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Practicing Psychology in Primary Care

H. Russell Searight
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Chapter 1

Introduction to Primary Care Psychology

A Day in the Life of a Primary Care Psychologist

6:30 a.m.

You are riding your exercise bicycle at home when your cell phone rings. The hospital unit clerk from Six North, a general medical floor, is on the phone indicating that a Dr. Johnson has requested that you see a patient in the hospital this morning. The patient, Ms. St. Laurent, is a 75-year-old White female who was admitted after falling at home. It was later determined that she had fractured her hip. Surgery is scheduled for this afternoon. However, late yesterday, she became increasingly confused and her thoughts disorganized. Given the planned surgery, nursing staff and the surgeon were concerned about whether or not she could give meaningful informed consent to the procedure. During the course of the night, she became increasingly agitated and described visual hallucinations of circus clowns singing in her room and tormenting her to keep her awake. The surgeon would like to proceed with the procedure if she can give competent consent.

Since your first patient is not until 8:30 this morning, you decide to cut short your workout and see Ms. St. Laurent first thing this morning. Driving to the hospital, you take a call from Dr. White, an internist asking about a patient he is about to see this morning in his clinic. The patient, a “frequent-flier” in the hospital’s emergency department, is a 45-year-old man who insists that something is “seriously wrong” with his heart and believes he has been having a series of “heart attacks.” He has been in the emergency department four times in the past 3 weeks with shortness of breath, chest pain, lightheadedness, and intense fear. Typically, however, by the time the emergency room physician sees him, the worst of his symptoms have resolved. Despite two thorough cardiac evaluations (which were negative), the patient was not reassured and did not accept the strong probability that he was having panic attacks. At his last two emergency room visits, he has had an electrocardiogram and has been instructed to see your colleague for an office visit. He is finally appearing for an office visit – prompting the phone call. Dr. White adds that a representative from the patient’s health insurance company has been calling the physician about the amount of cardiac testing that the patient has had. After indicating to Dr. White that you would be happy to see the patient later this week, you also suggest that he evaluate the patient further for possible panic disorder and remind Dr. White that selective serotonin reuptake inhibitor (SSRI) antidepressant medications are typically used to treat the condition.
7:55 a.m.

Ms. St. Laurent is indeed confused. When you ask her what season it is, she reminds you that “Christmas is just around the corner” even though it is mid-July. She cannot tell you why she is in the hospital and often responds to questions with incoherent rambling. However, during your 30-minute assessment, she also has brief bouts of clarity and can repeat seven digits forward, and at one point anxiously says, “Something’s just not right with me.” You note in her chart that, at this point in time, her mental status is fluctuating to such an extent that, in your judgment, she cannot provide genuine informed consent for surgery. However, you also write that the history of a sudden onset of confusion, together with the fluctuating consciousness that she demonstrated during your interview, strongly suggests a diagnosis of delirium. In your note, you suggest that she be further evaluated for a cause for her confusion and note that these states are often triggered by systemic illness and/or medication interactions.

8:45 a.m.

Your first patient has been waiting 15 minutes. This is a 7-year-old boy who you hear before you actually see. He is in the waiting area with his mother, and as you open the door you are greeted with a boy jumping off a chair. You observe that he appears to have thrown most of the waiting room’s magazines all over the floor. As you are talking with the mother and the boy in your office, there is a knock on the door. Dr. Overman, another physician in the practice, asks if you can see a patient who is in exam room 12. Dr. Overman describes the patient as a 30-year-old woman who suddenly broke into uncontrolled sobbing when he walked into the exam room. He states that she seems to “have some kind of stress” and adds, “You’re better with this sort of thing than I am and besides, I’m already behind – I’ve got two other patients I need to see.”

After spending 10 more minutes with the mother and child, providing some questionnaires for mother, father, and the boy’s teacher to complete, as well as scheduling a follow-up appointment, you go to exam room 12. You find a slightly disheveled woman sitting on the exam table sobbing while the nurse tries to console her. Upon your arrival, the nurse leaves, saying to the patient, “I’m sure you will feel much better after talking with the doctor,” as she nods in your direction. In between sobs, the patient says that she has been “going out of my mind.” Last night, she explains, her husband of 5 years told her that he was in love with another woman, packed some clothes, and left: “I came to the doctor because I didn’t know what to do with myself. I couldn’t go to work like this.”

