

CHAPTER 4

Starting with the BATHE Technique

Because the body-mind is essentially one, and patients' responses to stress can precipitate an office visit, are we really suggesting that the patient's psychological needs should be addressed during *every* patient visit? Actually, we are! Of course, there are exceptions. If a patient is profusely bleeding, is comatose or in acute pain from an ongoing cardiac event, you might want to postpone this inquiry, but it is not necessarily irrelevant. If a patient appears psychotic or becomes hostile or defensive, obviously it is best to focus directly on the patient's stated needs. However, just as there are recognized advantages to periodic health screening from a biomedical perspective, many benefits accrue from assessing a patient's emotional and social status as part of each visit. Moreover, it is not a difficult task to obtain psychosocial data in an efficient and effective manner. The BATHE technique is extremely versatile and can be used for both opening and closing the psychosocial inquiry, to access important information for the clinician in a variety of situations, and to provide support for the patient.

Imagine a reasonably sensitive and specific screening test that takes about one minute, uses no supplies, is noninvasive, has no harmful side effects, and is generally acceptable to patients. Imagine further that this test may pick up potentially serious problems in an early, treatable stage and can be expected to yield *at least* 30% positive results.^{1,2} Finally, imagine that use of the test might provide beneficial results for the patient, that completing the test might actually be therapeutic. Would you use such a test regularly? We think so.

Another benefit of using the BATHE technique is that exploration of the psychosocial aspects of the patient's problems provides an additional level of complexity of treatment and adds value and quality to the services delivered. In any case, use of the test is likely to improve clinical outcomes as well as increasing patient satisfaction.³

OPENING THE THERAPEUTIC INQUIRY

Primary care practitioners have a unique opportunity to address the emotional needs of their patients, but regardless of their importance, these needs must be handled in a time-effective manner. The psychosocial aspect of patients' problems must be effectively addressed within the regular 10 or 15-minute medical visit. The therapeutic goal is to help patients reorganize some small aspect of their self-concept or behavior in a more comfortable, productive, or, at minimum, less destructive manner. The healing grows out of the established practitioner-patient relationship.

The specific treatment attempts to modify patients' images of themselves, their problems, and their options by adjusting their *assumptive world view*, the story they tell themselves about the way things are. As we have said earlier, good interviewing techniques, a caring manner, and genuine interest demonstrated by paying serious attention to the patient's problems pave the way toward establishing a therapeutic milieu. In the process, patients feel supported and less stressed and able to raise their level of self-esteem as well as reengage their healthier coping styles.⁴ Not only does the practitioner gain a healthier and more reasonable patient, but using this technique, with its small investment of time during each patient visit, may save the practitioner a tremendous amount of time in some future encounter. If a patient's psychological needs are not addressed and are allowed to compound over time, they can present as a monumental problem that will overextend the practitioner's resources at a subsequent visit.

Determining the Context of the Visit

Optimally, every physical complaint or office visit should be seen in the context of the patient's and his or her family's total life situation. This means that in addition to descriptions of presenting symptoms, which may well represent a response to situational stress, the practitioner must determine what is going on in the patient's life as part of the history of the present illness.

Nowadays, most primary care practitioners organize their charts around the problem-oriented medical record.⁵ Problems are listed and notes are arranged in *SOAP* fashion. Most practitioners are familiar with this system, which classifies progress notes into subjective, objective, assessment, and plan elements. In order to understand patients' problems in the context of their total life situations, primary care practitioners need a larger concept of *SOAP*.⁶ The total package of patient assessment requires determination of the background situation, the patient's affect, what is most troubling for the patient, and how the patient is handling things. To achieve closure, this assessment needs to be followed by an empathic response.⁷

THE BATHE TECHNIQUE

TABLE 4.1

B	-	BACKGROUND: What is going on in your life?
A	-	AFFECT: How do you feel about that?
T	-	TROUBLE: What troubles you the most?
H	-	HANDLING: How are you handling that?
E	-	EMPATHY: That must be very difficult.

The acronym “BATHE” connotes memory jogs for the protocol to determine the context of the visit. It can also be viewed as an informal screening test for emotional problems.

B stands for background. A simple question, “What is going on in your life?” will elicit the context of the patient’s visit. Alternative opening questions can take the form of “Tell me what’s been happening since I saw you last?” It is useful to connect with patients in this personal way at each visit.

