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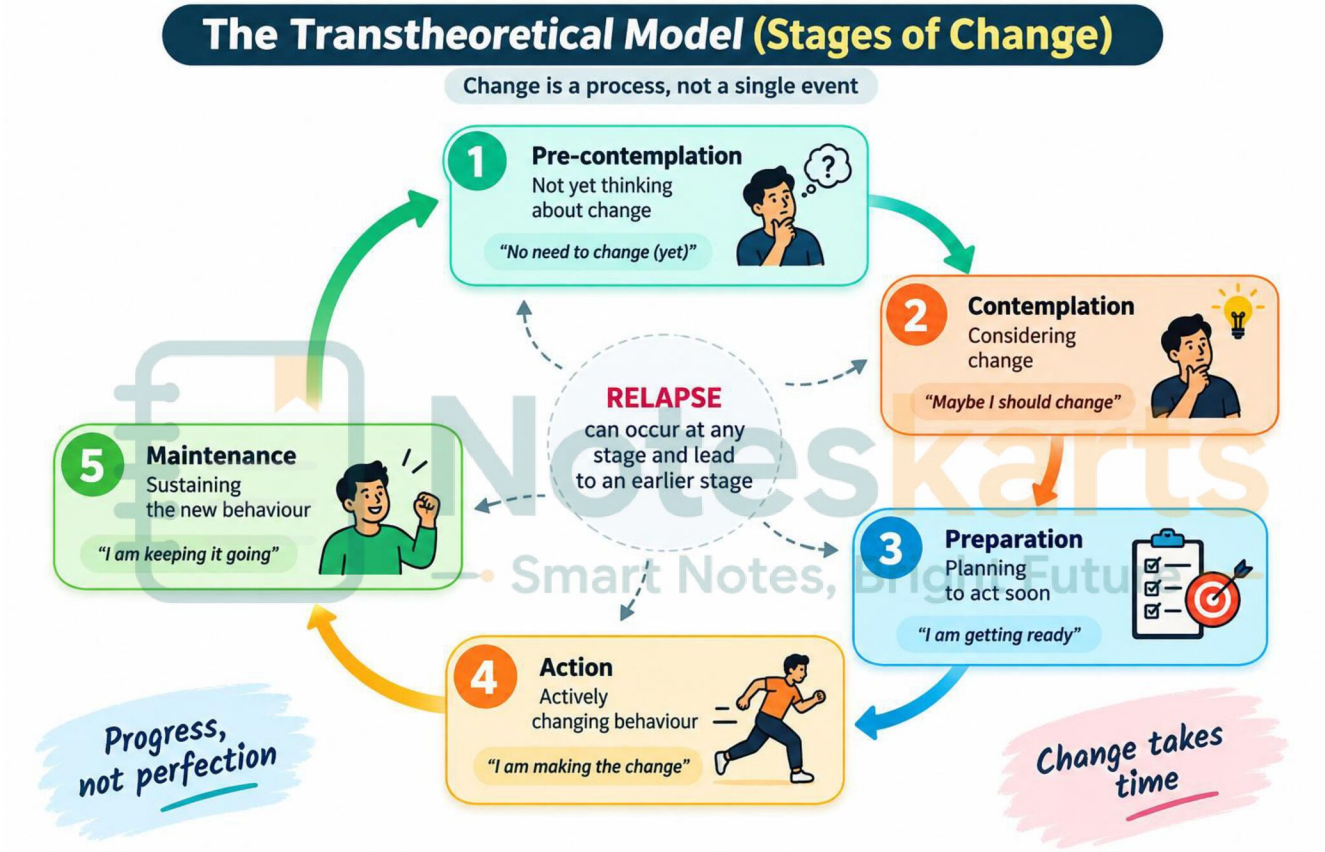
BP103T

Healthcare Psychology and Communication Skills

UNIT V

Health Psychology and Behavioural Interventions



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Unit V: Health Psychology and Behavioural Interventions

This final unit brings together psychology and communication into practical, applied intervention. It examines why people do or don't act on health advice, how the mind and body influence each other in illness, the theories behind lasting behaviour change, how to respond in the first critical moments of a crisis, and how thoughtful communication can reduce one of the most persistent barriers to mental healthcare — stigma.

1. Health Belief Models and Illness Behaviour

1.1 The Health Belief Model

The Health Belief Model (HBM), developed by Rosenstock and colleagues, explains why people do or do not engage in health-protective behaviours such as taking medication, attending screening, or getting vaccinated.

It proposes that a person's readiness to act depends on a combination of beliefs, not just knowledge of the facts.