After you make some empathic comments and seem to have established rapport, the patient calms down a little and indicates that she is most concerned about the impact that this will have on her 4-year-old son. You and the patient develop a plan – she will ask her mother to stay with her for the next several days, you suggest that the physician provide her with a work excuse, and encourage the patient to contact her two sisters as well as her group of friends and finally, to consult with an attorney. You caution her against taking any significant action on her marriage at this time but do schedule her back
for an appointment in 3 days. After she has calmed down somewhat, you leave the room, find Dr. Overman, briefly summarize the patient’s situation and your plan, and encourage him to write the work excuse.

11:00 a.m.

You meet with a 40-year-old male who is a three-pack-a-day smoker. He explains that after a benign nodule appeared on his neck about 3 months ago, he has decided to quit smoking, “This time, for good.” He is also a patient of Dr. Overman. Because of the quantity and duration of his cigarette use, Dr. Overman has suggested a trial of medication – bupropion – to assist with cessation. After learning that the patient had tried cessation before but had only been able to go without smoking for less than 12 hours, you conclude that nicotine replacement is also likely to be helpful. Before you begin discussing environmental and behavioral smoking cessation strategies with the patient, you query him about symptoms of major depressive disorder. He seems to have at least five of the required symptoms for a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis of major depressive disorder. Recognizing that untreated depression will make cessation much more difficult, you suggest that the mood disorder be addressed first and that the smoking cessation protocol be initiated after those symptoms have improved. You step out of the room, find Dr. Overman, and briefly explain the situation. The physician responds: “Don’t you think that if we can get him to stop smoking his depression will get better?” You explain the much poorer success rate for smoking cessation among depressed smokers and suggest that maybe the patient will be more likely to be successful in about 6 weeks, if the depression is promptly treated. Dr. Overman sighs, “Ok, you win,” and pulls out his prescription pad: “What should I write for?” Since the patient had not been treated for depression previously, you tell the physician that as a general rule, any of the SSRIs would probably work equally well. Dr. Overman presses you: “Just tell me which one?” After pointing out that sertraline may have fewer side effects and a better record of adherence, he writes the script and hands it to you: “Tell him to schedule back with me in 2 weeks.”

11:45 a.m.

You are now a half hour behind schedule. The pediatrician across the hall from your office has referred a 12-year-old boy to you who weighs approximately 180 pounds. His blood pressure is elevated. On entering the exam room, you are struck by the boy’s size – he is bigger than you are. When you ask the patient and his mother about their understanding of their meeting with you, she immediately and firmly states that she does NOT believe that her son has any “psychological problems,” just “slow metabolism.” You do your best to diplomatically explain the risks of obesity, particularly in children, and recommend that the boy begin some type of regular physical activity – even if only walking 5–10 minutes a day as a start. You also refer the patient and his mother to a nutritionist at the local pediatric hospital. You write all this information down and give one copy of your
recommendations to the boy and one to his mother, but you have a sinking feeling that they will not follow through. As they leave the office, you smell Chinese food.

12:30 p.m.

You go to the office conference area where a pharmaceutical representative is giving a luncheon. After getting some food and admiring the drug representative’s Brooks Brothers’ suit, you listen as he explains the benefits of a new medication for type II diabetes. Given the number of patients that you see regularly with this condition or who are at risk for type II diabetes, you listen, take some of the literature, and eat quickly.

12:45 p.m.

While you are eating, Dr. Smithson, another physician in the practice, asks if you will be around this afternoon. She explains that she has an elderly patient who is coming in with his daughter to see her. The daughter called Dr. Smithson expressing concern about her father continuing to live alone. He apparently has been forgetting to take his medication and does not seem to be bathing regularly. The daughter had recently arrived at her father’s home to find the oven on, no food in the oven, and her father asleep on the sofa. You had hoped to get the morning’s chart notes done early this afternoon, but it looks like they will have to wait until early evening.

1:15 p.m.

