Counseling tips, techniques, and caveats

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SUMMARY

Many medical visits are generated by psychosocial problems or their symptoms. Every family physician, therefore, should have counseling skills despite constraints of time and training. This article discusses issues such as the characteristics of effective therapists, the limitations of the medical model, the core role of self-esteem in anxiety and depression, and the importance of purpose and meaning to physical and mental health.

RÉSUMÉ

Les troubles psychosociaux et leurs manifestations symptomatiques engendrent de nombreuses visites chez le médecin. Tous les médecins de famille doivent donc posséder des habiletés en counselling malgré les contraintes de temps et de formation. L'article discute de certains aspects comme les caractéristiques d'un thérapeute efficace, les limites du modèle médical, le rôle essentiel de l'estime de soi dans l'anxiété et la dépression et l'importance d'avoir un but et un sens pour le maintien de la santé mentale et physique.

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MANY PATIENT VISITS ARE DUE TO psychosocial problems.[1,2] Counseling is, therefore, an important activity for family physicians, but there are few books on the subject and relatively little training in counseling during the crammed 2-year Canadian residency program. One study[3] reported that 43% of Ontario graduates felt inadequately trained in psychotherapy. In several provinces physicians can bill for counseling or psychotherapy, but at present there is little accountability for skill level. Family physicians compete with trained psychologists and social workers and others whom patients usually pay. The medical profession must grapple with the issues of cost effectiveness, training, and accountability if provincial funding is to continue.

It seems crucial not to limit funding to physical maneuvers, which would only encourage the somatization already prevalent. "Is it all in my head, doctor?" is a symptom of the stigma of psychosocial issues and of the mind-body split that says we are responsible for our psychological problems but not for our physical ones. A vast amount of data now suggests that those same psychological problems, stresses, and unhealthy coping and lifestyles contribute considerably to organic physical illnesses. Some studies[4] point to the limitations of the medical model for explaining many presenting problems in practice: 50% of 109 patients with chest pain had no proven disease[5]; 62.3% of 300 patients with fatigue had no organic cause[6]; 79% of 552 men with abdominal pain had no specific organic diagnosis.[7]

I chose the word counseling because it is general, covering problems related to physical illness, lifestyle, and problems of living. It is defined in the Ontario Health Insurance Plan (OHIP) as an educational dialogue. The OHIP definition of psychotherapy refers to mental illness and attenuating or reversing disturbed patterns of behaviour and has the ring of hierarchy, pathologizing, and a fix-what-is-broken approach, rather than mutual education and negotiation.

Family medicine residents tend to mistrust the efficacy of talk therapy in contrast to pill therapy, but patients say very clearly they want physicians who listen. An Ontario project[8] surveyed a diverse public on what they wanted in a physician. Eight roles were distilled

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from their answers: communicator, educator, humanist and healer; collaborator (with patients, their families, other health professionals, and community organizations); health advocate (emphasizing prevention); gatekeeper to the health care system and resource manager; medical decision maker; scientist and scholar; learner; and finally, person. This study epitomizes a new respect for the consumer and emphasizes the crucial role of the doctor-patient relationship.

Whether family physicians do counseling as a regular part of practice depends on education, ability, exposure to role models during residency, and, increasingly, necessity. Often in rural areas no one else is available to deal with family problems, abuse, or even serious mental illness. The alternative to counseling is to turn a blind eye and avoid the appropriate questions. Even in the city, access to psychiatry or psychology can be costly or difficult, and patients often refuse referral.

Family physicians often learn counseling by trial and error, getting better at it with experience. Some take training and then discover it is as hard or harder to get good at talk therapy as it was to become a good physician. It is humbling to take a 3-year course in family therapy, as I did, and realize I was equipped to handle only simple problems, compared with the social worker down the street who has had years of training and experience. Courses in transactional analysis, hypnotherapy, neurolinguistic programming, and supportive psychotherapy are also useful for family physicians.

However, some encouraging research suggests that a therapist's characteristics are more important than training. Characteristics of a good therapist are also those of a good physician. Whether or not we spend time counseling per se, a patient-centred approach to medical care and good doctor-patient relationships are important to medical outcomes[9] and are the best prophylaxis against litigation. We must ask patients about their ideas and feelings about their illness and its impact on function, and about their expectations of their physicians.

