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Brief Psychotherapy in Primary Care

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Brief Psychotherapy in Primary Care

Overview

Case thread

Goals:

- Acknowledgement
- Rationale
- Background ‘theory’
- Framework(s)
- Practical applications

Case

33 y/o male lawyer

CC: Headache, not sleeping

HPI: Recent divorce

PMHx: None

- Has history of anxiety treated with xanax

PE: Dark room, anxious, talking fast

- Normal neuro exam

Case

What do you do?

A: BHC Consult

B: Rx xanax

C: MRI Brain

D: Rx SSRI

E: “Lengthy discussion >25 minutes”

Context…

60% of mental health care is provided in primary care settings

One study showed that 'patients with psychosocial problems confided in their PCP more often than any other professional'

- *95% reported that contact as being helpful*

Primary care providers fail to recognize 66% of 'emotional disorders' contributing to patient presentation

We provide therapeutic interventions whether we know it…or not

Context:

‘Frontline’

We recognize the biopsychosocial model

Treating medical illness often is impossible without addressing mental illness

+

Barriers exist to accessing mental health services*

Number of Patients by Diagnosis

Last 6 months

Diagnosis	Number of Patients
Essential (primary) hypertension(ICD-10-CM: I10)	452
None of the above	418
Gastro-esophageal reflux disease without esophagitis(ICD-10-CM: K21.9)	222
Hyperlipidemia, unspecified(ICD-10-CM: E78.5)	193
Allergic rhinitis, unspecified(ICD-10-CM: J30.9)	156
Anxiety disorder, unspecified(ICD-10-CM: F41.9)	141
Pure hypercholesterolemia, unspecified(ICD-10-CM: E78.00)	140
Encounter for general adult medical examination without abnormal findings(ICD-10-CM: Z00.00)	131
Encounter for immunization(ICD-10-CM: Z23)	128
Vitamin D deficiency, unspecified(ICD-10-CM: E55.9)	122
Morbid (severe) obesity due to excess calories(ICD-10-CM: E66.01)	117

Population **452**

Base: **My Patients (PCP)**

Diagnosis: **Essential (primary) hypertension(ICD-10-CM: I10)**

Between

4/14/2020 and 10/13/2020

Measures

Number of Patients: **452**

Skills you already have…

INTERVIEWING SKILLS: Data collection, communication (diagnosis, caring attitude, reassurance)

RELATIONSHIP BUILDING: Trust, continuity

INFLUENCE: Demonstrated power vs. assumed power (source of information), motivational interviewing, social power (influence beliefs, attitudes)

Pitfalls with the medical model…

TOP DOWN TREATMENT: Rash -> steroid

DIAGNOSIS-FOCUSED: Discrete diagnoses, uniform patient experience of disease

LIMITED TREATMENT OPTIONS: Lifestyle modification vs. medication

The PCP as Psychotherapist?

What are the constraints?

What resources are available in your practice? Locally?

What are the drivers?

Is it effective?

Show me data…

(Difficult to study)

British study 128 pts with anxiety - GP 1/2 hr therapy vs. psychiatry 1/2 hr therapy (8 session)

- No difference in outcome (survey of symptoms)
- Satisfied practitioner and patient
- Conclusion that demand outstrips supply of psychiatry services = PCP's can provide adequate psychotherapy.

**No meds other than benzo's used*

**8 wks not enough for some patients in either group.*

Primary care vs. specialist care...

PATIENT FACTORS:

- 15-75% of referrals to psych not fulfilled (especially when somatic complaints involved)
- Stigma / labeling fear (self worth needs to be re-established before therapy effective)

Primary care vs. specialist care…

PRIMARY CARE SETTING ADVANTAGES:

- Treatment without labeling
- Small doses at a time
  - May be more effective, learning model
- No rejection
- No implication that body and mind separate

Primary care vs. specialist care…

SPECIALIST CARE:

- In patients with somatic complaints managed by PCP’s, one consultation with a psychiatrist reduced cost by 53% over the year
  - Collaborate after initial therapy

- Nature of therapeutic relationship is different in psych referral

Primary care vs. specialist care...

