

# chapter seven

## Mental health

### Key knowledge and skills

#### This knowledge includes:

- concepts of normality and differentiation of mental health from mental illness
- systems of classification of mental conditions and disorders: underlying principles of classification; strengths and limitations of discrete categorical (DSM-IV and ICD-10) and dimensional (graded and transitional) approaches to classification of mental disorders
- use of a biopsychosocial framework (the interaction and integration of biological, psychological and social factors) as an approach to considering physical and mental health
- application of a biopsychosocial framework to understanding the relationship between stress and physical and mental wellbeing:
  - physiological and psychological characteristics of responses to stress including fight-flight response, eustress and distress; strengths and limitations of Selye's General Adaptation Syndrome
  - psychological determinants of the stress response; strengths and limitations of Richard Lazarus and Susan Folkman's Transactional Model of Stress and Coping
  - social, cultural and environmental factors that exacerbate and alleviate the stress response
  - allostasis (stability through change brought about by the brain's regulation of the

body's response to stress) as a model that integrates biological, psychological and social factors that explain an individual's response to stress

- strategies for coping with stress including biofeedback, meditation/relaxation, physical exercise, social support.

#### These skills include the ability to:

- formulate research questions and construct testable hypotheses
- analyse and interpret data, and draw conclusions consistent with the research question
- evaluate the validity and reliability of research investigations including potential confounding variables and sources of error and bias
- use research literature to demonstrate how psychological concepts and theories have developed over time
- process and interpret information, and make connections between psychological concepts and theories
- evaluate the validity and reliability of psychology-related information and opinions presented in the public domain
- analyse issues relating to and implications of scientific and technological developments relevant to psychology
- communicate psychological information, ideas and research findings accurately and effectively.

## MENTAL HEALTH

### Normality

- Sociocultural approach
- Functional approach
- Historical approach
- Situational approach
- Medical approach
- Statistical approach

### Defining mental health and illness

### Classifying mental health

- Categorical approaches (DSM-IV & ICD-10)
- Dimensional approaches
- Labelling and stigma

### Biopsychosocial model of physical and mental health

### Stress (a biopsychosocial framework)

- Eustress and distress
- Stress response
  - Physiological (fight–flight response)
  - Psychological (emotional, cognitive and behavioural)
- General adaptation syndrome (Selye)
  - Alarm-reaction
  - Resistance
  - Exhaustion
- Psychological determinants of the stress response
  - Transactional model of stress and coping
- Social, cultural and environmental determinants of the stress response
- Allostasis
- Coping with stress
  - Biofeedback
  - Meditation and relaxation
  - Physical exercise
  - Social support

## Normality

What is the normal bedtime for a teenager? What sports are normal to play and watch? Do I look normal when I go to out on the weekend and interact with my friends? **Normality** (and, conversely, abnormality) is a difficult concept to define. Popular conceptions of normality are derived from looking at what a majority of people do. On casual dress days at school, most people wear jeans – so if you are wearing your pyjamas, are you characterised as abnormal? If most people in your year level are more than five feet tall but you are shorter than that, are you abnormal?

Generally, psychologists agree that normality refers to patterns of behaviour or personality traits that are typical, or that conform to some standard of proper and acceptable ways of behaving. By this definition, wearing pyjamas to school on a casual dress day may be considered abnormal, as it is not typical behaviour. Likewise, behaviour that is considered unacceptable, such as smoking in a car with children, can also be considered abnormal.

When something is considered normal or abnormal, terms such as ‘typical’ or ‘acceptable’ are also commonly used. These terms are also ambiguous and very subjective, and require some level of value judgement. They can also have cultural and social variations (see Figure 7.1), because what might be acceptable in one culture or society may not be acceptable or typical in another (Sadock & Sadock, 2003).

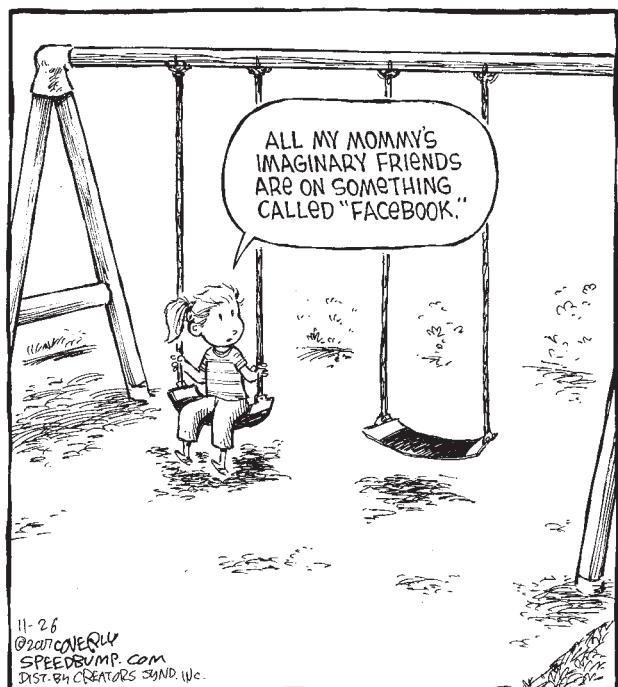


Figure 7.1 Definitions of normal and abnormal behaviour change over time

## CONCEPTS OF NORMALITY

Because some behaviour may be considered normal in one context but not normal in another, there are a number of different theories that are used to explain the concept of normality. We will now examine several of these.

### The sociocultural approach

The **sociocultural approach** considers whether behaviour is typical according to the cultural values and beliefs of a particular society – whether behaviour fits in with the **norms** of that society. Culture is one of the most influential contexts in which any behaviour is judged.

In some cultures it is considered normal to talk loudly, wave your arms in a spirited manner during a conversation, or hug or kiss someone in public; in some cultures, the norm is to be more demure. In some cultures, women are considered normal and even virtuous if they remain housebound, do not work and have little say in matters of the outside world. However, in modern-day Western cultures these same women might be diagnosed as suffering from agoraphobia or be considered significantly disempowered (Widiger & Sankis, 2000). In Australia it is illegal and considered abnormal to be married to more than one person at the same time, but in some Middle Eastern countries this is considered a tradition and seen as normal and acceptable behaviour. We can see that there is a fine line between classifying behaviours as normal and abnormal across certain cultural contexts.

**Social nonconformity** refers to disobeying the standards set by society for what is acceptable conduct. Social nonconformity can result from faulty socialisation, and often leads to destructive or self-destructive behaviour (such as drug abuse) and emotional instability. However, we must be careful to distinguish between *unhealthy* nonconformity and *healthy* creativity and uniqueness. People who dress or act differently to the majority are not necessarily nonconformist in an unhealthy way, nor is their behaviour necessarily unacceptable – unique individuals are generally emotionally stable and function normally in society (see Figure 7.2).

#### normality

Patterns of behaviour or personality traits that are typical, or that conform to some standard of proper and acceptable ways of behaving

#### sociocultural approach

Defines normality by determining whether behaviour is typical according to the cultural values and beliefs of a particular society

#### norm

A general ‘rule’ or standard

#### social nonconformity

Failure to conform to societal norms or the usual minimum standards for social conduct



**Figure 7.2** Social nonconformity does not automatically indicate abnormality.

When individuals do not conform to society's norms, many judgements are made about their decisions and behaviours. A lack of ability to conform to society's expectations can be an indicative factor of a lack of mental well-being. **Cultural relativity** (the idea that judgements are made relative to the values of one's culture) can affect the diagnosis of what may be considered a psychological disorder (Alarcon, 1995). All cultures classify people as abnormal if

they consistently fail to communicate with others or are consistently unpredictable in their actions. That is, for behaviour to be considered abnormal, not only should it be unacceptable, unusual and out of keeping with acceptable social norms, but it must also be enduring and persistent, leading to disability in several domains of the person's life.

### The functional approach

The **functional approach** defines normality by the level of one's ability to interact and involve oneself in society. 'Functioning' refers to the ability to undertake everyday tasks such as personal hygiene, going to work or eating food. If you do not regularly wash or eat, or you are unable to hold a job, according to the functional approach you would be defined as abnormal. Another example is staying in bed all day. It is 'normal' to stay in bed all day every now or then, when you are sick or very tired, but to do it every day is not considered normal according to the functional approach.

Table 7.1 shows the different levels of functioning on a scale from 10 to 100, as defined by the *Diagnostic and Statistical Manual of Mental Disorders, Edition IV, Text Revision (DSM-IV-TR)*. (We will discuss the *DSM-IV* later in this chapter.) This scale is used to determine if a person's behaviour is considered normal or abnormal according to functionality.