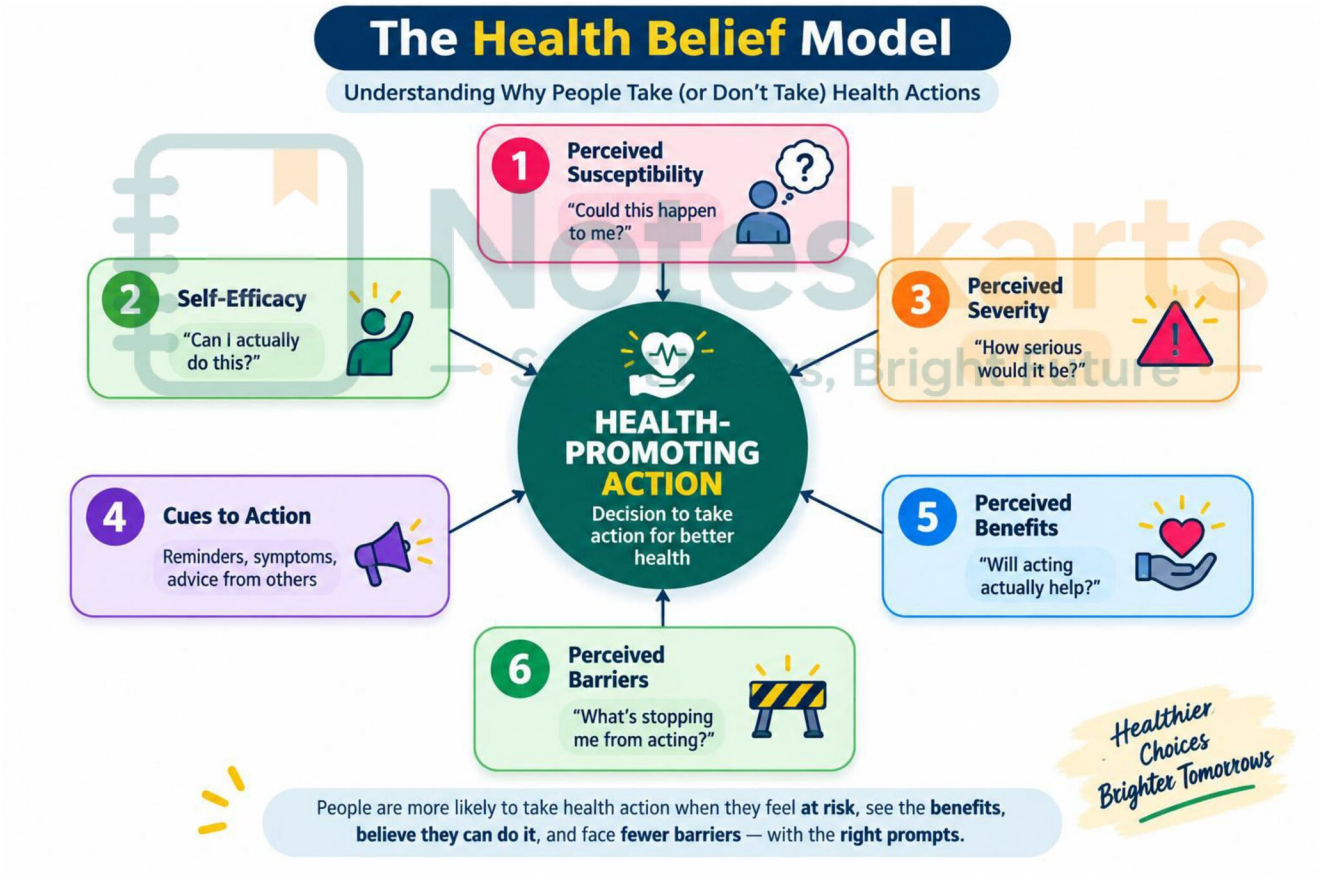

Fig 1.1 — The Health Belief Model

Component	Pharmacist Application
Perceived Susceptibility	Help the patient realistically understand their personal risk
Perceived Severity	Explain the real consequences of untreated or poorly managed illness
Perceived Benefits	Clearly link the treatment to a meaningful outcome the patient values
Perceived Barriers	Proactively ask about cost, side effects, and practical obstacles

Cues to Action	Use reminders, labels, and follow-up contact to prompt behaviour
Self-Efficacy	Build the patient's confidence with small, achievable steps

Exam Focus

A patient may know all the facts about their condition (knowledge) and still not act, because the Health Belief Model shows that behaviour depends on subjective beliefs, not objective information alone — this is why patient education must go beyond simply stating facts.

Case Vignette

A 55-year-old man with a strong family history of heart disease keeps skipping his cholesterol medication. Applying the HBM, the pharmacist discovers he doesn't feel 'sick' (low perceived susceptibility) and finds the tablets expensive relative to a benefit he can't feel (perceived barriers outweigh perceived benefits). Rather than repeating warnings, the pharmacist shows him his actual risk score (raising susceptibility) and discusses a generic alternative (lowering the barrier) — addressing the real obstacle instead of assuming simple forgetfulness.

1.2 Illness Behaviour and the Sick Role

- Illness behaviour refers to the way a person perceives, interprets, and responds to bodily symptoms — including whether they seek help, self-treat, or ignore the symptom altogether.
- Sociologist Talcott Parsons described the 'sick role' as a social role with associated rights and obligations once a person is recognised as ill.

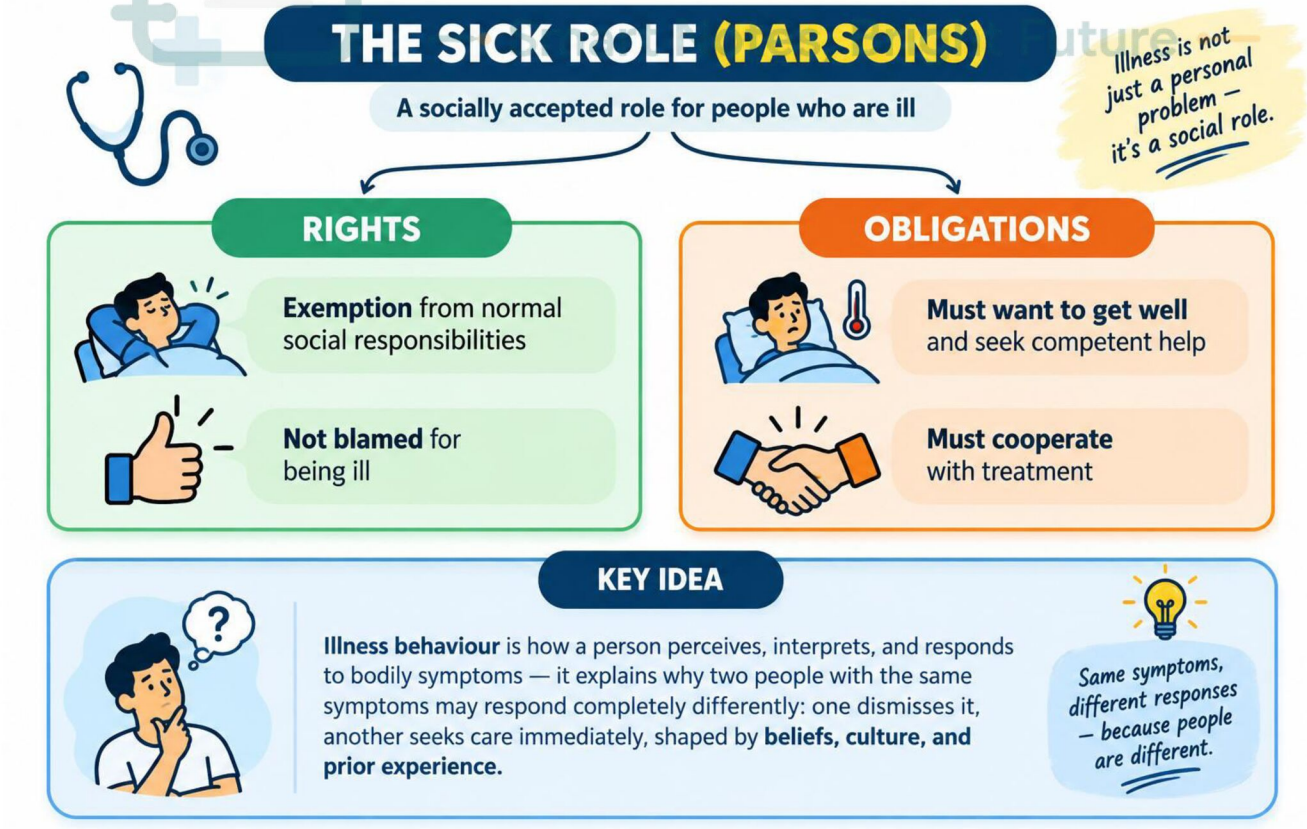

Fig 1.2 — The sick role (Parsons) and illness behaviour

- Illness behaviour varies widely between individuals and cultures.
- Factors influencing it include the visibility and disruptiveness of symptoms, prior experience with illness, cultural beliefs about the meaning of symptoms, and the perceived cost (time, money, stigma) of seeking care.
- Sociologist David Mechanic identified several further factors that shape whether and how quickly a person acts on a symptom, beyond the sick role itself.

Factor	Effect on Illness Behaviour
Frequency and persistence of the symptom	Frequent or persistent symptoms are more likely to prompt action
Degree of disruption to daily life	Symptoms that interfere with work or family duties prompt faster action
Availability of information and resources	Easier access to care and information speeds up help-seeking
Competing needs	Financial pressure or caregiving duties can delay a person's own care
Interpretation of the symptom's meaning	A symptom seen as minor or 'normal for my age' is more often ignored

Case Vignette

Two patients each develop persistent fatigue. One works a desk job, has flexible hours, and immediately books a check-up. The other works long manual shifts, cannot easily take time off, and interprets the fatigue as 'just being tired from work' — delaying care for months. The Health Belief Model alone does not fully explain this difference; Mechanic's illness behaviour factors — disruption, competing needs, and interpretation — do.

1.3 Health Locus of Control and Illness Delay

Health locus of control describes the degree to which a person believes their health is controlled by their own actions (internal locus) versus external forces such as fate, chance, or powerful others, including doctors (external locus). Patients with a strongly internal locus of control tend to engage more actively in self-care, while those with an external locus may be more passive.

