The Differential Diagnosis of Fatigue and Executive Dysfunction in Primary Care

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The diagnosis of the patient reporting fatigue or the signs of executive dysfunction can be perplexing for the primary care physician. Both symptoms are associated with a wide range of both somatic and psychiatric symptoms and often occur together, although they can exist independently. Using some simple diagnostic and mnemonic tools, such as BATHE, SIG E CAPS, and SWIKIR, may aid the clinician in differentiating possible causes of fatigue and executive dysfunction and determining whether they are signs of physical or mental disease.

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Fatigue and executive dysfunction are encountered by primary care physicians in a variety of forms, and, although they are often found together in the same patient, the 2 symptoms can exist independently of each other. Fatigue may be easier to identify than executive dysfunction. One of the challenges in identifying fatigue is differentiating it from sleepiness, but whereas the tiredness of sleepiness is usually alleviated by increasing the quality or quantity of sleep, fatigue is often unrelated to the sleep habits of the patient.

Primary care physicians may encounter executive dysfunction in many different expressions; it has no standard medical definition and is better regarded as a concept than an easy-to-spot symptom. Patients rarely report executive dysfunction directly; instead, they will report signs of executive dysfunction such as tiredness, forgetfulness, apathy, or a constant bad mood. Family and colleagues may also complain that the patient is making poor decisions and communicating poorly.

DIAGNOSTIC TOOLS AND MNEMONIC DEVICES

The diagnosis of the patient reporting fatigue or the signs of executive dysfunction can be perplexing for the primary care physician since both are associated with a wide range of somatic and psychiatric disorders. Using some simple diagnostic tools may aid the clinician in differentiating possible causes of fatigue and executive dysfunction and determining whether they are signs of physical or mental disease. Key to this process is the ability to listen to the patient, provide support, legitimize concerns, elicit and reflect feelings, show respect, and establish a healing partnership.

Regardless of the thickness of a patient's chart, it is important to allow the patient to tell his or her story without interruption during the first minute or two of the interview. The clinician's tendency is to request details immediately, but if that impulse can be tempered, the patient will usually provide pertinent information with very little prompting. Questions about particular aspects of the problem can then be posed. Adequate treatment of medical problems also includes confronting the psychological aspects. Whether or not the physician desires it, patients often expect help with emotional problems along with physical problems. The physician therefore needs to find out what concerns the patient, what the patient expects of the clinician, and why the patient is coming for help at this time.

SOAP

The problem-oriented medical record in primary care typically classifies progress notes into subjective, objective, assessment, and plan elements (SOAP), a technique first popularized in the 1970s (Table 1).[1] Problems are listed and notes are arranged in SOAP order. The SOAP method gives the clinician a way to organize the patient's complaints, but it has limitations, especially when it comes to making a mental health diagnosis. It encourages the physician to investigate somatic complaints from a somatic perspective instead of allowing the exploration of possible psychological or psychiatric causes.

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Table 1. The SOAP Procedure

Subjective:	the patient's stated reason for visiting the clinician
Objective:	the biomedical findings (physical, laboratory, imaging, etc)
Assessment:	the clinician's overall determination of the patient's status and diagnosis based on the information in the S and O steps
Plan:	the clinician's plan for treating or managing the patient

Table 2. The BATHE Procedure[a]

Background:	"What is going on in your life?"
Affect:	"How do you feel about that?"
Trouble:	"What troubles you the most about this?"
Handling:	"How are you handling that?"
Empathy:	"That must be very difficult for you."

[a]Based on Stuart and Lieberman.[2]

BATHE

The BATHE technique is a simple patient-centered procedure that consists of 4 specific questions about the patient's background, affect, troubles, and handling of the current situation, followed by an empathic response.[2] Table 2 gives a brief outline of the technique. The BATHE technique supplements the SOAP process—"BATHEing" patients as they are "SOAPed" will give the physician useful information, take only about a minute, screen for emotional problems, and be therapeutic for the patient. The BATHE procedure is psychotherapeutic in nature, meaning that the clinician's words and relationship with patients can affect patients' views of their reality. BATHE seeks to empower patients to trust themselves and others, confirm their positive feelings about themselves, and enhance their ability to control the circumstances of their lives. The BATHE technique can also serve as a rough screening test for anxiety, depression, or situational stress disorders and should be routinely employed, because 25% to 75% of outpatient visits are triggered by these disorders.[3] As a screening tool, the test is acceptable to patients, it allows early recognition of these conditions, and time costs are minimal.

