COLLEGE OF MEDICINE
DEPARTMENT OF FAMILY MEDICINE

TO: ALL FAMILY MEDICINE RESIDENTS, FACULTY, and CCOC STAFF

FROM: Johanna Shapiro, Ph.D., Director
Behavioral Science Program

DATE: July 1, 1993

RE: Counseling Clinics

Many of you may have heard about "Counseling Clinics," but are not exactly certain as to what they are, or who they are for. The purpose of these counseling clinics is to provide third year residents with specialized training in patient counseling. They also provide a valuable service to patients who do not have ready access to no-cost counseling. Every counseling clinic is directly supervised by a member of the behavioral science faculty. Below is specific information about the counseling clinics which may prove useful.

1) **WHO HAS COUNSELING CLINICS?:** At present, only third year residents are scheduled for counseling clinics, which are year-long, continuity experiences. Each third year resident is generally scheduled for between one and two counseling clinics per month.

2) **HOW CAN I REFER PATIENTS TO COUNSELING CLINICS?:** Third year residents are expected to schedule patients from their own practices for counseling clinics. However, first and second year residents, as well as medical students and faculty may also make patient referrals to counseling clinics contingent on space available. A patient may be referred to a specific third year resident or simply to "counseling clinic." Referral forms should be used and are available at the nursing stations.

3) **WHEN AND WHERE ARE COUNSELING CLINICS HELD?:** Morning counseling clinics are scheduled from 9:00-12:00 noon; afternoon counseling clinics from 2:00-5:00 p.m. All counseling clinics are scheduled at CCOC.

4) **HOW MANY PATIENTS MAY BE SCHEDULED FOR A COUNSELING CLINIC?:** No more than three patients may be scheduled for a given counseling clinic. With permission from your behavioral science supervisor, you may overbook one additional patient, particularly if the patient is known to you. The wait to be seen in counseling clinic is generally shorter than for County Mental Health.

5) **WHO IS AN APPROPRIATE PATIENT TO BE SEEN IN COUNSELING CLINIC?:** Most types of patients are appropriate for counseling clinic. However, chronic schizophrenic or floridly psychotic patients with multiple problems probably will not receive great benefit from

counseling sessions because of their necessarily limited and infrequent nature. An uninterrupted string of such patients can also be frustrating for the counseling resident. Therefore, please use judgment regarding the number of such patients you refer.

Common referrals of patients who can be helped through counseling clinics include depressed patients; anxiety disorder patients; alcohol and substance abusing patients; patients with marital and family problems, including family violence; issues of loss and grief; and patients adjusting to chronic illness (e.g., diabetic patients, AIDS patients, cancer patients).

In terms of third year self-referrals, counseling clinic patients do not necessarily need to have a psychiatric diagnosis. A perfectly "normal" prenatal patient is an excellent candidate for counseling clinic--you can take an in-depth family history!

6) **WHAT IS THE COST OF COUNSELING CLINICS TO THE PATIENT?:** Patients who agree to come to counseling clinic primarily for the education of the resident (you perceive little direct benefit to the patient) will not be billed at all. In any case, only patients with private insurance or MediCal are billed for counseling clinics--there is no direct cost to the patient.

7) **WHAT ABOUT LANGUAGE DIFFERENCES?:** Language differences can be a problem. Spanish and Vietnamese language student volunteer interpreters are generally available. The volunteer interpreter should be listed on the daily CCOC schedule. If no interpreter is present, it is the responsibility of the behavioral science supervising faculty to discuss the situation with Pat Shimamora, R.N. and reach a resolution.

8) **CAN THE SAME PATIENT BE SCHEDULED MORE THAN ONCE FOR COUNSELING CLINIC?:** Yes, it frequently makes sense to schedule the same patient in situations where follow-up is indicated.

9) **HOW DO I KNOW WHEN COUNSELING CLINICS ARE SCHEDULED?:** Counseling clinics are listed both on the clinic master schedule, as well as on the behavioral science monthly schedule. You should receive this latter schedule approximately two weeks before the start of each month.

JS:yb

cc: Pat Lenahan, LCSW
Mike Masters, Ph.D.

