REVIEW

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A primer on referring patients for psychotherapy

ABSTRACT

Forty percent of the mental health care in this country is provided by primary care practitioners alone, and another 20% is provided by primary care practitioners working with mental health professionals. Primary care physicians can serve a valuable role by educating their patients about various forms of psychotherapy. Finding a good "fit" between patient and therapist is crucial to a good outcome. We discuss which psychotherapeutic techniques are appropriate for various emotional problems and the advantages and disadvantages of each.

KEY POINTS

In many situations, psychotherapy should be combined with pharmacotherapy, as it can enhance the durability of pharmacologic treatments.

Cognitive-behavioral therapy is based on the assumption that maladaptive thoughts and behaviors are learned from experience, and that they can be modified through corrective experiences.

Interpersonal therapists attribute psychiatric problems to difficulties in current interpersonal relationships. Patients are taught better interpersonal skills to resolve problematic relationships.

Psychodynamic therapists attribute problems to internal unconscious conflicts dating from childhood. The conflicts are played out in the therapist-patient relationship, and insight into these conflicts is used to help resolve them.

Client-centered therapists strive to make the therapist-client relationship an ideal human relationship, characterized by empathy, genuineness, and active listening. Such an atmosphere is thought to encourage personal growth.

PRIMARY CARE PHYSICIANS provide much of the nation's mental health care, but they generally do not have the time or the training to provide psychotherapy. Familiarity with the main types of psychotherapy will help in:

- Clinical decision-making
- Timely, accurate referral of patients who can benefit from psychotherapy
- Communicating with mental health specialists
- Overcoming patients' prejudices against psychiatric care.

In this article, we present a brief primer on two empirically based models of psychotherapy (cognitive-behavioral and interpersonal therapy) and two insight-oriented models (psychodynamic and client-centered therapy).

We also discuss four formats in which psychotherapy is typically administered: individual, family, marital or couple, and group (both ordinary group meetings and intensive outpatient programs).

Readers interested in enhancing their own psychotherapy skills and the practical application of psychotherapeutic techniques will find the reference list helpful.

PRIMARY CARE PHYSICIANS PROVIDE HALF OF MENTAL HEALTH CARE

Primary care physicians carry an inordinate share of the burden of mental health care. Epidemiologic studies have estimated that 20% to 25% of patients in primary care settings have a psychiatric disorder.[1] Primary care practitioners are the sole providers of 40% of the mental health care in this country, and they work with mental health professionals in another 20% of cases.[2]

Nevertheless, time constraints and competing responsibilities make it difficult for primary care practitioners to diagnose and treat psychiatric conditions.[3] Stigmatization of mental illness, confidentiality requirements, and limited third-party coverage for treatment of mental disorders compound the challenge, especially now that practitioners face more stringent productivity demands and documentation requirements.

Under these conditions, psychotherapy may be underutilized. Primary care physicians generally do not have expertise or training in psychotherapy, nor do they have time to provide it. In addition, information about psychotropic drugs is often more widely disseminated than information about behavioral and psychological therapies. Many of the clinical practice guidelines for the primary care physician[4,5] emphasize pharmacologic management of psychiatric problems, and many research studies and continuing medical education programs on mental health are sponsored by pharmaceutical companies and emphasize the use of psychotropic medications.

Psychotherapy is effective for depression and anxiety

Although pharmacologic management is frequently appropriate, psychotherapy is indicated for many disorders. For example, psychotherapy is effective for the acute control of symptoms associated with depression, anxiety, or problematic adjustment to medical illness, and is useful when used alone for mild to moderate depression and other psychiatric disorders. In many situations, psychotherapy should be combined with pharmacotherapy, and it can enhance the durability of pharmacologic treatments.[5,6]

More than 250 models of psychotherapy have been described, each based on distinctive theories of etiology and change.[7] Here, we describe four currently used models.

