Realistic Approaches to Counseling in the Office Setting

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Although it is often unrecognized, family physicians provide a significant amount of mental health care in the United States. 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. For some clinical conditions, providing individualized feedback alone leads to improvement. The five A’s (ask, advise, assess, assist, arrange) and FRAMES (feedback about personal risk, responsibility of patient, advice to change, menu of strategies, empathetic style, promote self-efficacy) techniques are stepwise protocols that are effective for smoking cessation and reducing excessive alcohol consumption. These models can be adapted to address other problems, such as treatment nonadherence. Although both approaches are helpful to patients who are ready to change, they are less likely to be successful in patients who are ambivalent or who have broader psychosocial problems. For patients who are less committed to changing health risk behavior or increasing healthy behavior, the stages-of-change approach and motivational interviewing address barriers. 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. (Am Fam Physician. 2009;79(4):277-284. Copyright © 2009 American Academy of Family Physicians.)
behaviors, such as smoking and alcohol use, and may be adapted to promoting healthy behaviors, including regular exercise. Asking questions presumptively (“How much do you smoke?”) may elicit more reliable information.

When advising patients, communication theory suggests that a defensive reaction is less likely if the physician begins with an “I” statement (“I recommend that you...”) rather than a “You” statement (“You need to...”).15,16 Although educational handouts may augment the physician’s advice, printed material should not replace direct verbal recommendations.

Before developing a plan, it is necessary to assess the patient’s motivation for imminent change. After assisting the patient in developing concrete strategies for change, close follow-up should be arranged. For example, because nicotine withdrawal during smoking cessation includes unpleasant physical and emotional reactions, arranging supportive contact increases the likelihood of success.13

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**SORT: KEY RECOMMENDATIONS FOR PRACTICE**

<table>
<thead>
<tr>
<th>Clinical recommendation</th>
<th>Evidence rating</th>
<th>References</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care counseling leads to short-term benefits for psychiatric symptoms.</td>
<td>B</td>
<td>45, 46</td>
<td>Most studies involved a mental health counselor in a primary care practice; heterogeneous counseling models were used.</td>
</tr>
<tr>
<td>Brief alcohol intervention is associated with reduced alcohol use over time.</td>
<td>B</td>
<td>47, 48</td>
<td>Systematic review and meta-analysis; benefit may be more enduring for men; counseling methods included the FRAMES technique.</td>
</tr>
<tr>
<td>The five A’s technique is effective for smoking cessation.</td>
<td>B</td>
<td>12, 13</td>
<td>Most studies in the systematic review evaluated pregnant women.</td>
</tr>
<tr>
<td>Stages of change (transtheoretical model), using individualized patient feedback, is associated with improved adherence to a hypertensive regimen at 12 and 18 months.</td>
<td>B</td>
<td>24</td>
<td>Study relied solely on patient self-report of adherence behavior.</td>
</tr>
<tr>
<td>Brief motivational interviewing provided by nonspecialists for substance abuse reduces alcohol and marijuana use.</td>
<td>B</td>
<td>32</td>
<td>Follow-up periods were variable; there was a limited number of marijuana studies.</td>
</tr>
</tbody>
</table>

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.

A = consistent, good-quality patient-oriented evidence; B = inconsistent or limited-quality patient-oriented evidence; C = consensus, disease-oriented evidence, usual practice, expert opinion, or case series. For information about the SORT evidence rating system, go to http://www.aafp.org/afpsort.xml.

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**Table 1. Approaches to Counseling in the Primary Care Setting**

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

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.

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Research including pregnant smokers found that the five A’s technique led to greater cessation rates than physician recommendations alone.12,13

FRAMES Protocol
The FRAMES (feedback about personal risk, responsibility of patient, advice to change, menu of strategies, empathetic style, promote self-efficacy) protocol (Table 314,17) also targets health risk behaviors. It begins with concrete, individualized patient feedback related to the behavior,17 such as a CAGE questionnaire score for alcohol use, blood pressure, glucose levels, or A1C levels. The physician may also link a presenting complaint, such as sleep disturbance in a heavy drinker18 or frequent respiratory infections in a long-term cannabis user,19 to the underlying substance abuse.

