

Integration of Behavioral Medicine in Primary Care

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KEYWORDS

- Behavioral medicine • Primary care • Integration • Organization

KEY POINTS

- Incorporating behavioral medicine in the delivery of care offers a wide range of opportunities to implement sustainable changes in the health care system.
- Within primary care settings, pain disorders, addiction, depression, and anxiety disorders are highly prevalent. In addition, numerous chronic health conditions require behavioral support for lifestyle change. These disorders are optimally managed through interdisciplinary collaborations that include a behavioral medicine component.
- Extant models of behavioral medicine in primary care settings have lacked the qualities of truly integrative, interdisciplinary collaborations.

The current health care system is broken and there are many incentives to identify ways to implement and to sustain changes for physicians, for clinics and hospitals, for patients, and for payers. Employers and employees are paying more for health care coverage than ever and are getting fewer covered services. Co-pays and annual deductibles are high, leading many patients to postpone or to default on preventive and routine health care. Primary care patients increasingly display high levels of complexity in terms of both medical and psychological conditions. In California, the breadth of services offered by primary care physicians has also increased, whereas payments for those services have stayed the same or decreased. Patients who are uninsured and who use emergency department services for problems most efficiently treated in primary care settings default on huge bills, creating costs that ultimately are passed on to patients with health coverage in the form of continually rising costs for health care. These changes are happening while primary care clinics increasingly manage patients with chronic diseases.¹

This challenging, but chronic, condition of the health care landscape calls for interdisciplinary and integrative approaches that promote delivery of efficient,

The authors gratefully acknowledge NIH training grant T32DA 024600 on Addiction Medicine in Primary Care (Shoptaw PI).

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Prim Care Clin Office Pract 39 (2012) 605–614

<http://dx.doi.org/10.1016/j.pop.2012.08.003>

0095-4543/12/\$ – see front matter © 2012 Published by Elsevier Inc.

primarycare.theclinics.com

cost-effective, and high-quality medical care. No medication can cure chronic diseases. Instead, behavior change is required to manage the impacts of chronic diseases on an ongoing basis. Integration of behavioral medicine and primary care represents an alternative to delivering comprehensive, high-quality care to patients, and, in doing so, forges new relationships within the health care team and administrative leadership. However, few models exist to guide the integration of this team-based approach into primary care settings, in which the predominant model consists of care being delivered by the individual provider. This article reviews the rationale for undertaking the integration of behavioral medicine in primary care and describes the experience of the UCLA Family Health Center in integrating behavioral medicine into an urban, primary care, patient-centered medical home that provides services to a mix of insured and underinsured patients.

RATIONALE

As patients increasingly present to primary care with chronic conditions, they require more than prescriptions from their doctors to teach and maintain positive health outcomes. Given time constraints, these needs are best addressed by an interdisciplinary team that has an explicit focus on prescribing medications in the context of sustained behavior change.^{2,3} The team can extend the physician by focusing on behavioral domains that range from medication adherence to lifestyle factors (dietary changes, exercise) to behavioral care approaches for mental health, addiction, and pain disorders that are both highly prevalent and comorbid with other chronic illnesses.

Showing that primary care can breach the gap, general medical care settings now represent an important sector for the treatment of mental health disorders. For example, care for depression in general medical practice more than doubled in a comparison of data from 1990 to 1992 and 2001 to 2003.^{4,5} Further, exclusive reliance on general medical providers without support from a psychiatrist or mental health specialist increased by 153% during the same period.^{6,7} A similar pattern may be developing regarding the treatment of addictions, with the recent approval of a palette of medications. As with mental illness, substance abuse disorders are highly prevalent. An estimated 22.1 million Americans have substance abuse or dependence, excepting tobacco dependence,⁸ with more than two-thirds of these visiting primary care doctors regularly.⁹ The increased access to mental health services in primary care coupled with the decreased stigma of seeking treatment of a substance disorder and/or mental illness in these settings is critical to reaching individuals affected by these illnesses. This point is particularly relevant because the consequences of addictions and mental illness are disproportionate for those living with economic and health care disparities.