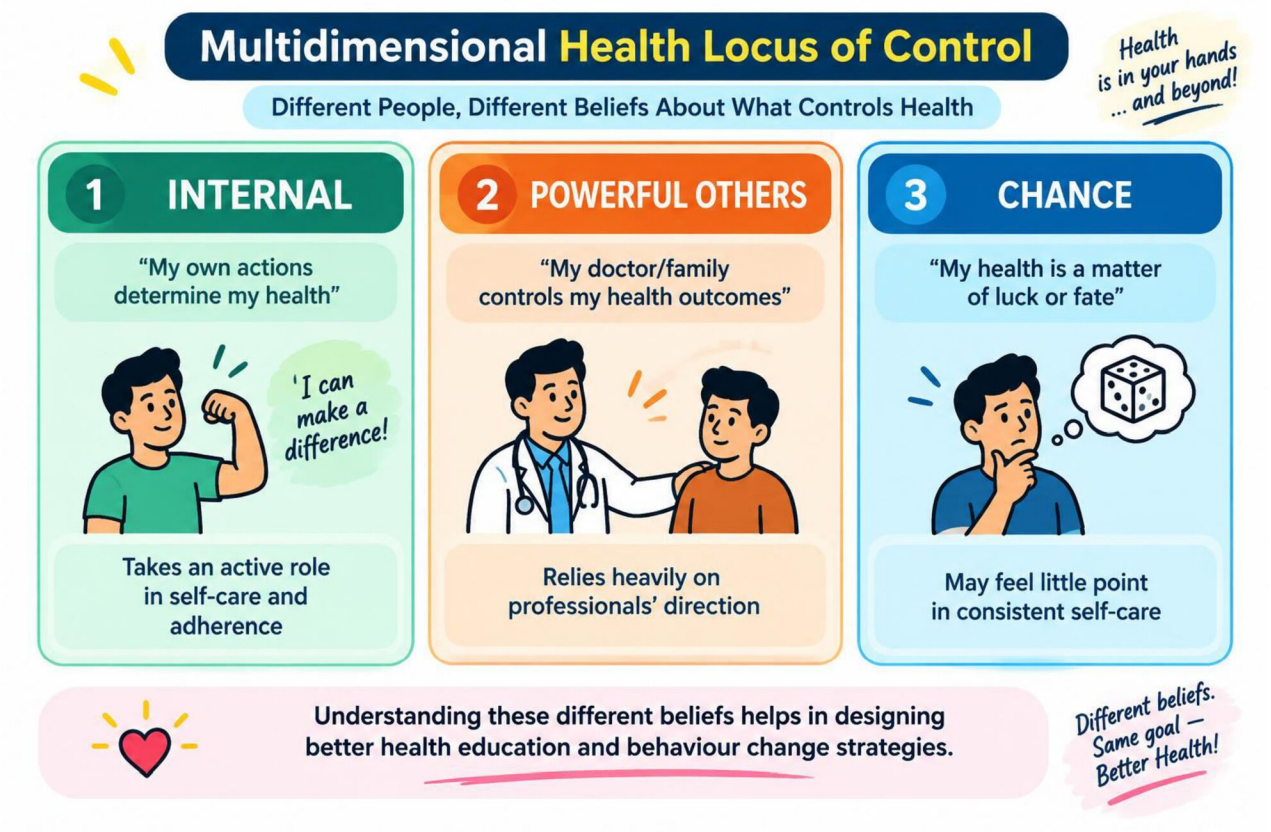

Fig 1.3 — The multidimensional Health Locus of Control

Wallston's Multidimensional Health Locus of Control scale recognises that 'external' control is not a single category — a patient may attribute their health strongly to powerful others (like a trusted physician) while placing little weight on chance, or vice versa. Knowing which pattern applies helps tailor communication: a patient high in 'powerful others' orientation often responds well to clear direction from a trusted pharmacist, while a patient high in 'internal' orientation usually responds better to being given options and information to decide for themselves.

- Appraisal delay: time taken to recognise a symptom as a sign of illness
- Illness delay: time taken to decide the symptom warrants professional care
- Utilisation delay: time taken to actually attend an appointment once the decision is made

Pharmacist's Role
Recognising which type of delay a patient is experiencing helps target the right intervention — a patient stuck in 'appraisal delay' needs help recognising the symptom's significance, while one stuck in 'utilisation delay' may need practical support such as help scheduling an appointment.

1.4 Self-Efficacy — Bandura's Four Sources

Self-efficacy — a person's belief in their own ability to carry out a specific behaviour — appears throughout health psychology, from the Health Belief Model to the Transtheoretical Model. Psychologist Albert Bandura identified four distinct sources through which self-efficacy is built or undermined.

Source	Description	Pharmacist Application

Mastery experience	Succeeding at the behaviour builds the strongest sense of confidence	Start with a small, achievable adherence goal before a harder one
Vicarious experience	Seeing someone similar succeed builds belief in one's own ability	Share relatable (anonymised) examples of other patients managing well
Verbal persuasion	Genuine encouragement from a credible source	Offer specific, sincere praise for real progress, not generic encouragement
Physiological states	Interpreting bodily sensations (calm vs anxious) as a signal of capability	Help an anxious patient reframe nervousness as normal, not a sign of failure

Exam Focus
Mastery experience is considered the single most powerful source of self-efficacy — this is why breaking a large behaviour change into small, genuinely achievable first steps is such an effective clinical strategy.

2. Psychosomatic Illnesses and the Mind-Body Connection

2.1 The Mind-Body Pathway

Psychosomatic illness refers to physical conditions that are genuinely caused or significantly worsened by psychological factors, particularly chronic stress. The connection operates through a well-documented physiological pathway linking the brain's stress response to measurable changes in the body.

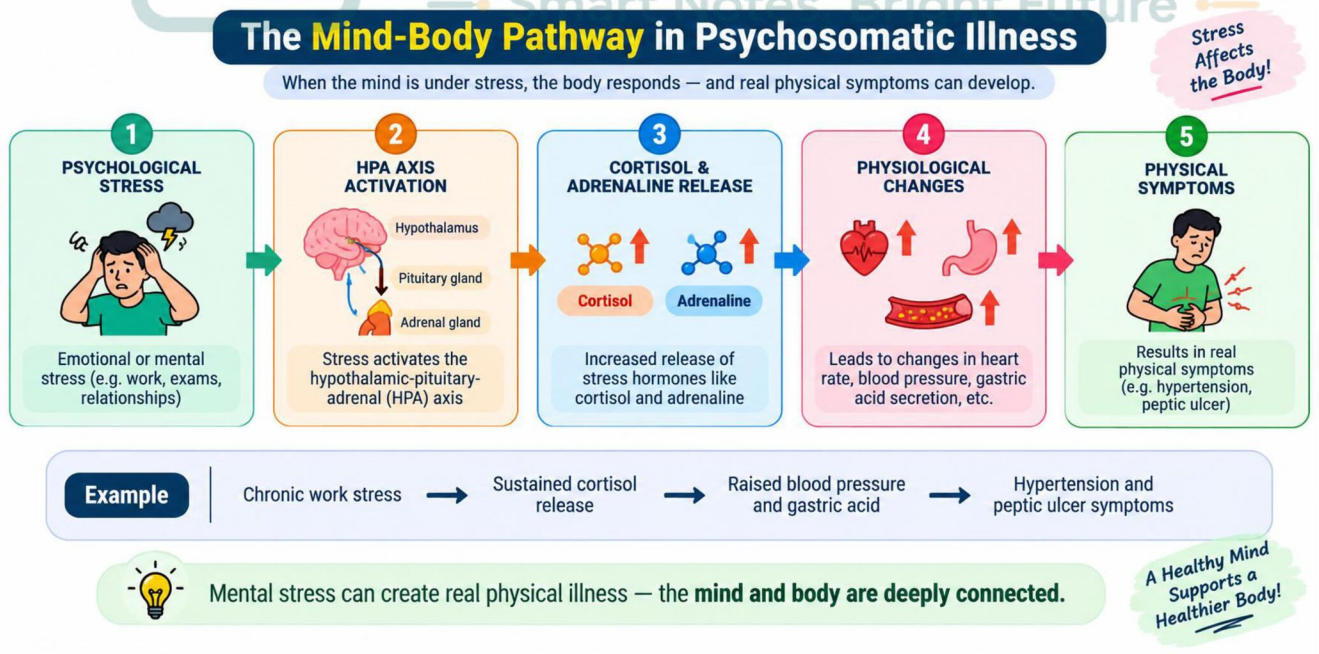

Fig 2.1 — The mind-body pathway in psychosomatic illness

Chronic activation of the hypothalamic-pituitary-adrenal (HPA) axis keeps cortisol and adrenaline elevated for extended periods. Over time, this contributes to raised blood pressure, altered immune

