Open Access

OBM Integrative and Complementary Medicine

LIDSEN Publishing Inc.

Opinion

Doing Brief Work, Slowly: Compassion as Intervention in Behavioral Medicine

Ron Dolgin *, Matthew J. Davis

Edward Hines, Jr VA Hospital, Hines, IL, USA; E-Mails: ron.dolgin@va.gov, matthew.davis2@va.gov

* **Correspondence:** Ron Dolgin; E-Mail: ron.dolgin@va.gov

Academic Editor: Steven K. H. Aung

Special Issue: How Compassion Benefits in the Healing Process

OBM Integrative and Complementary Medicine
2019, volume 4, issue 2
doi:10.21926/obm.icm.1902037

Received: March 20, 2019
Accepted: June 14, 2019
Published: June 18, 2019

Abstract

Integration of behavioral health consultants and specialists into medical settings has accelerated the development of evidenced-based practices for an array of problems and concerns common to behavioral medicine. Though these treatments have shown to be beneficial for those that engage in protocols, attrition remains high. With an emphasis in directed problem solving and skill building, many brief treatments leave little room for compassion, validation, and understanding. This article explores this trend and advocates for behavioral health providers to prioritize compassion as an evidence-based intervention itself.

Keywords

Compassion in healthcare; Primary Care Mental Health Integration; brief treatment

A patient sits nervously in a cold and sparse clinic room. Left alone after a brief conversation with their primary care provider, he wonders if he said too much. Thoughts flood through his mind. Yes, he has been more stressed lately. Yes, he has been more tired with little to no motivation. But did he really need to talk to someone? He works to convince himself that it is not really that bad,

though he is also aware just how much he has been beating himself up lately. He has never heard of "behavioral health" before, but it sounded a lot like mental health. Now he is wondering if his provider thinks he is crazy, and worries even more that whoever walks through the door could not possibly understand his experience. His heart starts to beat faster. He looks over at his coat, tempted to grab it and sneak out, when he hears a tap on the door before it opens.

Taking time to think about the experiences of our patients is an important part of clinical care, though a task that is likely not often completed. What is it like for a patient to meet with a trained mental health provider for the first time? How hard is it to open up emotionally for the first time, and to a stranger? What would it be like to go in for a primary care appointment, and to suddenly be seen by mental health? Despite perceived benefits of stigma reduction by integrated mental health services [1], many patients continue to perceive mental health in a negative light [2], as if to think it is something for others, not themselves.

Clinical work can be thought of as a unique relationship, one that requires the training and experience of a professional to empower the trust of the patient, along with actionable skills for a patient to implement. However, while clinical work does require specific and distinctive skills, there are lessons to be learned from other impactful relationships in our lives, including those of caregivers and parents. Though these positions lack formal training in behavioral and mental health, those equipped with and ready to employ relational tools – like comfort, validation, hope, or love – often ease the emotional tensions brought by problems in sleep, pain, or sickness. It is important for medical and behavioral health communities to remember how, in these clinical relationships, much like parental relationships, simple acts and interactions steeped in humanness and compassion can alter behavior and be therapeutic.

When we discuss these terms of humanness and compassion we are focusing on authentic and empathetic interactions from the provider. This centers on taking the time to connect emotionally with a patient, understand their concerns, experiences, and their goals, prior to attempting to modify behavior or problem solve. Too often the pressures of time, leadership and system demands, as well as internal pressures to fix, serve as barriers to the basic principles of beneficence, unconditional positive regard, and acceptance that all humans should feel from a provider truly trying to offer assistance. As patients experience ambivalence, miss appointments due to life struggles, or reject treatment plans defined as too difficult, it is important for us as providers to take that a step back to be compassionate and accepting that struggle is a normal and appropriate part of humanness, and the therapeutic process.

Research on compassion in medicine has, historically, focused on medical outcomes and patient satisfaction. Rightfully so, as compassionate communication from their providers has been connected to an array of positive medical outcomes. Though the majority of studies are largely correlational, links have been found between compassionate interactions and, among others, lower blood pressure, greater metabolic control in patients with diabetes, and reports of chronic pain severity [3-5]. Beyond these medical outcomes, the psychosocial benefits of compassion are clear, with patients consistently showing greater psychological adjustment to diagnosis or medical treatment, adherence to medication regimens, and report higher satisfaction in care with more compassionate providers [6-7]. Further, from an administrative angle, decline in malpractice claims and readmission rates have also been pointed to by champions of those seeking to increase compassion and effective communication between providers and those they treat [8-9].