The primary care setting also allows for a developmental lifespan approach to identifying and treating mild-to-moderate mental health and addiction disorders. Adolescents and young adults are more likely to use substances than all other age groups,¹⁰ with the incidence of drug abuse and dependence disorders peaking at ages 19 to 25 years.¹¹ This pattern coincides with initial onset of major mental illnesses. To that end, primary care clinicians are in a unique position to serve sentinel and early intervention functions. Across the lifespan, alcohol and drug problems can emerge when patients use these substances to cope with family problems, chronic pain, and economic hardships, which are situations that also are detectable by primary care physicians. Concerns about substance use no longer remit with advanced age, because older adults (baby boomers) are now aging up, but not out, of substance use, particularly marijuana. Again, the primary care clinic represents

an ideal setting for identifying and treating mild-to-moderate mental health problems, including substance misuse.

Several physical and organizational factors serve to maintain separate silos for primary medical care, substance abuse treatment, and mental health care. There is no systematic approach to providing behavioral health in primary care settings and, without 1 or more behavioral health specialists and physician champions to advocate change, the inertia of the status quo often prevails. Concerns over billing and reimbursement for behavioral health services predominate because primary care clinics operate on tight margins that preclude providing services that are not (at least) budget neutral. Physicians typically avoid discussions about addiction with their patients, believing there may not be much they can do to help, which may reflect stigma and inadequate training.¹² A notable exception is the increasing willingness of physicians to discuss tobacco smoking and cessation.

EPIDEMIOLOGY

The need for integrating behavioral health into primary care is great. The prevalence of mental health or addiction disorders in primary care is high and increases substantially when factoring in mental health, addiction, or pain disorders that are comorbid to chronic diseases. This article reviews the prevalence of these disorders with a focus on primary care settings.

Depression and Anxiety

Depression and anxiety disorders are common in primary care. In a large representative sample of US adults, 26.2% had at least 1 past-year mental disorder, with anxiety (18.1%) and mood disorders (9.5%) figuring most prominently.⁴ In primary care practices, depression or dysthymia diagnoses were observed in 27% to 29% of patients; anxiety disorders were observed in 19% to 26% of patients.^{13–15} These figures are striking given that only 5% of patients visited their provider for a psychiatric complaint and that most patients with current depressive disorders do not receive mental health treatment. Depression also is commonly comorbid to diabetes mellitus,¹⁶ to coronary artery disease,¹⁷ and to stroke.¹⁸ Untreated depression is associated with difficulties in accessing primary care and obtaining comprehensive services; 2 critical markers of quality of care.¹⁹ To that end, the cost of care for depressed older adults is significantly increased for both ambulatory and inpatient services.²⁰ It is commonly accepted that depression is a distinguishing feature of high users of medical services.²¹

Addiction

About 1 in 11 American adults older than 12 years met criteria for substance abuse or dependence⁸; alcohol abuse and dependence represent most cases (17.9 million; 7.0% of adults and 81% of the total substance abuse/dependence population). Heavy alcohol use is associated with a huge public health burden²² and most (70%–80%) individuals with problematic drinking and drug abuse do not seek treatment.²³ Primary care clinics have been identified as an important resource in using Screening, Brief Interventions, Referral to Treatment (SBIRT) procedures to identify and to make appropriate dispositions of cases based on levels of use or nonuse.²³ A growing number of medications for addictive disorders, whose efficacy is boosted by providing short-term behavioral therapies, are available for use in outpatient settings (**Table 1**). In addition to identifying patients with addiction problems in primary care settings, intervention with mild-to-moderate cases may reduce stigma and circumvent barriers to treatments in individuals who would be unlikely to seek care at a specialty clinic.

Medications Approved for Use	
Smoking	Nicotine replacement therapy, bupropion, varenicline
Opioids	Metadone, buprenorphine, naltrexone
Alcohol	Oral and injectable naltrexone, acamprosate, disulfiram
Methamphetamine	Strong signal for bupropion
Behavioral Therapy Models with Efficacy	
Cognitive behavior therapy	Smoking, opioids, alcohol, stimulant disorders
Contingency management	Stimulant disorders
Motivational interviewing	Smoking, alcohol, stimulant disorders
12-step facilitation	Alcohol disorders

