Compassionate Care in Psychiatry: An Unattainable Goal?

Details
Name Marco Narajos
Year 1
Medical school University of Oxford
Student Associate number 919180

Summary
Compassionate care in psychiatry delves into the patient experience. In this piece, I explore how compassion is distinct from the concept of compassionate care and argue that compassionate care has a unique role in psychiatry compared to its role in other medical specialities. In order to tackle the subject, I define compassionate care in terms of compassion and competency, creating a DSM-essque summary table of the ‘diagnostic criteria’ for compassionate care.

I look at whether compassionate care is something to which psychiatry should even aspire to achieve in the first place, citing compassion fatigue as a barrier to success in healthcare. Further to this, I give an overview of the challenges to achieving compassionate care in the context of my diagnostic criteria at different tiers of interaction, based on Bronfenbrenner’s ecological systems scheme. In response to the challenges listed, I provide practical solutions to aid in the goal of achieving compassionate care in psychiatry.

Word count (without references) 2927
Background

Imagine lying on a bed, straps around your wrists and ankles. The air fills with tension, and yet men in white uniforms reassure you. Dabs of an unknown gel on your temples cool your skin, while a woman thrusts a rubber device into your mouth, for your own safety – so they said. Then, the pain of the electric current hits...

Many viewers of One Flew Over the Cuckoo’s Nest may see the motivation to treat mental illness, but few would describe this as compassionate care. While 21st century psychiatrists use ECT in an evidence-based manner, under general anaesthetic, and with the patient’s consent, there have been similar, albeit rarer, images of clinicians today.

The NHS document Compassion in Practice¹ discusses how quality of care is just as important as quality of treatment. A positive experience is, in turn, based on six action areas² for developing compassionate care set by the Department of Health (see Figure 1), one of which is compassion. But what exactly is it?

Compassion in Practice defines compassion as a central component of patient’s perception of care; it is how care is provided through the patient-clinician relationship, with the tenets of compassion being empathy, respect, dignity, and intelligent kindness.

In Randle McMurphy’s fictional world, it is plausible that these characteristics are compatible with a paternalistic model of care. For example, the clinicians reassure McMurphy, exhibiting an empathic nature. Similarly, Nurse Itsu calls him ‘Mr McMurphy,’ and is respectful when asking him to enter the treatment room. However, the treatment could be described as akin to torture.

Thus, in the following discussion, I would like to explore how compassion is distinct from the concept of compassionate care and then argue that compassionate care has a unique role in psychiatry compared to its role in other medical specialities.

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¹ (Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser, 2012)
² (Department of Health, 2013)
Defining Compassionate Care

Compassion

The Department of Health (DH)\(^3\) notes the following in its discussion on action plans to promote good healthcare:

“Our shared purpose will only be achieved if staff is supported to do their job well... Research evidence supports the correlation between staff experience and quality of care.”

This poses the question: should compassionate care even be our goal? It is well documented in literature\(^4\) that healthcare professionals can experience burnout. Burnout occurs when the demands of a task exceed the resources a person has. Compassion fatigue is the phenomenon of burnout resulting from an emotionally-exhausting environment. The mechanisms of this are numerous but may be summarised as follows (Figure 2).

<table>
<thead>
<tr>
<th>Demands are high</th>
<th>Resources are low</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal</strong></td>
<td>Psychiatrists may have a perfectionist trait. Although this has allowed them to get through an academically challenging medical school and postgraduate training, this may predispose them to compassion fatigue.</td>
</tr>
<tr>
<td><strong>External</strong></td>
<td>Dealing with patients with mental illness has a hefty workload. Huge decisions are made about a patient, such as whether to section them, and there are many ethicolegal issues involved.</td>
</tr>
</tbody>
</table>

Some evidence shows that nurses who are more empathic are more likely to develop compassion fatigue\(^5\). We also know that compassion fatigue is associated with a less effective delivery of care\(^6\), measured by patient satisfaction and longer recovery times\(^7\). So why are we not promoting an apathetic culture in nursing and psychiatry?

