greater sense of meaning and social

support base.

4. Maintain current information about resources (Alcoholics Anonymous, Narcotics Anonymous and Moderation Management meeting schedules, housing resources, etc.).
5. Schedule follow-up with PCP and emphasize availability of same-day service from BHC.

PCP Teaching Points Concerning Patients with Drug and Alcohol Problems. While more and more PCPs are learning the basics of motivational interviewing and brief interventions, stigma may continue to be a barrier to successful intervention with patients with drug and alcohol problems. It is probably painful for many, if not most, PCPs to witness the long-term impact of excessive consumption of alcohol on the human being, as it is harmful to all organ systems. PCPs are a group of people who have committed themselves to improving health, and witnessing the destruction of the human body associated with use of un-prescribed, unregulated and sometimes illegally obtained substances can easily pull forth a sense of indignation and disgust. On more than one occasion, we have heard PCPs suggest to patients, "I've seen people treat their cockroaches better than you've been treating your body." While understandable, this line of intervention is usually not helpful. We recommend that the BHC talk with PCPs about the common problem of stigma (even in substance abuse counselors) and explore the impact it has on engaging in collaborative health care with the patient. We use the "thank your mind for that thought" technique to help PCPs provide more mindful care to these patients, most of whom differ most from us only in the number and nature of traumas endured. As suggested in Table 10.22, BHCs can encourage PCPs to take a team approach with the

BHC, particularly with patients with long histories of abuse and substantial health problems. More frequent follow-ups may improve outcomes with this group of patients, many of whom need a great deal of treatment, but in fact receive little. PCPs are less likely to become overwhelmed if they are encouraged to prioritize the medical and psychological needs of the patient at each visit. The bottom line with this group of patients is to promote the sense that they are being accepted as human beings, while keeping the issue of making choices about drug/alcohol abuse on the table.

Table 10.22

PCP Teaching Points Concerning Adult Patients with Drug and Alcohol Problems

1. Teach PCPs to assess readiness for change and to use brief interventions.
2. Facilitate PCP discussion concerning stigma and teach PCPs the "Thank your mind for that thought" technique, so that they can be present with patients and make a strong effort to engage them in medical care.
3. Encourage PCPs to prioritize care needs for patients with numerous health problems and to use the BHC to provide additional care.
4. Encourage PCPs to access current referral information from the BHC (by perhaps making such easily available in wall files in common areas).
5. Suggest that PCPs ask patients at the end of the visit, "How did this go for you? Did you get the care you needed?" (When these patients experience greater satisfaction with care, they are more likely to be successful in plans related to reducing problematic use of alcohol and drugs and to return for more care.)

SERIOUS MENTAL ILLNESS

Increasingly, patients with serious mental illness are receiving treatment services exclusively in primary care settings. This is due in part to the serious financial problems besieging Community Mental Health Centers (CMHC). As requirements for accessing CMHC services have become more complex and restrictive, more patients with serious mental illness have been driven out of the mental health system and into the primary care system. The integration of behavioral health services provides a platform for delivering one-stop services for these patients, who tend to underutilize all health care and to have elevated risk for physical as well as mental health problems. The case example of Elizabeth highlights how the BHC and PCP can take a team approach to helping a seriously mentally ill patient makes gains in both mental and physical health.

Elizabeth: I am hearing voices again and can't sleep.

Dr. South referred this 31-year-old, single mother of two for a consultation concerning sleep hygiene and increasing medication adherence. Dr. South had cared for Elizabeth in the past, and she was now returning to the clinic after having lived in another area for several years. Elizabeth had a diagnosis of schizophrenia and a history of living with a man who behaved violently toward her. She had received care in the past from a local CMHC, but reported to Dr. South that they didn't want to see her there anymore and that she wanted him to prescribe her medication.

At the initial contact, Elizabeth's Duke Scores suggested poor Mental and Social Health Scores. She was very concerned about her difficulties with sleep and the extent to which voices distracted her from relaxing and from attending to her children. Elizabeth had recently separated from her violent partner and moved in with another family, who had meager

resources, but were supportive of her and her children. They transported Elizabeth to her clinic visit, and they were helping with her children.

