Practitioner interpersonal skills

Lesson 5.1.1 | Health psychology

Core ideas

Interpersonal skills are the communication behaviours that help a practitioner build a working relationship with a patient.

Active listening, empathy and clear explanations can help patients feel respected and understood.

Open questions can encourage patients to describe symptoms and concerns, while closed questions can check specific details.

Non-verbal behaviour, such as eye contact, posture, facial expression and tone, can change how caring or rushed the practitioner seems.

Good rapport can increase patient satisfaction, disclosure, understanding and willingness to follow advice.

Poor communication may lead to confusion, anxiety, low trust, missed information or weaker adherence to treatment.

Practitioner interpersonal skills

Lesson 5.1.1 | Health psychology

Key terms

Interpersonal skills: Communication behaviours used to build a helpful relationship with another person.

Rapport: A positive, trusting connection between practitioner and patient.

Active listening: Showing attention by listening carefully, checking meaning and responding appropriately.

Empathy: Understanding and showing concern for another person's feelings or situation.

Open question: A question that invites a fuller answer, such as asking how a symptom affects daily life.

Closed question: A question that asks for a short specific answer, such as yes, no or a number.

Non-verbal communication: Messages sent through body language, facial expression, eye contact and tone.

Adherence: Following agreed medical advice, such as taking medication or attending appointments.

Practitioner interpersonal skills

Lesson 5.1.1 | Health psychology

Further detail and evidence

Practitioner clothing is non-verbal information about role, professionalism and approachability. McKinstry and Wang (1991) asked 475 Scottish patients to rate photographs of doctors in different clothes. More traditional dress was generally preferred, especially by older patients. The task measured impressions, not clinical competence.

Verbal communication includes the terminology used, checking meaning and inviting questions. McKinlay (1975) compared actual understanding of medical terms with doctors' estimates in maternity-service users/underusers in Aberdeen. Users understood more, and doctors underestimated respondents' understanding. Do not reverse that finding into a universal claim that doctors overestimated it.

A familiar term can still have different everyday and technical meanings. Open questions can reveal a patient's interpretation; asking the person to explain a plan in their own words checks understanding more directly than asking only "Do you understand?"

Applying the ideas

A smart outfit can increase initial confidence without ensuring listening or empathy. A practitioner who notices uncertainty can clarify a term and check the patient's explanation. Evaluate clothing, words, tone and listening as interacting features of a consultation.

Evaluation and connections

Photographs standardise appearance but omit movement, voice and a real consultation. Local preferences may change over time and culture. Comprehension studies need reliable scoring and an appropriate vocabulary sample. Respectful communication avoids assuming that social class, age or limited technical vocabulary implies lack of intelligence.

Practitioner diagnosis and style

Lesson 5.1.2 | Health psychology

Core ideas

Diagnosis depends on collecting accurate information from symptoms, patient history, observation, tests and clinical reasoning.

A practitioner-centred style gives the practitioner more control over questions, decisions and the direction of the consultation.

A patient-centred style encourages the patient to explain concerns, ask questions and take part in decisions.

Practitioner style can affect how much information the patient shares, especially about sensitive or uncertain symptoms.

Diagnostic errors can happen when information is missed, assumptions are made too quickly or communication is unclear.

A good consultation style should balance medical expertise with patient involvement, time limits, safety and clear advice.

Key terms

Diagnosis: Identifying a health problem from symptoms, history, examination or test evidence.

Practitioner-centred style: A consultation style where the practitioner controls most questions and decisions.

Patient-centred style: A consultation style where the patient's concerns, preferences and questions are actively included.

Clinical reasoning: Using evidence and professional knowledge to judge what condition or action is most likely.

Patient history: Information about symptoms, past illness, medication, lifestyle and relevant background.

Practitioner diagnosis and style

Lesson 5.1.2 | Health psychology

Continued

Shared decision-making: Practitioner and patient discussing options and agreeing a plan together.

Diagnostic error: A wrong, delayed or missed diagnosis.

Compliance: Following medical instructions, often used when the practitioner directs the treatment plan.

Further detail and evidence

Key study: Savage and Armstrong (1990) compared directing, doctor-centred consultations with sharing, patient-centred consultations rather than assuming sharing is always preferable.

At one inner-London practice, 359 patients aged 16-75 consulting one GP were selected; four refused and five were excluded. Follow-up had substantial non-response.

Random allocation using face-down cards determined consultation style. Standardised prompts varied advice, treatment and prognosis.

Immediate and one-week questionnaires assessed satisfaction with understanding, explanation and perceived help; consultations were audiotaped.

Directing consultations generally produced greater satisfaction, particularly for physical problems and prescriptions; differences were not significant for every subgroup.

For physical problems, 34% rated the directing explanation excellent, compared with 15% in the sharing condition.

A false-positive diagnosis identifies a condition that is actually absent; a false-negative diagnosis misses a condition that is actually present. For example, wrongly diagnosing an infection is false positive, while overlooking an existing infection is false negative.

Patients' willingness and ability to disclose symptoms affect the information available for diagnosis. When presenting a diagnosis, practitioners should explain its meaning and uncertainty in understandable language and check the patient's interpretation. Communication style can affect satisfaction without proving that the diagnosis was correct.

Practitioner diagnosis and style

Lesson 5.1.2 | Health psychology

Continued

A false positive identifies a condition when it is absent; a false negative misses a condition that is present. Consequences can include needless anxiety/intervention or delayed care. Neither error is defined by whether the patient feels satisfied with the consultation.

Disclosure matters because embarrassment, fear, memory and the way questions are asked can change the information available. Presenting a diagnosis requires an understandable explanation, attention to uncertainty and an opportunity for the patient to respond.

Doctor-centred consultations are comparatively directive, with the practitioner controlling advice and decisions. Shared consultations involve the patient's concerns and preferences in discussion. Patient involvement is compatible with clear professional advice; it does not mean abandoning clinical expertise.