Firstly, there is some dissenting opinion as to whether empathy or compassion directly increases compassion fatigue. Graber argues\(^8\) that in the context of a spiritual ethos, compassion can promote spiritual and mental wellbeing. Furthermore, a study\(^9\) shows that in order to benefit from the positive aspects of a career in medicine, one must have a minimum level of empathy.

\(^3\) (Department of Health, 2013)
\(^4\) (Beck, 2011)
\(^5\) (Johnson, 1992)
\(^6\) (Vahey, et al., 2004)
\(^7\) (Shanafelt, et al., 2002)
\(^8\) (Graber & Johnson, 2001)
\(^9\) (Gleichgerrcht & Decety, 2014)
A more teleologically pleasing argument is that compassion is an evolutionary adaptation, found in relationships such as parenting. Paul Gilbert and Alys Cole-King liken compassion to Bowlby’s model of attachment as a relationship between two individuals, and develop a psychological model of compassion, known as multimodal compassionate mind training.

In this model, they describe the attributes of compassion: a motivation to be caring, the sensitivity to notice when others need help, sympathy or being emotionally moved by another’s distress, distress tolerance or the ability to suppress the distress felt from sympathy, empathy or the ability to understand another’s affective and cognitive processes, and finally non-judgement or being accepting and validating of someone’s experiences.

In order to enhance these attributes, Gilbert proposes that certain skills need to be developed. These include an attention to what may be helpful to a patient, focusing on reasoning, imagery, feeling, and sensory input to understand people’s emotions, as well as developing behaviour that relieves distress.

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10 (Gilbert, 2009)
11 (Cole-King & Gilbert, 2011)
Competence

The therapeutic alliance formed in compassionate care is important; there is a relationship formed between the patient and the clinician. The patient knows the affective and cognitive symptoms manifested by the illness, whilst the doctor brings the expertise to the relationship. Thus, in order for this relationship to be therapeutic, communication is vital to share information.

In psychiatry, the therapeutic alliance is more integral to the healing process than in other specialities. In no other speciality does every minute cognitive and affective detail impact on diagnosis, prognosis, and treatment. Furthermore, a collaborative communication style that promotes compliance positively influences pharmacological treatment, in both depression\(^{12}\) and schizophrenia\(^{13}\).

Another aspect to the therapeutic alliance is a balance in power. In 1992, Roter and Hall models\(^{14}\) this equilibrium in the context of four possible interactions (see Figure 3).

<table>
<thead>
<tr>
<th>Interactions</th>
<th>Patient has high power</th>
<th>Patient has low power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor has high power</td>
<td><strong>Mutuality.</strong> There is a balance in control. Both are equal partners in the consultation and have a participatory interaction.</td>
<td><strong>Paternalistic.</strong> The doctor controls the direction of the therapy, with the patient having little to no say.</td>
</tr>
<tr>
<td>Doctor has low power</td>
<td><strong>Consumerism.</strong> The patient controls the direction of the therapy and as such, the doctor has to be more aware of the patient’s needs and goals.</td>
<td><strong>Default.</strong> Neither the doctor nor the patient is willing to lead or control the therapy. While there are no expectations between the doctor and the patient, there is an increased chance of non-participatory behaviour.</td>
</tr>
</tbody>
</table>

*Figure 3 A summary of the four states of patient-doctor interaction by Roter & Hall*

Communication is most effective in the state of mutuality as no one person is more powerful than the other is. This would be the ideal relationship in any medical interaction; however, in many cases of mental illness, this is simply not possible.

For example, in psychotherapy for narcissistic personality disorder, the narcissist may feel that he or she is leading a therapy session. To hear more of the patient’s experience, there must be a consumerist-type interaction. If the doctor were to increase his control, the narcissist may be less likely to adhere to therapy or to be trusting of the doctor. In comparison, in catatonic depression, the patient has little to no power or control. The doctor must guide the direction of the therapy to promote wellbeing, even if this breaches the patient’s autonomy.

\(^{12}\) (Bultman & Svarstad, 2000)
\(^{13}\) (McCabe, et al., 2013)
\(^{14}\) (Roter & Hall, 1992)
Summary
Integrating the above, I would like to propose the following model and definition for compassionate care in psychiatry, in the style of DSM-esque criteria (Figure 4).

