1 Psychological care: the neglected element of medicine and nursing

A greeting

Rather curiously perhaps, given that this is a serious minded book, I want to use my first few sentences as a greeting. In so doing, I can make clear whom I have in mind while writing on the theme of providing psychological care to people who are ill or injured. Basically, the greeting is to any member of the caring professions who has significant contact with people who are ill or injured. The list of professions is, therefore, quite long. It includes hospital nurses, community and practice nurses, physiotherapists, occupational therapists, dieticians, social workers, health visitors, speech and language therapists, audiologists and technical staff providing diagnostic procedures such as echocardiogram or treatment procedures such as radiotherapy – in fact, any health care practitioner who has significant or extended contact with medical patients and their partners.

Naturally, since this book is concerned with situations in medical settings, the medical profession is also very much in my mind. This is because where doctors or surgeons have no understanding of psychological care there is quite likely to be little by way of encouragement for psychological care, so that a situation of psychological neglect may prevail. A further profession that does not fit the pattern, but nevertheless has a strong impact, is that of hospital or community health service managers. Again, where managers are ill-informed on the key issues to do with psychological care in illness and injury they may exert a direct influence that has the effect of suppressing the provision of psychological care.

Why does it matter and why should all these professions have an
involvement in psychological care for the ill and injured? There are several good reasons, as I will demonstrate in stages throughout the book. Here, though, let us simply note that *the absence of psychological care in hospitals or health centres will sometimes undermine medical and nursing efforts to provide effective treatment*. It can also cause much distress for patients and their partners. Psychological care is thus something that should concern all professions engaged in providing a health care service.

I do realize that at first sight this long list of those who should be involved might cause raised eyebrows. Is it really the case that I am about to suggest that hard pressed staff repeatedly break off their work to sit in a corner with distressed patients conducting informal counselling sessions? No, that is not the case. As will be made clear in the following pages, the psychological care of patients and their partners should be pitched on one of three levels. *At its most basic level it is as much an attitude as a procedure*. This attitude promotes the habit of good, effective communication and a raised awareness in noting patients’ psychological state – that is, how they are reacting to their situation and how they are handling the information that has been

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**Figure 1.1** Some of the community of health care practitioners who should be involved in the provision of psychological care.
given to them. The only time demand might then be passing the word that a particular patient is in need of further help to other staff better placed to provide it. So, at its most basic level, your involvement with psychological care in general medicine, nursing or therapy roles means that ‘you have to have attitude’ – but it has to be the right attitude. That is what this book is about.

The key concept: psychological care in general hospitals and health centres

As the book unfolds the full meaning of the phrase ‘psychological care’ will be developed. I cannot offer you a crisp definition of one sentence length because the construct is complex – although in no way difficult to understand. Essentially, psychological care refers to an approach to looking after the ill and injured that can be integrated with nursing or the various therapies to provide an organized and practical psychological content to overall care. It represents a big step towards meeting the requirements of truly holistic care for the ill and injured. Although the scheme of psychological care to be presented is designed particularly for adoption by nurses and therapists in general hospitals and health centres, other professions are also encouraged to become involved, as you will have realized from my opening paragraph.

To avoid confusion, it should be noted that there are similar terms in current use: psychosocial care, for example. This is essentially similar in general meaning to psychological care.

Rather than leaving the description of psychological care as a no doubt irritatingly vague statement, I set out the basic components of the approach in diagram form in Figure 1.2 in order to give you an immediate preliminary picture. The message within the diagram is simple. Psychological care for people who are ill or injured requires an organized approach with an associated set of disciplines. It involves various skills and objectives, with the involvement of certain staff in specific tasks. The key aim is to monitor the psychological state of our patients in a systematic way and then either to provide or to arrange for preventive interventions designed to deal with psychological issues arising from their illness and injury. If this preventive effort is not successful then the work refocuses on therapeutic and supportive interventions in an attempt to help the person cope with the psycho-
logical reactions that have arisen. Following Figure 1.2, the next section gives you a brief overview of psychological care on the three levels of intensity identified. Note that the description of level 1 is organized in relation to various categories of health care profession.

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<td>Self-care by staff providing psychological care (participation in support, supervision and self-monitoring schemes)</td>
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Figure 1.2 The components of psychological care.

**Level 1: awareness**

*Concerning managers in general hospitals and community health services*

As mentioned above, personal involvement with psychological care can be pitched on one of three levels, depending on one’s role within health care. For those with no direct patient contact, but who nevertheless exert an influence on the range of care procedures made available in an institution – managers, for example – the minimum asked for would be an informed and facilitating stance to psychological care. Sadly, if I may divert for a moment of general comment, in my 25 years
of personal experience in British hospitals, I have not often met hospital or community health service managers with much real understanding of the key issues concerning psychological care in medicine. It is not often that one meets managers who hold the essential concept of psychological care as being an ‘investment’ that underpins physical medicine. Nor, in my experience, is psychological care usually seen by managers as a potential means of saving expenditure in specified areas of medicine (e.g. cardiac medicine). Often it is confused with psychiatry and construed to be of minimal relevance to a general hospital or health centre. As a result, the organized provision of psychological care in our hospitals and health centres is often neglected, or it is conducted at a patchy, low-key level, with little involvement by the managers. Fortunately, there are some notable exceptions, but I do worry they might be a minority. In the British, state-funded National Health Service, managers are, to be fair, constrained by the dictates of the government of the day and, effectively, told what is to be considered important and fashionable. Even so, a manager with an understanding of and sympathy for the aims of psychological care can make an enormous difference. Thus, at the distant level of involvement that befits managers, the key requirement is informed, supportive awareness and an effort to facilitate psychological care within their organization.

**Concerning health care practitioners with patient contact**

With reference to level 1 in psychological care, the hope is that a loose but broad group of health practitioners will be involved. As you look at Figure 1.2 you will notice that what is sought is a continuing effort to make contact with patients in a manner that allows some awareness of their general status in terms of their information and general coping. For example, the medical physicist who conducts an echocardiogram or the practice nurse who is taking a blood sample at the start of a warfarin regime is, in reality, free to work in an interpersonal style that is quite ‘minimalist’. They may be bright and cheery but somehow manage to avoid all meaningful conversation concerning their patient’s current experiences. But this is not good care and it does not have to be like this.

The alternative would be that, just before, just after or while carrying out the procedure, they might engage with their patient briefly to explore the level and accuracy of information held and the understanding of what is happening. Following this they might pose one or two comments that would allow a patient to voice any emotional
distress. *This is the task of making oneself aware of the patient’s psychological state.* It involves some moments of face-to-face contact and some ‘listening skills’ on the part of the staff. If poor levels of information are detected then there needs to be a brief effort at further explanation, pitched at a level that is suitable for the particular person in the clinic. In the example, the practice nurse might make a note to set aside five minutes when taking the next blood sample in a few days’ time to consolidate the conversation that she started. The cardiology technician could offer a similar brief review of information on the spot. However, probably having no further contact with the patient, she would, if concerned about the patient’s state, leave a note for the cardiac liaison nurse, the GP or the referring cardiologist.

