Health Psychology
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Lecture 7, Prep. Guide 6
Chapter Eight: Use of Health Services
Chapter Nine: Patient-Provider

Symptom Perception & Reporting
Perception ➔ interpretation ➔ reporting
Symptom perception depends upon
1. Individual differences in somatic attention
2. Transitory situational factors
   o Stress aggravates symptom experience
   o Exciting demanding situations, & physically active situations ➔
   o Boring situations ➔

Recognition and Interpretation of Symptoms: Recognition
Mood
- Those in a positive mood
  • Rate themselves as more healthy
  • Report fewer illness-related memories
  • Report fewer symptoms
- Those in a negative mood
  • Report more symptoms
  • Are pessimistic about relieving their symptoms
  • Perceive themselves as more vulnerable to future illness
  o Recall optimism and health findings

Symptoms and Mood
Mood - Current & dispositional
Watson & Pennebaker (1989, 1991) - those high in Negative affect (NA) are more sensitive to physical discomfort than those low in NA
- NA ➔ self reported health (strong correlation)
- weak relationship to actual physiological health measures
WHY?
Symptoms and Mood

Watson & Pennebaker (1989) suggested 3 hypotheses to explain this relationship

1. Disability Hypothesis: health problems lead to greater NA
2. Psychosomatic Hypothesis: high NA leads to more health problems (e.g. anxiety, anger, depression → poor health)
3. Symptom perception Hypothesis: those high in Negative affect (NA) are more sensitive to physical discomfort than those low in NA

Symptom Interpretation

- Age differences - normal age related changes are often interpreted as signs of illness
- Meaning is influenced by how common the symptom is and past experience
- Learning: sick role behavior - how to act when ill
- Cultural Experiences & Norms: cross-cultural differences in the meaning attributed to symptoms affects symptom reporting
- Lay referral system: an informal network of non-practitioners who offer interpretations

Recognition/Interpretation of Symptoms: Cognitive Representations of Illness

- Illness Schemas - Illness Representations
  - Organized conceptions of illness
  - Acquired through the media, personal experience, family and friends
- Illness Schemas influence
- Models of illness – acute, chronic, cycling

Recognition and Interpretation of Symptoms: The Internet

- Is the Internet a lay referral network?
  - 58% of Canadians use the Internet to search for medical or health related information
  - Illness support groups & message boards
  - WebMD, etc.
  - Symptom checkers
Seeking Medical Care

Symptom characteristics that are interpreted as serious:
- new, unexpected, painful, disruptive, highly visible, are to a valued body part
- serious symptoms
- Familiar symptoms & symptoms that can be explained or attributed to known causes are often ignored
- Ignored symptoms \rightarrow treatment delay

Medical Care-seeking Models

- Medical help-seeking as a form of “illness behavior” (Mechanic, 1964, 1978)
- The self-regulatory model of care seeking (Cameron, Leventhal, & Leventhal, 1995)
- Medical care-seeking as a coping process
  - symptom detection initiates a complex process of cognitive and emotional responses and coping procedures that lead to outcome appraisals

Self-regulatory Model of Care-seeking

Stages of Delay in Seeking Treatment

Patient delay = the period between 1st awareness of symptom(s) & treatment
1) Appraisal delay: time it takes to appraise symptom as a sign of illness
2) Illness delay: time between recognizing you are sick & deciding to seek medical care
3) Behavioral delay: time between decision to seek care & the person acting on that decision
4) Medical delay: time between making an appt. & 1st receiving medical care
Other Factors That Affect Treatment Delay

1. Stress - Cameron, Leventhal, & Leventhal (1995) found that stress influenced symptom perception
   - ambiguous symptom + recent life stressor →
   - ambiguous symptom + chronic stressor →
   - unambiguous symptoms + stressor →

2. Personality/Coping Style
   - procrastinators & those who use denial as a coping strategy are more likely to delay seeking treatment for non-serious or ambiguous symptoms

Anxiety and Medical-care Seeking

Anxiety & Arousal

ANXIETY
- Negative emotional state with feelings of nervousness, worry and apprehension associated with activation or arousal of the body
We interpret unexplained arousal as something wrong
- Cognitive – worry, nervousness, negative thoughts
- Somatic – physical activation, muscle tension, sweating
- State Anxiety – emotional component, situationally induced
- Trait Anxiety – acquired behavioral tendency or disposition that influences behavior

Misusing Health Services: Emotional Disturbances

- About 2/3 of physicians’ time is spent with psychological complaints
- Why do people seek physicians’ time when the complaints are not medical?