Applying the ideas

Savage and Armstrong changed consultation style within one GP practice and measured satisfaction. Greater satisfaction with the directing style for some physical problems challenges the assumption that every patient always wants the same degree of shared discussion. It does not establish better diagnostic accuracy or recovery.

Evaluation and connections

This concerns consultation fit and satisfaction, not demonstrated clinical recovery. Random allocation and a common GP support control, but one doctor and attrition limit generalisation.

Evaluate situational explanations, cultural expectations, satisfaction-scale validity and informed consent for recording.

Random allocation by prompt cards strengthens the style comparison; recording consultations helps check implementation. One GP limits practitioner generalisation, and follow-up losses may bias later responses. Separate patient expectations, satisfaction, disclosure, adherence and health outcomes when judging a consultation style.

Misusing health services

Lesson 5.1.3 | Health psychology

Core ideas

Misuse of health services can include overusing appointments, delaying help, missing appointments or using emergency care for non-urgent problems.

Overuse may happen when people are very anxious about symptoms, seek repeated reassurance or misunderstand normal bodily changes.

Underuse may happen when people deny symptoms, fear diagnosis, feel embarrassed, mistrust services or face practical barriers.

Health anxiety can increase checking, reassurance-seeking and repeated consultations even when serious illness is unlikely.

Missed appointments waste resources and can delay care for both the patient and other people.

Reducing misuse requires clear information, accessible services, appropriate triage and communication that respects patient concerns.

Misusing health services

Lesson 5.1.3 | Health psychology

Key terms

Health service misuse: Using medical services in a way that is unnecessary, delayed, inappropriate or wasteful.

Overuse: Using health services more often than is medically needed.

Underuse: Not using health services when help, screening or treatment is needed.

Health anxiety: Excessive worry about having or developing an illness.

Reassurance-seeking: Repeatedly asking for confirmation that symptoms are not serious.

Triage: Sorting patients by urgency so care is directed appropriately.

Missed appointment: Not attending a booked health appointment without cancelling in time.

Barrier to access: Anything that makes it harder for a person to use health services.

Further detail and evidence

Safer et al. (1979) divided delay into appraisal (noticing a symptom to recognising illness), illness (recognising illness to deciding to seek help), and utilisation (decision to seek help to attending). Their retrospective patient evidence indicates that different factors can influence each stage.

Health Belief Model: perceived susceptibility and severity contribute to threat; perceived benefits are weighed against barriers; cues to action prompt response, and self-efficacy concerns ability to act. It is an alternative account of why someone seeks or avoids care, not a fixed three-stage timetable.

Misusing health services

Lesson 5.1.3 | Health psychology

Continued

Munchausen syndrome is a severe factitious presentation involving recurrent fabrication/induction of illness and assuming the sick role, without obvious external reward being the defining motive. It differs from malingering for an external gain such as money or avoiding duties.

Aleem and Ajarim (1995) reported a young woman repeatedly hospitalised with unexplained physical problems and evidence of self-induced illness. Essential features concern fabricated/induced illness and repeated presentation. Supporting features in the review included extensive medical knowledge, repeated hospital use/scars and unusual presentations; these are clues, not proof on their own.

Applying the ideas

Not recognising a symptom illustrates appraisal delay; recognising illness but fearing a diagnosis can delay deciding to seek care; transport or appointment barriers can delay attendance after that decision. A change aimed at access will not necessarily solve earlier symptom interpretation.

Evaluation and connections

Retrospective time estimates are vulnerable to recall bias. A detailed factitious-disorder case reveals complexity but cannot establish prevalence or a universal cause. Genuine symptoms must not be dismissed merely because a patient seeks repeated help. Analyse practical barriers, beliefs and clinical evidence separately.

Types of non-adherence and reasons why patients do not adhere

Lesson 5.2.1 | Health psychology

Core ideas

Adherence means following agreed medical advice, such as taking medication correctly, changing behaviour or attending follow-up appointments.

Non-adherence can be intentional, when a patient chooses not to follow advice, or unintentional, when barriers such as forgetting or confusion interfere.

Primary non-adherence happens when treatment is never started, such as not collecting a prescription.

Secondary non-adherence happens after treatment has started, such as stopping tablets early or taking the wrong dose.

Reasons for non-adherence include side effects, cost, complex routines, low perceived risk, poor understanding, lack of trust and social pressure.

Non-adherence matters because it can reduce treatment effectiveness, increase complications and make it harder to judge whether a treatment works.

Types of non-adherence and reasons why patients do not adhere

Lesson 5.2.1 | Health psychology

Key terms

Adherence: Following agreed medical advice or treatment as intended.

Non-adherence: Not following medical advice or treatment as intended.

Intentional non-adherence: Choosing not to follow advice because of beliefs, preferences or concerns.

Unintentional non-adherence: Failing to follow advice because of practical barriers such as forgetting or confusion.

Primary non-adherence: Not starting treatment, such as not collecting or filling a prescription.

Secondary non-adherence: Starting treatment but not continuing it correctly.

Side effect: An unwanted effect of a treatment that may reduce willingness to continue.

Treatment regimen: The plan for how and when a treatment should be followed.

Further detail and evidence

Non-adherence can involve not starting, missing doses, changing timing/amount, stopping early, or missing appointments. Intentional non-adherence is a considered choice; unintentional non-adherence includes forgetting, misunderstanding and practical difficulty. Both can occur in the same person.

Types of non-adherence and reasons why patients do not adhere

Lesson 5.2.1 | Health psychology

Continued

Consequences include reduced treatment benefit, complications, unnecessary changes to prescriptions and wasted appointments/resources. A clinician can mistake non-adherence for an ineffective medicine if the pattern is not explored.

Rational non-adherence considers a person's trade-offs between expected benefits, adverse effects, cost and demands. Laba et al. (2012) used a discrete-choice experiment in an Australian community sample to investigate such medication choices. Hypothetical choices reveal preferences rather than directly observing a prescription being followed.