At first encounter this might sound like more hassle for you when you almost certainly have hassle enough as it is. In reality though, it is more an issue of attitude, values and style. At this basic level psychological care rarely takes much out of the day. For one thing the number of cases needing much intervention are unlikely to be that high unless something is badly wrong in your locality. *In short, for a health care practitioner to walk away from a patient with no knowledge of how they are coping or whether they are confused or in distress is the opposite of holistic care. In my view it is very unprofessional.* Added to this, attending to patients’ needs in the simple manner required for psychological care on level 1 usually leads to a greater sense of professional completeness and therefore job satisfaction.

**Concerning hospital doctors, GPs and psychological care**

I once asked a consultant oncologist roughly how much time he managed to spend with the average patient whom he had diagnosed as having cancer and was treating on an outpatient basis, with perhaps occasional admissions to hospital. He replied, ‘About an hour a year.’ At the other end of the scale I have also watched young senior house officers (SHOs) scurrying about, often at a half run. Clearly, they can have periods when they are under exceptional pressure too. It has to be recognized, therefore, that some consultants are very hard pressed, with very demanding case loads. Similarly, doctors in more junior grades can have patches of rush and extreme busyness.

An important question thus has to be faced. Should hospital doctors who are often under extreme time pressure be exempt from a call to improve psychological care? The answer is *of course not.* As Dixon and Sweeney (2000) reveal, the current leaning towards a more holistic
approach in nursing is, quite rightly, mirrored by the beginnings of a parallel movement in medicine. There is a growing awareness of the importance of a doctor’s style of relating and communicating with patients as an influence on the outcome of medical treatments.

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<th>Box 1.1  The psychologically minded dietician</th>
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<td>Gillian, a dietician in a general hospital, attended a ward to meet her third patient contact of the day. This was Ruth, a middle-aged woman who had recently been diagnosed as having insulin-dependent diabetes. Ruth was unexpectedly angry and difficult in her manner to begin with and then became a little tearful. Gillian, noting the obvious risk that, if the situation was not dealt with in a supportive and exploratory manner, compliance problems could well result, decided not to deal with dietary issues in a standard way. Instead, she gave a little time to letting Ruth talk about why she was angry and distressed.</td>
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<td>It transpired that the young registrar who had informed her of her diabetes had been brief and ‘matter of fact’ in his manner, leaving her both offended and somewhat frightened. The diabetes was a surprise to her and she feared it, since a friend with a history of diabetes had suffered badly with microvascular disorder, leading to very poor sight and kidney failure. Ruth also, it emerged, had a mild fear of needles and injections and so did not want to administer two insulin injections everyday. She believed that the doctors could give her tablets instead. Nor was she keen to start changes in the way she was used to eating and so she was very negative about instruction in new diet plans.</td>
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<td>Being quite psychologically minded and having had some training in psychological care, Gillian put her initial effort into building rapport and offering a reassuring and supportive presence. On this first contact she settled for answering any questions that Ruth had and assessing what Ruth actually knew and how she felt about managing her situation. Another meeting was organized, which was designed as an information and support session. Gillian also told Ruth that she could arrange for help from a clinical health psychologist for her fear of needles and her general distress. On the second meeting Ruth proved to be rather more welcoming, if still indignant about her encounter with the registrar. She did settle to the information session, did accept the need for insulin and diet management and did accept referral to the psychologist for assistance with her difficulties.</td>
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Similarly, a patient’s psychological status (which includes information held and expectations derived from this information) is known to influence the physical progress that a patient makes in recovery from illness. If doctors of any grade ignore this then, to be blunt, it becomes a case of them opting to follow an approach that undermines their own efforts and reduces the chances for a full and efficient recovery by their patients – in other words it is a form of negligence. The involvement of hospital doctors in the overall provision of psychological care is, therefore, essential.

A similar argument holds good for general practitioners. GPs have a greater spread of responsibilities than hospital doctors and a wider set of roles. Some would argue that there is a more obvious holistic component and more generalized caregiving emphasis contained within the role of the general practitioner than in that of the technically focused hospital doctor: hence the alternative title ‘family doctor’. It is essential, then, as indicated in Dixon and Sweeney (2000), that these elements of the role of the GP are developed and available to all patients. This is a good start from the perspective of providing psychological care on level 1, since, as Dixon and Sweeney illustrate, an effective consultation process with an emphasis on good listening skills and an ability to help the patient to express important issues is fundamental. They do not develop things far enough, in my view, but at least their recommendations take a GP to within a step of consciously providing psychological care. With good communication and listening the doctor will be in a position to monitor psychological state, arrange for informational and emotional care and refer for psychological therapy should this be necessary – that is, involvement on level 1 in psychological care.

Some GPs will occasionally have the time to function on level 2 by providing some of these interventions themselves on an individual case basis, which is even better. Time constraints may prevent this from being a frequent event, however. Crucially, though, involvement on level 1 should be routine, since the GP is often the eyes and ears of a practice in relation to an individual patient’s needs. If he or she does not have an orientation towards monitoring psychological state (and the skill to do it) then the practice functions ineffectively and neglect of psychological issues will undermine the medical effort at times, as is described in case studies later. Hence, the involvement of general practitioners in the overall provision of psychological care is essential.
Ray, a 43-year-old builder with lower back problems, attended hospital for an epidural injection procedure. Unfortunately, this procedure did not go well and he was left with continual, distressing sciatic pain and a very weak leg as a result. He became exhausted physically and emotionally by both the pain and the physical effort of coping with reduced mobility. He was also very angry because he found that he could get very little information about the event. His experience was that the doctors involved, although concerned, seemed reluctant to talk with him. Above all else, he resented the failure of any of his doctors to sit down and explain to him what might have happened, why it went wrong and what the long-term outcome was likely to be. Ray was prescribed various pain killers and other chronic pain treatments but none of the treatments produced a significant reduction in the pain. He became more demoralized and depressed. He withdrew socially and exercised little. He was in steady decline and, as the months went by, was on a deteriorating trend in terms of pain and mobility.

Ray then moved from the area and his care was transferred to another hospital. The range of his treatment then, belatedly, expanded to include more emphasis on psychological care. A consultant anaesthetist at the local pain clinic teamed up with a clinical psychologist and met Ray in a sequence of sessions. Together they emphasized good communication, full information, full discussion and an opportunity for emotional expression. An atmosphere of close engagement with support and encouragement was created. It was not a rapid process but Ray’s anger did ease and his depression became patchy rather than continuous. He slowly re-engaged with his friends and hobbies and took part again in gentle exercise. His leg was not miraculously cured, nor was the pain eliminated, but it became less troublesome to him as an experience. Over the next year he slowly acquired a greater degree of mobility, to the extent that he was able to participate once more in his sport of bowling.

