Treating Psychological Problems in Medical Settings: Primary Care as the De Facto Mental Health System and the Role of Hypnosis

RODGER KESSLER

Berlin Family Health and Central Vermont Medical Center, Berlin, Vermont, USA

Published online: 20 Aug 2006.

To cite this article: RODGER KESSLER (2005) Treating Psychological Problems in Medical Settings: Primary Care as the De Facto Mental Health System and the Role of Hypnosis, International Journal of Clinical and Experimental Hypnosis, 53:3, 290-305, DOI: 10.1080/00207140590961385

To link to this article: http://dx.doi.org/10.1080/00207140590961385

PLEASE SCROLL DOWN FOR ARTICLE

Taylor & Francis makes every effort to ensure the accuracy of all the information (the “Content”) contained in the publications on our platform. However, Taylor & Francis, our agents, and our licensors make no representations or warranties whatsoever as to the accuracy, completeness, or suitability for any purpose of the Content. Any opinions and views expressed in this publication are the opinions and views of the authors, and are not the views of or endorsed by Taylor & Francis. The accuracy of the Content should not be relied upon and should be independently verified with primary sources of information. Taylor and Francis shall not be liable for any losses, actions, claims, proceedings, demands, costs, expenses, damages, and other liabilities whatsoever or howsoever caused arising directly or indirectly in connection with, in relation to or arising out of the use of the Content.

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-
TREATING PSYCHOLOGICAL PROBLEMS IN MEDICAL SETTINGS:
Primary Care as the De Facto Mental Health System and the Role of Hypnosis

RODGER KESSLER1,2

Berlin Family Health and Central Vermont Medical Center, Berlin, Vermont, USA

Abstract: Psychological comorbidity with medical illness is associated with poor health status, complicated medical management, and increased utilization and greater costs of medical services. Hypnosis practitioners in specialty psychological or psychiatric treatment settings infrequently treat such patients, since there is a greater likelihood of patients’ psychological problems being treated solely in primary medical care. Referring patients from primary care to the mental health system will most likely not result in patients initiating psychological or hypnotic treatment. At the same time, integrated provision of medical and psychological treatment in the medical office has demonstrated much higher rates of initiation of treatment and improved medical outcomes. Although hypnosis has been found to be an empirically effective treatment for many medical problems, when hypnosis practitioners do not practice in these medical sites then patients do not have access to effective hypnotic interventions for cotreatment of medical problems.

The inside cover and first page of the November 26, 2003, and December 3, 2003, issues of the Journal of the American Medical Association (JAMA) display advertisements for the use of sertraline in the treatment of social anxiety disorder. Drug companies frequently advertise psychoactive medications in nonpsychiatric medical journals. These advertisements are marketing examples of a robust literature that suggests when primary care patients have psychological disorders; they will turn almost exclusively to the primary care medical office, not to traditional mental health and substance abuse services (Regier et al., 1993).

Manuscript submitted January 23, 2004; final revision received December 26, 2004.
1The author would like to acknowledge the assistance of Nicholas Covino, Ph.D., for his review and feedback on this manuscript.
2Address correspondence to Dr. Rodger Kessler, 130 Fisher Road, Suite 3-1, Montpelier, VT, 05062, USA. E-mail: rodger.kessler@hitchcock.org
Untreated psychological comorbidity with medical illness results in poorer physical health, less effective medical treatment and management, increased utilization of services, and increased costs of medical services (Katon, Roy-Byrne, Russo, & Cowley, 2002; Kelly, Russo, & Katon, 2001). In primary care, diagnosis and treatment rates for the most frequently seen psychological diagnostic categories in primary care (depression, anxiety disorders, and substance abuse) are generally poor (Herrman et al., 2002), and the most frequent intervention is psychopharmacology alone, which is ineffective at least half the time (Kroenke et al., 2001; Lin et al., 1997). This, despite evidence that the addition of cognitive-behavioral treatments that include some self-regulation component (i.e., relaxation training or hypnosis) enhances treatment effectiveness over time (Keller et al., 2000; Raine et al., 2002).