Use the HBM explicitly: a person may see little susceptibility or benefit, perceive severe barriers, lack confidence or receive no cue to act. A treatment plan viewed as sensible by a clinician may be judged differently by the patient.

Applying the ideas

A person can forget a dose (unintentional), deliberately skip it because of an expected side effect (intentional), or be unable to afford a refill (practical barrier). A reminder addresses memory but not all concerns about benefits and costs. Identify the barrier before choosing an intervention.

Evaluation and connections

Calling a decision rational describes the patient's reasoning, not proof that the medical outcome is optimal. Self-report may hide missed doses. Belief models organise factors but can understate poverty, access and habitual behaviour. Cultural and individual differences limit one universal explanation.

Measuring non-adherence

Lesson 5.2.2 | Health psychology

Core ideas

Non-adherence can be measured using self-reports, interviews, pill counts, prescription records, electronic monitoring and biological tests.

Self-report methods are quick and can reveal reasons for non-adherence, but patients may forget, misunderstand or give socially desirable answers.

Pill counts compare the number of doses left with the number expected, but they cannot prove when or whether the medicine was actually taken.

Pharmacy or prescription records show whether treatment was collected or refilled, but they do not prove correct use at home.

Electronic monitoring can record when a container is opened, giving detailed timing data, but opening a container is not the same as swallowing a dose.

Biological tests can detect medicine or health markers in the body, but they may be costly, invasive and affected by individual biology.

Measuring non-adherence

Lesson 5.2.2 | Health psychology

Key terms

Self-report: A patient's own account of whether and how they followed advice.

Social desirability: Giving an answer that seems acceptable rather than fully accurate.

Pill count: Counting remaining tablets to estimate how many doses were taken.

Prescription record: A record showing whether medicine was collected or refilled.

Electronic monitoring: Using a device to record behaviour such as opening a medication container.

Biological test: A test of bodily evidence, such as drug levels or health markers.

Objective measure: A measure based on observable records or tests rather than only personal report.

Measurement validity: How well a method measures the behaviour it claims to measure.

Further detail and evidence

Subjective measures include clinician impressions, patient questionnaires and semi-structured interviews. They can explain reasons and timing, but depend on memory, honesty and judgement. Riekert and Drotar (1999) compared participation groups in adolescent diabetes adherence research: selection/nonresponse can affect whose adherence is represented.

Measuring non-adherence

Lesson 5.2.2 | Health psychology

Continued

Objective measures include pill counts, electronic dispensers and biological tests. Chung and Naya (2000) followed 57 asthma patients for 12 weeks using TrackCap bottle-opening records alongside tablet counts. The electronic record added dose-timing information that a final pill count could miss.

Blood/urine assays detect a drug, metabolite or relevant biological marker. Results depend on metabolism, timing and the marker's relationship to the regimen. Taking treatment just before a visit can produce a misleading picture of the usual pattern.

Applying the ideas

The expected number of tablets missing could reflect correct use, discarded pills or several doses removed together. A cap opening could occur without ingestion. An interview may reveal a change in working hours that explains timing. Combine evidence rather than treating one indicator as perfect proof.

Evaluation and connections

Electronic devices supply detailed, relatively objective records but are costly and can alter behaviour through monitoring. Biological tests may be invasive and give only a time-limited snapshot. Interviews offer rich context but interviewer expectations matter. Reliability and validity should be assessed for the behaviour actually measured.

Improving adherence

Lesson 5.2.3 | Health psychology

Core ideas

Adherence can improve when patients understand what the treatment is for, how to follow it and what problems to expect.

Patient-centred communication helps by checking concerns, inviting questions and agreeing a realistic plan rather than simply giving orders.

Simplifying a treatment regimen can reduce unintentional non-adherence by making doses, timings and instructions easier to manage.

Reminders, prompts and packaging aids can support memory, especially when treatment has to be repeated over time.

Behavioural methods such as contracts, goal-setting, rewards and self-monitoring can turn advice into specific actions.

Follow-up, social support and problem-solving can help patients continue treatment when side effects, cost or daily routines get in the way.

Key terms

Adherence intervention: A strategy designed to help patients follow agreed medical advice.

Patient-centred communication: Communication that explores the patient's concerns, preferences and understanding.

Regimen simplification: Making a treatment plan easier to follow by reducing complexity.

Reminder: A prompt that helps a patient remember a dose, appointment or health action.

Behavioural contract: An agreement that sets out a specific health behaviour and commitment.

Self-monitoring: Recording one's own health behaviour or symptoms to guide change.

Social support: Help from other people that makes treatment easier to continue.

Follow-up: Later contact that checks progress, problems and next steps.

Improving adherence

Lesson 5.2.3 | Health psychology

Further detail and evidence

Key study: Yokley and Glenwick (1984) tested community interventions to increase preschool immunisation, applying prompts and reinforcement to health-service use.

Families of 1,133 preschool children lacking required immunisations were randomly assigned to six public-health conditions.

Conditions were general prompt; child-specific prompt; specific prompt plus easier clinic access; specific prompt plus monetary incentive; contact control; and no-contact control.

The independent variable was intervention package; the outcome was immunisation attendance rather than stated intention.

Except for general prompting, interventions showed some improvement over controls. Monetary incentives plus specific prompts had the largest effect, followed by easier access and specific prompts alone.

Behavioural contracts agree a clear action, monitoring and consequence. Prompts cue the action at a relevant time; customising the regimen fits it around the person's practical needs. A useful intervention addresses the cause of non-adherence rather than adding an unrelated reward.

Chaney et al. (2004) tested the Funhaler with young children using asthma inhalers. A whistle/spinner provided contingent feedback for appropriate breathing. Parent reports favoured easier use and better adherence compared with the usual device. The short home comparison and parental report limit conclusions about long-term clinical improvement.

Yokley and Glenwick compared six community conditions for families whose preschool children lacked immunisation. Specific prompts, improved access and monetary incentives can change different barriers. The strongest attendance effect was associated with the incentive condition; a general prompt alone was not sufficient.

