CME

Short counseling techniques for busy family doctors

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ABSTRACT

OBJECTIVE To introduce two short counseling skills for busy family doctors: the BATHE technique and the DIG technique.

QUALITY OF EVIDENCE The BATHE technique indicates five areas for questioning patients who require counseling: background, affect, trouble, handling, and empathy. No research on use of the technique has been published. The DIG technique is the author's modification of the BATHE technique.

MAIN FINDINGS While the efficacy of counseling in general was validated, more research on the effectiveness on these two techniques needs to be done.

CONCLUSION Since counseling is an integral part of family practice, family doctors will find these techniques useful. Each is easy to learn and takes less than 15 minutes to complete.

RÉSUMÉ

OBJECTIF Présenter deux brèves interventions de counselling aux médecins de famille qui vivent une pratique achalandée : la technique BATHE et la technique DIG.

QUALITÉ DES PREUVES La technique BATHE indique cinq domaines où devrait porter le questionnaire des patients nécessitant un counselling : background (antécédents), affect (affect), trouble (trouble), handling (intervention) et empathy (empathie). Aucune recherche portant sur l'utilisation de cette technique n'a été publiée. La technique DIG est une modification de la technique BATHE effectuée par l'auteur.

PRINCIPAUX RÉSULTATS Malgré la validité reconnue de l'utilité du counselling en général, l'efficacité de ces deux techniques devra faire l'objet d'un recherche plus poussée.

CONCLUSION Puisque le counselling fait partie intégrante de l'exercice de la médecine familiale, ces techniques seront utiles aux médecins de famille. Les deux sont faciles à apprendre et leur application ne nécessite que 15 minutes.

Can Fam Physician 1997;43:705-713.

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hile family medicine has established itself as a specialty, it is only recently that the importance of the family has been emphasized.[1-7] Family doctors often need to counsel their patients and families. I define counseling as the process of assisting people to overcome obstacles to their personal and interpersonal growth and to achieve optimum development of their personal resources and goals in life. This definition describes family practice counseling.

In daily practice family physicians see both normally functioning and dysfunctional people. Patients' physical illnesses and psychosocial problems sometimes constitute obstacles to growth. These problems affect both the individuals and others, especially family members. Because family doctors provide comprehensive care to their patients, family counseling should become integral to practising family medicine.

Although a large proportion of patients' complaints probably have a psychological component, family doctors shy away from counseling patients and families for two main reasons.[8,9] The first is that they are busy and unable to spend much time with patients, and the second is that they do not have adequate training or knowledge regarding counseling.[10] Christie-Seely[11] wrote an excellent article on counseling in this journal. She described the attributes of a counselor and some of the principles of counseling. However, family physicians are still looking for specific counseling techniques that are useful in daily practice.

This paper aims to introduce two counseling techniques: the BATHE technique and the DIG technique. Each technique takes 5 to 15 minutes to complete. I chose these techniques because they represent two levels of counseling. The first level is basic; the amount of time spent and the degree of doctor-patient interaction is minimal. This is the level of the BATHE technique. The second level is intermediate: more time is spent with the patient and the doctor is more involved in the counseling process. This is the level of the DIG approach. Beyond these two levels is an advanced level where the doctor is actively involved in the counseling process and the time spent is much longer, usually 30 minutes to 1 hour. This level of advanced counseling is usually outside an average family doctor's domain.

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I describe the two techniques and present case examples and comments to illustrate the concepts. In practice, cases are unlikely to be as smooth as the examples presented. The cases are based on actual patient encounters, but details have been altered to guarantee patient confidentiality.

BATHE technique

The BATHE technique was pioneered by Stuart and Lieberman[12] and promoted in Canada by psychiatrists Buchanan and Sehon.[13] The technique is simple and takes only 5 to 7 minutes to complete. **Table 1** shows indications and contraindications to using the technique. In general, the technique can apply to almost everyone. The exceptions are those who need more intensive immediate help or protection from potential self-injury and those with personality disorders who would probably not benefit from the approach.

Table 1. Indications and contraindications for the BATHE technique

INDICATIONS
Basic level of counseling
Little time for counseling (about 5 minutes)
Patient has psychosocial issues
CONTRAINDICATIONS
Suicidal patients
Victims and perpetrators of family violence
Substance abusers
Patients with personality disorders

BATHE is the acronym derived from the words background, affect, trouble, handling, and empathy (**Table 2**). To use the BATHE technique correctly, physicians should give full attention to patients by providing proper eye contact while asking the five questions.