"M"
BR COUNSL
7-1-91

BRIEF COUNSELING TECHNIQUES

I. STRUCTURE
- A. Every encounter should have beginning, middle, end
- B. Goals of beginning
  1. Establish rapport
  2. Establish therapeutic contract
     a. Time limits
     b. Role clarification (what you can and can't do)
  3. Find out patient's understanding of the problem
  4. Compare that to your understanding of the problem
  5. Negotiate a mutual definition
- C. Goals of middle - INTERVENTION
  1. Continue rapport building
  2. Supportive intervention (reinforcement, support)
  3. Reframing intervention
  4. Change intervention
  5. Homework assignment
- D. Goals of ending
  1. Reinforce patient for participating in counseling process
  2. Summarize content of session
  3. Repeat homework assignment
  4. Express appreciation to patient
  5. Establish specific follow-up time if necessary

II. HOW TO ESTABLISH RAPPORT
- A. Show interest in what patient is saying
  1. Listen, don't talk
  2. Look at the patient
  3. Position yourself appropriately in relation to the pt.
- B. Minimal encouragers
  1. Verbal (yes, mmhmm, and?)
  2. Nonverbal (nodding)
- C. Encouragers
  1. Tell me more
  2. What makes you say that?
- D. Self-disclosure
  1. Curvilinear - too much or too little harms relationship
  2. Most people want personal relationship with helper
  3. Avoid disclosure of actively toxic issues
- E. Treat patient with respect and dignity
  1. Unconditional positive regard
  2. Nonpossessive warmth
  3. Person has value as he or she is, without changing

III. IDENTIFYING THE PROBLEM - A PATIENT-CENTERED APPROACH
- A. Nonverbal
  1. Patient mood, posture, tone of voice
- B. Patient self-statements - fears, expectations
- C. Paraphrasing and clarifying
  1. Useful with both statements of fact and statements of feeling

2. Helps negotiate a mutual understanding between patient and physician agendas

D. WH questions
1. Who, what, where, when, why?
2. Move from general to specific

IV. SUPPORTIVE INTERVENTIONS
A. Empathic
1. This must be really difficult for you (painful, hard, terrible, suffering, brokenhearted etc)

2. Self-disclosure: I've been through something similar...

B. Reinforcing
1. You're really doing a good job
2. What are you doing that's working?
3. Focus on process as well as outcome

V. R
FRAMING INTERVENTIONS
A. Goal not to change the situation, but how the patient understands the situation
B. Normalizing
1. Patient thinks she's crazy
2. You assert response is normal, even healthy
C. Weakness vs. patient strength and resources
1. Bad parent vs. good-enough parent
2. authoritarian vs. authoritative
3. Project belief in patient's own competence
a. Crystal Ball Technique - project yourself into future without this problem
b. promote view of self as functioning satisfactorily

VI. CHANGE INTERVENTIONS
A. Behavioral analysis
1. Antecedents-Behavior-Consequences
2. Discrete, realistic goals
3. Successive approximation
4. Cognitive restructuring -
a. identify inaccurate or distorted thoughts
b. replace with more appropriate cognitions
5. Behavioral rehearsal - practice of new behaviors
6. Homework assignments - specificity, concreteness
7. Reinforcement, recognition of progress
B. Problem-solving
1. Get patient involved - ask for help
2. Overcoming resistance - switch roles
3. Brainstorm several alternatives
4. Make a general statement
a. Do something different
b. Let the patient decide what

C. Confrontation
   1. Expression of experience of discrepancies in pt. statements and behavior

D. Interpretation
   1. Goes beyond patient verbalizations, adds something of helper's own insight into meaning beyond patient's intended meaning
   2. Pt: "If I could only leave my husband, my problems would be over"
      Res: "But you're worried you may not be strong enough to leave"
   3. Relies on insight to produce change

E. Identification of social support
   1. Involvement of relatives and friends
   2. Utilization of existing resources and/or creation of new ones

DIAGNOSTIC CRITERIA CHECKLIST

ANXIETY

Anxious mood must have persisted for at least a month with symptoms from three of the following four categories:

1. Motor tension:

    Shakiness, jitteriness, jumpiness
    Trembling
    Tension, muscle aches
    Fatigability
    Inability to relax
    Fidgeting, restlessness, easy startle
    Eyelid twitch, furrowed brow, strained face