A stands for affect (the feeling state). “How do you feel about that?”, “How does that make you feel?” or “What’s your mood?” allows the patient to report the current feeling state.

T stands for trouble. “What about the situation troubles you the most?” helps both the practitioner and the patient focus on the subjective meaning of the situation.

H stands for handling. “How are you handling that?” gives an assessment of functioning.

E stands for empathy. A response such as “That must be very difficult for you” legitimizes the patient’s reaction.

The empathic response reassures the patient that the practitioner has understood the situation and accepts the patient’s response as reasonable, given the circumstances. BATHE is all that is minimally required to make the patient feel supported. At the same time, the technique will also enable the practitioner to identify depression, anxiety, or other disturbing symptoms. Ideally the BATHE technique will be employed early in the interview after the chief complaint and history of the presenting illness have been explored. BATHE may help determine why the patient is here now. It is useful to discuss each of the elements of BATHE separately.

“B” Stands for Background

The opening question of the BATHE sequence addresses what has been happening in the patient’s life. If the patient’s chief complaint concerns a problem that started perhaps two weeks previously, then the question becomes “What was going on in your life about that time?” We do not recommend asking if there was anything “new” or particularly stressful. Yes or no questions do not supply many bits of information, and there may or may not have been a major stress. Furthermore, daily hassles are often more detrimental to a patient’s sense of well-being than a new major stressful event.⁸

Although it is useful to determine what might have precipitated the patient's problem, the background question is probably the least important of the BATHE questions. Even with a positive response concerning a specific problematic situation, it is best not to encourage patients to tell you more about the situation; if you do, they will. And that will use up precious time without necessarily leading to any useful outcome. The situation will not change. You simply want to understand the patient's response. Further discussion of dealing with the "run-on" patient can be found in Chapter 6.

Often, patients will deny any particular stress. They may say that nothing has been going on – or perhaps just the "same old thing." Regardless of the patient's answer to the first question, about what is going on, it is effective to go directly to the next question: "How does that make you feel?"

"A" is for Affect

Asking patients how they feel about what is going on in their lives serves several important functions. In the first place it satisfies one of the critical requirements of the patient-centered interview,⁹ addressing the patient's emotional response. Often patients are not in touch with their emotional response. Illness behavior is a universal mechanism used by people with psychological disturbance to express their distress and seek medical care.¹⁰⁻¹² Helping patients get in touch with and express their feelings directly is highly therapeutic. Once expressed, feelings do not have to be "somatized." When patients are labeling their feelings, they should be encouraged to use adjectives such as mad, glad, sad, disappointed, frustrated, devastated, or guilty. Sometimes patients will use the phrase "I feel that" to express a judgment. Any time you can substitute the phrase "I feel" for the words "I think" – that is not a feeling. Feelings are whatever feelings are. They are neither good nor bad, but that individual's response to the particular situation. Feelings do not need to be justified or explained; they just have to be accepted. Many people are uncomfortable with the feelings they have. It is highly therapeutic to give people permission to feel the way they feel. In the BATHE sequence, the practitioner uses attentive listening and body language to make the patient feel accepted. If the patient is having a problem labeling a feeling, the practitioner may wish to suggest that under similar circumstances many people would feel angry, frustrated, overwhelmed, or whatever an appropriate response might be.

"T" Stands for Trouble

This is the most important of the BATHE questions. "What about the situation troubles you the most?" helps the patient to get in touch with the meaning of the situation. This question generally requires the patient to stop and think. Many people are not particularly self-reflecting without some coaching. It has been our experience that confronted with the question "What about that troubles you?", after pausing and focusing, patients often have an "Aha!" reaction and realize something that had been out of their awareness until that time.

Practitioners are often surprised by the answers that this question elicits since people have unique reactions to common situational circumstances. Since what is most troubling about the situation constitutes the definition of the problem, arriving at some constructive solution now becomes possible. When patients relate some positive event in their lives and a positive feeling to accompany it, it is still useful to ask whether anything about the situation troubles the patient, since ambivalence is a common human experience. Posing this question allows the patient to express reservations that may or may not be significant but need to be acknowledged.

“H” Stands for Handling

This question can be used in different ways. Asking “How are you handling that?” gives the practitioner valuable information about possibly destructive behaviors that the patient may be using to cope. Perhaps the patient is abusing alcohol, binge eating or fighting with significant others. Often the patient will reply, “not very well” and list some of the symptoms that prompted the office visit and then wonder if perhaps the situation precipitated those reactions. In other words, the (Socratic) questioning allows patients to get in touch with answers they already have but are not aware of.