There are evidence-based psychological interventions for psychological disorders that have been demonstrated to be effective (Allen, Escobar, Lehrer, Gara, & Woolfolk, 2002; Raine et al., 2002). Some studies have demonstrated effectiveness in the primary care office (Katon et al., 2002). For example, Chiles, Lambert, and Hatch (1999) found most dramatic treatment effects to be behavioral medicine interventions that provided psycho-educational interventions that assisted coping. Such interventions have been demonstrated effective in enhancing medication adherence, a major problem confronting the effectiveness of medical treatments (Haynes, McDonald, Garg 2002).

Recently Pinnell and Covino (2000) critically reviewed the applications of hypnosis as part of medical treatment. Their review suggests that there is moderate empirical support for the integration of hypnotic techniques as part of medical treatment but conclude that acceptance of hypnosis in medical care requires further effort.

In response to their observation, this paper will review the scope of medical psychological comorbidity and identify some important barriers to providing effective evidence-supported treatment. It will then discuss the importance of integrating the practice of psychological and hypnotic treatments into medical settings and conclude with a recommended set of tasks to enhance further effort.

The prevalence of psychiatric disorders in the general population is substantial, with lifetime prevalence of 48% and within any 12 months a prevalence of 29.5% (L. G. Kessler et al., 1987). In primary care, the figures are similar, with prevalence of 21 to 26% at any given time (Katon & Schulberg, 1992).

Depression, anxiety, panic, somatization, and substance abuse are the most frequently observed diagnoses (Sartorius et al., 1993).

Psychological factors influence physiological functioning and in some situations appear to determine the course and the utilization of medical care (Rollman, Belnap, Reynolds, Schulberg, & Shear, 2003). For example, psychological comorbidity in medical inpatients is
associated with longer lengths of stay and rehospitalization up to a year after initial medical discharge (Fulop, Strain, Fahs, Hammer, & Lyons, 1989; Simon, Von Korff, & Barlow, 1995). Anxiety or depression prior to childbirth is associated with amplification of physical symptoms during pregnancy (Kelly et al., 2001). Patients who are treated for mental-health-related problems use significantly more medical services than patients who are not so treated (Kisch, 1997).

The problem is particularly severe for patients with chronic medical disorders. More than 20 years ago, the Medical Outcome Study noted medical behavioral comorbidity in any chronic medical condition to be 65%. In spring of 2002, United Health Care, as part of the Goal Focused Treatment and Outcome Study, observed that 40% of the 1,859 patients treated for depression also displayed at least one chronic medical condition (United Health Care, 2002). When there is a psychological comorbidity along with a chronic medical condition, significantly more impaired functioning and worse health status is reported (Felker et al., 2001; Koike, Unutzer, & Wells, 2002; Rollman et al., 2003). Neurological conditions, heart disease, chronic lung disease, cancer, and arthritis are the most frequently cited disorders associated with psychological comorbidity (Levenson, 1992).

The Jeopardy of Behavioral Dysfunction

Untreated psychological comorbidity has medical, clinical, and financial consequences. Depressed patients who have a myocardial infarction or a stroke have higher mortality rates (Carlos-Poston, Haddock, Conard, Jones, & Spertus, 2003; Frasure-Smith, Lesperance, & Talajic, 1993). Cardiac patients with comorbid untreated anxiety have a higher incidence of sudden death (Kawachi, Sparrow, Vokonas, & Weiss, 1994). Depression comorbid with cardiac problems is associated with increased disease-related morbidity and mortality (Carlos-Poston et al., 2003).