**Table 7.1** Levels of functioning

SCALE	LEVEL OF FUNCTIONING	EXAMPLES
91–100	Superior functioning in a wide variety of activities No symptoms	Life's problems never seem to get out of hand. This person is sought out by others because of his or her many positive qualities.
81–90	Absent or minimal symptoms, functioning well in all areas, no more than everyday problems	A student has mild anxiety before exams and occasional arguments with family members
71–80	If symptoms are present, they are brief and common reactions to stressors. No more than slight impairment in relationships, work or school	A student has difficulty concentrating after family arguments, is falling behind in schoolwork
61–70	Some mild symptoms or some difficulty with relationships, work or school	A student has wagged school and stolen things at home. The person's mood is depressed and he or she has mild insomnia.
51–60	Moderate symptoms or problems with relationships, work or school	A person's experiences are blunted and speech is evasive; they have occasional panic attacks, no friends, and are unable to keep a job or stay in school.
41–50	Serious symptoms or any social impairment in relationships, work or school	A person has suicidal thoughts, engages in obsessive rituals, shoplifts, has no friends, is unable to keep a job
31–40	Some impairment in grasp of reality or in communication, plus major impairments in work or school, relationships, judgement, thinking or mood	A person's speech is illogical, obscure or irrelevant. A person is depressed and avoids friends, neglects family and is unable to work.
21–30	Behaviour is consistently affected by delusions or hallucinations, or person is seriously impaired in communication or judgement, or is unable to function in most areas	A person is sometimes incoherent; acts grossly inappropriately; is preoccupied with suicide; stays in bed all day every day, has no home, job or friends
11–20	Some danger of hurting self or others, or sometimes fails to maintain minimal personal hygiene, or communication is grossly impaired	A person makes tentative suicide attempts, is frequently violent and manically excited, and is either incoherent or mute
1–10	Persistent danger of severely hurting self or others, persistent inability to maintain minimal personal hygiene, or engages in serious suicidal acts	A person is repeatedly violent or has made potentially lethal suicide attempts

Source: American Psychiatric Association (2000) *Diagnostic and Statistical Manual of Mental Disorders*

## The historical approach

Over time, a particular culture's definition of normal and abnormal behaviour can change. Thus, the **historical approach** to defining normality depends on the period of time, century or era in which the judgement is made. For example, up until the 17th century it was considered normal to burn people at the stake for crimes of heresy in England. This type of punishment is not considered normal in modern times.

In Ancient Greece, homosexuality was considered to be normal; yet, society frowned upon homosexuality and it was classified as a mental disorder by various psychiatric associations around the world up until the 1970s. In the early 1970s, homosexuality was removed as a 'diagnosis' from psychiatric diagnostic manuals, meaning it was no longer considered 'abnormal' to be homosexual. In many countries today, particularly in Australia, there is greater acceptance of homosexuality; however, homosexuals are still fighting to be treated equally and be allowed to legally marry. Australia still appears divided on this issue, although around the world the historical context is changing. The local council of Washington DC, USA, voted to allow gay marriages within the district in late 2009 (see Figure 7.3).



Figure 7.3 Definitions of normal behaviour depend on the period of time, century or era in which the judgement is made; e.g. same-sex marriages are no longer described as abnormal in some parts of the world.

## The situational approach

The **situational approach** to classifying what is considered normal refers to the social situation, behavioural setting or general circumstances in which the behaviour occurs (see Figure 7.4). Is it normal to stand outside and water a lawn with a hose? It depends on whether it is raining or if there are water restrictions in place. Is it abnormal for a grown man to remove his pants and expose himself to someone in a place of business? It depends on whether the other person is a bank clerk or a doctor!



Figure 7.4 Shouting would be considered normal behaviour at a football match, but it could be seen as abnormal at a funeral.

Almost any imaginable behaviour can be considered normal in some contexts, as the following example indicates. In October 1972, a plane carrying a rugby team called the Old Christians crashed in the snow-capped Andes of South America. Incredibly, 16 of the 45 people who had been on board at the time of the crash survived for 73 days in deep snow and subfreezing temperatures. They were forced to use extremely grim measures to do so – they ate the bodies of those who had died in the crash. In any other situation, this would probably be classified as abnormal, but although cannibalism is certainly a taboo subject, this behaviour may be considered more acceptable because of the situation: the survivors would have died if they had not eaten those who were already dead.

## The medical approach

According to the **medical approach** to normality, an individual is considered to be normal if they are physically healthy; as such, abnormality is determined by having an illness that has an

### cultural relativity

The idea that judgements about normality are made relative to the values of one's culture

### functional approach

Defines normality by the level of one's ability to interact and involve oneself in society

### historical approach

Defines normality by the period of time, century or era in which the judgement is made

### situational approach

Defines normality by the social situation, behavioural setting or general circumstances in which a behaviour takes place

### medical approach

Defines normality in terms of physical health and well-being; an individual with an illness that has an underlying physical cause would be considered abnormal

underlying physical cause. Someone who is colour-blind would not be considered medically normal, nor would someone who has a common cold!

Psychologists and psychiatrists following this approach assume that mental illness is a reflection of medical abnormality. Therefore, they suggest mental illness can be diagnosed, treated and sometimes even cured using specific drugs or medical procedures. In support of this approach, there is a growing body of research that suggests a link between biological factors and mental disorders such as schizophrenia and depression. For example, there is now some evidence to show that schizophrenia is related to overactivity in brain dopamine systems (Heinrichs, 1993). Dopamine is a neurotransmitter that is found in the brain and is believed to be associated with emotional response. It appears to trigger a flood of unrelated thoughts, feelings and perceptions, which may account for voices, hallucinations and delusions in schizophrenia (Gottesman, 1991). The role of dopamine levels in schizophrenia will be examined in chapter 8.

### The statistical approach

Some psychologists try to define normality using so-called objective measures such as statistics. The *statistical approach* defines normality based on the experiences and behaviour of the statistical majority. For example, if an individual obtains an extremely high or low score on an IQ test, an extremely high or low ENTER score or a very high or very low score on an anxiety scale, this individual would be in the *statistical minority* and would therefore be considered abnormal.

Usually, the results of such tests will form a *normal curve* (bell-shaped curve). A bell-shaped curve has a large number of scores in the middle, tapering to very few extremely high and low scores. Notice that most people in the levels of anxiety graph in Figure 7.5 score in the central region of the curve. A person who deviates from the average by being anxious all the time (high anxiety) might be considered abnormal. So, too, might a person who never feels anxiety. These people's scores would be located on the extreme left or right side of the normal curved graph.

One limitation of the statistical approach to normality is that it does not distinguish between abnormal behaviour that is desirable and that which is

not desirable. For example, it is statistically abnormal for a person to score above 145 or below 55 on an IQ test, in which the average IQ score is 100. In our society it is desirable to score at the high end of a normal IQ curve, and it is only a score below 55 that is considered undesirable (Wakefield, 1992); although both scores are actually considered abnormal, only one is considered undesirable.



Figure 7.6 Bill Gates, co-founder of the software company Microsoft, is reported to have an IQ of 160. According to the statistical approach, this is classified as abnormal.

Another problem with statistical definitions is the issue of where to draw the line between normality and abnormality. To take another example, we could obtain the average (normal) amount of food eaten per day for people of a particular age and sex. It is probably fair to say that a person who feels driven to eat four packets of biscuits, two loaves of bread and half a chicken in two hours has an eating problem, because this would be very much outside the norm. But as we move back toward the norm we face the statistical problem of where to draw the line that determines what is normal and abnormal: How far must people deviate in order to be considered abnormal? If it is deemed normal to eat two serves of fruit and five serves of vegetables a day, is a person abnormal if they eat three serves of fruit and six of vegetables? Or are they not deemed abnormal unless they eat five or six serves of fruit and eight or nine of vegetables? As you can see, statistical boundary lines tend to be somewhat arbitrary (Widiger & Trull, 1991).

A summary of the different approaches to normality is detailed in Table 7.2. Some of the problems with diagnosing behaviour as abnormal are explained in 'A closer look: The politics of "madness"'. 'Try it yourself 7.1' contains an activity to help you look critically at what is considered normal and abnormal behaviour.