WHEN TO REFER A PATIENT TO A MENTAL HEALTH SPECIALIST

Many cases of depression or anxiety can be handled effectively in the primary care setting. Indeed, many are self-limited and require no intervention.[8] However, referral to a mental health specialist should be considered if any of the following are true:

- The patient's medical problems are so complex that there is inadequate time to attend to coexisting mental health problems
- The patient has complex or high-risk psychiatric problems
- The primary care practitioner lacks the requisite interest or expertise to manage the mental health problem
- One or, at most, two trials of psychotropic medications, under the direction of the primary care physician, have failed
- The patient requests evaluation and treatment by a mental health specialist.

The success of referral depends on the availability of mental health specialists, the primary care practitioner's familiarity with mental health specialists and their specialty interests, and the patient's willingness to accept the referral recommendation.[5] Inconvenience, poor access, and stigma are common reasons that patients do not follow through with suggested referrals.

A skillful recommendation by the primary care practitioner can minimize stigmatization and the patient's perception of being rejected or "dumped." If the physician stresses that the apparent cause of the problem is psychological, a patient may believe that the physician has dismissed the problem as "all in your head." Instead, it is often better to discuss psychiatric treatment in terms of its goals, which are to resolve the patient's symptoms and to restore function. Such an approach destigmatizes the referral by enlisting the mental health specialist as a team member who shares the goals of both the patient and the primary care practitioner.

COGNITIVE-BEHAVIORAL THERAPY

Case study: A man worried about hypertension

A 50-year-old man was chronically worried about his high blood pressure. Yet the patient was reluctant to use medications for either hypertension or anxiety. He was single and worked as both a college professor and business consultant. His days were demanding, and he had a tendency to become overwhelmed and develop physical symptoms of panic. The chronicity and intensity of worry and psychophysiologic activation were consistent with a diagnosis of generalized anxiety disorder.

His primary care practitioner referred him to a cognitive-behavioral therapy specialist.

The therapist used a variety of strategies to help the patient manage his anxiety. At first, the patient kept records of situations that provoked worry and panicky feelings and received instruction about methods for appraising the content and consequences of his worry. Next, he was taught strategies for confining worrying to a once-daily "worry period," and he rehearsed skills designed to enhance present-moment awareness. To learn to alter patterns of physiologic arousal, he was given a relaxation audiotape and additional instructions for using the relaxation skills in real-life settings.

The therapist also explored the patient's beliefs about medicines, learning that he valued personal control and disliked symbols of external governance and submission. He was fearful about side effects, as well. After cognitive interventions to alter faulty beliefs about medicines, the patient agreed to take low doses of antihypertensives. This regimen was thus successful at managing both the patient's hypertension and his generalized anxiety.

Assumptions and key concepts in cognitive-behavioral therapy

Cognitive-behavioral therapy is based on the understanding that thoughts and behaviors are learned from experience, and that faulty learning experiences produce maladaptive patterns of thought and action.[9] Under the cognitive-behavioral therapy model, emotional distress is considered to be the result of an A-B-C process: activating events (A) trigger maladaptive beliefs or behaviors (B), which produce negative emotional consequences (C) such as anxiety and depression.

The cognitive-behavioral therapy model suggests that thoughts and behaviors are modifiable, and that patients can learn more rational ways of thinking and more efficient and adaptive behaviors. Therapy is viewed as a program of learning. Faulty learning experiences are identified and challenged, and new thoughts and behaviors learned. Thoughts are described as rational or irrational, and behaviors are described as adaptive or maladaptive.

Therapeutic strategies in cognitive-behavioral therapy

A wide variety of treatment techniques have been developed and studied. Most are designed to create a corrective experience. For example, exposure-based methods in which patients confront feared events are commonly used to treat anxiety disorders such as obsessive-compulsive disorder, panic disorder, and social anxiety disorder.

For depression, patients are taught to monitor and ultimately dispute disparaging views of the self, the world, and the future to promote more favorable mood states. This procedure is termed "cognitive restructuring." The therapist may add adjunctive strategies, such as relaxation training for somatic symptoms including headache, hypertension, and insomnia.