function, increased gastric acid secretion, and muscular tension — the physiological basis for a range of stress-linked physical conditions.

Two nervous system branches interact throughout this process. The sympathetic nervous system drives the acute 'fight-or-flight' response — raising heart rate, redirecting blood flow to muscles, and sharpening alertness. The parasympathetic nervous system normally restores calm afterward ('rest-and-digest'). When stress is chronic rather than occasional, the sympathetic system stays persistently over-activated and the body rarely completes a full return to its parasympathetic baseline, which is what allows short-term stress responses to translate into long-term physical illness.

System Affected	Typical Change Under Chronic Stress
Cardiovascular	Sustained rise in heart rate and blood pressure
Gastrointestinal	Increased gastric acid, altered gut motility
Immune	Suppressed immune response, slower wound healing
Musculoskeletal	Chronic muscle tension, particularly neck and shoulders
Respiratory	Faster, shallower breathing; can trigger bronchospasm

2.2 Common Psychosomatic Presentations

A number of common physical conditions have a well-established stress component, meaning psychological intervention alongside medical treatment often improves outcomes.

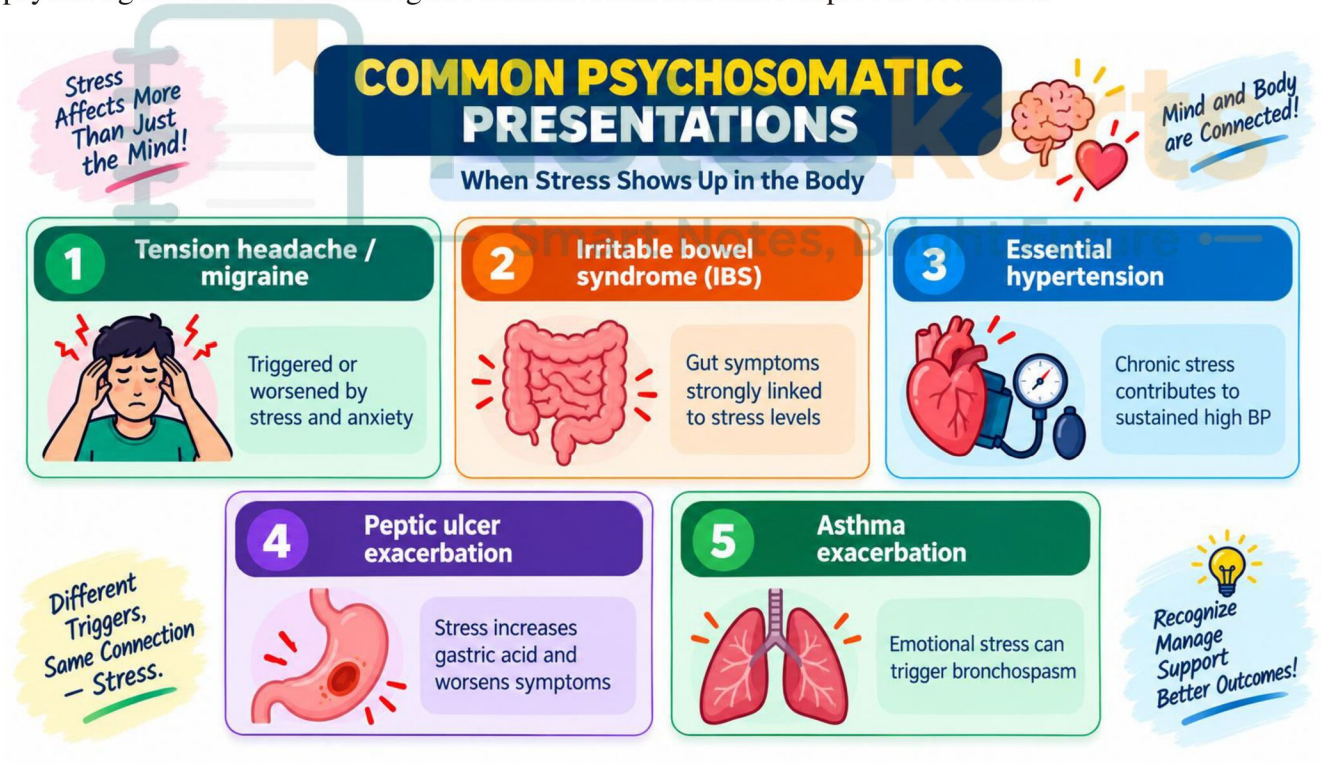

Fig 2.2 — Common psychosomatic presentations

Condition	Stress Link
Tension headache	Sustained muscle tension in the scalp and neck under stress
Irritable bowel syndrome	The gut-brain axis makes bowel symptoms highly stress-reactive
Hypertension	Chronic sympathetic activation raises baseline blood pressure

Peptic ulcer disease	Stress increases gastric acid and reduces protective mucus
Asthma	Emotional stress is a recognised trigger for bronchospasm

It is worth noting these conditions are multifactorial — genetics, diet, infection (as with H. pylori in peptic ulcers), and environmental triggers all play a role alongside stress.

Psychosomatic influence should be understood as one contributing factor among several, not the sole cause, and this nuance matters both for accurate patient education and for avoiding over-attribution of every symptom to stress.

2.3 Distinguishing Psychosomatic Illness from Malingering

It is essential to distinguish psychosomatic illness from malingering (deliberately faking symptoms for secondary gain, such as avoiding work). In psychosomatic illness, the physical symptoms and the patient's distress are completely genuine — the mechanism is stress-mediated physiology, not intentional deception. Treating a psychosomatic patient with suspicion or dismissal damages trust and delays appropriate care.

> **Applied Insight**
> A useful clinical stance is to validate the symptom as real while gently exploring the possible role of stress — "Your stomach pain is very real, and I notice it tends to flare during stressful periods; would it help to talk about what's been going on?" — rather than implying the patient is imagining or inventing it.

A related concept is alexithymia — a marked difficulty identifying and describing one's own emotions. Patients with high alexithymia may be unable to say "I feel anxious" and instead experience and report that same internal state purely as a physical sensation, such as chest tightness or nausea. This is not deception either; it is a genuine difference in how emotional distress is processed and expressed.

