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contents

VOLUME 82, NUMBER 8 OCTOBER 2022

ALSO INSIDE

The Pennsylvania Psychologist is the official bulletin of the Pennsylvania Psychological Association and the Pennsylvania Psychological Foundation. PPA dues include member subscriptions. Articles in *The Pennsylvania Psychologist* represent the opinions of the individual writers and do not necessarily represent the opinion or consensus of opinion of the governance or members or staff of PPA or PPF.

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INTEGRATED CARE, PROFESSIONAL PSYCHOLOGY, AND VALUE: AN INTRODUCTION FOR PSYCHOLOGISTS

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Integrated health care is a much encountered and frequently discussed subject not only among clinicians but also among researchers, policymakers, and leadership across organizational entities be they health care providers and systems, insurance/third-party payors, or governmental. Despite this, integrated health care defies a simple definition. It is beyond the scope of this issue, much less this introduction, to comprehensively define integrated health care. We pragmatically define integrated care as an approach within the health care system to improve treatment access, delivery, and outcomes for patients without losing sight of the broader context. We subscribe to the working definition of integrated care by the American Psychological Association (APA, 2014) with a focus on the multidisciplinary treatment of the patient emphasizing improved communication and collaboration to meet the full biopsychosocial needs of the individual. As psychologist-providers working in primary care, clinical, and/or applied health psychology subfields, we experience firsthand the value of psychological treatment in the promotion of biopsychosocial health within integrated care settings not only from the clinical data and feedback that we receive from patients, but also from the data and feedback that we receive from our fellow providers in other disciplines such as medicine, nursing, physical therapy, clinical nutrition, and others.

As psychologists, we recognize the literature that has long established the value of psychology in integrated care (Suls et al., 2010; Carlstedt, 2009). The value of psychology in integrated care is based not only on patient health and outcomes but also on its cost-effectiveness. This is attested to by the highly influential actuarial analysis commonly known as the Intermountain Healthcare Study, which conclusively demonstrates the higher expenditures and worse treatment and health outcomes for those experiencing chronic "physical" conditions along with untreated "mental" health concerns in the United States (Melek et al, 2018). While the evidence base of integrated care continues to emerge and conclusively positive results remain elusive, there are compelling lines of research and trends conveying its value worldwide, as will be discussed.

Hardly unique to the United States, integrated care is a truly global movement in health care largely deriving from the increasing prevalence of chronic conditions and the associated high costs of treatment that threaten individual and population health as well as the stability of health care systems across nations. Only by apprehending the research outcomes of integrated care, both in terms of patient health and the financial health of the system(s), can we deduce the true value of integrated care and professional psychology's contribution therein. Post-hoc analyses of large numbers of prior research allow for some inferences to be drawn even if they must remain tentative. One such study on integrated care in the United Kingdom (UK) and internationally noted variance among a wide array of select outcomes while also conveying "stronger evidence" for "patient satisfaction, increased perceived quality of care (staff perception in the UK studies, staff and patient perceptions in the non-UK studies) and increased/improved patient access" as well as decreased use of emergency medicine (Baxter et al., 2018, p. 6). Another systematic review of international findings documented the positive economic impact of integrated care for chronic conditions (i.e., diabetes mellitus, schizophrenia, and

multiple sclerosis) in terms of lowering treatment costs and expenditures (Desmedt et al., 2016). Such emerging evidence supports the value of integrated care and professional psychology's place therein.

The following articles focus on a range of clinical and practical issues integral to integrated care and improved outcomes for patients. Articles that include discussions of integrated care across the developmental lifespan and applications among specific health conditions recognize direct clinical applications. A recent article in Family Practice Management noted that "up to 75% of primary care visits include mental or behavioral health components (Schrager, 2021, p. 3). "CBT for Depression and Anxiety in Integrated Care Settings" discusses empirically supported cognitive behavior therapy strategies and includes specific guidelines for application with older adults, while "Pediatric Integrated Primary Care" emphasizes a whole family approach. Integrated care is not limited to mental health but has a range of empirically supported behavioral medicine applications (Dobmeyer, 2018). "The Treatment of Headache, Migraine, and Traumatic Brain Injury (TBI)" exemplifies this fact with empirically supported behavioral health techniques to treat and demystify headaches and TBI. Additional articles emphasize the pragmatic application of integrated care through teaching, interprofessional relationships, telehealth, and billing/insurance. "Considerations for Teaching in Primary Care Settings," coauthored with a primary care physician, details how the different educational backgrounds and requirements of physicians and psychologists can augment one another through integration. "Building Relationships" offers suggestions to initiate dialogue between psychologists and physicians in professional settings. However, telehealth is mitigating the limitation of physical location. "Telehealth in Primary Care Settings" recognizes the empirical support for telehealth in integrated care, notes techniques and recommendations for use, and includes physician commentary on applications in rural settings. Finally, we address Pennsylvania billing and insurance matters in a colocated setting (a psychology practice sharing office space within a medical practice).

Integrated care offers a breadth of empirically supported treatments for a range of populations while providing value-added benefit for patient, provider, and payor. We invite additional discussion and feedback on the contents of this issue and more through our next Connecting Hour on Tuesday, November 8 at 7:00 pm on Zoom.

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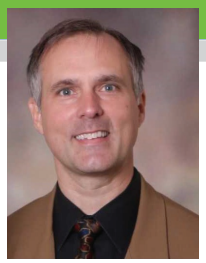
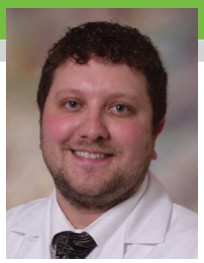




TELEHEATH IN INTEGRATED PRIMARY CARE SETTINGS

RICHARD KUTZ, PsyD

BERNARD LEECH, DO

Telehealth visits increased over 550% between March 11, 2020, and April 22, 2020 (Connolly et al., 2021). The reality of this increase through the COVID-19 pandemic is apparent; however, telehealth should not be viewed as a recent fad with limited empirical support. The Substance Abuse and Mental Health Services Administration (SAMHSA; 2021) reports the use of telehealth as a mode of service delivery in clinical settings for over 60 years. Further, telehealth has been empirically studied throughout the past 20 years, establishing a body of support that includes randomized controlled trials of significant power to show cost-effective, feasible care applicable to a wide population inclusive of children through elderly patients, in rural and urban settings, with positive outcomes across a wide range of mental and physical health disorders (Bashshur et al., 2016).