The BHC provided education about sleep hygiene practices (See Healthy Sleeping Tips handout on the compact disc in Appendix D), taught Elizabeth a visual metaphor for observing the voices that troubled her, and explored issues related to medication adherence. The BHC also introduced the possibility of Elizabeth seeing the BHC in a ping pong pattern with Dr. South. Dr. South would attend to her physical health problems and prescribe her medication. The BHC would help her to be a good mother and get along with her adoptive family. Dr. South provided her with a prescription, and she agreed to follow-up with both Dr. South and the BHC in two weeks or earlier if her symptoms worsened or she was unable to take the medication as prescribed.

At follow-up, Elizabeth's Duke Scores suggested improvement in mental health, and she indicated success in taking the medication as prescribed. She had implemented the sleep hygiene plan, but continued to have problems relaxing at night when she was more aware of external noises as well as hearing voices. However, she reported the voices were a little less troubling to her when she used the observing technique. The BHC taught patient the CALM Exercise (see handout on compact disc in Appendix D), and Dr. South increased her medication dosage. Patient agreed to continue with her sleep hygiene practices and to practice the mindfulness and relaxation exercise in the morning and evening. Patient felt she was more attentive to her children, but wanted to talk about parenting issues at her next follow-up with the BHC.

Patient came for monthly follow-ups over the following three years, alternating visits with Dr. South and the BHC. She attained stability and began to provide care for the children of

the adults in whose home she was living. The BHC helped her learn specific skills related to parenting and addressing common behavioral problems exhibited by young children. Elizabeth resumed knitting and made several things to sell in a craft fair. She took her medication consistently, and, when she began to put on weight, the BHC helped her develop a plan involving controlling portion size and taking daily walks. Elizabeth then lost twelve pounds over a 6-month period.

BHC Intervention Possibilities for Adult Patients with Serious Mental Illness. Elizabeth's case demonstrates the essentials for successfully managing a patient with serious mental health problems. The PCP provided medication, and the BHC supported medication adherence, initiated development of a plan to improve quality of life, provided skill training as needed, and initiated a weight management program. The Primary Care Patient Values Plan (See practice tool on compact disc in Appendix D) is useful in structuring a behavior change plan directed by values. It can be integrated into an electronic medical record and supported by the multiple providers. The BHC also provided support to Elizabeth's children once or twice over the course of several years of care. BHCs may often become involved in assisting the parents or partners of patients with serious mental illness.

Table 10.23 summarizes the numerous interventions a BHC can provide to patients and PCPs to help improve both mental and physical health. Because many patients with serious mental illness may not be organized enough to describe their medical and psychological needs, it is important to create a welcoming protocol for such patients. Most primary care scheduling programs allow for creation of patient alert messages, which can be used to support welcoming plans. Alert messages for patients with serious mental illness typically instruct the receptionist to call the BHC, PCP, or a specified nurse on patient's care team immediately, so that the

patient is not left waiting in an often noisy and sometimes confusing room full of strangers. These patients benefit from having a specific team of three or four providers that are familiar with and responsible for the care plan over time. This assures that someone who knows and understands them is always available in the clinic. A charge nurse is often a good team member, as she or he will probably be the person talking with the patient over the phone when an appointment is scheduled. The goal is to create a welcoming experience and the BHC may need to take the lead in creating a welcoming committee of providers for each patient with serious mental illness.

Table 10.23

BHC Intervention Possibilities for Adult Patients with Serious Mental Illness

1. Support medication adherence by carefully exploring and addressing barriers to using medicine as prescribed.
2. Develop a plan to improve patient health-related quality of life (e.g., use of the Primary Care Patient Values Plan) and provide skill training as needed for patient to succeed in behavior change plans.
3. Assist patient's family members as necessary with problem-solving issues related to patient's health.
4. Support development of a team of three or four providers for the seriously mentally ill patient, so that at least one informed provider will be available when the patient comes to the clinic.
5. Create a welcoming protocol for patients who have frequent periods of instability and place it into the scheduling program alert system.

6. Address health-risk behaviors, such as smoking and weight gain associated with medication adherence

PCP Teaching Points Concerning Adult Patients with Serious Mental Illness.