This article is systemic in approach. It tries to show the broad social context for psychological and often physical symptoms that might be a family's dysfunctional way of maintaining homeostasis when it is afraid to face problems of communication, abuse, or addiction. I do not try to cover the vast area of counseling in family practice in one article; my objective is to give a general approach to counseling that I have found effective.

Characteristics of effective counselors

Carkhuff[10] showed that, regardless of training level or school of psychotherapy, therapists were effective if they had three characteristics: warmth and genuineness, or congruence (being the same inside as outside, giving the same message verbally and nonverbally); unconditional regard for patients; and accurate empathy.

Congruence. Satir and colleagues[11,12] describe congruence as expressing one's own thoughts, feelings, and opinions; acknowledging the thoughts, feelings, and opinions of the other; and acknowledging the context of the relationship. Each interaction has these three components. If one or more component is omitted, the communication is not congruent. If the speaker ignores his or her own feelings but acknowledges the other's, the result is placating or subservient behaviour. If the speaker ignores the other's responses and feelings, the behaviour is blaming. When both self and other are ignored and only the context discussed ("just give me the facts"), the communication is super-reasonable, a stance well developed by physicians and needed in the operating room or emergency room, but not helpful at other times nor healthy for the physician. This cool approach to problems is one of the main complaints of patients who want

a warmer, more human approach to life and death issues. When all three components of an interaction are ignored, distraction or irrelevance results; the escape artist changes the subject, leaves the room, or goes off for a drink.

Each incongruent response masks an unacknowledged feeling: the placator hides underground anger, the blamer helplessness, the super-reasonable robot a fear of feelings of any sort, and the distracter despair. All of us are skilled in these incongruent responses and usually expert in one (eg. tendency to blame or placate) and use them when our self-esteem is threatened or when we feel defensive. When we feel confident, we tend to respond to others congruently. Ironically, the habits of blaming, placating, being super-reasonable, or distracting tend in themselves to lower self-esteem.

Physicians, who often believe they should be detached and unemotional (ie, super-reasonable), suffer an increasing sense of alienation and loneliness as incongruence spreads to behaviour with colleagues and family. Patients lose the sense that the physician is a real person behind the inscrutable mask. A good bedside manner requires a feeling person who reacts with sadness or pleasure to a patient's story and is capable of self-disclosure when appropriate. Obviously, overdoing the emotional response can be inappropriate if not dangerous, but most physicians err in the other direction.

Unconditional regard. Expecting to like all patients is a tall order. Some patients are unlikely to be popular with any doctor, so referring them on does nothing to help. If you cannot stand a patient, do a genogram.[13] It will almost invariably help you change tack from the exhausting list of symptoms and chronic complaints to an exploration that will interest both patient and doctor and help the latter understand why the patient is the way he or she is. Empathy tends to flow from this process. A skeletal genogram is useful for every patient, but a more detailed one will help with diagnostic problems, relationship or genetic problems, and difficult patients. Quite often, a genogram will switch the focus from physical symptoms to the real issues of loneliness and relationship problems that underlie them.

Empathy. Accurate empathy comes from careful listening and fully putting oneself in the patient's shoes. This is possible only when physicians have freed themselves from blocking difficult issues such as abuse, death, or family distress. Withdrawal into super-reasonable distance is a physician's defense, but it kills a trusting empathic relationship.

Empathy is difficult to feign. Anger, irritation, or revulsion must be acknowledged to oneself first and accepted as normal and human, or these feelings will subconsciously interfere with the doctor-patient relationship. Denying feelings blocks communication. In fact, using one's feelings and expressing them tactfully can be very helpful feedback for patients.