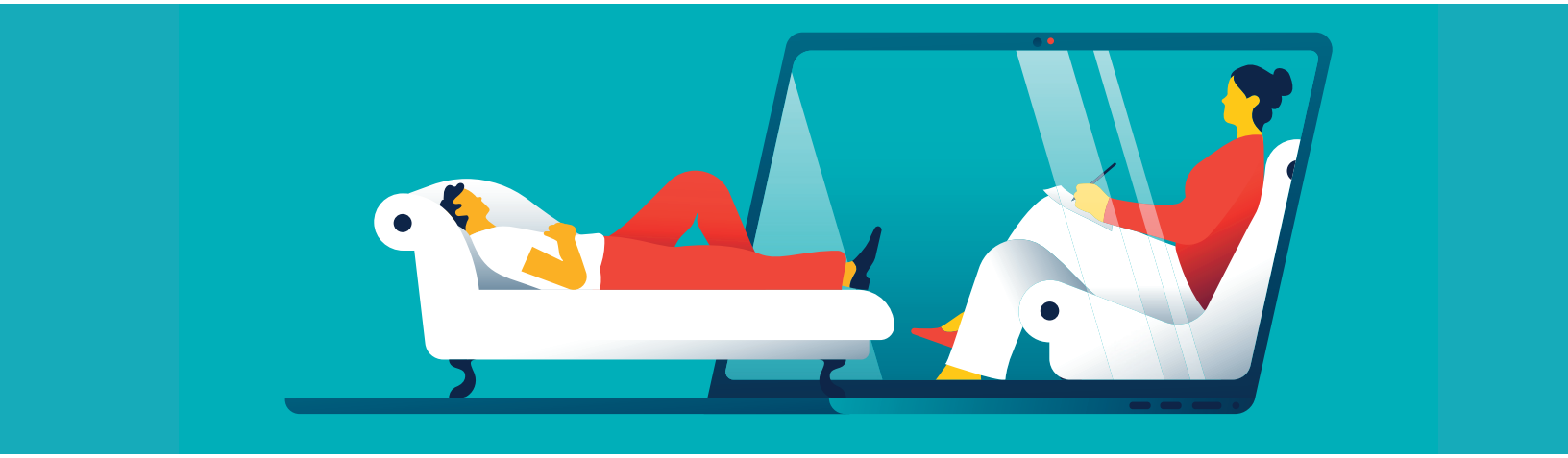
The models discussed for integrated care (IMPACT, Collaborative Care, and PCBH) are adaptable to telehealth modalities. Multiple training options are available for psychologists through PPA and the American Psychological Association (APA), and the American Medical Association (AMA) likewise offers training resources for physicians. Telehealth is a viable treatment modality, but also includes a range of considerations specific to that modality.

Telehealth is dependent on internet access, yet a Pew Research Center study (Perrin & Atske, 2021) found 7% of the U.S. population lacks access, a health inequity that has greater impact on persons in rural areas, with lower education, senior citizens, and persons of color. The Center for Rural Pennsylvania (2020) has designated 48 out of Pennsylvania's 67 counties as "rural." Internet access and comfort using telehealth technology cannot be assumed and assessing patient access and familiarity is a recommended first step. Physical signs in clinic areas, as well as discussions and demonstrations with patients, can help increase familiarity. Among patients where internet access and/or associated technology is not an option, conducting telehealth via standard telephone remains an option with high patient satisfaction (Brenes et al., 2012). Different insurance payors provide varying levels of coverage for different modalities with different authorization requirements. It is advisable to recommend patients confer with their specific payor for details.

While patients may be familiar with the ritual signing for privacy and confidentiality during office registration, changes in this process through telehealth should be clearly detailed. Verification that Health Insurance Portability and Accountability Act requirements are met through the virtual platform (e.g., Zoom, Doxy Me) should be confirmed in addition to private space considerations such as the presence of absence of others in both the provider's and patient's physical location. A back-up plan in the event of technology failure or the need for higher level of care should also be included. These recommendations are incorporated into a customizable telehealth consent template developed by the Agency for Healthcare Research and Quality (2020).

Recognizing the potential need for a higher level of care acknowledges that telehealth is not appropriate for all patient visits. Some treatment requires in-person visits, and for some cases, changing this might disrupt the patient-provider relationship. SAMHSA and AMA address these issues with recommendations in the 2021 report Telehealth for the Treatment of Serious Mental Illness and Substance Disorders, and the 2022 Telehealth Implementation Playbook, respectively.

APA produced guidelines in 2013 for the



practice of telepsychology that are based on the history of telehealth empirical support and consistent with the APA Ethics Code. These guidelines remind us that telehealth practice is different and acknowledging this difference with patients is helpful. Mutually acknowledging the frustration of audio lags or the momentary confusion of poor connectivity can sometimes shift a negative moment toward one of building rapport through shared experience.

PHYSICIAN PERSPECTIVE

As a primary care physician, it is vital to assess the mental health of each patient. Often this is straightforward; however, there are times when the situation calls for more than my attentive ear or a prescription. In these instances, a psychologist is integral to the patient's overall health. Three days per week, I see patients in a remote office. When I see a patient who would benefit from psychological care, I am able to coordinate virtually through shared EMR with the psychology team who then takes the initiative to coordinate with the patient.

Telehealth increases access to patients who were previously difficult to reach. In my rural practice, a large population of elderly patients often avoid care because they do not want to be a burden on their family who will have to take time off work to drive them to the visit. With telehealth, we can maintain regular visits with these patients. Initially, the learning curve for technology was a concern, but patients have found that the technology is simple to use and only requires a smartphone, tablet, or computer.

This was exemplified in an 82-year-old patient who established telehealth psychology visits via smartphone with her son's initial help. The patient was frequently contacting my office regarding minor somatic complaints and not aware of her complicated grief. I recommended cognitive behavioral therapy, which she completed over a 3-month period using telehealth. Unsurprisingly, her somatic complaints dwindled significantly.

Telehealth's ability to increase access is not limited to patients unable to drive. One patient was unable to commit to routine, in-person appointments due to his commitment as a primary caregiver for his 19-year-old daughter managing stage 4 melanoma. Utilizing telehealth, he was able to engage in psychotherapy without leaving the home and maintain management of his daughter's health.