Sometimes it is more efficacious to ask, “How could you handle that?” This intervention empowers patients to arrive at solutions they may not have considered previously. The implication is that they are capable of dealing with the situation constructively. Later chapters will discuss a variety of tasks that can be assigned as homework to help patients come to positive resolution of their problems.

“E” Stands for Empathy

It is crucial that practitioners finish the BATHE sequence with a statement that demonstrates understanding and empathy. Acknowledging the difficulty of the situation, the fact that the patient is doing the best that can be expected under the circumstances or that this is obviously very painful, validates the patient’s experience and makes him or her feel competent and connected in a positive way to the practitioner. This acknowledgment provides effective psychological support. It also closes the inquiry and allows the practitioner to move back to the physical aspects of the patient’s problem.

When the BATHE technique is used effectively, situational factors are identified, feelings are validated, meaning is assessed, a plan is made, and psychological support is provided. Nothing further is required. The intervention is complete. The whole interaction usually takes less than one minute.

WHAT IS THE BEST TIME TO BATHE?

When practitioners apply the BATHE technique as part of the history of present illness (HPI) in the interview, an effective and efficient therapeutic intervention

is structured into every patient encounter. The context of the visit has been incorporated into the session, patients' emotional reactions are addressed, and there is closure. A basic screening for anxiety or depressive disorders has also been accomplished. Sometimes there may not be a problem, but having the opportunity for social intercourse is still gratifying for the patient.^{13,14} Most of the time, patients reveal some ongoing concern. Often the patient feels better immediately after completion of the BATHE protocol, having become aware of the underlying issue that makes a situation problematic. The practitioner's interest and empathic response make the patient feel connected. Being able to sort out the problem and exploring the notion of "handling it" makes the patient feel more competent. The practitioner then proceeds with further medical history and the appropriate physical examination. When the routine BATHE interaction uncovers a serious problem, additional support and/or provision for follow-up or referral can be addressed with the assessment and plan part of the visit, as shown by the following example:

A 34-year-old woman, who had been a patient at the family practice center for about one year, presented in the office complaining about a vaginal discharge. She appeared to be quite agitated. Dr. W., in his second year of training at the time, inquired about what was going on in her life. The patient started to cry. She reached for the box of tissues on the desk. The physician waited quietly for her to answer his question.

"I just found out that my husband has been having an affair with my oldest sister for the past year and a half."

"How do you feel about that?" (The physician felt a little foolish. It seemed like this was an inane question to ask under the circumstances, but he really did not know what else to ask.)

Between sobs, the patient responded, "I feel angry. I have mood swings. I go up and down. I also feel depressed."

After taking several deep breaths to center himself, Dr. W. asked what about the situation troubled the patient the most. She replied, "I have two children. They are two and five, and I really don't want to be a single parent."

(The physician was surprised. He would have expected her to be most troubled because of the familial involvement, the betrayal, or the time frame.)

"How are you handling it?" was his final question.

The patient stated that she was handling things very badly. She was angry and did a lot of shouting at her husband. She also added that she was afraid that the children were starting to be affected, she was very short-tempered with them, and they really did not deserve that.

The physician was taken aback by this history. Still, he managed to respond, "That sounds like a horrendous situation. It's got to be hard for you to deal with all of that."

“Yes, it is,” said the patient and visibly relaxed.

“Why don’t we examine you now and find out what we can do about your vaginal discomfort,” said the physician, “and then we’ll talk some more and get you some help.”

Patients’ Understanding of Stress

Happily not all situations are as dramatic or traumatic as the above example. In our practice BATHE is used routinely and uncovers a variety of situations, more often chronic rather than acute. Our experience has been that the technique is well accepted by patients, even those coming from a variety of cultures. Once confronted by a focused question, patients are often acutely aware of the role of stress in precipitating their symptoms. Consider the following description of a visit reported by a psychology intern who had monitored the encounter over closed-circuit television:

Ms. K. is a middle-aged African-American female, a college student, who has come to the office for an initial visit. Her presenting problem is a dry scalp with associated peeling and flaking. She reports that she has been experiencing this problem for several weeks but that lately it seems to have worsened. She appears pleasant and cooperative during the discussion of her symptomatology and throughout the subsequent physical examination by the physician. However, she offers no complaints regarding situational stressors or issues of concern in her life.

