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Primary Care, Health-Behavior Groups

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ABSTRACT

Due to the increased physical, emotional, and financial burden of chronic health conditions on patients and the larger medical community, efforts have intensified to provide health-behavior focused group therapy in primary care settings. The goal of these groups is to increase access for patients who may be hesitant to engage in more traditional mental health services due to stigma, and to reduce medical costs and improve overall emotional and physical health of patients with chronic conditions. Groups are focused on providing patients with the information and tools they need to understand and improve their conditions. Success is measured by increase in knowledge and behavioral action in group members. Interventions provided in primary care are brief, solution-focused, and contextually relevant. A skilled primary care clinician leading a health-behavior group will unify participants around common themes and foster focus on the health-related topic while adjusting to the their contextual needs.

The clinical example under discussion offers a familiar mix of personalities likely to present in groups offered in a primary care setting. Groups within primary care tend to be focused on a specific topic that is often health-related, such as diabetes, weight, or pain management. As a result, sessions tend to be structured with attempts to keep emotional and cognitive processing concentrated on the patient's experience within the context of the health-related issue: for example, how one feels when one overeats; how one's pain is exacerbated when one is anxious; or ways to increase medication adherence behaviors in patients with diabetes.

As a therapist leading one of these groups, the topic, the educational goal, and the boundaries of group process would be established during the first session. It is the role of the therapist during the group process to serve as a guide and keep people "on the path" with respect to the topic. Group members will occasionally bring up issues or make comments that are not consistent with the intent of the group. In such situations, the role of the therapist is to try to relate this content to the intended thematic context, or to refocus the group by reestablishing boundaries.

The goal of the primary care integration model is to empower patients to participate in managing and improving both their physical and their mental health. Groups are focused on providing patients with the information and tools they need to understand and improve their conditions, thereby engaging member interest and participation. Success is measured by the increase in knowledge and behavioral action of group members. For example, an intervention in a diabetes management group session might focus on education about what diabetes medications do for blood sugar levels and underline the necessity of taking medications as prescribed. The goals of this group would be: 1) increased investment in taking medications as prescribed as a result of enhanced understanding; 2) follow through with actually taking the medications as prescribed via behavioral activation; and 3) a greater sense of self efficacy, resulting in lower levels of anxiety or depression.

The primary care integration model views the change agent of intervention as patient motivation for improved health and improved mood. Change is facilitated by increased knowledge and the ability to apply this knowledge to one's own life in a way that results in positive change. The group therapy component adds a cohort of people who share the patient's experience and can aid the patient in developing practical change strategies. This "shared experience" in the group setting is perhaps the most important part of the group context for health-related issues. Patient experiences are "normalized" by the presence of other people who have, and similarly struggle with, the health condition of focus.

Interventions provided in primary care are brief, solution focused, and contextually relevant to the patient. For example, if patients attending a group focused on weight management are on limited income or live in a "food desert" where there is a limited supply of fresh fruits and vegetables, the focus of primary care integration for this group may shift from specific foods to portion control, increased water intake, and exercise, rather than focusing on consumption of lower calorie, healthy foods to which the patients have no access. Group members will often challenge group leaders

at the onset of groups in primary care settings if they fear they are getting a rote education that lacks relevance to their particular culture and environment. Patients will challenge the therapist, much in the style of Angela, or insist on the uniqueness of their experience, like Ned. A skilled primary care clinician leading a health-behavior-related group will need to unify participants around common themes while adjusting to the contextual needs of participants.

Chronic health conditions are often debilitating, which is one reason they are highly comorbid with psychological diagnoses like depression and anxiety. Participants can, like Angela, be critical of the premise of the group and of the therapist due to the frustration of navigating the health-care system and the difficulty finding a balance between hope for improvement and acceptance of limitations. Angela's style of questioning the structure of the group and the purpose of its recommendations is something that group therapists in a primary care setting will face. Similar to many other group approaches, the focus is to acknowledge, reflect, and return to the group premise. Here is an example of an approach from a primary care/health behaviors perspective, following Angela's comment, "That doesn't strike me as a good idea at all," assuming the group is a pain management group.

Dr. Newland: This group can be very frustrating for you, Angela.
Angela: I just don't see the point of it.
Dr. Newland: That's one of the hardest parts of any form of treatment: trying to decide if it is worth it to try, and trying to prepare yourself for disappointment if it doesn't work. Sometimes that makes us not even want to try at all. We get so tired of disappointment. (Addressing the group) I'm sure it is difficult for every one of you to be here and to try one more thing when you've tried so many other things in the past to be better. What are some of the things you have tried to improve your pain in the past?

This type of reflection and behavior-related question attempts to unify group members through acknowledgement of their experience, re-unify around the common theme, and discover some of the common behaviors and contextual awareness of participants. Even people who are hesitant to engage, like Will, are encouraged to participate through providing at least one example. For example, if following this prompt, Will attempts to divert, a primary care therapist may make some direct reflections and engage other group members to foster participation.