On your way back to your office area, you pick up two phone messages and several insurance company forms to complete. Before getting to your office, you are stopped by the office manager. She asks if she can talk to you for “just a second.” She is concerned about the office receptionist who has been coming in progressively later in the morning for the past 2–3 weeks. The office manager adds, “Twice, I think I smelled alcohol on her breath. She is a good employee and I really don’t want to fire her. Could you possibly see her?” This one sounds complicated and you think twice before answering. Given office politics, you know that there are likely to be other issues here but you have no idea what they are – only that you would like to avoid stepping on an office land mine. After a pause, you say, “Let me think about the situation and then I’d like to talk to you some more about it, maybe tomorrow when we both have some time.” The office manager is not going to let you slide out of this one: “Okay then. Let’s meet at 7:45 tomorrow morning before the patients start coming in.”

1:45 p.m.

After taking a phone call and reviewing some records, you note that you are only 15 minutes behind schedule. The first patient of the afternoon is a 16-year-old girl
who was recently seen by one of the family physicians in your group. The girl, Susan, is accompanied by her mother. The record indicates that Susan recently had episodes of fainting at school. Laboratory work suggested electrolyte imbalances. The family physician, fairly knowledgeable about mental health issues, asked Susan about her eating habits as well as binging and purging behavior. Susan described episodes of purging three times a week as well as laxative use. While Susan appears to be of normal weight, her mother says that Susan is obsessed with her body image: “She asked if she could have liposuction for her birthday.” Susan looks acutely embarrassed. You decide to ask a few more questions with the mother present and then to talk with Susan alone. After spending approximately 45 minutes with Susan and her mother, a fairly long time in your practice, you recommend a local intensive day treatment program for teenagers with eating disorders. After describing the program to the mother and daughter, they reluctantly agree to consider it.

2:45 p.m.

Dr. Smithson’s 70-year-old patient and his daughter are in an examination room finishing up with the physician. While looking through his chart, your cell phone goes off. Apparently the teenage girl with eating disorder symptoms does not have a health insurance plan accepted by the treatment center. You speak briefly with the girl’s mother, indicate that you will look into some alternatives, and contact her later today or early tomorrow. You also ask the name of the health insurance company and make a note to check with them about eating disorder treatments that they will authorize.

Dr. Smithson comes out of the examination room shaking her head. She says, “I’m really worried about having this guy live alone much longer. Let me know what you think.” After introducing yourself to the patient and his daughter, you ask the patient if he understands why he is here. He says, “To get a checkup.” You go on and ask him directly if he has noted any changes in his thinking, attention, or memory. He says, “I’m just fine. I don’t know what all this fuss is about” and glares at his daughter. You feel the tension in the room and decide that it might be better to briefly separate the two. You ask the patient and his daughter if it would be okay if you saw the patient alone and then, looking directly at the patient, ask if it would be okay if you spoke with his daughter by herself as well. You explain that oftentimes it is difficult to talk about family members in front of them because adult children do not want to hurt their parents’ feelings. He is agreeable to this and you spend the next 45 minutes assessing the patient with the Mini-Mental Status Examination (MMSE), screening for depression, inquiring about medications and alcohol use, and then speaking with the daughter, alone. The patient does demonstrate some mild difficulties with short-term memory that do appear to be slightly greater than would be expected for his age. Moreover, the daughter does appear to be extremely worried about her father’s safety. You close the visit by indicating that you would like to see the father again in several weeks, repeat the MMSE to help determine if the memory changes you detected are transient or stable, as well as speak with the physician about how she would like to manage the patient’s living situation. For the
interim, you ask the patient if he would mind if his daughter checked on him on a daily basis, and tell the daughter that if there is anything that is concerning to her that she can contact you or Dr. Smithson. The father agrees to this plan and the daughter appears relieved.

4:00 p.m.

After gathering up some notes and presentation materials, you head over to the nearby university where you are teaching in the graduate program in psychology. As soon as you pull into the parking lot, your cell phone goes off again. Dr. White’s office is calling – the patient with the anxiety/cardiac symptoms who you and the physician had discussed early that morning just called the office and was very distressed. He took his first dose of fluoxetine several hours ago and says he is nauseous, the room is spinning, and he feels jumpy. You encourage the office staff to let Dr. White know and point out that the patient’s reaction to beginning an SSRI is not uncommon and will typically get better in about 5 days.