Typology of mental health disorders in primary care[6]

Type	Description	Example disorders	Current care
1	Severe mental disorders, unlikely to remit spontaneously, associated with major disability	Schizophrenia, organic disorders, bipolar disorder	Involves both primary and secondary care
2	Well defined disorders, associated with disability, for which there are effective pharmacological and psychological treatments. Disorders may remit, but relapse is common	Anxious depression, pure depression, generalised anxiety, panic disorder, obsessive-compulsive disorder	Can usually be managed entirely within primary care
3	Disorders in which drugs have a more limited role, but for which psychological therapies are available	Phobias, somatised presentations of distress, eating disorder, chronic fatigue	Rarely treated within primary care; only a small proportion of cases are treated by specialist services
4	Disorders that tend to resolve spontaneously	Bereavement, adjustment disorder	Supportive help, rather than a specific mental health skill, is needed

BMJ. 2005 April 9; 330(7495): 839–842.

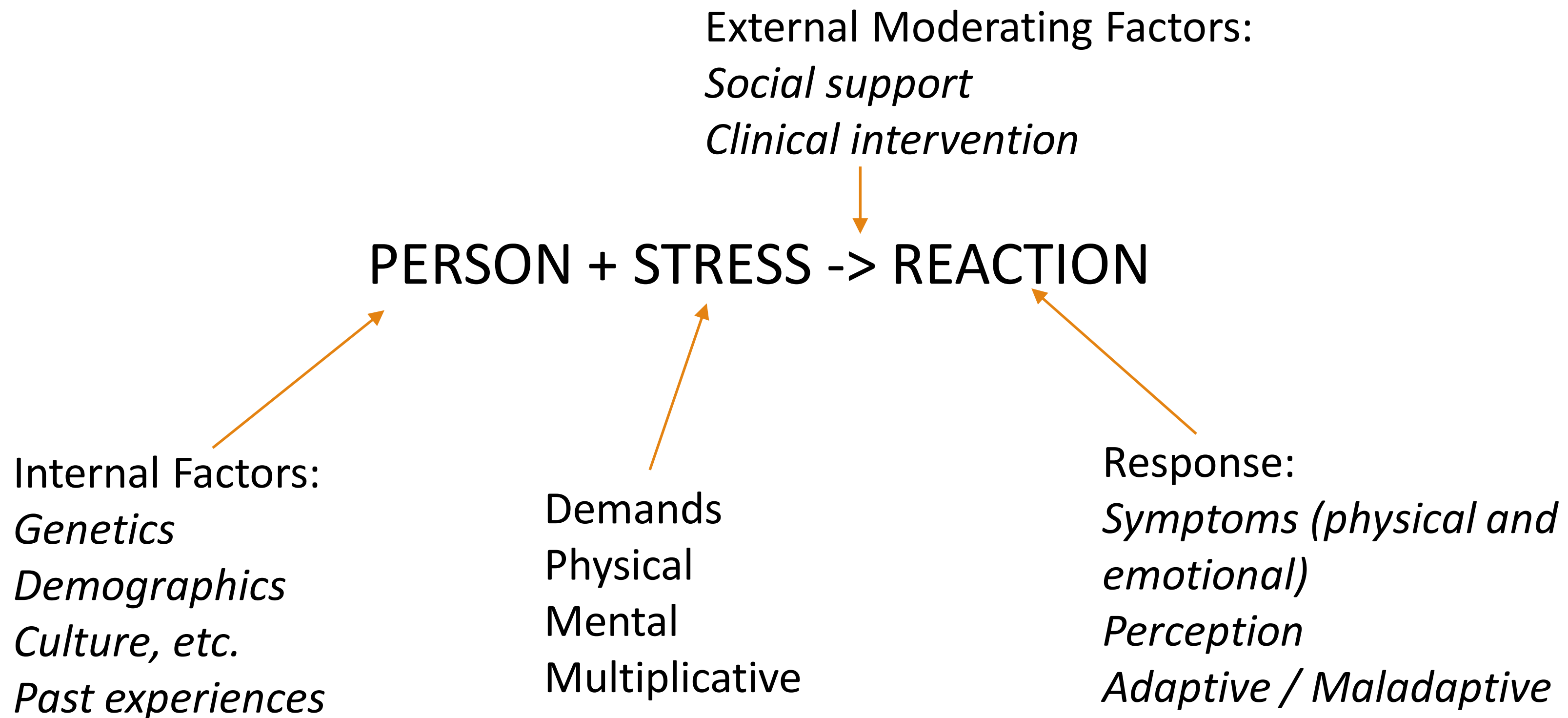
So, what can you do?