Will: I'll pass, thanks.

Dr. Newland: Have you not tried anything to try to improve your pain in the past, Will?

Will: I didn't say that. I'm just fine to listen to what the group has done.

Dr. Newland: The goal of this group is to help you and every other member feel better. You're an important part of everyone's experience in this group. We appreciate your thoughtful attention to each member, and this is something we want to offer back to you. I, for one, would really benefit from hearing some of your insights on ways to help make pain a little easier to live with. (Addressing the group) Many times, it is your efforts and insights that go on to help others coping with pain. (Addressing Will) What do you think, Will, is there anything you've found to be helpful or not so helpful in the past for your pain?

Unlike more traditional process groups, groups in primary care remain very focused on a specific topic, and therapists may be more direct with participants in engaging this topic and engaging feedback from participants. This type of gentle, yet firm direction often elicits feedback from a specific participant and can be very rewarding when the group and therapist provide validation for a disclosure. It can also be somewhat anxiety-provoking for quieter, more introverted participants, so it is important to foster participation but not overly target an individual. There is a fine line to walk between fostering engagement and infringing on more cultural and endogenous attributes of a person in a group context.

A common error in primary care integration is the assumption of cultural neutrality in health conditions. One may assume that diabetes is diabetes and, therefore, does not require the incorporation of cultural adaptations to interventions. In practice, however, culture often plays a role in the development and management of health conditions. At their foundation, primary care groups are focused on education and implementation, both of which are highly culturally sensitive. This is increasingly evident in health-behavior groups in a region with a high concentration of lower SES, LGBTQ, and Native peoples. Encouraging open acknowledgement and discussion of the cultural paradigms within the group context (e.g., assumptions about health, assumptions about resources, power dynamics between providers and patients) and encouraging members freely to adapt interventions and incorporate personal cultural practices in the implementation of interventions in their own lives can serve to

bridge gaps and promote cultural relevance and adaptation in health behaviors.

Research on the effectiveness of group methods of delivery of health education and development of self-management behaviors has demonstrated sustained health benefits and reduced overall healthcare costs across many health conditions (Cutler & Lleras-Muney, 2006; Glanz, Rimer, & Viswanath, 2015; Lorig, Mazonson, & Holman, 2005). As with all theoretical models and psychological interventions, one size does not fit all. Even though primary care integration is a valuable methodology with the potential to impact the health and well-being of its patients, it should not be considered a substitute for traditional mental health. Primary care groups are often specific to particular health conditions, short term in duration, and limited in time given to the processing of emotional and psychological issues. Such groups do not necessarily prohibit processing, since "working through" psychological factors is an important component of primary care groups, but most of the processing relates to the medical aspects of the health conditions—unless the clinician makes these psychological aspects a focus. Patients in these groups may not feel as much freedom to express their full inner experience nor bring up pressing issues not related to the specific health-related topic of the group.

Trying, then, as a primary care therapist to address the needs of Angela, Betty, Diane, Otto, Ned, and Will, I would take more of a leadership role in reminding the group of the importance of the central focus around the health-related topic, and the development of specific methods of improving health and well-being in each group member. Continuing in the assumption that participants are members of a pain management group, a primary care group therapist might following this type of re-directing approach:

Diane: I'm happy to begin. This weekend, I didn't want to work on my dissertation so I went to a party and had too much to drink. And then some random guy thought I was flirting with him and began to pressure me to leave with him, and I began to leave with him until I thought, is this really a good idea? I was remembering when I did this before and wound up in a lot of trouble. Still, I went with the guy, and he took me to my place and then left in the middle of the night. With my credit cards.

Dr. Newland: It's a real honor that you feel comfortable enough to share your weekend experience with us, Diane. I think it's an encouraging sign we're growing together as a group and feel more comfortable sharing authentic experiences. It's also important to remember that our lives are not always about pain; sometimes they're a wonderful mess of

> thoughts and emotions as well. I'm hearing some frustration and disappointment with the way things went this weekend, maybe some self-judgment as well. How have these thoughts and emotions affected your physical self? Have you noticed more body tension, or a change in your pain experience?

This type of reflection and re-focus serve to acknowledge the subjective importance of Diane's weekend and the value of discussing the impact of this event, but it also promotes a return to the group's focus. I would encourage each member to express a way in which their mood or behavior over the weekend had an impact on their experience of pain, and facilitate the development of methods for managing and/or improving this impact.

Perhaps one of the greatest benefits of providing groups in a primary care setting is the reduction in stigma associated with more traditional mental health services, resulting in increased access for participants who may have avoided services associated with a mental health practice, but who feel comfortable entering a primary care practice or a medical building for care. As with all group therapy modalities, change is inevitably up to the patient. In the context of primary care, however, we have a unique opportunity to provide knowledge, a community of understanding, and specific methods of change in a safe, structured environment.

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