

# Psychology

## for Health Professionals

2nd Edition

Patricia Barkway

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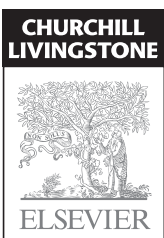
# Psychology

## for Health Professionals

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Second edition

**Patricia Barkway**



Sydney Edinburgh London New York Philadelphia St Louis Toronto

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# Foreword

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We are living in a time of rapid change in the way in which health and illness are understood and healthcare services are organised and provided. New treatments, better ways of providing health services, greater use of evidence to guide practice, the emergence of a health consumer movement – these trends and many others have had a significant impact on health policy and practice and on the education of health professionals. Such developments have undoubtedly made the complex business of healthcare even more complicated. If undergraduate students of medicine, midwifery, nursing, paramedic, psychology and the allied health professions are to be prepared for effective practice in the health services of the 21st century, careful thought needs to be given to what will be taught and how the learning material will be delivered. A judicious selection of topics, authors and learning/teaching approaches is evident in this compilation edited by Patricia Barkway.

The main purpose of the volume is to introduce psychology to undergraduate health professional readers. However, the text goes beyond what one would typically expect of an introductory psychology text and herein is its novelty and strength. The initial chapters provide a clear overview of theories of individual personality, human behaviour and lifespan development. This is followed by consideration of how health and health outcomes might be influenced by the complex interaction of biological, psychological and social factors, contextualising this in relation to key national and global concerns and priorities (Chapter 4). Chapter 5 crosses over into health sociology to examine the social context within which people live, work, maintain health or become unwell – the social determinants of health. If this is a departure for a psychology text, it is one to be applauded. Increasingly, healthcare is being seen as a shared responsibility involving health professionals from a range of disciplines, communities, families and individuals. Examining the personal alongside the social and individual troubles in the context of public issues will contextualise the learning for students and foster interdisciplinary consideration of encounters with consumers, models of care and communication between health professionals. This is at the leading edge of developments in health policy and practice and health professional education.

The chapter introducing health research (6) is primarily concerned with establishing the basics for becoming an effective consumer of research to guide practice: how to access and appraise the quality of research findings; approaches for systematically critiquing research reports; and the application of evidence-based findings to healthcare practice. The remaining chapters address the psychological and social aspects of a range of encounters, issues and interventions relevant to health professional students. Chapter 7 examines theories and models informing understandings of behaviour and techniques of health behaviour change. The role of communication problems in healthcare failures highlight the importance of the material covered in Chapter 8. The requirements for effective communication are examined in relation to cultural difference, power imbalances, advocacy and interpersonal relationships. The impact of information communication technology,

including social media, has made it even more important that health professionals are thoroughly grounded in the requirements for effective communication. The chapter on partnerships (9) raises a number of contemporary concerns arising out of the changing nature of encounters between health professionals and consumers. The very practical treatment of recovery-oriented practice provided is likely to demystify a concept that students and qualified practitioners understand to be important but often find elusive. The next three chapters, addressing stress and coping (10), loss (11) and pain (12), touch on topics of considerable relevance to all health professional students. The final chapter revisits much of the content of the previous chapters, demonstrating how health promotion has shifted over time from a largely individualised focus to also include the social determinants of health and a population focus.

The carefully selected combination of foundational and clinically relevant content delivered in a lucid and lively style, combined with a range of learning objectives, illustrative case studies, critical thinking prompts, classroom activities and extensive reference lists, will ensure the book has a shelf life extending well beyond the student years.

**Mike Hazelton**  
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Head of Nursing and Midwifery  
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# Preface

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The first edition of *Psychology for Health Professionals* was designed to introduce healthcare students to psychological and other theories to assist them in developing an understanding of the complex and interactive nature of the factors that influence health behaviours and health outcomes. In this second edition we have maintained the original focus while updating the materials with evidence-based research, references and clinical examples to ensure the content remains relevant to contemporary healthcare practice. Students can apply the material in the text to the health behaviours of the people they care for, their colleagues and themselves. It is written for, but is not limited to, undergraduate students of medicine, midwifery, nursing, paramedic, psychology, social work and the allied health professions.

Unlike many health psychology textbooks *Psychology for Health Professionals* examines individual personality and psychological theory within the social context of people's lives. This approach is taken because of the increasing awareness that a person's behaviour is not only influenced by internal biological and psychological factors but also by external factors within the person's social and physical environment. There is abundant evidence to support this hypothesis, for example, the report of the World Health Organization Commission of the Social Determinants of Health *Closing the gap in a generation: Health equity through action on the social determinants of health*. In keeping with a social determinants theme the book takes into account the social, political and cultural contexts of healthcare in Australia and New Zealand. Nevertheless, despite the theories and practices outlined in the book being situated in these two countries, they are also relevant to other countries and contexts.

The book also includes material that is not always found in undergraduate health psychology texts, such as an introduction to psychological theory and healthcare research. Furthermore, in order to reflect the current interdisciplinary focus of tertiary healthcare education and practice, contributors to the book were recruited from and represent a range of healthcare disciplines including psychology, nursing, sociology and physiotherapy. All contributors are currently engaged as health professionals or academics in their respective fields.

The first half of the book outlines psychological and other relevant theory and, in the second half, those theories are applied to health issues and healthcare practice.

Chapters 1–5 present psychological, lifespan and social theory; Chapter 6 addresses the role and contribution of research to healthcare practice; and Chapters 7–13 cover the psychological aspects of specific health encounters, issues and interventions. Throughout the book critical thinking questions, case studies and examples of research are included to encourage students to reflect on the application of theory to practice. Activities are provided for lecturers to use in the classroom.