Improving adherence

Lesson 5.2.3 | Health psychology

Applying the ideas

A calendar reminder may help someone who intends to attend but forgets. Easier clinic access helps a practical obstacle, and an engaging child device changes the immediate experience of treatment. A contract should specify what counts as adherence and how both parties will review difficulties.

Evaluation and connections

The conclusion supports tailored, practical interventions: reminders may be insufficient when barriers remain.

Random allocation and behavioural records support application. Combined packages do not isolate every mechanism; one community and health behaviour limit generalisation.

Evaluate child-research ethics, parental decisions, incentives and controls. Clinic attendance is not the same as complete long-term adherence.

Randomised community conditions support comparison and real attendance is a behavioural outcome. Incentives can impose costs and may not persist after removal. Parent reports can be optimistic and short comparisons are vulnerable to novelty. Evaluate treatment adherence, appointment attendance and health outcomes separately.

Types and theories of pain

Lesson 5.3.1 | Health psychology

Core ideas

Pain is an unpleasant sensory and emotional experience, so it is shaped by both body signals and psychological interpretation.

Acute pain is usually short-term and linked to recent injury or illness, while chronic pain continues for longer and may remain after tissue healing.

Nociceptors detect potentially damaging stimulation and send signals through nerves toward the spinal cord and brain.

Specificity theory treats pain as a direct signal from pain receptors to the brain, but it struggles to explain why context and emotion change pain.

Gate control theory argues that pain signals can be increased or reduced in the spinal cord before they reach conscious awareness.

Phantom limb pain and chronic pain show that pain can involve brain interpretation, memory, attention and emotion, not just current tissue damage.

Types and theories of pain

Lesson 5.3.1 | Health psychology

Key terms

Pain: An unpleasant sensory and emotional experience linked with actual or possible damage.

Acute pain: Short-term pain usually linked to recent injury, illness or tissue damage.

Chronic pain: Pain that continues for a long time, sometimes after healing has occurred.

Nociceptor: A sensory receptor that responds to potentially damaging stimulation.

Specificity theory: The idea that pain travels through a direct pathway from pain receptors to the brain.

Gate control theory: A theory that pain signals can be modulated in the spinal cord before reaching the brain.

Phantom limb pain: Pain felt in a limb or body part that is no longer present.

Biopsychosocial view: The view that biological, psychological and social factors all shape pain experience.

Further detail and evidence

Pain has a protective function by signalling potential damage and encouraging withdrawal/protection, but persistent pain can be disabling beyond that immediate function. Acute/chronic describe time course, not necessarily intensity. Chronic pain is real even when current tissue damage does not explain its full severity.

Types and theories of pain

Lesson 5.3.1 | Health psychology

Continued

Specificity theory proposes dedicated pathways carrying pain information from receptors towards the brain. Gate control includes modulation in the spinal cord: activity in different nerve fibres and descending influences from the brain can increase or reduce transmission. Attention, anxiety and expectations can therefore affect experience.

Phantom limb pain is pain experienced in an absent limb. MacLachlan et al. (2004) reported lower-limb mirror treatment in a case: viewing the reflected intact limb provided altered visual feedback and was associated with reduced phantom pain and improved movement control. A case suggests usefulness without proving a universal treatment effect.

Applying the ideas

Two similar injuries can produce different pain ratings because attention, appraisal and context affect processing. Phantom pain challenges a simple one-to-one mapping from current limb damage to experienced pain. It does not show that all pain is imagined or voluntarily controllable.

Evaluation and connections

Biological pathways explain transmission, while gate control integrates bodily and psychological influences. Objective injury measures cannot directly establish the subjective intensity. Case evidence permits personal detail but limited generalisation; controlled comparison and follow-up are needed to evaluate mirror interventions more broadly.

Measuring pain

Lesson 5.3.2 | Health psychology

Core ideas

Pain is subjective, so self-report is often central because the person experiencing pain has direct access to its intensity and quality.

Numerical rating scales and visual analogue scales turn pain into a score, making changes over time easier to compare.

Questionnaires can measure more than intensity by asking about the quality, location, duration and emotional impact of pain.

Pain diaries record pain in everyday life, helping researchers see patterns linked to activity, mood, medication or time of day.

Behavioural observation can record visible signs such as guarding, facial expression, movement limits or requests for help.

Physiological measures may show arousal or bodily stress, but they cannot prove exactly how much pain a person feels.

Key terms

Self-report: A person's own account of their pain experience.

Numerical rating scale: A scale where pain is rated with numbers, such as 0 to 10.

Visual analogue scale: A line or visual scale where a person marks how strong their pain feels.

Pain questionnaire: A structured set of questions about pain intensity, quality or impact.

Pain diary: A record of pain episodes, triggers, activities and changes over time.

Behavioural observation: Recording visible pain-related behaviour rather than only asking the patient.

Physiological measure: A bodily measure such as heart rate, muscle tension or stress response.

Subjective measure: A measure based on personal experience or judgement.

Measuring pain

Lesson 5.3.2 | Health psychology

Further detail and evidence

Key study: Brudvik et al. compared children's pain ratings with parent and physician ratings and examined links to pain-relief decisions.

The syllabus labels this 2016 and its Reference List cites the 2017 journal issue: online-first and issue dates of the same study.

This cross-sectional study involved 243 children aged 3-15 at Bergen emergency outpatients in 2011. Children used age-adapted scales; parents and physicians made independent numerical ratings.

The same child supplied the basis for three assessments; participants were not randomly assigned to pain conditions.

Mean ratings were 5.5 for children, 4.8 for parents and 3.2 for physicians. Physicians underestimated pain; only 42.1% of children with severe pain received pain relief.

The McGill Pain Questionnaire uses sensory, affective and evaluative descriptors to capture more than pain intensity: what pain feels like, its emotional qualities and the person's overall appraisal. Selecting words creates structured self-report data; language and cultural interpretation can influence scores.