The telling point in this case was that no new treatments were introduced to bring about this change. The only alteration was in the move to include an effort at psychological care and deal with the voids in supportive, patient-centred communication, information and emotional care. His physical treatments had been undermined by his doctors’ failure to provide psychological care, but when it was provided and his psychological status changed the physical treatments seemed to acquire more power.
My main assertion is now emerging. It is the claim that the psychological status of people who have experienced serious illness or injury can influence the outcome of medical treatment and recovery. Thus, doctors should feel an obligation to include psychological care in their approach to all cases in terms of patient-centred communication, together with an ongoing effort to note a patient’s general psychological status. However, the extent to which doctors personally offer interventions in psychological care beyond this level will depend on circumstances. Sometimes it will not be possible, I recognize that. However, what is absolutely vital is that the hard pressed doctor who has little time to take things further with a patient personally ensures cover by referral to someone else on the team who can deal with it – be it nurse, therapist or clinical psychologist. In other words, the presence of a doctor who has a positive attitude to psychological care and who ‘sponsors’ it by means of making sure that it is dealt with and not overlooked is vital.

Level 2: Interventions

A deeper involvement in psychological care is needed for those working on level 2. Typically, these tasks fall to staff who maintain some sort of extended contact with patients. For example, this might be during a period of admission to a hospital for surgery or following a heart attack. Alternatively, where repeated outpatient visits are required with, say, people with diabetes or those attending for regular haemodialysis sessions, psychological care interventions of the level 2 type are essential. It is equally important that this sort of provision of psychological care exists in the treatment routines offered by therapists. Patients recovering from accidents, surgery or illness will usually attend for a sequence of therapy sessions with the same member of staff – an ideal situation. Obvious opportunities are found in the roles of physiotherapists, occupational therapists and speech and language therapists, for example. Primary care also provides an important option for psychological care work on this more involved level. When a health centre is solely or jointly managing the care of a person suffering from serious illness or injury, the staff will be in regular contact with the person involved. Practice or community nurses and also health visitors will encounter important opportunities to improve the care of their patients by interventions of the level 2 type.

Although the interventions needed to provide psychological care
are dealt with at some length later in the book, let us take a very brief look at the sort of activity involved on level 2. With repeated contacts, the task of being aware of the psychological needs (including information and education) of the patient hardens up into an active role of monitoring psychological state using brief, simple records. The nurse or therapist (who is probably the only health care practitioner with regular contact) becomes the ‘psychological eyes and ears’ for the case. Thus, as part of routine work with a patient, at each contact there will always be a little conversation initiated by the member of staff that is designed to check the information, understanding and expectations of the patient and, if relevant, their partner. Similarly, there will be a question or two that should reveal how the patient is coping generally. This in turn will usually give an insight into their emotional state. The

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<th>Box 1.3  Psychological care by the dialysis nurse</th>
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<td>Linda was assigned as named nurse to Sheila, a 58-year-old woman who had collapsed in renal failure and been taken on to a unit-based haemodialysis programme. She was dialysed three times a week. Not surprisingly, Sheila was in great distress and confusion. She was initially very anxious, in part because her understanding of the situation and the techniques of dialysis was poor. Later, she became more depressed than anxious as the implications of survival by dialysis became clearer. She worried about the strain she was imposing on her husband and began to see herself as a burden and nuisance to him and her family. As her named nurse, Linda covered the majority of her dialysis sessions. As part of her routines she would spend a little time talking with Sheila during sessions, checking her information and exploring how she was emotionally. To assist with adaptation to life on dialysis and to help emotional processing, Linda regularly gave her patient an opportunity to express her feelings and talk through her shock and subsequent reactions. They also edged into problem-solving discussion when troublesome issues arose. Sheila later commented that she found her nurse to be a true emotional companion, and this was a great comfort. She also found her nurse to be a helpful teacher who worked with her to improve understanding and keep her up to date on the clinical plan. Sheila valued this psychological care and regarded it as an important contribution to her first two months of treatment. It helped her through the early emotional reactions and enabled her to achieve a stable pattern of coping.</td>
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whole emphasis is on brief but ‘patient-centred’ communication with the aim of providing a more complete picture of the patient’s status through these routine contacts – even though the main work of the day might be physiotherapy or speech therapy.

When significant needs are revealed a little time can be set aside for information work or emotional care along the lines described in later chapters. Where the member of staff has some training and capability this work can extend into basic counselling if required. On level 2 it is the nurse or therapist who, in the first instance, is active in providing information and offering an opportunity for emotional expression and processing. It is also for the nurse or therapist to engage further help with the patient if it seems necessary – that is, if the patient or partner requires psychological therapy provided by a specializing psychological therapist, such as a clinical psychologist.

**A note on ‘preventive psychological care versus psychological therapy’**

Before I introduce the third level of psychological care it is timely to point out an important distinction, namely that psychological care work with the ill and injured can either be preventive in nature or oriented towards dealing with cases where prevention has failed. *The general scheme for psychological care that I offer in this book is heavily biased to the preventive approach*: hence the involvement of nurses, therapists and other health care practitioners who are not psychological therapists. Being realistic, though, there will, despite this preventive effort, be many occasions when people dealing with illness and injury do cross the clinical threshold and will need assistance from a psychological therapist – they will have become ‘**psychological casualties**’.

The borderlines between preventive psychological care and psychological therapy are not at all distinct. I regard it as something of a waste of time trying to find tight definitions that denote sharp boundaries, other than perhaps noting the related distinction between staff trained to offer psychological therapy and those not so trained, which is a fairly objective distinction. I will, though, give brief expansions of the terms ‘preventive psychological care’ and ‘psychological therapy’ as a guide.

*Preventive psychological care.* When people become seriously ill or injured it is normal that they will react psychologically, usually
experiencing various reactions as described in some detail in Chapter 2. It is important to understand that, in many ways, a lack of reaction is the more abnormal state.

This progress through psychological reactions takes the person involved into important cognitive and emotional processing as the impact of their situation is grasped and the effort towards adaptation and coping is begun. Naturally, there is considerable individual variation in the type and strength of these reactions, so we should beware of relying on stereotypes only as a guide. It should also be said that not all reactions are negative; sometimes there are positive psychological gains. However, one thing is certain: a significant proportion of the patients and their partners that you will encounter in a career as a health care practitioner will manifest negative psychological reactions such as anger, anxiety, grief and depressed episodes. These should not, in the first instance, be construed as something wrong. Often they are normal reactions, signs of emotional processing. However, if the reactions become prolonged and intensify then they can become disabling in various ways and possibly impair physical recovery. At this point the phrases ‘psychological disturbance’ and ‘psychological casualty’ begin to be more relevant to a case. It clearly makes great sense to try to reduce the likelihood of this type of deterioration into psychological disturbance by means of preventive psychological care – that is, intervening in a way that supports and helps people through their initial reactions and then on to adaptation and adjustment. This includes providing a situation where efforts are made to minimize the stress and threatening impact of illness or injury by effective communication, information provision and education.