Additionally, systems of reinforcement that lead to dysfunctional behaviors are altered. For instance, a patient's chronic pain behaviors may be maintained in part by the subtle rewards provided by frequent doctor visits, financial compensation from disability payments, relief from responsibility, and gratification of dependency needs. Cognitive-behavioral treatments would attempt to upset this constellation of contingencies and require higher levels of function from the patient.

In cognitive-behavioral therapy, patients learn more adaptive behaviors

In cognitive-behavioral therapy, the patient is also expected to acquire therapeutic strategies that can ultimately be self-administered to minimize the potential for relapse.

Therapy is often completed in 8 to 16 sessions. The therapist functions as an active instructor who self-discloses more freely than the traditional psychoanalytically oriented therapist. Homework and record-keeping assignments help promote skill development.

Treatment goals in cognitive-behavioral therapy

Measurable symptom reduction is the usual target of cognitive-behavioral therapy. For example, depression inventories may be used to measure progress in treating depression. Other goals such as developing more effective behaviors, decreasing avoidance behavior, and governing mood can also be operationalized (expressed in terms of specific and measurable outcomes) and assessed.

Advantages of cognitive-behavioral therapy

Because of its emphasis on measurable goals, cognitive-behavioral therapy has been extensively studied and empirically validated. Thus, it is included in practice guidelines as a recommended treatment for anxiety and mood disorders,[5] and it is favored by third-party payers, which typically request behaviorally operationalized treatment plans with specific strategies and goals. Patients also value the approach because it is interactive, short-term, and devoted to both symptom reduction and skill development.

Disadvantages of cognitive-behavioral therapy

Cognitive-behavioral therapy requires patients to participate actively in their own treatment by monitoring themselves and doing homework. Patients who are unmotivated, suffering from inertia caused by depression, or otherwise resistant may not be able to exert the required energy.

Cognitive-behavioral therapy also requires therapists to be robust in their efforts and energy.

Psychodynamic theorists criticize cognitive-behavioral therapy for neglecting underlying psychic conflict, and other critics suggest that patients may experience symptom substitution, that is, manifest new symptoms after suppressing old ones.

Interpersonal therapy is short-term and focuses on conflicts with others

INTERPERSONAL THERAPY

Case study: A widower unhappy in a new relationship

A 36-year-old widowed man reported a 4-to-6-month history of insomnia, tension, and fatigue. His comments also suggested problems in his current dating relationship. Although the woman he was dating appeared loyal and had established a good relationship with his 4-year-old son, the man felt that she was overly critical and judgmental. He worried that she objected to things he valued. They had numerous breakups and reconciliations. The primary care practitioner referred the patient for psychotherapy with a specialist in interpersonal therapy.

The therapist found the patient to be pensive and ruminative. His history was remarkable for a difficult first marriage that ended in divorce that the wife initiated just months before her death from cancer. Although the patient had never had difficulty establishing relationships with women, his tendency to worry about potential future conflict got in the way.

Using interpersonal therapy techniques, the therapist helped the patient explore feelings about the dual abandonment in his first marriage. The therapist and the patient also explored his emerging roles as a single man and as a single parent. The treatment focused on examining patterns of conflict in his marriage and in his dating relationship. His tendency to analyze and predict future mishaps was recognized as a potential inhibiting factor, yet also as a natural outgrowth of his marital history.

The patient was taught skills for addressing conflict (ie, how to raise issues of conflict with others), resolving conflict, and separating the emotions generated from his difficult marriage from his feelings about his current relationships. With some difficulty, he decided to terminate his dating relationship and focus on his role as a single father.

Assumptions and key concepts in interpersonal therapy

Developed in the early 1980s, interpersonal therapy is based on the theory that psychiatric disorders derive principally from current interpersonal experience.[10] The goal is to alter one's interpersonal competencies and experience in a short-term, present-focused manner. Improvements in communication and interpersonal skills are assumed to improve self-concept and lead to more effective coping strategies and greater connectedness in relationships.