A visual analogue scale (VAS) normally asks the person to mark a point on a line between endpoints such as no pain and the worst pain. It differs from choosing a numbered category on a numerical rating scale; both quantify a subjective experience.

The University of Alabama at Birmingham (UAB) Pain Behavior Scale is a standardised observational measure of observable pain behaviours. Richards et al. (1982) developed it for rapid use by pain-team staff, with inter-rater reliability and validity evaluated. Behavioural indicators do not provide direct access to another person's experience.

Compare clinical interviews, McGill descriptors, visual ratings and behavioural observation: each captures different information. Observer agreement can support reliability without establishing validity, and absent visible behaviour does not prove absence of pain. These are separate required methods; do not assume the Brudvik study used every measure listed in the topic.

Measuring pain

Lesson 5.3.2 | Health psychology

Continued

Clinical interviews explore location, onset, duration, intensity, quality and interference. McGill Pain Questionnaire uses descriptors addressing sensory and emotional qualities, alongside other pain information. A visual analogue scale marks intensity along a line between defined endpoints, usually converted to a distance score.

The UAB Pain Behavior Scale structures observation of visible pain-related behaviours such as facial/vocal expressions, movement and protective posture. Behavioural indicators are not identical to private experience: people differ in expression and suppression.

Brudvik compares children's own ratings with independent parent/physician estimates in an outpatient setting. Mean ratings differed substantially, with doctors estimating less pain. Inter-rater differences here can reflect differing access to experience, rather than the child's report simply being wrong.

Applying the ideas

A child reporting severe pain while appearing quiet may still be in pain. A face scale can help younger children communicate, while an interview adds quality/context. Repeated ratings should use an appropriate consistent instrument. A lower score and improved functioning are related but separate outcomes.

Evaluation and connections

The conclusion supports listening to children's age-appropriate self-reports and parental information rather than automatically treating professional estimates as objective.

Independent ratings aid comparison, but subjective scales do not directly measure tissue damage. One centre and observational data limit causal claims.

Evaluate psychometrics, subjective/objective data, child participation and agreement versus validity.

Self-report is essential to subjective experience but depends on comprehension and scale use. Structured observation improves consistency yet may underestimate hidden distress. Brudvik has real clinical relevance; age-appropriate scale differences and one setting restrict direct comparisons/generalisation. Combine information without assuming that objective-looking behaviour overrides the patient.

Managing and controlling pain

Lesson 5.3.3 | Health psychology

Core ideas

Pain management can involve medical, psychological and behavioural approaches, especially when pain is long-lasting or affects daily life.

Drug treatments can reduce pain signals or inflammation, but they may have side effects and may not address fear, stress or behaviour.

Cognitive approaches help patients change unhelpful thoughts about pain, such as catastrophising or expecting all activity to cause damage.

Behavioural approaches use pacing, graded activity and reinforcement to reduce avoidance and rebuild functioning step by step.

Relaxation, breathing and distraction can reduce tension and shift attention away from pain, which may influence pain experience.

Biofeedback and multidisciplinary pain programmes help patients notice body responses, practise coping skills and combine support from different professionals.

Managing and controlling pain

Lesson 5.3.3 | Health psychology

Key terms

Pain management: Strategies used to reduce pain or help a person cope with it.

Analgesic: A medicine used to reduce pain.

Catastrophising: Thinking about pain in an exaggeratedly negative or helpless way.

Cognitive restructuring: Changing unhelpful thoughts into more balanced ways of thinking.

Pacing: Balancing activity and rest so pain does not lead to repeated overdoing and crashing.

Graded activity: Increasing activity gradually through planned steps.

Relaxation technique: A method such as breathing or muscle relaxation used to reduce tension.

Biofeedback: Using information about body responses to learn control over tension or arousal.

Further detail and evidence

Biochemical management changes physiological transmission: medicines can act peripherally on inflammatory processes or centrally on pain processing. Compare potential relief, side effects, tolerance/dependence where relevant, adherence and whether the underlying cause is addressed.

Managing and controlling pain

Lesson 5.3.3 | Health psychology

Continued

Cognitive strategies include attention diversion (focus elsewhere), non-pain imagery (imagine a pleasant unrelated scene), and cognitive redefinition (reinterpret the sensation and its meaning). They aim to change processing and distress rather than deny the experience.

Acupuncture uses stimulation at selected body sites with needles; TENS uses electrodes providing transcutaneous electrical stimulation. Proposed mechanisms involve modulation of pain signalling, including gate-control processes. Neither should be described as simply repairing all damaged tissue.

Applying the ideas

Listening to an absorbing story diverts attention; imagining a calm beach is non-pain imagery; viewing a sensation as manageable rather than catastrophic changes its meaning. These strategies can affect coping and reported intensity. A lower pain score does not necessarily show that an injury healed faster.

Evaluation and connections

Compare self-reported pain with activity, sleep and quality of life. Blinding and credible sham comparisons help assess expectation effects, although complete blinding can be difficult. Treatments may suit different pain types and individuals. Long-term effectiveness, acceptability, adverse effects and access matter alongside immediate relief.

Sources of stress

Lesson 5.4.1 | Health psychology

Core ideas

A stressor is a demand or threat that a person perceives as difficult to cope with, not just any unpleasant event.

Major life events such as bereavement, divorce, moving home or serious illness can create stress because they require major adjustment.

Daily hassles are smaller repeated irritations, such as traffic, deadlines or conflicts, that can build up over time.

Chronic stressors are long-lasting pressures, such as caregiving, poverty, discrimination, work overload or ongoing health problems.

Workplace stress often increases when demands are high, control is low, support is weak or roles are unclear.

Stress depends partly on appraisal: people judge how serious a demand is and whether they have the resources to cope.

Sources of stress

Lesson 5.4.1 | Health psychology

Key terms

Stressor: A demand, threat or pressure that may trigger stress.

Stress response: The psychological and bodily reaction to a perceived demand.

Major life event: A significant change that requires adjustment.

Daily hassle: A small but repeated irritation or demand in everyday life.