You return to your class preparation. This semester you are teaching a course on theories of psychotherapy and personality. Today’s topic is Jungian analysis. Sitting in your car in the university parking lot, as you glance through your notes reviewing concepts such as archetypes, the ego, and the integration of the self, you smile. This class, which is much like the one you took during your graduate training in clinical psychology, seems a world away from the type of psychology that you practice everyday.

Overview of the Book

This psychologist’s workday is very different from the one for which most mental health professionals were trained. It is fast paced, full of surprises and interruptions, and includes a wide variety of clinical problems across the lifespan. Time is of the essence. “Running behind,” with scheduled activities interrupted by patients and events requiring a rapid response, is a daily challenge. The uninterrupted 50-minute psychotherapy hour is rare. Regular challenges include determining when symptoms are due to a mental health versus a nonpsychiatric medical condition as well as the ability to assess, diagnose, and make treatment decisions quickly. These determinations must be made without the benefit of the “full battery” of psychological tests that many psychologists were trained to see as the only way to do a “real” evaluation.

Philosophically, primary care physicians and mental health officials have had very different professional and educational socialization and, as a result, approach patients differently. Additionally, the two professions are trained to see patients in very different contexts. The traditional psychologist’s private office with stuffed chairs, sofas, and artwork on the walls is a world away from the austere exam room and general hospital suite of the medical setting. While mental health problems occupy a good deal of the daily work of a pediatrician, family physician, or internist, their patients often present these symptoms very differently in primary care as opposed to the mental health setting. Primary care
patients with psychiatric issues also differ from those seen in mental health settings, since symptoms of depression or anxiety are likely to be part of a clinical picture that includes hypertension, asthma, type II diabetes, or other physical problems.

The growing area of clinical health psychology has included useful techniques for addressing public health problems such as obesity, smoking, lack of physical activity, poor diet, and alcohol abuse. However, practicing psychologists often view these lifestyle risks as secondary to the diagnosis and treatment of psychiatric conditions as described in the Diagnostic and Statistical Manual (American Psychiatric Association, 2006). In primary care, however, and particularly with the growing prevalence of chronic illness in which lifestyle factors play an etiological role, these habits are among the most common presenting behavioral conditions.

Despite these realities, most psychologists, like the author, who have had rewarding careers in primary care, have been essentially self-trained. While postdoctoral psychology training programs in primary care are growing, and there is increased attention to collaboration between mental health and medical providers, there is still relatively little practical information to guide mental health clinicians new to this setting.

This book is designed as a practical guide for mental health professionals entering primary care, as well as for those who have had professional experience collaborating with primary care physicians. The book is divided into two major sections, the first basically about the primary care culture and the second primarily about interventions suited to this setting.

The first section, covering Chapters 1 through 4, describes the culture of primary care. It includes a description of the patients, their expectations, and common clinical problems. In many respects, patients in the primary care sector are more heterogeneous than those seen by most mental health professionals. It is generally assumed that when a patient appears in a psychotherapist’s office, his or her chief concern is to address psychological distress. However, in primary care, the psychologist cannot make the same assumption. One of the major challenges in the general medical setting is “sorting out” symptoms and assigning them to diagnostic categories. Mental health professionals working in this setting will need to be aware that while symptoms of lethargy, insomnia, poor concentration, and lack of appetite characterize many mental health conditions, the same symptoms may signal a range of medical problems such as hyperthyroidism, hypothyroidism, cardiovascular disease, or type II diabetes, as well as interactions or side effects of medications used to treat medical conditions. Patients themselves interpret psychiatric symptoms as stemming from a physical condition and, understandably, see their medical doctor as the appropriate person to diagnose and treat their distress.

As the practice diary above suggests, the primary care setting is a unique culture with its own values, norms, language, and explanatory models. In my years of practicing, writing, and lecturing about primary care psychology, I always return to one implicit, yet critical principle: This culture will not be readily changed by even the most gifted mental health professional. I have seen many psychologists become frustrated and angry because the setting does not value their 15-page, single-spaced psychological evaluations, 13-generation genograms, or the year of weekly psychotherapy sessions that we have been trained to provide. Psychologists have much to offer their physician colleagues. However, efforts to change primary care practice so that it is more in line with psychologists’
professional values are seriously misguided. Having an impact in this setting occurs when psychologists accept and work within the primary care culture and avoid the missionary zeal to transform their physician colleagues into “mini-psychotherapists.”