Four areas are the targets for intervention in the interpersonal therapy model:

- Grief from loss or abandonment
- Role transition (such as starting a new job, getting married, or becoming a parent)
- Interpersonal disputes or conflicts
- Interpersonal deficits (such as critical or cynical styles of interpersonal communication that alienate others).

Under the interpersonal therapy model,

problems in one or more of these domains result in unpleasant or pathological emotional experiences.

Therapeutic strategies in interpersonal therapy

Like cognitive-behavioral therapy, interpersonal therapy is an active form of treatment that promotes new skill development and behavior change. Treatment is generally designed to be conducted over a short period of time. Because interpersonal therapy focuses on interpersonal conflict, common strategies are clarification of role disputes, analysis of interpersonal communications, active behavioral alterations, and encouragement of affect (external expression of emotion). The patient's current interpersonal experiences are the target of interpersonal therapy. The therapist teaches new adaptive behaviors in order to enhance interpersonal communication and enrich interpersonal skills, and thereby reduce negative emotional states and psychopathology.

Treatment goals in interpersonal therapy

Goals of interpersonal therapy include minimizing conflict among various interpersonal roles, mastering grief reactions, resolving disputes, and correcting communication deficits. Another goal is to help patients become increasingly self-sufficient with durable skills to prevent relapse. Like cognitive behavioral therapy, interpersonal therapy emphasizes the prevention of relapse, is considered an evidence-based therapy, and has been empirically tested.[10]

Cognitive-behavioral therapy and interpersonal therapy have been tested empirically

Advantages of interpersonal therapy

Like cognitive-behavioral therapy, interpersonal therapy is attractive to insurance carriers because it offers short-term, behaviorally specific treatment plans and focused, measurable outcomes. By teaching conflict resolution, role clarification, and skill development, it teaches strategies for effective living.

Disadvantages of interpersonal therapy

Interpersonal therapy requires that the patient be an active participant, not a passive recipient of treatment. The patient must implement new behavior strategies for treatment to be successful. Critics claim that interpersonal therapy is too narrow in its emphasis on interpersonal dilemmas and neglects intrapsychic conflicts. It has been studied primarily as a treatment for depression, and its efficacy for other disorders including somatic conditions is as yet unclear.

PSYCHODYNAMIC THERAPY

Case study: A woman with headache and fatigue

A 47-year-old accountant consulted her primary care practitioner because of enduring headaches and fatigue. During the visit, she attributed a great deal of tension to her relationship with her critical and vindictive male boss. She also admitted feeling like an inadequate mother and spouse. The primary care practitioner diagnosed major depression and recommended antidepressant medication. The evidence of intrapersonal and interpersonal conflict led to the additional recommendation that she undergo evaluation for psychotherapy. The patient disliked the thought that she needed to see a "shrink," but she agreed to follow her physician's advice.

At the first meeting with the therapist, who was psychoanalytically oriented, the patient presented a history suggesting longstanding difficulties with authority figures, especially her father. She had become a perfectionist, presumably in response to his prediction that she "would never amount to anything." She had set ambitious career goals, but she tended to procrastinate and to feel victimized by the political climate of her large organization. As if living out her father's prediction, she rarely completed assignments on time and was not considered a candidate for promotion.

The psychotherapeutic treatment strategy was to examine how these characteristics surfaced in the relationship with the therapist (transference). From the beginning, the patient appeared to expect that the therapist would be critical of her. She worried that she was wasting his time and that he would ultimately reject her.

The therapist helped the patient practice interpretation, a technique that helps the patient see the link between her current attitude toward the therapist and similar attitudes

toward important figures of the past. The patient developed an understanding of her lifelong pattern of self-defeating behaviors. She began to see that perfectionism was a self-defeating attempt to overcome criticism and win approval. It became clear that her procrastination and missed deadlines were responses to her fear of criticism and failure.