Chronic stressor: A long-lasting source of pressure.

Work overload: Having more work demands than a person feels able to manage.

Perceived control: How much influence a person believes they have over a situation.

Appraisal: A person's judgement of a demand and their ability to cope with it.

Further detail and evidence

General Adaptation Syndrome: alarm mobilises an immediate physiological response, resistance sustains adaptation, and prolonged demands can lead to exhaustion. Sympathetic activation and stress-hormone systems support short-term action; prolonged activation can carry health costs.

Holmes and Rahe's life-event approach sums weighted life changes, including desirable changes requiring adjustment. The same total can conceal different meanings, resources and timing. Daily hassles are useful context, but do not replace the required life-event account.

Sources of stress

Lesson 5.4.1 | Health psychology

Continued

Chandola et al. (2008) used the Whitehall II cohort to examine work stress and coronary heart disease alongside behavioural/biological pathways. Work stress was associated with CHD, with health behaviours and physiological processes helping explain the relationship. A longitudinal association is not random assignment to stress.

Type A pattern involves competitiveness, time urgency and hostility, compared with a more relaxed Type B pattern. Friedman and Rosenman linked the pattern with coronary risk. Treat it as an historical risk account, rather than proof that a personality label inevitably causes disease.

Applying the ideas

An upcoming deadline can activate alarm; continuing demands may sustain resistance. A life-event score estimates adjustment demands, whereas a work-stress questionnaire concerns the organisation of everyday demands. Neither alone reveals exactly how stressed every individual feels.

Evaluation and connections

GAS provides an organised physiological model but can understate individual appraisal and differences between stressors. Life-event measures rely on recall and fixed weights. Cohorts improve temporal evidence but retain confounds. Personality and work exposures may interact with smoking, sleep, support and health history.

Measures of stress

Lesson 5.4.2 | Health psychology

Core ideas

Stress can be measured through self-report questionnaires, interviews, diaries, life-event scales, daily-hassle scales and physiological measures.

Self-report measures can show how stressful a person feels an event is, but answers may be affected by memory, honesty and interpretation.

Life-event scales estimate stress from major changes, but the same event can have different meanings for different people.

Daily-hassle measures can capture repeated everyday pressures that may be missed by only counting major life events.

Physiological measures such as heart rate, blood pressure, skin conductance and cortisol can provide biological evidence of arousal.

No single stress measure is perfect, so researchers often combine methods to compare subjective experience with bodily response.

Measures of stress

Lesson 5.4.2 | Health psychology

Key terms

Self-report measure: A measure based on what a person says about their own stress.

Life-event scale: A checklist or rating method for major changes that may create stress.

Daily-hassle scale: A measure of repeated everyday irritations and demands.

Stress diary: A record of stressful events, feelings and responses over time.

Physiological measure: A bodily measure used as evidence of stress or arousal.

Heart rate: The number of heart beats per minute, often higher during arousal.

Cortisol: A hormone linked with HPA-axis stress activity.

Skin conductance: A measure of sweat-related electrical activity in the skin, often linked with arousal.

Further detail and evidence

Heart rate is relatively objective but responds to exercise, caffeine and illness as well as stress. fMRI measures physiological brain signals, not thoughts directly. Wang et al. (2005) induced stress with monitored mental arithmetic and combined perfusion MRI, subjective ratings, heart rate and salivary cortisol.

Measures of stress

Lesson 5.4.2 | Health psychology

Continued

Wang found stress-related cerebral blood-flow patterns, including right prefrontal activity related to reported stress. Combining physiological and subjective measures supports convergent evidence, while an artificial task may differ from chronic daily pressure.

Evans and Wener (2007) studied 139 rush-hour train commuters using salivary cortisol, self-report and proofreading performance. Nearby seat density, rather than whole-car density, was associated with adverse stress indicators. Do not substitute their separate 2006 commuting-duration study. A later corrigendum corrected Table 1 formatting.

Psychological measures include Type A questionnaires and life-event scales. They are standardised and economical but subjective. A numerical questionnaire score is quantitative data without becoming an objective hormone measure.

Applying the ideas

To assess commuting stress, take cortisol samples at standardised times and compare with an appropriate baseline, since hormone levels vary naturally. Record local seating conditions, not merely the number in the carriage. A questionnaire can add perceived control and personal meaning.

Evaluation and connections

Physiology can be recorded reproducibly yet lacks complete specificity for stress. Self-reports provide experience but are affected by recall and expectations. Multiple methods strengthen interpretation when their limits are recognised. A natural commute improves realism but leaves participant and journey differences uncontrolled.

Preventing and managing stress

Lesson 5.4.3 | Health psychology

Core ideas

Stress prevention tries to reduce demands before they become overwhelming, while stress management helps people cope once stress is present.

Problem-focused coping targets the source of stress through actions such as planning, time management, seeking information or asking for practical help.

Emotion-focused coping targets the emotional response through methods such as relaxation, breathing, reappraisal, mindfulness or social support.

Cognitive strategies can reduce stress by challenging catastrophic thoughts and building more realistic appraisals of demands and resources.

Behavioural strategies such as exercise, sleep routines, activity scheduling and assertiveness can improve coping in daily life.

A coping method may help in one situation but fail in another, so students should judge whether the stressor is controllable and whether the strategy has long-term costs.

Key terms

Stress prevention: Reducing stressors or risk factors before stress becomes severe.

Stress management: Strategies used to cope with stress once it is present.

Problem-focused coping: Coping by trying to change or solve the source of stress.

Emotion-focused coping: Coping by managing emotional reactions to stress.

Reappraisal: Changing how a situation is interpreted so it feels more manageable.

Relaxation training: Practising methods that reduce tension and arousal.

Social support: Emotional, practical or informational help from other people.

Coping fit: How well a coping strategy matches the situation and the person's resources.

Preventing and managing stress

Lesson 5.4.3 | Health psychology

Further detail and evidence

Key study: Bridge et al. (1988) tested whether relaxation, with or without peaceful imagery, reduced distress during breast-cancer radiotherapy.