In earlier approaches to both medicine and nursing little heed was given to this psychological side of illness. Medical treatment was generally seen as a physical event, while psychological reactions were usually held to be (as much by patients as doctors) some sort of weakness or failure that was best kept hidden. A stroke or heart attack was just another of life’s trials that one bravely dealt with. If there was emotion this was better kept out of sight.

Fortunately, this bias is giving way to a much more informed and balanced view. If, for example, you spend an hour or two just browsing through Baum et al. (1997), you will find over 200 short, briefing chapters that demonstrate beyond question the predictable, parallel psychological processes that accompany illness and injury. The importance of emotional state, levels of information, effective
communication and supportive counselling or psychological therapy is a recurring theme. Thus, a key argument in the rationale for preventive psychological care emerges. *If we know that, during illness or injury, psychological processes are often set in train that both affect physical outcome and lead to people being much more stressed and uncomfortable than is their norm, then, as part of our caring procedures, it makes sense to work with these psychological processes from the outset. The aim in such work is, where possible, to prevent patients and partners from becoming psychological casualties and to prevent progress in physical recovery being hindered by adverse psychological status.*

However, while this effort will pay off in many cases, some patients or their partners will become psychological casualties despite the preventive interventions. At this point it is relevant for us to take a brief look at the place of psychological therapy as part of the scheme of psychological care.

**Level 3: psychological therapy**

As a simple scheme for organizing thoughts on this topic I tend to think of psychological care as being offered at a basic level by staff with relatively basic training and supervision in psychological interventions. These interventions include monitoring psychological state, information, education and emotional care, as described above. Those staff who have gained experience and taken further approved training are able to extend their contribution to include a valuable form of basic counselling, which can be a very powerful form of support and greatly help people with problem-solving. Beyond that, the role of staff who feel that their client needs assistance at a greater depth has to be one of *acting as a referring agent*, since ‘greater depth’ implies psychological therapy and that is the specialist function of the clinical or health psychologist. Thus, if you feel that the routines of psychological care (as outlined in detail in later chapters) are not sufficient because your patient is clearly in considerable difficulties, then a referral to a clinical health psychologist is an important link in the chain of care. I should mention that referrals do not have to be to clinical health psychologists exclusively, since there may well be other members of staff who have recognized qualifications in psychological therapy. Some psychiatrists and professional counsellors may be able to function in this role. To illustrate the basis for this sort of transfer I will sketch out
the background of several referrals that have been made to a health psychology department in recent years.

Eileen, a nurse specialist in dermatology, usually found 10 minutes or so once every other week to talk with Tamsin, a 31-year-old woman receiving PUVA treatment for severe psoriasis. Eileen realized that her patient was becoming increasingly stressed with a difficult situation at work. It was clearly affecting her greatly and possibly responsible for the flare-ups of her psoriasis. This was the third flare-up in 18 months. From the content of her conversations Eileen formed the impression that Tamsin’s difficulties had to do with her inability to deal with male authority figures. She therefore sought Tamsin’s consent and then contacted the department of clinical and health psychology with a referral request. The five sessions of therapy offered by the clinical psychologist explored her approach to managing the work situation and why she might have difficulties with the particular figures involved. Tamsin found this useful and was able to alter things to reduce the levels of work stress. She certainly was not psoriasis-free as a result but there were no more flare-ups for quite a while.

Cheryl had experienced a difficult childhood, in the sense that she felt unwanted within her family. Her parents had been adequate rather than loving and she never felt that she had their true interest or concern. Two marriages in succession had failed because she found that the pattern of lack of love and true interest repeated itself. At the age of 47 she required surgical treatment in the form of a fusion of two lumbar vertebrae to deal with increasing back pain. This surgery was not entirely successful and left her with further pain and a weak leg. Following sessions with a physiotherapist and with the surgeon, she felt great anger because she experienced both of them as being indifferent and lacking true concern with her problems. She felt angry and abandoned and became so distressed that she consulted her GP. The GP referred her to a clinical health psychologist. This psychologist opted first to work at rebuilding her basic trust and rapport with professional figures. They then looked at the situation she found herself in and worked on understanding how Cheryl had transferred expectations and feelings of anger from her earlier childhood into the situation of her surgery and relationships with the health care professionals involved. Cheryl realized that, in part, her anger was more to do with her expectation that the staff would not be truly interested in her and the angry, defensive style that
she rapidly adopted with the surgeon and physiotherapist made things worse. Further work led to the discovery that she tended to adopt this difficult style with many people in her life and had done so for years. The behaviour was based on defensive expectation of being let down in relationships. Her habitual perceptions of people in her life and herself were explored in some depth. Cheryl emerged from this therapy feeling much less distressed. She felt that she had a greater understanding of situations that troubled her and a better capacity for managing them. This in turn helped her to relax with her pain problems and eventually accept a place on a back pain management programme, from which she gained considerably.

Jane had suffered a surgical accident and consequent cardiac arrest. She spent four days on a ventilator in an intensive care unit as a result. At follow-up clinic six weeks after discharge she was found to be suffering stressful and frightening flashbacks related to her stay time on the ventilator. She was showing all the symptoms of post traumatic stress disorder. The consultant anaesthetist and sister in charge of the unit gave her some time to talk through her experiences and reassure her, but decided on an immediate referral to a clinical health psychologist for therapy. Three months later, after six sessions of therapy, she was much less troubled by flashback and generally stronger emotionally.

Having worked with David for a year, Becky, a diabetes nurse specialist, began to feel that he was coping with his diabetes and with life in general increasingly less well. He continued to work as an architect but was emotionally up and down with the shock of the diagnosis, and found himself lacking in concentration. Then his wife was diagnosed as having ovarian cancer. Becky thought that David was near to breakdown and also judged that his health was being badly affected by events. She referred him to a clinical health psychologist, who set up an extended support regime and helped him with issues to do with anger and fright for the future.

After a coronary artery bypass operation followed by numerous admissions with chest pain and two further angiograms, Robert, a Methodist minister, was again present for review with his consultant cardiologist. The cardiologist was convinced that there was now no vessel pathology and that the pains, lassitude and low-key sense of illness that Robert reported were psychological in origin – hence he referred Robert for
assessment by a clinical health psychologist. In the first interview it emerged that Robert, who was disposed to the classic Type A coronary-prone behaviour pattern, had blamed himself for his heart attack and felt that he was letting his congregation and God down by his enforced retirement. He felt enduring guilt and a strong sense of failure. These feelings had undermined his sense of well-being and rehabilitation. After some time of personal reflection and exploration of personal issues in therapy sessions, Robert began to relax rather more with his situation and was able to see a path for returning to a less driven part-time role in the church. He managed to move on from his preoccupation with guilt and failure and, over the next year or so, suffered less chest pain and became more confident. There were no further admissions to hospital.

