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Stress, Psychological Factors, and Health

Chapter Overview:

Adjustment Disorders

Adjustment disorders are maladaptive reactions to identified stressors. Impairment usually takes the form of problems at work or in social relationships or activities, or by signs of personal distress that are greater than expected given the circumstances.

Stress and Illness

Many factors interact to determine physical health. Health is NOT a matter of luck. Biological variables such as family history of an illness, exposure to pathogens, the ability of the immune system to fight them off, and inoculations are all common causes or deterrents of physical illnesses. The immune system combats disease by producing white blood cells that systematically envelop and kill pathogens, worn out body cells, and cancerous cells.

Stress and life changes that affect our health include economic realities, cultural issues, and ethnic variables. Health problems have differential impacts on diverse cultural and ethnic groups. Social support helps buffer the impact of stress. Natural and technological disasters are dangerous as they occur and also create lingering problems in adjustment.

Psychological factors that affect our health include our personalities and our behavior patterns. Many personality features, such as self-efficacy expectancies, psychological hardiness, optimism and a sense of humor, are believed to have positive effects on our health. The stress imposed by social, biological, and physical environmental factors reflect people's psychological appraisal of these factors. Persistent stress eventually exhausts our capacities to cope by compromising our immune systems.

Psychological Factors and Physical Disorders

Psychological factors are involved in the origins, course, and treatment of many physical health problems. The principle of individual response specificity holds that people respond to stress in idiosyncratic ways, giving rise to particular health problems.

Headaches are symptomatic of many medical disorders. The most common headache is the muscle-tension headache, which is often stress related. Behavioral methods of relaxation training and biofeedback can be helpful in treating headaches.

Risk factors in cardiovascular disorders include age, gender, family history, socioeconomic status, obesity, hypertension, blood cholesterol, eating and drinking patterns, Type A behavior, anger, phobic anxiety, stress, and a sedentary lifestyle.

Asthma attacks can be triggered by allergic reactions; cold, dry air; emotional responses such as anger; and stress. Treatment for asthma often consists of medications, including bronchodilators, but asthma sufferers can improve their breathing by muscle relaxation training and family therapy that reduces stresses on asthmatic children.

Risk factors for cancer include family history, dietary practices (especially high fat intake), heavy alcohol use, smoking, and sunbathing. Research shows that a fighting spirit and an optimistic outlook on treatment may help people recover from cancer. Psychological interventions help cancer patients cope better with the symptoms of the disease and its treatment.

Our behavior patterns influence our risk for contracting AIDS. Psychologists have become involved in the prevention and treatment of AIDS because AIDS, like cancer, has devastating psychological effects on victims, their families and friends, and society at large, and because HIV infection can be prevented through reducing risky behavior.

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Anxiety Disorders

Chapter Overview:

Types of Anxiety Disorders

Panic disorder is characterized by repeated panic attacks, which involve intense physical features, notably cardiovascular symptoms, that may be accompanied by sheer terror and fears of losing control, losing one's mind, or dying. Etiological speculation focuses on biological causes or interaction between biological and cognitive factors. Panic attack sufferers often limit their outside activity in fear of recurrent attacks. This can lead to agoraphobia, the fear of venturing into public places.

Generalized anxiety disorder involves persistent anxiety that seems to be "free floating." The

central feature of generalized anxiety disorder is worry. Although specific manifestations of anxiety vary from individual to individual, generally there are signs of motor tension, autonomic hyperactivity, apprehensive expectation, and vigilance.

Phobias are excessive irrational fears of specific objects or situations. Phobias involve a behavioral component, avoidance of the phobic stimulus, in addition to physical and cognitive features. Specific phobias are excessive fears of particular objects or situations, such as mice, spiders, tight places, or heights. Social phobia involves an intense fear of being judged negatively by others. Agoraphobia involves fears of venturing into public places. Agoraphobia can occur with or in the absence of panic disorder.

Obsessive-compulsive disorder involves recurrent patterns of obsessions, compulsions, or a combination of the two. Obsessions are nagging, persistent thoughts that create anxiety and seem beyond the person's ability to control. Compulsions are apparently irresistible repetitious urges to perform certain behaviors, such as repeated elaborate washing after using the bathroom.

In acute stress disorder (ASD) and posttraumatic stress disorder (PTSD), people develop stress reactions that follow exposure to traumatic events. Acute stress disorder occurs in the days and weeks following exposure to a traumatic event. Posttraumatic stress disorder persists for months or even years or decades after the traumatic experience and may not begin until months or years after the event.

Theoretical Perspectives

Psychodynamic theorists view anxiety disorders as attempts by the ego to control the conscious emergence of threatening impulses. Feelings of anxiety are warning signals that threatening impulses are nearing awareness. The ego mobilizes defense mechanisms to divert the impulses, thus leading to different anxiety disorders. Phobic objects symbolize aspects of unconscious conflicts, for example.

Learning theorists explain anxiety disorders through conditioning and observational learning. Mowrer's two-factor model incorporates classical and operant conditioning in the explanation of phobias. Phobias, however, appear to be moderated by cognitive factors, such as self-efficacy expectancies. The principles of reinforcement may help to explain patterns of obsessive-compulsive behavior. People may be genetically predisposed to acquire certain types of phobias that may have had survival value for our prehistoric ancestors.

Cognitive factors may also play a role in the anxiety disorders, such as overpredictions of fear, irrational beliefs, self-efficacy expectancies, self-defeating thoughts, and attributions for panic attacks.

Biological perspectives have sought explanations of anxiety disorders on the basis of studies of genetic factors, neurotransmitters, and the induction of panic by biological means.