Patients who are high utilizers of medical services have high frequencies of psychological distress (Katon et al., 1990). Patients with a chronic medical illness who are high utilizers of medical services have a high prevalence of comorbid psychological disorder, with affective disorders, somatization, and anxiety disorders the most frequent comorbidity (Katon & Sullivan, 1990). One-month prevalence of psychiatric disorders among high utilizers of medical services reveals a prevalence of somatization disorder and anxiety disorders over 20% and panic disorder over 10% (Katon & Sullivan). The top 10% of utilizers of medical services account for 25% of all primary care visits, 52% of specialty visits, 40% of hospital days, and 26% of all prescriptions written. Katon has further observed that the top 10% of primary care patients use more services than the lowest 50% (Katon et al., 1990).
Patients with untreated comorbidities have more costly health care. Simon and colleagues (1995) found that the annual health costs of depressed patients are $4,246 as compared with $2,371 for nondepressed patients. Controlling for morbidity, depressed patients utilize three times the amount of health care services and incur twice the medical costs, while making seven times the number of visits to the emergency room (Simon et al.). Anxiety disorders account for 6 to 12% of all outpatient medical visits, and anxiety disorder comorbid with asthma triples the hospitalization rate (Katon & Roy-Byrne, 1989). Patients with panic disorder have 10 times the number of emergency room visits, and 70% of patients with panic disorders see up to 10 physicians before an accurate diagnosis is made (Ballenger, 1987).

Patients with psychological problems are most likely to receive medical services related to such problems solely in primary care medical settings (Dietrich et al., 2003; Narrow, Regier, Rae, Manderscheid, & Locke, 1993). It has been demonstrated that 43 to 60% of patients with psychological problems are solely treated in primary medicine, whereas 17 to 20% of patients with psychological problems are treated in the specialty mental health system (Academy of Psychosomatic Medicine, 1996; Katon, 1987). Evidence such as this has led to the observation that nonpsychiatric medicine is really the de facto mental health system (Regier et al., 1993). Eighty percent of people who come to primary care because of psychological and social distress present with physical findings (Allen et al., 2002; Regier et al., 1993).

Such psychological problems are often undetected and primary care is unequipped to respond to the majority of psychological need. There are multiple clinical and systems barriers that limit attention (Pincus, Hough, Houtsinger, Rollman, & Frank, 2003). There is less than optimal management of psychological disorders and lack of use of evidence-based treatments (Frank, Huskamp, & Pincus, 2003). Among medical outpatients, diagnosis of psychological disorders is missed in up to half of all cases (Katon & Roy-Byrne, 1989). Among inpatients, formal diagnosis is made in only 11% of cases, depression was only accurately diagnosed in 14 to 50% of cases, and alcohol related disorders only 5 to 50% (Mayou, Hawton, & Feldman, 1988, 1991).

In a study of medical inpatients done in four Vermont hospitals to measure levels of depression in medical inpatients, 46% of the 128 hospitalized medical patients in the sample were measurably depressed, 19% moderately to severely. There was only one mental health consultation during hospitalization, six diagnoses of depression, no referrals for mental health treatment at discharge, and documentation of 3 patients receiving psychological treatment (Vermont Program for Quality of Health Care, 1994).

When pharmacology, the most common treatment intervention for psychological disorders, is initiated, less than half remain on the
medication for a therapeutic length of time (Korsen, Scott, Dietrich, & Oxman, 2003; Kroenke et al., 2001; Lin et al., 1997). Coyne and colleagues note that, even with efforts to detect comorbidities, a quarter to a third of primary care patients will screen positive, but only 18 to 30% of those positively screened will meet criterion for diagnosis. Even for those patients identified with comorbidity, treatment initiation is very low (Coyne, Thompson, Palmer, & Kagee, 2000; Scholle, Haskett, Hanusa, Pincus, & Kupfer, 2003).

We are therefore left with a large patient population whose often unrecognized and untreated psychological comorbidities worsen health status and contribute to significantly greater utilization of medical services. Parenthetically, the task of identifying, assessing, and treating the majority of patients with psychological disorders in primary care has generated a substantial literature and a long history focused on providing information and education to physicians about psychological and psychiatric treatments (Hodges, Inch, & Silver, 2001).