Finally, I've seen telehealth provide an otherwise unavailable lifeline. One long-term patient was the victim of ongoing intimate partner violence. She agreed to start psychotherapy, but her partner would not allow this and would withhold the car and money. Telehealth allowed her to engage in psychotherapy without aggravating her home situation. Through telehealth, her self-esteem has evolved and she recently reported active plans to leave her abusive situation. Thanks to the help of telehealth, I now listen with the real hope of hearing her voice say, "I'm free!"

Telehealth provides an empirically supported mode of service that can increase patient access and provide vital treatment. While telehealth has specific needs and challenges, professional organizations like PPA have successfully met these challenges with recommendations and trainings to maximize use.

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PEDIATRIC INTEGRATED PRIMARY CARE: AN APPROACH TO ADDRESSING THE NATIONAL EMERGENCY IN CHILDREN AND ADOLESCENT MENTAL HEALTH

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SHERI L. GOLDSTROHM, PhD

In 2021, the American Academy of Pediatrics (AAP), the American Academy of Child and Adolescent Psychiatry (AACAP), and the Children's Hospital Association (CHA) declared a national emergency in child and adolescent mental health (AAP et al., 2021). Prior to the start of the COVID-19 pandemic, children and adolescents experienced several barriers to accessing mental health care including transportation, long wait times, and stigma related to care. The COVID-19 pandemic highlighted these challenges in an unprecedented manner. The negative effects of the COVID-19 pandemic for children and adolescents can go well into adulthood (Panchal et al., 2021). COVID-19 and racial injustices were particularly challenging for Black, Indigenous, and People of Color (BIPoC) and lesbian, gay, bisexual, transgender, or questioning (LGBTQ) youth due to preexisting systemic inequalities within the health and mental health care systems. The declaration released by AAP, AACAP, and CHA (2021) called for the adoption of integrated mental health and the strengthening of efforts to reduce these barriers and risk factors in children and adolescents through various settings, including primary care.

The term integrated care refers to the involvement of behavioral health care through primary care service (Asarnow et al., 2015). In particular, pediatric integrated primary care (IPC), which has been present for over 40 years, focuses on child development and behavior (Schroeder, 1979). IPC distinguishes itself from adult integrated primary care in its focus on prevention, early intervention, and promotion of healthy childhood behavior (Lines, 2022; Talmi & Fazio, 2012). IPC provides care for many presenting concerns, among them depression, anxiety, attention-deficit/hyperactivity disorder, and learning difficulties. IPC also plays a crucial role in treating and managing chronic health conditions such as obesity, diabetes, headaches, and sickle cell anemia (Stancin & Perrin, 2014).

Primary care in pediatrics is one of the most utilized health systems for children, adolescents, and their families (Stancin & Perrin, 2014). High utilization of pediatric primary care may be attributed to the existing relationship with the child and adolescent's pediatrician as well as the familiarity of their office (Campo et al., 2018; Talmi & Fazio, 2012). The care received through their child and adolescent's pediatrician (through wellness or sick visits) allows families the space to discuss matters that may be attached to stigma or shame. Pediatric psychologists within IPC work alongside pediatricians to provide greater access to care and improve mental health outcomes in children. In many sites within IPC, a pediatrician can walk to a pediatric psychologist and request a consult, also known as curbside consultation. Alternatively, pediatricians can engage in a warm hand-off in which patients are transferred from one team member to another in front of the patient's family (Agency for Healthcare Research and Quality, 2017). Curbside consultation and warm hand-offs allow children and adolescents to receive care without delay, creating a seamless transition and an increased probability of follow through with treatment. Parents and caregivers often appreciate having various services available to them onsite, including mental health services as they are familiar and easy to access.

WHAT IS THE ROLE OF PEDIATRIC PSYCHOLOGISTS WITHIN IPC?

Early intervention is critical in reducing the influence of the social determinants of health in children and adolescents, like adverse childhood experiences (ACEs), which are linked to negative health outcomes and substance abuse in adulthood. IPC plays a crucial role in changing the trajectory of that path for

a child (National Scientific Council on the Developing Child, 2004). By utilizing a "whole-family" approach, pediatric psychologists within IPC connect with children, adolescents, and their caregivers to support their needs and to provide them with evidence-based interventions. Pediatric psychologists have a unique role in providing initial evaluations, screening, and short evidence-based interventions. Pediatric psychologists can collect data about a child's functioning at school and at home. They can also administer universal screenings such as the Pediatric Symptom Checklist, Strength and Difficulties Questionnaire, and ACE Questionnaire. IPC is also able to use evidence-based parent management training, which can, at times, be completed at the pediatrician's office (Page et al., 2016). Pediatric psychologists are trained to collaborate with individuals from various areas of a child's life including teachers, guidance counselors, families, and health professionals.

The declaration released by AAP, AACAP, and CHA (2021) underscored the mental health crisis among our youth and placed urgent calls for action. Given their focus on treating the whole family, IPC is an ideal setting to rise to the challenge of the national mental health crisis, especially among BIPoC and LGBTQ youth. Furthermore, pediatric psychologists are uniquely positioned to provide the care needed due to their training in health promotion and prevention (McCabe et al., 2020). It is important to note that when it comes to a national youth mental health crisis, it is the ethical responsibility of all psychologists or trainees in the field to intervene. As professionals, we have a shared duty, whether through advocacy, research, or clinical work, to be part of the solution to eliminating this national mental health crisis among our youths.

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BUILDING RELATIONSHIPS: ACCESS TO BEHAVIORAL HEALTH THROUGH BEHAVIORAL HEALTH INTEGRATION

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The demand for mental health treatment has increased in recent times, and its effects on the health care system are palpable. Access to behavioral health and physical health services have been impacted, health care costs have increased, and the importance of collaboration to improve these issues has never been more important.

In reference to health care costs, one large commercial insurance company recently reviewed their utilization data regarding the impact of mental health issues. BlueCross BlueShield (2018) estimated that 9 million commercially insured U.S. citizens have mental health issues, and this significantly impacts the overall cost of health care for all diagnoses. The report specifically highlights the impact of depression on overall heath, and it found that those with a diagnosis of depression were 30% less healthy than those not diagnosed with a depression. Moreover, those diagnosed with major depressive disorder experienced "10 years of healthy life lost," and used more health care services with a utilization rate over twice the amount of those not diagnosed with major depressive disorder. The cost of mental health is found not only in the emotional struggles of clients, but also in financial cost. It was estimated that the impact of mental health on health care costs from 2010 to 2020 totaled $238 billion a year (Substance Abuse and Mental Health Services Administration, 2014). Based on this information, the connection and integration of physical health care and behavioral health care can benefit individuals as well as the overall health and wellness fields, both by reducing costs and by positively increasing treatment outcomes in both areas.