Other attributes of successful therapists

Therapeutic optimism. It is important to see the positive intentions behind a patient's behaviour, such as the need to remain independent and feel healthy rather than take hypertensive medication or the caring and worry behind an alcoholic's wife's nagging. Positively reframing behaviour will enlist the positive, healing parts of the patient rather than create more resistance: "Forgetting your insulin is part of your wanting to see yourself as healthy. I understand that." The positive intention of a physical symptom can be usefully reframed: "It sounds as if your headaches are giving you a message about your lifestyle." Actually inviting a patient to have a conversation with the symptom can often get at the symbolism or unconscious purpose of that symptom. Positive reframing

and normalization indicate acceptance of patients as they are.

Acceptance by the physician facilitates a patient's self-acceptance, which is a necessary step in the process of behaviour change. Again, self-esteem is central. I believe that, in successful doctor-patient encounters, patients leave the room feeling better about themselves than they did when they came in.

An accepting attitude comes mainly from a physician's own self-acceptance, just as therapeutic optimism tends to go with the experience of successful change in a physician's own life.[14] It is, therefore, unwise to ignore self-awareness and personal growth and development, although this is rarely spoken of in medical circles. Physicians' fear of problems in themselves and their families appears to be an important factor in avoiding any "can of worms" in their patients.

Good listening skills. The term "active listening" refers to the components of nonverbal attention and verbal comments and clarifications that do not give advice or judgments but encourage speakers to continue their own line of thought. This often leads to problem solving without prompting; patients find inner resources to resolve their own problems. For some people, the experience of feeling fully heard, often for the first time, is powerful (an effective homework for a couple is for each to listen to the other for 15 to 30 minutes, without interrupting or commenting, with the simple goal of understanding the other).

The idea of a therapist as a reflective surface and mirror in which patients can see themselves and their problems works if you believe in people's ability to heal themselves. This is the basis for the empowering therapeutic relationship. The ability to clarify what patients are feeling, to help them name feelings and dilemmas, to reflect back what is going on accurately, and sometimes to connect current experience with past (particularly childhood) experience, helps patients gain a distance and objectivity that can mobilize them to find answers for themselves. It breaks a cycle of escalating anxiety and circular worrying. It also normalizes. If a physician can understand the dilemma, it cannot be that weird or unique.

Often the issue is shame or guilt, and simply naming the feeling or behaviour helps the person move beyond it. Bradshaw, in *Healing the Shame that Binds You*,[15] says that sharing the shame automatically makes the unspeakable speakable and forgivable.

Patient empowerment. The ability to empower patients to take responsibility for their own health and process of change requires tact and timing. In *Reality Therapy*[16] Glaser says physicians should first develop a relationship with a patient. This could take 2 minutes, 2 years, or longer. Before they have this connection, they can do nothing effective. Second, physicians should confront patients with the responsibility for their own lives and point out that only they can change things.

As family doctors, we have the advantage of seeing patients over time and can capitalize on the flexibility and increased motivation individuals and families have during personal or health crises. The tone in which physicians make suggestions (empathy or lecture) could be the determining factor in whether patients opt for change. Diagnosis is the physician's responsibility; what patients do with it is their responsibility. But doctors should not underestimate their influence.

General principles of counseling

Stages in the process of change. Satir et al[12] provided a model of the change process. A person is in a certain status quo that is comfortable because it is familiar. People resist change, often even when the status quo is producing psychosocial or physical symptoms. Satir[11] reframed resistance as "people's way of saying they are OK, even if they do not feel that way." Symptoms bring patients to physicians who then

can become one of the "foreign elements" that prompts change. Other foreign elements can be life crises, illness, death, falling in love, or a chance statement or television program that disturbs the status quo.