*Psychology for Health Professionals* is intended to assist future health professionals to understand the diversity of human responses, particularly in relation to health behaviours, and to develop the knowledge, skills and disposition required to care for the patients and clients they will encounter in their chosen career. I trust that readers will find the content to be engaging, interesting and professionally relevant.

Pat Barkway  
May 2013

# Chapter 9

## Partnerships in health

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DEB O'KANE

### Learning objectives

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The material in this chapter will help you to:

- understand the dynamics of health professional–client partnerships
- understand the issues in client engagement with treatment
- appreciate the importance of involving clients in their own care
- gain insight into differences in treatment expectations between health professionals from different cultural backgrounds
- understand how effective partnerships impact on working with people who have chronic illness, disability or complex health issues
- appreciate the interplay between clients' and health professionals' attitudes and backgrounds in the clinical setting and the influence of these and environmental factors on successful treatment outcomes.

### Key terms

- Partnership
- Compliance, concordance and adherence
- Client-centred practice
- Empathy
- Recovery
- Biomedical
- Chronic illness
- Health locus of control
- Collaborative practice



## Introduction

The title of this chapter takes for granted the fact that the health professional–client relationship requires involvement of at least two people. Those two people may encounter each other in a variety of settings: in a busy acute surgical ward; in an outpatient or emergency department; in the client's own home or practice rooms; in a community health centre; or in an ambulance to give only some examples. Whatever the setting, something is happening: an encounter between two human beings, both with varying agendas, needs, attitudes and feelings.

As already discussed in Chapter 8, communication is essential to establish and maintain personal and professional relationships, from our own family and friends to the colleagues we work with or clients and families in our care. In clinical practice, it remains the responsibility of health professionals to initiate and maintain a working relationship with their clients and team members. This may prove to be easy or challenging. Not all clients are good communicators and some may exhibit challenging behaviours. However, whatever the client's personal qualities are, it is important to think about how you approach interactions with clients and what your own motivations and goals are. These are factors health professionals have control of and are responsible for.

Person-centred communication goes some way to thinking about how an alliance can be established with the people we work with and care for, but as well as being a relationship between two people, the relationship also needs to be seen as a partnership. The term partnership in healthcare is often used to reinforce the concept of a relationship where health professionals and clients both share some degree of responsibility for the treatment decisions, implementation and outcomes. However, partnerships similarly can occur across multiple sectors and include a variety of people, disciplines and organisations, all with a clear purpose or goal in mind. A partnership such as this brings together a diverse range of skills and resources, offering more opportunities to impact on health issues such as chronic illness, health prevention, health promotion and education. The following considers some of the implications in such partnerships.

## Fostering partnerships

It is first beneficial to examine the language used for the people being cared for within a healthcare setting as this demonstrates how language and the power of language can influence partnerships. Historically when someone is a recipient of a health service, whether in the public or private sector, inpatient or community, they are generally known as a 'patient'. However, recently a wider variety of terms have been used in various fields of healthcare such as 'client', 'service user' or 'consumer', with the aim of trying to identify and express the relationship between the parties involved. Rusch et al (2005) argue that it is an innate human quality to place labels on people, not only in healthcare but to a population at large if there are easily recognisable traits, behaviours or characteristics to distinguish particular groups of people such as skin colour or clothes that identify someone's affinity with a particular

music style. The term or label we use to describe a person can invoke different perceptions, attitudes and behaviours towards that person.

While labels can serve a purpose when they provide us with generic information about a person or population, such as people with chronic fatigue syndrome, labels are problematic when they are used to stereotype people such as 'frequent flyers' or 'drug addict'. The label is very powerful in that the use of one word can not only identify the recipient of care but also the relationship and possible power dynamics (McLaughlin 2009). Language influences the very nature of how health professionals establish and maintain a professional relationship due to the assumptions we make from the terms we use (McDonald 2006). For example, the different terms used over a number of years to refer to people who receive mental healthcare has long been in the literature, with little agreement on the particular term used nationally or internationally. Australians tend to use the term 'consumer' while Britons use the term 'service user'. Each term, though different, has the same underlying value; that is, for the person to feel empowered rather than stigmatised and to ultimately have an impact on care delivery.

## PERCEPTION IS REALITY

On a similar note, how a health professional describes a person's contribution to their own health needs can affect how people perceive that person. Much of the literature concerned with health professional–client communication issues focuses on getting the client to cooperate with the health professional's treatment goals or compliance (Zolnieriek & Dimatteo 2009). The word compliance seems to be used without consideration of how it might shape health professionals' attitudes to relationships with clients. If an individual is not willing or able to do what is requested of them at a particular time, they may be described, both verbally and in their client records, as noncompliant. The problem with this is that such a descriptor can frequently be taken up by other healthcare team workers, often without any thought or questioning of its origins.

The danger is the strong possibility that a client may then be perceived as such for the rest of their treatment history. It can then become a self-fulfilling prophecy, where other health professionals expect a person to have a particular attitude to treatment and relate to them in such a way that leads the client to demonstrate that attitude. Possibly, some health professionals may describe a client as noncompliant because they present a challenge of some sort, usually to do with not wishing to accept a particular form of treatment that has been prescribed for them. Sometimes it might be as straightforward as the client having very little English and not understanding what the health professional is expecting of them; it may be a well-educated person who simply questions what is being done to them; or it might also be a client who refuses to accept any kind of treatment.

