# BATHE: An Approach to the Interview Process in the Primary Care Setting

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The American health care delivery system is undergoing a rapid and substantive change. Health care providers are now expected to depart from their traditional role of healers of the sick to a more comprehensive one of including maintenance of health as well. Incentives are being put in place to encourage physicians to interdict disease at its early, more curable stage and to detect and treat previously unrecognized or underrecognized conditions. Research indicates that there is a great need in the area of mental heath. In order for primary care practitioners to recognize patients who have mental health problems with some facility, it is recommended that they employ the BATHE technique for developing a psychosocial history. This technique will enable primary care practitioners to succinctly and efficiently uncover psychosocial problems while at the same time to lend support to patients as they attempt to come to grips with these issues. *(J Clin Psychiatry 1997;58[suppl 3]:3–6)*

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Thomas Paine, the famous pamphleteer of the American Revolution described the era as "These are times that try men's souls" (Common Sense, January 1776). Seventy-five years later, Charles Dickens proclaimed in a *Tale of Two Cities,* "It was the best of times, it was the worst of times." In the more recent past, the controversial vocalist Bob Dylan penned and sang the popular "The Times They Are Achangin" in an album of the same name. As true as any of these comments were relative to those respective societies, the same can be said today about the practice of medicine in this country. "American medicine, although undergoing evolution, now faces changes of a magnitude that has never before been encountered."[1] Up until now, "I'm a doctor, I take care of sick people," has been axiomatic to the American health care delivery system. But we are well into the 90s, and many axioms are being called into question, not the least of which is the one that has formed the base for the system of health care delivery in the United States. Physicians' practices are now expected to focus on prevention, screening, and patient education as the traditional therapy of disease becomes a more distant consideration. The evolving health care delivery system seems to have as its endpoint the maintenance of the health of populations as opposed to concentration on the treatment of an individual patient's disease. This paradigm shift has been manifested by a movement from inpatient to outpatient, to ambulatory management of patients (and the concomitant de-emphasis on hospitalization), to the imposition of "financial risk" on the actual providers of services, and to global- or population-based reimbursement for health care services. Figure 1 portrays the changes involved as we move from our traditional "fee for service"-dominated system to one that is driven by the notion of "accountable care."

Clinicians are encouraged to intervene early at the frequently more curable stage of diseases. They are also expected to deal efficiently and effectively with patients' problems that in the past were virtually ignored because there was no incentive to aggressively ferret out and treat these conditions. For instance, in the mental health arena, the Medical Outcomes Study[2] provided substantial evidence that depressive disorders are often untreated at the present time, and there is compelling evidence that these disorders are frequently underdiagnosed also. The study reported on the use of minor tranquilizers and antidepressants in 634 patients with a current depressive disorder or depressive symptoms who visited general medical clinicians, psychiatrists, psychologists, or other therapists. Of these patients, 59% were receiving neither an antidepressant nor a minor tranquilizer, while 12% were taking an antidepressant only, 19% were taking a minor tranquilizer only, and 11% were taking both types of medications. It was determined that 23% of these patients used antidepressants, while 30% used minor tranquilizers despite the unproven efficacy of minor tranquilizers for depressive disorders. In addition, of patients using antidepressant medications, 39% were receiving subtherapeutic doses

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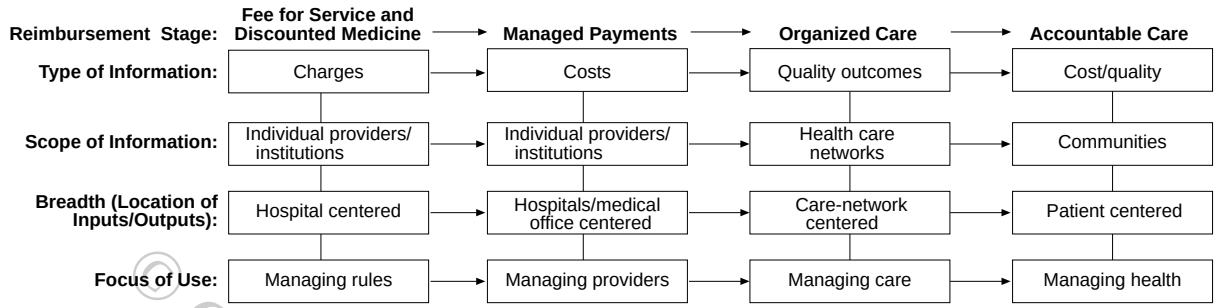
Figure 1. Evolving Health Care Delivery System*