Feature	Psychosomatic Illness	Malingering
Symptom experience	Genuinely felt and distressing	Consciously fabricated or exaggerated
Underlying mechanism	Stress-mediated physiological changes	Deliberate deception for external gain
Patient's insight	Often unaware of the psychological link	Fully aware the symptom is not genuine
Appropriate response	Validation, biopsychosocial management	Requires a different, evidence-based clinical approach

2.4 Biopsychosocial Management of Psychosomatic Illness

Because psychosomatic illness arises from the interaction of biological, psychological, and social factors, effective management addresses all three dimensions rather than treating the physical symptom in isolation.

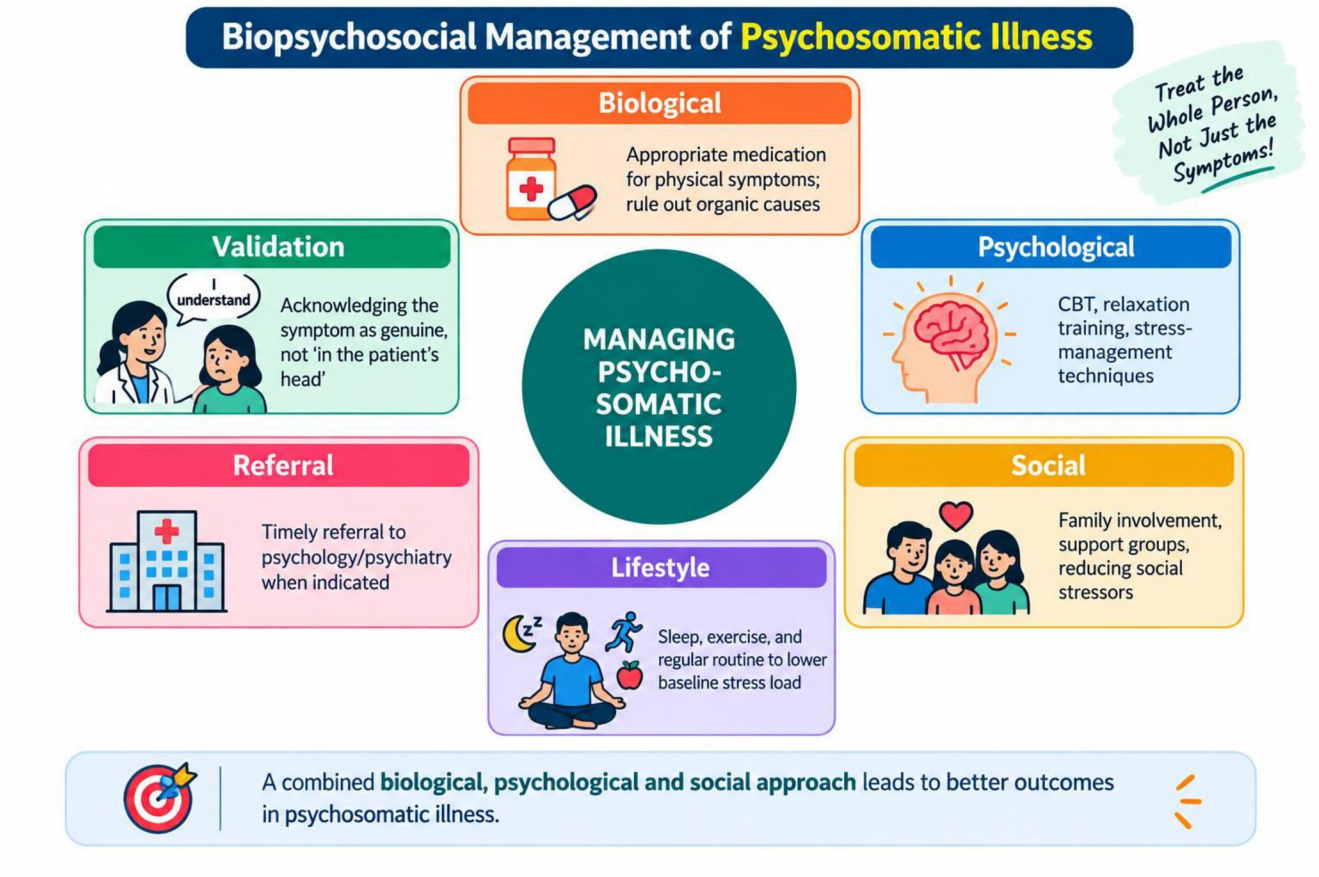

Fig 2.3 — Biopsychosocial management of psychosomatic illness

Pharmacist's Role

Even outside a formal psychology referral, a pharmacist can meaningfully support biopsychosocial management — validating the patient's experience, gently introducing the idea of stress as a contributing factor, and pointing toward simple relaxation techniques or support resources alongside appropriate medication counselling.

3. Behaviour Change Theories in Treatment Adherence

3.1 Cognitive Behavioural Therapy (CBT)

Cognitive Behavioural Therapy is based on the principle that thoughts, feelings, and behaviours are interconnected — changing one changes the others. In the context of treatment adherence, unhelpful automatic thoughts about a condition or medication often drive the behaviours that undermine treatment.