## TERMINOLOGY

The term *compliance* itself has been criticised because of its paternalistic or even coercive implication that all medical advice or treatments should be followed without question. Often health professionals can be quick to assume a client is being uncooperative or disobedient if they choose not to follow the recommended

treatment regimen (Horne et al 2005, Horne 2006). This noncompliance, however, may at times be unintentional such as a person with significant memory problems who frequently forgets to take their medication or it may be as simple as a person being unable to afford the prescribed treatments. On the other hand, the client may intentionally be noncompliant due to their health beliefs or concerns about side effects, for example, a client who decides to stop taking their steroid medication due to weight gain.

An alternative term *adherence* has since been introduced into the healthcare literature, aiming to signify a stronger implication of choice by a client, that is, having the opportunity to decide whether to adhere to the recommended treatment or advice. However, it is debatable as to whether this is an improvement; for instance, adherence also has the implication of following rules or direction. Both compliance and adherence focus on the client's behaviour in following treatment regimens, whereas in the United Kingdom, the term *concordance* has recently been used with the purpose of defining the relationship, rather than the behaviour between a health professional and a client. It is based on collaboration and respect for each other's contributions (Horne 2006). Despite the various labels, it could be argued that it is better for none of them to be used, but instead to simply describe the client's behaviour as part of a partnership between a health professional and a recipient of care, with the emphasis on the engagement process.

## Person-centred practice

Person-centred practice (PCP) is not a new concept and though significantly different to the health-professional-led biomedical model, it has been in the literature for many years exerting significant influence on policy, practice and delivery of care. Definitions vary between identifying the elements needed for individualised client care, while others look at it from an organisational perspective in order to provide best possible care. Either way at the heart of PCP is the person receiving care. It provides a model of care based on mutually beneficial partnerships among healthcare providers, clients and families, and is the foundation from which patient-centred communication stems (Ch 8). In PCP attention is paid to all elements of the person (the 'whole'), taking into account the wider context of the person's lifestyle such as those social, environmental and psychological factors that may contribute to the assessment and management of the health issue. Collaboration, therapeutic alliance, sharing power and responsibility for decision making, and the freedom of choice and autonomy, become central to the delivery of care (Department of Human Services 2006, 2008) and require commitment and considerable effort on the part of health professionals and organisations. In Australia and New Zealand many healthcare organisations have started to encourage clients, particularly those with a chronic illness, to adopt personalised care plans or self-management plans. These offer an opportunity for health professionals to collaborate with clients and develop a formal written record that respects the client's opinions in relation to their care so that control and ownership is held by the client rather than the professional.

A successful partnership between a health professional and client can go a long way to achieve PCP yet several barriers are often cited as reasons for being unable to establish the partnership or deliver PCP. The literature shows time constraints, lack of

resources, differing agendas, organisational constraints and a belief they 'know best' as reasons for health professionals being unable to deliver PCP (Rabinowitz et al 2004, van Weel-Baumgarten 2010). Although some of these may seem inevitable, particularly in light of the increasing pressure to undertake the growing number of tasks, paperwork and staff shortages, you need to question if this is truly saving time and money in the longer term when evidence suggests there is a negative impact on the health outcomes including engagement in treatment regimens, pain management and client and carer satisfaction (Venetis et al 2009). While acknowledging these barriers, as a health professional there are several features of establishing a partnership that can be undertaken in practice to support PCP. McCormack (2001) identifies these as:

- getting close to the person
- providing care that is consistent with the person's values
- taking a biographical approach to assessment
- focusing on ability rather than dependency.

### CASE STUDY: PATRICK

Patrick is a 19-year-old male who has recently been diagnosed with schizophrenia after a short period of hospitalisation for an acute psychotic episode. One nurse has informed him that it is highly likely he will need to take neuroleptic medications for the rest of his life. This has greatly upset him because he has found he has an increased appetite and therefore put on weight as a side effect of the medication. He describes feeling helpless and unable to see a future while living with his illness. His weight is a major issue for him because he believes it will reduce his chances of finding employment in the hospitality industry and affect his chances of finding a girlfriend.

### Classroom activity

In small groups discuss:

1. As a health professional listening to Patrick, how would you respond?
2. What could you do to demonstrate PCP?
3. How could the core principles of recovery-oriented care (see below) be applied to this situation?

## Recovery

As healthcare moves away from an exclusive biomedical-focused model, and embraces psychosocial aspects of care, healthcare services similarly have begun the process of examining how they deliver fundamental services. Parallel with the PCP

philosophy of care is the concept of a recovery-oriented health system, which can have major implications on care delivery.

The concept of 'recovery' in health usually has an emphasis on regaining or restoring something that has been lost. For example, we often describe people as recovered after a bout of illness, implying they have regained their full strength and returned to the state of being healthy once more. But this is a limited understanding. What happens to the person who as a consequence of trauma loses a limb or the person who is diagnosed with type 1 diabetes? Some of these issues have already been discussed in previous chapters when exploring the concept of 'health', and whether people who have not returned to a previous health status are now not 'healthy'? For each individual, recovery will be a different personal experience. If we accept there are other dimensions of health then the notion of recovery likewise should support internal and external factors that may contribute to a person's journey of recovery.

Since the 1980s when people with a lived experience of mental illness began to challenge the biomedical driven model of care, the concept of recovery-oriented health has grown remarkably to the point that it now guides and underpins all mental health reform in policy and practice (Commonwealth of Australia 2009, New Zealand Ministry of Health 2005, Shepherd et al 2008). In the mental health context recovery refers to a person being able to live a full and meaningful life, despite having an ongoing mental illness. It embraces notions of hope and setting goals for the future – not just symptom management. For health professionals, working in a recovery framework involves not just working with a consumer to manage the symptoms of their mental illness, but also working with the person to enable them to live a fulfilling life (Muir-Cochrane et al 2010). However, it should not be thought of as a philosophy of care for mental health practice only. The guiding principles of recovery-oriented healthcare are universal and can be applied to a range of healthcare settings, particularly in chronic illness where the person plays a significant role in managing their illness.