PCPs feel frustrated by barriers to obtaining psychiatric care for patients with poor reality testing. While some respond to this challenge with a commitment to learn more about psychiatric care issues, others recoil and make demands for better psychiatric resources. Therefore, it may be helpful for the BHC to address PCPs individually in pursuing the activities suggested in Table 10.24. The BHC does need to be aware of community resources for psychiatric care and to network with local agencies and resources. When resources are scarce in the specialty sector, it is important for the BHC and PCS to make plans to use them wisely. For example, the PCP may reserve requests for psychiatric assistance for new, unstable patients and agree to assume prescribing responsibility once the patient is stabilized. PCPs may also want to use precious psychiatric resources for telephone consultations at the time of need. The BHC can also be an advocate for educational resources that provide PCPs training for prescribing anti-psychotics. While perhaps not interested enough to go to a weekend workshop, a significant number of PCPs might be willing to view a series of 30-minute videos aimed at improving their prescribing skills.

Table 10.24

PCP Teaching Points Concerning Adult Patients with Serious Mental Illness

1. Address frustration with lack of psychiatric resources by learning about community resources and networking with psychiatric providers in an effort to make a plan that

uses limited resources strategically.

2. Teach PCPs to better understand the function of various symptoms in psychosis, rather than to simply view symptoms as a sign of "mental illness".
3. Since PCPs vary in their interest in learning more about psychiatric care, support learning venues that are feasible and give providers a choice (e.g., a series of short videos about prescribing anti-psychotic medications).
4. Help PCPs learn key strategies for supporting patient adherence to medications (e.g., regular visits scheduled in a ping-pong fashion with the BHC, exploring barriers to adherence, providing reminders and reinforcements for adherence, etc.)

SUMMARY

1. While domestic violence often motivates patient care, patients may present with vague pain complaints and even deny domestic violence when providers inquire about it. Still, we recommend that providers find culturally sensitive ways to screen for violence in the home and be prepared to develop safety plans and refer to community resources. The single most important goal beyond detection is that of having the patient leave the clinic with a feeling of having been understood and an intention to return.
2. BHCs need to teach patients who complain of pain a variety of skills, such as mindfulness, acceptance, pacing, relaxation and comfort strategies. Additionally, these patients benefit from value-driven behavior change plans and on-going support from their PCP. Development of a clinical pathway utilizing a pain and quality of life class provides more in depth opportunities for skills training. Pathways also provide a structure that allows for systematic evaluation of pain treatment outcomes, where the focus is on improving functional status.

3. Hypertension, obesity, and diabetes are common in patients, and the BHC has a great deal to offer patients in the way of skill training to support implementation of a healthy lifestyle plan and to PCPs in the way of teaching motivational interviewing.
4. Dizziness and chest pain are common complaints among primary care patients. Often, these complaints mask an underlying anxiety state such as panic or somatization. A BHC can complete a functional analysis and help the patient learn skills that address the troubling symptoms and reduce stressful life circumstances.
5. Many adult primary care patients are trying to learn to live with chronic conditions (such as diabetes), and they often struggle with avoidance patterns. The BHC can help newly diagnosed patients get off on the right foot and partner with PCPs to offer group services which make necessary on-going support for behavior change and medical monitoring feasible. Practice support tools may help the BHC take a systematic approach to newly diagnosed patients (See BHC Diabetes Screener on the compact disc in Appendix D).
6. Fatigue, sleep disturbance and other symptoms of depression and traumatic stress are common in primary care. The BHC can use the functional analysis to identify and target the most troubling symptom for the patient. When improvements occur in the targeted symptoms, many other symptoms improve spontaneously as the patient develops self efficacy. BHC can offer a range of services to these patients, including behavior change support, evaluation of response to medication treatment, and relapse prevention training. The BHC can teach PCPs the biopsychosocial model and encourage a practice philosophy emphasizing behavioral interventions as the active ingredients necessary for long term change.

7. The BHC will see patients in primary care who are considering suicide, and needs to be prepared to reframe suicidal behavior in cognitive-behavioral terms. In addition, the clinic needs to have an emergency referral protocol in place so that a suicidal emergency does not disrupt the flow of patient care for either the PCP or the BHC. A new diagnosis of a chronic disease and any other number of other life problems can trigger a sense of hopelessness that results in health-care seeking.
8. While there are many primary care patients with alcohol and drug problems, they may be difficult to recognize until problems become more severe. Much can be gained from screening and brief intervention. The BHC also can help patients with more chronic problems by functioning as a "safety net", linking the patient with existing community programs and using motivational interviewing and harm reduction strategies.
9. Many patients with serious mental illness seek care exclusively in the primary care setting. BHCs can support the PCPs who want to develop expertise in pharmacological treatment of these patients by offering to be a member of the team that provides care at the time of need and that focuses on establishing stability and functioning in all major life roles.