When the doctor specifically *asks what was going on in the patient’s life*, she responds by saying she is an older woman and is currently back in school. The physician then *asks how she feels about this*. The patient seems slightly uncomfortable disclosing her feelings and focuses instead on discussing the content of her college program. The physician listens intently for a brief while. Then he patiently *asks again how she feels about that*. Ms. K.’s shoulders appear to relax as she admits to feeling rather stressed out concerning the challenges of returning to school later in life. The physician then comments that *that must be very difficult for her*. The patient nods her head in agreement and seems relieved to have her feelings validated.

The doctor then asks *what troubles the patient the most about her situation*. The patient discloses that she finds the workload and associated stress and anxiety most disconcerting. The doctor then *inquires how she has been handling the anxiety*. At this point, the patient shares laughter with the doctor as she replies that a lot of prayers have been getting her through.

The physician acknowledges the helpfulness of prayer and then introduces the importance of exercise as a further means of reducing stress. Ms. K. reports that she used to exercise but has not lately. The doctor then explains, “The reason that I am asking about your stress is that there is a mind-body connection and often

psychological issues can manifest as or exacerbate physical problems such as with your scalp.” This appears to strike a responsive chord with the patient as she relates, “Oh, yes, Doctor, in fact a few years ago when I was going through a stressful divorce, I remember having similar problems with my scalp.” The discussion then returns to the topic of exercise, and with the patient’s eager collaboration, together they formulate a daily exercise regimen that can realistically be implemented given the rigorous demands of Ms. K.’s scholastic program.

In this situation, the physician weaves BATHE into the encounter and is able to use it to help the patient make sense of her symptoms as well as prescribing and getting agreement for an effective management plan.

SUPPORTING THE PATIENT

In Chapter 2 we defined social support as a psychological mechanism that provides positive information to the individual about his or her interaction with other people. More technically, in social science studies social support has been defined as “the sum of the social, emotional and instrumental exchanges with which the individual is involved having the subjective consequence that an individual sees him or herself as an object of continuing value in the eyes of significant others.”¹⁵ Certainly, the interaction between the patient and the practitioner involves social, emotional, and instrumental exchanges. It is obviously important that practitioners behave in such a manner that patients get the impression that they are seen as individuals who have continuing value in the eyes of the practitioner. Social support has been shown to be critical in mitigating the effects of various stressors.¹⁶ Social support is demonstrated by engaging in one or more of the following behaviors: (1) an expression of positive affect, (2) an endorsement of the person’s behavior, perception, or expressed views, (3) giving symbolic or material aid, and (4) giving the opportunity to express feelings in an accepting atmosphere.

It is clear that when practitioners incorporate BATHE into a patient visit, many of the above criteria will be satisfied. Interest and positive affect have been expressed, and feelings have been accepted. Information is gathered that helps both patient and practitioner understand the situation and the patient’s reaction to it, and the diagnosis becomes a large part of the cure. Clearly defining the problem helps focus the patient and the practitioner on the resources necessary to reach an acceptable resolution.

Dealing with Multiple Problems

In the course of an interview, the practitioner often finds that the patient has multiple problems. Here, again, having a practical structure for dealing with these problems is helpful both in keeping the practitioner focused and meeting

the patient's needs. If an unexpected emotional response occurs during the interview, the practitioner finds out what is going on, explores the issue with the three questions, "How does that make you feel?" "What troubles you the most?" and "How can you handle that?" then effects closure with an empathic statement. In this way, a simple technique, sequentially applied, can effectively be used to handle complex situations. The following case, reported by one of our senior physicians in training, illustrates the principles we are promoting:

A new patient, a 38-year-old woman, presented with multiple concerns, including vaginal itching, dyspareunia, need for contraception, and frequent headaches. On further questioning, she was a working mother of three teenage children, widowed six years previously, and remarried one year ago. Family history was positive for hypertension and diabetes in her grandparents and multiple sclerosis (MS) in her mother. The mother was currently 56 years old and had been in a nursing home for 12 years. At this point in the interview, the patient appeared tearful but attempted to suppress the tears. I asked her what was going on and then used the rest of the BATHE technique. The patient started to cry, saying that she had not cried for years about her mother. I asked her what her mom had been like. She stated she had always admired her mother's energy and unselfishness, which was why she felt so guilty about having her in the nursing home. I empathized, and we went on. Subsequently, I found out that her mother's diagnosis had been made at the age of 38. I asked her what she thought might be causing her headaches. She said I shouldn't think she was crazy, but she had considered whether it might not be MS. I supported her by telling her that that was a natural concern under the circumstances and that I would do a thorough evaluation in that regard.