2. Autonomic hyperactivity:

    Sweating
    Heart pounding or racing
    Cold, clammy hands
    Dry mouth
    Dizziness, light-headedness
    Paresthesia
    Upset stomach
    Hot and cold spells
    Frequent urination
    Diarrhea
    Stomach discomfort
    Lump in throat
    Flushing, pallor
    High resting pulse and respiration rate

3. Apprehensive expectation:

    Anxiety, worry
    Fear
    Rumination
    Anticipation of misfortune

4. Vigilance and scanning:

    Hyperattentiveness
    Difficulty in concentrating
    Insomnia
    Irritability, impatience

DIAGNOSTIC CRITERIA CHECKLIST

DEPRESSION

Four of following symptoms present for at least two weeks:

1. Appetite changes; weight loss/weight gain
2. Insomnia or hypersomnia (esp. early morning awakening)
3. Psychomotor agitation or retardation
4. Loss of interest or pleasure in usual activities
5. Loss of energy; fatigue
6. Feelings of worthlessness, guilt, hopelessness, helplessness
7. Poor concentration, indecisiveness
8. Recurrent thoughts of death, suicidal ideation

BE SURE TO ASK ABOUT:

1. Suicidal ideation or suicidal attempt
2. Previous history of psych hospitalizations, other episodes of depression
3. Functional level (daily activities)
4. Current medications
5. Alcohol and drug use

DIAGNOSTIC CRITERIA CHECKLIST

PTSD

1. Existence of a recognizable stressor

2. Reexperiencing the trauma as evidenced by at least one of the following:

   a. Recurrent and intrusive recollections of event

   b. Recurrent dreams or nightmares of events

   c. Sudden feeling trauma were reoccurring

3. Numbing of responsiveness to or reduced involvement with external world, shown by at least one of the following:

   a. Diminished interest in significant activities

   b. Feelings of detachment or estrangement from others

   c. Constricted affect

4. At least two of the following symptoms:

   a. Hyperalertness or exaggerated startle response

   b. Sleep disturbance

   c. Survivor guilt

   d. Memory impairment, trouble concentrating

   e. Avoidance of activities that arouse recollection of traumatic event

   f. Intensification of symptoms when exposed to events that represent or resemble traumatic event

OUTLINE

COUNSELING CLINIC PROGRESS NOTES

SUBJECTIVE:

Impressions of the patient, including cognitive functioning (intelligence, alertness, orientation, coherency); affect (clinical signs of depression, anxiety etc.); and any information used in arriving at Axis I and Axis II diagnoses.

OBJECTIVE:

Objective data should include:

a) Social/employment history, including education, religious affiliation, work patterns, social support, living situation, means of financial support

b) Family history, including marital status, number of children, parents living or dead, siblings, extended family support; history of incest, physical, sexual abuse, problems of alcohol, drugs

c) History of specific traumatic events, such as rape, reeducation camp, physical assault, death of family member, etc.

d) Current stressors, including food and shelter difficulties; abusive relationships, drug and alcohol problems, etc.

ASSESSMENT:

Assessment should include DSMIII-R Axis I, V Code Assessment, Axis II, Axis IV-Psychosocial Stressors, and Axis V, GAF Evaluation (or reevaluation).

PLAN:

Plan should include:

a) Cognitive/behavioral interventions
b) Homework assignments
c) Referrals (including names and phone numbers)
d) Return visit

INTINSTR
7-1-91

INSTRUCTIONS TO INTERPRETERS

BACKGROUND. Welcome to the pilot program, "Interpreter-Mediated Brief Counseling for Hispanic Patients." This program, funded by the Latino Research Program at UC Irvine, is an effort to meet some of the basic counseling needs of the low-income, Spanish-speaking patients at the Community Clinic of Orange County (CCOC). This clinic is a general outpatient medical clinic, administered and staffed by the Department of Family Medicine, UC Irvine. Medical care is provided by family practice residents and medical students.

It has been repeatedly observed that many of the clinic patients have psychological and psychosocial problems as well: depression, anxiety, panic disorder; marital conflict, parenting problems, alcoholism and substance abuse in the home. But the crowded schedule of regular clinic hours rarely allows more than superficial attention to these issues. Historically, the clinic has regularly referred patients to Nueva Esperanza, a local, non-profit mental health center; and to County Mental Health. However, it was felt that an additional resource was needed. At the same time, department faculty were looking for a mechanism to teach basic counseling skills to family practice residents.