Pain

Chronic noncancer pain (typically defined as pain persisting longer than 3 months) affects a large proportion of the population. Prevalence is estimated to be approximately 20%,^{24,25} although representative surveys find rates exceeding 30%.^{26,27} As the prevalence and burden of chronic pain has been more fully recognized, the last 2 decades have seen large increases in opioid prescribing rates,²⁸ resulting in an estimated 10 million Americans currently receiving chronic opioid treatment. Those at increased risk for prescribed opioid misuse include individuals with comorbid psychiatric disorders,²⁹ younger individuals, and those with prior substance abuse problems.³⁰ Annual direct medical expenditure is in the tens of billions of dollars,³¹ with associated losses in economic productivity estimated in excess of \$60 billion.³² For low back pain, for example, primary care costs represent 13% of direct medical expenditures, comparable with inpatient services (17%) and pharmacy (13%).³³ Behavioral interventions targeting functional impairment and depressive symptoms associated with chronic pain have been advanced as means of addressing this public health burden.³⁴ These figures highlight the potential value of behavioral medicine in mitigating some of the consequences and health impacts that lie at the intersection of chronic pain, opioid treatment, and substance misuse or addiction.

INTEGRATION OF BEHAVIORAL MEDICINE INTO PRIMARY CARE: PREPARATIONS

Moving from a primary care clinic to a patient-centered medical home with an integrated model that includes behavioral medicine as an essential part of the clinic takes time, foresight, and patience. In the early phase, introducing behavioral medicine, with its focus on mitigating impacts of chronic diseases, into an urban primary care clinic requires administrative and clinical leadership to be not only a champion, but a booster. With time, goodwill will be forthcoming from nursing staff and other clinicians who observe positive outcomes for patients who access behavioral medicine services. However, foresight is vital. Executive leadership's prospective definition of the level of integration for the behavioral medicine clinic in primary care ranges from minimal (refer patients in primary care to specialty clinics) to basic (having behavioral health providers close by or on-site) to close (behavioral health is partially or fully integrated). Fully integrated behavioral health in primary care contains (1) screening for comorbid conditions, (2) embedded behavioral health staff, (3) active linking of patients to services, (4) roaming consultants or accessible telemedicine services that can aid cases that emerge during clinic, and (5) continuity of care (ie, returning

the patient to the primary care provider). Full integration requires support from leadership during the introduction of the services, while also retaining perspective over the long term as the system accommodates to service provision and begins to experience its benefits and unique challenges.

At all stages, from introduction to consolidation to maintenance, a fully integrated model of behavioral health in primary care requires formalized regular communication, care coordination, and case management between primary care physicians, the behavioral specialist, and the support of the health care team, which includes both front and back office staff members. Problems that arise when integrating behavioral health into primary care often signal inadequate, unclear, or insufficient levels of communication between physicians, nurses/back office staff, behavioral specialists, and administrative support staff. One mechanism for communicating in multidisciplinary or team practice settings is a huddle, or a period before clinic when all members of the team meet briefly to share information about patients on the schedule to prepare the team for cases that may need extra attention or support. Communication using a brief consult or an e-mail regarding the diagnosis and expected treatment plan for a patient aids case coordination and team building. Preparation of a discharge summary by the behavioral medicine team, which is complete with concrete behavioral recommendations that can help the primary care physician evaluate and support healthy behavior change, is essential.

Developing methods for frequent formal and informal communication between team members facilitates smoother operations when integrating behavioral medicine into primary care. Adequate forethought must be given to the documentation of behavioral health services in relation to the patient's medical record. Additional privacy issues require consideration when documenting care, particularly in cases in which mental health and substance abuse diagnoses are involved, because these invoke higher levels of requirements for privacy and restrictions on who can access progress notes or other documentation. Privacy issues are particularly important in clinic settings that have already migrated from paper charts to electronic health records. A separation of behavioral medicine records from medical records may be recommended to meet the requirements for confidentiality associated with mental health records. It is important that the organization addresses how key information such as a complete medication list that includes psychiatric and addiction medications, as well as access to behavioral health records by need-to-know medical staff, must be adequately addressed by executive leadership to ensure safe and effective medical care to the patient.