Physician information and education are certainly important and necessary components of changing the current state of affairs. However, such efforts have had limited impact in changing physician behavior and patient care or the organizational setting in which these occur (Lin et al., 1997). The academic medical literature that reviews methods of fostering physician change anticipates such limited success by demonstrating that if changes in practice are to occur, implementation of an agreed-upon set of procedures that works in all phases of primary care practice must occur if patient care is to change (Davis, Thompson, Oxman, & Haynes, 1995). Ultimately, training, education and implementation must occur at the practice level if they are to affect patient care. It is there that psychology and hypnosis are provided such a great opportunity.

It Is a Complicated Task

From the data described above, it would seem that we have a problem with a simple solution. Just improve the hypnosis and psychological services referral system, and the patients would receive access to psychological and hypnotic treatments, and the problem is resolved. It is not that simple. Improving the hypnosis referral system has proved elusive. Even in situations where referrals are made, patients rarely follow through and participate in off-site treatment (Scholle et al., 2003; Watkins, Pincus, & Tanielian, 2001). Studies show 50 to 90% of referrals made to out-of-the-office mental-health practitioners result in no appointment made (Callahan et al., 1994; Katon, 1995). This is contrasted with emerging data that suggest that when referred to psychological services within the primary care office, appointments are scheduled at rates often over 90% of the time (Watkins et al.) and that
integrated medical psychological care results in better medication compliance (Watkins et al.).

Also, such a strategy, even with its flaws, does not respond to the core dilemma of detection and intervention in physician’s offices.

Let’s Improve

If the specialty mental health system is interested in helping, we have already observed that patients do not typically arrive at their door. There is a specific set of skills and training that is necessary to effectively work in medicine that goes beyond clinical skill. This includes the reengineering of clinical, office organizational, administrative, insurer, and regulator activities; all of which are critical to success and that require effort that takes time and incurs costs (McDaniel, Schroeder, Belar, Hargrove, & Freeman, 2002). Historically, inattention to such issues—and inadequate funding—has generated failed efforts.

Currently, medical practices are set up to respond to acute presentations that more or less rapidly resolve. Historically, referral to off-site specialty care has dealt with more complex, chronic medical problems. Such a model has not been effective in dealing with psychological and psychiatric problems, and it is not usual medical practice to have “specialty services” being provided as part of usual care. This has begun to change with both positive and negative consequences. Within the last 10 years, the chronic-care model has been the subject of substantial medical attention (Wagner et al., 2001).

Such a model both identifies that ongoing chronic medical problems require ongoing, often interdisciplinary, care and that, since psychosocial issues often interfere with optimal patient participation and compliance with medical care, there is a need to also adopt behavior change as a focus of care. Unfortunately such efforts have not often included assessing and treating the underlying psychological issues that limit effective adaptation and coping, and without that attention behavior change has proved elusive (Ewart, 1990). Even more recently, there has been a focus on applying the chronic-disease model to depression. Unfortunately again, the limited diagnostic reference, and the lack of focus on significant psychological involvement in the model, reinforces mental health issues as carved out from other medical issues and limits the effectiveness of the intervention.

If Psychological Interventions in Medicine and Hypnosis are Effective, Why have they not been Generally Adopted?

As any primary care physician (PCP) trying to find psychological assistance for his or her patients knows too well, most psychological care has been carved out to managed care. Because managed care
focuses on cost savings within given patient populations, it has also focused on limiting access and supply of services for short-term cost savings. There is no incentive to use behavioral health to assist in the reduction of the need and demand for medical services, even though untreated comorbidities are the demonstrable cost drivers. Managed care incursion into medicine is seen as adding to carve-out costs, so there is no motivation to assist patients’ access psychological care within physicians’ practices. This has resulted in increasing difficulty for physicians accessing already difficult to access psychological services and a natural reluctance on the part of medicine to add to its already difficult tasks.