Theory

3 Tools

Case

“Nothing has changed and yet everything is different”



Some Basic "Truths"

1. A mental / physical linkage exists (BPS model)

2. Crises usually resolve in 4-6 weeks

3. Coping mechanisms under stress may not be the same under normal circumstances – in general, individuals have consistent coping patterns, some functional, some not AND support during stress can return to normal adaptive behaviors

4. Locus of control (internal vs. external)

Stress

Experimental psychology:

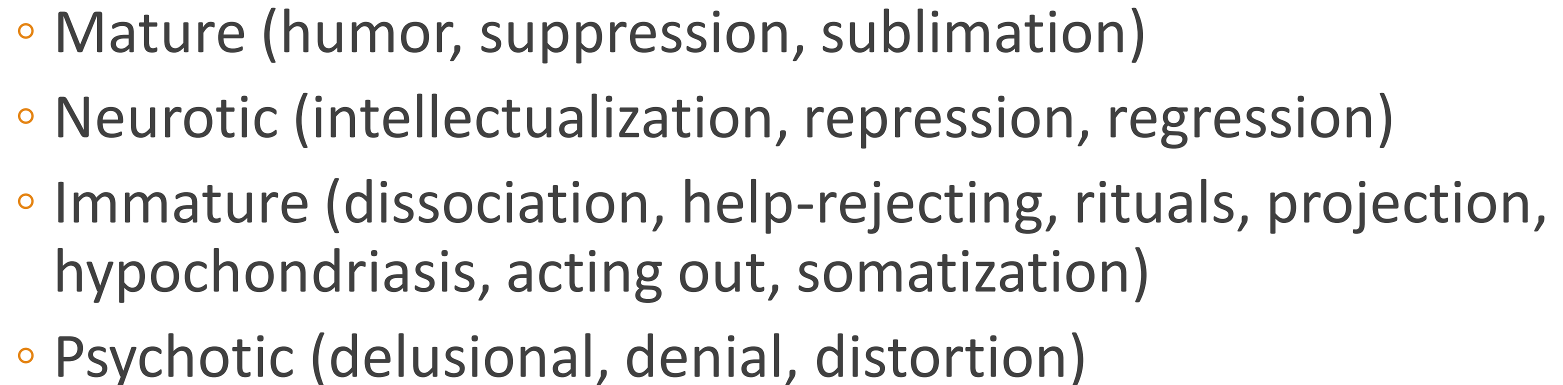
- Stress causes ‘overstimulation’
- Revert to primitive coping mechanisms
- Cannot learn, use automated behaviors
- Goal of therapy is to decrease arousal to allow for learning new behaviors

Stress puts people on ‘tilt’

- Threshold effect
- Goal of tx --> support to maintain equilibrium

Coping with Stress

Some defense mechanisms:



EXTREME stress -> regression

Crisis Intervention Model

1. Prevent dire consequences
2. Return to pre-stress level of function (support)
3. Expand behavioral repertoire
4. Enhance self-esteem

- Prevent dire consequences
- Return to pre-stress level of function (support)
- Expand behavioral repertoire
- Enhance self-esteem

Case

External Stressors

33 y/o male lawyer

HPI: Headache, not sleeping, recent divorce

PMHx: None

- Has history of anxiety treated with xanax

Past experience

PE: Dark room, anxious, talking fast

- Normal neuro exam

Response ('emotionalization')

A ‘how to’ guide

The initial visit (EVERY visit)

- Crisis intervention
- BATHE
- SOB-NO!
- Three-step therapy

Follow-up visits

- Narrative therapy review
- BATHE-R

The initial visit: Think, Crisis intervention model

Acute stress disrupts equilibrium

BY DEFINITION: self limited

- Most *4-6* weeks with some resolution

4 goals:

- Prevent dire outcome
- Return to pre-morbid function (connected/competent)
- **Expand behavior repertoire**
- **Promote resiliency**

The initial visit:

Ask -- update social history and 'life situation'

Ask yourself how the patients medical complaints may be related to acute or chronic 'tilt'

Consider using the BATHE technique, one or more SOB-NO! elements or 3-step problem-solving

The initial visit: **BATHE** Technique

Background:

- "What is going on in your life?"
- Narrative, story
- Ask open-ended questions
- May not get much (it's ok!)
  - Go directly to next step...

The initial visit: **BATHE** Technique

Affect*:

- "How do you feel? What is your mood?"
- Address emotional response, *i.e.* angry
- Give permission to *feel*
- Once named, makes less personal, apart from the individual

* Different from mental exam affect

The initial visit: BATHE Technique

Trouble:

- "What troubles you about this situation?"
- Focus to meaning of situation
- Patient will need to think/interpret/project
- You may need to nudge, re-ask

The answer is the core problem and leads to constructive solution

The initial visit: **BATHE** Technique

Handling:

- "How are you handling this?"
- Assess functioning
- Identify destructive behaviors
- Follow up question: How *could* you handle this?