### Diagnostic Criteria for Compassionate Care in Psychiatry

The psychiatrist must show compassion.

A. **Awareness**: The clinician must have an understanding of what a patient may be feeling or thinking. This includes an appreciation for the dignity of patients.

B. **Attention**: The clinician must be responsive to a patient’s thoughts, feelings, or behaviours.

C. **Motivation**: The clinician must feel the need to do something about distress or to promote a positive psychology.
   1. Commitment: The clinician must continuously build on the vision of the best care for the patient. This may involve demonstrating probity and performing audits in their clinical practice.
   2. Courage: The clinician must have the personal strength to whistleblow, or make a disclosure of any neglect or wrongdoing. The clinician must also be able to tolerate distress and prevent one’s emotional reactions from negatively affecting clinical practice.
   3. Wisdom and intelligent kindness: The clinician must be able to reflect on one’s own experiences to build on one’s own knowledge, and have the imaginative capacity to be innovative about one’s practice.

The psychiatrist must have the following competence.

D. **Good Medical Practice**: The clinician must follow Good Medical Practice.

E. **Therapeutic Alliance**: The clinician must be able to form a therapeutic alliance, a special form of patient-doctor relationship. The therapeutic alliance would be based on an appropriate balance of power that builds trust and maximises the communication and fiduciary relationship.
   1. Empathy: The clinician should be able to understand another’s emotions, thoughts, motivations, and intentions, and thus allow the clinician to predict the effects of one’s actions on the patient.
   2. Respect and non-judgement: The clinician should be able to appreciate another’s individuality and accept a person’s experiences.
Challenges

While compassionate care can be distilled to several criteria, there are barriers that face its implementation at the levels shown in Figure 5.

The Patient

In mental disorders, it is often very difficult, if not impossible, to achieve a therapeutic alliance. For example, in autism, there is a difficulty in forming a relationship, due to an impairment in the development of socio-emotional communication.

Issues therefore arise when there is a clash between the patient’s choice and the best interests of the patient (as determined by the psychiatrist). For example, a patient with anorexia nervosa may not want to consume anything; a psychiatrist may have to breach the patient’s autonomy and perform a forced nasogastric feed (that is, in line with the legislation). This action ticks all the boxes, except the therapeutic alliance, as this clash hinders the therapeutic relationship.

Similarly, sectioning patients under the Mental Health Act would violate the therapeutic alliance as the psychiatrist cannot simply accept a person’s experience if the patient is at risk of harming oneself or others.

Therefore, compassionate care cannot be achieved in its totality in the context of sectioning under the Mental Health Act. However, this may be seen as an unavoidable, ‘necessary evil,’ similar to the Doctrine of Double Effect. In these cases, we refuse to provide compassionate care and we apply a paternalistic approach, breaching the patient’s autonomy for the benefit of the patient, with the patient’s welfare at the forefront of the care provided.

The Psychiatrist

The greatest barrier that is faced by the psychiatrist is oneself. Compassion fatigue is more likely if the psychiatrist faces a perfectionist trait or a wounded healer archetype (see Figure 2). Charles Figley comprehensively details the effects of burnout in his book *Compassion Fatigue.* Figley argues that burnout is a progressive condition that leads to the erosion of idealism and a void of the feeling of achievement – preventing the attainment of the upper two levels in Maslow’s hierarchy of needs. Because of the progressive decline and increased emotional, physical, and behavioural symptoms, a burnt-out psychiatrist would be unable to have the competence or compassion for one’s patients.

Therefore, it is crucial that the psychiatrist remains able to deal with stress, as the inability to do so would prevent one from compassionate care. That is to say, caring for oneself as a psychiatrist is part of compassionate care to patients.
It can also be argued that unless a psychiatrist lived exactly the same life as that of the patient, then, in a psychiatric corruption of Descartes’s *cogito ergo sum*, it is not possible for the psychiatrist to understand the patient completely. However, taking a more pragmatic approach, with greater experience, the psychiatrist need not have an extensive understanding, only an understanding that maximises compassion and the therapeutic relationship.