Psychological therapy is, of course, a blanket term for a diverse collection of approaches and theoretical influences. I will not attempt to describe these here. But it may be helpful to outline some of the basic features that most approaches to psychological therapy in a medical setting have in common.

Referral will be because a health care practitioner will at some point have sensed ‘caseness’. This is a phrase that you may find used sometimes to imply that a person has passed a threshold of psychological discomfort, disturbance or impairment, as a result of their illness or injury, that justifies psychological therapy to halt deterioration and deal with a crisis. Sometimes the problems may involve longstanding interpersonal or behavioural difficulties, and therefore be less of an emergency but still need psychological therapy to facilitate all-important change.

In terms of obvious psychological status, patients or partners meriting referral for therapy may be in distress and disabled by strong emotions, such as overwhelming worry, anxiety, general anxious tension, panics, phobic reactions, hypochondria, depression, anger or grieving. A second large group of patients or partners may be in a generalized stressed state, feeling that they cannot deal with what is demanded of them and fearing some sort of breakdown. In contrast, other patients struggle (or, perhaps, fail to struggle) with issues that may be more to do with a pattern of behaviour that is damaging their health and well-being – eating disorders, excessive dependency, damaging lifestyles (e.g. excessive workload and work hours), non-compliance with treatment and so on. Much less often, fortunately, a few clients may be found to be suffering mild organic effects, such as
minor brain damage resulting from surgery (e.g. coronary artery bypass surgery) or anoxic incidents. These patients also need referral.

On receiving a referral a psychological therapist will have two initial tasks. The first is to begin the work of creating a genuine rapport that will lead on to the development of a therapeutic alliance. In basic language this means that the therapist sets up a situation in which the client feels truly safe, accepted and free of any need for defence or evasion. Then begins the work of assessment, which is, in reality, a joint task. With the therapist’s help the client explains the situation and then explores the perceptions and feelings related to it in increasing depth. Some therapists will then move on to rather directed therapy systems, such as cognitive behaviour therapy or cognitive analytic therapy. As used here, ‘directed’ means that the content of the therapy follows a loose schedule of objectives linked to a particular theoretical system – for example, tracking down the identity and origin of automatic negative thoughts that, in the system called cognitive behavioural therapy, are believed to trigger anxious or depressive feelings. Other therapists work in a less scheduled, more exploratory way. Sometimes they put much more emphasis on the relationship between therapist and client, using this as a springboard for assisting personal development away from damaging past interpersonal relationships, which, in turn, lead to failing present patterns in relationships (as in some of the clinical examples above). Davidson and Neale (2001) give a brief, manageable breakdown of the theoretical and practical elements of contemporary approaches to psychological therapy, together with references, should you wish to read further.

The key problem: lack of psychological care in general hospitals and health centres

At times you might find that this book expresses views in a rather forceful, perhaps passionate, manner, especially with reference to the lack of organized psychological care in hospitals and health centres. In fact, in places, I even refer to this as negligence. In view of this, it is probably best to reveal to you the origins of my vehemence early on in the book rather than later. To do so takes us straight to a case example and, later, a little personal history. The case of Peter J serves well as an illustration of the issues I have in mind.
Case study: Peter J

Peter J, a 46-year-old man, was eventually referred to me for assistance by his general practitioner. Two months previously, while visiting his daughter in the north of England, he had been admitted to an emergency medical unit with chest pains that were thought to be an ongoing heart attack. This took place after a family row that had been quite upsetting for him. He was transferred to a cardiac unit for diagnostic tests and treatment. After five days of observation he was discharged as stable and well. He returned home, and was transferred to outpatient and GP care while on the waiting list for an exploratory angiogram. The basis of the referral to me (as a clinical psychologist attached to the coronary rehabilitation programme) was that he was extremely anxious and had been in and out of the doctor’s surgery numerous times complaining of chest pains and associated panic attacks. On two separate occasions he had called for an ambulance to take him to casualty, believing that he was having another heart attack. He had then spent a day or two on a cardiac unit under observation and was discharged on both occasions with no significant finding.

In a sense there is nothing remarkable about this history. Many people do have heart problems and many of these people do become quite anxious about their situation, but it is worth recording some of the statements that Peter made to me in our first session together. For example:

‘Lack of information is my real complaint. What has made me really angry is that nobody told me anything in the hospital up north and I’ve not been told anything much since I left either. I don’t know what I am supposed to do about exercise or eating – I’ve been eating little more than toast for two months, it’s very frightening. I don’t know what state my heart is in. They said I’d get all the information at the coronary rehabilitation class, then they said I could not go to that until after the angiogram, which is another four months to wait. The nurse on night duty at the cardiac ward said that I must have fallen through the hoop somehow and missed out on information. I’m in limbo, I’ve lost all my confidence and I have panics now – I’ve never felt so bad.’

One element of psychological care comprises regular and organized checks to establish the accuracy and depth of information that
patients hold. Another element is the task of assessing the patient’s psychological condition in simple everyday terms. If action needs to be taken in relation to these then it follows in natural progression. The problem for Peter was not that he was being dealt with by negligent and unhelpful people, quite the opposite in fact. They were a caring team. The problem was that the cardiac units and the health centre involved had no practice of organized psychological care. Thus it became possible for him to be discharged in an ill-informed state and to develop increasing levels of confusion, anger and anxiety without this being identified. The situation persisted until he had, effectively, become a psychological casualty. As a result of his state of insecurity and emotional upheaval, together with worries about his future, Peter developed panic attacks with hyperventilation that were sometimes accompanied by chest pains. These chest pains were possibly caused by episodes of dynamic angina. This term refers to a contractile spasm of one of the coronary arteries rather than an actual blockage. It causes angina-like pains and it is thought that it can be provoked by stress and emotional states. Not unreasonably, Peter interpreted these episodes of chest pain as another heart attack and so panicked and sought immediate medical help. It happened on several occasions, leading to call-outs for the general practitioner and two admissions to hospital. These emergency interventions were necessary but a waste of resources, since his heart was in fairly good order and no physiological signs of a further heart attack were ever detected.

Much of Peter’s problem seemed to be insecurity caused by a lack of understanding of his situation combined with a sense of being abandoned when not fully recovered. Quite possibly nurses or doctors had given him some explanation, guidance and information during his stay in hospital, but this clearly had not been delivered in a way that enabled Peter to retain and make use of the material. Given, as described above, that the basic routine of psychological care is to check what people know about their situation, then to amplify or correct this information as necessary, it was a clear example of absent or failed psychological care procedures. He was discharged with little useful information and left in a bewildered, frightened state.