## RECOVERY PRINCIPLES

The principles of recovery in healthcare are not difficult to understand, though the reality of its implementation may prove more difficult in a biomedically driven healthcare system. The philosophy of recovery encompasses a range of factors that require individual, organisational and systematic change. Therefore, rather than a model in its own right, recovery should be seen as a flexible process or framework to guide health professionals in their practice. While recovery from illness and/or disability continues to be perceived as synonymous with cure or symptom relief, then those elements that also contribute to a person's health, including personal, social, vocational, family and education, become largely ignored. These elements, alongside others such as service provision, access/funding, human rights and social inclusion, can all have an impact or be affected as a consequence of illness or poor health. It is therefore important that they are not pushed aside when we consider a person's journey to recovery. Collectively, these factors constitute an individual's 'lived experience' of recovery and are the foundation to guide health professionals in delivering care to support someone to understand and come to terms with their illness. People who have experienced chronic mental illness often describe their

recovery in terms of having the ability to live a satisfying and meaningful life despite their serious illness or the lasting effects the illness may have on them.

## RECOVERY-ORIENTED PRINCIPLES

The past decade has seen a growing international body of literature from researchers, service providers, clinicians and service users that has developed, refined and operationalised the concept of recovery-oriented healthcare in an attempt to find commonalities that can be used to facilitate and promote recovery-oriented care in different healthcare systems. In terms of what can be done as a health professional, if the aim of recovery is for people with chronic illness or disability to develop new meaning and purpose in their lives, not just the alleviation of symptoms, then it is up to health professionals to assist in this process by developing and maintaining a collaborative partnership not just with the identified client. Family, carers, teams or agencies may need to be involved in different aspects of care and resource provision. From listening to people's stories of how they accepted and overcame the challenges of their illness or disability, several key facilitators have been identified as underpinning the philosophy of recovery and supporting clients in their journey. These include taking control of one's life through hope, empowerment, support, education, medication management, spirituality, choice, advocacy and autonomy to name a few (Davidson 2008, Deegan 1996, Mental Health Coordinating Council 2008, Roberts & Wolfson 2004, Shepherd et al 2008). Health professionals can work towards supporting a person with their health issue by helping them identify their strengths and the protective factors that promote recovery rather than focus on the changes, limitations and losses that may have occurred as a result of the illness or disability.

Shepherd (2007) provides '10 top tips' for recovery-oriented practice in mental health that could easily be applied in other healthcare settings. See Box 9.1 for how Shepherd's tips can be applied to general health issues.

Adapted from Shepherd G. 2007 Specification for a comprehensive 'Rehabilitation and Recovery' service in Herefordshire. Hereford PCT Mental Health Services. Available at [www.herefordshire.nhs.uk](http://www.herefordshire.nhs.uk) (last accessed 10th January, 2012).

### Box 9.1 '10 top tips' for recovery-oriented practice

After each interaction, the health professional should ask, did I...?

1. Actively listen to help the person to make sense of their health problems?
2. Help the person identify and prioritise their personal goals for recovery – not professional goals?
3. Demonstrate a belief in the person's existing strengths and resources in relation to the pursuit of these goals?
4. Identify stories of individuals' experiences of illness, which inspire and validate hope? (be aware, though, of confidentiality when telling another client's story and, if you recount a story of your own, be mindful of whose interests are served in telling the story i.e. the client's not your own).

Cont... ▶



5. Pay particular attention to the importance of goals that take the person out of the 'sick role' and enable them to actively contribute to the lives of others?
6. Identify non-health resources – friends, contacts, organisations – relevant to the achievement of their goals?
7. Encourage self-management of health problems (by providing information, reinforcing existing coping strategies, etc)?
8. Discuss what the person wants in terms of therapeutic interventions such as biomedical and psychological treatments, alternative therapies and joint crisis planning, respecting their wishes wherever possible?
9. Behave at all times so as to convey an attitude of respect for the person and a desire for an equal partnership in working together, indicating a willingness to 'go the extra mile'?
10. While accepting that the future is uncertain and setbacks will happen, continue to express support for the possibility of achieving these self-defined goals – maintaining hope and positive expectations?

Table 9.1 illustrates the many similarities between the philosophy of recovery and that of PCP. Ultimately the partnership established between the person receiving a healthcare service and the health professional delivering it is based on the premise that the recipient of care knows themselves better than anyone else and hence is an 'expert by experience' (Roberts & Wolfson 2004). The health professional while acknowledging and valuing the person's contributions, can offer advice and guidance via their own knowledge and experience gained through professional training to help support the person in managing their own healthcare needs (Roberts & Wolfson 2004).

If you think about the role of a health professional working with someone who has type 1 diabetes, the partnership would incorporate advice on exercise, dietary intake, medication management/administration, support groups and education regarding risk factors related to the illness. However, you need to remember that not everybody will require the same amount of support and guidance; for instance, a 19-year-old newly diagnosed person with diabetes may want very different things from the partnership compared with a 55-year-old who has managed their diabetes over a number of years. The partnership, therefore, initially needs to establish the goals for each party through an open and trustworthy relationship based on transparency and respect for each other's contributions.

