**Counselling**

1. *In patients with mental health concerns, explore the role of counselling in treating their problems. (Intervention is not just about medication use.)*

Family physicians provide a significant amount of mental health care. Time is one of the major obstacles to providing counseling in primary care. Counseling approaches developed specifically for ambulatory patients and traditional psychotherapies modified for primary care are efficient first-line treatments. Patients with psychiatric conditions and acute psychosocial stressors will likely respond to problem-solving therapy or the BATHE (background, affect, troubles, handling, empathy) technique. Although brief primary care counseling has been effective, patients who do not fully respond to the initial intervention should receive multimodal therapy or be referred to a mental health professional

**Approaches to Counseling in the Primary Care Setting**

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| ***Counseling approach*** | ***Problem type*** | ***Patient characteristics*** |
| Five A’s | Health risk behavior | Highly responsive to medical authority; benefits from education alone with concrete plan |
| FRAMES | Health risk behavior | Requires objective evidence to consider change; benefits from emotional support and recognition of personal strengths |
| Stages of change (transtheoretical model) | Specific behavior (positive or negative) | May be at various stages with respect to readiness for change; needs to consider pros and cons of changing |
| Motivational interviewing | Applies to specific behavior; however, range of behavior is broad | Highly ambivalent, at best, about change; core values and behavior often are inconsistent; responds to empathy |
| Problem-solving therapy | Anything that can be formulated as a “problem” | Able to view life issues from an intellectual perspective; not overwhelmed by emotional expression; able to process information sequentially and brainstorm |
| BATHE\* | Any type of psychosocial problem | Reasonable verbal skills; able to meaningfully respond to questions; benefits from emotional support |

*BATHE = background, affect, troubles, handling, empathy; five A’s = ask, advise, assess, assist, arrange; FRAMES = feedback about personal risk, responsibility of patient, advice to change, menu of strategies, empathetic style, promote self-efficacy*.

\*— *Developed specifically for family physicians*.

**Problem-Solving Therapy**

Problem-solving therapy is a four-step approach (problem definition, generating alternative solutions, decision making, solution verification and implementation). Its systematic framework begins with the physician asking questions to specifically define the problem using factual, concrete information. This method is particularly useful for patients exhibiting catastrophization, a cognitive and emotional escalation process in which life difficulties are exaggerated. Diffusing concerns and targeting a specific, potentially modifiable feature is particularly important when addressing psychosocial crises.

While brainstorming for alternative solutions, the patient may indicate that the problem would be readily solved if someone else would change. When this occurs, physicians should redirect the patient to solutions that the patient can control to facilitate decision making and evaluation of possible consequences for each possible solution.

**Principles of Problem-Solving Therapy**

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| ***Component*** | ***Description*** | ***Examples of physician statements*** |
| Problem definition | Obtain factual, concrete information; clarify nature of the problem; describe the problem objectively and succinctly | “What part of this situation is most distressing for you?” |
| “It sounds like the key difficulty is…” |
| Generating alternative solutions | Encourage the patient to brainstorm and generate several possible solutions | “What options have you considered?” |
| Any others?” If the patient cannot provide options, the physician may suggest several possibilities and then encourage the patient to generate options. |
| Decision making | Evaluate possible solutions; predict possible consequences of the selected solutions | “Which of the options that we’ve talked about seem better to you?” “Of those, which one seems best?” |
| Solution verification and implementation | Restate the behavior plan; review any obstacles and develop a plan for each | “At this point, your plan is…” |
| “Is there anything that could get in the way?” “What could you do about that specific challenge?” |

After the patient makes a decision, the physician verifies the solution by restating the plan and addressing any obstacles that might interfere with its execution. Lastly, the physician addresses the practical implementation of the plan. Research in health care settings supports the effectiveness of problem-solving therapy for a range of clinical problems, including major depressive disorder and nonadherence to a diabetes regimen.

**BATHE**

The BATHE (background, affect, troubles, handling, empathy) technique, developed specifically for family physicians, is helpful for patients exhibiting psychiatric syndromes or a broad range of psychosocial problems. The initial open-ended background question is a reminder to listen to the patient’s presenting narrative. Although the hesitancy with open-ended questions is that they will lead to overly long answers, most patients complete their answers in less than one minute, with 90 percent completing their answer in less than two minutes. If the patient takes longer than a few minutes, keep the interview moving by politely interrupting and asking how the patient feels about his or her concerns.

