Nursing Practice
Review
Mental health

Nurses cannot claim to be holistically caring for their patients until they acknowledge and address those patients’ psychological needs

Meeting the psychological needs of the physically ill

In this article...

- The impact of psychological distress on physical wellbeing
- The importance of assessing patients’ psychological state
- Policy documents on psychological care

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Abstract
The psychological health of physically ill people has received more attention from other healthcare professions than it has from nursing.

Many patients with physical health conditions have high rates of psychological distress resulting in poorer quality of life, higher rates of consultations, a greater use of healthcare services and poor adherence to treatment.

This article explores the issue in terms of policy, prevalence, patient presentation and practice implications. It argues that nurses have a pivotal role in addressing the issue and offers models of delivery that may be helpful in developing a strategy to overcome this inequality.

Until several decades ago, nursing practice was closely aligned to a medical model of illness. However, nurses today are expected to have the knowledge, skills and competencies to meet the evolving holistic health needs of the patients they care for.

Engel’s (1977) biopsychosocial model of health incorporated psychosocial factors and went on to heavily influence current nursing constructs and practice. As Borrell-Carrió et al (2004) said, Engel’s model is both a philosophy of care and a practical clinical guide. Philosophically, it enables us to understand how suffering, disease and illness are affected by multiple biopsychosocial variables while, at a practical level, it helps us to understand the subjective experience of the patient as an essential contributor to health outcomes and humane care.

Despite the adoption of the biopsychosocial model into nursing practice, the literature suggests that nurses are not meeting their patients’ holistic needs, resulting in unnecessary suffering, poor access to relevant services and, in some cases, death (Eldridge et al 2011; Nursing and Midwifery Council, 2010; Royal College of Psychiatrists and Royal College of General Practitioners, 2009).

As the largest workforce in healthcare provision, nurses are in a pivotal position to positively influence and contribute to effective holistic care. This article explores the issues relating to the psychological needs of patients presenting with physical health problems in acute and primary care settings, with a specific emphasis on the two most common disorders, depression and anxiety.

Policy context
Colleagues in other professional disciplines have recognised that services are not meeting the psychological needs of the physically ill adequately and have initiated strategies to address this issue.

The joint report from the Royal College of Psychiatrists and the Royal College of Psychiatric Nurses (2003) recognised that many people with psychological distress will make contact with medical services before reaching mental health services. For example, a person may come to accident and emergency services through acts of self-harm or may contact specific medical services that treat complications of drug and alcohol misuse. The report encourages...
Clinicians need to develop skills in good psychological care so they can take a more holistic approach to patient care, rather than a purely medical one, and organisations need to promote an understanding of psychological issues.

Building on this, the Academy of Medical Royal Colleges (2009) published No Health Without Mental Health to draw attention to the close links between physical and mental wellbeing, hoping to provide a much-needed impetus for the development of better care for people both physically and mentally. NICE's (2009) guideline on depression in adults and those with physical illness. For example, and the role of psychological services for improving the evidence that exists in patient presentations, there can be no doubt about the importance of actively engaging in strategies that seek to address the psychological needs of the physically ill.

**Patient prevalence**
Approximately one quarter of people with physical illness develop mental health problems as a consequence of their condition (AMRC, 2009).

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**BOX 1. SCREENING TOOLS**

- Hospital anxiety and depression scale (Zigmond and Snaith, 1983)
- Patient health questionnaire (PHQ9) (Spitzer et al, 1999)
- A cognitive-behavioural therapy assessment model (Williams and Garland, 2002)
- See also www.neurotransmitter.net/ratingscales.html

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Depression is the third most common reason for GP consultations and mental health problems alone are now implicated in 25% of primary care consultations, second only to those for respiratory infections (World Health Organization, 2004).

Up to one third of medical inpatients report mild to moderate symptoms of depression. They have poorer levels of functioning and higher rates of mortality and morbidity than those with similar illnesses but no depression (MacHale, 2002). Using current studies, NICE (2009) illustrated that rates of depression in adults with long-term physical disease such as diabetes, hypertension and cardiac conditions were double those in healthy controls; in other conditions, such as end-stage renal failure, chronic obstructive pulmonary disease (COPD) and cerebrovascular disease, the rates were triple those of healthy controls.

While presentations that result in a diagnosis of anxiety are less common than those with depression in medically ill patients, nevertheless, many patients do experience symptoms of anxiety that can cause significant distress (RCP and RCPsych, 2003). Evidence suggests that 25% of people attending A&E departments with acute chest pain have panic disorder and that the prevalence rate of panic disorder in patients with COPD is in the region of 67% (Increasing Access to Psychological Therapies, 2008a). Anxiety symptoms such as worry and rumination are also common in people with coronary heart disease (CHD), thyroid disease, palliative care, pain-related disorders, stroke, pregnancy (AMRC, 2009) and many other physical states that require investigations and a period of waiting for a diagnosis.