With Peter’s care being transferred to his primary care team, a further opportunity was on hand for monitoring and checking his understanding and handling of his situation. Nothing much was done, presumably because the general practitioner and practice nurse felt they had too little available time for such interventions and
believed that the cardiac unit would have done what was necessary. Paradoxically, assuming that lack of time had prevented interventions to provide support and education for Peter, this effort at saving time directly caused a situation to build up, where the same staff then had to find the time for frequent consultations and call-outs to Peter. His psychologically induced problems – that is, panic attacks, hyperventilation and possibly dynamic angina – all of which indicated another heart attack in Peter’s eyes, then necessitated further admissions and diagnostic efforts by the cardiac team. *The lack of psychological care caused more time consumption in the end.*

The moral in this case (and hundreds of others that I have encountered) is that with the monitoring and support that comes with good, organized psychological care Peter’s general situation would have been picked up and he would probably not have ended up in this state. He would certainly not have consumed anywhere near as much of the doctors’ and nurses’ time. Nor would he have had to endure so much personal stress and distress. This provides our first example of a key point that I highlight below. **If some small amount of time is not given to psychological care work with the ill and injured, then, in a proportion of cases, this will lead to a larger amount of extra medical and nursing time needing to be found.**

By way of clinical evidence to support my view of this case I should record that, after a couple of sessions with me in which I offered little more than the typical content of nurse-provided, preventive psychological care (including basic informational and emotional care), Peter settled and the panics and chest pains receded. He had no further admissions and his contact with his GP became routine only. Any cardiac nurse, practice nurse, physiotherapist or occupational therapist could have achieved the same. If there had been a scheme of preventive monitoring and psychological care in the hospital units and the health centre that dealt with him it is unlikely that he would have become a psychological casualty.

**Other evidence?**

Am I making a fuss about one patient and over-generalizing? Clearly, when observing clinical practice in one’s own locality it is important to guard against the risk that local approaches are seen as applying to the rest of the country in an unfair generalization. Therefore, as we reflect on Peter’s situation, it is worth mentioning at this point that I
have kept a particular form of record with regard to over 200 cardiac patients I have met in recent years who have received cardiac surgery. The record has been of their response to the following two questions:

1. When you were in hospital did anyone on the staff discuss with you how you were reacting personally to your illness or surgery and what you were thinking and feeling about your future? (Emotional care work.)

2. Before you were discharged did anyone review with you your understanding of your situation and the information you had received? (Informational and educational care work.)

Now what is of interest to us in this group is that my own hospital does not have a specializing cardiac surgery unit, so all these patients were treated at quite a wide range of units elsewhere in Britain – all for coronary bypass or valve repair/replacement surgery. While I do not claim that the information is anything more than informal survey material, the average answers are not very encouraging. Very few people, less than 10 per cent, have any memory of any such interventions. In fact, none of these people has related their experiences in a way that suggests that they benefited from organized psychological care; quite the opposite in fact. Most had similar, although less strident, complaints to those of Peter J, noting that they had not had sufficient information and guidance and felt rather abandoned and unsupported until (often months later) they were offered a place on coronary rehabilitation courses, which are specifically set up to give exercise training, information, guidance and support. The regrettable indication here is that organized psychological care was weak or absent at the various hospitals involved.

One slightly more encouraging finding was that over 20 per cent spontaneously said something like ‘but my own doctor has been very helpful to me’, indicating that things might be a little better at the health centres receiving patients back into their care after hospital treatment. My conclusion is, then, that there are indications of inadequate psychological care at a significant number of cardiac units throughout the country – it is not, therefore, just a problem in my own locality. Incidentally, I also have similar information from a group of patients who have received general or orthopaedic surgery from hospitals around this country. These are people who have run into
problems with post surgical pain and been referred to me through the local pain clinic.

Finally, I might also mention that four years ago I was able to be a first-hand observer in the cardiac care situation when I had to have open heart surgery to repair a failed mitral valve. My finding was that all the staff gave excellent medical and nursing care that was well supported by good physiotherapy. It was noticeable though that, while all the staff involved were supportive and helpful on an individual basis, I encountered no established, organized practices in psychological care. It was also obvious that the staff were generally untrained in the business of monitoring psychological state (including levels of information) and not required to provide appropriate psychological interventions. There was no instance in any of the diagnostic or treatment units that I visited that might be identified as a conscious intervention linked to a scheme of preventive psychological care. This was a disappointment because, like most cardiac patients, I would have found it helpful.

**Others think this way too**

We are reviewing the issues around my claim that, although routine, preventive psychological care of ill and injured people, particularly by nurses and therapists, can make a significant contribution to patients’ general progress, this type of care seems to be the exception rather than the rule in our general hospitals and health centres. There are some types of unit where developments are more likely to have taken place with staff who are more psychologically minded. I recognize and applaud this. Often it is in specialist units that have specialist staff. Breast cancer screening nurse counsellors and diabetes nurse specialists are such examples. Even so, it is often the case that these specialist staff work in isolation in units that do not have an overall, organized scheme of psychological care and where the rest of the staff are neither required nor trained to provide psychological care.

It might be argued that such practices are yet to be developed because the notion of psychological care is relatively new. In reality this is not the case. The general awareness of the importance of patients’ psychological state is not at all new. Added to this, the importance of doctor–patient and nurse–patient communication with effective information provision has been recognized for quite some while. For example, Janis and Levanthal (1965), writing under the title
‘Psychological aspects of physical illness and hospital care’, describe typical reactions to illness and the potential role of a counsellor to assist with these reactions. They also recommended ‘setting up and maintaining a therapeutic milieu in the general hospital’. During the 1970s and 1980s there were a steady stream of publications in both psychological and nursing journals and, occasionally, in medical journals that brought the issue to our attention. There are many examples, including the issue of Nursing (number 27, July 1981) that was composed of 12 articles all designed to illustrate the importance of good nurse–patient communication and information provision in a hospital setting. This theme was consolidated by Ley (1989) who has proved a vigorous campaigner for improved communication and information provision by all health care practitioners. Lynch (1977) wrote an impassioned book using research and clinical observation to support the psychosomatic theory that loneliness was associated with increased illness and death rates. On this basis he argued that human physical contact, emotional support and continual effort at communication in settings such as cardiac units were vital for patient recovery. Later publications, such as Lacey and Burns (1989) and Davis and Fallowfield (1991), reflect the development of knowledge concerning the psychological impact of illness and injury and the importance of attention to psychological status and psychological reactions among patients and their partners. Baum et al. (1997) is one of the latest examples, and gathers together a huge amount of material in this field from many authors. Curiously, though, even their authors fail, in general, to grasp the importance of improving basic psychological care through organized schemes that guarantee basic psychological monitoring and preventive interventions for all patients. This is exactly the scheme proposed in this book.