Access to behavioral health services remains a challenge. Patients may experience challenges in connecting with mental health treatment for a variety of reasons. Obstacles to access may include cost, location, and identification of providers in particular specialties, and stigma or bias surrounding seeking mental health treatment (National Alliance on Mental Illness, 2017). Further, it has been reported that 60 million adults and children in the United States meeting mental health criteria may go untreated. In another study, it was reported that 53 million U.S. adults live with unaddressed mental health issues (National Institute of Mental Health, 2020).

Patients often seek treatment with their trusted primary care practitioner (PCP). Koirala and Anand (2018) found that patients seek a "majority" of their mental health treatment with their PCP. Similarly, Kessler (2007) found that of those seeking mental health treatment, half sought this care with their primary care office. According to the Centers for Disease Control and Prevention (2014), one-fifth of all visits to the PCP's office are connected to mental health complaints. Moreover,

PCPs tend to prescribe many psychotropic medications. Barkil-Oteo (2013) found that PCPs prescribe 79% of antidepressant medications taken by patients in the United States.

The daunting challenge of meeting these needs is larger than one solution, but it can be positively impacted by collaboration. The push for behavioral health integration has increased over the past two decades. Cohen et al. (2015) suggests that through collaboration, the PCP and behavioral health consultant can move care in a direction that will improve outcomes and overall well-being for patients.

How can psychologists connect with PCP offices? Relationships can be forged by building bridges to the PCP team. A psychologist may connect with a PCP by simple communication. When treating a

patient, consider contacting the treating PCP to share updates, offer treatment plan ideas, or simply check in to introduce yourself. Second, send the treating PCP a consult. This can be done by mail, fax, or email, or even stop by the office to introduce yourself while dropping off the consult. Psychologists may consider being available for curb-side consultations on challenging patients. Some ways to demonstrate value for a PCP's office might include offering to help treat "difficult" patients, or those who tend to take up office staff time (i.e., a "needy" patient). An expeditious response confirming the consultation to the provider may be valuable. The consult may include a treatment plan, goals in therapy, and educational information for the provider. Communicating with a provider can be engaging and open the door to additional referrals.

You can also offer to provide services to a local PCP office. For instance, offer to attend a brown-bag lunch meeting at the PCP office. Psychologists can present on needed topics (e.g., assessing suicide risk, tips on treating highly anxious patients, or disorder-specific topics). The brown-bag lunch can also be an open forum to field questions about the PCP's challenging cases.

In addition, consider offering a patient group or educational session. Psychologists may offer health and wellness groups for a diabetic population or a stress management group for PCP office administration staff. It may take a special intervention to demonstrate worth to a PCP, but these gestures of collaboration may open the door and build bridges toward an integrative relationship. Finally, psychologists may develop connections with their local medical community by offering to present on behavioral health topics at local school districts or at a medical organization conference. Through these steps, psychologists can forge relationships with the providers and their communities and lead to collaborative relationships.

How can PCPs connect with psychologists? Physicians may collaborate with the behavioral health team in a variety of ways to develop more collaborative relationships. First, a PCP can reach out to a psychologist when they receive feedback from patients in treatment. If a PCP hears good things from a patient about a psychologist, the PCP can call to talk about the patient's progress. Also, if a psychologist sends a report to the PCP, the provider may consider calling the psychologist to discuss the case or how to further collaborate. Additionally, a PCP may engage with a psychologist on a joint project or pilot program to positively affect the practice. For example, the PCP may suggest working together on research or collaboration with demonstrating collaborative efficacy to payers.

Building bridges between the medical and behavioral health communities can serve the greater public by providing conjoint and unified care. Treating patients in a collaborative manner may also enhance treatment adherence (DiTomasso et al., 2010), improve access to care (Harmon et al., 2022), positively impact health and wellness, and even increase overall health care utilization (Thapa et al., 2021). The integration of medical and mental health treatment modalities can help to improve outcomes as well as the overall health of patients. It offers opportunities for professionals to share knowledge and approaches to care, thus enhancing their practices. Building these collaborative relationships can lead to more creative solutions to address the obstacles and limitations to the access of behavioral health care.

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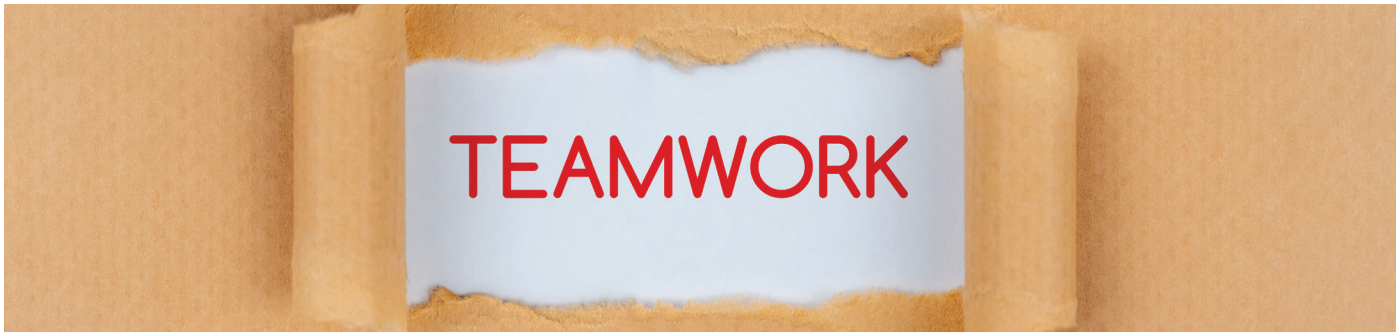

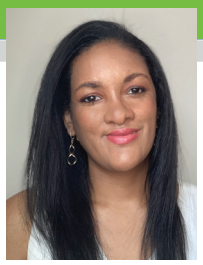
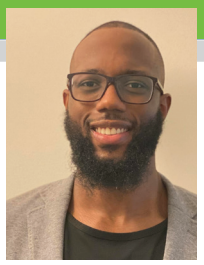