There has only been limited behavioral health attention to working within nonpsychiatric medicine. Most psychologists and other providers are not on staff of community and regional hospitals. They generally do not participate in settings and tasks in which medical practitioners get to know each other and each other’s practice and plan for the delivery and planning of health care. Recently, a “Clinical Privileges White Paper-Psychology” was published by the Credentialing Resource Center regarding hospital privileges for psychologists. The Credentialing Resource Center is a national organization broadly used by medical centers and medical staffs to define hospital and staff privileges. In the white paper, it recommends hypnosis as one part of psychologists’ hospital privileges. Hypnosis is one of only two subspecialties specifically identified as being a reasonable part of a psychologist’s hospital privileges. Further, because we are trained to be largely autonomous practitioners, there is a limited knowledge of how primary care operates and what is expected in order to function successfully in a primary care setting (Coyne & Thompson, 2003). This is compounded by mental health practitioners’ limited embrace of the empirically supported treatments demonstrated as effective in medicine. The emerging culture of medicine includes a strong focus on evidence-based support. Unless psychological treatments address the importance of evidence-based support, we risk continuing to be viewed by primary care as a black hole, with no relation to medicine as practiced.

*If it Is as Glum as it Sounds, Why Bother?*

In contrast, right treatment would include coordinated, integrated treatment that focuses on how and when services are delivered and on the resources necessary to generate optimal health status. If we could achieve such right treatments, the focus would shift toward the greatest measurable treatment effect with the use of the most effective and the lowest volume of resources in the fewest discreet intervals and locations of health care delivery. Such efforts form the basis of a well-organized system of integrated medical and psychological care
designed to affect health status with a focus on outcomes and the utilization and costs of care.

This approach is the next evolution of the emerging chronic-care model discussed earlier. Such effort acknowledges that psychosocial factors affect patient participation in their care, and their psychological treatment becomes a core component of medical treatment.

It then becomes clear that the existence of empirically validated psychological and hypnotic treatments is insufficient. A model must be supported in which such treatments are delivered within the primary care office.

There is evidence that such collocated integrated medical and psychological care provided within the primary care office results in better compliance with both medical and psychological aspects of care as well as enhanced outcomes. For example, within the primary care setting in which I work, a consecutive series of 125 referrals was monitored to track entrance into psychological care after referral from PCPs. Over 90% of referrals resulted in first appointment. Treating medical psychological comorbidities has been the subject of a robust literature that suggests that there are available behavioral health treatments that are clinically and potentially cost effective. Such psychological treatments of medical problems has demonstrated a reductions of physician visits, prophylactic analgesic medication costs, disability claims, hospital stays, rehospitalizations, and mortality and an enhanced quality of life (Chambless & Hollon, 1998; Friedman, Myers, Sobel, Caudill, & Benson, 1995). Such interventions have generally focused on enhancing self-management, self-efficacy, stress management, and social support; reducing psycho-physiological arousal; and altering behavior patterns (Friedman et al., 1995).

A right-treatment model, featuring evidence-based practice, availability of hypnotic treatments with collocated medical and psychological practitioners, is seen as the best response to many of the problems described in this paper, resulting in better identification, easier referral, more frequent patient compliance with referral, better communication between behavioral health practitioner and primary care physician, and greater use of evidence-based treatments as part of medical care (Blount, 1998). In my own experience, such a model has been effective in family medicine, internal medicine, gynecology and obstetrics, and neurology. Such a model of right treatment and integrated setting gives us the opportunity to respond to Pinnell and Covino’s notion of greater acceptance in medicine generating greater opportunities for hypnotic practice in medical settings.

Opportunities for Hypnosis and Self-Regulation in a Right-Treatment Model

It is quite clear that hypnosis is an effective treatment component of medical problems. Hypnosis has been successfully used to diminish procedural anxiety (R. Kessler & Dane, 1996) and in treatment of
thyroid issues, cancer, gastro-intestinal disorders, cardiac problems, and orthopedics (Evans & Stanley, 1990). It has long been demonstrated effective in the treatment of a variety of pain conditions (Chaves, 1998; Kessler, Patterson, & Dane, 2003; Patterson & Jensen, 2003). Pinnell and Covino (2000) concluded that there is empirical support for the efficacy of hypnotically assisted treatments in preoperative preparation of surgical patients, asthma, dermatological disorders, irritable bowel syndrome, hemophilia, postchemotherapy nausea and emesis, and with obstetrical patients.