A formative experience

I, among many others, have been a campaigner for improvements in the provision of psychological care in general hospitals and health centres since 1978. In that year I first started some clinical sessions in a renal unit and then slowly developed links with various other sectors in general hospital activity, including the care of patients with cardiac problems, cancer, chronic pain, neurological disorders, orthopaedic difficulties, diabetes and so on. It was a valuable if rather sobering experience that led me to conclude that the average patient in the average
general hospital or health centre receives little or no psychological care, and this is often to the disadvantage of everyone involved.

This period of general clinical duties and observation was then followed by some research into what might best be described as the life and times of patients in renal failure (Nichols and Springford 1984). This research did not produce a very encouraging picture. Both renal patients and their partners were often very stressed by the circumstances and responsibilities of home or unit haemodialysis and clearly suffered psychologically. It was also clear that the provision of information to patients and partners was unreliable and that the staff did not have a habit of communicating in depth with their patients about their experiences, expectations and feelings. They were kindly and well motivated staff with good technical skill. Somehow, though, they sustained a situation in which patients and partners, although surrounded by caring staff, felt that the staff were out of touch with their feelings and needs and often did not manage to keep them informed in an effective way.

This led on to some proposals for the improvement of psychological care in general hospitals. Essentially, these involved a simple model from which Figure 1.2 was derived. The early proposals advanced the idea that nurses and allied professions become the frontline agents of psychological care in hospitals under the training, support and supervision of clinical psychologists, as described in Nichols (1993). This book develops these proposals further.

**Psychological care as an ‘investment’**

On one level psychological care in medicine is an expression of the human capacity to support and care for those in distress or distressing situations. It is, effectively, an extension of the physical caring provided through nursing and the therapies. But there are dangers with this fine notion of psychological care as simply a higher form of human expression. There is a sense in which it is too closely linked to a ‘tissue box’ image – that is, limited to dealing with emotional casualties in weepy sessions in the counselling room, with constant recourse to the tissue box. Inevitably, a smaller proportion of psychological care activity does involve this type of emotionally laden interaction, but I would prefer that you think of it in quite different terms from this right from the start.
The important (vital) alternative perception is that psychological care is seen as an investment of effort that underpins medical, nursing and therapist interventions. Investment might seem a curious word when applied to the context of a person arriving in hospital with a myocardial infarction or attending a renal unit for their first session of haemodialysis. Indeed, the definition of investment describes the term as referring to an initial laying out of money in order to make a return and end up with more money than you started with. Here, partly in metaphor, I assert that if organized psychological care is provided the patient will often end up in a better state physically or further down the road of rehabilitation than if there is no psychological care provided – it is a good investment of effort. This is such a fundamental point that I will repeat it from time to time through the book, rather like a mantra. Thus:

In serious illness and injury good psychological care complements and underpins physical treatment regimes. Psychological care contributes to recovery. When there is no psychological care physical treatment plans may sometimes be undermined, and thus the power of medical, nursing and therapist interventions will be reduced.

Writing a decade ago in Nichols (1993), I set out the basis for this notion of psychological care as an ‘investment’ by advancing some rather bold claims. It is relevant to review these in support of this point. Thus, when people become seriously ill or injured but no psychological care is included in their regime of care or therapy, there is a definite risk that:

- the patient (and partner) will suffer more stress and distress.
- the patient may have less understanding and therefore less motivation, leading to poorer levels of compliance with treatment.
- the patient may exercise less self care or fail to rehabilitate, and thus there will be greater utilization of doctor or nurse resources.
- medical, nursing and therapist achievements with an individual patient may be undermined or reversed when there is no psychological care.
At first sight you could be forgiven for rejecting these claims as dramatic and overstated, particularly when combined with my other major claim that the provision of psychological care in general hospitals and health centres is usually inadequate or non-existent. It suggests quite a severe problem. However, when you stroll through the wards of the average general hospital or visiting the average health centre there is not usually an immediate impression of many people in distress or, for that matter, distraught staff battling with endless problems of non-compliance and readmission. In these terms you might well say ‘He’s got to be wrong.’ I have to accept that there is local variation but, overall, both my past and my ongoing experience consistently takes me to the position that the effects I describe are actually quite widely occurring. The little case vignettes given above indicate the type of clinical evidence that repeatedly presents itself when one talks in depth to patients or their partners. In the next chapter the weight of clinical evidence is quadrupled and supplemented by evidence from research sources.

**Research supporting the concept of psychological care as an ‘investment’ that underpins medical treatments**

The claim that psychological care should be regarded as an investment of effort that underpins medical treatments is so important that some supporting research should be presented, especially in the current climate of ‘value for money’ within our health service. I will present evidence only from the field of cardiology at this point but material from other specialities will be found in Chapter 2. The material cited is all from respected, peer reviewed journals and is therefore of reliable quality.

Maeland and Havik (1987) reported a prospective study that sought to establish the psychological features that predicted failure to return to work after a heart attack. A total of 249 patients were involved. They found that the following features were strongly linked with failure to rehabilitate and get back to work:

- marked feelings of hopelessness;
- anxiety and depression at nine days and six months;
• poor knowledge of coronary-prone lifestyle;
• expectation of reduced physical abilities;
• expectation of reduced autonomy;
• expectation of reduced work capacity;
• expectation of reduced emotional stability.

Put simply, patients who sustain a heart attack, are treated and then returned home with negative expectations, lack of information and emotional distress are much less likely to return to their job than those who have the reciprocal, positive features. This demonstrates that the psychological status of patients can undermine their overall progress to normality. Without psychological care as an attempt to identify and deal with these negative features, one of the primary aims of the medical and nursing effort with post infarction patients (to return them to as near a normal life as is possible) may be undermined, possibly to a significant degree.

A more recent analysis that lends general support to the work of Maeland and Havik is that of Hemingway and Marmot (1999). They reviewed a large collection of research papers of a prospective design and derived a consistent pattern of findings within these studies. The psychological features that were associated with a second heart attack were clearly identified. The main culprits were:

• depression and anxiety following the first heart attack;
• low levels of social support (including emotional support);
• work characteristics (e.g. job strain, in jobs featuring low levels of control and conflicting demands).

Again, the import is that failure to monitor and attend to emotional state in post infarction patients increases the likelihood of a second heart attack. As you can see, this allows a rather startling deduction that is so important that it is worth emphasizing. If relatively cheap and easily provided psychological care to detect and deal with adverse psychological reactions is not offered by the health care practitioners involved with cardiac care, then this situation itself becomes an indirect risk factor for further heart attacks. The investment of psychological care must be made to minimize the risk of second heart attacks.
Incidentally, issues concerning a return to work where the situation is one with job strain characteristics might possibly be included within the routines of coronary rehabilitation education, but this may be beyond the range of everyday psychological care on the ward. Referral to a psychologist might be the best route.