## Chronic illness, disability and complex health issues

Chronic illness has become a leading cause for concern worldwide, accounting for 60% of deaths, particularly in low-middle income countries (World Health Organization (WHO) 2011). Marmot and Wilkinson (2006) note several underlying risk factors such as poverty and inequality, poor nutrition, inadequate environmental health conditions, physical inactivity, alcohol misuse and tobacco smoking that are

**Table 9.1****COMPARABLE PRINCIPLES IN RECOVERY-ORIENTED PRACTICE AND PERSON-CENTRED CARE**

<b>Recovery-oriented practice</b>	<b>Person-centred care</b>
Recovery is fundamentally about a set of values related to human living applied to the pursuit of health and wellness.	A value base that asserts the absolute value of all human lives regardless of age or cognitive ability.
The helping relationship between clinicians and clients moves away from being expert–patient to clinicians being ‘coaches’ or ‘partners’ on an individual’s journey of discovery.	The need to move beyond a focus on technical competence and to engage in authentic humanistic caring practices that embrace all forms of knowing and acting, to promote choice and partnership in care decision making.
Recovery is closely associated with social inclusion and being able to take on meaningful and satisfying roles in society.	Provides an enriched environment that can foster opportunities for personal growth.
People do not recover in isolation. Family and other supporters are often crucial to recovery and should be included as partners wherever possible.	Recognises that all human life is grounded in relationships.
Recovery approaches give positive value to cultural, religious, sexual and other forms of diversity as resources and supports for wellbeing and identity.	An individualised approach – valuing uniqueness. Accepting differences in culture, gender, temperament, lifestyle, outlook, beliefs, values, commitments, taste and interests.

From Hill L, Roberts G, Wildgoose J, Perkins R & Hahn S 2010 Recovery and person-centred care in dementia: common purpose, common practice? *Advances in psychiatric treatment* Vol. 16, p.288–298

**Classroom activity**

In small groups:

- Using the 10 top tips identified by Shepherd (2007), identify other areas of healthcare practice in which tips could be utilised when working with a client diagnosed with:
  - juvenile arthritis
  - chronic obstructive pulmonary disease (COPD)
  - Alzheimer’s disease
  - type 2 diabetes mellitus
  - motor neurone disease.
- How would the client benefit?
- How do you foresee yourself using these tips in daily practise?



common throughout the world. Such lifestyle-related risk factors can greatly contribute to the poor outcome of chronic illness and to the overall burden of chronic disease in today's society.

The costs of delivering healthcare for health problems that are often preventable is making the issue a forerunner in debate, policy and practice. With a predicted ageing population, a decrease in mortality and advanced practice regimens extending life expectancy (Australian Institute of Health and Welfare (AIHW) 2011) there seems little expectation that things will change, particularly in light of costs expected to continue rising and concern about how healthcare services will manage these escalating figures.

Chronic illness remains complex and difficult to define though commonly refers to any illness or disability that a person may endure permanently or over a prolonged period of time. There is a significant number of conditions that can be termed chronic, with coronary heart disease, stroke, lung cancer, colorectal cancer, depression, type 2 diabetes, arthritis, osteoporosis, asthma, COPD, chronic kidney disease and oral disease identified as major concerns for the Australian healthcare system (National Health Priority Action Council 2006). Other conditions include epilepsy, fibromyalgia, other cancers, chronic fatigue syndrome, hypertension and multiple sclerosis. Some chronic conditions deteriorate over time (e.g. Alzheimer's disease), while others such as cancer may have periods of remission. It may be that some people make a complete recovery where as for others death is an inevitable outcome. The AIHW (2011) characterises a chronic illness by the following:

- complex causality
- multiple risk factors
- long latency periods
- a prolonged course of illness
- functional impairment or disability (AIHW 2011).

In any of these given situations it can be true to say having a chronic illness will certainly have a lasting effect on the person's quality of life, affecting the emotional, physical, psychological and behavioural aspects of their daily living.

In health psychology, understanding how the biological, behavioural and social factors can influence chronic illness allows us to explore the human dimension of how a person lives with the chronic health issue and how this may influence their health behaviour and the behaviour of those around them. Larson (2011) describes this as how the illness is 'perceived, lived with and responded to by others'. She goes on to say that as health professionals, you shouldn't necessarily think about disability only in terms of severity or physical deterioration but to also think about disability and how it can be affected due to an individual's perception of the illness. The implications of how much a person's lifestyle is altered are very much related to their own understanding and health beliefs about the onset of the illness, its treatment and the outcomes (Larson 2011). As already identified there are numerous biological, psychological, social and environmental risks associated with chronic illness, but with the appropriate behavioural strategies implemented prior to the onset of problems being evident, these illnesses can be prevented. Areas to be targeted in health promotion, prevention and education include exercise, nutrition,

cessation of smoking and alcohol moderation to name a few (see also Ch 13). Alongside these preventative support mechanisms the access to resources also needs to be improved if we hope to see any tangible long-term impact of enhancing a person's health and reducing the pressure on the health system.

## Factors influencing partnerships

People with an existing chronic illness or disability can offer valuable insights into how the illness has affected them and how they best manage their health issue; therefore, as part of a partnership it is important to listen to the person as an expert in their own healthcare. That being said there are a variety of reasons why at least 50% of clients do not carry through with treatment prescribed for them. These include: side effects and costs; treatment difficulties; fatalism or resistance to control; forgetting to take medication; and little external support (Coulter 2011). For example, when the symptoms begin to subside they may see no need to complete their medication, or they cease because there may be no sign of improvement; they may decide that if a little works then a lot will be even better; or if suffering from a chronic illness, a client may tire of taking medication or other treatment. Sometimes when the client refuses, health professionals may see him or her as a problem client (i.e. someone who does not passively accept treatment), as uncooperative or constantly complaining, perceiving the client negatively without attempting to understand why it is happening by listening to the person's expertise in their own lived experience of the chronic illness. Horne (2006) suggests there is no such thing as a non-adherent client and that we have all been non-adherent at some point in our lives. Health professionals should therefore refrain from attempting to identify such people on factors such as behaviour, sociodemographics and dispositional characteristics but rather focus time and energy on understanding the person and their health issue.