The therapist's comments facilitated expression of the anger and frustration that had fueled tension both at work and at home. Gradually, the patient's self-esteem improved, and her perfectionist strivings and tendency to procrastinate diminished. Both her headaches and her mood improved significantly.

Assumptions and key concepts in psychodynamic therapy

Psychodynamic therapies assume that problems in living occur as a result of internal and often unconscious conflicts, which may date back to early childhood. These conflicts are thought to repeat themselves, not only in the current life of the patient, but also in the therapeutic relationship. Grief work, ie, the process of coming to terms with loss, is an important focus of psychodynamic psychotherapy.

Psychodynamic theorists, particularly Sigmund Freud, suggest that unconscious conflict occurs between the id (human primitive impulses) and the superego (the conscience). The ego (conscious experience in the world) is considered the mediator of the conflict. Ineffective mediation results in psychopathology. Insight into the conflict is considered necessary for the success of the treatment.

Therapeutic strategies in psychodynamic therapy

The psychodynamic therapist attempts to make the patient conscious of these unconscious conflicts by interpreting the patient's relationship to the therapist, any resistance to therapy, and links to past relationships and conflict. The therapist tends to be rather nondirective and interpretive. The therapist is trained not to self-disclose so that a patient will view the therapist through his or her own idiosyncratic lens and reenact the conflict within the treatment setting. In short, the treatment relationship is viewed as a microcosm of the patient's world and is a source for interpretive intervention.

Treatment goals in psychodynamic therapy

The goal of treatment is insight, self-understanding, and working through and resolving conflicts or repressed emotions. Therapy is expected to remove barriers to living more efficiently and effectively, so that the patient's ability to live, love, and work will be enhanced. Psychodynamic treatment is often used for anxiety and depression but can also be used for conditions in which physical symptoms have their origin in psychological stress: eg, somatization, hypochondriasis, and conversion disorders.

Advantages of psychodynamic therapy

Psychodynamic psychotherapy is useful for patients whose symptoms are indeed a product of unconscious and therefore unresolved conflict. Psychodynamic therapists claim that treatment outcomes are durable, because once the conflict is understood and resolved, it will not produce interference in the future. Although psychodynamic therapy formerly involved a lengthy course of treatment, abbreviated and time-limited forms of therapy have been developed to meet the demands of patients and managed care.[11]

Psychodynamic therapy is based on the theories of Freud

Disadvantages of psychodynamic therapy

Psychodynamic therapy may be misapplied to patients whose symptoms are not based in unconscious conflict. It relies on hypothetical constructs that have not been evaluated empirically in systematic and controlled studies. It may have limited application to patients with intellectual limitations and those with severe psychopathologic disorders such as severe or psychotic depression or severe personality disorders.

CLIENT-CENTERED THERAPY

Case study: A woman torn between career and motherhood

During a routine physical examination, a 34-year-old woman described her frustrations with the challenge of balancing child-rearing responsibilities and career aspirations. She was

open about her feelings and continued talking while the physician examined her. Her frustration had been growing for some time, and she expressed concern about unleashing it on her husband and children. She described undergoing periods of sadness and lethargy but did not meet criteria for major depression. She gladly accepted a referral to a client-centered psychotherapist.

In her discussion with the therapist, she disclosed her desire to return to school and obtain a bachelor's degree in computer science. Her desire aroused guilt because it conflicted with a sense of duty to her children. Guilt, she believed, guided many of her choices. She described growing up in a family with traditional values that expected mothers to be the primary caretakers of children. Her parents encouraged excellence, but they seemed to dissuade her from professional pursuits. She felt stuck.

As the therapist established an atmosphere of accurate empathy (empathy that the patient agrees with), warmth, and genuineness, the patient was able to experience herself as competent in a wide variety of roles. She was able to challenge the familial role assignments that had blocked her from professional pursuits. Consequently, she reentered the course of study that she had abandoned. She reported enhanced feelings of self-worth, an increase in her tolerance for frustration, and a sense of greater balance and freedom as she used more of her capacities.

