Realistic Approaches to Counseling in the Office Setting

H. RUSSELL SEARIGHT, PhD, MPH, *Department of Psychology, Lake Superior State University, Sault Sainte Marie, Michigan*

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.

ILLUSTRATION BY CHRISTY KRAMES

The primary care sector provides at least one half of all U.S. mental health services.[1,2] In the United States, 50 percent of patients treated for major depressive disorder are treated solely by primary care physicians,[3] and about 20 percent of psychotherapy sessions are provided in primary care.[4] However, family physicians often report time pressures and lack of knowledge as barriers to providing systematic counseling. Several models for brief counseling have been developed specifically for the outpatient primary care setting, and other problem-focused psychotherapies may be adapted for this setting.

Family physician counseling is an efficient and cost-effective initial intervention in a stepped-care approach.[5-7] As a first-line therapy, brief counseling is effective for many problems; is acceptable to most patients; and reduces the need for more time-intensive, costly treatment and referral for specialty care.[6,7] Evidence indicates that assessment and treatment overlap with many psychiatric conditions and health risk behaviors. Providing individualized feedback and recommendations about a patient's alcohol consumption,[8,9] diet,[10] and mood disorders[11] often leads to at least short-term improvement without other therapies.

Patient responsiveness to physician education and direct advice is variable. *Table 1* summarizes counseling approaches that address health risk behaviors or adherence problems, ambivalence to change, and broader psychosocial issues.

The Five A's

The five A's (ask, advise, assess, assist, arrange)[12] technique *(Table 2*[13,14]*)* is an efficient strategy for addressing health risk

SORT: KEY RECOMMENDATIONS FOR PRACTICE

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

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.

Table 1. Approaches to Counseling in the Primary Care Setting

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.*

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]

Table 2. Five A's: A Brief Intervention for Addressing Health Risk Behavior

Five A's	*Physician intervention*
Ask	"How often do you drink alcohol?"
	"How much do you smoke?"
	"How often do you exercise?"
	Administer self-report questionnaire.
Advise	"As your doctor, I strongly recommend that you quit smoking/quit drinking/initiate regular exercise. It is one of the most important things you can do for your health."
	Briefly describe patient-relevant risks of continuing the behavior and the benefits of changing.
	Provide written educational material to reinforce your message.
	Do not admonish the patient.
Assess	"Are you ready to quit drinking/quit smoking/initiate exercise in the next 30 days? I can help you with this change."
Assist	"Quitting smoking/drinking can be a real challenge. Pharmacotherapy/community resources/spousal support may help."
	Develop a clearly stated action plan; write it down and make a copy for the patient and for the patient's chart.
Arrange	"I'd like to see you again in two weeks. A nurse will call you next week to see how the plan is going."

Information from references 13 and 14.

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 3[14,17])* 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 drinker[18] 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

Table 3. FRAMES Protocol for Addressing Health Risk Behavior

Component	*Physician intervention*
Feedback about personal risk	Describe the relationship between heath risk behavior and objective indicators, including CAGE questionnaire score, laboratory test findings, and documented recurrent illness.
Responsibility of patient	"The decision to quit smoking/drinking/adhere to a treatment plan is a choice that only you can make."
	"How long do you think you'll continue to smoke/drink?"
Advice to change	"For your health, I strongly recommend that you quit smoking/reduce alcohol use."
	For patients who appear ambivalent about change: "Are you interested in this discussion, do you want to continue?"
	For patients who are not yet ready to change: "Do you mind if I ask about this again at your next visit?"
Menu of strategies	Offer the patient a range of options to assist in making the change, such as pharmacotherapies, avoiding high-risk situations, alternate behaviors, changing environmental antecedents, and enlisting social support.
Empathetic style	"Staying on this diet is a real challenge."
	"Quitting smoking after all these years will be hard. It sounds like you appreciate how tough those first few days without a cigarette can be."
Promote self-efficacy	"Your plan sounds like you have thought through some of the most difficult situations you'll face. You seem very determined to make this important change in your life."

FRAMES = feedback about personal risk, responsibility of patient, advice to change, menu of strategies, empathetic style, promote self-efficacy.

Information from references 14 and 17.

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.

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

Stage	*Physician intervention*
Precontemplation	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?"
Contemplation	"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…"
Preparation	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?"
Action	"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.
Maintenance	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?"

Information from references 14, 22, and 23.

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.