The physician directly or indirectly communicates the importance of the patient taking responsibility for change. Patient ambivalence should be briefly explored—if
the patient appears ambivalent or is currently uninterested in addressing the issue, the physician should provide direct, succinct advice and indicate that it is an important future topic. Whenever feasible, the patient should receive a range of options to consider rather than a specific directive. By providing a menu of strategies, the physician communicates a willingness to collaborate while emphasizing that implementation is the patient’s responsibility. Communicating with empathy has been shown to increase patient satisfaction\(^{20}\) and adherence.\(^{21}\) The final step is promoting the patient’s sense of self-efficacy with an encouraging statement about the plan he or she has developed.

### Stages of Change (Transtheoretical Model)

The transtheoretical model (Table 4\(^ {14,22,23}\)) assumes that health behavior changes in stages that reflect various levels of patient motivation and perceived self-efficacy (i.e., precontemplation, contemplation, preparation, action, and maintenance).\(^ {22}\) The physician asks targeted questions designed to increase patient motivation for change until motivation increases to the point of initiating action. The transtheoretical model, originally developed for smoking cessation, is supported by considerable research and appears to be effective for reducing other health risk behaviors\(^ {22}\) and for improving chronic disease self-management.\(^ {24,25}\) The model, using individualized patient feedback, is associated with improved adherence to a hypertensive regimen at 12 and 18 months.\(^ {24}\) With self-management of chronic diseases, such as type 2 diabetes, patients are likely to be at different stages for specific aspects of management (e.g., diet, activity level, blood glucose self-monitoring, taking medications).\(^ {25}\)

During precontemplation and contemplation, patients are more likely to respond to a cognitive approach, such as discussing the benefits of habit change, possibly supported by written information. In the precontemplation stage, the patient perceives that the disadvantages of changing outweigh the benefits, whereas this pattern is reversed in the action stage.\(^ {23}\) Therefore, during precontemplation and contemplation, physicians should highlight the advantages of change.\(^ {23,26}\)

In the preparation stage, the patient chooses a starting date and strategy for change. The action stage should target the behavioral skills and day-to-day challenges the patient encounters during his or her efforts to change.\(^ {23}\)

During action and maintenance, brief lapses or more enduring relapses are common.\(^ {23,26}\) Physicians should praise and support the patient’s efforts to change and use statistical evidence to stress that episodes of relapse are normal. For example, only about 7 percent of persons initiating a smoking cessation attempt are abstinent after one year,\(^ {13}\) and multiple attempts are usually needed before achieving lifetime cessation.

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**Table 4. Stages of Change (Transtheoretical Model) to Facilitate Counseling in Primary Care**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Physician intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation</td>
<td>Provide a factual statement about the health effects of the behavior (e.g., smoking, alcohol abuse, nonadherence), then ask the patient what he or she thinks about it. “What do you like about smoking/drinking?” “How long do you think you’ll smoke/drink?” “Have you tried to quit before?” (If yes) “What happened?” “What would tell you that it might be time to quit?”</td>
</tr>
<tr>
<td>Contemplation</td>
<td>“What are the advantages of changing?” “What are the disadvantages of changing?” “What could get in the way of changing?” If advice is offered, state it as a generalization: “Many patients find it helpful to…”</td>
</tr>
<tr>
<td>Preparation</td>
<td>Discuss a specific date for change with the patient. If the patient has chosen a date, ask: “How did you choose that particular day?” “What specific strategies are you planning to use?” “Do you foresee any situations where you might be tempted to overeat/smoke/drink?”</td>
</tr>
<tr>
<td>Action</td>
<td>“How is the plan working?” “Has anything come up that you didn’t expect?” “Any lapses?” (If yes) “What did you learn from that experience?” “How did you get back on track?” Praise and support the patient’s efforts.</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Continue to praise and support the patient. Remind the patient that lapses and relapses are common but can be useful for learning about unexpected situations that may trigger the problem behavior. “Are there any other situations that you didn’t anticipate?” (If yes) “What was it about the situation that was a trigger for you?”</td>
</tr>
</tbody>
</table>

Information from references 14, 22, and 23.
Motivational Interviewing

Motivational interviewing (Table 5) recognizes that patients may be ambivalent about change and emphasizes patient autonomy, values, and collaboration with the physician. The technique includes agenda setting, exploration, providing information, listening and summarizing, and generating options and contracting.