Given these findings, the assertion that medical providers serve their patients best when practicing from a compassionate stance is hardly controversial. However, only 53% of patients and 58% of physicians report a belief that the U.S. health care system generally provides compassionate care [10]. While these perceptions are likely born from many factors, one likely concern is the increasing pressures and demands providers face in their practice. These burdens are reflected throughout the literature, as recent studies showed physicians at greater risk now more than ever for burnout due to factors that include sheer number of work hours, expectations for on call services, eroding intrinsic satisfaction, and increasing caseload volumes [11-12]. If compassion is seen as a finite resource, it certainly may be spread too thin for all patients being served by a single medical provider.

In the past several decades, integration of specialty services into various medical settings, namely primary care, began to be promoted as solutions for both medical providers and their patients [13-15]. Headlined by primary care mental health integration models, incorporation of behavioral health specialists tasked with sharing the weight of comprehensive patient care offered both a unique expertise in human behavior as well as a precious resource not afforded to medical providers: time. Indeed, the shift from health as a spectator sport to one where patients were empowered to participate required additional providers with the ability, and availability, to motivate and educate. A wave of evidence-based practices emerged, designed for trained behavioral health specialists to combat an assortment of medical and behavioral problems, with insomnia, chronic pain, alcohol abuse, and medication adherence topping the list. Brief treatments (defined as normally 4-6 sessions, often 30 minutes or less per appointment) in behavioral medicine for these concerns have shown tremendous promise in their intended goals for change [16-19].

Yet, these outcomes are reported only for those that complete the treatment protocols. Studies in treatment of chronic pain, insomnia, and weight loss have examined dropout rates in clinic settings and report concerning trends [20-23]. Though predictors of attrition are difficult to pinpoint, it is important to note that manualized treatments in brief models emphasize education, skill building, and behavioral experiments. Without question, the rationale is sound. However, the assumption that most patients will dive headfirst into application may be naive. As seen every day by those in helping professions, people from all walks of life behave in ways far against their self-interest, and often cling, if not fight for, maintaining these patterns. In the face of evidence, a willing teacher, and techniques to better ones health and life, a sizeable portion will scoff and continue in their suffering, if for no other reason than fear of the unknown. This begs an important question: are behavioral health providers rushing into skill building at the detriment of those in the population who are most vulnerable and in need of help?

Behavioral medicine is, like most mental health therapies, a dance with the irrational where the provider must choose their steps carefully. Though perhaps easy to scoff at such theories as the gate-control theory of chronic pain treatment or in the benefits of progressive muscle relaxation when coping with tobacco cessation, nearly all patients will respond to the most basic of human needs, human connection. Foundational principals in psychotherapy- validation of struggle, communications of nonjudgement, understanding of circumstance, feeling heard and accepted- are perhaps the most basic of dance steps, yet are at risk of being lost in the shuffle. With emphasis on actionable interventions, perhaps forgotten is that compassion, and the therapeutic relationship that blooms from those efforts, have always and continue to be an evidence-based

intervention in and of itself [24-26]. For example, research has suggested that use of immediacy (or discussions of the here-and-now therapeutic relationship), even in brief treatment, can increase patient involvement, emotional expression, and reduce defensiveness [27]. Even motivational interviewing, one of the most valuable tools in brief behavioral medicine, advises to engage with the patient through empathic reflection, values clarification, and active listening before any attempts are made to evoke reasons for change [28].

The perspective that this article hopes to open for consideration is that space can be made for compassion within the brief model. Despite a push to begin a change plan, to do something, true demonstration of understanding and patience may be what our patients need most. The push for brief encounters is understandable, as availability for same-day access is paramount in engaging patients that might otherwise be less likely to follow-up with care, particularly psychiatric populations who may need a higher level of treatment [29]. The cost, however, is providers that feel they need to work at break-neck speed, often pushing a patient through a treatment, rather than the intended collaborative relationship where patient and provider walk alongside each other. In these moments, it is compassionate exploration that is often sacrificed, as it is by nature slow and methodical, which may seem antithetical to brief models. This may be especially true in behavioral medicine, as it is easy to justify the focus of the treatment as the disorder (the sleep, the pain, the weight loss, etc.) rather than the person.