Table 5. Motivational Interviewing to Facilitate Counseling in Primary Care

Component	*Examples of physician statements*	*Rationale*
Agenda setting	"Would you mind if I talked with you about managing your diabetes?"	Asking permission emphasizes patient autonomy
Exploration		
Patient's desire	"Are you interested in better controlling your blood pressure?"	Assesses value of changing
Patient's ability	"Would you be able to walk for 30 minutes each day?"	Assesses patient self-efficacy
Patient's reasons	"You mentioned that you're now more open to taking medication for depression. What makes you open to it now?"	Assesses current sources of motivation
Patient's need	"How important is it that you quit smoking?"	Assesses degree of motivation
Providing information	"Drinking alcohol while pregnant has been found to increase the likelihood of physical and developmental problems in infants. Not drinking alcohol is one of the best things you can do for your baby. There are several options available to help you quit."	Conveys hope; relates risk behavior to long-term health outcomes; indicates that there are treatment options
Listening and summarizing	"What do you think about that idea?" "It sounds like you are interested in seeing a therapist for depression but are worried about finding the right one."	Elicits patient's views of personal health risk and acceptable interventions; identifies sources of patient ambivalence
Generating options and contracting	"It sounds like you have several good ideas about how to reduce your fat intake. Which one do you think would work best? I look forward to hearing about it at our next appointment."	Patient selects specific plan, which will be reevaluated in a specific time frame

Information from references 27 and 28.

Motivational Interviewing

Motivational interviewing *(Table 5[27,28])* recognizes that patients may be ambivalent about change[27] and emphasizes patient autonomy, values, and collaboration with the physician.[28] 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.[28] 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,[29] is in contrast to the "righting reflex" (in which the physician unilaterally presents the correct course of action).[28]

Proponents of motivational interviewing believe that physician directiveness activates patient resistance.[27,28] 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,[30] exercise efforts,[31] decreased substance use,[32] and blood pressure control.[33]

Problem-Solving Therapy

Problem-solving therapy *(Table 6[34])* 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.[34,35] 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.[36] 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

Table 6. Principles of Problem-Solving Therapy

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?"

Information from reference 34.

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]

Table 7. BATHE Technique for Addressing Psychosocial Problems

Component	*Examples of physician statements*
Background	"What's going on in your life?"
	"What has happened since I last saw you?"
Affect	"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?"
Troubles	"What bothers/troubles you most about the situation?"
Handling	"How are you coping with/handling the situation?"
Empathy	"It sounds very frightening/frustrating/sad."

Information from references 14, 40, and 41.

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,

but handling the problem is the patient's responsibility. However, the patient's attempted solutions often cause more upheaval than the problem itself[43]—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.[41] Most BATHE interviews can be conducted in less than five minutes.[41]

Approach to the Patient

In mental health settings, most evidence-based psychotherapies require a minimum of 10 to 15 sessions,[44] and approximately 50 percent of patients do not complete the treatment course.[3] Evidence-based reviews of primary care counseling indicate that brief approaches may lead to short-term reductions in psychosocial distress[45,46] and longer-term reductions in alcohol use[47,48] and depressive symptoms.[49] The models presented in this article 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[5,50] 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.

The Author

H. RUSSELL SEARIGHT, PhD, MPH, is an associate professor of psychology and head of the Division of Social Sciences at Lake Superior State University, Sault Sainte Marie, Mich. For 18 years, Dr. Searight served as director of behavioral medicine at the Forest Park Hospital Family Medicine Residency Program, St. Louis, Mo., and was a clinical associate professor of community and family medicine at Saint Louis University School of Medicine. He received his doctoral degree in clinical psychology and his master's of public health degree from Saint Louis University.

Address correspondence to H. Russell Searight, PhD, MPH, Dept. of Psychology, Lake Superior State University, 650 W. Easterday Ave., Sault Sainte Marie, MI 49783 (e-mail: hsearight@lssu.edu). Reprints are not available from the author.

Author disclosure: Nothing to disclose.