Much of primary care work is consultation. While formal models of consultation (Caplan & Caplan, 1993) are familiar to most psychologists, consultation in primary care is often of the “curbside” variety: Physicians will stop you in the clinic corridor or contact you by phone when they have a spare minute to discuss patient issues. Reasons for consultation are sometimes obvious, but may also have a number of unspoken meanings. I owe a debt to the British National Health System, which has regularly employed counselors and therapists in general practitioners’ offices for decades (Bor & McCann, 1999; Webster, 2002). These professionals have helped articulate many of the conflicts arising in primary care consultation that I have experienced but was unable to label (Bor & McCann, 1999). Finally, basic practice issues such as documentation, and ethical concerns such as dual relationships, will be explored in the early section of the book to provide an appropriate context for the latter section addressing specific psychotherapeutic interventions.

The first section concludes with a discussion of screening and applied epidemiology. A primary care practice cares for a small population of patients. As a result, epidemiological research, when applied thoughtfully, can assist with screening and diagnosis. Knowledge of risk factors for mental health conditions, as well as for behaviors such as smoking, excess alcohol use, and nonadherence, helps narrow the range of diagnostic possibilities in a heterogeneous patient population. Additionally, when intervention is viewed at a population level, brief counseling and screening have been demonstrated to reduce a population’s alcohol use, smoking, and improve well-being. Because of the number of patients in an average primary care practice with psychiatric conditions or behavioral risk factors, psychologists, in order to have optimal impact, will need to implement brief and focused treatments.

The second section of the book focuses primarily upon brief interventions that either have been developed specifically for the primary care setting or have been adapted to this context. These approaches include targeted interventions for health risk behavior (the five A’s; FRAMES), applications of the stages of change model to move patients toward healthier lifestyles, and motivational interviewing, a relatively new technique that emphasizes the role of patient values and personal investment in behavioral change. For larger-scale psychosocial issues, including relationship conflicts as well as mood and anxiety disorders, the BATHE technique and adaptations of narrative therapy will be useful. Patients who, like their physicians, are good logical problem solvers, will probably benefit from problem-solving oriented techniques. Acceptance and commitment therapy holds promise for increasing the coping skills of patients with chronic illness. Finally, the growing cultural diversity that influences patients’ health behavior concludes the discussion of interventions.
Chapter 2

The Patients

When seeing patients in the primary care context, a useful distinction is that between disease and illness (Kleinman, 1988). Disease reflects the physician’s perspective. This is usually a biological explanation reflecting some alteration in physiology and/or anatomy. Kleinman (1988) uses chest pain as an example. Chest pain is a fairly common presenting complaint. When chest pain can be diagnosed as treatable acute pneumonia, the disease model works well. Unfortunately, symptoms are usually not as directly linked to the disease state. Anginal-type chest pain, while reflecting coronary artery disease, may also reflect a long history of hypertension, discontinued pharmacotherapy because of erectile dysfunction and/or other side effects, family conflict, unrecognized anxiety, and the patient’s own intense fear of death.

Illness, on the other hand, is the content of most day-to-day primary care practice. Illness describes “… how the sick person and the members of the family or wider social network perceive, live with, and respond to symptoms and disability” (Kleinman, 1988, p. 3). While many readers may consider upper respiratory symptoms to be the sine qua non of disease, most of the time these symptoms actually reflect illness. The majority of patients with upper respiratory symptoms do not have a clear bacterial cause leading to appropriate prescribing of antibiotics. However, both quantitative and qualitative studies have demonstrated that antibiotics are prescribed frequently when there is no evidence of bacterial cause. Why, then, do most patients who bring these symptoms to their physician receive a prescription for antibiotics? Qualitative studies indicate that there is an upper respiratory “dance” that occurs between physician and patient in which the patient uses several justifications for needing an antibiotic (fear of missing too much work, children missing school, prior positive experience with antibiotics, an emphasis on level of discomfort, and demanding “something” for it) (Scott et al., 2001), and physicians often respond with their opinion that the condition is viral and does not require an antibiotic. The dance may become more intense as the physician tells the patient about the growing concern about antibiotic-resistant infections that have developed – possibly from the inappropriate overuse of antibiotics. Still, more often than not, the patient leaves the office with a prescription.