The therapeutic relationship can be so routinely and obligatorily discussed in counseling and psychotherapy that there is a danger that it has lost all meaning. In manuals and training seminars, it has become, in some ways, a disclaimer or preface on the way to discussion and overview of technique or skill. What has the patient learned? What has the patient done? This article seeks to be a reminder that behavioral medicine needs re-focusing on the most basic of therapeutic stances. What does the patient feel? Can providers appreciate the fear that which prevents a behavioral activation plan from execution? Is there an understanding of the shame a patient may feel when discussing weight loss? Do the worries that push a patient away from sleep need exploration and validation? Honoring and addressing these questions and reflecting their answers to the patient can, in itself, be an intervention, even if only in an initial session. In some cases, perhaps 4-6 sessions spent only on securing the therapeutic attachment is also indicated and therapeutically appropriate, if not necessary. This can be a signal to the patient that a connection has been established that then allows steps to be taken into the unknown of behavior change and, in many cases, it may be the only reason a patient returns to treatment and is, eventually, able to better accept actionable, skill based intervention.

The question then becomes, how does a provider become more compassionate? The answer to this can be simple, yet often difficult to remember, and ultimately centers on slowing down and listening to the patient. The power of feeling heard can feel like a luxury that many are unable to access. To feel sick, sad, desperate, hurt, or broken, having another human sit in those emotions is an initial ingredient for change. Certainly not the only ingredient, as there are many treatment models and theories for the skills to apply in these moments, but to jump into these without this element can quickly lead to attrition in treatment.

We all have a choice as to what kind of provider we choose to be that comes through the door to greet a possibly nervous, confused, or hesitant patient. We can choose to focus on the “what to change” or “what to fix,” or we can choose to focus on the human in the room, to provide validation, comfort, and connection before engaging in what might be broken. A compassionate

therapeutic relationship should take precedence above overzealous and premature action planning, problem solving, and fixing. Doing brief work slowly means having comfort and security in knowing that the byproducts of basic human connection and compassion, and the space made to create that bond, will only accelerate the treatment once established. We urge all behavioral medicine providers, as well as researchers and administrators of these programs, to embrace and prioritize compassion as the most active ingredient toward greater emotional and physical health. As generations of caregivers have already shown us, above technique and skill, we must make room for safety, patience, trust, love, and compassion.

Author Contributions

Dr. Dolgin led the overall conceptualization and theme, as well as the majority of the second half of this paper. Dr. Davis worked mainly on the first half of this paper. Both authors reviewed and edited the entire manuscript.

Funding

No funding was provided for this project.

Competing Interests

The authors have declared that no competing interests exist.

References

1. Wray LO, Szymanski BR, Kearney LK, McCarthy JF. Implementation of primary care-mental health integration services in the Veterans Health Administration: Program activity and associations with engagement in specialty mental health services. J Clin Psychol Med S. 2012; 19: 104-116.
2. Clement S, Schauman O, Graham T, Maggioni F, Evans-Lacko S, Bezborodovs N, et al. What is the impact of mental health-related stigma on helpseeking? A systematic review of quantitative and qualitative studies. Psychol Med. 2015; 45: 11-27.
3. Cooper LA, Roter DL, Carson KA, Bone LR, Larson SM, Miller ER, et al. A randomized trial to improve patient-centered care and hypertension control in underserved primary care patients. J Gen Intern Med. 2011; 26: 1297-1304.
4. Hojat M, Louis DZ, Markham FW, Wender R, Rabinowitz C, Gonnella JS. Physicians' empathy and clinical outcomes for diabetic patients. Acad Med. 2011; 86: 359-364.
5. Farin E, Gramm L, Schmidt E. The patient–physician relationship in patients with chronic low back pain as a predictor of outcomes after rehabilitation. J Behav Med. 2013; 36: 246-258.
6. Lelorain S, Brédart A, Dolbeault S, Sultan S. A systematic review of the associations between empathy measures and patient outcomes in cancer care. Psychol Oncol. 2012; 21: 1255-1264.
7. Vlasnik JJ, Aliotta SL, DeLor B. Medication adherence: Factors influencing compliance with prescribed medication plans. Case Manager. 2005; 16: 47-51.
8. Levinson W, Roter DL, Mullooly JP, Dull VT, Frankel RM. Physician-patient communication: The relationship with malpractice claims among primary care physicians and surgeons. JAMA. 1997; 277: 553-559.