The convergence of these two needs led to the development of the counseling clinics. The purpose of the counseling clinics is twofold: 1) To provide limited counseling on a range of problems to the CCOC patient population 2) To educate family practice residents in a) basic counseling and psychotherapy techniques b) cross-cultural interactions with a Hispanic population. In order to fulfill goal #2, residents will attend a series of lectures and group discussions on psychotherapy in general, and cross-cultural helping in particular. The first set of these presentations will be the first three Mondays in July, in the biomedical library at UCIMC, and you are all encouraged to attend.

DESCRIPTION OF COUNSELING CLINICS. The counseling clinics are scheduled for 3 hours, from 9:00 - 12:00 in the morning, and 2:00 to 5:00 in the afternoon. They are staffed by the behavioral science faculty: Johanna Shapiro, Michael Masters, and Pat Lenahan. In addition to a behavioral scientist, a resident will also be scheduled. Generally, 3 patients are scheduled per session. The behavioral scientist and resident meet briefly (usually the first half hour before the clinics commence) to review the scheduled patients and discuss their problems. Each session lasts approximately 50 minutes, with 10 minutes for discussion and case write-up.

Only third year residents participate in counseling clinic (this is a total of about 7 residents at CCOC). They are expected to refer patients to themselves for counseling from their regular practices. In addition, first and second year residents as well as medical

students may refer patients to counseling clinic. Whenever possible, they should complete the referral form which can be found at the nursing stations.

ROLE OF THE INTERPRETER. As interpreter, your role is essential. You will provide a linguistic and in some cases cultural bridge between patient and helpers. There are a few guidelines to follow which will make your task both easier and more effective.

1) As soon as the patient has entered the room, invite her to be seated. Introduce yourself, explain your function, and introduce both the resident and the behavioral scientist (address both as doctor).

2) We encourage the resident to look at the patient when he is speaking, even though he is speaking English and she only understands Spanish. When this happens, don't feel that you are being ignored.

3) For interpretation to be successful, small units of communication are essential. Most of us, helpers and patients, have a tendency to want to tell our entire story in one breath. Don't be reluctant to politely interrupt a patient or helper: "Excuse me, senor, allow me to tell what you have just said to the doctor. I want to make sure she understands exactly what you are saying." "Excuse me, doctor, let me tell that to the patient."

4) As much as possible, try to translate the patient's or helper's EXACT words. This may seem more time-consuming than a simple summary, but the purpose of the interpreter is to approximate an actual dialogue as closely as possible.

a) Never "censor" a patient's communication because you think it sounds uneducated, superstitious, illogical, or doesn't make sense. We want to know exactly what the patient says, in her own words, and then we will sort it out together.

b) We understand that sometimes, as Anglo helpers, we may phrase a question in an unintentionally insensitive way. Don't edit us! Instead, don't be afraid to voice your concern, and the resident or behavioral scientist will work on more appropriate phrasing.

c) By the same token, if you are not clear about what the helper or patient has said, don't simply try to translate anyway. Ask for clarification.

5) We value any expertise you might bring regarding Mexican or Latin American culture and customs; or about the experience of Mexican-Americans in the United States. In addition to accurate translation, we hope you will share any insights or ideas you have as to the best way to help a particular patient.

After the session is over, thank the patient for coming. Then mention that you would like to ask her a few brief questions. The

resident and the behavioral scientist will leave the room. You will explain that we are still learning how best to help patients at the clinic, and we would like them to answer these questions as honestly as possible. Inform them that their answers will be handled confidentially and anonymously. Then ask them the accompanying questions, thank them again, and escort them to the waiting room.

After the patient has left, please jot down in the appropriate section any OBSERVATIONS you had about the counseling session, either about the patient, the resident, or the behavioral scientist. "Patient did not seem to understand what the doctor was trying to get her to do." "Patient seemed relieved and happy to have someone to talk to." "Resident worked very hard at really understanding what was going on with this patient." "Behavioral scientist was asleep (Just kidding!."