The six-week randomised trial included 154 women with stage I or II disease; 139 completed. Participants were English-speaking outpatients under 70 at one London hospital.

Random allocation produced relaxation, relaxation-plus-imagery and conversational-control groups. Weekly half-hour individual contact and home practice supported treatment.

Relaxation involved muscle awareness and diaphragmatic breathing; the combined group additionally imagined a personally chosen peaceful scene.

Profile of Mood States and Leeds anxiety/depression ratings were collected before and after treatment.

Mood disturbance was lower in intervention groups, and combined-treatment participants felt more relaxed than relaxation-only participants. Leeds scores did not differ between groups.

Randomisation and control-group attention are strengths; attrition, subjective measures and one patient group limit inference. Evaluate ethics, application and individual differences.

The topic also requires biofeedback: physiological activity is measured and fed back so the person can learn to control a response, for example reducing muscle tension. Budzynski et al. (1969) is a syllabus example.

Stress inoculation training has three phases: conceptualisation (understand stress and personal reactions), skills acquisition/rehearsal (learn and practise coping skills), and application/follow-through (use and refine them in progressively challenging situations). These are required prevention content; generic coping advice alone is insufficient.

Preventing and managing stress

Lesson 5.4.3 | Health psychology

Continued

Biofeedback gives immediate information about a body response so the person can learn to alter it. Budzynski and Stoyva (1969) linked tone pitch to muscle activity: appropriate EMG feedback supported deeper muscle relaxation than comparison feedback. Learning the bodily response differs from simply hearing soothing music.

Guided imagery directs attention towards a calming mental scene. Bridge compares relaxation with relaxation plus imagery and a conversational control during breast-cancer treatment. Better mood/relaxation supports psychological benefit; the study did not demonstrate removal of cancer.

Stress inoculation training has three phases: conceptualisation identifies stress and explains its processes; skills acquisition/rehearsal develops coping tools such as self-instruction and relaxation; application/follow-through practises them in progressively demanding situations and reviews transfer.

Applying the ideas

Before a demanding presentation, identify catastrophic predictions, rehearse realistic coping statements, and practise the skills under manageable simulated pressure. This follows SIT's sequence rather than offering relaxation without identifying the stressor. An uncontrollable demand may require a different coping emphasis from a changeable one.

Evaluation and connections

This supports help with treatment-related distress, not a claim that imagery cures cancer or prolongs survival.

Bridge's random allocation and attention control strengthen comparison, but home practice/adherence and attrition can affect outcomes. Self-report mood and physiological relaxation need not coincide. Individual coping skills can help while leaving an organisational source of stress unchanged; evaluate both the person and the situation.

Strategies for improving health

Lesson 5.5.1 | Health psychology

Core ideas

Health-promotion strategies try to reduce risk by changing what people know, believe, feel or do before harm becomes worse.

Fear arousal uses a threat or possible consequence to make a health risk feel serious enough to act on.

A fear appeal is more likely to help when the message is credible and gives clear, realistic action; very high fear can make people deny, avoid or reject the message.

Providing information gives people practical knowledge about a risk and the steps they can take to improve health.

Information alone may not change behaviour if people lack confidence, support, time, money or belief that the advice applies to them.

Studies such as Janis and Feshbach on dental hygiene and Lewin et al. on home-based rehabilitation show that effectiveness depends on message design, audience and follow-up evidence.

Strategies for improving health

Lesson 5.5.1 | Health psychology

Key terms

Health promotion: Action designed to encourage healthier behaviour or reduce health risks.

Fear arousal: Using threat or danger in a message to encourage behaviour change.

Fear appeal: A persuasive health message that highlights serious negative consequences.

Defensive avoidance: Ignoring or rejecting a frightening message to reduce anxiety.

Providing information: Giving clear knowledge or instructions so people know how to improve health.

Self-efficacy: A person's belief that they can carry out the recommended action.

Target audience: The group a health message is designed to reach.

Outcome measure: Evidence used to judge whether a health strategy worked.

Further detail and evidence

Fear arousal highlights a threat to motivate protective action. Janis and Feshbach (1953) compared fear levels in dental-hygiene communications: the strongest fear was not the most effective for reported behaviour change, and a milder message performed better. Increased anxiety is different from improved health behaviour.

Strategies for improving health

Lesson 5.5.1 | Health psychology

Continued

Information provision explains risk, benefits and practical steps. Lewin et al. (1992) randomly allocated 176 heart-attack patients to a heart-manual self-help rehabilitation package or standard care with comparison information/counselling. The package included exercise, relaxation and education, not information alone.

Lewin reported better psychological adjustment at one year, less GP contact and fewer early readmissions in the rehabilitation group. Benefits were greatest for those initially anxious/depressed. The bundled programme prevents attributing the whole effect to a leaflet by itself.

Applying the ideas

A health message should make an action understandable and achievable, as well as communicating a threat. If a viewer feels helpless, vivid risk information may provoke avoidance. Measure actual protective behaviour where possible, rather than treating recall or fear as sufficient success.

Evaluation and connections

Fear studies require distress safeguards, especially with children. Self-reported hygiene can be socially desirable and short follow-up may miss persistence. Lewin's randomised active comparison improves causal inference, but participants know the programme and practices may change over time. Generalise to appropriate patient groups and available support.

Health promotion in schools and worksites

Lesson 5.5.2 | Health psychology

Core ideas

School health promotion often targets habits early because children eat, learn and copy social behaviour in a setting that can be organised by adults.

Healthy-eating programmes can use peer modelling, repeated taste exposure and small rewards to encourage children to try fruit and vegetables.

Worksite health promotion can target safety by changing the consequences of behaviour, making safe actions more visible and reinforcing safe routines.

Token economy programmes reward desired safety behaviour, so workers have an immediate reason to follow protective procedures.

Longitudinal follow-up matters because a short-term increase in healthy eating or safety behaviour may fade once rewards or attention stop.