At this point, about 10 minutes into the interview, I pointed out that she had come with quite a few concerns and asked her which one she wanted most to deal with in this visit. She stated that she was most concerned about her vaginal itch. After some routine questions regarding the genitourinary (GU) system, I asked how this condition was affecting her sexuality, to which she replied that she and her husband had not slept together in six months! She stated that she suspected him of having an affair. Six months ago also corresponded to the anniversary of her first husband's death. I asked a background question about the circumstances of her marriage and again finished the BATHE sequence. I then asked her to prepare for the physical examination and assured her I would check for venereal disease. She appeared relieved and revealed that she had also had a "fling" just before the onset of the itching.

During the physical exam, I did enough of a review of systems to assure myself that her headaches were not of an immediately serious nature, and I reassured her regarding her pelvic exam. I supported her by stating that she seemed to be handling things well under such stressful circumstances. I asked her to make an appointment for evaluation of her headaches and further discussion of her other

concerns, including contraception. I asked her if she had any questions, and she said no but that she was very relieved after talking with me. The entire session lasted 25 minutes.

In this case, the practitioner sequentially dealt with a variety of problems, related to both present circumstances and unresolved grief from the past. By repeatedly using the BATHE structure, she dealt with these problems in a timely, effective, and sensitive manner.

The Resistant Patient

Certainly there are patients who are highly invested in separating their physical symptoms from their emotional states. Somatization is commonly seen in primary care across cultures and is generally associated with significant health problems and disabilities.¹⁷ A few patients may be taken aback when questioned by their practitioners about what is going on in their lives. They may respond with “nothing.” The practitioner has several choices when this happens. First, the subject can be dropped. We do not recommend this, because it reinforces somatization and wastes an opportunity to help the patient learn to connect physical conditions to emotional states. The second option, to repeat the word “nothing” with a questioning inflection, often results in the patient hesitantly revealing some current problem or a list of chronic annoyances. The rest of the BATHE sequence is then followed. The third option is simply to continue with the BATHE protocol, asking how the patient feels about the fact that nothing is going on. Practitioners tell us that they get some fascinating responses, such as the following common examples: “Just dreadful. I’m bored to tears.” “Kind of mad, I guess. I’m tired of the same old thing!” “Awful. By now I was expecting to be promoted and nothing has happened.” Regardless of the patient’s reaction, BATHE usually provides important insights for the patient, as the following case illustrates:

A 29-year-old woman came to the Family Practice Center complaining of having had a headache for four days. Her past history included headaches that started 12 years previously and recurred intermittently around the time of her period. After getting a complete description of her symptoms and the history of the present illness, the young physician in training, who was not the patient’s regular doctor, asked her what was going on in her life. She replied, “Nothing.” “How do you feel about that?” he continued as taught. “How am I supposed to feel with nothing going on?” He tried one more time. “What about it troubles you the most?” She seemed exasperated, “What is supposed to trouble me when there is nothing going on in my life?” The doctor dropped the subject and proceeded with his exam.

Discussion of the case with the preceptor led to the conclusion that, in spite of the patient's denial, this was most likely a muscle tension headache, probably precipitated by stress or conflict. A decision was made to treat. When the doctor went back into the examination room and gave the patient her prescription for an analgesic, he gently posited, "There is something going on in your life, isn't there? You just don't want to talk with me about it."

The patient looked at him with admiration and smiled slightly. He suggested that she might want to come back and talk with her regular doctor. The clinician felt terrific. There had been a moment of real communication. He was sure that the patient had felt it also.