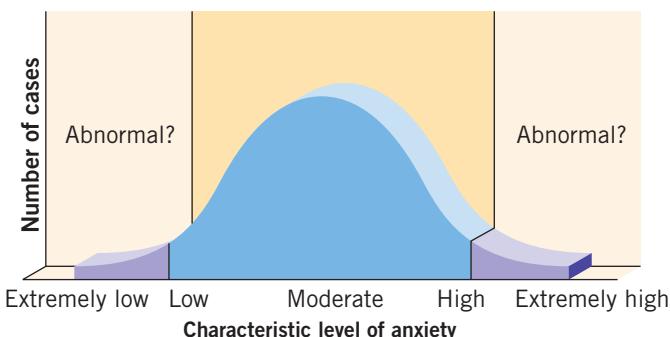


Figure 7.5 The number of people displaying a personal characteristic may help define what is statistically abnormal

**Table 7.2 Summary of the different approaches to normality**

APPROACH	DEFINITION OF NORMALITY	ADVANTAGES	LIMITATIONS
Sociocultural	Obeying societal standards for acceptable conduct	There are some universal norms; e.g. all cultures consider it normal to be able to communicate with others and behave in a predictable fashion	Different cultures often have different ideas about acceptable behaviour
Functional	Functioning or coping adequately in society	Provides an understandable framework in which to classify normality	People's ideas about functionality vary
Historical	Obeying standards for acceptable conduct in a particular era	Standards change over time, which may be positive	Normality may not be consistent in every culture in a particular era
Situational	Obeying popular or common standards in a particular social situation	Almost any behaviour can be classified as normal in some contexts	Sociocultural or functional views of normality may impact on situational factors
Medical	The absence of illness with an underlying physical cause	Allows professionals to communicate, diagnose, treat and possibly cure illness	Mental illness may be a social problem rather than a physical one
Statistical	Fitting in with the most commonly occurring characteristics in a society	Commonly occurring characteristics or behaviours are usually seen by society as acceptable and positive	Some extreme characteristics are desirable, but also classified as abnormal. It doesn't give any information about the meaning of the deviations from the norm.

### A CLOSER LOOK

#### The politics of 'madness'

The year is 1840. You are a slave who has tried repeatedly to escape from a cruel and abusive master. An expert is consulted about your 'abnormal' behaviour. His conclusion? You are suffering from 'drapetomania', a mental disorder that causes slaves to run away (Wakefield, 1992).

As this example suggests, psychiatric terms are easily abused. Historically, some have been applied to culturally disapproved behaviours that are not really disorders. For example, all of the following were once considered disorders: homosexuality, self-defeating personality and nymphomania (Wakefield, 1992). Even today, race, gender and social class continue to affect the diagnosis of various disorders (Nathan & Langenbucher, 1999).

Gender is probably the most common source of bias in judging normality because standards tend to be based on males (Hartung & Widiger, 1998). According to psychologist Paula Caplan (1995) and others, women are penalised both for conforming to female stereotypes and for ignoring them. If a woman is independent, aggressive and unemotional, she may be considered 'unhealthy'. Yet at the same time, a woman who is vain, emotional, irrational and dependent on others – considered 'feminine' traits in our culture – may be classified as a histrionic or dependent personality (Bornstein, 1996). Indeed, the majority of people classified as having dependent personality disorder are women. In view of this, Caplan (1995) asks, 'Why isn't there a category called "delusional dominating personality disorder" for obnoxious men?'

The differences we have reviewed illustrate the subtle influence that culture can have on perceptions of disorder and normality. Be cautious before you leap to conclusions about the mental health of others.

### TRY IT YOURSELF 7.1

#### Normal vs abnormal

Images of what is considered normal and abnormal are all around us. For example, celebrities are airbrushed on magazine covers to portray flawless images, leading teenagers to believe that a skin blemish is abnormal.

Obtain a piece of poster paper and draw a line down the middle of the page. Label one half 'Normal' and one half 'Abnormal'. Cut out images or articles from magazines or newspapers that reflect the views of society, and attach them to the appropriate side of your poster paper.

#### QUESTIONS

- 1 Discuss these images and their classifications with your class.
  - Are they a negative or positive influence on an individual?
  - Are all the 'abnormal' behaviours negative?

#### statistical approach

Defines normality according to the experiences and behaviours of the statistical majority

#### normal curve

A bell-shaped curve with a large number of scores in the middle, tapering to very few extremely high and low scores

## CHECK YOUR UNDERSTANDING 7.1

- 1 The idea that judgements about normality are made relative to the values of one's culture is called the \_\_\_\_\_.
- 2 Match the 'abnormal' behaviours to the approach under which they would be considered abnormal.
- |  |                           |
|--|---------------------------|
| a A man dressed as Ned Kelly runs around Flinders Street Station | i Medical approach        |
| b A man is married to two women                                  | ii Functional approach    |
| c A woman who is unable to hold a job at 25 years old            | iii Situational approach  |
| d A child who was born deaf                                      | iv Sociocultural approach |
| e A man who scores 147 on an IQ test                             | v Statistical approach    |
- 3 In the following scenarios, identify which behaviours might be considered normal (N) or abnormal (A) today, according to the historical approach.
- a A woman holding a job
  - b A woman being unmarried at 30 years of age
  - c Indigenous Australians being unable to vote
  - d An Asian couple being refused service at a restaurant
- 4 If a person was found to be adequate in their everyday life activities such as work, study, play, they would be defined 'normal' using the \_\_\_\_\_ approach.
- 5 A curve that shows the normal distribution of scores for a population is known as a \_\_\_\_\_-shaped curve.
- A normal
  - B bell
  - C u
  - D upside-down



Figure 7.7 Mental and physical health is a lifelong pursuit. Tai chi is a suitable activity for older people.

with others, do meaningful work, and live in a clean environment.

'Videolink: Nutrition and your mental health' explores the relationship between the food we eat and our emotional well-being.

VIDEO

Nutrition and your mental health

## MENTAL HEALTH AND MENTAL ILLNESS

**Mental health** (as opposed to ill health or mental disorder) is often defined as the psychological state of someone who is functioning at a satisfactory level of emotional and behavioural adjustment. This also means that they are functioning well in the usual domains of their everyday life: work, study and relationships.

However, we cannot function at optimal levels at all times, as our behavioural and emotional adjustment can be influenced by the world around us. We could feel stressed from the pressures of VCE, part-time work, friends and parental expectations. We could feel low when our team loses in football or netball, or on top of the world when the team wins. These are very normal feelings. Feeling 'blue' or 'down' in itself does not constitute mental ill-health or a mental illness, so it is important that we have normal human emotions in perspective.

**Mental illness** is a psychological state characterised by emotional difficulties that lead to emotional or behavioural impairment or disability serious enough to require psychiatric intervention. It is important to recognise such an illness when it arises – we sometimes tend to minimise our problems for fear of stigma, or believe that there is no help available and fail to take the opportunity to talk about it with others.

## What is health?

What does the term 'health' mean to you? The World Health Organization (WHO) defines **health** as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO, 1948). This holistic approach to health means that health is not simply the absence of physical illness – we also need to feel mentally, socially and spiritually well to have a complete sense of good health.

Maintaining health or wellness is a lifelong pursuit and people who attain optimal wellness are both physically and psychologically healthy (Figure 7.7). They engage in positive thinking, show emotional resilience and are optimistic and self-confident (Lightsey, 1996). People who enjoy a sense of well-being also have supportive relationships

The scientific and systematic study of abnormal experience, cognition and behaviour is known as **psychopathology** (Sims, 2003). The term ‘psychopathology’ also refers to mental disorders themselves or to psychologically unhealthy behaviour. Thus, it covers not only maladaptive (inappropriate) behaviour – such as drug addiction, compulsive gambling (Figure 7.8), or a loss of contact with reality – but also any behaviour that interferes with personal growth and self-fulfilment (Carson, Butcher & Mineka, 1997).



**Figure 7.8** Compulsive gambling is indicative of psychologically unhealthy behaviour that can be a sign of mental illness.

Some people, such as Dr Thomas Szasz, psychiatrist and author of *The Myth of Mental Illness* (1961), say that normality can be measured only in terms of what people do and do not do, and that defining normality is beyond the realms of a mental health practitioner. This also applies to mental health and mental illness. Even someone diagnosed with a mental illness may experience some aspects of mental health.

When we learn about mental illness, we may be susceptible to developing the psychological equivalent of ‘medical school syndrome’. Medical school syndrome is a form of **hypochondria** that affects some people in training to be a physician – as medical students learn about symptoms of physical illness, they may see such symptoms in themselves and begin to think they are unwell. Hypochondria refers to a preoccupation with minor bodily problems and the presence of illnesses that appear to be imaginary.

The psychological equivalent may afflict VCE students learning about mental health and illness because students are always encouraged to apply what they learn to their own lives and experiences. However, this is one topic where doing so may cause confusion and unnecessary worry. It is quite natural to question whether or not you may have a mental illness. In all likelihood none may exist – it is absolutely acceptable and ‘normal’ to feel stressed and experience symptoms discussed within this and the next chapter because adolescence is a time filled with challenges and pressures. However, it is also equally important not to trivialise your experiences and feelings when feeling stressed for fear that you would ‘look stupid’ or that your friends will think of you as ‘weak’. If you feel something is wrong, seek the help of a trusted teacher or school counsellor (see Figure 7.9), and also remember that many people experience symptoms of mental illness during their lifespan. In fact, research shows that almost one in two Australians will suffer a mental illness during their lifetime and one in five have experienced a mental illness in the last 12 months. See ‘Focus on research: One in five’ to learn more.



**Figure 7.9** Talking about your worries with a school counsellor is a positive step towards maintaining good mental health.