Client-centered therapy feels good to patients

Assumptions and key concepts in client-centered therapy

Client-centered psychotherapy is based on the premise that humans are essentially good, rational, and free. Given a loving, nurturing environment, people will grow in healthy and fulfilling ways. Becoming a "whole person" involves the process of actively and freely choosing one's path. People are considered to act according to their self-concept, which may be positive or negative.

Unconditional love, warmth, and genuineness set the stage for developing a positive self-concept. Conversely, conditional, punitive, and guilt-inducing experiences promote negative views of the self. Psychopathology is viewed as the result of a negative self-concept, which may fuel hopelessness, despair, depression, anxiety, anger, or other problematic emotions. The negative views become barriers to self-actualization, which is the zenith of human emotional growth and development.

Therapeutic strategies in client-centered therapy

Client-centered therapy remains insight-oriented but focuses on here-and-now experience rather than on the past. Therapists are trained to provide accurate empathy, warmth, and genuineness, which is defined as honest understanding of their own feelings and honest sharing with the client.

Therapists practice active listening, in which they rephrase and repeat both the emotional and factual content of the patient's words. The therapist is distinctly nondirective, which gives rise to the description of this therapy as "client-centered." Problem solving is thought to evolve from the therapeutic relationship, which is intended to be an idealized human encounter.

Treatment goals of client-centered therapy

The explicit goal of client-centered therapy is for patients to become fully functioning through the emergence of a positive self-concept. This goal includes becoming more open to experience, increasingly trusting of one's decisions, and more self-accepting, spontaneous, and free. It tends to prove useful to patients interested in growth experiences and can also be used to treat mild or moderate emotional disturbances that are accompanied by coping problems.

Advantages of client-centered therapy

This approach feels good to patients. Many have only rarely experienced unconditional acceptance. Indeed, the therapeutic relationship provides patients with a new model for relationships and creates a platform for personal growth and discovery.

Disadvantages of client-centered therapy

Client-centered therapy lacks scientific concepts and relies on hypothetical constructs. The duration of therapy is uncertain, and the end point is not clearly defined. These ambiguities create difficulties in responding to managed

care inquiries, because managed care groups usually want evidence of rapid symptom reduction. Like psychodynamic approaches, client-centered therapy has no empirical body of supporting evidence. Client-directed therapy may not be effective for severe forms of depression, anxiety, and somatization. Additionally, it does not deal with intrapsychic conflicts postulated by psychodynamic theorists.

FORMATS FOR DELIVERING PSYCHOTHERAPY

Individual psychotherapy

Typically, patients prefer psychotherapy on an individual basis. Most do not relish the thought of sharing their most personal problems with a stranger, much less many strangers in a group. Seeing a patient individually allows the therapist to explore the areas of intrapersonal and interpersonal conflict in detail. At the same time, the patient has an opportunity to become familiar with the psychotherapeutic process, including the disclosure of personal material to a professional, presumably nonjudgmental listener.

The major disadvantage of the individual format is that the therapist hears only the patient's perspective. This can be problematic if patients distort their experiences or have severe interpersonal difficulties.

Group psychotherapy

Group psychotherapy, a viable alternative to individual treatment, tends to be less costly, offers supportive networks of patients with similar difficulties, and may be particularly indicated for patients with social skill deficits or interpersonal difficulties. Patients who have become comfortable with self-disclosure in individual therapy or during a psychiatric hospitalization adapt with relative ease to the group format and can benefit greatly from it.

Therapy groups led by one or two group leaders function best with six to eight members. Psychodynamic, cognitive, supportive, and other techniques are used singly or in combination, depending on the types of problems addressed.

One problem that lends itself to treatment in a group format is the psychological aftermath of a chronic or life-threatening illness such as cancer, diabetes, or ischemic heart disease. Such groups, often called psychoeducational groups, use a mix of stress management, guided imagery, medical instruction, and sharing of similar experiences to enhance coping.