## Challenges for health professionals

A shared knowledge base and expertise developed by various client interest groups is a natural outcome of the accessibility of information on the internet and the empowerment of people with a disability or chronic illness. Following an internet community of individuals suffering from fibromyalgia, Barker (2008), a Canadian researcher, observed how members empowered each other and shared knowledge and research findings to not only validate the disorder but also to challenge the expertise of clinicians and seek out sympathetic health professionals to educate other practitioners who had less knowledge of the disorder than group members.

Furthermore, health professionals who aim to support and empower their clients may find that not all clients will necessarily follow the advice and direction they are given. Sometimes, too, health professionals will be working with people who are more knowledgeable about the health condition than they are. Such clients may contest the health professional's directions and decisions, and use a valid evidence base to support their viewpoint, which can be challenging, even threatening to the health professional. This, of course, must be balanced with the fact that not all information on the internet is reliable and people may have completely inaccurate, false information about their illness from reading various websites. Either way,

patience is often required on the part of health professionals to listen and ensure clients understand all available information. It may be that further questioning is needed to address the concerns or decide on the best treatment options. It may also be necessary to offer the client an opportunity to see another health professional.

## HEALTH PROFESSIONALS FROM A DIFFERENT CULTURE

Aspects of cultural safety and how to communicate with clients from various cultures have been explored in Chapter 8. We will now look at working with a health professional from another culture and how this may affect partnerships of care. As the healthcare workforce continues to become multicultural in nature, expectations about the client and the different roles and responsibilities of each team member may be quite different to the usual Western individualist tradition for some healthcare graduates from non-Western collectivist cultures.

What constitutes a partnership and the attitudes a health professional has about this health professional–client partnership can be very different from the client’s perspective, particularly if there was an emphasis on a biomedical approach with little focus on the psychosocial aspects of treatment in a health professional’s education. For instance, some cultures differ on the client’s entitlement to consent to treatment or believe that the family should be responsible for any decisions about an individual’s healthcare rather than advocating for client autonomy to be the main priority (Fogarty 2012). In other cultures, it is not acceptable for a health professional to challenge or confront a doctor’s decision-making process but instead unquestioningly agree with all given medical directives (Meeuwesen et al 2009). Australian research has found it is frequently a culture shock for non-Western healthcare workers to encounter such differences and so do nothing to embrace the partnership model and true shared care in practice (Meeuwesen et al 2009). To overcome potential issues and maintain partnerships with other work colleagues, clients and carers, workplaces can offer acculturation programs to support the international workforce. Such programs can address concerns, reduce misunderstandings and identify and/or resolve potential cross-cultural issues. What may be required is not simply assistance with the English language and its colloquialisms, but how to relate to clients from another culture (Woodward-Kron et al 2007).

## Making decisions about one’s own health

Becker and Rosenstock’s (1984) work that resulted in the health belief model (HBM) (see Ch 7) was concerned with how people make decisions about their health. They concluded that a person’s motivation to engage in healthy behaviours depended on how severe they saw their problem to be, how susceptible they perceived themselves to be and whether they believed that making a change would make a difference to their health. Over time the HBM was developed and extended by social psychologists seeking to promote better preventive health (Janz & Becker 1984, Rosenstock 1974). It is still a commonly used model of health behaviour change and has been used in measuring individuals’ likelihood of changing their health behaviours (Caltabiano & Sarafino 2007). Its basis is that preventive health behaviour in an individual is

influenced by five factors: (1) any barriers they perceive to carrying out a particular response; (2) perceived benefits of performing the recommended response; (3) their perceived susceptibility to a health threat; (4) perceived severity of a health threat; and (5) cues to the person taking action in response (Becker & Rosenstock 1984). So it follows that it is what the client thinks is important in influencing their decision regarding the health behaviour (see also Ch 7).

The HBM raises the important question of how much health professionals should honestly and carefully explain to clients about their health status. It also implies the importance of having to consider the individual's capacity and ability to cope with these facts, understand them and to then act on them. This can often be an issue. It is important, therefore, for health professionals to attempt to engage clients in a working partnership, or alliance, while also recognising that this may at times be a challenge, due to the client having a variety of reasons for not wishing, or being able, to cooperate. Such factors include: not experiencing a significant degree of distress from the illness; not accepting the fact of being ill; having poor communication skills; the regimen of treatment being too complex; feeling embarrassed about the treatment; possible side effects; and the possible gains from being seen as ill (Coulter 2011). All of this reinforces the need for good communication skills, easy-to-comprehend treatment plans with clear instructions emphasising the positive gains of following treatment and, following from this, the client experiencing treatment successes. However, there will be times when communication may not be successful. For example, even given the best health professional communicator, the client may not possess adequate communication skills her/himself.

## THE HEALTH PROFESSIONAL'S ROLE

In spite of the above challenges, it still remains for health professionals to aim at working successfully with their clients. Viewing treatment as a partnership rather than a battle of wills or a procedure to be done is one way to achieve collaboration. It should be seen as entering into interactions with clients with the goal of seeking to form a working alliance. While bearing in mind an individual's diagnosis and treatment plan, it is important to keep in mind the following: What are the client's needs here and now? How may they be assisted in making informed decisions about their treatment? How could their needs be incorporated into a treatment plan?