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regardless of the specialty sector treating them.[2] Katon et al.[3] observed in another study that "among a sample of 119 distressed high utilizers of primary care, 45% of patients evaluated by a psychiatrist as needing antidepressant treatment had been treated in the year before the examination. However, only 11% of the patients needing antidepressants had received adequate dosage and duration of pharmacotherapy."[3(p67)] In still another study in which Stokes[4] investigated "a primary care perspective on management of acute and long-term depression," he observed that "the frequency of presentation of patients with clinical depression at the primary care physician's office is in sharp contrast to the frequency of the diagnosis of depression made in these same patients."[4(p75)] All of this occurs despite reasonable evidence that in mental health, as well as in medicine in general, recognition and early intervention can improve a patient's quality of life and can conserve health care resources in the process. Considerable effort and energy is expended by physicians in attempts to identify such conditions as coronary artery disease, cancer, and AIDS, whereas mental health disorders, in general, and mood disorders in particular are frequently overlooked. Compounding this problem is the reality that many effective treatments are available for mood disorders, whereas coronary artery disease, cancer, and AIDS have, at best, a variable response to therapeutic interventions (Table 1).

Table 1. Recognition and Treatability of Mood Disorders and Other Major Illnesses in Primary Care

| | Mood Disorders[a] | Coronary Heart Disease[b] | Cancer[c] | AIDS[d] |
|---|---|---|---|---|
| Recognition Rate | Low | High | High | High |
| Treatability | High | Variable | Variable | Variable |

[a]Data from reference 5.
[b]Data from reference 6.
[c]Data from reference 7.
[d]Data from reference 8.

But why then do we physicians not deal effectively with psychosocial problems when they account for a significant portion of our practices at a time when there is increasing emphasis on the efficient practice of medicine? A case could be made that the complexity of psychiatric conditions contributes significantly to the problem. As Zal observed in an article on diagnosing and treating generalized anxiety disorders, "anxiety and its frequent somatic manifestations may be symptoms of many medical and psychiatric conditions."[9(p19)] Certainly this is the case with many psychiatric disorders, anxiety included, but I would submit that a goodly portion of the problem originates with the medical education process itself. Since the famous Flexner Report of 1910,[10] American medical education has been linked to the scientific method of scholarly inquiry. Reductionism prevails as the dominant research and practice methodology, which results in a system that has become more and more subspecialized in its orientation. This is a wonderful approach for problem solving in the biomedical sphere, but it has left the medical education system bereft of most inquiry into the psychological (with the exception of psychiatry) and the social dimensions of patients. Thus, contemporary medical practitioners have become very good at dealing with exotic diagnoses, high tech medical practice, in an organ system orientation, at the expense of dealing effectively with undifferentiated patient problems heavily laden with psychosocial baggage. Sadly, we have not come very far since the White et al. landmark study[11] of "The Ecology of Medical Care" in 1961, which demonstrated that "data from medical-care studies in the United States and Great Britain suggest that in a population of 1000 adults (sixteen years of age and over), in an average month, 750 will experience an episode of illness, 250 of these will consult a physician, 9 will be hospitalized, 5 will be referred to another physician and 1 will be referred to a university medical center. The latter sees biased samples of 0.0013 of the 'sick' adults and 0.004 of the patients in the community, from which students of the health professions must get an unrealistic concept of medicine's task in both Western and developing countries."[(p891)] To its credit,

the medical education system is scrambling to rectify, at least to some degree, this problem. Since the introduction of the American Board of Family Practice in 1969 and formal training programs in family practice (which from the outset required a significant outpatient experience and a designated family medicine center), the American medical education system has moved to incorporate more and more ambulatory experiences into the process of undergraduate and graduate medical education. Although some individuals in the medical education as well as the health policy arenas consider this to be "too little too late," nonetheless substantive changes are under way that will certainly represent an improvement over making no changes at all.