Sirois, F. M., & Gick, M. L. Psychological factors in medical care seeking: To seek or not to seek has always been the question. Paper presented at the 65th annual convention of the Canadian Psychological Association, St. John’s, Nfld.
Misusing Health Services: Emotional Disturbances

- Secondary gains:
  - Benefits that an illness brings
  - Ability to rest
  - Freedom from unpleasant tasks
  - Care of one’s needs by others
  - Time off from work
- Secondary gains can
  - Be reinforcing
  - Interfere with return to good health

Who uses health services? Gender

- Women more frequently than men
  - the care-seeking paradox
  - Pregnancy/childbirth account for much of the difference but not all
- Women compared to men may
  - Women’s health care is fragmented

Complementary & Alternative Medicine (CAM)

Eisenberg, et al. (1993; 1998): 1 in 3 people has used CM at least once (1993); 46.3% by 1998

- Massage
- Homeopathy
- Herbal Medicine
- Imagery
- Biofeedback
- Energy Healing
- Chiropractic
- Acupuncture

CAM use: Beliefs & Motivations

Murray & Sheppard (1993): extra time & attention spent by the alternative therapists was the most valued aspect of receiving alternative treatment

Dissatisfaction with OM as a Push to try CAM
(poor communication, not enough time, OM seen as ineffective for one’s problem)

More health awareness, more personal control as a Pull to try CAM (CAM focuses on preventative health behaviors, patient involvement, more holistic)
Participants and procedure
- Participants were recruited by distributing questionnaires at 11 orthodox medicine health clinics and 16 complementary medicine health clinics in Windsor.
  - CAM clinics included provided the following treatment(s): chiropractic, massage therapy, acupuncture, naturopathy, homeopathy, and energy healing with reiki and reflexology.
- 239 participants who were classified participants into three client groups depending on the extent of their CAM use
  - Conventional medicine users (n = 54)
  - New/infrequent CAM users (n = 73)
  - Established CAM users (n = 112)

CAM use in Windsor
- Research has suggested both ideological and pragmatic reasons for CAM use (e.g., Boon, Brown, Gavin, & Westlake, 2003; Sirois & Gick, 2002).
- Few studies have examined CAM use in underserved regions or the impact of physician availability on intentions to use CAM.
- Ontario has third worst patient to physician ratio in Canada
- Southwestern Ontario in particular has the lowest proportion (4.5%) of current physicians accepting new patients (College of Physicians and Surgeons of Ontario, 2005).

Figure 2: Responses to Doctor Availability Questions for the Total Sample (N = 239)
OTHER RESULTS

- New CAM clients were less satisfied with the technical quality of their conventional medical care and reported greater health-related distress than the CM clients.
- More experienced CAM clients (and New CAM clients to a lesser degree) preferred a more egalitarian doctor-patient interaction style.
- Congruency vs. reciprocal influence hypothesis
- Non-CAM users indicated that they might try CAM if a friend or family member recommended it.
Patient-Provider Communication: Judging Quality of Care

- People judge adequacy of care by criteria that are irrelevant to its technical quality
- The manner in which care is delivered is used as the criteria
- Satisfaction declines when physicians express uncertainty about a condition
- Actually, technical quality of care and the manner in which it is delivered are unrelated

Patient-Provider Communication: Judging Quality of Care

- What qualities make you feel more satisfied with your doctor?
- What are some things that a doctor does that make you feel
  - less satisfied with the visit?
  - Less confident in her/his recommendations and treatment?