FACING PAIN WITH SIMPATÍA: CHRONIC PAIN AND ACES AMONG LATINX ADULTS

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Since the initial groundbreaking study linking the experience of childhood adversity to a wide range of chronic physical and psychological illnesses in adulthood (Felitti, 1998), research into the connection between persistent, distressing experiences in childhood has grown exponentially (Briggs et al., 2021; Hughes et al., 2017). Adverse childhood experiences (ACEs) are traumatic events that occur during early childhood and are linked to mental illness, substance abuse, and chronic health problems, including pain that goes well into adulthood (Briggs et al., 2021; Felitti et al., 1998; Hughes et al., 2017). Numerous meta-analyses have further reinforced the connection between ACEs and heightened risk for physical and mental illness in adulthood (Briggs et al., 2021; Hughes et al., 2017). While specific causal connections between ACEs and negative health outcomes have not yet been proven, a robust hypothesis based on the current understanding of the stress response cycle explains how childhood adversity has significant health consequences later in life (Hughes et al., 2017; Nakazawa, 2015). Described by some researchers as the, "Biological Theory of Everything" (Nakazawa, 2015), the purported pathway when a child experiences adversity rests in the impact of chronic hyperarousal on the hypothalamic pituitary stress axis (HPA), leading to sustained and unregulated cytokine activity and inflammation (Nakazawa, 2015). Over time, the body's unmitigated exposure to stress hormones creates an upward spiral of chronic hyperarousal, damaging DNA, so that a variety of disease processes that might otherwise not emerge are more likely to manifest in adolescence and adulthood (Nakazawa, 2015). Robust research findings suggest, in comparison with adults reporting no ACEs, those experiencing four or more ACEs are at significantly greater risk of autoimmune illness, cardiovascular disease, migraines, chronic pain (Briggs et al., 2021; Felitti et al., 1998; Hughes et al., 2017; Nakazawa et al., 2015), as well as increasing the risk of depression, suicide, substance use disorders, and chronic obstructive pulmonary disease (COPD) in adulthood (Briggs et al., 2021; Hughes et al., 2017). Based on these findings, Hughes and colleagues (2017) concluded, "To have multiple ACEs is a major risk factor for many health conditions," and increases the likelihood of premature death from all causes. The original study conducted by Filetti and colleagues (1998) consisted of predominantly White, middle-class participants recruited from a large health care system. Since then, researchers, utilizing a more diverse sample, broadened the definition of adversity to include racism, gender inequality, and other forms of

systemic bias.

Despite the abundance of research on the links between ACEs and negative health effects over the past 30 years (Jackson, 2020), the links between ACEs and physical outcomes, particularly among underrepresented groups, have been severely understudied (Goya Arce et al., 2022). In particular, Latinx adults are more likely to experience ACEs than non-Latinx Whites (Rassu et al., 2020). They are also disproportionately impacted by chronic pain and more vulnerable to psychological distress (Rassu et al., 2020). Latinx adults are at a greater likelihood to experience ACEs in the form of racial or ethnic discrimination, which may be related to their experience of pain (Green et al., 2003, Rassu et al., 2020). In turn, racial and ethnic discrimination is more likely linked to greater pain severity among Latinx adults (Rassu et al., 2020).

Chronic pain is one of the most reported concerns among Latinx adults (Green et al., 2003). Latinx adults report experiencing pain more frequently and severely than their White counterparts (Grol-Prokopczyk, 2017). Furthermore, Latinx adults report pain at a greater prevalence and higher levels of pain-related anxiety (Flores et al., 2020). Yet, Latinx adults are more likely to experience poor pain management and longer wait times to receive care by health care professionals (Epps et al., 2008). They are also more likely to underreport pain severity, which may result in less-than-sufficient treatment. Other factors in this prevalence are related to social determinants of health, such as lower socioeconomic status (SES) (Goya Arce et al., 2022). Latinx adults also represent a large percentage of the U.S. workforce's manual labor, which places them at greater risk for injury and chronic stress (Bureau of Labor Statistics [BLS], 2010). Taken together, Latinx patients experience specific barriers to treatment that are specific to them such as lower health literacy and SES, and immigration or acculturation challenges (Flores et al., 2020).

Pain can be seen among Latinx adults as a common problem that does not need treatment compared to non-Latinx Whites (Rassu et al., 2020). Latinx adults hold several cultural beliefs regarding pain, such as simpatía, which is the cultural belief in seeking harmony and respect within family and friendships while avoiding conflict and negativity (Acevedo et al., 2020; Triandis et al., 1984). Other beliefs are that pain is a predestined part of life that should be navigated with a sense of stoicism and should not interfere with interpersonal relationships (Sherwood et al., 2003). These beliefs may make it difficult for Latinx adults to seek appropriate care or answer health care questionnaires appropriately. Instead, Latinx cope by utilizing self-management strategies such as prayer, exercise, seeking chiropractic care, and using pain relief creams instead of medication management, which have been found beneficial for this population (Flores et al., 2020).

The pain experience for Latinx patients presents in distinct ways such as reporting pain that may be mild as more severe or underreporting the severity of intense pain due to mistrust. To reduce the disparate gap in health care treatment, it is our responsibility as psychologists or trainees to acknowledge and address these differences. To deconstruct these barriers, we must examine and dispel our race-related judgments about the pain experience to engender trust in our patients. These patients are often skeptical and mistrust health care professionals due to a pervasive history of racism and oppression (Whaley, 2001). We want to collaborate with patients transparently and include them in the treatment process. Finally, we want to encourage and recruit Latinx providers into health care to diversify representation, but we want to be mindful not to pigeonhole Latinx providers into only working with minority patients as that is an improper expectation.

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THE TREATMENT OF HEADACHE, MIGRAINE, AND TRAUMATIC BRAIN INJURY (TBI)

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Many psychologists feel uncomfortable treating headache, migraine, or traumatic brain injury (TBI) as the primary presenting concern for therapy. However, psychotherapeutic interventions are often effective and within the realm of training for most psychologists. We hope to provide an overview on these diagnoses, outline existing treatment research, and provide supporting approaches to aid a client coping with headache, migraine, or TBI.

HEADACHES AND MIGRAINES

There are many forms of headache, including tension headache, cluster headache, allergy/sinus headache, rebound headache, and migraines. Typically, headaches and migraines are diagnosed and treated as separate medical issues (Gilmore & Michael, 2011). While headaches are more common, roughly 18% of women and 6% of men in the United States are estimated to have migraines and about half of these individuals report reduced work or school productivity (Lipton et al., 2001). Migraines may also be differentiated diagnostically based on whether they are accompanied by an aura. The International Headache Society (2018) defines migraines without aura as:

- Lasting at least 72 hours
- Experiencing at least two of the following: aggravation causing avoidance of routine physical activity, moderate or severe pain intensity, pulsating quality, and unilateral location
- During the headache, there must be at least one of the following: nausea and/or vomiting and/or sensitivity to light or sound.