#### health

A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity

#### mental health

The psychological state of someone who is functioning at a satisfactory level of emotional and behavioural adjustment

#### mental illness

The psychological state of someone who has emotional or behavioural problems serious enough to require psychiatric intervention

#### psychopathology

The scientific and systematic study of abnormal experience, cognition and behaviour; also a term used to refer to psychologically unhealthy behaviour

#### hypochondria

A preoccupation with minor bodily problems and the presence of illnesses that appear to be imaginary

## One in five: Facts about mental illness in Australia

- In 2007, of the 16 million Australians aged 16–85 years, almost half (45% or 7.3 million) had a lifetime mental disorder; that is, a mental disorder at some point in their life.
- One in five (20% or 3.2 million) Australians have experienced a mental disorder at some time in the last 12 months.
- Younger people are more likely to experience a mental illness than older people. The prevalence of mental disorders is greatest in the 18–24 age group and then declines with age.
- Anxiety disorders and substance misuse disorders are the most common illnesses in any 12-month period in the 18–24 age group (see Table 7.3).

**Table 7.3 Prevalence of mental disorders in Australian adults: 12-month period (2007)**

DISORDERS	MALES		FEMALES	
	POPULATION ESTIMATE	% OF TOTAL POPULATION	POPULATION ESTIMATE	% OF TOTAL POPULATION
Anxiety disorders	860 700	10.8	1 442 300	17.9
Affective disorders	420 100	5.3	575 800	7.1
Substance use disorders	556 400	7.0	263 500	3.3
Any mental disorder	1 400 100	17.6	1 797 700	22.3

Source: ABS (2007) *National Survey of Mental Health and Wellbeing: Summary of Results*

- Women experience slightly higher rates of mental disorders than men (22% compared with 18%) and rates are higher for single adults. Women are more likely to experience depression and anxiety disorders, while men are more likely to experience substance abuse.
- Unemployed adults have a higher incidence of mental illness, compared with people in full-time employment. Homelessness seems to be a significant factor in mental health – more than half (54%) the people who had ever been homeless had a disorder, nearly three times the rate of people who had a home.
- One third (34%) of people living in one-parent families had a mental disorder compared with 19% of people in couple families with children.
- People living in country or rural areas are about 30% more likely to report symptoms of mental illness than their city counterparts (ABS, 2007).
- Children and adolescents who live in low-income, step or blended, and sole-parent families are also more likely to suffer from a mental illness (Al-Yaman, Bryant & Sargeant, 2002).

### QUESTIONS

- What was the population of interest for this research?
- What type of statistics have been used to represent the data in this study? Explain your answer.
- Give an example of two conclusions that can be drawn from these research findings.

### CHECK YOUR UNDERSTANDING 7.2

- Health is characterised by:
  - mental well-being.
  - physical well-being.
  - social well-being.
  - All of the above
- When the emotional difficulties one faces leads to some level of impairment or disability, it is referred to as \_\_\_\_\_.
- The scientific and systematic study of abnormal experience, cognition and behaviour is known as \_\_\_\_\_.
- Indicate whether the following statements are true (T) or false (F).
  - If I think I have a mental illness, I probably do.
  - Mental illnesses are imagined; they are not real problems.
  - Mental illness can have a physiological basis.
  - Almost half of Australians will suffer from mental illness at some time in their lives.
  - Mental illness cannot be cured.
- The number of Australians who have suffered from a mental illness in the last 12 months is:
 

<b>A</b> one in two.	<b>B</b> one in five.
<b>C</b> one in 10.	<b>D</b> one in 100.

# Classifying mental disorders

We have already discovered that it is difficult to classify what is normal and what is abnormal behaviour. Determining whether or not someone is mentally ill is just as difficult. Where is the point at which their well-being is compromised? What is the difference between being scared and suffering from a phobia? What is the difference between sadness and depression?

Unlike physical illness, such as a bout of influenza, mental illnesses are not always tangible. The symptoms of mental illnesses rely on personal accounts of symptoms and experiences and this can be problematic for classification. See 'A closer look: Measuring mental health' to read about scientific methods used to try to collate data in the community.

## Measuring mental health

How would you 'measure' mental health or ill health in the community? Drawing from the information in chapter 9, what would you think to be appropriate methods of investigating mental health or ill health in our community?

A health survey is one such method of scientific enquiry. Although it has its own advantages and limitations, it can be a useful tool to use to ask some initial questions.

Measuring mental health in the community through household surveys is indeed a complex task, as mental disorders are usually determined through detailed clinical assessment. To estimate the prevalence of specific mental disorders, the 2007 National Survey of Mental Health and Wellbeing used the World Mental Health Survey Initiative version of the World Health Organization's *Composite International Diagnostic Interview, version 3.0* (known as *WMH-CIDI 3.0*).

The *WMH-CIDI 3.0* is a structured diagnostic interview document that can be used even by interviewers not trained in formal mental health assessment. This is important, as we do not want to over- or under-diagnose mental illness in the community. This document has also been used widely around the world and hence its validity has been established as a survey document that gives reasonably accurate information whenever used and is comparable to similar surveys conducted worldwide.

The *WMH-CIDI 3.0* provides an assessment of mental disorders based on the definitions and criteria of two classification systems (these will be discussed next): the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV)*; and the *WHO International Classification of Diseases, Tenth Revision (ICD-10)*. Each classification system lists sets of criteria that are necessary for diagnosis. The criteria specify the nature and number of symptoms required, the level of distress or impairment required, and the exclusion of cases where required (ABS, 2007).

## CATEGORICAL APPROACHES TO CLASSIFYING MENTAL DISORDERS

To help provide guidelines and a standard for classification of mental illnesses, **categorical approaches** to defining mental disorders have been developed. Categorical approaches involve grouping psychological

problems into broad categories, or groups, with common symptoms. Two examples of categorical approaches to classifying mental disorders are those provided by the *Diagnostic and Statistical Manual of Mental Disorders, Edition IV, Text Revision (DSM-IV-TR)*, published by the American Psychiatric Association (2000) and the *International Classification of Diseases, Edition 10 (ICD-10)*, published by the World Health Organization (1992).

### DSM-IV-TR

The *DSM-IV-TR* (see Figure 7.10) characterises mental disorders into 16 major categories (Table 7.4 gives an overview of these). The *DSM-IV-TR* lists known causes of these disorders; provides statistics in terms of gender, age at onset and prognosis; and also provides information about some research concerning optimal treatment approaches (Allpsych Online, 2004).

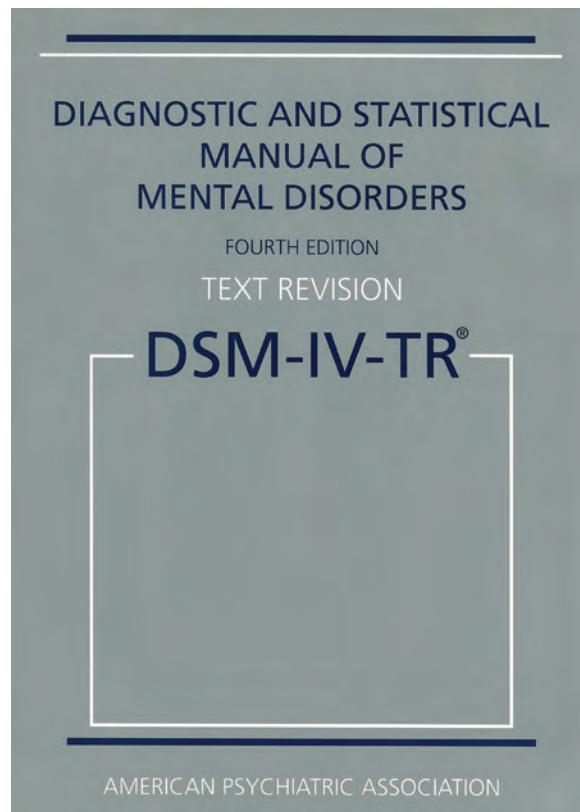


Figure 7.10 The *DSM-IV-TR* is both a scientific document and a social one.