Patient Satisfaction

Patient satisfaction with care is predicted by several factors

- Overall quality of health-care
- Competence of the provider
- Communication with provider
- Efficacy of the treatment – symptom outcome
- Patients’ expectations about the care they will receive
- Demographic predictors

Patient-Provider Communication: Patient Consumerism

- At one time, patients accepted the physician’s authority
- Now patients have attitudes of consumers
  - To induce a patient to follow a treatment plan requires the patient’s cooperation
  - Patients often have considerable expertise about their health problems
  - Use of the Internet for health information
- These changes require better communication
Patient-Physician Interaction

Active-Passive Model: patient is unable to participate in the relationship due to incapacitation -- common in emergency situations

Guidance-cooperation Model (authoritarian; doctor-centered): patient seeks advice, answers questions as asked, doctor responsible for decision making

Mutual-Participation Model (egalitarian; patient-centered): patient & doctor share in treatment decisions

Interaction, Satisfaction, Compliance

Ditto, et al. (1995): examined patients beliefs about physicians as related to compliance & satisfaction

- measured patients beliefs/expectations about physicians: authoritarian vs. egalitarian
- presented medical scenarios w/doctor using either egalitarian or authoritarian style
- Those who expected egalitarianism responded more positively to egalitarian than to authoritarian doctors, & were more likely to comply to doctors that matched their style preference.
- Those who expected authoritarian rated both styles the same

WHY?

Patient-Provider Communication: Changes in Health Care Philosophy

- Physician’s role is changing
  - More egalitarian attitudes
  - Less dominance and authority
- Holistic health acknowledges
  - Eastern approaches to medicine
  - Low-technology interventions
  - Greater emotional contact between patient and provider

Patient-Provider Communication: Patient Attitudes Toward Symptoms

- Patients focus on
  - Pain
  - Interference with activities
- Providers are concerned with
  - Underlying illness
  - Severity
  - Treatment
- Embarrassment may lead patients to give faulty cues about health history and practices
Patient-Provider Communication: Providers and Faulty Communication

Problem: Use of Jargon
- Patients don’t understand many terms that providers use
- Examples?
- Why is jargon used?

Problem: Stereotypes of Patients
- Physician doesn’t like to treat this
  - Patient (examples: low SES, elderly)
  - Disease (examples: depression, chronic illness)
- Sexism is a problem
  - Male physicians and female patients do not always communicate well

Compliance/Adherence

Compliance/Adherence: degree to which patients carry out behaviors recommended by healthcare professionals

Nonadherence: When patients do not adopt the behaviors and treatments their providers recommend
  - Estimates range from 15% to 93%

Cultural differences, age, physician characteristics, & gender also affect adherence

Results of Poor Communication: Causes of Adherence

- The first step in adherence is understanding the treatment regimen
- Satisfaction with the patient-provider relationship increases adherence
- The final step involves the patient’s decision to adhere.
Results of Poor Communication: Causes of Adherence

Qualities of the Treatment Regimen influence the degree of adherence
- Low Levels of Adherence are associated with treatment regimens that:
  - Creative nonadherence
    - Also called, “intelligent nonadherence”
    - Modifying/supplementing a prescribed treatment regimen
    - Examples:
    - Why do patients alter their treatment regimens?

Results of Poor Communication: Causes of Adherence

- Physicians attribute nonadherence to
  - Patients' uncooperative personalities
  - Patients' ignorance
  - Patients' lack of motivation
  - Patients' forgetfulness
- The greatest cause of nonadherence is

Results of Poor Communication: Nonadherence to Treatment

- Behavioral change recommendations
  - 80% fail to follow through and stop smoking or follow through on a restrictive diet
  - Patients in cardiac rehab - adherence rates of 66-75%
  - Greatest adherence rates in
    - HIV, arthritis, gastrointestinal disorders, cancer
  - WHY?
The Placebo Effect

“Medicine is not a natural but a social science”
Henry Sigerist, 1946

Events evoked by belief have their immediate cause within the patient, so therefore they are under the control of the patient
Chaput de Saintonge & Henxheimer, 1994

“Belief becomes biology”
Norman Cousins, 1989

The Placebo Effect: The Power of Belief

The Origins of Placebos

- from Latin meaning “I shall please”
- ancient placebos included lizard’s blood, swine teeth, leechings, and most early “medical” practices
- imagination-alteration as a means of cure during the Renaissance relied upon unqualified belief in the physician’s words & practices

Galen: “he cures most in whom most are confident”
Paracelsus: “have a good faith, a strong imagination, and they shall find the effects.”