Commonalities among the psychological dimensions associated with the identified medical problems include dysregulation of cognitive, emotional, physiologic, and autonomic response while coping with the medical issue. The result is some combination of cognitive worry including distortion and inaccuracy; hyperarousal, hypoarousal, pain, and an overall maladaptive coping with their life situation (See Blount, 1998, and also Cummings, Cummings, & Johnson, 1997). When such results become a response to medical condition or procedure, it is apparent how attention, thinking, emotion, and physical response become both an element of the medical problem and affect the efficacy of the treatment.

Friedman et al. (1995) identified four dimensions of self-regulation focused treatment as most efficacious across psychological treatments in medicine. They are: enhancing self-management skills and self-efficacy; responding to psycho-physiological arousal and dearousal; altering specific behavior patterns while preventing relapse through stress reduction; and enhancing social support. The medical treatments identified in which hypnosis has been evaluated and in some cases empirically validated share the dimensions that are associated with not only hypnotic treatment success but in general psychological treatments in medicine demonstrated most effective.

Besides the demonstrated treatment efficacy hypnosis brings to medicine, there are other reasons to think that hypnosis can be positioned successfully within primary care. Hypnosis is a known, distinct, adjunctive treatment in medicine, perceived differently than “counseling” or “therapy.” It has considerable empirical support that has appeared in prominent medical journals. Empirically validated hypnotic treatments parallel a major focus of contemporary medical treatment—evidence-based interventions in medicine and treatment dimensions that are consistent with a chronic-care model that acknowledges the importance of cognitive and behavioral underpinnings of effective medical treatment even though it has not yet come to grips with how to provide psychological care.

Further, it is a portable and brief intervention. It fits into contemporary biopsychosocial conceptualizations of mind body. We can demonstrate physical and psychological change as an outcome of care, which destigmatizes our interventions as psychotherapy or counseling.
While there is no longer any question that hypnotically assisted treatments have a place as part of evidence-based medical treatments, practitioners are left to generate the opportunity to practice in medical settings in which such treatments are vitally needed. We have demonstrated that the psychological problems are brought to the attention of medicine and treated solely in medicine, and that referrals are not made and those that are made, more often than not, do not succeed. If that occurs, all the empirically supported evidence we can produce will not enhance patient treatment. For those who are so motivated, the effort must be furthered within primary care.

**Furthering the Effort: Considerations in Practicing Nonpsychiatric Medicine and Introducing Hypnosis as a Preferred-Treatment Strategy**

In an effort to assist the transition from independent psychological practice into integrated medical psychological practice, the following are suggested.

- Leave your ego at the door. Medicine is not going to recruit you, and if you are able to get in it will not consider you a peer until you demonstrate that you can practice on their terms and that you have something useful to provide.
- Mentor. The only ones who can show you how to do it are the ones doing it. Find someone using hypnosis in primary care and latch on to them until you are comfortable with the playing field.
- Join the medical staff of the affiliated hospital or medical center. Yes, you will probably be labeled an allied health professional. You may even need to work under M.D. supervision. But it allows you to be a part of what goes on, to be on committees, and to have access to a medical library.
- Read medical journals. Read psychology and psychiatry journals if you need to, but you already know much of that. Read what you don’t know. Read *Lancet, New England Journal of Medicine, JAMA,* at the least, and any medical journals in your practice specialty. Focus on evidence-based medicine.
- The clinical and cost outcome literature is critical. All medical care is viewed through that lens, and so must hypnotic treatments.
- Develop a medical-practice-based specialty.
- Do clinical research.
- Become a practice reengineer. This is a perfect time to act. There are new health and behavior CPT codes that focus on the provision of psychological treatments in medicine. There is a whole emerging subspecialty of quality and care management. Most of it focuses on the social psychology of care. It discusses reengineering office organization, medical practices and procedures, and monitoring best care. Work more briefly. Focus less on full diagnostic assessment and more on helping the physician. It is the transition of hypnosis from a solely clinical entity to a vehicle for reengineering medical treatment that offers the greatest opportunity.
SUMMARY