Many health professionals, however, still do not follow this approach. Unfortunately, the healthcare service industry is still largely based on medical diagnosis and treatment of disorders, rather than the client (Lyons & Chamberlain 2006). In spite of this *medically driven* model still being common, research now seems quite conclusive that, where health professionals use a *patient-based* approach to care rather than a diagnosis basis, clients are more likely to cooperate in their care (Coulter 2011). Caltabiano and Sarafino (2007) believe there is a danger in making health professionals totally responsible for the interaction, in that it may make the client seem to occupy the passive role and not able to be responsible. However, it is true that how a health professional responds to a client can influence the interaction, even though all clients should be treated equally, whether liked or not (Lyons & Chamberlain 2006).

## 'UNCOOPERATIVE' CLIENTS

All of the above is not to deny the existence of individual clients who do not cooperate with any form of treatment regimen, no matter how much a health professional attempts to explore their reasons and to empathise with them. Not all clients desire to be active in their treatment and some may simply require the health professional to make them better, with no ability or motivation to change behaviours that are harmful to their health. Others have no desire to improve their health status (Taylor 2006). Some may have previously been treated by health professionals who did not explain about their condition or who did not emphasise a working alliance with them, or were disinterested or even rude to them. Some clients may be actively antagonistic to accepting treatment that the evidence has shown is best for them (Lyons & Chamberlain 2006). It can sometimes require a great deal of explanation and education to enlist the client's cooperation (Downie et al 2003, Falvo 2011). Even then a health professional may not succeed with gaining the cooperation of a client.

## Beliefs and perceptions

At this point it may be worth thinking about how a person's belief system may influence their behaviour in developing partnerships with health professionals. As already discussed in Chapter 7, how a person perceives illness and health will affect their ability to cope and manage their own health behaviour, therefore one model worth exploring further is the health locus of control (HLOC). This model allows us to examine a person's perception of how much degree of control they possess over their personal health, which in turn affects their behaviour, beliefs and attitudes towards their health. Though Julian Rotter originally developed the social learning theory of locus of control in the 1950s, it was the 1970s that saw the concept being developed significantly in healthcare practice, with various tools emerging that had been specifically designed to measure a person's HLOC in areas such as drug dependency, mental health and chronic pain (Wallston et al 1976).

HLOC is concerned with how much a person believes their health is controlled by internal factors or external factors. For instance, if a person believes their personal health is the result of their own behaviour and sees themselves as having control of their lives, internal factors are said to be at play. On the other hand an external explanation results when the person believes their personal health is controlled by other causes such as health professionals, social forces or even plain luck. Recent research, such as Baker et al (2008), Knappe and Pinquart (2009) or Cavaiola and Strohmetz (2010), demonstrates that assessing a person's perception of control over their health helps to better understand their engagement in healthcare practice. The higher a person's internal HLOC, the more likely they are to see themselves as able to manage their own health and bring about change independently, whereas those with a lower internal HLOC see themselves as powerless to bring about any change, believing their health is being influenced by things beyond their control (Wallston et al 1976).

Whatever model is used, the importance of a person being assisted to make an informed decision and take as much responsibility as possible for their own health



reinforces the concept of the client as an active participant in the healthcare team. This is now an accepted aspect of most health service policies.

A rather different way of seeing the issue of client engagement argues that not engaging in treatment may sometimes seem like the sensible thing to the client, that is, it is a rational decision. When looking at the HBM (Becker & Rosenstock 1984), the client may not, for instance, believe that what the doctor has suggested is in their best interest and have what they see as a reasonable explanation for their belief. This is called *rational or intentional non-adherence* (Lehane & McCarthy 2007). The main reasons for rational non-adherence are side effects that are worrying, unpleasant or reduce the quality of life, practical barriers such as cost or changes to lifestyle and confusion about when and how much of the treatment to take. Others may choose not to accept treatment on philosophical, religious or cultural grounds.

### Critical thinking

- Reflect on a time when you have been prescribed medication or some other treatment. Did you remember all the health professional's instructions? Did you do everything the health professional told you to do? If you didn't, what were your reasons?
- Following from this, imagine if you were concerned about a client of yours. How would you attempt to ensure they followed the treatment that was ordered for them? If you looked at it from their point of view, could there be possible reasons for their attitude and behaviour?
- Thinking about the concept of HLOC, what internal and external factors may impact on a client who has decided to not accept treatment? How might you as a health professional attempt to engage with them?

## The context of the health professional-client partnership

It follows from the preceding discussion that another factor to be considered is the treatment context (Lyons & Chamberlain 2006). Usually most health professionals are employees of a health service or organisation. It is possible that an employer may disagree with your values or that their actions contrast with their stated policy. Words spoken and printed claiming that holistic, person-centred care will be provided may not, unfortunately, always fit with actual practice. A service may state that these concerns underpin their provision of care but there might not be adequate funding or facilities for such quality of care to be provided. There is a danger that services and health professionals can be consumed with more efficient, quicker, more economical approaches to treating clients and lose sight of the person. Diagnostic-related categories and treatment/care plans, where interventions are planned according to type and length of treatment usually required for a particular disorder, are useful to assist the efficient management of care in health agencies. But the risk is of quality of care being dependent on a budget that emphasises numbers of clients treated rather than the quality of care delivered.