Background: "What is going on in your life?" This question is designed to elicit nothing more than a simple statement about the patient's current life situation. The answer gives the primary care practitioner his or her first insights into the patient's psychodynamic state. The patient's response will give firm clues as to whether the patient is in an acutely stressful situation or whether the patient is exhibiting a personality disorder or comparable type of behavior. When the physician states the question specifically—not "How are you doing?"—the patient is encouraged to answer directly, instead of giving the uninformative "fine" as an answer. Caution needs to be exercised to ensure that the interviewer gets as much information as he or she needs to make a judgment but not so much information that it overwhelms the interviewer and prolongs the process. When asked what is going on in their life, many patients will go into 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 question takes the physician 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 voice and label his or her feelings. If the patient answers this question with more background information, the interviewer should redirect the patient by repeating the affect question. The interviewer is also presented with an opportunity to evaluate the appropriateness of the patient's labels. For example, it is common for depressed patients to say that they are angry or irritable. Therefore, an assessment of body language and other nonverbal clues is a necessary adjunct to direct questioning. Once the interviewer is comfortable that the patient has a grasp of, and an appropriate label for, his or 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 dealing with it.

If patients express positive feelings when answering the Trouble question, the interviewer should not presume that nothing troubles them and should modify this question appropriately. In almost every life situation, no matter how positive, there are usually some negatives, even if they are only very minor. It is important to recognize these and move to alter them before they become major problems. Pressing the patients to make sure they have considered all dimensions of their situation will accomplish this. Having identified 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 question gives the physician a sense of the patient's problem-solving skills and coping mechanisms. 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, the way patients handle a troubling situation may be causing them more problems than the situation 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.

Empathy: "That must be very difficult." An appropriate empathic statement should conclude this portion of the

Table 3. Reasons to Use the BATHE Technique[a]

To determine why the patient is seeking treatment as part of obtaining a medical history
To quickly establish personal rapport with patients
To screen for anxiety, depression, or situational stress disorders
To probe for psychosocial precipitants related to somatic complaints
To operationalize the biopsychosocial model by ascertaining the context of the patient's illness
To help patients connect their physical symptoms and emotional responses to the circumstances of their lives
To explore patients' reactions to being given a diagnosis
To handle unexpected psychosocial revelations during an interview
To explore compliance issues, inappropriate requests for referrals, or other difficult situations in the doctor/patient relationship
To provide a structure for a brief counseling session or a family interview

[a]Reprinted with permission from Lieberman and Stuart.[5]

Table 4. Reasons Not to Use the BATHE Technique[a]

The patient is in severe pain or life-threatening circumstances
You felt resistance on the part of the patient, expressed as suspiciousness or hostility
A patient is suicidal or is a battered spouse, sexual abuse victim, or substance abuser. Although BATHE may be helpful in uncovering these conditions, an empathic response must be followed by further exploration and possible action
You suspect the patient is psychotic. The BATHE technique may also be ineffective with personality disorder patients, especially borderline patients
Modifications may need to be made for patients with developmental disorders or physical handicaps, of different cultural backgrounds, or for whom language is a barrier

[a]Reprinted with permission from Lieberman and Stuart.[5]

encounter. This support for the patient makes the practitioner an ally as well as a resource for the patient. It also tells the patient that the clinician conducting the interview was both listening and understanding what the patient was saying. Support and compassion can be simultaneously offered a patient, frequently with great therapeutic benefit.

The BATHE technique is a specific verbal procedure. To be used effectively, it must be practiced. As with any procedure, some health care providers may feel awkward at first but will develop confidence and a comfort level after doing a number of them correctly. When using the BATHE technique, the clinician should try to say nothing except for the specific BATHE questions and discourage patients from elaborating at length about the circumstances or details of their situations. Instead, summarize briefly and ask the next question. It is important to remember that it is not the health care worker's job to fix the patients' problems, only to provide support and clarification.