The Placebo Effect: Modern Conceptualizations

- Current definition: A placebo is a substance or therapy that has no specific activity for the condition being treated (Shapiro, 1964).
- Placebo effects are often referred to as “non-specific effects” in contrast to the specific effects expected by prescribed medical treatment
- modern placebos include sugar pills, saline injection, vitamins, and other medications that are prescribed regularly but may be non-specific in their action

The Powerful Placebo: Mind over Medicine?

- Interest in the Placebo peaked after Beecher’s (1955) classic paper citing the constancy of the placebo effect as 35.2% (+/- 2.2%)
- Placebo control groups are used in testing the effectiveness of certain drugs – effects beyond the placebo group are considered to be due to the “real” effects of the drug
- Nuisance variable or “noise” that interferes with evaluating a drug’s strength??
Placebo Effects:
Power of Belief

Belief that a Placebo will work may be essential for its effectiveness
- cultural beliefs about medicine/treatment
- personal beliefs based on experience
- social influences through the media

Situational factors also influence administration of placebo - Placebo salient cues in the treatment environment

Explaining Placebo Effects:
Situational Factors

Administration of placebo - Placebo salient cues

Physical cues: any physical aspect of the Tx &/or environment
- Injection > oral, capsules > pills, more > less
- Blue, green best for tranquillizers, pink, yellow red for stimulants
- Brand name > no name

Informational cues: content of the Tx instructions
- Information about a drug’s effects can elicit a placebo response & alter the person’s responses in the direction suggested by the information given (Flaten, 1998)

Explaining Placebo Effects:
Situational factors

Interactive cues: the way in which the Tx instructions are delivered by Tx administrator

Behaviors & attitudes of the person administering the placebo influence placebo response
- A friendly, sympathetic practitioner > placebo effects cold, & distant practitioner < placebo effects
- doctor has high expectations about treatment outcome --> placebo more likely to be effective than if the attitude towards the placebo is negative (Shapiro, 1964)

The Search for the Placebo Responder

Individual differences proposed to have an influence on placebo responding
- Anxiety
- Traditionalism/ Acquiescence
- Openness to experience
- Self-focused attention
- Religiosity
- Susceptibility to hypnosis (primary suggestibility)
Relationship of Attention to Depression, Anxiety & Arousal

- High anxiety impairs attention to external cues.
- Self-focused attention increases anxiety.
- Depressive affect may be decreased by a shift from internal attention to external attention.
- An optimum level of arousal may be necessary for placebo effects to occur, but too much anxiety decreases the chance of a placebo response.

Treatment-centered vs. Person-centered models

**Tx-centered:** places the power of healing in the hands of the doctor or treatment administrator.
- **Conditioning models** suggest that situational variables elicit placebo responses.
- **Endogenous opiate theory** focuses on the biological factors in placebo analgesia.

**Person-centered:** healing as a natural resource residing within the individual.
- **Expectancy/Attribution models** suggest that previous experiences lead to expectancies about treatment outcomes.

Belief-activation Model

- Placebo-salient Cues:
  - Physical cues
  - Informational cues
  - Interactive cues

- Individual Differences:
  - Self-focused attention
  - Anxiety

- Health Beliefs:
  - Cultural
  - Personal

- Internal Somatic Stimulus:
  - Low
  - High

- Placebo-salient Cues
  - Positive placebo response
  - No placebo response
  - Negative side effects
  - Reverse placebo response

On the practical side...

If you want to improve your chances of experiencing a placebo effect and activate your body’s self-healing processes:
- Make sure you believe in the treatment/medicine you are taking as well as the person who has suggested or administered it.
- Avoid over-focusing on internal sensations/states.
- Avoid being overly anxious about the treatment.
- Be hopeful about the treatment outcome.