So, given the above, how should a healthcare student or recent graduate approach their professional practise? It can be somewhat disillusioning for people who have a passion for helping others to encounter colleagues who are cynical or seem to lack any ability to care for their clients. In spite of these problems, there are many individual health professionals and agencies that are genuinely committed to the importance of PCP and building partnerships. It is therefore important for individual health professionals to consider what they believe about the helping relationship and how they wish to practise their profession. As you begin to practise your profession, you will begin to discover the challenges and rewards of helping people in a variety of situations.

### CASE STUDY: SYLVIA

Sylvia is an 80-year-old widow who is soon to be discharged from hospital after a recent hip replacement operation. She lives alone and has no family members living in the local area. She was previously living independently but will require some short-term support for the first few weeks after discharge. Sylvia is frightened that a decision will be made to place her in a residential nursing home.

### Critical thinking

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You are the health professional who is responsible for Sylvia's discharge planning.

- What support do you think Sylvia will need?
- Who do you need to establish a partnership with? Provide your rationale for this.
- How will you establish and maintain the partnerships?
- What do you foresee your role to be as a health professional?
- What obstacles do you think may prevent the partnerships being effective? How would you overcome these?

## Partnerships and collaborative practice

The chapter has largely focused on the partnership between two key parties, the client and the health professional, yet for effective and quality care to be delivered health professionals are often not working alone. Person-centred care packages for people with chronic or complex issues will need to rely on other disciplines, services and organisations to play a vital role in the care delivery if they are to achieve optimal healthcare that allows the person to function to the best of their ability. With this in mind, partnerships need to be initiated and sustained with people other than the

client at the centre of care. Essential to an effective partnership with others is the skill of working in a cooperative and integrated way through professional collaboration in a multidisciplinary healthcare team.

Health professionals who work with others in an open and honest manner with the goal of providing care directly related to the client's needs may not always achieve the intended outcome. Evidence has shown several barriers that hinder interdisciplinary partnerships, with the most common being miscommunication and misunderstanding of each other's role and responsibility. Others include lack of trust, rivalry, stereotyping of professionals, conflicting opinions and role insecurity (Freshman et al 2010). Partnerships that promote collaborative care require time and effort by all key parties. It may be that, as a health professional, terms commonly used in one service are unfamiliar or are misunderstood due to the same word being used in a different way in another service. In this situation as in all situations when working with other professionals, clarification needs to be sought so that mutual understanding can occur just as each key player in the partnership needs to clarify their role and what they perceive their responsibility in the care package to be. Clear direction of who will do what task, expectations of each other, time management, and the overarching aim of the care package, if communicated clearly to all parties will go some way to avoid the previously mentioned barriers. Recent evidence from WHO suggests that one way of achieving effective partnerships and collaborative practice is by delivering interprofessional education. By different professionals learning together, they are able to learn 'from and about each other' (WHO 2010 p 7); this, in turn, will enhance their partnerships in practice, leading to improved health outcomes for the person at the centre of care.

## Conclusion

The chapter has considered the various issues involved in relationships between health professionals, clients and others. Successful health outcomes depend on the key people involved in care, including health professionals, families, carers and communities working together to create an effective partnership. We discussed the meanings and implications in the terms health professionals use on a daily basis and the importance of the client being involved in their own care based on the philosophy of person-centred practice and recovery-oriented care, particularly in chronic and complex health issues. Cultural differences may cause challenges, misunderstandings or negative reactions between health professionals and clients. Similarly, creating partnerships with other disciplines can bring a different set of challenges. An understanding of the factors involved in healthcare partnerships helps identify possibilities health professionals can utilise to create and maintain effective partnerships throughout their career.

### REMEMBER

- Successful health outcomes require a partnership between health professionals and clients.

Cont... ▶



- Terms such as compliance/adherence versus partnership, and patient/client versus consumer/service user impact differently on the health partnership relationship.
- A partnership approach enables a person to be involved in their own healthcare. This can be achieved by embracing philosophies such as person-centred and recovery-oriented practice.
- Clients may not always 'comply' with or accept the advice of a health professional.
- Cultural differences may influence the success or otherwise of health professional–client interactions.
- Factors in the healthcare agency may raise challenges in establishing effective partnerships.

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## Weblinks

### AlignMap

<http://alignmap.com/the-state-of-the-art/the-verdict/>

Compliance (adherence) is considered on this site, pooling a variety of research findings that question the effectiveness of strategies suggested to increase adherence by patients. It also asks if many health professionals even consider it as an issue in their clinical work.

### Health issues centre – patient-centred care

<http://www.healthissuescentre.org.au/subjects/list-library-subject.html?subject=35>

This site is a resource library with publications and presentations linked to patient-centred care.

**Respecting people's choices**

[http://www.respectingpatientchoices.org.au/index.php?option=com\\_content&view=article&id=30&Itemid=31](http://www.respectingpatientchoices.org.au/index.php?option=com_content&view=article&id=30&Itemid=31)

Information for clients and health professionals on advanced care planning

**The Royal Australian College of General Practitioners**

<http://www.racgp.org.au/runningapractice/relationships>

This helpful article asks health professionals to consider that relationships, rather than clients, may be a 'difficult' factor in clinical relationships.

**Patient-centred care – indigenous health**

<http://www.racgp.org.au/afp/200812/200812nguyen1.pdf>

This is an excellent resource to consider cultural safety in Indigenous health.

**Transforming patient experience – the essential guide**

[http://www.institute.nhs.uk/patient\\_experience/guide/home\\_page.html](http://www.institute.nhs.uk/patient_experience/guide/home_page.html)

This site offers useful resources for health professionals who have responsibility to improve the experience of those using a health service.

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