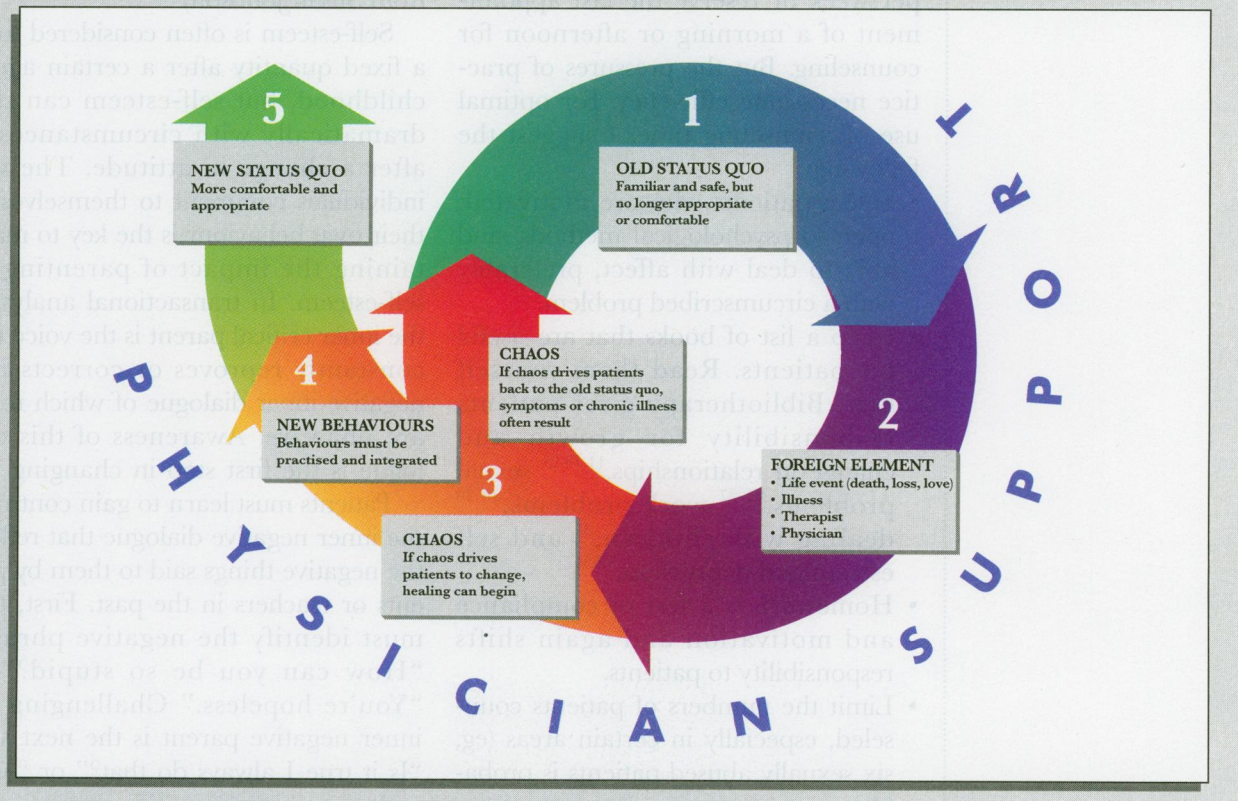
The next stage is chaos. Anything new evokes a stress response and temptation to return to the old status quo, until new behaviours are developed. New behaviours are practised until they become comfortable and a new status quo, more appropriate to circumstances, is reached. If a person returns to the old status quo, symptoms or chronic illness might be the means of maintaining a dysfunctional homeostasis, helping avoid conflict or expressing pain. Chaos and discomfort are normal for any change. Eventually, the new status quo becomes dated, inappropriate to current circumstances, and the cycle repeats.

Each crisis of change or challenge produces a period of insecurity, depression, and lowered self-esteem as people try to cope. As they master new situations and behaviours, they feel better about themselves. If people can learn to recognize that taking a risk means growth and to focus on the positive aspects of the outcome and reward or appreciate themselves for it, their self-esteem will improve with every risk taken.

However, crisis can be a dangerous opportunity. Without support and a positive approach to change, symptoms or depression can be overwhelming and lead people to decompensate. A physician's role as support during the change process can be the key to the outcome (*Figure 1*).

Limitations of the medical model. Weston et al[4] discuss the inadequacy of the medical model in

Figure 1. **The change process:** *Physicians must offer support throughout all five stages*



Data from Satir et al.[12]

understanding illness as opposed to disease. Symptomatic diagnoses, such as anxiety and depression, rather than etiologic diagnoses are helpful only in pointing to medication, not to psychotherapy or counseling. It is the cause that counts; etiologic diagnosis obviously precedes effective therapy.