At the start and periodically afterward, consideration of clinic forms and patient registries with outcome measures and metrics for assessing progress is essential. Documents for legal and billing purposes likely exist and require minor alterations, including consent/assent documents, releases of information, agreements regarding billing, charge documents, treatment plans, progress notes, and discharge summaries. Further, valid and reliable behavioral medicine domain measurements are available. These measures include domains of somatic complaints, depression and anxiety symptoms, functional impairment, and quality of life. Behavioral markers likely have the most profound strength in showing changes that correspond with provision of behavioral medicine services. These markers include number of visits to high-intensity medical care settings before and after behavioral medicine services are delivered (eg, emergency departments, hospital), percent arrival to scheduled primary care appointments before and following behavioral medicine services, and number of sessions attended during behavioral medicine treatment. Settings that have access to electronic medical records can more easily gather some of these metrics, whereas others may require the addition of paper-and-pencil (or computerized) instruments.

A UNIFIED BEHAVIORAL MEDICINE SERVICE: CASE EXAMPLE

In January 2009, our team integrated behavioral medicine into the UCLA Family Health Center (UFHC). In the behavioral medicine clinic, patients receive care from a multidisciplinary team that may include their referring family physician, an addiction medicine specialist, a pain management specialist (if required), and a behavioral medicine specialist, which results in coordination of primary care, pharmacotherapy (for medical, psychological, and pain conditions), brief (5–8 weeks) behavioral treatment, and assessment and treatment (or referral) for substance abuse in 1 facility. Communication is facilitated by a huddle before the weekly behavioral medicine clinic to coordinate concerns regarding shared patients with front and back office staff, physician, and clinic managers and creates integrated treatment plans to best support the patient. In between the clinic visits, the patient-centered medical home team meets via teleconference every other week for 60 minutes to review cases that require further discussion and as frequently as needed to address urgent issues.

All treatments delivered by the behavioral medicine clinic are short term, averaging 5 to 8 sessions, and are delivered using evidence-based models. Although evidence-based models are used, flexibility (ie, practical counseling) guides the delivery of these interventions. This flexibility is essential given the complex clinical presentations that are typical. A unitary, focused approach dictated by a single treatment manual generally fails to address the diverse needs of patients seen in our clinic. For example, behavior treatment manuals often fail to account for medication compliance and other medical health indices that are crucial to the primary care setting. In addition to the interplay of chronic diseases many of our patients present with, more than a single psychiatric diagnosis is common, a pattern found in nationally representative samples.³⁵ There is a dearth of evidence to guide decisions regarding adaptation of evidence-based psychosocial treatments to complex cases, leaving the clinician tasked with tailoring the intervention³⁶ to the client's presentation. The clinician may select a specific evidence-based intervention for the presenting concern, but elements of other empirically validated treatment models are often grafted onto the primary intervention. For example, case management is usually required to coordinate care and to avoid duplication between providers. As patients complete a course of treatment with the behavioral medicine clinic, the referring physician is routinely provided with recommendations for ongoing management to sustain, and perhaps enhance, gains. All behavioral medicine services are provided under the direct supervision of licensed clinical psychologists. Consistent with an attending model of care, the attending clinical psychologists join the master's-level clinicians for a portion of each visit, to ensure that the treatment goals were appropriately identified and that the recommended interventions were implemented flexibly and effectively.

Treatment is brief, with the initial contract typically being 5 sessions following the initial assessment. As signaled earlier, the primary objective for the patient is improved functioning (ie, avoiding emergency medical care, ability to return to work); improvements in mood and affect are desirable, but are secondary. This focus helps clinicians to avoid drift in treatment and to focus on relieving impairments from presenting symptoms. Although features of personality disorders are prominent in many of our patients, we do not directly challenge these traits and instead seek progress on the presenting complaints and reinforce patients' progress toward health. Where appropriate, patients who may benefit are referred for longer-term care. Preliminary qualitative data from initial patients treated show that session attendance corresponds with improvements in overall clinical ratings such that those who were rated as mildly to moderately improved averaged 6 to 8 sessions, whereas those who were rated as

showing no improvement or continued deterioration of functioning averaged 2 or fewer sessions.