#### categorical approach

A method of categorising mental illness that groups psychological problems into broad categories or groups that share common symptoms

#### *Diagnostic and Statistical Manual of Mental Disorders, Edition IV, Text Revision (DSM-IV-TR)*

A manual published by the American Psychiatric Association that groups psychological problems into categories based on similar symptoms, in order to try to diagnose and treat mental disorders

#### *International Classification of Diseases, Edition 10 (ICD-10)*

An international standard of diagnosing and categorising all health problems, published by the World Health Organization, which provides details on the incidence and prevalence of diseases and morbidity and mortality rates

**Table 7.4 Major categories of mental disorders according to the *DSM-IV-TR***

CATEGORY	GENERAL SYMPTOMS	EXAMPLES OF DISORDERS
Disorders diagnosed in childhood	Delayed development, behavioural problems, learning problems	Autistic disorder, attention deficit/hyperactivity disorder, Tourette's syndrome
Delirium and dementia	Problems with memory and cognition, disturbance in consciousness	Dementia, delirium
Substance-induced disorders	Poor functioning at home or at work; inability to stop using the drug; drug intoxication or drug withdrawal; delirium, dementia or amnesia; psychosis; emotional and sexual problems; sleep disturbances	Dependence on alcohol, barbiturates, opiates, cocaine, amphetamines, marijuana or nicotine
Psychotic disorders	Hallucinations, delusions, social withdrawal, retreat from reality, inability to control thoughts and actions	Schizophrenia
Mood disorders	Disturbances in affect (emotion); mania, agitation, euphoria, hyperactivity, depression, sadness or hopelessness; cycles between mania and depression	Bipolar disorder, depression, seasonal affective disorder (SAD)
Anxiety disorders	Feelings of fear, apprehension, anxiety, anxiety-based distortions of behaviour	Phobias, obsessive-compulsive disorder (OCD), panic disorder, post-traumatic stress disorder (PTSD)
Somatoform disorders	Physical symptoms that mimic disease or injury (paralysis, blindness, illness or chronic pain) for which there is no identifiable physical cause	Hypochondriasis, conversion disorder
Factitious disorder	Feigning symptoms to assume a sick role	Factitious disorder
Dissociative disorders	Feelings of depersonalisation, multiple personalities, memory loss	Dissociative identity disorder, dissociative fugue
Sexual disorders	Increased or decreased sexual desire and activity, deviant sexual behaviour	Male orgasmic disorder, sexual sadism
Eating disorders	Feeling fat, weight loss, changes in eating patterns, vomiting, increased exercise, low self-esteem, depression	Anorexia nervosa and bulimia nervosa
Sleep disorders	Increased or decreased time sleeping, sleep-walking, nightmares	Insomnia, narcolepsy, hypersomnia
Impulse-control disorders	Inability to control behaviour	Kleptomania, pyromania, pathological gambling
Adjustment disorders	Psychological response to stress resulting in emotional problems	Adjustment disorder
Personality disorders	Deeply ingrained, unhealthy personality patterns	Antisocial personality disorder, borderline personality disorder
Other conditions	Psychological response to physical illnesses and other issues that could be classified elsewhere	Response to physical illnesses, medication side effects, relational problems, abuse or neglect, malingering, acculturation problems

Source: American Psychiatric Publishing, Inc.

The *DSM-IV-TR* uses a multi-axial, or multidimensional, approach to diagnosis because many factors in a person's life can impact upon their mental health. It assesses five dimensions:

- Axis I – Clinical syndromes (what is known as the diagnosis; for example, depression)
- Axis II – Developmental disorders and personality disorders (disorders that may have been presented in childhood – such as autism – and disorders that may encompass how an individual interacts in the world – such as paranoia)

- Axis III – Physical conditions (this includes physical problems such as brain injuries that may result in symptoms characteristic of mental illness)
- Axis IV – Severity of psychological stressors (how events in a person's life, such as death of a loved one, can impact on mental illness)
- Axis V – Highest level of functioning (a clinician's rating of the current level of functioning compared to when they were at their highest level in the past 12 months) (Allpsych Online, 2004)

## **ICD-10**

The *ICD-10* is the international standard of diagnosing and classifying all diseases and health problems. This includes the analysis of the general health situation of population groups and monitoring of the incidence and prevalence of diseases and other health problems in relation to other variables, such as the characteristics and circumstances of the individuals. The *ICD-10* also provides the basis for the compilation of national mortality and morbidity statistics by WHO Member States (World Health Organization, 2010).

The *ICD-10* categorises health problems into 22 different chapters; mental and behavioural disorders are featured in chapter 5. An international survey of psychiatrists in 66 countries comparing the use of the *ICD-10* and *DSM-IV-TR* found that the former was more often used for clinical diagnosis while the latter was more valued for research (Mezzich, 2002).

### **Strengths and limitations of categorical approaches to classification**

In both of the manuals discussed, a range of mental disorders are arranged, organised and described in a particular manner and order. Psychologists and other mental health practitioners use these manuals as they provide a common language for therapists, researchers, social agencies and health workers worldwide. They also help professionals diagnose specific mental disorders and, more importantly, select appropriate treatments or therapies for those conditions. If a therapist in Australia diagnoses a person with a major depressive disorder using *DSM-IV-TR* and treats them with antidepressant medications, another health professional in the UK using the *ICD-10* would also give the same diagnosis and use the same treatment for another individual with similar symptoms. A major strength of this approach is that it allows for consistent diagnoses and treatments from hospital to hospital, clinic to clinic, all over the world.

Public health policy, statistics, funding, billing and insurance are all influenced by the *DSM-IV-TR* and the *ICD-10*. They classify, order and list disorders into several categories based on a series of criteria and rules with respect to the number and patterns of criteria needed for diagnosis. A person either does or does not meet the criteria for that specific disorder.

One limitation of these methods of classification has been that this approach ‘boxes’ people into one of the available categories, sometimes inappropriately, and it does not accommodate the unique nature of the human condition. These classifications do not account for people who have ‘atypical’ symptoms or those that do not clearly follow the ‘script’.

## **DIMENSIONAL APPROACHES TO CLASSIFYING MENTAL DISORDERS**

Some classification systems do not use clear cut-offs that determine if someone is ‘ill’ or ‘healthy’, ‘abnormal’ or ‘normal’. To prevent sufferers feeling

as though they are classified as abnormal when they are diagnosed as suffering from a mental illness, psychologists suggest that it would be preferable to incorporate a **dimensional approach** to classification.

A dimensional approach does not use discrete categories; it is based on a broader underlying spectrum of diagnoses and non-threshold symptoms that occur in the general population (Maser & Akiskal, 2002). Each individual, then, has a different profile of either high or low scores across the different dimensions (Krueger, Watson & Barlow, 2005). Some people may score low in one dimension but high in another, meaning that some aspects of their behaviour are classified as being indicative of mental illness while others are not. This means that an individual’s experience is on a continuum from perfect health to ill health, rather than being pigeonholed as one or the other.

For example, sufferers of mental disorders may feel that they have a low opinion of themselves, but on a self-ranking scale of how supportive their social network is, they may report that they are well-supported. This could give an indication that although their esteem is low, there are people they can talk to, allowing professionals to see how a range of symptoms may interact across different dimensions.

Dimensional approaches to classifying mental health allow the severity of a disorder to be established. As everyone lies somewhere on the spectrum, the experience can be graded and compared between individuals. It is not simply just a matter of ‘normal’ or ‘abnormal’ behaviour. This means that the classification of an individual is very fluid. Individuals can move up or down the dimensions, dependent upon a range of experiences that affect them at any given time. Using a dimensional system is therefore transitional. It can be viewed as a means by which to gauge how someone is changing as they move from one end of the spectrum to the other.

### **Strengths and limitations of dimensional approaches to classification**

As previously stated, the dimensional approach does not pigeonhole or label individuals. Although categorical criteria are important in determining which patients are sufficiently unwell enough to justify treatment, dimensions are much better suited to understanding relationships between social and biological variables in health and illness (Goldberg, 2000). It also enables sufferers to see improvement in their condition more readily and help to identify which factors have the largest impact on their well-being.

#### **dimensional approach**

A method of categorising mental illness where an individual has a profile of scores on different continuums of diagnoses and symptoms

However, the dimensional approach increases the complexity of the communication of the disorder to fellow professionals and the public (Helzer, Kraemer, & Krueger, 2006). As it is not based on meeting certain criteria, there can be greater inconsistency in its use. Another limitation of using the dimensional approach is that most theorists cannot agree on how many dimensions are required; some say one dimension is enough, while others have identified as many as 33 dimensions.

The *DSM* is constantly under review, and a new edition, which will be known as the *DSM-V*, is currently being planned. There has been a great push recently to combine the dimensional and categorical measures of classifying mental health, and *DSM-V* planning committees are establishing the research base to move towards a dimensional classification of some disorders, including personality disorders (Widiger et al., 2005). It is believed that this will help to remove some of the stigma attached to labelling (categorising) someone as mentally ill.

## LABELLING AND STIGMA

So far, we have considered the approaches to classifying mental health conditions in the context of professional use. However, the unfortunate reality is that **labelling** also occurs in a non-professional sense, and can be derogatory. Labelling occurs when a certain characteristic an individual possesses is used as a name or brand to describe them. For example, some people are labelled based on physical characteristics – such as ‘tall’, ‘short’, ‘thin’ or ‘fat’ – or characteristics of personality, such as ‘arrogant’, ‘reliable’, ‘caring’ or ‘selfish’. Some of these labels have a negative connotation, while some may be seen as positive. For people suffering from mental illness, however, labels are generally derogatory, and may include ‘psycho’, ‘nuts’, ‘schizo’ or ‘crazy’. Of course, when we have a broken leg we are not automatically labelled as ‘limpy’, so why should mental illness carry such labels? Read ‘Focus on research: The effects of labelling’ to see how a label can change perceptions of individuals.

