PERSONAL SPACE

KEITH NICHOLS *believes that years of research have failed to improve the psychological care of ill and injured people.*

Why is psychology still failing the average patient?

VISIT your local hospital, pick a ward at random, go with the clinical nurse manager to the third bed on the right and ask, 'Who is handling this patient's psychological care and how is it going?' This is my 'average-patient test'. The key point? Despite 20 years of major expansion and research in psychology – and in particular health psychology – the average-patient test will almost always reveal our failure to develop psychological care as part of the thinking, culture and routines of general hospitals and health centres.

This is something that troubled me when I began clinical sessions in a renal unit in 1978, and it provoked Nicky Springford and me to conduct a study of people who were surviving by haemodialysis in the unit. At that time renal failure was a slow terminal illness, and those involved had a very distressing time, partners as much as patients. This research has influenced my thinking ever since, because through some revealing interviews Nicky demonstrated that although the patients and partners were 'surrounded' by caring staff, in many subtle ways they were quite alone with their distress. They were cared for physically but there was little effective psychological care (Nichols & Springford, 1984).

It was obvious that this lack of psychological care was not something that a lone, part-time clinical psychologist could do much about. The problem applied to all patients and partners involved with the renal unit. Further, what we were noticing was not mental health issues needing treatment but more emotional disarray provoked by poor information exchange and lack of emotional care. The distressed psychological state of these people sometimes contributed to their death (through failure to keep to exacting daily fluid intake limits and consequent fluid overload, causing cardiac failure).

This situation led me to embark on a campaign. The problem to be solved was that of providing basic psychological care for the average seriously ill or injured patient in the average ward or unit of the average general hospital. What emerged was a model of psychological care (as distinct from psychological treatments such as cognitive behavioural therapy) that was designed to be suitable for use by nurses and therapists (occupational therapists, speech therapists, etc.). The key principle in this model was that, to provide psychological care effectively, it had to be on an organised basis with an allocation of staff time and with records being kept, although the demands of such routine psychological care could not be too onerous. Allied professions had to be the workforce used, simply because they were the only ones present in sufficient numbers to cover the large numbers of serious ill and injured patients in general hospitals.

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The content of psychological care was basic and used skills already in existence. These included regular monitoring of psychological state and routines to check and amplify information held by patients – so maintaining realistic expectations (informational care). This was combined with emotional care as required and referral for therapy to a clinical psychologist if needed. The clinical psychologist was seen as trainer, supervisor and available therapist in the scheme (Nichols, 1993).

This concern for psychological care fitted in with other developments of the time. Nursing was becoming more psychologically minded via the Project 2000. Publications of the era encouraged the introduction of psychological approaches into health care (e.g. Davis & Fallowfield, 1991). Importantly, the new discipline of health psychology was up and running, expanding fast and attracting a big research budget. In fact, by the mid-1990s with this new discipline pouring out research, I felt that my missionary-like quest was increasingly redundant and I let my campaign slacken off. This was a mistake.

There are, therefore, two failures to report. Firstly, in my quest to develop psychological care in general hospitals I failed to push things long enough and hard enough to have any lasting impact. Secondly, whilst there are various

The Components of Psychological Care (from Nichols, 2003)

Level 1 (awareness)	Awareness of psychological issues
	Patient-centred listening
	Patient-centred communication
	Awareness of the patient's psychological state and relevant action
Level 2 (intervention)	Monitoring the patient's psychological state with records kept
	Informational and educational care
	Emotional care
	Counselling care
	Support/advocacy/referral
Level 3 (therapy)	Psychological therapy

encouraging 'hot spots' around the UK where psychologists have produced specific local provisions, such as in some stroke, intensive care or cancer units (e.g. McWilliams, 2004), psychological care is still not a common provision in hospitals. Thus, psychology does not appear to have made itself known to the broad mass of practising nurses and therapists, and it has achieved little in terms of improved psychological care for the broad mass of patients who are seriously ill or injured. In this specific context it has, to date, been a low-impact science.