Successful implementation of a behavioral medicine clinic within an urban family medicine teaching/innovation center in a university medical department required coordination of individual, group, and organizational interests. In 2005, the academic roles of addiction and behavioral medicine expertise were integrated into the Family Medicine department. In 2006, the team conducted a clinical trial within the primary care clinic, integrating the academic research group with the primary care clinic team. In 2008, additional institutional support was gained by colocating addiction medicine, behavioral medicine, pain, and palliative care in the Family Medicine department. In 2009, the behavioral and addiction medicine services were offered to patients. In addition, a National Institute of Health training grant for fellows and post-doctoral trainees as well as a practicum for advanced clinical psychology graduate students were established, providing training opportunities and foundations for research. As the clinic developed, standardized procedures were developed to assist the coordination and integration of the primary care and behavioral medicine. Innovations were introduced and tested using Rapid Cycle Improvement Plan-Do-Study-Act methodology to implement changes quickly, receive feedback, and revise procedures. Standardized charts and measures were used to reduce redundancies and increase consistency in information. Brief meetings or huddles were instituted at the beginning of each clinic day to quickly review up-to-the-minute patient needs, including ensuring coordination when patients were seeing multiple care providers, confirming that new patients were provided with the appropriate previsit materials and introduced to all members of the team, and making certain that patients discharged from the behavioral care team were receiving appropriate and timely access to follow-up care. One additional marker of success was that the behavioral medicine reached financial viability in 2010, 1 year after implementation.

LESSONS LEARNED

At this point, behavioral medicine is a cost-effective addition to an urban and university-based family medicine practice. In addition to being well-received by patients and clinicians alike, there are multiple signs that integration of behavioral medicine has impacted the clinic: (1) staff members recognize that (for the most part) patients enrolled in behavioral medicine get better, as marked by reductions in no-shows/cancellations; (2) team treatment concepts are spreading, and the huddle initially linked to behavioral medicine is now used with additional team members within the clinic; (3) increased and focused communication about behavioral science and the ways it can be used by all members of the team has reduced the overall number of episodes with difficult patients requiring attention from the medical staff or police. Although the behavioral medicine clinic is a work in progress, there are more successes than failures at the level of the patients, of the clinical team, and of the bottom line.

This example of integrating behavioral medicine into primary care at UCLA may not generalize to all primary care settings. The assemblage of champions in administration, skilled behavioral specialists, and supportive team members willing to work toward financial viability may be uncommon. In those clinics where champions in administration, skilled behavioral specialists, and supportive team members are colocated, front office staff and other providers and administrators may require time to adjust to care delivery that deviates from the individual provider model. In addition,

it is necessary to refresh the soul. There are multiple successes along the way that show the important ways that the lives of patients who receive behavioral medicine can be profoundly changed (see the case example).

CASE EXAMPLE: GERARDO

Gerardo is a middle-aged Hispanic man with paranoid schizophrenia and alcohol dependence who lives alone in a low-cost care facility. He was referred to behavioral medicine services because of required emergency department treatment following drinking binges every 3 to 4 months. Gerardo was referred to behavioral medicine after it was determined that high liver function tests prevented use of naltrexone for alcohol dependence.

At intake, Gerardo and his clinician agreed to work toward alcohol abstinence using contingency management (ie, an evidence-based treatment that provides financial rewards in exchange for biologic or other observed markers of substance abstinence). This decision was made after noting that Gerardo enjoyed attending Alcoholics Anonymous (AA) meetings; it gave him something to do and he enjoyed the stories. However, his suspiciousness interfered with him becoming actively involved with the social aspects of the program. Gerardo did not drink on days when he attended the AA meetings.

Because there is no inexpensive biomarker of binge drinking, we designed a contingency management schedule that provided Gerardo with a \$5 coupon for a local fast food restaurant in exchange for a signature card documenting attendance at AA meetings on 6 of 7 days per week. Gerardo was able to meet this criterion quickly and within a few weeks was regularly attending meetings daily. He stopped binge drinking. He delighted in the reinforcement when he exchanged his signed attendance logs for a \$5 gift coupon. The behavioral specialist noted that Gerardo's ability to avoid binge drinking was stable. In a later session, the topic of appearance and hygiene was discussed. The next session Gerardo attended clinic freshly shaved, with a new haircut and clean clothes.

After about 3 months, we provided a report to the referring primary care physician describing how to continue the contingency management schedule, with recommendations of fading the reinforcements as sustained abstinence continued. Gerardo continues to maintain abstinence. His physician is discussing potential treatment with depot naltrexone as a prophylactic to binge drinking given that he no longer receives contingency management.

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