The reason that mental illness and physical illness are treated differently is because mental illness has a social **stigma** attached to it. Stigma refers to social disapproval of an individual’s personal characteristics or beliefs, or social disapproval of a type of behaviour. Stigma arises because people are often uncomfortable or embarrassed by behaviour that is different, and often the mentally ill are seen as violent, unpredictable or scary. People who have been labelled mentally ill are less likely to be hired for a new job, tend to be denied housing and are more likely to be falsely accused of crime (Hocking, 2003).

A community consultation of carers and mental health consumers in Australia in 2000 (SANE Australia’s *Have Your Say* report) identified a reduction in stigma and an increase in awareness

### FOCUS ON RESEARCH

#### The effects of labelling

A fascinating study undertaken by David Rosenhan and his colleagues of Stanford University illustrates the impact of psychiatric labelling. Rosenhan and several colleagues had themselves committed to mental hospitals with a diagnosis of ‘schizophrenia’ (Rosenhan, 1973). After being admitted, each of these pseudo-patients dropped all pretence of mental illness. Yet, even though they acted completely normally, none of the researchers was ever recognised by hospital staff as a phoney patient. Real patients were not so easily fooled. It was not unusual for a patient to say to one of the researchers, ‘You’re not crazy, you’re checking up on the hospital!’ or ‘You’re a journalist’.

To record their observations, Rosenhan and his colleagues took notes by carefully jotting things on small pieces of paper hidden in their hands. However, they soon learned that secrecy was totally unnecessary – they then simply walked around with a clipboard, recording observations and collecting data. No one questioned this behaviour. The note-taking was just regarded as a symptom of the ‘illness’ the pseudo-patients allegedly had. This observation clarifies why staff members failed to detect the fake patients. Because they were in a mental ward, and because they had been labelled schizophrenic, anything the pseudo-patients did was seen as a symptom of psychopathology.

As Rosenhan’s study shows, it is far better to label problems than to label people. Think of the difference in impact between saying ‘You are experiencing a serious psychological disorder’ and saying ‘You are a schizophrenic’.

#### QUESTIONS

- 1 Write a possible hypothesis that Rosenhan may have been testing.
- 2 What sort of sampling technique was used in this study?
- 3 What is one advantage and one disadvantage of this sampling technique?

and understanding as having the greatest potential to improve the lives of people affected by mental illness (Hocking, 2000). Respondents also considered it important to have better-trained health professionals and more available information and education for people with mental illness and their carers. Respondents wanted healthcare workers to ‘treat them more respectfully’ and the community to understand that they are not ‘lazy’ or ‘weak’ (Hocking, 2000).

The consequences of negative and unhelpful stereotypes are profound for people with a mental illness. They not only impair help-seeking behaviours, but affect medication adherence, overall recovery and, most importantly, impair self-esteem of the sufferer (Stuart, 2006).

Stigma about mental illnesses has an important role to play in the belief systems of society. Stereotypical views of mental illness begin in childhood and intensify in adulthood. Researchers believe that children learn from a very early age that mental problems are seen as a failure of character, and admitting such problems is looked down upon by their peers. Thus, people who are grappling with mental illness can be harmed as much by social stigma as they are by their immediate psychological problems (Corrigan & Penn, 1999).

## Dealing with social stigma

How can we improve community attitudes about mental illness? In recent years, our understanding of how to improve community attitudes has become more sophisticated. There is now awareness that we need long-term strategies to combat stigma by disengaging mental illness from associated fears and anxieties and by improving knowledge and attitudes. Two important ways of doing this are improving mental-health literacy (knowledge and awareness about mental health) and stopping the constant reinforcement of negative stigma by the media (Jorm et al., 1997).

A website called Headspace was launched in 2006 by the Commonwealth Government (see Figure 7.11). Part of the National Youth Mental Health Foundation, the initiative aims to provide important information and services to young people and their families across Australia, and also reduce stigma surrounding mental illness by raising community awareness. It provides support for mental health and well-being, and information that young people may not seek elsewhere because they feel intimidated or uncomfortable. Headspace employs a range of youth-friendly health professionals who can help young people with general health, mental health and counselling, education, employment services, and alcohol and other drug services. Headspace workers reinforce the fact that getting help early is the key to resolving mental health issues quickly (Headspace, 2006). Complete 'Try it yourself 7.2' to brainstorm ideas that may help reduce stigma associated with mental illness at your school.

Creative works such as art, music and writings by people experiencing mental illness can offer important insight into mental illness. See 'A closer look: The Cunningham Dax Collection' to read about how this art collection is trying to increase community awareness of



Figure 7.11 Organisations such as Headspace raise awareness and provide support and assistance to individuals experiencing a range of mental health issues.

mental illness. 'Try it yourself 7.3' involves an activity where you can investigate your feelings on the artwork in the collection.

### TRY IT YOURSELF 7.2

#### Brainstorming against stigma

One of the ways that social stigma surrounding mental illness can be reduced is through raising knowledge and awareness about mental health. Form a group of three or four students and imagine that you are on the Student Representative Council. Brainstorm ideas to help reduce the social stigma regarding mental health in your school. Share these ideas with the class. Can any of them be practically implemented to raise awareness of mental illness at your school?

### A CLOSER LOOK

#### The Cunningham Dax Collection

The Cunningham Dax Collection is a collection of artwork that contains more than 10 000 pieces that have been made by people experiencing mental illness. It is one of the largest collections of its kind in the world and the only such collection in the southern hemisphere (see Figure 7.12). The aim of the collection is to promote a greater understanding of people experiencing psychological trauma



Figure 7.12 This artwork (Untitled, Oil on canvas board, 30 X 40 cm) was donated to the Cunningham Dax collection by the artist Graeme Doyle. He exhibits his works regularly and publicly admits to suffering from schizophrenia.

Continued

#### labelling

When a certain characteristic of an individual is used as a name or brand to describe them

#### stigma

Social disapproval of an individual's personal characteristics or beliefs, or social disapproval of a type of behaviour

and/or mental illness, and to foster an appreciation of their creativity. The collection is currently in Parkville (Melbourne) under the auspices of the Mental Health Research Institute of Victoria. There is a permanent display of more than 150 works at the collection and some works may be seen on the collection's website.

In 1946, as the superintendent of a major psychiatric hospital in England, Dr Dax was one of the first to introduce art and other recreational therapies as therapeutic tools in the treatment of mental illness. Initially Dr Dax was interested in how the works produced could provide mental-health professionals with a powerful insight into the subjective experiences of these illnesses. It soon became apparent to Dr Dax that the artworks could also be very useful in educating the general public and helping to demystify and destigmatise mental illness.

Today the people who work at the Cunningham Dax Collection are particularly interested in the education of secondary school students about mental illness. They hope that by demystifying and destigmatising mental illness, young people will be more likely to seek help and also more likely to be sympathetic to and supportive of their peers who need help. Students have commented that the artworks 'bring to life what is in the textbook' and that 'they are the closest we get to people with mental illness'. Often for the first time, students are able to ask questions about mental health issues in an environment that is non-threatening, and also obtain information about mental health issues from appropriately qualified staff (Koh, 2004; Mental Health Research Institute of Victoria, 2003).

### TRY IT YOURSELF 7.3

#### Cunningham Dax artwork

Go to the Cunningham Dax collection website at <http://www.daxcollection.org.au>. Look at the different pieces of art displayed on the website and discuss the following questions with your classmates.

#### QUESTIONS

- 1 Why do you think artwork is used as a treatment tool for mental illness?
- 2 How does the art make you feel?
- 3 Do you feel you gain insight into the thoughts of people with mental illness by looking at this artwork?
- 4 Do you think the artwork helps to reduce social stigma associated with mental illness?

#### CHECK YOUR UNDERSTANDING 7.3

- 1 Two different ways in which mental illnesses can be classified are known as the \_\_\_\_\_ or \_\_\_\_\_ approaches to classifying mental disorders.
- 2 *DSM* stands for:
  - A the Diagnosis and Symptoms of Mental Health.
  - B the Diagnosis and Symptoms of Mental Disorders.
  - C the Diagnostic and Statistical Manual of Mental Disorders.

D the Diagnostic and Statistical Manual of Mental Health.

- 3 Match each *DSM* axis with the dimension that it assesses.

- |            |  |
|------------|--|
| a Axis I   | i Physical conditions                      |
| b Axis II  | ii Highest level of functioning            |
| c Axis III | iii Severity of psychological stressors    |
| d Axis IV  | iv Developmental and personality disorders |
| e Axis V   | v Clinical syndromes                       |

- 4 Which of the following is a limitation of using the categorical approach to classifying mental disorders?

- A It is difficult to use criteria to determine if someone should be diagnosed or not.
- B It provides very little information about symptoms.
- C It does not provide consistency in diagnosis around the world.
- D It is very rigid in boxing people into specific categories.