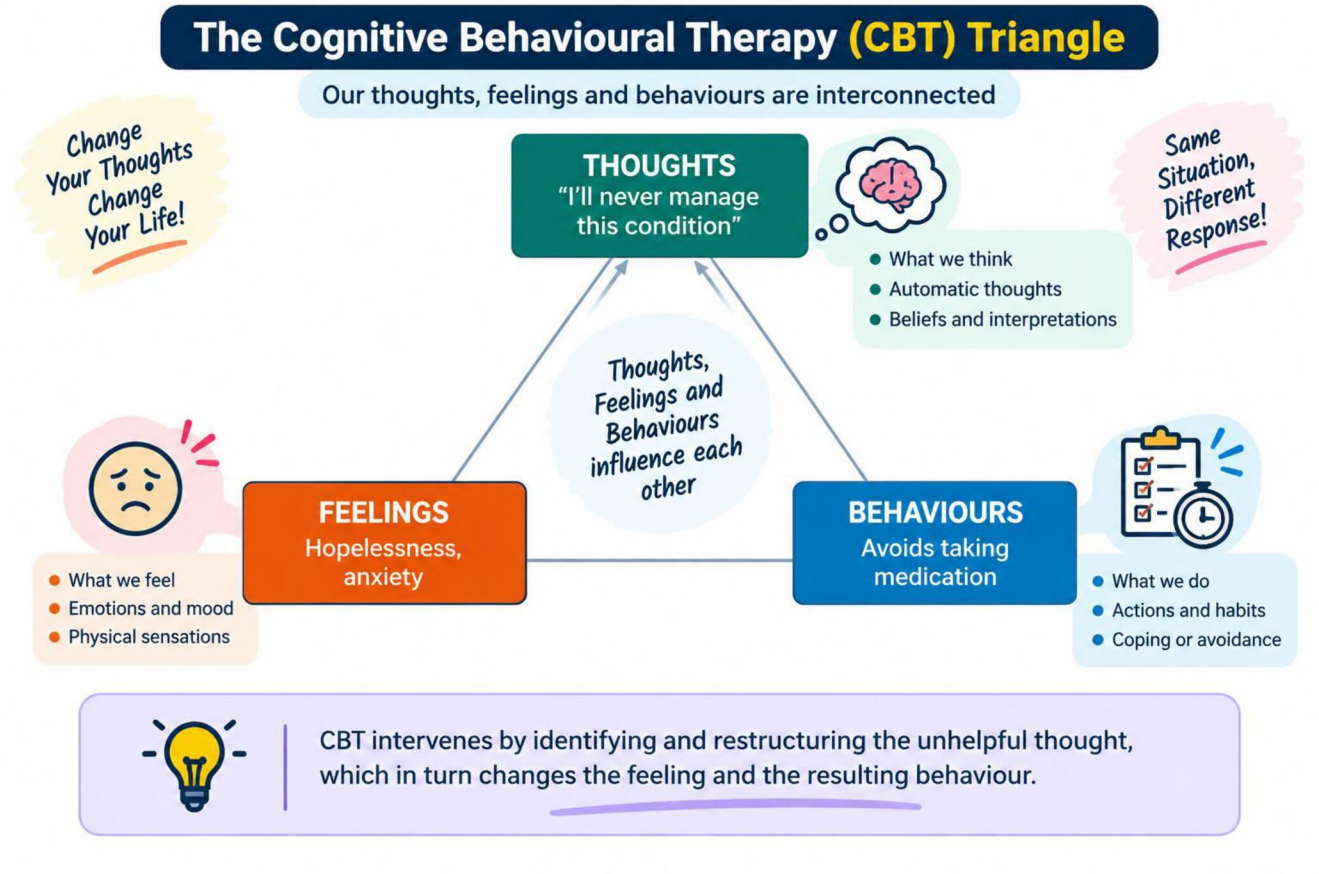

Fig 3.1 — The CBT triangle of thoughts, feelings, and behaviours

Certain patterns of unhelpful thinking, known as cognitive distortions, recur often enough in clinical practice to be worth recognising by name.

Cognitive Distortion	Example in a Health Context
Catastrophising	"This side effect means something is seriously wrong with me"
All-or-nothing thinking	"I missed one dose, so there's no point continuing the routine"
Overgeneralisation	"This medicine didn't work for my friend, so it won't work for me"
Fortune telling	"I just know this treatment is going to fail"

A pharmacist can apply CBT-informed techniques without being a therapist — simply helping a patient notice and gently question an unhelpful thought ("What evidence do you have that the medicine won't work?") can shift the feeling and the resulting behaviour.

Albert Ellis's ABCDE model gives a concrete structure for this kind of thought restructuring, extending the basic CBT triangle with two further steps: actively disputing the unhelpful belief and noting the resulting healthier effect.

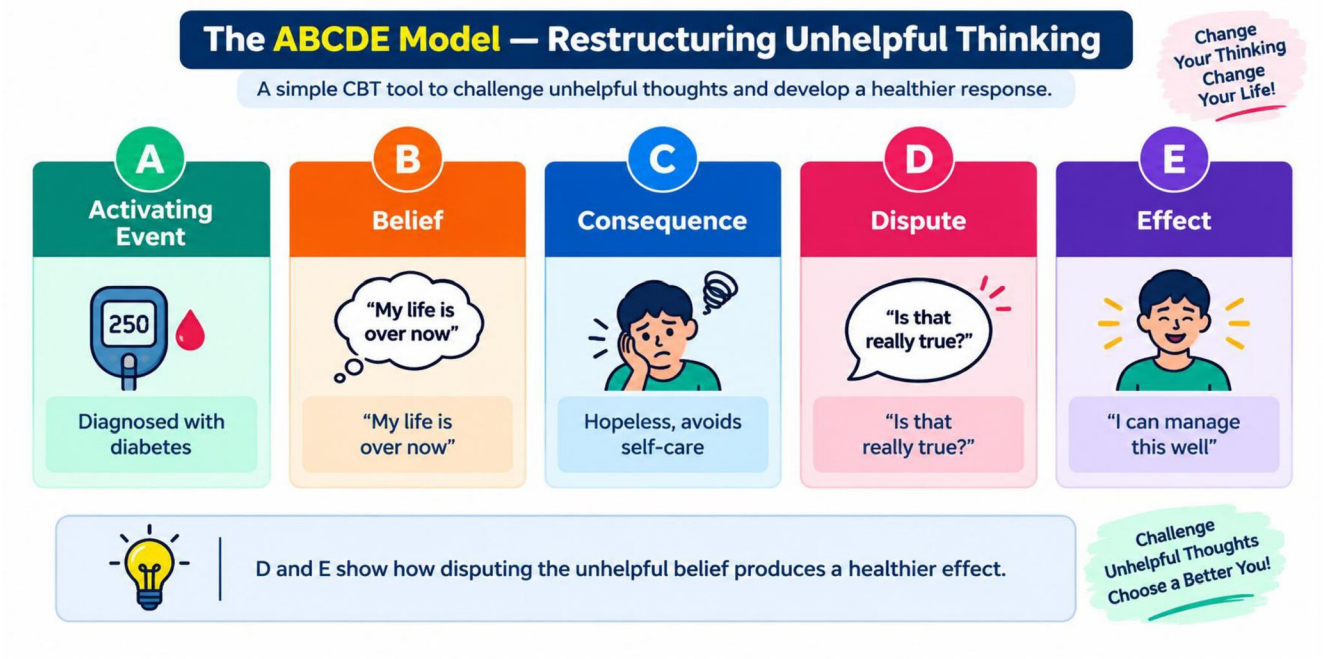

Fig 3.1b — The ABCDE model of restructuring unhelpful thinking

Step	Meaning
A — Activating Event	The situation that triggers the thought
B — Belief	The automatic thought or interpretation about the event
C — Consequence	The resulting emotion and behaviour
D — Dispute	Actively questioning the evidence for the belief
E — Effect	The healthier belief, emotion, and behaviour that follow

3.2 The Transtheoretical Model (Stages of Change)

Prochaska and DiClemente's Transtheoretical Model (TTM) describes behaviour change as a cyclical process moving through distinct stages, rather than a single decision. Recognising which stage a patient is in allows an intervention to be pitched appropriately, rather than pushing 'action' advice on someone who isn't ready for it.

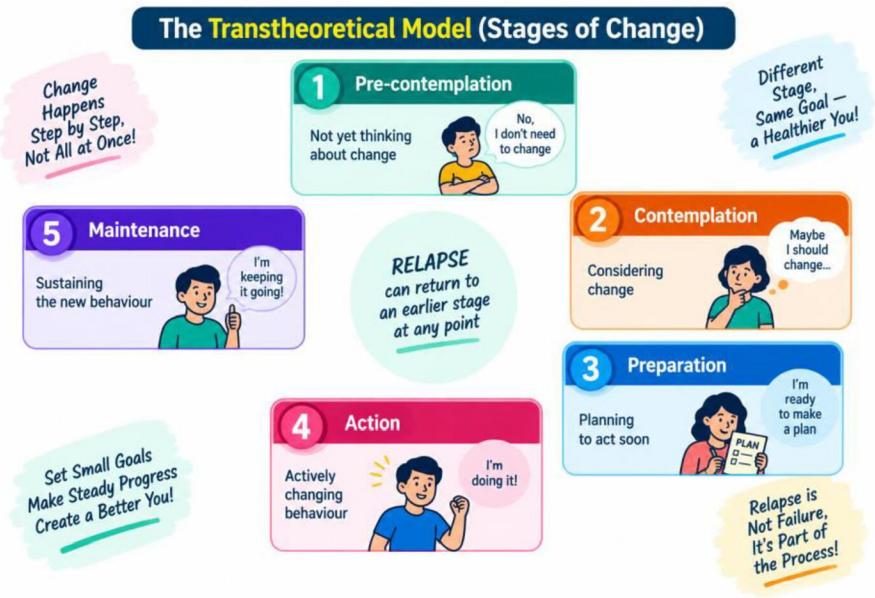

Fig 3.2 — The Transtheoretical Model (Stages of Change)

Stage	Patient Statement	Helpful Approach
Precontemplation	"I don't have a problem with my diet."	Raise gentle awareness without pressuring
Contemplation	"I know I should exercise more."	Explore ambivalence; discuss pros and cons
Preparation	"I'm planning to start next week."	Help build a specific, concrete plan
Action	"I've been taking it every day this month."	Offer praise and practical troubleshooting
Maintenance	"I've kept this up for six months now."	Reinforce identity change; plan for relapse risk

A common misconception is that relapse means the model has failed or that the patient has failed.