REFERENCES

1. Wedding D, Mengel M. Models of integrated care in primary care settings. In: Haas LJ, ed. *Handbook of Primary Care Psychology*. New York, NY: Oxford University Press; 2004:47-60.
2. Miranda J, Hohmann AA, Attkisson CC. Epidemiology of mental disorders in primary care. In: *Mental Disorders In Primary Care*. San Francisco, Calif.: Jossey-Bass; 1994:3-15.
3. Robinson P. Adapting empirically supported treatments to the primary care setting: a template for success. In: O' Donohue WT, ed. *Behavioral Integrative Care: Treatments That Work in the Primary Care Setting*. New York, NY: Brunner-Routledge, 2004:53-72.
4. Himelhoch S, Ehrenreich M. Psychotherapy by primary-care providers: results of a national sample. *Psychosomatics*. 2007;48(4):325-330.
5. Bower P, Gilbody S, Barkham M. Making decisions about patient progress: the application of routine outcome measurement in stepped care psychological therapy services. *Primary Care Mental Health*. 2006;4(1):21-28.
6. Carels RA, Darby L, Cacciapaglia HM, et al. Applying a stepped-care approach to the treatment of obesity. *J Psychosom Res*. 2005; 59(6):375-383.
7. Haaga DA. Introduction to the special section on stepped care models in psychotherapy. *J Consult Clin Psychol*. 2000;68(4):547-548.
8. Babor TF. Avoiding the horrid and beastly sin of drunkenness: does dissuasion make a difference? *J Consult Clin Psychol*. 1994;62(6):1127-1140.
9. Nilssen O. The Tromsø Study: identification of and a controlled intervention on a population of early-stage risk drinkers. *Prev Med*. 1991;20(4):518-528.
10. Kreuter MW, Strecher VJ. Do tailored behavior change messages enhance the effectiveness of health risk appraisal? Results from a randomized trial. *Health Educ Res*. 1996;11(1):97-105.
11. Mackinnon A, Griffiths KM, Christensen H. Comparative randomised trial of online cognitive-behavioural therapy and an information website for depression: 12-month outcomes. *Br J Psychiatry*. 2008;192(2):130-134.
12. Melvin CL, Dolan-Mullen P, Windsor RA, Whiteside HP Jr, Goldenberg RL. Recommended cessation counselling for pregnant women who smoke: a review of the evidence. *Tob Control*. 2000;9(suppl 3):III80-84.
13. Fiore MC, Bailey WC, Cohen SJ, et al. Treating tobacco use and dependence. Clinical practice guideline. Rockville, Md.: U.S. Department of Health and Human Services; 2000.
14. Searight HR. Efficient counseling techniques for the primary care physician. *Prim Care*. 2007;34(3):551-570.
15. Morreale SP, Spitzberg BH, Barge JK. *Human Communication: Motivation, Knowledge, and Skills*. Belmont, Calif.: Wadsworth/Thomson; 2001.
16. Matthews JR, Anton BS. *Introduction to Clinical Psychology*. New York, NY: Oxford University Press; 2008.
17. National Institute on Alcohol Abuse and Alcoholism. Brief intervention for alcohol problems. *Alcohol Alert*. 1999;43:1-4.
18. Searight HR. Alcohol abuse in primary care: current status and research needs. *Fam Pract Res J*. 1992;12(2):193-204.
19. Heyman RB, Anglin TM, Copperman SM, et al. American Academy of Pediatrics. Committee on Substance Abuse. Marijuana: a continuing concern for pediatricians. *Pediatrics*. 1999;104(4 pt 1):982-985.
20. Bertakis KD, Roter D, Putnam SM. The relationship of physician medical interview style to patient satisfaction. *J Fam Pract*. 1991;32(2):175-181.
21. Kim SS, Kaplowitz S, Johnston MV. The effects of physician empathy on patient satisfaction and compliance. *Eval Health Prof*. 2004;27(3):237-251.
22. Prochaska JO, Redding CA, Evers KE. The transtheoretical model and stages of change. In: Glanz K, Rimer B, Viswanath K, eds. *Health Behav-*

ior and Health Education: Theory, Research, and Practice. 4th ed. San Francisco, Calif.: Jossey-Bass; 2008.