Patients Report They Like Being BATHED

Some medical students, doctors in graduate training, practicing physicians, physicians' assistants and nurse practitioners attending our workshops have expressed concerns that the BATHE questions might not always be an appropriate addition to a medical history. They were afraid that patients might feel that the practitioner was being invasive of patients' personal space, asking for irrelevant information and might even offend patients. As in the case just described, of course, there are times when a particular patient may feel uncomfortable discussing personal issues, but in general our experience has been that patients are delighted to have the practitioner express interest in what is significant in their lives and that the technique helps to establish rapport. Until lately, we had only anecdotal evidence to support this view. Now a study by Leiblum and her colleagues³ has found that use of the BATHE technique significantly increased patients' overall satisfaction with their outpatient visits. These researchers used an assistant to recruit and randomize 80 patients in the waiting room of a Family Practice Center, and to instruct four experienced physicians to either BATHE ten consecutive patients or provide usual care. The research assistant collected data from the patients after the visit. Outcome measures were based on the Healthcare Effectiveness Data and Information Set (HEDIS)¹⁸ measures of patient satisfaction as interpreted by Press Ganey¹⁹ Scores, widely used by organizations in the United States that evaluate physician practices. BATHEd patients reported significantly more positive impressions of doctors' concern, explanations of problems, efforts to include the patient in decision making, information about medications, instructions about follow-up care, amount of time spent, likelihood of recommending the physician to others and overall satisfaction with that particular visit.³

WHEN THE PATIENT COMES BACK TO TALK

Subsequent chapters will provide many specific suggestions and techniques for use in a 15-minute visit. At this point, let us look briefly at how Dr. Alan Buchanan, a psychiatrist at the University of British Columbia, has used the BATHE protocol to teach primary care physicians how to structure a 10-minute “counseling session.”²⁰

B stands for background. The opening two minutes belong to the patient. You open with “Tell me what’s been going on since our last visit.” The underlying message is that the practitioner is **there** to listen to the patient – and there is no need to rush.

A stands for affect (the feeling state). Summarize the feelings. The underlying message is “I have been listening.” Dr. Buchanan suggests that since many patients cannot label feelings on their own, this can be very helpful to them.

T stands for trouble. “What is the worst thing about this situation?” The underlying message is a combination of “we can talk about anything here” and “our time is short so we must focus.”

H stands for handling. “And how did you handle this?” sends the message that “you can handle this situation.” What is important here is to manage this crisis, not to get stuck in overwhelming feelings.

E stands for empathy. Normalize the patient’s reaction to the crisis. “It sounds awful, and I agree with what you have done so far – anybody would have had problems with this situation.”

In the final few minutes, the physician asks, “What is the best thing that has happened lately?” Dr. Buchanan comments that this sometimes injects humor or initiates the process of seeing the crisis as an opportunity for change. Then the physician states, “For the next time I’d like you to (write the problem out in detail, or write down some options available, or reach out to some specific sources of support).” The underlying message is “You *can* handle this situation.”

He ends the interview with a closing statement: “I’m glad we had a chance to talk about this,” “I feel like I know you better,” or just, “Sorry, but our time is up for today.”

In later chapters more will be said about how to structure visits when the patient comes back to talk as well as the importance of focusing on something positive in the patient’s life.

THE USE OF MEDICATION

One of the beauties of providing psychotherapeutic intervention in primary care is the option to combine talk therapy with medication. The individual practitioner must determine how and when to prescribe pharmacological treatment to ease the patient’s symptoms. In general, when you screen for anxiety or depression by using the BATHE technique and determine that the patients’ acute distress is so severe as to seriously interfere with their functioning, you

may want to use medication to alleviate their symptoms. When patients are not able to sleep it is difficult to restore some measure of equilibrium. In treating depression, the practitioner has the option of prescribing psychotropic medication along with providing supportive therapy. Unfortunately, studies show that doctors do not necessarily talk with patients often once a diagnosis is made and a prescription issued.²¹ It is critical to help patients develop realistic expectations about the action of the medication as well as to help them to handle the problematic aspects of their current situations.

Although medication can be extremely useful in managing acute problems, treating symptoms without addressing the underlying causes of a chronic problem perpetuates a patient's sense of powerlessness and hopelessness. A prescription for alprazolam (Xanax) does nothing to fix a bad marriage where communications have broken down. Patients need to be mobilized to change their behavior. If the patient is requesting medication, however, this provides an opportunity to bond with the patient. Later, an ongoing negotiation may be required to taper the medication over time.

BATHE: A USEFUL TECHNIQUE FOR MANY REASONS

As discussed earlier, the BATHE technique was originally designed to help practitioners determine the psychosocial background underlying the biomedical problems presented by patients, to establish rapport with patients and to serve as a rough screening test for anxiety, depression and situational stress disorders. Ideally, the questions will be posed in the order presented after the history of present illness has been elicited. We promote using the questions in the order presented, but also encourage use of the individual questions during other parts of the interview, when it seems appropriate to ask how something made the patient feel, what troubled them the most, or how they handled something. Statements of empathy are always encouraged when patients reveal some traumatic material.