The initial visit: BATHE Technique

Empathy:

- "That must be hard", for example
- Legitimize reaction
- Demonstrate that you are listening and hear the patient

The initial visit: **BATHE** Technique

Where are the therapeutic interventions?

- Telling the story
- Externalizing the feeling, naming (compartmentalizing)
- ID central issue for patient
- Brainstorming alternative solutions *from patient*
- BEING THERE, empathy and support
- Prevent destructive behaviors

Socratic method

The initial visit: **BATHE** Technique

Some possible challenges:

- Multiple problems
  - ? most troubling
  - ? central issue
- Resistant patient
  - Vigorously separates physical / mental symptoms
  - Answers ‘Nothing.’ to, What is going on in your life?
  - That ‘Nothing’ may be poignant!
- Simply skip the ‘B’ in BATHE!

BATHE

Background

Affect

Troubling

Handling

Emphathy

The Initial Visit: SOB-NO!

REINFORCING ***S****TRENGTHS*

- Point out past successes, strengths, power
- Promote resiliency

ASK ABOUT ***O****PTIONS*

- People often not aware they have them
- Power to choose (decreases feeling of impotence / feeling of being overwhelmed)

ENCOURAGE NEW ***B****EHAVIOR*

- Your focus is NOT to solve a patient's problem, rather help them solve the problem
- Encourage patient to take time out, *not* to decide
- Encourage patients to ask directly for what they want

NO*RMALIZING* REACTIONS

- 'Anyone would feel this way'
- You don't have to like it BUT

  You have to make change and deal with it...
- 'OK to have emotions and not DO anything'

The initial visit: **3-step problem solving**

1. What are you feeling?
   Label
2. What do you want?
   Goal
3. What can you do about it?
   Focus on *what you can control*

Effective teaching tool for patients...

The initial visit: Ending the visit

Consider **homework**:

- List options, resources, advantages, disadvantages, etc.
- Goals, previous accomplishments
- Journaling
- "Do one thing new each day"

Promote independence

- Identify personal resources
- Daily 3-step problem solving

These techniques will allow you to fit all of this into a 15 minute visit!

The follow up visit:

Psychotherapy – talking

- **Set a follow up plan and agenda**
- Objective is therapeutic change
- Be explicit

Use scheduled, defined sessions

The follow up visit:

- Opening:
  - *What has happened?*
  - *How have you been?*
  - *How have you felt?*
- Revisit BATHE and Add ‘R’
  - Reinforce **resilience**

The follow up visit:

Review homework assignment

Legitimize feelings

"Acceptance must precede change"

Consider medical tx

Consider referral

Give advice (maybe)
- Parenting skills
- Relationship skills
- Workplace skills

More homework

Summarize, end visit

The follow up visit: Narrative therapy

Post-modern theory - ‘glasses’ or ‘frames’

- Goal is to separate patient from center of problem
- Ask to speculate about changing the future or present, what they would do differently
- Create new versions of life story
- Objective - identify meaning

- EMPOWER THEM
  - ‘I can’t do...’
  - Response: ‘Have not been able to do until now...’

Tailoring to specific affective responses

Anxiety: Stress management

- Relaxation exercises
- MBT

Depression: CBT

- Small steps -> exercise
- Focus on YET
- Resiliency

Grief: Revert to crisis intervention model

- Stages of grief
- Give time, provide support

Take home points… ‘how to’ guide

The initial visit

- Crisis intervention support
- BATHE
- SOB-NO!
- Three-step therapy

Follow-up visits

- Narrative therapy
- BATHE-R

Case

Background: *What is going on in your life?   Affair*

Affect: *How do you feel about it? Angry, mood swings, 'I go up and down'*

Trouble: *What troubles you most about the situation? Being a single parent, effect on children (guilt)*

Handle: *What helps you handle the situation? 'I'm not', short with kids, yells more at work, drinking more than ever How COULD you handle this situation?*

Empathy

- *This is a tough situation to be in*
- *Anybody would feel as you do*
- *Your reaction makes sense to me*

Case (revisited)

40 y/o male lawyer

CC: Tearful, stressed related to fathers' passing + recent failed relationship

PE: Tearful

On 'tilt' BUT actively coping: employing mature mechanisms now (intellectualization, pre-empting emotional response, seeking outside help, being more open with supports, etc.)

You promote resiliency, remind about past success, time,

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A ‘how to’ guide

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Follow-up visits

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