Radomsky[17,18] reported that 67% of women with chronic pain and chronic illness had a history of sexual or physical abuse and had had an average of 3.3 surgeries compared with 1.75 for those with no abuse. She describes her transition from the medical model of seeing illness within the individual to one in which women voiced psychosocial pain through their bodies. She postulated that this might have been the only safe means of self-expression for subservient or abused women through history.

Time management. Increasing numbers of family physicians across Canada do half- or full-time psychotherapy. Most do 1 to 2 half-days per week or reserve the last appointment of a morning or afternoon for counseling. But the pressures of practice necessitate efficiency. For optimal use of counseling time, I suggest the following:

- Select patients who are motivated, open to psychological methods, and able to deal with affect, preferably with a circumscribed problem.
- Keep a list of books that are useful for patients. Read them yourself first. Bibliotherapy gives patients responsibility for growth and change in relationships,[11,19-21] sexual problems,[22-27] work problems,[28-30] dealing with children,[31] and self esteem and depression.[32-34]
- Homework is a test of compliance and motivation and again shifts responsibility to patients.
- Limit the numbers of patients counseled, especially in certain areas (eg, six sexually abused patients is probably a maximum even for those counseling full-time). Limit appointment times (half-hour, occasionally 1 hour), visit frequency (once in 2 weeks to once a month usually), duration of therapy (maximum 10 sessions), and patient expectations (use contracts to define goals and number of sessions when starting counseling.) Refer patients if complexity or duration of counseling become excessive.

More than 1000 family physicians have joined the GP Psychotherapy Association, which can be reached at 939 Lawrence Ave E, PO Box 47556, North York, ON M3C 2S7

Central role of self-esteem. Depression and anxiety are often, or perhaps always, symptoms of low self-esteem. I have seen patients diagnosed as manic depressive become completely well with marital or family therapy that improved their self-esteem. A recent pilot study in Ottawa showed that marital therapy had better results than drug therapy and a lower recurrence rate.[34] (personal communication from Susan Johnson)

Self-esteem is often considered to be a fixed quantity after a certain age in childhood, but self-esteem can shift dramatically with circumstances or after a change in attitude. The way individuals comment to themselves on their own behaviour is the key to maintaining the impact of parenting on self-esteem. In transactional analysis,[35] the inner critical parent is the voice that constantly reproves or corrects in a negative inner dialogue of which many are unaware. Awareness of this dialogue is the first step in changing it.[32]

Patients must learn to gain control of the inner negative dialogue that reflects the negative things said to them by parents or teachers in the past. First, they must identify the negative phrases: "How can you be so stupid?" or "You're hopeless." Challenging the inner negative parent is the next step: "Is it true I always do that?" or "Am I really stupid?" Cognitive therapy aims at changing this inner dialogue of self-perceptions and expectations.

These perceptions and expectations were built up during childhood, usually from negative messages from parents who were themselves raised on negative messages. For most people a genogram will show that their parents too were victims of poor parenting or crises, such as war and family disruption, that made it impossible to develop nurturing behaviour and create a safe environment. Recognizing this helps patients see that their own self-worth has nothing to do with the chance circumstances of childhood.

A genogram eventually becomes the vehicle for understanding family patterns and helps patients see that they are victims of victims. Suggesting or expecting forgiveness is inappropriate, but as understanding and self-acceptance increase over time, some sort of acceptance or forgiveness of the perpetrators often follows. It might be useful to point out that perpetual anger tends to hurt only the owner.

Support healthy family functioning. High self-esteem automatically results when parents express love, affection, and encouragement and focus on children's positive attributes while setting limits firmly on negative behaviour. Healthy families provide clear but flexible rules. Coloroso[31] describes good parents as the "backbone" variety compared with poor "brick-wall" or "jellyfish" parents. Brick-wall parents produce children who are either very timid or rebellious and delinquent; jellyfish parents' children are often obnoxious, self-centred, and inconsiderate.

In the backbone family, parents and children have a win-win attitude with negotiation and mutual respect. Brick-wall parents tend to be perfectionists, have too many rigid rules, and win at the expense of the child losing. Jellyfish parents lose to children in chaotic families with unclear rules or rules not enforced. Low self-esteem in children results from either extreme.