In asking the first question on background, if doctors waste no time and get right into the heart of patients' life situations, patients have an opportunity to self-disclose. With the second question about affect, physicians should pose an open-ended question to let patients share their feelings. Proceeding right along to the third question, which deals with the most significant thing troubling the individual, physicians should not give patients unlimited time

Table 2. BATHE technique questions

B	**BACKGROUND: What is going on in your life?**
A	**AFFECT: How do you feel about that? (What is your mood?)**
T	**TROUBLE: What troubles you the most about this situation?**
H	**HANDLING: How are you handling this?**
E	**EMPATHY: That must be very difficult for you. It sounds terrible.**

to talk but should help them to identify only the most troubling thing. The fourth question inquires how patients are handling the situation. The underlying assumption is that the person *can* deal with the unhappy situation and the question enables the person to connect with his or her internal resources. The fifth and final interaction is a statement of empathy in which physicians should let patients know that they have heard and understood the predicament.

Case study. After checking out a 35-year-old married woman for an upper respiratory tract infection, the doctor noticed that the patient seemed to be bothered by something. Deciding to use the BATHE technique, the doctor said, "Mary, you have only a common cold. However, looking at you, I sense something is bothering you. Can you tell me what's going on in your life right now?"

Mary, taken aback by the doctor's discernment but happy that the doctor had noticed and cared about her worried demeanour, quickly replied, "I don't really know. In the last 3 months, I have had five bouts of cold. My life seems to be upside down. Nothing is working out for me. There is too much work. I am busy in the office and then, coming home, I have to do a lot of household chores. There is just no time to slow down."

The doctor proceeded with the BATHE questions. "Sounds like you are experiencing quite a bit of stress. How do you feel about that?"

Mary responded, "I feel overwhelmed, exhausted, and quite upset about everybody. My work situation is not any better. With the cutting down of staff, I have to do more work...."

Rather than let Mary return to the details of the first question, the doctor redirected her by saying, "So you feel overwhelmed, exhausted, and upset about your life. What troubles you the most about this situation?"

Mary paused to collect her thoughts and said, "I guess the lack of time to relax, just to do nothing, and not to run after the clock."

The doctor continued to the fourth question. "How are you handling this?" and, when Mary replied, "Not very well, I suppose," the doctor expressed empathy: "That must be quite hard for you." When the doctor finished the five questions, she concluded the visit by saying, "Well, I hope things will be better for you soon. In the meantime, for your cold, take the cough syrup with decongestant for your cough and acetaminophen for fever, drink plenty of fluids, and get some rest.

Mary replied, "Sure I will. Thank you, doctor, for listening." As she left the office, she felt more relaxed.

Comments. The doctor first had to become aware that something emotional or psychological in the patient's life adversely affected physical health. Then she decided to use the BATHE technique. Once the decision is made, doctors should follow very closely the sequence of the five questions. To make the technique work, doctors need to commit the five questions to memory so they can ask them relatively rapidly in correct sequence.

Table 3. Indications and contraindications for the DIG technique

INDICATIONS
Intermediate level of counseling
More time for counseling (about 10 minutes)
Patient has psychosocial issues
CONTRAINDICATIONS
Patient unable to comprehend what is happening
Patient cannot define goals

DIG technique: solution-focused therapy

The second short counseling technique I find useful is a solution-focused technique developed by de Shazer and Berg.[14-20] Proponents of the technique think almost anybody can benefit from brief therapy, unless they are psychologically unstable and unable to define a treatment goal **(Table 3)**.[12]

The basic tenet of a solution-focused approach is to help patients construct solutions rather than dissolve problems. It also gives patients a chance to work on small behaviour changes that contribute to their chosen goals. A more detailed way of using this approach is outside the scope of this paper.

I have simplified the DIG technique so busy doctors can complete it within 15 minutes. The acronym DIG represents three sets of questions doctors ask patients **(Table 4)**. The first set of questions helps patients "dream the miracle." Stating "When the miracle occurs, the problem is solved," presupposes that the problem is solvable and there is hope. Getting patients to describe what would change when the miracle occurs lets doctors find out some things patients could change. The second set of questions is to encourage patients to initiate action, construct solutions by themselves, and break solutions down into concrete, small, workable steps. The final set of questions aims to give patients the impetus to "get going," to motivate them to take that first step. Once patients experience something different and positive, they will be encouraged to pursue further the road to healing and recovery.

Case study. A patient had just finished explaining his frustration in his marriage to the doctor. The doctor summed up without placing blame, "You have just described to me how unhappy you are when you interact with your wife. Quite often your wife wants to resolve a problem with you, but you feel that she is nagging you, and you react to this by either simply withdrawing from her or leaving the house. In the process, both of you end up in a yelling match." Then he decided to use the DIG technique. "Suppose overnight a miracle happens and everything is changed and the problem solved. What do you suppose you will notice about yourself in the morning? What is it that your wife will notice different about you?"

After reflection, the patient replied, "Well, when I get up, I would feel refreshed and happy. I would feel that the world is smiling at me. I would probably bend over and give my wife a kiss and say good morning to her. I guess this is what she will notice different about me. Maybe she will have a smile on her face too, and we can even have breakfast together without fighting."