23. Zimmerman GL, Olsen CG, Bosworth MF. A 'stages of change' approach to helping patients change behavior. *Am Fam Physician*. 2000;61(5):1409-1416.
24. Johnson SS, Driskell MM, Johnson JL, Prochaska JM, Zwick W, Prochaska JO. Efficacy of a transtheoretical model-based expert system for antihypertensive adherence. *Dis Manag*. 2006;9(5):291-301.
25. Highstein GR, O'Toole ML, Shetty G, Brownson CA, Fisher EB. Use of the transtheoretical model to enhance resources and supports for diabetes self management: lessons from the Robert Wood Johnson Foundation Diabetes Initiative. *Diabetes Educ*. 2007;33(suppl 6):193S-200S.
26. Prochaska JO, Velicer WF, Rossi JS, et al. Stages of change and decisional balance for 12 problem behaviors. *Health Psychol*. 1994;13(1):39-46.
27. Miller WR, Rollnick S. *Motivational Interviewing: Preparing People for Change*. 2nd ed. New York, NY: Guilford Press; 2002.
28. Rollnick S, Miller WR, Butler C. *Motivational Interviewing in Health Care: Helping Patients Change Behavior. Applications of Motivational Interviewing*. New York, NY: Guilford Press; 2008.
29. Roter DL, Hall JA, Aoki Y. Physician gender effects in medical communication: a meta-analytic review. *JAMA*. 2002;288(6):756-764.
30. Pollak KI, Østbye T, Alexander SC, et al. Empathy goes a long way in weight loss discussions. *J Fam Pract*. 2007;56(12):1031-1036.
31. Ang D, Kesavalu R, Lydon JR, Land KA, Bigatti S. Exercise-based motivational interviewing for female patients with fibromyalgia: a case series. *Clin Rheumatol*. 2007;26(11):1843-1849.
32. Dunn C, Deroo L, Rivara FP. The use of brief interventions adapted from motivational interviewing across behavioral domains: a systematic review. *Addiction*. 2001;96(12):1725-1742.
33. Ogedegbe WC. Motivational interviewing improves systolic blood pressure in hypertensive African Americans. *Am J Hypertens*. 2005;18(5):A212.
34. D'Zurilla TJ, Nezu AM. *Problem-Solving Therapy: a Positive Approach to Clinical Intervention*. 3rd ed. New York, NY: Springer; 2007.
35. Nezu AM, Nezu CM, Lombardo ER. Problem-solving therapy. In: O'Donohue WT, Fisher JE, Hayes SC, eds. *Cognitive-Behavior Therapy: Applying Empirically Supported Techniques in Your Practice*. New York, NY: Wiley; 2003:301-307.
36. Beck AT. *Cognitive Therapy of Depression*. New York, NY: Guilford Press; 1979.
37. Nezu AM. A problem-solving formulation of depression: a literature review and proposal of a pluralistic model. *Clin Psychol Rev*. 1987; 7(2):121-144.
38. Hill-Briggs F, Gary TL, Yeh HC, et al. Association of social problem solving with glycemic control in a sample of urban African Americans with type 2 diabetes. *J Behav Med*. 2006;29(1):69-78.
39. Glasgow RE, Toobert DJ, Hampson SE, Brown JE, Lewinsohn PM, Donnelly J. Improving self-care among older patients with type II diabetes: the "Sixty Something..." Study. *Patient Educ Couns*. 1992;19(1):61-74.
40. Stuart MR, Lieberman JA. *The Fifteen Minute Hour: Applied Psychotherapy for the Primary Care Physician*. 2nd ed. Westport, Conn.: Praeger; 1993.
41. Lieberman JA III, Stuart MR. The BATHE method: incorporating counseling and psychotherapy into the everyday management of patients. *Prim Care Companion J Clin Psychiatry*. 1999;1(2):35-38.
42. Lipkin M, Putnam SM, Lazare A. The Medical Interview: Clincial Care, Education, and Research. *Frontiers of Primary Care*. New York, NY: Springer-Verlag; 1995.
43. Lieberman JA. The differential diagnosis of fatigue and executive dysfunction in primary care. *J Clin Psychiatry*. 2003;64(suppl 14):40-43.
44. Hansen NB, Lambert MJ, Forman EM. The psychotherapy dose-response effect and its implications for treatment delivery services. *Clinical Psychology: Science and Practice*. 2001;9(3):329-343.
45. Bower P, Rowland N. Effectiveness and cost effectiveness of counselling in primary care. *Cochrane Database Syst Rev*. 2006;(3):CD001025.
46. Bower P, Rowland N, Hardy R. The clinical effectiveness of counselling in primary care: a systematic review and meta-analysis. *Psychol Med*. 2003;33(2):203-215.
47. Kaner EF, Beyer F, Dickinson HO, et al. Effectiveness of brief alcohol interventions in primary care populations. *Cochrane Database Syst Rev*. 2007;(2):CD004148.
48. Bertholet N, Daeppen JB, Wietlisbach V, Fleming M, Burnand B. Reduction of alcohol consumption by brief alcohol intervention in primary care: systematic review and meta-analysis. *Arch Intern Med*. 2005;165(9):986-995.
49. Rowland N, Bower P, Mellor C, Heywood P, Godfrey C. Counselling for depression in primary care. *Cochrane Database Syst Rev*. 2001;(1): CD001025.
50. Carels RA, Darby L, Cacciapaglia HM, et al. Using motivational interviewing as a supplement to obesity treatment: a stepped-care approach. *Health Psychol*. 2007;26(3):369-374.