**The Organisation**

The organisations that deliver healthcare like the NHS and DH mould healthcare provision, including the capacity of psychiatrists to deliver compassionate care. Organisations place external demands on psychiatrists and provide them with external resources to deal with the demands. Reiterating the model in Figure 2, if the government places excessive demands and do not provide enough resources, then burnout may result. But what do these demands and constraints consist of?

The organisational culture can produce a huge workload on psychiatrists. Certain targets may need to be met – targets that do not necessarily focus on quality of care, but efficiency of ‘processing’ of patients, and the treatment of patients as objects, as opposed to subjects in their care. This, combined with increasing paperwork, decreases time spent with patients. Time is an important external resource that is needed not just in the therapeutic relationship, but also in ensuring the welfare of staff.
Solutions

The Patient
Organisations such as MindFreedom have called on psychiatry to aim for compassion and not compulsion; they question the notion that the use of force on mentally ill people is a necessary evil. However, I would argue that the use of force is only used in cases of serious risk to self or others. It maintains the principle that mental illness does not automatically call a patient’s capacity into question\textsuperscript{16}.

Nevertheless, there are still anecdotes of excessive use of force. The solution and compromise would be to develop more rigorous guidance or protocols on the use of force in patients with mental health conditions. A re-examination of the legal framework would help to create a culture that limits clashes between the patient’s autonomy and his or her wellbeing.

The Psychiatrist
As compassion fatigue is a clear and present danger to the provision of compassionate care, we can promote compassionate care by preventing burnout. Balint groups\textsuperscript{17} and Schwartz rounds\textsuperscript{18} can help to do this by acknowledging the stresses of working in a frankly distressing environment. These initiatives will help build on the upper hierarchies in Maslow’s pyramid.

The multi-modal compassionate mind training developed by Paul Gilbert can also develop the psychiatrist’s attributes of compassion and allow them to acquire the skills, not only to show compassion, but also to have a greater therapeutic alliance.

For example, a better understanding of what an auditory, verbal hallucination through a workshop focusing on imagery and sensation will help a psychiatrist to empathise with the patient, and to know best how to elicit information about a schizophrenia sufferer’s own verbal hallucinatory experiences.

The Organisation
In light of the challenges faced by compassionate care from organisational factors, I would like to make a call for a culture change. There are many transformations to be made to secure the future of compassionate care in psychiatry.

\textsuperscript{16} (General Medical Council, 2008)
\textsuperscript{17} (Mahoney, et al., 2013)
\textsuperscript{18} (Lown & Manning, 2010)
Training all healthcare providers, not just psychiatrists, to be aware of the signs of burnout will benefit compassionate care in psychiatry, as psychiatrists working in a multidisciplinary environment can all help each other, by acting as role models for each other and to provide supporting relationships.

A legal framework that promotes a culture of whistleblowing and probity will help to prevent medico-legal issues in psychiatry. However, avoiding a legal framework that promotes bureaucratic and defensive paperwork that may impinge on clinical time needs to be a consideration. Government targets on psychiatric treatment to improve patients’ experiences, such as on the appropriate use of force, will also promote a culture that focuses on quality of care.

Most importantly, healthcare should be provided in a wide variety of places to suit patients. Improving service user choice is a must, especially for those who are most vulnerable, such as refugee children. This is no easy endeavour, however. All this relies on a steady flow of funding that the psychiatry community is still waiting for.

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19 (Fazel, et al., 2009)
Conclusion

...As the pain of the electric current washes away, you wake up, feeling drowsy. You have the mother of all headaches and you are once again confused, unable to remember where you are. Your jaws hurt, and you reach with your strap-free hands to soothe it.

A flash of clarity bursts the bewilderment. You did consent to the ECT after all, and it was done under general anaesthetic. A few hours later, you head to your CBT session, and trust your therapist with your fears, hopes, and thoughts. You feel better.

This is today’s vision of compassionate care: both the patient and the psychiatrist working together to achieve a patient-centred approach to treatment. This patient-centred ethos cannot be accomplished without a holistic view of the patient and, of course, compassionate care.

Compassionate care is not just caring with compassion. Compassionate care is not just good medical practice; it is what healthcare should be and must be. Ultimately and most importantly, with some exceptions to allow for the best interests of patients, compassionate care is not unattainable.
References