Searching for small, concrete steps to bring the dream to reality, the doctor said, "It certainly sounds quite different from what you two are used to. What do you suppose it will take for you to move from here to there? What is the first small step you can take to start being more friendly and loving toward each other?

The patient replied, "Well, I don't really know." After thinking for a while, he said, "I guess I can try not to yell at her before going to bed. Or instead of constantly bickering at her, I can be nice and be more appreciative of what she has done."

Wanting to focus on some specific, small steps, the doctor said, "That sounds nice. Can you give me an example?" to which the patient replied, "I can say to her I enjoy her cooking, and maybe just say how nice she looks." To make sure that these are positive steps on the road of recovery, the doctor continued, "Do you think that, when you start doing these things, your wife would be happy about it?"

To the patient's reply, "I think so. I have done it before during the early part of our marriage and she was always nice to me in return," the doctor

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Table 4. DIG technique in solution-focused approach

D DREAM the miracle (ask the miracle question)

Suppose a miracle happens and your problem is solved overnight. The next morning, what do you think you will notice is different? What will let you know that there has been a miracle overnight? What is the first change you notice yourself? What is it that others notice different about you? How would their behaviour be affected by your difference? What would you do differently then?

I INITIATE the first small step

What will be the first small step in that direction? What does it take (what is needed) for you to start the first step to make the situation better (make the miracle happen)?

G GET GOING and implement the first move

When are you going to start this first small step? How are you going to start this process so that you can be sure that you are moving in the right direction?

countered, "When do you think you are going to start these small steps?"

The patient responded, "Anytime, I guess."

Again pushing for action, the doctor said, "Would you like to start today when you go home?" When the patient responded positively, the doctor said, "That's very good. Perhaps you can return to see me in a week's time and report how this worked. I would be interested to hear your wife's responses and to see how you two can move along the right track to not fighting."

Comments. The doctor begins by summarizing the current state of the patient and his wife without taking sides or placing blame on either party. This case is a common example of a conflict-filled relationship where one spouse tries to pursue and engage the partner in dealing with the problem and the other spouse either fights back or withdraws.

If patients are not so willing to dream the miracle, the doctor might engage them in discussing and visualizing the miracle and then ask the question again. With the "I" question, it is normal for patients to pause and reflect on actions they could initiate. When patients get stuck, doctors can help them use their imaginations to visualize the dream again. Affirmation and helping patients identify concrete answers are important strategies for preparing for the final set of questions. Doctors should push patients gently but firmly to get going, make a commitment, and take actions in the right direction. It is important to have follow-up visits for evaluating progress or identifying obstacles along the path.

Evidence for effectiveness of brief counseling

The outcome or efficacy of counseling and psychotherapy has been extensively studied. Most research has concentrated on long-term, time-unlimited psychotherapy. An important way of assessing different studies is meta-analysis. Since outcome studies have diverse outcome measures (eg, depression, anxiety, agoraphobia), a key step is computation of an effect size that converts each outcome measure to a common element.[21,22] Smith et al[21] found, in a meta-analysis of 475 controlled studies of individual psychotherapy outcome evaluations in the literature, that the average person in treatment has a better outcome than 80% of untreated people. Moreover, improvements have been shown to be stable over time.[23-25] Research on the effectiveness of marital and family therapy has shown similar results.[26-29] Research studies on short-term, time-limited (<25 sessions), brief therapy are fewer, yet these studies show similar effectiveness.[30-33]

The BATHE and DIG techniques are examples of brief psychotherapy. Since Stuart and Lieberman[12] introduced the BATHE technique, no research on the use of the technique in general practice has been published. However, many family doctors in North America have found it useful. At the June 1995 WONCA (World Organization of Family Doctors) conference held in Hong Kong, the BATHE technique was presented in a workshop to about 100 family physicians from various countries. Response from these physicians was overwhelmingly positive, and they indicated they would incorporate it in their practices.

The solution-focused approach has been used by therapists for more than two decades. Only a few outcome studies are available, and they are mostly surveys of new cases seen in the authors' centres. However, these studies show that the solution-focused approach is an effective mode of counseling with a success rate (either complete relief or significant improvement of the presenting complaint) of between 72% and 82%.[15,34-35] The DIG technique is my simplified version of solution-focused therapy, and this particular format has not been validated. In the field of counseling and psychotherapy, many useful interventions are not empirically validated at first[36]; only later are they critically evaluated and proved effective.

Conclusion

The BATHE technique and the DIG technique are two useful brief counseling methods. Each is easy to learn and takes less than 15 minutes to complete. Since counseling should be integral to family practice, family doctors should learn these techniques and apply them in their daily practices. In the future, critical evaluative studies of these interventions should be done.

Acknowledgment

The contents of this paper were presented in a workshop at the 14th WONCA World Conference in June 1995 in Hong Kong.

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