Treatment of Anxiety Disorders

Each theoretical perspective is connected with methods of treating anxiety disorders. Traditional psychoanalysis helps people work through unconscious conflicts that are thought to underlie anxiety disorders. Modern psychodynamic approaches also focus on current disturbed relationships and encourage clients to assume more adaptive behavior patterns. The biological perspectives have spawned the development of various drugs to treat anxiety.

Humanistic theorists believe many of our anxieties stem from social repression of our genuine selves. Anxiety occurs when the incongruity between one's true inner self and one's social façade draws closer to the level of awareness.

A variety of drugs are used to treat anxiety disorders. Medications such as the mild tranquilizers (benzodiazapines) and the antidepressants are quite effective. A potential problem with drug therapy is that patients may attribute clinical improvement to the drugs and not their own resources.

Learning perspectives encompass a broad range of behavioral and cognitive-behavioral techniques to help people overcome anxiety-related problems. Exposure methods help people with phobias overcome fears through gradual exposure to phobic stimuli. Cognitive restructuring helps clients pinpoint self-defeating thoughts and substitute rational alternatives. Obsessive-compulsive disorder is often treated with a combination of exposure and response prevention. Relaxation training is often used to help people with generalized anxiety learn skills of self-relaxation. Behavioral treatment of PTSD incorporates progressive exposure to trauma-related

cues and training in stress management skills, such as self-relaxation. Cognitive approaches, such as rational-emotive therapy and cognitive therapy, help people identify and correct cognitive errors that give rise to or maintain anxiety disorders. Cognitive-behavioral approaches to the treatment of panic disorder help people with a proneness to panic disorder learn to cope more effectively with cardiovascular and other bodily sensations.

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Dissociative and Somatoform Disorders

Chapter Overview:

Dissociative Disorders

Dissociative disorders involve changes or disturbances in identity, memory, or consciousness that affect the ability to maintain an integrated sense of self. Dissociative disorders include dissociative identity disorder, dissociative amnesia, dissociative fugue, and depersonalization disorder.

In dissociative identity disorder, two or more distinct personalities, each possessing well-defined traits and memories, exist within the person and repeatedly take control of the person's behavior. Dissociative amnesia involves loss of memory for personal information. There are five types of dissociative amnesia: localized, selective, generalized, continuous, and systematized. In dissociative fugue, the person travels suddenly away from home or place of work, shows a loss of memory for his other personal past, and experiences identity confusion or takes on a new identity. Depersonalization disorders involve persistent or recurrent episodes of depersonalization that are of sufficient severity to cause significant distress or impairment in functioning.

Psychodynamic theorists view dissociative experiences as a form of psychological defense by which the ego defends itself against troubling memories and unacceptable impulses by blotting them out of consciousness. There is increasing documentation of a link between dissociative disorders and early childhood trauma, which lends support to the view that dissociation may serve to protect the self from troubling memories. To learning and cognitive theorists, dissociative experiences involve ways of learning not to think about certain troubling behaviors or thoughts that might lead to feelings of guilt or shame. Relief from anxiety negatively reinforces this pattern of dissociation.

Within the diathesis-stress model, dissociative identity disorder may be explained in terms of a

diathesis consisting of psychological traits such as a rich inner fantasy life and high levels of hypnotizability interacting with traumatic stress in the form of severe childhood abuse.

Treatment of dissociative disorders from the biological approach focuses on the use of drugs to treat the anxiety and depression often associated with the disorder; but drugs have not been able to bring about reintegration of the personality. Learning perspectives focus on the use of behavioral methods of reinforcement of the most well-adjusted personality.

Somatoform Disorders

In somatoform disorders, there are physical complaints that cannot be accounted for by organic causes. Thus the symptoms are theorized to reflect psychological rather than organic factors. Four types of somatoform disorders are considered: conversion disorder, hypochondriasis, body dysmorphic disorder, and somatization disorder.

In conversion disorder, symptoms or deficits in voluntary motor or sensory functions occur which suggest an underlying physical disorder but no apparent medical basis for the condition can be found. Hypochondriasis is a preoccupation with the fear of having, or the belief that one has, serious medical illness, but no medical basis for the complaints can be found and fears of illness persist despite medical reassurances. People with body dysmorphic disorder are preoccupied with an imagined or exaggerated physical defect in their appearance. Somatization disorder, formerly known as Briquet's syndrome, involves multiple and recurrent complaints of physical symptoms that have persisted for many years and began prior to the age of 30, but most typically during adolescence.

The psychodynamic view holds that conversion disorders represent the conversion into physical symptoms of the leftover emotion or energy that is cut off from unacceptable or threatening impulses that the ego has prevented from reaching awareness. The symptom is functional, allowing the person to achieve both primary and secondary gains.

Learning theorists focus on the reinforcements that are associated with conversion disorders, such as the reinforcing effects of adopting a "sick role." A learning theory view likens hypochondriasis to obsessive-compulsive behavior. Cognitive factors in hypochondriasis include self-handicapping strategies and cognitive distortions.

Psychoanalysis seeks to uncover and bring to the level of awareness the unconscious conflicts, originating in childhood, that are believed to be at the root of the problem. Once the conflict is uncovered and worked through, the hysterical symptom should disappear because it is no longer needed as a partial solution to the underlying conflict. Behavioral approaches focus on removing sources of reinforcement that may be maintaining the abnormal behavior pattern. Behavior therapists may also work more directly to help people with somatoform disorders learn to handle stressful or anxiety-arousing situations more effectively. Cognitive techniques such as cognitive restructuring have been very helpful in treating hypochondriasis and body dysmorphic disorder.