However, it is noteworthy at this juncture that patients themselves also seem to play into this situation by virtue of the way they report "illnesses" to their physicians. Zung et al. reported in the *Journal of Family Practice* that "clinically significant depressive symptoms are highly prevalent in primary care patients; however, depression is an infrequent patient complaint."[12(p337)] In other words, even patients seem convinced that they need to legitimize their visit to a physician by presenting with an organic complaint, which is really only a manifestation of an unmentioned, underlying psychodynamic dysfunction. Physicians who treat only the complaint effectively turn off the alarm while the fire rages unchecked.

Dealing with all these issues and predispositions in the time-compressed environment of a primary care practice is, at the least, a monumental challenge. The question becomes: How do we direct the efforts and energies of the frequently hassled and harried primary care practitioner in such a way that, as part of his/her daily practice pattern, the practitioner will be able to identify psychodynamic problems? Dr. Marian Stuart and I, in our book *The Fifteen Minute Hour: Applied Psychotherapy for the Primary Care Physician*, propose a system that we feel satisfies this need.[1] The cornerstone of the system is the BATHE technique that is employed as part of the history-taking portion of a patient encounter. The technique itself is a system of inquiry that delves into psychosocial issues in a sequential and logical but brief fashion to get at the information the primary care practitioner needs in order for him or her to deal effectively with this dimension of medical practice. The acronym BATHE was chosen because it not only enables us to fill this need, but it also relates to the SOAP format of records keeping that is commonly employed in primary care medical practices. The acronym itself stands for:

**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 - An empathic or supportive statement made by the physician, where appropriate, to conclude.

Let us now look at each component of the acronym in order to more fully explore the utility of this approach to evaluating the psychosocial component of a patient's office visit.

**Background.** "What is going on in your life?" This question is designed to elicit nothing more than a simple statement as to what is going on in the patient's life. The answer gives the primary care practitioner his/her first insights into the patient's psychodynamic state and also a feel for the probable origins of the patient's problem(s). The patient's response will give firm clues as to whether the patient is in an acute stressful situation or whether the patient is exhibiting a personality disorder or a comparable type of behavior. When the physician states the question specifically and succinctly, the patient is literally forced to give a fairly direct answer (as opposed to responding with the uninformative "Okay" that usually follows an inquiry into how well someone is doing). Caution needs to be exercised here to ensure that the interviewer gets as much information as he/she needs to make a judgment but not so much information that it overwhelms the interviewer and prolongs the process. Many patients when asked what is going on in their life will tell you, and in great detail. The interviewer needs to interrupt, if need be, with a statement to the effect that, "I can see that there is a lot going on in your life, but how is it making you feel?" This takes you easily and logically to the next portion of the acronym.

**Affect.** "How do you feel about that?" This question flows quite smoothly from the assessment of "What is going on in your life?" It gives the patient the opportunity to get in touch with, and label, his/her feelings. It is important for the interviewer to push the patient to accomplish this if the patient is going to be expected to face, and deal, with his/her feelings. The interviewer is also presented with an opportunity to evaluate the appropriateness of the patient's labeling of feelings. For instance, it is not uncommon for patients who are depressed to state that they are angry. Therefore, an assessment of body language and other nonverbal clues is a necessary adjunct to our direct questioning. Once the interviewer is comfortable that the patient has a grasp of, and an appropriate label for, his/her feelings, the interviewer proceeds to the next question.

