Unfortunately, there are few guidelines from Canadian sources for this topic, and a great amount of quality content from the American Association of Family Physicians, As well as the American Psychology Association and "Psychiatry in Primary Care" (from CAMH). s o much of the content is from them.

This is a topic that I see essentially untouched in other CCFP resources and not very well covered through medical school. I don't think I ever discussed these things even when on psychiatry rotations.

Rather than run away from this, we felt this made it all that much more important that we do our best to cover this topic for your reviewing pleasure.

We are also incredibly fortunate to have Dr Todd Hill, Psychologist and Director of Behavioural Medicine with the University of Calgary department of Family Medicine as expert reviewer for this episode. He wears many hats and we are so thankful for his willingness to offer his time and expertise to review this episode for us and you. And we also are super lucky to have Sarah here to Co-Host

[Sarah stuff]

While we are discussing this topic, I want you to recognize the wide applicability of this. We aren't just talking mental health here, these tools in the Primary Care setting can be applied to: weight loss, smoking cessation, social adaptations, vaccine hesitance and almost anything else you can imagine. Whether you like it or not, as a general practitioner you are already doing counselling, so you should aim to do it well.

That was a long preamble, and there is a lot of content to cover, so lets goooo.

Objective One:

When counselling a patient: Set clear therapeutic goals with the patient, Allow adequate time, Evaluate your own skills, Recognize when you are approaching or exceeding boundaries, Recognize when your beliefs or biases may interfere with counselling. Remain aware of the risks of offering advice versus providing options and Pay close attention to the quality of the therapeutic relationship and alliance

In Dr. Judith Becks wonderful CBT book 'basics and beyond' she suggests the initial session be used just to establish the general goals for the patient and establish expectations for future sessions. They should know that this isn't intended to be 'fixed' overnight, but will likely look like small bite size progress every day towards the goals you have discussed.

Formally collaborating on the therapeutic goals with the patient achieves a few things:

1. ensures you and the patient are striving in the same direction
2. puts it down in the record for reference at subsequent appointments and for later consultations or referrals
3. formalizes the collaboration between yourself and the patient in developing these goals
4. meta-analysis suggest it actually enhances therapy success (*Psychotherapy*, Vol. 55, No. 4, 2018).

The most common format for therapeutic goals is the ubiquitous SMART goals. You want to establish goals with the patient that are:

- S pecific

- M easurable

- A chievable

- R elevant

- T imeline

Another thing to keep in mind when setting these SMART goals is that they have to be important to the patient. This is where some of your motivational interviewing is going to come in handy. Remember motivational interviewing is "a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence"

Motivational Interviewing Structure

A 2013 meta-analysis of 48 studies showed statistically significant advantage for motivational interviewing over usual care in medical settings in a number of clinically useful areas including: body weight, HIV viral load, death rate, alcohol use, tobacco use, sedentary behaviour, confidence in changing. They also noted it "appears efficacious when delivered in brief consultations"

This is a very general overview, but it is structured as i) understanding concerns and building rapport ii) sharing information neutrally iii) establishing the treatment plan.

An important thing to remember when considering the use of motivational interviewing techniques with your patient is that these techniques have only been shown to be useful with patients who are 'contemplative', that is, those who are willing to consider change, but without any immediate plans. That is, to urge them on to that planning phase.

A pre-contemplative patient may perceive the 'change talk' as preachy and can lead to a rift in the therapeutic relationship.

i) Understanding concern and building rapport

The commonly used OARS mnemonic helps to remember what to always include when utilizing motivational interviewing:

- **O**pen Ended Questions:

- **A**ffirmations: take joy in your patient's successes and express it to them, while acknowledging the struggles and emphasizing their strengths.

- **R**eflective Listening: your patients have the answers, so let them talk it through and reflect back at them what you have heard them say. This also allows them to know they have been understood or to correct you along the way.

- **S**ummaries can happen both in small chunks along the way and with a summary at the end. This allows you to ensure you are on the same page, and enables them to correct any misunderstandings in the summary

ii) Share information objectively

- Ask permission before presenting the information and ensure objective language
"can I share some information with you about drinking alcohol while pregnant?"

- after presenting information, ask for their perspective on it
"what do you think of the information I just shared with you?"