What is happening here? While disease is present, the patient’s illness experience becomes the central clinical issue. How did illness win out over disease – particularly when the physician has the prestige of biomedical research on their side? During the typical primary care encounter, patients bring illness complaints to the examination room that are translated into disease based upon a biomedical understanding of the complaints.
Disease is what practitioners have been trained to see through the theoretical lenses... [of their discipline]... That is to say, the practitioner reconfigures the patient’s and family’s illness problems as narrow technical issues, disease problems (Kleinman, 1988, p. 5).

Sore throat, cough, runny nose, and stuffy head interfere with the patient’s work and family life; it keeps the 8-year-old girl from her dance recital as well as from her second grade class; it contributes to further distancing between husband and wife in a marriage lacking in sex and affection. Successful primary care physicians are aware that they are dealing with illness and at times, may temporarily compromise the biomedical logic of disease in its favor.

**Primary Care Patients Are Different**

Patients seen by psychologists either referred by primary care physicians or seen in the primary care office differ significantly from those presenting in the traditional mental health sector. First, primary care patients do have high levels of psychiatric distress. However, psychiatric problems are rarely the problem bringing the patient to the physician’s office. Second, primary care patients’ mental health symptoms are intertwined with physical problems. At the same time, many of these physical complaints are vague and have no established etiology. While DSM-IV mental health conditions are common, primary care psychologists also spend a good deal of time dealing with a third problem type: behavioral issues that do not fall into a specific psychiatric category. These include obesity, diet, and sedentary activity, a desire to stop smoking, or difficulty adhering to a diabetic regimen. Furthermore, the patient’s distress occurs within the context of developmental issues and life events including fears about being a good mother of a newborn, focused family crises such as the death of a child, divorce, job loss, or conflict with a work supervisor, and decisions about placement of aging relatives. Finally, physicians struggle with patients that have physical symptoms for which no etiology can be established. All of these challenges may coexist with ongoing chronic illness, such as type II diabetes or hypertension, acute problems such as the common cold or sinusitis, or health maintenance visits for regular physicals for work or school.

**Demographics and Presenting Problems**

Demographically, there appear to be differences between patients seeing primary care physicians for mental health problems versus those seeing a psychiatrist or psychologist in the mental health sector. Primary care patients with psychiatric conditions are likely to be male, older than age 65 years, and have less formal education. Additionally, primary care patients with mental health concerns are more likely to have comorbid substance abuse and medical conditions as well as being members of racial and ethnic minorities (Cwikel, Zilber, Feinson, & Lerner, 2008).
As noted above, patients with psychological/behavioral issues seen in the primary care setting are different in other ways than those seen in the specialty mental health sector. First, presenting problems are more likely to focus on physical distress rather than emotional or social difficulties. Second, primary care is also the setting for ongoing treatment of the growing number of patients with chronic illnesses such as asthma, hypertension, or type II diabetes. Finally, primary care is the major clinical context for routine medical visits such as school physicals as well as the setting for most preventive care.

**Primary Care: The *De Facto* Mental Health System**

Psychiatric symptoms are very common in primary care settings. In the United States, the primary care sector is the most common treatment setting for mental health problems (Cwikel et al., 2008). For example, 50% of all patients in the US treated for major depressive disorder are managed solely in the primary care sector. These physicians spend a total of 12.1 hours per week – nearly a quarter of their direct patient contact hours – providing mental health services. When directly compared on the basis of patient contact time, primary care providers see far more patients with mental health conditions than psychologists or professional counselors. Nationally, approximately 20% of psychotherapy sessions are provided by primary care physicians (Searight, 2007).