TRAUMATIC BRAIN INJURY

A TBI is a disruption to normal brain function caused by a blow to the head, the head violently striking an object, or an object piercing the skull and entering brain tissue (Agarwal & Thakkar, 2020). Often there is a loss or decrease in consciousness, amnesia for events prior to or following the trauma, specific cognitive deficits like muscle weakness, loss of vision, change in speech, disoriented or slowed thinking, or trouble with concentration.

In 2014, the United States saw approximately 2.87 million TBIs, with more than 837,000 in minors. Approximately, one-third of all traumatic deaths are a result of head injury. Currently, 13.5 million individuals in the United States are disabled due to TBI, with males representing the majority (78.7%) of reported TBI accidents. The highest rates of TBI are observed in older adults (≥75 years), the very young (0 to 4 years), and young adults (15 to 24 years; Centers for Disease Control and Prevention, n.d.). TBI symptoms depend on the severity of the incident (mild, moderate, or severe) of injury and may include vomiting, lethargy, headache, confusion, paralysis, coma or other loss of consciousness, dilated pupils, vision changes, cerebrospinal fluid (clear or blood-tinged) appearing from the ears or nose, dizziness and balance concerns, breathing problems, slow pulse, slow breathing rate accompanied by increase in blood pressure, ringing in the ears or changes in hearing, cognitive difficulties, inappropriate emotional responses, speech difficulties, difficulty swallowing, body numbness or tingling,

droopy eyelid or facial weakness, and loss of bowel control or bladder control (Agarwal & Thakkar, 2020).

Groups at highest risk for TBI are racial and ethnic minorities, service members and veterans, people experiencing homelessness, people in correctional and detention facilities, and survivors of intimate partner violence (Barman et al, 2016). Military service members with TBIs often have higher rates of posttraumatic stress disorders, depressive disorders, substance use disorders, anxiety disorders, and higher rates of suicide attempts (Greer et al., 2020).

EVIDENCE-BASED TREATMENTS

Numerous meta-analyses, individual studies, and randomized control trials (RCTs) provide behavioral and cognitive treatments for headache, migraines, and TBI. We will provide only a brief overview here and will not address the plethora of studies on pharmacological treatments and supplements that are shown to be effective as well.

Most well-established behavioral interventions for headaches, migraines, and TBI are focused on cognitive behavioral therapy (CBT), relaxation training/stress management, and bio-/neurofeedback. Meta-analyses broadly show that these interventions yield statistically significant improvement in migraine and tension-type headache compared to control conditions (Rains et al., 2005; Holroyd & Drew, 2006) with more recent meta-analyses yielding mixed results (e.g., Verhagen et al., 2009).

In general, CBT supports individuals in altering negative thinking into more neutral cognitions via cognitive restructuring, behavioral activation/activity scheduling to reduce isolation, successive approximation to enhance motivation, communication skills training, and emotion regulation skills (Gómez-de-Regil et al., 2019). Cognitive rehabilitation has also been shown to support those coping with a TBI (Daugherty et al., 2019).

There is also emerging evidence that mindfulness-based interventions and acceptance and commitment therapy (ACT) are highly effective in treating headaches and migraines in particular (Smithernan et al., 2015). ACT approaches vary from standard behavioral strategies for headaches and migraines aimed at preventing symptoms by avoiding triggers (which may result in lifestyle restrictions and a decrease in internal locus of control), as well as emphasizing acceptance and valued living as alternatives to avoidance (Vasiliou et al., 2021).

Mindfulness interventions include mindfulness-based stress reduction and mindfulness-based cognitive therapy with "a specific practice that builds one's attention and awareness by initially focusing on physical bodily sensations, such as the breath, and returning the attention back again whenever the mind wanders away from the intended attentional focus. As the practice progresses, moment-to-moment awareness of body sensations, emotions, and thoughts are enhanced with an attitude of acceptance and non-judgement, with a transition from focused attention to open

awareness" (Wells et al., 2020, pp. 209–210). Mindfulness approaches are also applicable to TBI, whereby focusing on realistically achievable acceptance of the injury and related changes is an imperative part of psychotherapy.

Other important treatment approaches include increasing caregiver support and providing psychoeducation to address the patient's bio-psycho-social system. It can also be very helpful for longtime TBI, headache, or migraine patients to seek care at neurology practices that specifically target these issues. Sometimes nonspecializing physicians can treat patients as though they are malingering, when it may in fact be the treating providers' own sense of helplessness to manage the patient's pain that is creating that belief. Lastly, Neha Dixit, PhD, a Pennsylvania neuropsychologist who has worked with dozens of patients coping with effects of TBI, recommends disentangling the mechanisms of brain damage versus emotional trauma of brain injury. She says, "the symptoms are often the same but the mechanisms are different" and reiterates that it is imperative to validate the patient's experience and acknowledge that they are not "faking" their symptoms. At the same time, it is important to recognize that physical symptoms become exacerbated in times of stress or during negative mood states.

CONCLUSIONS

We hope that this article provides an introductory overview of some of the ways psychologists can effectively intervene with patients experiencing headache, migraine, and TBI. We suggest that you begin working with individuals coping with these concerns by asking about the emotional, cognitive, behavioral, and social aspects of their symptoms and develop a treatment approach that is consistent with your expertise. In other words, there are multiple ways of treating these symptoms that you are already using in your practice!

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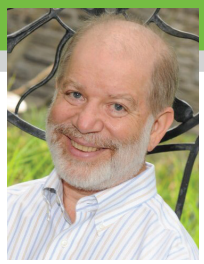

CBT FOR DEPRESSION AND ANXIETY IN INTEGRATED CARE SETTINGS

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Depressive and anxiety disorders are highly prevalent. If left untreated, these disorders can have a significant impact on a person's quality of life. Cognitive behavioral therapy (CBT) is effective in the treatment of depression and anxiety and its effects are comparable with those of antidepressant medication in the short term (Cuijpers et al., 2019). It is also likely more effective than medication in the longer term (Cuijpers et al., 2019) because it teaches patients a variety of coping tools that can be incorporated into their life and maintained with practice. CBT helps patients to identify unhelpful and self-defeating beliefs that undergird maladaptive coping responses and adjust belief structures that are ultimately more healthy and functionally effective.