- 5 Social disapproval of personal characteristics or beliefs that are held by an individual is known as social \_\_\_\_\_.

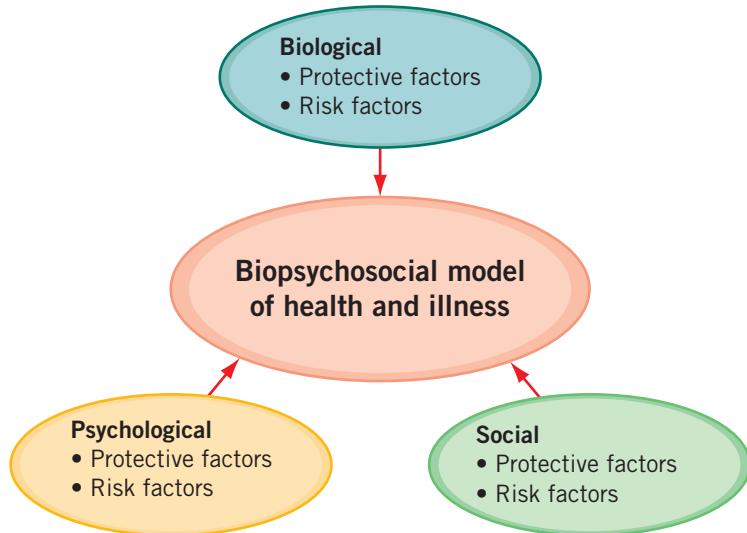
## Biopsychosocial approach to physical and mental health

As can be seen from its definition, health is not simply influenced by one or two factors. Indeed, there are many determinants that combine to influence the health of individuals and communities. These factors are broadly classified as *protective factors* and *risk factors*.

*Protective factors* enhance or have a positive effect on the health of an individual. Someone who maintains good physical and psychological health and maintains a good social support network is promoting their own well-being. *Risk factors* impede or have a negative effect on the health of an individual. Therefore, someone who has poor physical and psychological health and does not have a strong social network is not helping their own well-being.

Protective factors and risk factors also have a biological, psychological and social perspective. The *biopsychosocial model* of health and illness considers health and illness in the context of these perspectives; that is, health and illness outcomes are determined by the interaction and contribution of biological, psychological and social factors (see Figure 7.13).

*Biologically*, there are many *genetic factors* that influence our health. Genetic factors are those biological factors that can enhance (or reduce) an individual's risk of, or vulnerability to, developing a particular condition. Predetermined genetic risk factors cannot be directly controlled, but some non-genetic risk factors that affect our biology are well



**Figure 7.13** The biopsychosocial model of health and illness proposes that health and illness outcomes are a result of contributing biological, psychological and social factors.

within our control. These factors include personal behaviours that affect our biological condition such as smoking, drinking alcohol, using or not using illicit substances, keeping active and eating healthily (WHO, 2001).

*Psychologically*, we as individuals can also have a large influence on our health. Although some people are more susceptible than others to mental disorders due to certain personality factors, there are many ways to promote good psychological health. Engaging in stress management techniques, taking time out for ourselves, trying meditation and sharing and discussing feelings and concerns are all ways to try to achieve a positive psychological well-being.

*Social factors* (culture and environment) also play a large role in a person's health. For example, an accepting society and social network can be a great support to a person's health state. Feelings of acceptance and worth play an important role in the development of an individual's self-worth and importance. That is why a positive public perception of mental illness and a reduction of social stigma is important to encourage those suffering from mental illness to seek treatment.

So how do these factors work together to impact upon mental health and illness? If we look at a physical health issue such as diabetes, the risk factors could be either biological (e.g. a family history of diabetes or a history of having hypertension and a high body mass index) or psychological (e.g. having a mental illness) or social (e.g. not having a strong social network) (Strodl & Kenardy, 2006). Research also shows that having diabetes more than doubles the risk of developing depression, due to having to cope with biological and hormonal factors associated with having diabetes, as well as needing to manage the disease on a daily basis.

When investigating a mental health issue, if a person has a strong family history of mental illness and they then used illegal substances such as marijuana, ecstasy or speed, this interplay can put them at an increased risk of developing a mental illness. In this situation, an environmental or social behaviour (drug use) exploits the biological vulnerability (family history of mental illness) in a person to result in mental disorder.

Similarly, a person may have a family history of mental illness, but maintain strong social networks and good physical and psychological health, which can contribute to preventing the development of a mental disorder.

In order to maintain good psychological health, it is therefore important to understand some of the risk factors that we are exposed to or confronted with that can compromise our mental well-being.

#### protective factors (in health)

Factors that enhance or have a positive effect on the health of an individual

#### risk factors (in health)

Factors that impede or have a negative effect on the health of an individual

#### biopsychosocial model

An approach that proposes that health and illness outcomes are determined by the interaction and contribution of biological, psychological and social factors

#### genetic factors

Biological factors that commonly enhance (or reduce) an individual's risk of, or vulnerability to, developing a particular condition

# Stress: Applying a biopsychosocial framework

What does the term **stress** mean to you? If we ask 10 different people what stress means to them, we will no doubt receive 10 different answers, because what is stressful to one person may not be stressful to another.

Stress refers to a state of mental or physical tension that occurs when an individual must adjust or adapt to their environment but they do not feel they have the capacity to do so. Therefore, stress is thought to occur when the demands on an individual exceed the perceived ability of that individual to cope. Stress is the state experienced when an individual is exposed to a **stressor**. A stressor is the object or the event that causes stress, such as an exam, the death of a family member or financial difficulties.

When you think about stress, you probably consider it to be a negative experience. But stress can be a positive experience as well as a negative one, and whether or not we experience stress can be largely determined by the way in which we appraise situations. Canadian physiologist Hans Selye, a researcher who coined the term ‘stress’ in the 1930s, observed that ‘to be totally without stress is to be dead’ (Selye, 1976). Growing up, travelling (see Figure 7.14), waiting in an airport lounge, waiting your turn at a theme park during a crowded holiday at the Gold Coast, skiing at Mt Buller and other positive activities can be considered stressful. These activities can produce **eustress**, or a ‘good’ type of stress. Experiencing eustress releases adrenalin into the body to help us perform at an optimal level. Activities that are perceived as challenging and rewarding may therefore be energising even though they produce a certain level of stress.

Stress becomes a **distress** whenever emotional or physical pressures are intense, repeated, unpredictable and uncontrollable. Distress is a negative form of stress that impedes our ability to perform and cope at an optimal level (see Figure 7.15). Stress in these situations can become magnified



Figure 7.14 Travelling can produce eustress.

and damage is likely to result, not only to the person suffering, but also to the community. A Lifeline/University of Sydney survey in 2009 showed that the cost of distress to the community in terms of increased visits to doctors and missed days from work is approximately \$300 000 per day (Lifeline, 2009).

Distress caused as a result of a person’s profession can be particularly prevalent in the community, as we work longer and longer hours under increasing pressure, and the advent of new technologies means that the separation between home life and work life becomes less distinct. Table 7.5 shows the most stressful professions by gender according to mental stress claims in the combined years 2003–2005.

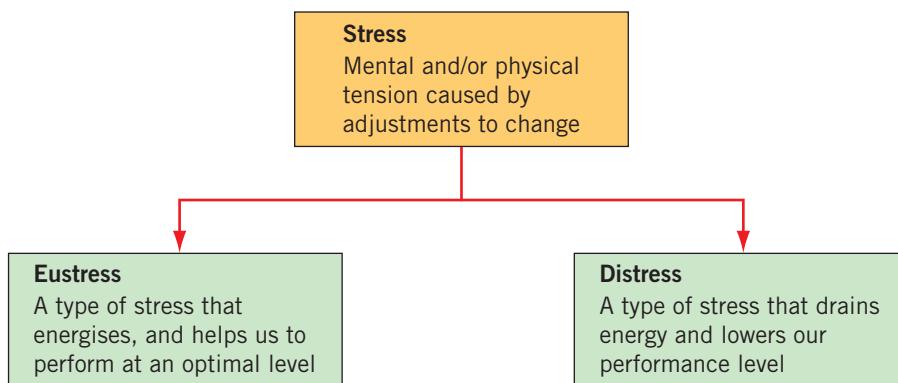


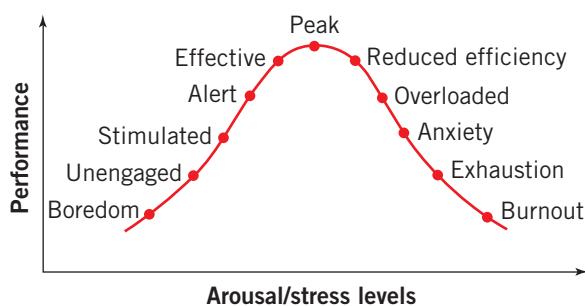
Figure 7.15 The two types of stress

**Table 7.5 The most stressful professions according to gender (2003–2005)**

WOMEN	MEN
<ul style="list-style-type: none"> <li>Caring professionals: Nurse managers, welfare associate professionals, social workers, welfare and community workers, counsellors</li> <li>Teachers: Special education, vocational education, secondary education, education aids</li> <li>Managers: Education managers, customer service managers, general managers, health services managers, child care coordinators</li> </ul>	<ul style="list-style-type: none"> <li>Public transport drivers: Train, bus and tram</li> <li>Law and order occupations: Prison officers, police officers, guards and security officers</li> <li>Caring professionals: Welfare professionals, community workers, ambulance officers and paramedics, special care workers, personal care and nursing assistants, registered nurses</li> <li>Teachers: Primary, secondary, vocational</li> </ul>

Source: Safe Work Australia (2007) *Compendium of Workers' Compensation Statistics Australia 2004–2005*. Australian Government: Australian Safety and Compensation Council.