Though I am running the risk of becoming repetitious with supporting evidence (which, anyway, is a comfort when seeking to establish a point), other recent research has demonstrated that depression adversely affects a person’s survival following a heart attack. Frasure-Smith et al. (1993) show that patients who meet the criteria for major depressive disorder following a myocardial infarction were five to six times more likely to die during the following six months. They report a 16 per cent mortality rate for depressed patients, in comparison with 3 per cent for patients who were not depressed. Later, Frasure-Smith et al. (1995) assessed the impact of lower levels of depression – that is, patients who recorded scores on the Beck Depth of Depression Inventory that fell into the mild (as opposed to major) depression category. At 18 months after the myocardial infarction depression was still associated with an increased risk of death. As Tabrisi et al. (1996) comment, ‘Despite the high prevalence of depression and associated risk of death in CAD [coronary artery disease] patients, depression is infrequently diagnosed or treated in this population.’ That would not occur if the investment of effort in providing psychological care were part of the overall provision of care in cardiac units and the health centres caring for patients after discharge.

The stress of illness and the immune system

As a further addition to my collection of arguments justifying developments to provide psychological care in hospitals and health centres, I want to mention the expanding area of knowledge linking the performance of the immune system to the experiences that people have and the general psychological state that they are in. Evans et al. (1997) note that current research lends some credence to the claim that differing psychological states have an effect of either up-regulating the immune system’s activity or down-regulating it. In other words, the experience that people have had during, say, the preceding six months may affect immunocompetence. Kennedy et al. (1988) review various experiments in which cell counts, proliferation rates and the attacking
power of various elements of the immune system (natural killer cells and T helper lymphocytes, for example) were explored in relation to psychological state. There were strong indications that exam stress in medical students, stressful life change, loneliness and enduring stressful situations such as divorce or being the caregiver for a partner with Alzheimer’s disease caused a reduction in the power of the immune system. Martin (1997) offers a very readable review of the current state of knowledge in this area. He concludes that long-term demanding and stressing situations can make us more vulnerable in health terms.

This is an issue that we, as health care practitioners, should reflect upon. Chapter 2 includes plenty of research and case studies to confirm the obvious. Illness, injury, hospitalization and treatment can sometimes be enormously stressful and affect people’s lives in a long-term, negative way. The implication for us is that if we do not work to identify those patients in stressed states or affected by other adverse psychological reactions, then we face the risk of standing by, complacently, while the health of these people is further threatened. We must, therefore, remain mindful of the basic psychosomatic premise that is mapped out in Figure 1.3.

The theory is clear. Eventually our body systems develop a hormonal and physiological emphasis in response to what is going on in our lives. If it is long-term stress, struggle and emotional upheaval, as can happen with serious illness or injury, this can affect health through increases in such hormones as cortisol. This hormonal change

Figure 1.3 The psychosomatic premise.
can, in turn, *downgrade* levels of immunocompetence, so making us more vulnerable to infection and cancer onset. Alternatively, it can increase levels of fatty acids in our blood and add to the risks of coronary heart disease. Here, then, is yet another reason to attend to psychological care in the ill and injured. It is about protecting physical health.

**Comments concerning the ‘user perspective’**

As we will see in Chapter 4, there is evidence to show that most people prefer doctors and health care practitioners to spend a little time with them to give good information concerning diagnoses and treatments. These days, many medical and nursing conferences include talks by patients. A common theme in these is of a general need for good communication, combined with a general effort by health care practitioners to give empathic, emotionally sensitive care. Most seriously ill or injured patients and their partners have a natural need for basic psychological care. I find this demonstrated over and over again in situations such as coronary rehabilitation, the pain clinic or the diabetes clinic.

I would like you to assess your own needs too. What response would you have given concerning your own family in the situation described below?

A somewhat hard minded, financially orientated hospital manager recently asked of me, ‘What evidence is there in terms of cost effectiveness or increased turnover of patients if you introduce this sort of thing [psychological care]?’ Well, as has been shown already and as will be shown throughout the book, there is evidence to support such developments, but from the users’ point of view the case is already established. Thus, I replied to the manager, ‘Imagine that your wife needs some distressing surgery to deal with cancer. There are two units available to choose from. One is technically good but being traditional has no special scheme for keeping patients properly informed and caring for them emotionally. The other has staff who, as well as medical and nursing competence, have also been trained in the basics of psychological care and operate a scheme of psychological care – monitoring how their patients are and giving good informational and emotional care with supportive counselling if required. Which unit would you choose and why?’ He replied ‘Point taken.’ I hope that you will see it that way too.
I will pause in my flow for a moment to try to head off the risk of offending some readers. Some psychologically minded nurses, physios, dieticians, speech and language therapists etc. will almost certainly be saying something like, ‘What a cheek, who does this guy think he is? We already do give psychological care as part of our work and we do think that it is important.’ It is, most certainly, a reasonable protest.

I am well aware that there are many individual health care practitioners who provide elements of psychological care – often as a personal initiative. There are others who provide aspects of psychological care as part of their job requirement. I have met and been impressed by a breast cancer screening programme’s nurse counsellors, for example, and home dialysis nurse counsellors. But this is not exactly what is in my mind when I campaign for psychological care to be introduced into hospitals and health centres. What I have in mind is reflected in the following question:

If you and I were to go to your hospital, select a ward at random, go in with the clinical nurse manager and select, say, the third bed on the right and then ask ‘What is being done about the psychological care of this patient, and who is handling it?’ would we get a satisfactory reply? (A modified version of this question could clearly be put to a practice nurse or GP at a health centre.)

In other words, does the average patient at the average general hospital or health centre have the resource of an organized scheme of psychological care? That is the key question.

I hope that you can see the distinction. It is not so much a case of my complaining that individual staff do not offer psychological care. Many will do so, which is pleasing. However, it then falls to the luck of the draw for the patients as to whether or not they are cared to by such members of staff. This will not do. We cannot allow an important resource to be so ‘hit or miss’ in distribution. Hence my complaint is about the relative rarity of units, wards or health centres that have an organized provision of psychological care. That is, they are organized at a level that provides an effective guarantee that all patients will at least be monitored for psychological state.

As a follow-up point look at the questions below and decide if your particular unit, ward or centre provides psychological care according to the criteria given.
Discussion time

Is there psychological care in my unit?

• Have the nurses and therapists had relevant training?

• Is there an *explicit scheme* for psychological care interventions?

• Is there a systematic allocation of ‘psychological care duties’ to staff?

• Are there prepared materials (e.g. brief psychological report sheets)?

• Are brief records kept of significant psychological interventions, including educational work?

• Is there a guarantee of basic psychological monitoring and care for all patients?

• Do medical staff support the effort at psychological care and coordinate their work with the psychological care programme?

• Is there an established link with a clinical psychology or counselling service for referrals? Are referrals made?