- pair the health risk with important parts of the patient's life
"How does your alcohol use fit with your values regarding your wish for a healthy child?"

iii) Establishing a treatment plan

- summarize the patients own words relating their desire to change

- ask her for her own ideas for how to make these desired changes
"what approaches do you know for stopping drinking?"

- ask if she wants to hear about available supports or treatments

- if so, provide a menu of options, and provide a recommendation if she seems to want your suggestion of one option over others

b) Allow adequate time

This process is not quick and will likely involve a lot of quiet periods of time as you allow the patient to reflect and think on, and aim to solve, their ambivalence in the area we're discussing.

Ensure you book more than 10 minutes for these sessions, particularly the initial meeting. There are often billing codes for counselling sessions with adders for xx minutes of time spent beyond the base appointment.

But don't despair, there is good evidence that even a brief intervention at each visit can have clinical significant benefit for your patients. Similar to smoking, a Cochrane review in 2018 found moderate evidence suggesting that brief 5-15 minute interventions were enough to reduce hazardous consumption compared to no interventions within 6 – 12 months of intervention.

N.B. good for physicians to set realistic expectations. Don't push patients to 'set goals' too early – can lead to 'setting patients up for failure. Set goals during 'Preparation' phase (ready to make the change within the next 6 months)

As with anything, you will become more adept and efficient with these methods the more you use them.

c) Evaluate your own skills (e.g., Does the problem exceed the limits of your abilities? Are you the right person and is this the right time to unpack the patient's concerns?)

Just as with any area of general practice, you need to take your own pulse first. Are you worried about this patient when they leave your clinic? Do you have specific training in this area or experience in this area?

If you don't feel comfortable with your ability to counsel this patient, they are degrading despite your best efforts, or you will lose sleep thinking about what you could have done, then phone a friend.

Locate a counsellor or psychologist with expertise in this area, refer to psychiatry if appropriate, detox if the patient is willing, or even to a GP colleague who does have expertise in this area.

The point here is to realistically evaluate your own comfort and reach out for help when you are not comfortable or when you think the patient will likely benefit from seeing someone with more experience that you have.

d) Recognize when you are approaching or exceeding boundaries (e.g., transference, counter-transference)

Transference = "a projection of a relationship dynamic that you as an individual have, onto another person" in this case, what your patient feels towards you.

Counter-transference = refers to when the person you are transferring onto, responds back to you with that same dynamic. In this case, the care providers response to transference from their patient.

For skilled counsellors, psychologists and psychiatrists, these dynamics are not necessarily a bad thing. However, to make them beneficial or to neutralize any difficulties they may cause, they have to be recognized for what they are and included in the therapeutic plans.

For most of us, unless you have attained additional specialty training, the presence of strong transference and / or counter-transference affecting the therapeutic relationship, it is likely a good signal that it is time to refer these patients on to one of our skilled colleagues.

e) Recognize when your beliefs or biases may interfere with counselling. Remain aware of the risks of offering advice versus providing options

The principles of motivational interviewing and the benefits of the therapeutic alliance were related previously. Both of these tools require that you and the patient function as allies in their treatment, and not as a directive structure.

As such, one needs to be careful about offering advice without first having it explicitly requested. Without this request, it becomes paternalistic and can be damaging to the relationship.

If not requested, focus on your motivational interviewing fundamentals and guide the patient to exploring their feelings, thoughts and ambiguities to arrive at some options that suit them and their context.

If you find yourself becoming frustrated, emotional, bored, consider if these emotions are triggering you towards offering advice as a means to cope with these feelings. If so, this may be a helpful reflection to assess your own struggles with the relationship.

g) Pay close attention to the quality of the therapeutic relationship and alliance

We know from much research that one of the most important variables for successful counselling interventions is the therapeutic relationship and alliance. A 2018 review of 16 meta-analyses by the APA concluded “Anyone who dispassionately looks at effect sizes can now say that the therapeutic relationship is as powerful, if not more powerful, than the particular treatment method a therapist is using,”

This means recognizing the therapeutic benefit of simply establishing and maintaining your therapeutic relationship and alliance with your patient. You should reflect and actively assess this at each session and do not take it for granted.