**Trouble**. "What about the situation troubles you the most?" The answer to this question gives the interviewer a sense of the patient's powers of perception, ability to prioritize, sense of self, and other pertinent qualities. It is, after all, the *trouble* that frequently brings the patient to the doctor. An ability to appreciate the nature and magnitude of the *trouble* is critical if the practitioner is to assist in developing a strategy for

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dealing with it. Having crystallized what troubles the patient the most, the interviewer then proceeds to the critical assessment of how the patient is functioning.

**Handling.** "How are you handling that?" This gives the interviewer a sense of the patient's problem-solving skills and coping mechanisms. One needs to keep in mind that patients in acutely stressful situations tend to regress to a lower level of functioning as they strive to deal with the situation. The clinician needs to respond accordingly. In addition, although it is frequently the trouble that bothers patients, it is the handling of the trouble that may be causing them more problems than the trouble itself. The ability to identify coping mechanisms and understand how a patient is employing them is critical to successfully understanding how a patient is handling a situation. This is also an area where suggestions can be offered, which may be most beneficial to the stressed and frequently dysfunctional patient.

**Empathy.** "That must be very difficult." An appropriate sympathetic statement can be offered by the interviewer to conclude this portion of the encounter. This form of support for the patient makes the practitioner an ally as well as a resource for the patient and indicates to the patient that the interviewer was both listening and assimilating what the patient was saying. Support and compassion can be simultaneously offered a patient, frequently with great therapeutic benefit.

In *The Fifteen Minute Hour,* we propose that the BATHE technique be employed on each and every patient encountered by a primary care practitioner. As with any facet of medical history–taking, it has to be practiced to be perfected. Once accomplished, however, it enables the interviewer to gain incredible insights at the cost of a minimal expenditure of time. In addition, the BATHE technique can be viewed, not only as a screening test to determine the psychosocial status of the patient, but also as a therapeutic entity. It builds upon the preexisting doctor/patient relationship and enables the practitioner to demonstrate interest in the patient as a person while simultaneously developing a psychosocial history. It positions you to support the patient as he/she attempts to solve his/her problems. In this era of managed care, cost containment, and continuous quality improvement, the primary care provider is well served by expanding his/her diagnostic as well as therapeutic armamentarium. The better and more comprehensively one practices medicine will go a long way toward determining the success or failure of the practitioner in these troubled but exciting times.

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## REFERENCES

1. Stuart MR, Lieberman JA III. The Fifteen Minute Hour: Applied Psychotherapy for the Primary Care Physician. 2nd ed. Westport, Conn: Praeger; 1993
2. Wells KB, Katon W, Rogers B, et al. Use of minor tranquilizers and antidepressant medications by depressed outpatients: results from the Medical Outcomes Study. Am J Psychiatry 1994;151:694–700
3. Katon W, VonKorff M, Lin E, et al. Adequacy and duration of antidepressant treatment in primary care. Med Care 1992;1(30):67–76
4. Stokes PE. A primary care perspective on management of acute and long-term depression. J Clin Psychiatry 1993;54(8, suppl):74–84
5. Greenberg PE, Stiglin LE, Finkelstein SN, et al. Depression: a neglected major illness. J Clin Psychiatry 1993;54:419–424
6. Data Fact Sheet: Morbidity From Coronary Heart Disease in the United States. National Heart, Lung, and Blood Institute, National Institutes of Health; May 1992
7. Cancer Facts and Figures. Atlanta, Ga: American Cancer Society; 1990
8. HIV/AIDS Surveillance Report, Year-End Edition. Atlanta, Ga: US Dept Health and Human Services Publication, Center for Infectious Diseases, Centers for Disease Control; January 1992
9. Zal HM. Diagnosing and treating generalized anxiety disorder. Family Practice Recertification 1995;17(10):17–32
10. Flexner A. Medical Education in the United States and Canada. New York, NY: Carnegie Foundation for the Advancement of Teaching; 1910
11. White KL, Williams TF, Greenberg BG. The ecology of medical care. N Engl J Med 1961;265(18):885–892
12. Zung WK, Broadhead WE, Roth ME. Prevalence of depressive symptoms in primary care. J Fam Pract 1993;37:337–344