The technique can be used for a variety of purposes, as shown in Table 3; there are very few contraindications for using BATHE except for the ones shown in Table 4.[4,5] When the patient returns for a follow-up visit, the opening BATHE question becomes "Tell me what's been happening since I saw you." For further information and additional techniques, see *The Fifteen Minute Hour*.[2]

Table 5. SIG E CAPS

S:	increased or decreased **S**leep or decreased **S**exual desire
I:	decreased **I**nterest or pleasure in favorite activities
G:	inappropriate **G**uilt or feelings of hopelessness or worthlessness
E:	decreased **E**nergy or increased fatigue
C:	decreased **C**oncentration
A:	change in **A**ppetite with weight gain or loss
P:	**P**sychomotor agitation or retardation
S:	**S**uicidal ideation or suicide attempt

Table 6. SWIKIR

S:	**S**omatic symptoms
W:	**W**orries
I:	**I**rritability
K:	**K**eyed up, on edge
I:	**I**nitial insomnia
R:	**R**elaxation difficulties

Diagnosing Depression: SIG E CAPS

Mood disorders can often cause problems with energy levels and executive function. If a mood disorder such as depression or an anxiety disorder is suspected after the application of the BATHE technique, the primary care practitioner can use mnemonic devices to determine what the root problem is. A preliminary screen for depression consists of 2 simple questions for the patient: In the past month, have you lost pleasure in the activities you usually enjoy? Have you felt sad, down, depressed, or hopeless? A "yes" answer to either question (or both questions) is a positive screen for depression. The mnemonic SIG E CAPS, based on the diagnostic criteria for depression and explained in Table 5, can be used to confirm the diagnosis of depression.[6,7] If a patient has 5 or more of the symptoms in SIG E CAPS as well as depressed mood and/or anhedonia, he or she meets the criteria for a major depressive episode.

Diagnosing Anxiety: SWIKIR

Anxiety is also a relatively common phenomenon in primary care, especially in those who present with fatigue or executive dysfunction. The mnemonic SWIKIR (Table 6) may help the primary care physician identify anxiety.[8] Patients who report 3 or more of the SWIKIR symptoms may meet the criteria for an anxiety disorder. Anxiety disorders and depression are often comorbid, making the selection of treatment challenging. The clinician may decide to determine which type of disorder is more prominent and then select the appropriate treatment to remedy it first.

CONCLUSION

Psychosocial and psychiatric aspects of patients' situations have a significant impact on the state of patients'

medical health. Recognizing this relationship requires the physician to shift from a purely biomedical view to one that considers the whole patient and the context of the visit, especially when treating a patient with vague symptoms such as fatigue and executive dysfunction. After establishing a positive relationship with patients, physicians can employ the techniques mentioned here to connect meaningfully with patients and screen for mental health problems, which will enable clinicians to treat the mental or biological conditions that underlie symptoms such as fatigue and executive dysfunction.

Disclosure of off-label usage: The author of this article has determined that, to the best of his knowledge, no investigational information about pharmaceutical agents has been presented in this article that is outside U.S. Food and Drug Administration–approved labeling.

REFERENCES

1. Weed LD. The problem oriented record as a basic tool in medical education, patient care and clinical research. Ann Clin Res 1971;3:131–134
2. Stuart MR, Lieberman JA. The Fifteen Minute Hour: Practical Therapeutic Intervention in Primary Care. 3rd ed. Philadelphia, Pa: WB Saunders; 2002
3. Kroenke K, Mangelsdorff D. Common symptoms in ambulatory care: incidence, evaluation, therapy and outcome. Am J Med 1989;86:262–266
4. Stuart MR. The BATHE technique. In: Rakel RE, ed. Saunders Manual of Medical Practice. Philadelphia, Pa: WB Saunders; 1996:1108–1109
5. 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;1:35–38
6. Wise MG, Rundell JR. Concise Guide to Consultation Psychiatry. 2nd ed. Washington, DC: American Psychiatric Press; 1994:55–56
7. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC: American Psychiatric Association; 1994
8. Baughman OL III. Rapid diagnosis and treatment of anxiety and depression in primary care: the somatizing patient. J Fam Pract 1994;39:373–378