In reality, TTM explicitly treats relapse — a return to an earlier stage — as a normal, expected part of the cycle for most behaviours, not a sign of permanent failure. Patients who relapse typically re-enter the cycle at contemplation or preparation, often with useful lessons learned from the attempt, rather than starting from zero.

Pharmacist's Role

When a patient who had been adherent for months suddenly relapses, avoid framing it as 'starting over' — instead, acknowledge the months of real progress and help them identify what specifically triggered the relapse, which speeds the return to action far more than generic re-encouragement.

3.3 Motivational Interviewing — OARS

Motivational interviewing is a collaborative, patient-centred communication style designed to strengthen a person's own motivation for change, rather than imposing motivation from outside. Its four core skills are remembered by the acronym OARS.

Fig 3.3 — OARS, the core skills of motivational interviewing

Exam Focus
Motivational interviewing works with, not against, the patient's own ambivalence — rather than arguing for change (which often provokes resistance), the practitioner draws out the patient's own reasons for change already present within them.

Directing Style (Avoid)	Motivational Interviewing Style (Use)
"You need to take this every day without fail."	"What would make it easier to take this every day?"
"Smoking is bad for your heart condition."	"What have you noticed about how smoking affects you?"
"You really should exercise more."	"On a scale of 1-10, how ready do you feel to be more active?"

- **Change talk** = Patient's statements supporting **change**.
- It can be **small or big**.
- The practitioner **listens and encourages** these statements.
- Example: *"I want to quit smoking."*
- Change talk helps patients find **their own reasons to change**.
- More change talk often means a **higher chance of behaviour change**.
- **Key idea:** Let the patient **talk about why they want to change**..

3.4 Applying Behaviour Change Theory to Medication Adherence

Combining these theories gives a practical toolkit for improving medication adherence, one of the most persistent challenges in pharmacy practice.

- Assess the patient's stage of change before choosing an intervention (TTM)
- Use open questions and reflective listening rather than direct instruction (OARS)
- Help identify and gently challenge unhelpful beliefs about the medication (CBT)
- Address specific perceived barriers and build self-efficacy with small wins (HBM)

Pharmacist's Role
Non-adherence is rarely simple forgetfulness — it is usually rooted in a belief, a barrier, or a stage of readiness. Matching the intervention to the actual cause is far more effective than repeating the same advice more forcefully.

Root Cause of Non-Adherence	Matched Intervention
Doesn't believe the illness is serious	Raise perceived susceptibility/severity (HBM)
Not yet convinced change is worthwhile	Explore ambivalence with open questions (OARS)

Holds an unhelpful belief about the medicine	Gently dispute the belief (CBT/ABCDE)
Cost, side effects, or complexity of regimen	Problem-solve the specific barrier directly (HBM)
Doesn't feel confident managing the routine	Build mastery through small, achievable steps (self-efficacy)

Case Vignette

A newly diagnosed hypertensive patient keeps missing doses. Using TTM, the pharmacist first identifies she is only in the 'contemplation' stage — she isn't fully convinced she needs daily medication for a condition with no symptoms. Rather than lecturing (which HBM and stages-of-change theory both predict will backfire), the pharmacist uses an open question from OARS: "What are your thoughts about starting this medicine long-term?" The patient reveals a CBT-relevant belief — "If I feel fine, the medicine must not be needed." The pharmacist gently disputes this using the ABCDE approach and connects it to her actual stroke risk (raising perceived susceptibility per HBM), moving her toward preparation for consistent daily use.

It can help to see all four frameworks side by side, since each answers a different question about the same patient.

Model	Core Question It Answers
Health Belief Model	What beliefs are making this patient more or less likely to act?
Transtheoretical Model	How ready is this patient to change, right now?
Motivational Interviewing (OARS)	How should I talk with this patient to strengthen their own motivation?
CBT / ABCDE	What specific thought is driving the unhelpful behaviour?

4. Psychological First Aid and Crisis Communication

Crises relevant to a pharmacist's practice range widely in scale and nature, and recognising the type of crisis helps determine the appropriate response.

Crisis Type	Example	Typical Response Needed
Individual medical emergency	A patient collapses in the pharmacy	Immediate first aid, emergency services, PFA for bystanders
Individual psychological crisis	A patient in acute distress or expressing suicidal thoughts	Calm PFA, safety assessment, referral to crisis support
Community/mass casualty event	A serious road accident or building fire nearby	PFA for multiple affected people, coordination with responders
Public health emergency	A disease outbreak affecting the wider community	Population-level crisis communication, consistent messaging

4.1 Psychological First Aid — Look, Listen, Link

Psychological First Aid (PFA) is a humane, practical approach to supporting someone in the immediate aftermath of a crisis, disaster, or highly distressing event.

It is not therapy or counselling — it does not require a mental health qualification, and it focuses on immediate safety, stabilisation, and connection to support.

Fig 4.1 — Psychological First Aid: Look, Listen, Link

- Do not force someone to talk about the event if they do not want to
- Provide accurate, simple information about what is happening and what to expect
- Help meet immediate practical needs — safety, water, contacting family — before anything else
- Avoid making promises you cannot keep, and avoid minimising what happened

Case Vignette

A pharmacy is near a road accident, and a shaken bystander comes in asking for water and to sit down. Applying PFA: Look (assess she is physically unhurt but visibly trembling), Listen (let her describe what she saw without pressing for details, staying calm and present), Link (help her contact a family member and suggest she wait until someone can accompany her home) — no diagnosis or counselling is needed, just calm, practical human support.

- PFA **does not force** a person to talk about the trauma.
- It does **not require detailed retelling** of the event.
- It avoids **forced emotional debriefing** soon after trauma.
- Forcing people to remember trauma may **increase distress**.
- PFA lets the person **choose the pace** and what they want to share.

Exam Focus

A key exam distinction: Psychological First Aid supports stabilisation and does not require disclosure; formal debriefing that mandates recounting the traumatic event is no longer recommended practice and should not be confused with PFA.

4.2 Principles of Crisis Communication

Crisis communication is the practice of communicating clearly and credibly during an emergency, outbreak, or other high-stakes event where public trust and accurate understanding are critical. The Centers for Disease Control's widely-taught CERC (Crisis and Emergency Risk Communication) framework and related models converge on a consistent set of principles, developed from decades of studying how the public actually responds during emergencies — including the finding that people who receive an honest, if incomplete, picture early tend to trust and cooperate with authorities far more than those who receive delayed or overly reassuring messaging.

Fig 4.2 — Six principles of crisis communication

Exam Focus
The order matters: showing empathy typically comes before delivering facts and figures — people cannot absorb detailed information while their emotional need for acknowledgement is unmet.

Channel	Best Suited For
In-person announcement	Small, local audiences needing immediate, high-trust information
SMS / messaging alerts	Fast, direct reach when internet access may be unreliable
Social media	Rapid, wide reach and two-way engagement, but higher misinformation risk
Official press briefings	Establishing a single authoritative source amid conflicting reports

4.3 Communicating in a Public Health Emergency

Pharmacists are often a frontline, trusted source of information during public health emergencies such as disease outbreaks. Effective crisis communication in this setting follows the same core principles, applied at a population scale.

