

Briefing

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What do we mean by 'psychosocial'?

A discussion paper on use of the concept within palliative care

The term psychosocial has played an important role in conveying the broad remit of palliative care and in ensuring that palliative care is not defined merely in terms of a concern with physical symptom management. It highlights the central importance of a broad set of inter-related psychological and social needs of people who are dying. However, psychological needs have received more attention than social needs and greater consideration of the latter is necessary. This might best be achieved by abandoning the use of the term 'psychosocial' and returning to the earlier four-fold specification of the remit of palliative care as encompassing physical, psychological, social and spiritual aspects.

Emphasising the psychological

The National Council's 1997 discussion paper on psychosocial care in specialist palliative care defines psychosocial care as 'concerned with the psychological and emotional well-being of the patient and their family/carers, including issues of self esteem, insight into an adaptation to the illness and its consequences, communication, social functioning and relationships'. It can be seen from this definition that psychosocial care encompasses a very broad range of factors. Although this may once have been desirable, it is now a major disadvantage and the psychological and social needs of dying people should be identified more precisely.

In practice, the term 'psychosocial' is usually interpreted in terms of the psychological needs of patients and, to a lesser extent, their families. This is very evident in the discussion paper's

answer to the question 'what is psychosocial care?' This identifies two elements:

- Psychological approaches are concerned with enabling patients and those close to them to express thoughts, feelings and concerns relating to illness.
- Psychosocial interventions are inventions by health professionals...using psychological methods, intended to improve the psychological and emotional well being of the patient and their family/carers.

The interventions listed are counselling and psychotherapy; behavioural and cognitive techniques, educational therapies such as training in coping skills; and psychosocial support to enhance well being, confidence and social functioning. It is only in the last category that any reference is made to social aspects. These are couched primarily within the essentially social psychological frame of 'mutual emotional support and the sharing of personal experience' and befriending or visiting schemes which are aimed at emotional support and companionship.

Re-emphasising the social

For palliative care to be fully effective its practitioners must recognise that for its clients the meaning, experience and expression of their terminal illness is shaped and influenced by the communities within which they live. The social fabric of their lives is central to how they make sense of their illness experiences, the meanings they draw upon to understand these, and the range of resources they can call upon to help them manage them. Section 3 of Council's

Occasional Paper 13, *Feeling Better: Psychosocial Care in Specialist Palliative Care*, makes direct reference to only the last of these elements, and then only in terms of 'help with shopping and other practical tasks'. The broader issues of social relationships, the influence of cultural beliefs and values and of family functioning are scarcely addressed.

There is now a clear recognition that palliative care services do not adequately reach disadvantaged sectors of our society. This failure seems in large part due to social and cultural factors, importantly including the ways in which palliative care services are provided within communities and to individuals and the extent to which they respond appropriately to their needs and values. Monitoring the performance of palliative care services in serving their local communities will require the routine collection of information about social factors such as place of residence, social status, ethnic background and religious affiliation. It will also require the development of clear definitions of quality standards for social aspects of care.

In practice the social aspects of palliative care are normally reduced to a focus upon the patient's family, and community influences are unlikely to be taken into account in any systematic way. Admission processes to Hospice services typically focus upon physical and psychological needs, with social and spiritual needs being attended to after the patient has been accepted into the service. The failure to enquire routinely about social needs on admission suggests to patients and their families that social needs are not important. This may inhibit patients and families raising such needs subsequently.

Unlike physical and psychological aspects of palliative care, there are less likely to be members of the multidisciplinary team who have specific responsibility for social aspects of care. Not all hospices and palliative care services have a social worker on the team, and where they do these may well be part-time and marginal to decision-making processes. Thus, the 'skill base' to deal effectively with social needs is not well established and palliative care services are less likely to contain members who have expert knowledge about how social organisations 'work' and what feasible action may be taken to address social issues. Yet dealing with social needs is neither clear cut nor easy, especially as this typically involves negotiating with a range of other agencies.

Summary and recommendations

- The current use of the term 'psychosocial' is primarily defined in terms of psychological aspects of care and thus deflects attention away from social aspects of patient and family experiences. *It is therefore recommended that the two terms 'psychological care' and 'social care' replace it.*
- The broad social contexts within which patients and families live their lives are significant features that need to be addressed in the care of people who are dying, yet many palliative care services do not contain members with expert knowledge of social care. *It is recommended that social workers should be included as core members of specialist palliative care teams.*
- To introduce a more sustained and thoroughgoing focus upon social aspects of palliative care will be difficult, especially in the absence of well-established protocols and examples of good practice. *It is recommended that criteria to judge good practice in social care be developed, initially through the collection, evaluation and dissemination of current good practices in social care.*
- Palliative care staff from the health professions may have difficulty identifying social needs. This may be partly the result of their education and training and partly due to the differing 'cultures of care' found in health and social service settings. Similarly, palliative care staff from social services backgrounds may have some difficulty working in health care settings. *It is recommended that joint training programmes for health and social services staff are developed to improve the co-ordination and appreciation of these differing knowledge bases and skills.*

We are grateful to Professor David Field, Professor of Sociology of Palliative Care, Centre for Cancer and Palliative Care Studies, The Institute of Cancer Research, London, for producing this *Briefing* on behalf of Council's Working Party on Quality Improvement in Palliative Care. This *Briefing* is for further discussion by the Working Party – please let us have your views on this very important area in palliative care.