Objective Two:
For a patient who is considering or requesting referral for

counselling/psychotherapy, clarify concerns and provide realistic information about the process and available resources (e.g., expectations, timing, frequency, costs, duration, homework, starting/ending the relationship if ineffective).

This is going to require you to know the available local resources where you are practicing. For example, some of the primary care networks I have rotated through have psychologists and counsellors available for referral within 2-3 weeks time, which is incredible. However, there are many areas in the same city where the wait for public options can be months. There are often private practices, but the cost may be too much for many patients. This accessibility piece is a big one to discuss up front.

Getting specifics about their reason for requesting referral for counselling or psychotherapy may be a helpful first step. It may be that referral would be inappropriate and a consult somewhere else may be a better first step. It may be also that, in fact, you may be able to offer them the assistance they need in your clinic. Even if you are going to refer them, clarifying the reasons is still needed to enable a clear reason and requested goals of therapy for the receiving consultant.

- As an example, someone wanting counselling for spousal abuse is quite different from counselling for feelings of depression or psychosis.

When planning to refer, you need to be realistic with your patient about how long a referral is likely to take, how it can often require many sessions over an extended period of time, and will require hard work and buy-in from them to get benefit. You can also ensure they know the important of the therapeutic relationship and that they can elect to end the relationship if it is ineffective.

Tools for Primary Care

All this being said, the AAFP has created an article with some of the more evidence-based motivational interviewing techniques for primary care, that we

are going to quickly review for you here, link to this excellent article in the show notes:

We will also link to an excellent article from the PorticoNetwork. We have mentioned this awesome resource in our episode on Anxiety. This time it is to mention the supported self-management technique which is used to enable a Family Physician to 'coach' the patient through managing some of their own mental health difficulties without having to engage significant resources. It is a low-intensity behavioural intervention in which the patient uses a self-care tool with support from a health care provider.

A couple other common tools we wanted to review were also the Five A's and the BATHE technique.

1. The Five A's
   Classically we know this one as it relates to smoking cessation. It does indeed show benefit in this area, but what you might not know is that is has grade B evidence for application to alcohol use reduction and modest weight loss.
   To review, the five A's are:
   A- sk them if they smoke/drink/would like to discuss weight loss, etc
   A – dvise them on how this can be achieved
   A – ssess their readiness to make the needed changes and their understanding of the effects of their harmful behaviours
   A – ssist them with resources to help accomplish these changes
   A – rrange for follow-up to either reassess readiness for change or track and support progress

2. The BATHE technique
   'the fifteen minute hour: therapeutic talk in primary care' – the book that this comes from is listed in the shownotes.
   New to me, this has been shown to be beneficial for primary care in

approaching patients with psychiatric conditions or psychosocial stressors. And it goes a little something like this:

Background "what is going on in your life?" or "What has been happening since I saw you last?"

Affect "How do you feel about that situation?" "How are you feeling about that situation since we spoke last?"

Can also use non-verbal cues, tone changes to point out emotional states that aren't explicitly mentioned.

Troubles "What bothers you most about this situation?" "When we talked about this last time, you said _____ was the most upsetting, is that the same today?"

This helps to narrow down what might be an overwhelming situation into a priority piece. It may also surprise you what aspect is most bothersome for them.

Handling: "How are you handling/coping with this situation?" "How are you planning on approaching this situation going forward?"

Empathy: "That sounds frustrating", "This sounds like it could be very difficult for you"

Sources Used

https://www.cfp.ca/content/53/6/1013

https://www.aafp.org/afp/2018/1215/p719.html

https://onlinelibrary.wiley.com/doi/abs/10.1080/14733140802453794

Lundahl B, Moleni T, Burke BL, Butters R, Tollefson D, ButlerC, Rollnick S, Motivational interviewing in medical care settings: A systematic review and meta-analysis of randomized controlled trials, Patient Education and Counseling(2013), http://dx.doi.org/10.1016/j.pec.2013.07.012

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy, 55*(4), 316–340. https://doi.org/10.1037/pst0000172

Judith S. Beck Cognitive Behaviour Therapy: Basics and Beyond

https://www.cochrane.org/CD004148/ADDICTN_effectiveness-brief-alcohol-interventions-primary-care-populations