- Communicate uncertainty honestly — acknowledge what is not yet known rather than overstating confidence
- Repeat key messages consistently across channels to counter misinformation
- Provide clear, specific, actionable guidance ("wash hands for 20 seconds") rather than vague advice
- Actively monitor and gently correct misinformation circulating in the community

Misinformation Pattern	Constructive Response
Fear-driven rumours spreading faster than facts	Issue timely, calm corrections from a trusted local source
Distrust of official sources	Acknowledge past failures honestly rather than dismissing concern
Conflicting advice from different outlets	Point consistently to one clear, authoritative reference
Well-meaning but inaccurate advice shared by family	Correct gently without shaming the person who shared it

Correcting misinformation works best when it avoids repeating the false claim prominently (which can inadvertently reinforce it) and instead leads with the accurate information, briefly acknowledges the misconception, and explains why the correct guidance is correct.

Pharmacist's Role
During the COVID-19 pandemic, community pharmacists in India were frequently the first and most accessible source of guidance for many patients — a reminder that pharmacy-level crisis communication has real, population-scale impact, not just an individual one.

5. Mental Health Promotion and Stigma Reduction

5.1 Types of Mental Health Stigma

Stigma is one of the most significant barriers preventing people from seeking mental health care. It operates at several distinct levels, each requiring a different response.

Fig 5.1 — Types of mental health stigma

- **Public stigma**: Negative attitudes of society toward people with mental illness.
- **Self-stigma**: A person starts believing these negative ideas about themselves.
- **Structural stigma**: Unfair treatment through **systems, rules, or policies**.
- These forms of stigma **reinforce each other**.

In the Indian Context

- Mental illness may be seen as affecting the **whole family's reputation**.
- It may affect **marriage prospects and social status**.
- Mental problems are sometimes described as **physical or spiritual problems**.
- Families may first seek help from **traditional or religious healers**.
- Healthcare professionals should **respect cultural beliefs** while guiding people toward **appropriate professional care**.

5.2 Strategies to Reduce Stigma Through Communication

Communication itself — the words used, the stories told, and the platforms chosen — is one of the most powerful tools available for reducing stigma.

Fig 5.2 — Strategies to reduce mental health stigma

Language to Avoid	Preferred Alternative
"Committed suicide"	"Died by suicide"
"Suffers from depression"	"Has depression" / "Is living with depression"
"Crazy", "psycho", "insane"	Specific, accurate clinical terms
"A schizophrenic"	"A person with schizophrenia"

5.3 Stigma's Clinical Cost — Diagnostic Overshadowing

Stigma is not only a social harm — it has a direct, measurable clinical cost.

Diagnostic overshadowing occurs when a physical symptom in a person with a known mental illness is wrongly attributed to that mental illness, delaying or preventing proper investigation of a genuine physical problem.

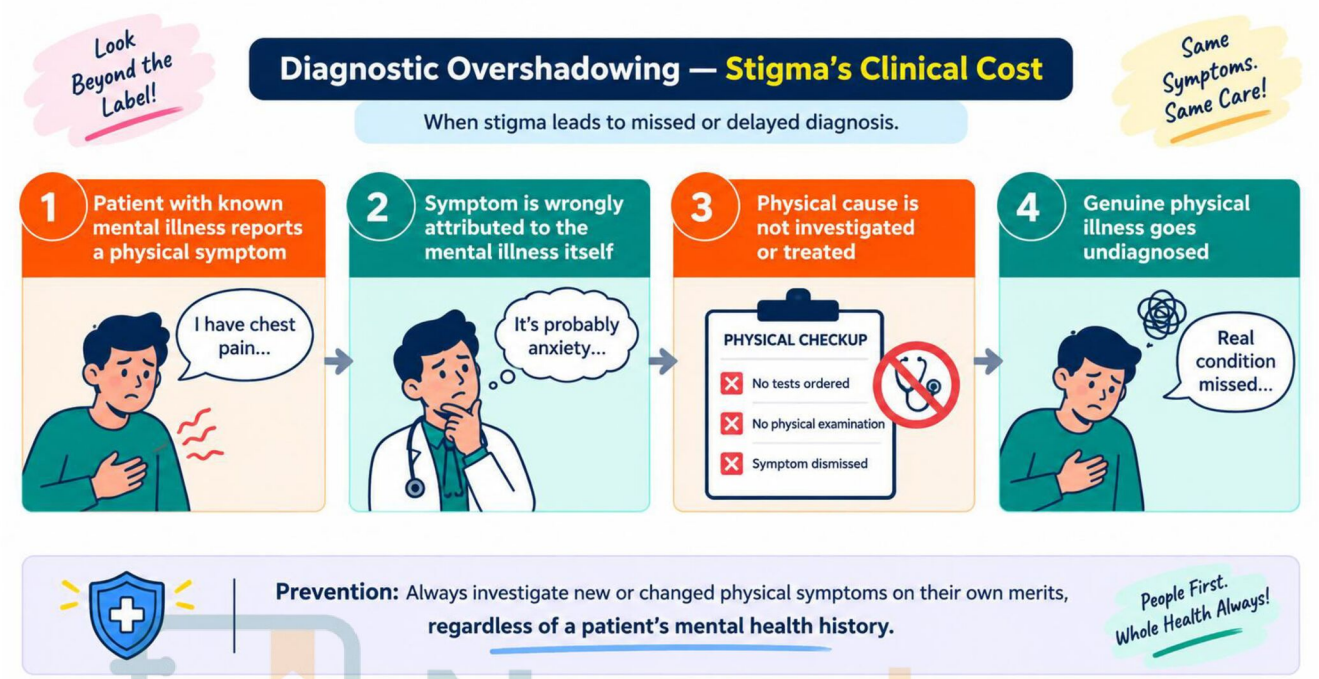

Fig 5.3 — Diagnostic overshadowing and its clinical cost

Applied Insight

A patient with a documented history of anxiety who reports chest pain deserves the same cardiac work-up as any other patient — attributing the symptom to 'just anxiety' without appropriate investigation is a well-documented pattern that has led to missed diagnoses in real clinical settings.

5.4 The Pharmacist's Role in Mental Health Promotion

As one of the most accessible healthcare professionals, a pharmacist is often the first point of contact for someone experiencing mental health difficulties, whether or not the visit is framed that way.

- Dispense psychiatric medication with the same calm, non-judgemental manner as any other medicine
- Watch for signs that someone may be struggling — repeated requests for sleep aids, visible distress, or questions phrased indirectly
- Know local referral pathways for mental health support and offer them without pressure
- Model person-first, respectful language in every patient interaction, not only when discussing mental health explicitly

Pharmacist's Role

A pharmacist does not need to diagnose or treat mental illness to make a meaningful difference — consistently respectful, unhurried, non-judgemental communication is itself a stigma-reducing intervention, delivered every single day at the counter.

Mental health promotion also extends beyond individual interactions to the wider community. Pharmacies are trusted, low-barrier community spaces — well suited to hosting simple awareness materials, supporting local screening or awareness days, and signposting toward helplines and support groups, particularly in areas where dedicated mental health services are scarce or carry significant social stigma to visit directly.

Everyday Situation	Stigma-Reducing Response
Patient seems embarrassed collecting antidepressants	Hand it over exactly as routinely as any other prescription
Family member asks to hide a diagnosis from the patient	Explain gently why the patient has a right to understand their own treatment
Patient jokes self-deprecatingly about being 'crazy'	Respond warmly without echoing or reinforcing the label
Colleague uses stigmatising language about a patient	Model corrected, respectful language rather than confronting harshly