Intensive outpatient programs. The intensive outpatient program format offers short-term, high-intensity therapy for a specific disorder. A mood disorders program, for instance, may meet for 4 to 6 hours a day, 3 days per week for 4 weeks. Intensive outpatient programs provide aggressive treatment to those with significant impairment who might otherwise require hospitalization. Problems that are amenable to this format include mood, anxiety, and eating disorders. A cognitive-behavioral orientation is often used to enhance behavioral control and affective regulation. Intensive outpatient programs are increasingly popular, especially among third-party payers interested in cost containment.

Marital or family psychotherapy

Marital (couples) or family therapy is indicated for patients whose distress is driven by difficult relationships with family members, spouses, or significant others. Marital conflict or disruption of the family unit is a common stressful life event that can trigger depressive or other physical symptoms.[5] The unanticipated or life-endangering illness of a key family member can also cause significant disruption of the family unit. When patients experience difficulties within a marriage, a couple, or a family relationship, referral to a therapist trained in these interventions is warranted. Marital or couples therapy is more effective than placebo in reducing depressive symptoms and improving family functioning.[5]

Group therapy can help patients facing chronic or life-threatening illness

Family therapists typically apply a systems approach.[12] The family is viewed as a system that has achieved a particular balance. If the balance is unhealthy and distressing to its members, the therapist attempts to move the system toward a more efficient and rewarding equilibrium.

Couples therapists and family therapists are widely available, and the cost of such therapy is often similar to that of individual treatment.

TABLE 1

Psychotherapy techniques and their indications

TECHNIQUE	INDICATED FOR
Cognitive-behavioral therapy	Anxiety disorders (panic, phobias, obsessive-compulsive disorder, generalized anxiety disorder, post-traumatic stress disorder) Mood disorders (depression, bipolar disorder) Somatoform disorders (pain, chronic fatigue) Sexual dysfunction Substance abuse Borderline personality disorder (dialectical behavior therapy)
Interpersonal therapy	Anxiety disorders Mood disorders Role changes (job loss, career change, death, marriage, divorce, separation)
Psychodynamic therapy	Personality disorders Relationship problems Early childhood traumas Adult traumas Problems unsuccessfully treated with cognitive-behavioral therapy or interpersonal therapy Enduring mood and anxiety disorders
Client-centered therapy	Personal growth problems Self-esteem problems Career uncertainty Conditions requiring supportive intervention

Collaborative care gives the best results

COLLABORATING WITH A MENTAL HEALTH SPECIALIST

Collaborative care arrangements[13,14] offer the best possibility of achieving the goals of symptom resolution and restoration of function. When the mental health practitioners and the primary care team work together in the same facility, consultation and treatment are immediately available when necessary. The primary care practitioner can personally introduce the patient to the mental health specialist during a primary care office visit, engage in rapid and impromptu consultations, and see patients in tandem with the mental health specialist. Such collaboration lends added credibility to the role of the mental health specialist and helps break down any patient resistance to mental health evaluation and treatment.

TALKING WITH PATIENTS ABOUT PSYCHOTHERAPY

The primary care practitioner can serve a valuable role by educating the patient about various forms of psychotherapy and their indications. For instance, published guidelines recommend cognitive-behavioral therapy for anxiety disorders such as panic and obsessive-compulsive disorders (TABLE 1). The primary care practitioner should advise the patient referred for psychotherapy to ask the psychotherapist about his or her treatment orientation, fees, and standard practice for communicating with the primary care practitioner. Conversely, the primary care practitioner could be aware of the treatment orientations of the psychotherapists to which he or she refers patients, and help the patient select a therapist that suits his or her needs.

The patient can also be educated about the proper "fit" between patient and psychotherapist. A strong alliance between patient and therapist is crucial to a good outcome. Patient preference plays an important role in establishing a therapeutic relationship. A therapist's age, gender, experience, theoretical orientation, warmth, and style are often important to patients and should be addressed before undertaking active psychotherapy. By addressing these practical issues, the primary care practitioner can dispel some of the myths and misgivings that cause patients to resist psychotherapy referral.

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