Another dimension of healthy families is a balance between closeness and autonomy.[36] Extreme independence results in a disengaged family where isolation, loneliness, and denial of feelings is the norm. In an overly close or enmeshed family, everyone lives out of everyone else's emotional pocket and family boundaries are loose or non-existent, sometimes resulting in incest. In healthy families, each person has a separate relationship with each other member without dragging in a third, keeping the communication direct and congruent. Triangulation affects health. Scapegoated children are more likely to be physically ill.[37] The extremes of rigidity, chaos, enmeshment, and disengagement are also associated with physical illness.[36]

Understanding the past. The genograms I do routinely for patients in my practice alert me to genetic and family patterns to consider for primary and secondary prevention. If not done routinely, genograms should be used where they will help most – for difficult patients, diagnostic problems, or complex families. For patients in psychotherapy, a genogram is essential. I start looking for patterns of trauma, triangulation, addiction, conflict, and alliances.

For patients who do not believe in a connection between their current struggle and their past, I recommend using an "affect bridge" to connect their feelings around a recent event to the earliest time they can remember feeling that way. To do this, have patients visualize a recent, painful event in all its detail. Then, when they are immersed in the memory, ask them about the feeling and where it is located in their body. Then ask them to use that feeling as a vehicle to ride back to an event in childhood that evoked a similar feeling. Exploring these scenes in the past frequently shows a remarkable pattern of repeated emotional reaction, often with a similar trigger to the current life situation.

An affect bridge can help define the key issue and locate the event from

which the patient's life script was developed. Scripts are essentially the explanation children make of what is going on around them and of their own position in it. For example, being left with a foster family in the war was interpreted as "I am not good enough" or being physically abused was interpreted as "I am unlovable." Once people recognize their emotional patterns, the emotional charge from the present situation usually decreases markedly and problem solving becomes much easier. Writing a letter to one's past child self is another powerful technique.[15]

Search for meaning. In *Man's Search for Meaning*,[38] Frankl describes three sources of meaning that allowed concentration camp victims to survive: a life work, a love, or a sense of meaning through suffering. Those with no sense of meaning tended to die of starvation or disease. Antonovsky,[39] an Israeli researcher, found that the one variable that correlated most with physical health was what he termed a sense of coherence, defined as "the world is ordered as it should be and I have a place in it."

Over years in practice I have found increasingly that patients' sense of purpose or meaning is essential to mental and physical well-being. Sometimes illness facilitates clarification of values and recognition of what is important in life. For example, a heart attack might help a workaholic to recognize the value of his relationship with his wife and estranged teenagers. For physical symptoms or illness, I ask, "Why do you think this has happened now?" Equally useful is the question, "If you got miraculously better tomorrow, what would be different in your life or your relationships?" Illness is often a symptom of malaise over lack of direction in life or could even represent frankly suicidal tendencies. Helping people recognize what they most value, or even resurrecting childhood dreams and goals, can be extremely rewarding and much more effective than medication. Having them write their 100th birthday memoires or epitaphs is one way to look at long-term goals.

Physicians often feel uncomfortable in the domain of religion or spirituality. Gradually this last conspiracy of silence is breaking down in medicine, with workshops helping physicians deal with the larger issues of life, death, and meaning. Clearly tolerance for all religious perspectives is needed, and physicians must take great care not to impose philosophy or spiritual concepts. Many people reexamine their religious or spiritual views at times of crisis or with middle or advancing age. Referral to the appropriate religious help is often important, but many people are not ready for this.

Conclusion

If therapists can believe that people are inherently good and have a natural tendency to grow, and if patients feel safe and accepted as they are, change for the better can occur. A growth-based or love-based approach to life works better than a fear-based one.[40] I believe that optimists usually have good lives. Pessimism is a self-fulfilling prophecy.

Helping people see their illnesses and events in their lives as meaningful, particularly as learning events, and the planet as a schoolhouse and crisis as opportunity moves them to a new level of growth and optimism. Physicians should try to help their patients find a sense of coherence in their lives. Family physicians, who know patients and their families for years, are in an ideal position to do this. ■

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