Thank you very much for your participation in this project. If you have any questions, please direct them either to the behavioral scientist to whom you are assigned, or to Dr. Johanna Shapiro, 634-5171.

APPENDIX C
INTERPRETER CODE OF ETHICS

1. Interpreters shall keep all assignment-related information strictly confidential.

2. Interpreters shall use discretion in accepting assignments with regards to skills and setting.

3. Interpreters may refrain from interpreting for patients in instances where family, close personal or professional relationships may affect impartiality.

4. Interpreters shall render faithful interpretation always conveying the content and spirit of the speaker.

5. Interpreters shall use the language mode most readily understood by the person for whom they are interpreting.

6. Interpreters shall explain cultural differences or practices to health care providers and patients when appropriate.

7. Interpreters shall communicate any special needs of the patient to the provider.

8. Interpreters shall maintain an impartial attitude with patients, their families and hospital staff.

9. Interpreters shall keep a low profile remembering that they are not carrying on an independent conversation, but rather expressing the comments of others.

10. Interpreters shall not counsel, advise or interject personal opinions.

11. Interpreters shall accept the responsibility of maintaining the integrity of their profession and improving their competency to achieve the highest standards.

III -
PT QUEST
7-1-91

DATE: PATIENT CHART NUMBER:
INTERPRETER: RESIDENT: FACULTY:

PATIENT QUESTIONNAIRE

1. What was the reason you came to see the doctor today?_____

_____

2. What did you expect to happen when you came to see the doctor today? _____

_____

3. How satisfied were you with this visit?

1	2	3	4	5
not at all	a little bit	somewhat	satisfied	very satisfied

4. Did the doctor seem to care about you?

1	2	3	4	5
not at all	a little bit	somewhat	cared	cared a great deal

5. Do you think talking with the doctor will help your problem?

1	2	3	4	5
not at all	a little bit	somewhat	will help	will help a great deal

6. What did the doctor tell you to do about your problem?

_____

_____

7. Did the doctor ask you any questions that were too personal?
YES NO
If so, what were they?_____

_____

8. Do you feel that doctor treated you with respect?

1	2	3	4	5
not at all	a little bit	somewhat	with respect	with a great deal of respect

9. Did the doctor appear to be concerned about your family?

1	2	3	4	5
not at all	a little bit	somewhat	concerned	very concerned

10. Do you think it would be helpful to come back for another visit with this doctor?

1	2	3	4	5
not at all	a little bit	somewhat	helpful	very helpful

11. Do you plan to return for a follow-up visit? (If reccomended)
YES NO

INTERPRETER COMMENTS AND OBSERVATIONS: _____

_____

_____

_____

B copies
"I"
Pt. gave
7-25-

PATIENT QUESTIONNAIRE

Date: Patient Chart Number: Faculty:

Interpreter: Resident:

1. ¿Por qué razón vino a ver al doctor hoy?

2. ¿Qué esperaba que pasara en esta visita?

3. ¿Qué tan satisfecho(a) está con esta visita?

1	2	3	4	5
nada	poco	algo	satisfecho	muy satisfecho

4. ¿Parecía interesado en Ud. el/la doctor(a)?

1	2	3	4	5
nada	poco	algo	interesado	muy interesado

5. ¿Cree Ud. que el hablar con el/la doctor(a) le va a ayudar con su problema?

1	2	3	4	5
nada	poco	algo de ayuda	ayuda	mucha ayuda

6. ¿Qué le dijo el/la doctor(a) que hiciera acerca de su problema?

7. ¿Le hizo el/la doctor(a) algunas preguntas demasiado personales?

sí no

8. ¿Piensa Ud. que el/la doctor(a) le trató con respeto?

1	2	3	4	5
para nada	Un poco	algo	Con respeto	Con much respeto

9. ¿Pareció el/la doctor(a) preocupado(a) ó interesado(a) en su familia?

1	2	3	4	5
Para nada	Un poco	Algo	Preocupado	Muy preocupado

10. ¿Cree Ud. que regresar para otra visita con el mismo doctor le sería útil?

1	2	3	4	5
Para nada	Un poco	Algo	Ayudaría	Ayudaría mucho

11. ¿Planea Ud. regresar por otra visita? (sí es recomendada)

sí ✓ no

Observer comments: _____

_____

_____

_____