The Fifteen Minute Hour: Therapeutic Talk in Primary Care, Fourth Edition Paperback – Sept. 25 2008

by Marian R. Stuart (Author), Joseph A. Lieberman III (Author), Jane Seymour (Author)

https://www.porticonetwork.ca/web/psychiatry-primary-care/special-topics/supported-self-management

Self-management

- *The Feeling Good Handbook* by Dr. David D. Burns, Penguin Books, 1999.
- *Mind Over Mood* by David Greenberg and Christine Padesky, Guilford Press, 1995.
- *Reinventing Your Life: How to Break Free of Negative Life Patterns* by Jeffrey Young and Janet Klosko, Penguin Books, 1993.
- *The Mindful Way through Depression* by Mark Williams, John Teasedale, Zindel Segal and Jon Kabat-Zinn, Guilford Press, 2007.

Online resources

- Canadian Mental Health Association
- Canadian Network for Mood and Anxiety Treatments
- Internet Mental Health
- Mood Disorders Society of Canada
- National Institute of Mental Health
- Academy of Cognitive Therapy

- British Association for Behavioural and Cognitive Psychotherapies
- Centre for Addiction and Mental Health

Psychotherapy: References

Butler, A.C., Chapman, J.E., Forman, E.M. & Beck, A.T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review, 26* (1), 17–31. DOI: 10.1016/j.cpr.2005.07.003

DeRubies, R.J., Hollon, S.D., Amsterdam, J.D., Shelton, R.C., Young, P.R., Salomon, R. et al. (2005). Cognitive therapy vs medications in the treatment of moderate to severe depression. *Archives of General Psychiatry, 62*(4), 409–416.

Fiejo de Mello, M., de Jesus Mari, J., Bacaltchuk, J., Verdeli, H. & Neugebauer, R. (2005). A systematic review of research findings on the efficacy of interpersonal therapy for depressive disorders. *European Archives of Psychiatry and Clinical Neuroscience, 255* (2), 74–82. DOI: 10.1007/s00406-004-0542-x

Gingerich, W.J. & Eisengart, S. (2000). Solution-focused brief therapy: A review of the outcome research. *Family Process, 39*(4), 477–498. DOI: 10.1111/j.1545-5300.2000.39408.x

Hollon, S.D., DeRubies, R.J., Shelton, R.C., Amsterdam, J.D., Salomon, R.M., O'Reardin, J.P. et al. (2005). Prevention of relapse following cognitive therapy vs medications in moderate to severe depression. *Archives of General Psychiatry, 62*(4), 417–422.

King, M., Davidson, O., Taylor, F., Haines, A., Sharp, D., & Turner, R. (2002). Effectiveness of teaching general practitioners skills in brief cognitive behaviour therapy to treat patients with depression: Randomized controlled trial. *British Medical Journal, 324* (7343), 947. DOI: 10.1136/bmj.324.7343.947

Klomek, A.B. & Mufson, L. (2006). Interpersonal psychotherapy for depressed adolescents. *Child & Adolescent Psychiatric Clinics of North America, 15* (4), 959–975.

Maccarelli, L. (2002). Maintenance interpersonal psychotherapy (IPT-M) treatment specificity: The impact on length of remission in women with recurrent depression. *Dissertation Abstracts International: Section B: The Sciences and Engineering, 63*, 536.

Rollman, B.L., Benlap, B.H., Reynolds, C.F., Schulberg, H.C. & Shear, M.K. (2003). A contemporary protocol to assist primary care physicians in the treatment of panic and generalized anxiety disorders. *General Hospital Psychiatry, 25*, 74–82.

Stein, M.B., Sherbourne, C.D., Craske, M.G., Means-Christensen, A., Bystritisky, A., Katon, W. et al. (2004). Quality of care for primary care patients with anxiety disorders. *American Journal of Psychiatry, 161* (12), 2230–2237.

Teasdale, J.D., Fennell, M.J., Hibbert, G.A. & Amies, P.L. (1984). Cognitive therapy for major depressive disorder in primary care. *British Journal of Psychiatry, 144* (4), 400–406.

Van Schaik, A., van Marwijk, H., Ader, H., van Dyck, R., de Haan, M., Penninx, B. et al. (2006). Interpersonal psychotherapy for elderly patients in primary care. *American Journal of Geriatric Psychiatry, 14* (9), 777–786.