What has gone wrong? Publications like Baum *et al.* (1997) hold clues. This seminal book contains 230 chapters that outline the focus of health psychology. Real progress is evident, yet there is a serious blind spot. There is little recognition by the editors or authors that psychological care for the ill and injured is distinct from psychological therapy, that it should be a primarily preventive endeavour, and that it is only going to happen when undertaken by professions present in far greater numbers than psychologists. Another factor is that health psychology evolved as a university-based research enterprise. Hence, as Giermer (2004) comments, a standard entry into health psychology education and research 'would most likely be more removed from direct patient/client work'.

This negligence of psychological care is worrying clinically. Common psychological reactions to illness and injury include shock and even post-traumatic stress, confusion and distress, loss of self-worth, lowered personal control and a collapse into dependency. Such reactions can not only cause considerable distress, but they can also undermine medical efforts and obstruct rehabilitation. Hemingway and Marmot (1999) found that the probability of a second heart attack in cardiac patients increased with emotional disarray and lack of support. This is what psychological care is about: monitoring for signs of such reactions and intervening with basic care techniques or referral. It is a good 'investment' that underpins medical and surgical efforts.

Recently I have had two experiences related to cardiac medicine that have provoked my renewed involvement in the project. Firstly, in an informal survey I asked about 200 patients who had all recently received cardiac surgery at various cardiac surgery units in the UK whether psychological care was provided at these units. Stunningly, fewer than one in 10 replied with anything approaching an affirmative.

Secondly, I was able to assess the nature of the situation at first hand. In 1998 I suffered a mitral valve failure that required prompt open heart surgery to repair it. I experienced echocardiograms, an angiogram, a trans-oesophageal echocardiogram, admission for surgery and eventual discharge. I can report that in this brief career as a patient I received nothing that could be construed as psychological care. Additional enquiries in various other hospital specialities (orthopaedics, neurology, etc.) reveal much the same – psychological care in hospitals has not improved much for the average patient since my observations in the early 1980s.

'we need to communicate our knowledge and influence the approach to care'

Where does this leave things? With something of a tired sigh I have taken up the 'missionary stance' again. In Nichols (2003) I present a revised scheme that sets involvement in psychological care at one of three levels, depending on context (see box).

Level 2 in the scheme is the sector in which psychological care is delivered by means of the effective monitoring of psychological state, relevant interventions of informational and emotional care and initiatives for referral to psychological therapy. It is intended that nurses, therapists, medical staff, and so on, can all play a part in this activity under the guidance of psychologists. It is only when there is organised preventive care of this nature that the various possible psychological reactions to serious illness and injury may be headed off or dealt with by referral for therapy.

It would be a thrill to think that the huge engine of health psychology research might turn a little more of its effort in this direction. It is really about fostering better ways of promoting what is known to be beneficial – that is, caring for ill and injured people psychologically by the application of simple techniques of intervention that already exist.

It is also relevant to note a significant criticism from Averil Overton, a clinical psychologist in New Zealand. She rebuked me for the narrowness of my perspective, arguing that this model of psychological care was needed just as much in the mental health sector for patients receiving psychiatric treatment. I concede that my view has been narrow, but the wider body of clinical psychologists must respond to this particular complaint.

Perhaps I can use my age as an excuse to hand over the baton and say to the health psychology and clinical psychology professions generally that this won't do – a change of strategy is truly needed. To be fair, holistic care of this type is not currently fashionable at government level, although it may well be more so soon with forthcoming national frameworks for medical care. Nor has it helped that hospital management is required to run a money care system as much as a health care system. But within the system we have, we need to communicate our knowledge and influence the approach to care in hospitals and health centres much more effectively. For all the undoubtedly well-conceived and reliable knowledge that is accumulating, why does psychology still fail the average-patient test?

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