Over the years, clinicians have discovered many other indications for the use of the BATHE technique. For example: When breaking bad news, to explore a patient's reaction to a diagnosis; to address lack of adherence to prescribed treatment, requests for inappropriate referrals or other difficult situations in the doctor/patient relationship. BATHE can be used to explore barriers to making positive life-style changes. It can be used to handle an unexpected revelation at the end of an interview or to probe for psychosocial precipitants related to somatic complaints; finally, BATHE can be used to educate patients regarding the interaction between their bodies and their minds.

Differentiating Approaches for Chronic and Acute Problems

The BATHE technique is useful for determining whether a problem is chronic or acute. Different approaches depend on this classification.²² There are different underlying stories that must be considered.

Treating Acute Conditions

The medical model lends itself quite well to dealing with acute situations and/or very dependent patients. The underlying story in acute situations is that the patient is not to blame for creating the problem – the patient is sick. The practitioner therefore takes responsibility for finding a solution for the problem: to diagnose, counsel, suggest, prescribe, and give orders that must be followed. All that is required of the patient is to comply with the treatment. This helps the patient to feel secure. The more acute the problem, the more important it is for the practitioner to take charge, at least temporarily. The practitioner makes suggestions and guides the patient in handling the situation. Close follow-up is necessary so that the patient feels supported and connected. In an emergency situation, and emergency for the patient is a subjective state, authoritarian behavior relieves anxiety. Ultimately, however, responsibility and control need to be returned to the patient.

Managing Chronic Problems

When dealing with chronic problems a useful approach also employs the story that patients are not to blame for creating their problems. They may have been abused, uninformed, or otherwise deprived. Perhaps it was circumstance, karma, bad parenting, some unavoidable breakdown, inexperience, or just bad judgment. Regardless, this story says that the patient is responsible for effecting solutions. The patient may begin by asking for and accepting help, coping constructively with the problem, and using it as a learning opportunity. In dealing with patients who are having chronic problems, this is a very useful approach. The removal of blame for creation of the problem is therapeutic. It relieves guilt and raises the patient's level of self-esteem. Although no blame is placed for developing chronically difficult situations, the patient is expected to take responsibility for dealing with these problems constructively and finding solutions. The practitioner will help, be a sounding board, and lead the cheering section, but the patient retains responsibility for managing the problem. The practitioner's positive expectation regarding the patient's ability to resolve the problem – the infusion of hope – is a powerful therapeutic tool.

Actually, the practitioner may believe the patient to be responsible for creating the problem, as in the case of the 38-year-old woman who had had a “fling”; however, pointing this out is rarely therapeutic since it underscores the patient's sense of hopelessness, guilt, and self-deprecation. Relieving patients of blame allows them to direct their energies outward, to work on solving their problems or transforming their environments without wasting energy berating themselves for creating these problems or permitting others to create them.¹⁵

As we have seen, determining whether a problem is chronic or acute allows the practitioner to choose the more effective therapeutic strategy. In either case, BATHE maintains the focus on the problem and how the patient might deal with it. In general, empowering patients and holding them responsible for finding solutions fosters self-esteem. However, when patients are in crisis, the

practitioner may want to take a more active role and satisfy dependency needs. In either case, the patient feels better and functions better.

Engaging the Patient in a Psychotherapeutic Contract

After the physical examination and medical management decisions have been made, the practitioner returns to the information elicited by the BATHE technique. Determining the nature of the problem and giving an empathic response constitute a psychotherapeutic intervention. As has been stated, it focuses the patient and legitimizes his or her feelings. The practitioner now suggests that regardless of the origin of the problem, little can be gained by placing blame. Rather, it is important to determine what can be done and to evaluate the available options to manage the situation. The practitioner becomes the patient's ally in dealing with the problem. One approach is to advise the patient to take some time to think about it and return in one or two weeks if the problem is not resolved. If a patient is feeling overwhelmed and problems are numerous and complex, a contract, specifically a verbal understanding, is made for follow-up. It is helpful to specify that the practitioner will meet with the patient for a particular number of sessions or to discuss referral.