**BATHE Technique for Addressing Psychosocial Problems**

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| ***Component*** | ***Examples of physician statements*** |
| **B**ackground | “What’s going on in your life?” |
|  | “What has happened since I last saw you?” |
| **A**ffect | “How do you feel about (a situation that has happened to the patient)?” |
|  | “Many people in that situation report feeling…” |
|  | Suggest descriptors, then ask: “Do any of those words seem to fit how you’re feeling?” |
| **T**roubles | “What bothers/troubles you most about the situation?” |
| **H**andling | “How are you coping with/handling the situation?” |
| **E**mpathy | “It sounds very frightening/frustrating/sad.” |

Although the physician may briefly summarize the patient’s answer to the background question, the physician should quickly proceed to the “affect” question. Some patients have difficulty articulating feelings and continue to describe the problem, or they are simply unaware of their emotions. In response, the physician may repeat the question or suggest descriptors.

The “troubles” question provides a useful focus, particularly when the problem seems overwhelming. Although the physician may believe that he or she knows what is most upsetting, the assumption may be incorrect. It may be tempting to recommend solutions, but handling the problem is the patient’s responsibility. However, the patient’s attempted solutions often cause more upheaval than the problem itself - a point that the physician may reflect back to the patient. By focusing and labeling key dimensions, the physician’s questions facilitate the patient’s ability to generate realistic coping strategies.

Communicating empathy creates a physician-patient partnership and indicates that the physician is actively listening to the patient. If the visit is a follow-up, the opening question should target events in the time interval from the last visit. Most BATHE interviews can be conducted in less than five minutes.

1. *When making the decision about whether to offer or refer a patient for counselling*:

a) Allow adequate time to assess the patient.

b) Identify the patient’s context and understanding of her or his problem/situation.

c) Evaluate your own skills. (Does the problem exceed the limits of your abilities?)

d) Recognize when your beliefs may interfere with counselling.

1. *When counselling a patient, allow adequate time.*
2. *When counselling a patient, recognize when you are approaching or exceeding boundaries (e.g., transference, counter-transference) or limits (the problem is more complex than you originally thought), as this should prompt you to re- evaluate your role.*

Transference: Transference is the unconscious displacement onto the clinician of feelings, thoughts, wishes, and qualities associated with an important individual from the patient’s past (e.g., parent figure). It represents the unconscious re-creation of a past relationship in the present. The clinician’s behavior also influences how the patient responds to him/her. Transference to the clinician is thus based partly upon individuals from the patient’s past and partly upon the real characteristics of the clinician.

Counter-transference: Countertransference is the clinician’s conscious and unconscious feelings and thoughts about the patient. It consists of:

* The clinician’s feelings and thoughts about an individual from a previous relationship that are displaced onto the patient
* Feelings and thoughts induced in the clinician by the patient’s behavior

Recognizing countertransference provides data that help the clinician to discern problems that the patient encounters in relationships outside the therapy. Other people probably respond to the patient in a manner similar to the clinician

In mental health settings, most evidence-based psychotherapies require a minimum of 10 to 15 sessions and approximately 50 percent of patients do not complete the treatment course. Evidence-based reviews of primary care counseling indicate that brief approaches may lead to short-term reductions in psychosocial distress and longer-term reductions in alcohol use and depressive symptoms. The models presented above may be implemented in approximately five to 10 minutes and can be integrated into most office visits. These strategies make up the first stage of a stepped-care approach in which brief interventions, including providing patients with screening information, are the initial treatments. There are typically two options for patients who fail or incompletely respond to the initial intervention. For highly symptomatic patients or those with multiple high-risk behaviors, referral to a mental health specialist may be the next step. Alternatively, in less severe situations, the physician may add a second intervention, such as pharmacotherapy, more intensive education, or an additional counseling strategy. If problems persist, referral to a mental health or substance abuse specialist is recommended.

*References:*

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