When compared with the general population, primary care patients have elevated levels of psychiatric symptoms. An early large-scale survey of primary care patients found that approximately 20% had a current psychiatric condition (Barrett, Barrett, Oxman, & Gerber, 1988) with major depressive and anxiety disorders being the most common. An additional 11% were diagnosed with another psychiatric condition. However, a number of these patients had comorbid depressive symptoms as well. Generalized anxiety disorder was the second most common mental health diagnosis. Of note, when examining the presence of symptoms rather than specific conditions, only 30% of this primary care population were free of psychiatric symptom with approximately 40% exhibiting mild symptoms (Barrett et al., 1988).

More recent studies suggest that rates of psychiatric distress in primary care are rising. When examining the prevalence of mental health conditions in primary care attendees during the past year, approximately half of all patients reported significant psychiatric symptoms (Cwikel et al., 2008). Women were more likely (54.8%) than men (44.9%) to be exhibiting significant psychiatric distress. When the more stringent criterion of meeting a formal DSM diagnosis was employed, 26% of men and 34% of women had a mood, anxiety, or eating disorder and/or somatoform disorder. While mood disorders were the most common with 17.4% of men and 22.2% of women meeting criteria for major depression during the past year, anxiety disorders were a close second with 13.5% of men and 20% of women having at least one of these disorders during the past year (Cwikel et al., 2008).

Among pediatric patients, the majority of diagnoses of attention deficit hyperactivity disorder are made by pediatricians and family physicians. When examined from the perspective of sheer numbers, the majority of prescriptions for stimulant medication used...
to treat the condition are also written by primary care physicians (Mayes, Bagwell, & Erkulwater, 2009).

**Subsyndromal Psychiatric Conditions**

Of particular note is the large percentage of patients with subthreshold psychiatric syndromes. Cwikel et al. (2008) found that approximately 15% of male and female primary care patients have at least some of the symptoms associated with cognitive impairment, depression, panic attack, or hypochondriasis. Other studies have found that these subthreshold psychiatric conditions are associated with high levels of impaired functioning and greater utilization of medical care.

Minor depression, similar to major depressive disorder (MDD) with the exception of requiring only 2–4 symptoms (rather than five) for 2 weeks to meet diagnostic criteria (Wagner et al., 2000), has been associated with similar levels of disability. Among a group of older primary care patients, subsyndromal depression was found to be persistent at 1 year follow-up and as in previous studies, predictive of poorer global functioning (Lyness, Chapman, McGriff, Drayer, & Duberstain, 2008). The construct of minor mood disorders was further supported by the finding that levels of impairment for minor depression were intermediate between a major depressive disorder group and those without mood disorder symptoms (Lyness et al., 2008). Minor depression also appears to have two longer-term outcomes of concern; the complement of minor symptoms may persist or develop into major depressive disorder over time (Lyness et al., 2008). While associated with significant disability, there is less consensus about treatment for minor, as compared with major, depressive disorder. Pharmacotherapies such as selective serotonin reuptake inhibitors and/or evidence-based psychotherapies of choice for MDD, such as cognitive behavioral and interpersonal therapy, may have some efficacy for minor mood disorder but benefits do not appear to be as pronounced.

While less frequently studied, subsyndromal anxiety symptoms also appear common and are associated with impaired functioning and poorer health status. In a large sample of Dutch women, approximately one third reported significant anxiety symptoms (Denollet, Maas, Knothnerus, Keyzer, & Pop, 2009). Symptoms, such as chronic worry, free-floating anxiety, and excessive fear or panic, were associated with increased mortality through atherosclerosis as well as cardiac death. Among a group of middle-aged women, subsyndromal anxiety symptoms, even when depression and other cardiac risk factors were controlled, were associated with increased rates of cardiovascular death. Of interest, anxiety symptoms also predicted later lung cancer death even when the effects of smoking were controlled (Denollet et al., 2009).

Finally, while not as thoroughly investigated, combined subsyndromal anxiety and depressive disorder is also associated with significant functional impairment. In this condition, patients do not meet formal diagnostic criteria for either a mood or anxiety disorder but have symptoms of both conditions (Roy-Byrne et al., 1994). Similar to the other “unofficial” psychiatric syndromes described above, this mixed condition is also associated with a greater number of physical symptoms, disability, and a greater likelihood of