In later chapters we will discuss specific considerations that must be applied to patients presenting with certain problems, or perhaps we should say certain problem patients: hypochondriacs, depressed, suicidal, or grieving patients. All these lend themselves to therapeutic intervention by the primary care practitioner, provided that the contract is made clear. The practitioner's role, commitment, and limitations must be clearly spelled out. The patient's responsibilities must also be stated, acknowledged, and documented in the chart. Once a patient recognizes the need for a therapeutic process, referral to a mental health professional providing collaborative care is a superb option. The BATHE technique enables practitioners to identify patients who need these services. Any time the practitioner feels overwhelmed by the extent of the patient's problems, a psychiatric consult or referral is indicated. Patients to be referred include psychotic, addicted, or violent patients or any patient whose condition makes the practitioner feel uncomfortable. When referring a patient, there is an understanding that the practitioner will continue to be involved with the patient and continue to provide ongoing medical care.

Example: the Grieving Patient

Patients are often overcome when they suffer significant losses. Traumatic grief has been shown to negatively affect both physical and psychological health.²³ When working with a bereaved patient, or discovering a situation of unresolved grief during a routine BATHE inquiry, the practitioner should explain the need for working through feelings related to significant relationships that have been terminated through death or other circumstances. Grief work can usually be accomplished in six or eight sessions.

The process of mourning requires that patients come to terms with both the

positive and negative feelings related to the person who is gone. It requires the patient to reflect, remember, and process significant milestones in the relationship. Much of this work can be done by writing about the deceased person, their history, and characteristics.²⁴ Patients should also be encouraged to look at photographs, talk with friends and relatives, and regularly check in with the practitioner to report on their progress. Although this can be a painful process, it is necessary in order to bring closure and allow the survivor to reengage with life.

The practitioner may contract with the patient for six or eight sessions to supervise the grief work or can refer the patient to a collaborating mental health practitioner or an ongoing support group. In any case, therapy must focus on reviewing the significant aspects of the terminated relationship, accepting the pain and finality of the loss, coming to terms with the good and bad aspects, and finally letting go.

THE EFFICACY OF TIME

Using the framework of *The Fifteen Minute Hour*, the practitioner provides focused attention and a safe environment for the patient to tell and assess some aspect of his or her story. The patient is invited to reexamine responses to situations, look at options, chart new goals, and acquire a more positive sense of self-efficacy. The clinician provides a structure for the patient to examine one particular problem and suggests that the patient will be able to replicate the process.

The time constraint is useful because it prevents overloading the patient and adding to the confusion. The practitioner conveys optimism that problems can be resolved one at a time and indicates that he or she is there to help the patient work through the problems. By returning to patients the sense of having some potential for affecting the course of their lives, for making their own decisions and choices, the practitioner is acting in a most highly therapeutic manner. In addition, when the practitioner routinely incorporates BATHE into every patient encounter, efficiency is built into the practice. A little energy invested in this process on each visit fosters the image of the practitioner as an empathic and involved figure. As a result, the practitioner is able to handle the patient's problems in an effective and timely fashion often before they assume overwhelming proportions.

ONE LAST POINT

In addition to asking patients the right questions, it is important to make sure everyone involved in the patient encounter is listening. Your listening skills and also the patient's are vital to resolving medical problems and promoting healing.²⁵

SUMMARY

Many benefits accrue from assessing a patient's emotional status as part of each visit. Every physical complaint or office visit should be seen in the context of the patient's and his or her family's total life situation. The therapeutic effect grows out of the practitioner-patient relationship. The letters "BATHE" represent an acronym to recall a framework for handling the context of the visit. "B" stands for background: "What is going on?" "A" stands for affect: "How do you feel about it?" "T" stands for trouble: "What about it bothers you most?" "H" stands for handling: "How are you dealing with that?" "E" stands for empathy: "That must be very difficult for you!"

BATHEing the patient early in the interview structures an effective and efficient psychotherapeutic intervention into every patient encounter. BATHE has been shown to improve patient satisfaction with a visit. Multiple problems can be handled by sequentially applying the simple technique. BATHE can also be used to structure a return visit and to determine whether a problem is chronic or acute. The practitioner may wish to use medication as an adjunct to talk therapy. In acute situations it is useful for practitioners to take an active role in finding solutions, whereas chronic problems require that patients be held responsible for problem resolution. Any time the practitioner feels overwhelmed by the extent of a patient's problems, a psychiatric consult or referral should be considered.

The time constraint inherent in the brief session is useful because it prevents overloading the patient. The practitioner's optimism and focus on one problem at a time are an effective strategy and provide a model for further work. Attentive listening is a prerequisite for positive outcomes.

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