Evaluation should consider ethics, generalisability, quantitative accident or consumption data and qualitative information about how participants experienced the programme.

Health promotion in schools and worksites

Lesson 5.5.2 | Health psychology

Key terms

School health promotion: Health intervention delivered through a school setting.

Worksite health promotion: Health or safety intervention delivered through a workplace.

Healthy eating: Food choices that support health, such as eating more fruit and vegetables.

Peer modelling: Learning by watching people of a similar age or role perform a behaviour.

Taste exposure: Repeated chances to try a food so it becomes more familiar.

Token economy: A reward system where tokens or points are earned for desired behaviour.

Safety behaviour: Actions that reduce risk of accidents or injury.

Longitudinal follow-up: Checking outcomes again after time has passed.

Further detail and evidence

Food Dudes combines peer models enjoying fruit/vegetables, repeated tasting, praise and small rewards. Tapper et al. (2003) describe programmes using adventure videos, themed rewards, letters and home support. The combined components increased consumption more than provision or modelling alone in the reported evaluations.

Health promotion in schools and worksites

Lesson 5.5.2 | Health psychology

Continued

Learning mechanisms differ: attractive peer models provide observational learning; rewards reinforce trying/eating; repeated exposure can increase familiarity. Tasting a small amount and eating a target portion are different behavioural outcomes.

Fox et al. (1987) introduced trading-stamp tokens at two open-pit mines for injury-free work, group safety, useful safety suggestions and preventative acts. Stamps were exchangeable for goods. Reported injury-related lost time and costs decreased, with benefits sustained over several years.

Applying the ideas

A school programme can reward tasting before expecting a full portion, use models pupils identify with, and maintain support at home. A workplace programme can reinforce observable safe actions rather than merely give a safety lecture. The reinforcer must be linked clearly to the intended behaviour.

Evaluation and connections

Real consumption and long-term injury records improve practical relevance. Packages make individual components difficult to isolate. Injury-based rewards can discourage reporting, so examine reporting safeguards and near-miss data. Children need assent/guardian consent, fair inclusion and sensitivity to dietary needs. Assess maintenance when reinforcement becomes less frequent.

Individual factors in changing health beliefs

Lesson 5.5.3 | Health psychology

Core ideas

Health beliefs affect whether a person thinks advice is relevant, serious, achievable and worth acting on.

Unrealistic optimism happens when people believe negative health outcomes are less likely for themselves than for similar others.

Unrealistic optimism can make people disregard positive health advice because the risk feels like a problem for other people.

Positive psychology focuses on strengths, wellbeing and flourishing rather than only illness, symptoms or deficits.

The pleasant life, good life and meaningful life describe different routes to wellbeing through positive emotion, engaged activity and purpose.

School positive-psychology programmes can aim to improve mental health, but evaluation should consider culture, individual differences, psychometric measures and generalisability.

Key terms

Health belief: A belief about risk, illness, treatment or personal ability to change.

Unrealistic optimism: Believing that negative outcomes are less likely for oneself than for others.

Risk perception: A person's judgement of how likely or serious a health risk is.

Positive psychology: A field that studies strengths, wellbeing and ways people can flourish.

Pleasant life: A route to wellbeing based on positive emotion and enjoyment.

Good life: A route to wellbeing based on engagement, strengths and absorbing activity.

Meaningful life: A route to wellbeing based on purpose and connection to something larger than oneself.

Psychometrics: The measurement of psychological qualities using tests, scales or questionnaires.

Individual factors in changing health beliefs

Lesson 5.5.3 | Health psychology

Further detail and evidence

Key study: Shoshani and Steinmetz (2014) evaluated whole-school positive psychology for adolescent mental health, extending promotion beyond correcting illness.

The analysed sample comprised 1,038 Israeli middle-school students: 537 in the intervention school and 501 in a demographically similar wait-list control school.

A longitudinal comparison followed pupils across two years, including a one-year intervention. Existing schools were compared; pupils were not individually randomly allocated.

Trained teachers delivered activities on positive emotions, strengths, meaning and relationships. Repeated questionnaires measured symptoms and wellbeing.

Intervention participants showed less distress, anxiety and depression, alongside greater self-esteem, self-efficacy and optimism; control symptoms increased.

Weinstein (1980) examined unrealistic optimism about future life events. In Study 1, 258 college students compared their chances of 42 events with classmates. As a group they expected comparatively more desirable and fewer undesirable events. This is comparative bias, not proof that any one person's low risk estimate is incorrect.

Contributing factors include selective focus on personal precautions, stereotypes of high-risk people, perceived control and lack of relevant experience. The 1980 paper should not be confused with the separate 1982 study of health problems.

Positive psychology distinguishes the pleasant life (positive emotion), good/engaged life (using strengths in absorbing activity) and meaningful life (serving something larger than oneself). The approaches can coexist and are not a claim that positive thinking prevents all illness.

Shoshani and Steinmetz's school programme combined activities around strengths, emotions, relationships and meaning. Repeated scales showed improved wellbeing indicators and reduced distress relative to the comparison school. Existing schools, rather than randomly allocated individual pupils, were compared.

Individual factors in changing health beliefs

Lesson 5.5.3 | Health psychology

Applying the ideas

A student may believe a health risk applies to others because they picture an extreme stereotype and overlook their own exposure. A school intervention could build realistic agency alongside strengths and social connection. It should not encourage denying real risk or blaming students for distress.

Evaluation and connections

This supports combining pleasant experience, engagement and meaning in school health promotion, not claiming that positive thinking prevents every disorder.

The large real-school sample and follow-up aid application; school differences, attrition and self-report threaten causal inference.

Evaluate cultural differences, child-research ethics and psychometric validity; results from two schools need not apply worldwide.

Comparative ratings can reveal a group bias but depend on the comparison group and event definitions. The school study has ecological relevance and long follow-up; school differences and self-report limit causal certainty. Culture influences valued strengths and meanings. Distinguish questionnaire improvement from a diagnosed disorder being cured.