At this point, it is pertinent to remember that not all patients presenting with psychological distress have a medical diagnosable condition. Medically unexplained physical symptoms (MUPS) account for up to 20% of new consultations in primary care, and this figures rises to an average of 52% in secondary care consultations. It is thought that up to 70% of people presenting with MUPS will also be experiencing depression or anxiety (IAPT, 2008b).

**Pathways to distress**
Becoming physically ill may trigger many distressing emotions, which can range from feeling vulnerable to becoming hopeless.

While people react differently, most go through a dynamic process that changes over time. This process may involve...
initially appraising the threat or meaning of the illness, followed by a period of adjustment where the patient assimilates the information and develops coping mechanisms (AMRC, 2009). However, for some people, adjusting to the illness may be more difficult and "coping strategies", such as worrying or denying a problem exists, may further add stress or perpetuate the illness.

Other causal pathways suggested by NICE (2009) include pain, disability and changes in the allostatic load (the “price” that the body pays for being forced to adapt to the adverse psychosocial or physical situations). Pain increases the risk of depression and contributes to emotional distress; its presence not only causes physical discomfort but also can adversely affect thoughts and emotions in so far as the person may think that this is indicative of "things to come" and consequently have a negative view of their future.

Disability can have a profound effect on individuals’ lives; it may prevent them from engaging at an occupational and social level, and require them to make radical changes to daily living activities. For example, people with COPD may find their social level, and require them to make radical changes to daily living activities. For example, people with COPD may find their condition acceptable to refer patients to specialist mental health services when they need lower-level interventions such as listening or screening.

At a fundamental level, nurses need to ensure that they embrace the biopsychosocial model and understand that there can be no health without mental health (DH, 2011). They also need to understand that, however high their standards of physical care may be, their care will continue to fall short if they do not take steps to address the psychological aspects of patient care.

Such steps will initially entail improving screening and detection of psychological distress in their practice areas; a number of screening tools have been developed for this purpose (Box 1). To increase detection rates, nurses need to develop their clinical interview skills to gain a better understanding of the distress their patients are experiencing.

Before extending their roles in this area, nurses will need support, supervision and training in how common mental health disorders present. Training need not be expensive or require access to a range of databases; some of the introductory theoretical components of training may be self-directed through the use and support of computer-based training programmes or web-based information. For example, many of the resources and articles cited in this article are freely accessible online.

Physically ill patients with poor psychological health have poorer outcomes, are less adherent to treatment, use more healthcare resources and have a poorer quality of life than those with good psychological health (NHSE Employers, 2011). Addressing these using psychological interventions has many benefits for patients, services and the economy (Box 2), so initial investments may have relatively quick returns for all. These returns can be sustained with regular updates made available for staff through inexpensive access to mental health specialists, as well as training and role play opportunities to practise their skills. To put this into action, organisations may need to develop new ways of working as in the case of the Improving Access to Psychological Therapies (IAPT) initiative.

While psychological services were traditionally provided by qualified counselors, psychotherapists and psychologists, IAPT psychological wellbeing practitioners provide less intensive services that are proving effective for patients with psychological distress of mild to moderate severity (Clark et al, 2009). Since many nurses will have already built up a rapport with their patients, and patients may feel able to trust and talk with them, in a similar way to psychological wellbeing practitioners, nurses may be ideally placed to provide brief psychological interventions.

Another step may be to make mental health awareness training mandatory. Many organisations provide mandatory training in areas such as basic life support and infection control; providing mental health training in detection and interventions for all staff would demonstrate their commitment to this important aspect of care. This need not be at an advanced level but one that provides staff with the skills to detect, signpost or refer on to other services where necessary.

An alternative approach may be to...
employ more mental health practitioners in general hospitals and health centres. While psychiatric liaison teams are employed in general hospitals, these teams are often too small to offer anything more intensive than assessment or referral to other services. Expanding these teams would enable them to actively engage with patients throughout their hospital stay, providing opportunities to provide strategies and skills such as psycho-education and problem-solving skills, and posting that would empower patients to engage in strategies that may improve their mental health. Non-mental health trained staff could shadow these practitioners and use this as a learning opportunity for building and enhancing their psychological intervention skills.

Conclusion
The psychological needs of the physically ill are gaining more attention in policy, providing opportunities to provide strategies and skills such as psycho-education and problem-solving skills, and posting that would empower patients to engage in strategies that may improve their mental health. Non-mental health trained staff could shadow these practitioners and use this as a learning opportunity for building and enhancing their psychological intervention skills.

References