Beginning with agenda setting, the physician asks permission before discussing psychosocial conflicts, adherence, or health risk behavior. After eliciting permission, the physician then explores the topic with change-oriented queries focusing on the patient’s investment, urgency, perceived need, and reasons for considering change. With an understanding of the patient’s motivation and values, factual information about the importance of change and treatment availability is presented in an emotionally neutral manner. This interpersonal style, which facilitates a partnership between patient and physician, is in contrast to the “righting reflex” (in which the physician unilaterally presents the correct course of action).

Proponents of motivational interviewing believe that physician directiveness activates patient resistance. However, using this technique, information is immediately followed by eliciting the patient’s reaction, which the physician then summarizes. In concluding the encounter, the patient is encouraged to consider treatment options and tentatively agrees to a specific plan with the physician (contracting). Evidence indicates that in primary care clinics, brief physician motivational interviewing has a positive effect on weight loss attempts, exercise efforts, decreased substance use, and blood pressure control.

Problem-Solving Therapy

Problem-solving therapy (Table 6) is a four-step approach (problem definition, generating alternative solutions, decision making, solution verification and implementation), which was developed from research comparing the problem-solving skills of clinical versus nonclinical populations. Problem-solving therapy’s 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.

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.37-39

### 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.40 The questions are almost always asked in the specific order listed in Table 7.14,40,41 The initial open-ended background question is a reminder to listen to the patient’s presenting narrative. Physicians are often concerned that initial open-ended questions will lead to overly long descriptions. However, most patients complete their answers in less than one minute, with 90 percent completing their answer in less than two minutes.42 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.41

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.40,41 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,

### Table 6. Principles of Problem-Solving Therapy

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
<th>Examples of physician statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem definition</td>
<td>Obtain factual, concrete information; clarify nature of the problem; describe the problem objectively and succinctly</td>
<td>“What part of this situation is most distressing for you?” “It sounds like the key difficulty is...”</td>
</tr>
<tr>
<td>Generating alternative solutions</td>
<td>Encourage the patient to brainstorm and generate several possible solutions</td>
<td>“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.</td>
</tr>
<tr>
<td>Decision making</td>
<td>Evaluate possible solutions; predict possible consequences of the selected solutions</td>
<td>“Which of the options that we’ve talked about seem better to you?” “Of those, which one seems best?”</td>
</tr>
<tr>
<td>Solution verification and implementation</td>
<td>Restate the behavior plan; review any obstacles and develop a plan for each</td>
<td>“At this point, your plan is...” “Is there anything that could get in the way?” “What could you do about that specific challenge?”</td>
</tr>
</tbody>
</table>

Information from reference 34.

### Table 7. BATHE Technique for Addressing Psychosocial Problems

<table>
<thead>
<tr>
<th>Component</th>
<th>Examples of physician statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td>“What’s going on in your life?” “What has happened since I last saw you?”</td>
</tr>
<tr>
<td>Affect</td>
<td>“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?”</td>
</tr>
<tr>
<td>Troubles</td>
<td>“What bothers/troubles you most about the situation?”</td>
</tr>
<tr>
<td>Handling</td>
<td>“How are you coping with/handling the situation?”</td>
</tr>
<tr>
<td>Empathy</td>
<td>“It sounds very frightening/frustrating/sad.”</td>
</tr>
</tbody>
</table>

Information from references 14, 40, and 41.
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.

**Approach to the Patient**

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—projects 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.

The Author

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**REFERENCES**

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Office-Based Counseling