9. Boulding W, Glickman SW, Manary MP, Schulman KA, Staelin R. Relationship between patient satisfaction with inpatient care and hospital readmission within 30 days. AM J Manag C. 2011; 17: 41-48.
10. Lown BA, Rosen J, Marttila J. An agenda for improving compassionate care: A survey shows about half of patients say such care is missing. Health Affair. 2011: 30; 1772-1778.
11. Dyrbye LN, Varkey P, Boone SL, Satele DV, Sloan JA, Shanafelt TD. Physician satisfaction and burnout at different career stages. Mayo Clin Proc. 2013; 88: 1358-1367.
12. West CP, Dyrbye LN, Shanafelt TD. Physician burnout: Contributors, consequences and solutions. J Intern Med. 2018; 283; 516-529.
13. Butler M, Kane RL, McAlpine D, Kathol RG, Fu SS, Hagedorn H, et al. Integration of mental health/substance abuse and primary care. Rockville, MD: Agency for Healthcare Research and Quality; 2008. p. 173.
14. Post EP, Van Stone WW. Veterans Health Administration primary care-mental health integration initiative. N C Med J. 2008; 69; 49-52.
15. Zivin K, Pfeiffer PN, Szymanski BR, Valenstein M, Post EP, Miller EM, et al. Initiation of primary care-mental health integration programs in the VA Health System. Med Care. 2010; 48: 843-851.
16. Battersby M, Von Korff M, Schaefer J, Davis C, Ludman E, Greene SM. Twelve evidence-based principles for implementing self-management support in primary care. Jt Comm J Qual Patient Saf. 2010; 36; 561-570.
17. Csaszar N, Bagdi P, Stoll DP, Szoke H. Pain and psychotherapy, in the light of evidence of psychological treatment methods of chronic pain based on evidence. J Psychol Psychother. 2014; 4: 145-151.
18. Bertholet N, Daeppen JB, Wietlisbach V, Fleming M, Burnand B. Reduction of alcohol consumption by brief alcohol intervention in primary care: Systematic review and meta-analysis. Arch Intern Med. 2005; 165: 986-995.
19. Pigeon WR, Funderburk J. Delivering a brief insomnia intervention to depressed VA primary care patients. Cogn Behav Pract. 2014; 21: 252-260.
20. Ong JC, Kuo TF, Manber R. Who is at risk for dropout from group cognitive-behavior therapy for insomnia? J Psychosom Res. 2008; 64: 419-425.
21. Glombiewski JA, Hartwich-Tersek J, Rief W. Attrition in cognitive-behavioral treatment of chronic back pain. Clin J Pain. 2010; 26: 593-601.
22. Moroshko I, Brennan L, O'Brien P. Predictors of dropout in weight loss interventions: A systematic review of the literature. Obes Rev. 2011; 12: 912-934.
23. Thorn BE, Day MA, Burns J, Kuhajda MC, Gaskins SW, Sweeney K. Randomized trial of group cognitive behavioral therapy compared with a pain education control for low-literacy rural people with chronic pain. Pain. 2011; 152: 2710-2720.
24. Lo Coco G, Gullo S, Prestano C, Gelso CJ. Relation of the real relationship and the working alliance to the outcome of brief psychotherapy. Psychother. 2011; 48: 359-367.
25. Fuertes JN, Gelso CJ, Owen JJ, Cheng D. Real relationship, working alliance, transference/countertransference and outcome in time-limited counseling and psychotherapy. Couns Psychol Quart. 2013; 26: 294-312.
26. Gelso CJ, Kivlighan Jr DM, Busa-Knepp J, Spiegel EB, Ain S, Hummel AM. The unfolding of the real relationship and the outcome of brief psychotherapy. J Couns Psychol. 2012; 59: 495-506.

27. Kasper LB, Hill CE, Kivlighan Jr DM. Therapist immediacy in brief psychotherapy: Case study I. Psychother. 2008; 45: 281-297.
28. Miller WR, Rollnick S. Motivational interviewing: Helping people change. 3rd ed. New York: Guilford press; 2013.
29. Davis MJ, Moore KM, Meyers K, Mathews J, Zerth EO. Engagement in mental health treatment following primary care mental health integration contact. Psychol. 2016; 13: 333-340.