While combined treatment is more effective than either psychotherapy or pharmacotherapy alone, the majority of patients prefer psychotherapy over pharmacotherapy (Cuijpers et al., 2019). CBT has been found to be effective in primary care settings, which for many patients, especially the underserved, function as de facto mental health clinics, and increase the likelihood of participation in care since it is provided in a "one stop shopping" environment (Zhang et al., 2019). Of note, some effect sizes in research on CBT for depression are small in comparison to treatment as usual; however, these outcomes are likely still clinically important given the high prevalence of depression seen in this setting (Santoft et al., 2019).

Psychologists providing evidence-based treatments in primary care improve patient access and reduce physician care burdens. Psychologists are uniquely and expertly prepared to implement evidence-based behavioral health and psychotherapeutic interventions while working collaboratively with interdisciplinary care providers based on their extensive training and supervised clinical experience treating a wide variety of problems, including those that are comorbid with depression and anxiety, such as sleep disorders, pain, and substance misuse, to only name a few (Santoft et al., 2019; Zhang et al., 2019).

CBT interventions may get better results when delivered in individual sessions versus group therapy and when combined with motivational interviewing (Zhang et al., 2019). As technology continues to advance, it is worth noting that CBT appears to work just as effectively for treating depression and anxiety disorders in primary care when delivered via telehealth or in person (Zhang et al., 2019).

COMMONLY USED CBT STRATEGIES IN A PRIMARY CARE SETTING

Behavioral Activation

Avoidance is a common characteristic present in depression and anxiety. According to Boswell et al. (2017), "behavioral activation strategies work to undermine punishment and increase positive reinforcement from one's environment through decreasing avoidance and promoting more adaptive self-regulation" (p.231). Behavioral activation components often include daily activity scheduling with mastery and pleasure ratings (Beck et al., 1979), and evaluation of predicted satisfaction contrasted with actual satisfaction post-activity using the Pleasure Predicting Sheet and Anti-Procrastination Sheet (Burns, 2018).

Cognitive Restructuring

Individuals are taught to actively reinterpret the anxiety-inducing aspects of a stimulus, thereby reducing negative emotional responses when the stimulus is encountered and using cognitive reappraisal to reinterpret stimuli in a less negative way (Beck & Emery, 1985). The process includes a combination of helping

the individual develop awareness of negative self-statements (e.g., "I'll never be able to manage my blood sugar."); understanding the vicious cycle of negative thinking, emotions, and behaviors and its impact on maintenance of presenting problems; and replacing those unhelpful patterns with more positive, adaptive and realistic coping statements and behaviors that are grounded in the science of recovery (e.g., "I can manage this one step at a time.") (Glogower et al., 1978). Additional components and tools of cognitive restructuring include restructuring automatic thoughts, modifying cognitive distortions, reframing, adaptive thought records, and behavioral rehearsal (Beck, 2021).

Psychoeducation

Goals of psychoeducation may include (1) aiding the individual (and family) in understanding the illness/diagnosis and the principles of recovery; (2) exploring the physiology and etiology of depression/anxiety; (3) identifying common signs and symptoms, coping strategies, and treatment options (e.g., CBT); and (4) in conjunction with the medical team, helping the individual decide how and when to seek treatment.

Exposure Therapy

Exposure-based techniques are some of the most commonly used CBT methods for treatment of anxiety disorders. Exposure therapy is a form of CBT that is commonly used to assist in reducing avoidant behavior driven by anxiety. It was designed to modify the pathological fear structure by first activating it, then providing new information to disconfirm faulty associations in the structure. By carefully and gradually confronting the feared stimulus/response, followed by introducing corrective information and experiences, fear and maladaptive avoidance are expected to decrease (Kaczkurkin & Foa, 2015). The four primary ways that exposure therapy works are through habituation, extinction, self-efficacy, and emotional processing. Over time, reactions to feared stimuli decrease, previous associations with feared stimuli and bad consequences are weakened, the capability to confront fears and manage feelings of anxiety are recognized, and attachment of new, more realistic beliefs about feared stimuli/increased comfort with the experience of fear are created (American Psychological Association, 2017).

Older Adults

CBT can be effective as a treatment for older adults, those with general medical disorders, and persons with perinatal depression (Cuijpers et al., 2019). With older adults, it is essential to distinguish between dementia and depression, which may mimic dementia (pseudodementia), and polypharmacy and the side effects of multiple medications which can affect mood, substance misuse (alcohol, abuse of prescribed and nonprescribed medications), and chronic versus late onset depression. Depression in the elderly is not always easily self-identified, and may be expressed more commonly by means of multiple vague complaints of not feeling "right" or "like oneself" or the concerns of significant others or family members.

Often, depression is associated with loss of social support and loss of meaning in life, and it is mirrored by a decline in functioning and execution of premorbid activities of living such as self-care and independence (e.g., mobility, cooking, bathing, dressing) and overall well-being. Anxiety regarding loss of independence may be denied or overtly minimized, for fear of becoming financially and physically vulnerable and dependent upon the decisions of others.

CBT focuses on dispelling the myth (which is often held by patients and professionals alike) that "depression is just a natural outcome of aging," and helping patients to appropriately grieve their losses in social networks and functioning, while emphasizing the positive abilities that still reside within their control (Zahn & Zahn, 2006). Techniques can include cognitive restructuring (focusing less on what one can no longer do independently to what one can still accomplish with or without support), challenging regret orientation and replacing that with healthy acceptance, meaning-making through realistic goal setting and activities, and keeping an open and inquisitive mind toward outcomes, rather than automatically presuming that one is no longer capable or has diminished value to others (Gallagher-Thompson et al., 2008).

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CONSIDERATIONS FOR TEACHING IN PRIMARY CARE SETTINGS

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The Accreditation Council for Graduate Medical Education (ACGME) accredits all graduate medical training programs for physicians in the United States. The ACGME creates and enforces competencies for medical residencies. Family medicine (FM) program requirements include that "there must be faculty members dedicated to the integration of behavioral health into the educational program" and "the curriculum must be structured so behavioral health is integrated into the residents' total educational experience, to include the physical aspects of patient care" (ACGME, 2022). These requirements increased the behavioral health focus on training in FM residencies and created more opportunities for behavioral health clinicians (BHC, e.g. psychologists) to be residency faculty. Reiter et al. (2018) report, "The BHC works as a generalist and an educator who provides high volume services that are accessible, team-based, and a routine part of primary care" (p. 112). Though such integration has been happening for over a decade there are continued calls for competencies and continued research to further standardize and enhance behavioral health teaching in integrated settings (Ogbeide et al., 2022).