While hypnosis is a well-known, evidence-supported, adjunctive medical treatment, its application is limited by its limited practice in the medical settings in which the majority of patients who present with psychological problems receive care. Historically such medical settings are limited in detection and treatment and referring out to the specialty-treatment system has been ineffective. The consequences of nontreatment or inadequate treatment of such psychological disorders are significant clinically and result in increased inappropriate utilization of health care. An alternative approach to current treatment models is proposed in which psychological and medical treatments are integrated within the medical office. Such an approach supports a right-treatment model, in which there is a common focus on providing the best evidence-supported treatment with attention to timing, amount, and types of service to promote the best outcomes and awareness of utilization of services.

There is good reason to think that hypnotic treatment can be an important part of that evolution clinically. However, considerable efforts must be directed to a set of clinical-support tasks that will allow hypnosis practitioners access to those medical settings. Without such efforts, the promise of hypnotic treatments as part of medicine will continue to be limited.

REFERENCES


Die Behandlung psychologischer Probleme im medizinischen Umfeld: die Rolle von Hypnose in der primärmedizinischen Versorgung als dem de facto Gesundheitssystem

Rodger Kessler


RALF SCHMAELZLE
University of Konstanz, Konstanz, Germany

Traitement de problèmes psychologiques dans un cadre médical : les premiers soins/le médecin généraliste en tant que système de santé mentale de facto et le rôle de l’hypnose

Rodger Kessler
Résumé: la comorbidiad entre maladie somatique et psychologique est associée à un statut de faible santé, de gestion médicale compliquée, d’une utilisation croissante et de plus en plus coûteuse des services médicaux. Les praticiens en hypnose spécialisés en psychologie ou psychiatrie traitent de tels patients épisodiquement car il y a une plus grande probabilité pour que ces patients à problèmes psychologiques soient pris en charge uniquement dans le cadre des ‘premiers soins’ (par leur médecin généraliste). Envoyer un patient de médecine générale à une consultation dans le système de santé mentale n’aboutira probablement pas à un traitement psychologique ou hypnotique. En même temps, l’intégration simultanée d’un traitement médical et hypnotique par le médecin généraliste prouve un plus fort taux de mise en oeuvre du traitement et des résultats médicaux meilleurs. Bien qu’il soit prouvé empiriquement que l’hypnose rend plus efficace beaucoup de traitements médicaux, si les praticiens en hypnose ne pratiquent pas sur les lieux même, alors les patients n’ont pas accès à une intervention hypnotique efficace pour un co-traitement des problèmes médicaux.

VICTOR SIMON
Psychosomatic Medicine & Clinical Hypnosis Institute, Lille, France

Tratamiento de problemas psicológicos en instituciones médicas:
El cuidado primario como el sistema de salud mental de facto y el papel de la hipnosis

Rodger Kessler
Resumen: La comorbilidad psicológica de las enfermedades médicas se asocia con un estado pobre de salud, utilización médica complicada, y servicios médicos más costosas. Los facultativos de la hipnosis en centros psicológicos o psiquiátricos especializados de tratamiento rara vez tratan
tales pacientes, ya que la mayor probabilidad es que los problemas psicológicos de los pacientes sean tratados únicamente en el sistema médico primario. Lo más probable es que referir pacientes de cuidado primario al sistema mental de salud no resulte en que los pacientes inicien un tratamiento psicológico o hipnótico. Al mismo tiempo, la provisión integrada de tratamiento médico y psicológico en la oficina médica ha demostrado tasas mucho más altas de iniciación de tratamiento y mejores resultados médicos. Aunque se ha encontrado que la hipnosis es un tratamiento empíricamente efectivo para muchos problemas médicos, cuando los facultativos de la hipnosis no practican en estos sitios médicos los pacientes no tienen acceso a intervenciones hipnóticas efectivas para el co-tratamiento de problemas médicos.

ETZEL CARDEÑA
University of Texas, Pan American,
Edinburg, Texas, USA