Teaching in primary care settings while designed for FM learners can also be applicable to psychology learners. BHCs can teach FM (and psychology) learners through a variety of approaches in medical settings. Residents who have comanaged more than five patients alongside BHCs report significantly higher confidence in providing care and communicating with patients with common behavioral health conditions (Hemming et al., 2017; Hemming et al., 2018). Additional teaching and experiential learning approaches for behavioral health include shared precepting, lectures, video or direct observations, clinic huddles, warm handoffs, shadowing, and research collaboration (Porcerelli et al., 2013).

Co-/shared precepting often involves the BHC sitting alongside a physician preceptor to listen to the FM resident talk about a patient they are currently seeing in clinic. FM residents need to review all their patient encounters with a physician preceptor who helps them shape, and ultimately signs off on, their treatment approach. BHCs listen along with the physician preceptor and help FM residents consider psychosocial aspects of engaging with, assessing, and treating their patients. For example, the FM resident may talk about a patient feeling "anxious." The BHC can help guide the FM resident in considering questions and screeners (e.g., GAD-7) to use with the patient to help build their differential and better guide their treatment plan. Of note, during the pandemic, it was found that coprecepting can be done successfully through telehealth (Kowalski et al., 2020).

Through feedback from direct observations and video reviews of FM resident encounters, BHCs help residents build critical patient engagement skills. This includes helping them hone their skills in setting an agenda, using empathetic statements, building rapport, assessing behavioral health needs, redirecting patients, reducing their use of medical jargon, applying practical feedback with techniques such as motivational interviewing, and managing patients in psychiatric crisis. FM residents graduate medical school with varying levels of training and competence in interpersonal communication and professionalism. FM residents benefit from skill sets that are integral parts of BHC training, such as improving their frequency and skill in use of open-ended questions.

Two areas for consideration are ethics and time limits. Educating learners in FM settings creates challenges due to the difference between the ethics codes of psychologists and physicians. Kaddari et al. (2018) found that family physicians and psychologists behave similarly when confronting dilemmas concerning confidentiality, inappropriate practice due to personal problems, improper professional conduct, and academic issues. However, family physicians and psychologists endorse different behaviors when confronting payment issues or dual relationships. One specific example is that psychologists more often decline to treat a colleague's child, while physicians are more likely to not treat a patient without continued payment.

FM learners are often pressed for time. They are routinely expected to stay on schedule with as many as 10 appointments in a 4-hour period. This means that all faculty need to be mindful about how much time they spend with each resident during precepting, while balancing the needs of the patient, the resident, and the clinic staff (e.g., nurses). BHCs need to consider how they can teach quickly, distilling information down to the most critical components for the benefit of all.

PHYSICIAN PERSPECTIVE

Working alongside a psychologist while serving as a FM faculty preceptor in a residency program has been an enriching and clearly positive experience. As I expected, a BHC was able to provide expert insight and teaching in the "precepting room" regarding evaluation and management of common behavioral health patient issues (e.g., anxiety, depression, adjustment reactions, personality disorders, attention-deficit/hyperactivity disorder, posttraumatic stress disorder). However, without the benefit during my own FM residency of having a BHC as part of my clinic training, I had not anticipated the extended benefit of a BHC in the precepting environment (both in the outpatient and inpatient care settings). Our psychologist has brought clear expert (and practical) advice for our FM residents regarding agenda setting, motivational interviewing, and building communication skills within patient-provider therapeutic interactions.

Our FM residents benefit from the BHC coprecepting with a physician to build the necessary skill set of primary care behavioral health management. I had not anticipated the personal growth toward my own clinical approach as well as my precepting/teaching skills in working with our psychologist. Myself and other faculty elicit feedback from our psychologist regarding precepting interactions with our FM resident-learners and the variety of personal and professional areas for growth for each resident. In essence, working alongside a BHC has served as a longitudinal behavioral health and educator faculty development program.

Additional benefits such as peer mentorship and coauthorship for scholarship have also been personal and professional gains for myself and other FM physician faculty in our department. I would highly support the addition of a BHC for any FM residency program. I also encourage medical students applying to FM programs to seek out residencies with the inclusion of a BHC with both formal and informal behavioral health curriculum, education, and coprecepting as well as for personal development/support and wellness during the challenging years of residency.

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Calendar

Friday, January 27, 2023
The Minds, Lives, and Motivations of Mass Attackers
Webinar
2:00 - 5:00 pm

Friday, January 27 - Sunday, January 29, 2023
Wellness Weekend
Inn at Leola Village
Leola, PA

Thursday and Friday, March 30-31, 2023
PPA's VIRTUAL Spring Conference

Wednesday, June 21 - Saturday, June 24, 2023
PPA2023 Convention
In-person at The Penn Stater Hotel & Conference Center
State College, PA

Thursday and Friday, October 5-6, 2023
PPA's VIRTUAL Fall Conference 2023

November 30, 2023
License Renewal Deadline for Psychologists in Pennsylvania

Wednesday, June 12 - Saturday, June 15, 2024
PPA2024 Convention
Lancaster Marriott at Penn Square
Lancaster, PA

Home Study CE Courses

Act 74 CE Programs

Essential Competencies when Working with Suicidal Patients—1 CE
Four Ways to Enhance Your Suicide Assessments (Webinar)—1 CE
Talking about Suicide: The Patient's Experience and the Therapist's Experience (Webinar)—1 CE
The Assessment, Management, and Treatment of Suicidal Patients: 2020—3 CE
The Essentials of Managing Suicidal Patients: 2020—1 CE
The Essentials of Screening and Assessing for Suicide among Adolescents—1 CE
The Essentials of Screening and Assessing for Suicide among Adults—1 CE
The Essentials of Screening and Assessing for Suicide among Older Adults—1 CE
The Essentials of Treating Suicidal Patients—1 CE

Act 31 CE Programs

Pennsylvania Child Abuse Recognition and Reporting—2 CE Version
Pennsylvania Child Abuse Recognition and Reporting—3 CE Version
Pennsylvania Child Abuse Recognition and Reporting (Webinar)—2 CE

General

Ethical Issues with COVID-19 (Webinar)—1 CE*
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Act 74 CE Programs qualify for the suicide requirement mandated by the Pennsylvania State Board of Psychology.

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