It can be difficult to assess the point at which eustress becomes distress and vice versa. The **Yerkes-Dodson curve** demonstrates the relationship between arousal level (pressure) and performance. If arousal is too low, stress is too low, and performance is therefore low. If arousal is too high, stress is too high, and performance is therefore also low. For optimal performance, our arousal must be somewhere in the middle (see Figure 7.16). It is generally accepted that the optimal level of arousal is higher for simple, physically active tasks than for complex, highly-skilled tasks.



**Figure 7.16** The Yerkes-Dodson curve of stress and performance: insufficient or excessive arousal results in insufficient performance.

## STRESS REACTIONS

Stress reactions consist of a set of physical or psychological reactions that are set in motion when faced with threatening situations; they are the body's way of dealing with pressure. This set of reactions helps the body and mind to function at their optimal levels. It enables us to harness all necessary resources to help combat the stressor. Figure 7.17 shows the relationship between stressors, stress and stress reactions.

Stress reactions can involve either physiological or psychological responses to stress.

### Physiological responses to stress

The physiological stress response is associated with the activation of the sympathetic nervous system that occurs during emotionally threatening situations. However, our body reacts differently to a short-term stress than it does to a long-term stress. For example, if you are about to undertake your first bungee jump, you will experience a surge in your heart rate, blood pressure and respiration rate, as well as muscle tension and other sympathetic nervous system responses. There is literally an adrenaline rush, as the hormone is secreted into your system to prepare the body for action.

This physical response of the body to a sudden perceived threat is described as a fight-flight response (see chapter 2). The fight-flight response is

#### stress

A state of mental or physical tension that occurs when an individual must adjust or adapt to their environment but they do not feel they have the capacity to do so

#### stressor

The object or the event that causes a feeling of stress

#### eustress

A 'good' type of stress that helps the body perform at an optimal level

#### distress

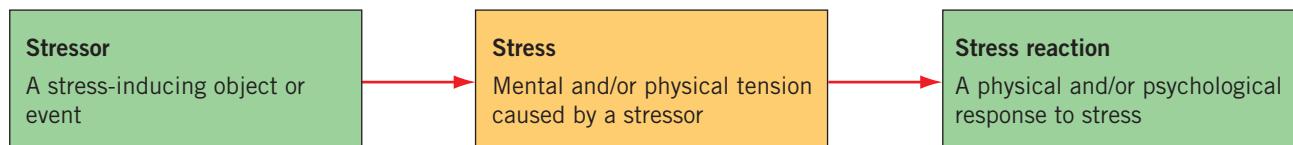
A 'bad' type of stress that has a negative effect on an individual and their performance

#### Yerkes-Dodson curve

A graph that demonstrates the relationship between arousal and performance, showing the optimal level of performance; insufficient or excessive arousal results in insufficient performance

#### stress reactions

The physical and psychological responses to stress



**Figure 7.17** The relationship between a stressor, stress and a stress reaction

an automatic response triggered by the sympathetic nervous system as it prepares the body to either confront the stressor (fight) or run from it (flight). The fight-flight response is an adaptive response that enhances our chances of survival. The effects of releasing adrenaline into the bloodstream and increasing heart rate increases the body's arousal level and prepares an individual with the necessary energy level required to protect itself in the face of danger.

If stress is more prolonged, the heightened arousal level produced by the sympathetic nervous system can result in negative physical effects. The continued release of adrenalin into the bloodstream causes the heart to beat at a faster than normal rate, which can cause damage to the heart, leading to heart palpitations and heart disease. Abnormal levels of internal activity can also lead to ulcers and stroke. Other physical effects of prolonged arousal are a weakened immune system, leading to an increased susceptibility to infection and disease. Skin irritations (including rashes and acne) and fatigue are also physiological effects of long-term stress.

### Psychological responses to stress

The many psychological effects of stress can be divided into three distinct categories: *emotional effects*, *cognitive effects* and *behavioural effects*.

Emotional effects may range from feeling increased levels of frustration, depression, anxiety, tension, irritability, anger and aggression, to feeling unable to cope with normal activities.

Our cognitive functions, or the way we process information and think about things, may also be affected by prolonged arousal. For example, we may find it difficult to focus our attention and direct our concentration. Our thoughts may be dominated by whatever is stressing us, and we may become confused, forgetful and unable to make rational decisions or solve problems. Our ability to think in a logical manner may also be negatively affected.

Prolonged stress also results in negative behavioural changes. Our normal sleeping patterns may be interrupted, causing us to experience excessive tiredness during the day. Eating habits may change too, as we may restrict food intake or indulge in more food or high-calorie food more often. Generally, we may experience a negative feeling about ourselves and feel that we are in conflict with our life situation but powerless to change it. As a result, we may withdraw from social contact. Some individuals may also indulge in a range of harmful behaviours, including drug abuse or excessive exercise.

Table 7.6 outlines some of the warning signs of someone having a physiological or psychological response to stress.

**Table 7.6 Warning signs of stress**

<b>EMOTIONAL SIGNS</b>	<ul style="list-style-type: none"> <li>Anxiety</li> <li>Apathy</li> <li>Irritability</li> <li>Mental fatigue</li> <li>Excessive worry about illness</li> </ul>
<b>BEHAVIOURAL SIGNS</b>	<ul style="list-style-type: none"> <li>Avoidance of responsibilities and relationships</li> <li>Extreme or self-destructive behaviour</li> <li>Self-neglect</li> <li>Poor judgement</li> </ul>
<b>PHYSICAL SIGNS</b>	<ul style="list-style-type: none"> <li>Exhaustion</li> <li>Frequent illness</li> <li>Overuse of medicines</li> <li>Physical ailments and complaints</li> </ul>

Source: Doctor & Doctor, 1994



'Videolink: Stress responses' examines some of the psychological and physical signs of stress as well as behavioural changes and ways to control stress.

### SELYE'S GENERAL ADAPTATION SYNDROME (GAS)

As we have discovered, when we perceive a threatening situation, our body automatically puts into motion a set of physiological and psychological responses to combat the stressor. Hans Selye, who considered stress a nonspecific bodily response caused by any demands placed on it by either unpleasant or pleasant conditions, developed a model of stress called the **general adaptation syndrome (GAS)**.

The GAS is the body's typical response pattern in terms of resistance to stress over time. Selye said that a bodily mechanism called *adaptation* was required to accept both eustress and distress. He noticed that the sequence of reactions to any illness or traumatic event was very similar, and thus we react to any stress (real, symbolic or imagined) by putting into motion a set of responses that attempts to alleviate the impact of the stressor.

According to Selye, the GAS consists of three stages: an *alarm-reaction stage*, a stage of *resistance* and a stage of *exhaustion* (Selye, 1976).

#### Alarm-reaction stage

The *alarm-reaction stage* comprises two sub-stages: **shock** and **countershock**. When we first perceive a stressful situation, we go into a state of 'shock' and our resistance level falls below normal; our body acts as though it is injured. Body temperature and blood pressure drop and our muscles temporarily lose tone. These physical effects of shock reduce the individual's ability to deal with the stressor, and they feel momentarily helpless.

Let us consider the example of a VCE student heading into a critical exam period. As the exams loom closer, the student enters the shock stage, and may feel they cannot cope with the demand. They may stop studying, have trouble concentrating and under-perform.

After the shock stage, the body rebounds and enters the stage of ‘countershock’. Countershock is characterised by the activation of the sympathetic nervous system and a higher-than-normal arousal level. Now the body’s resources are mobilised so it can cope with the stress and arousal levels. Endocrine glands such as the pituitary and adrenal glands pour more adrenaline and noradrenaline into the bloodstream. This speeds up some bodily processes while others are slowed down, thereby allowing energy to be used where it is most needed. Countershock also leads to the fight-flight response as detailed in chapter 2.

In the example of a student in a critical exam period, when countershock kicks in our student may feel that they have revived energy. They will have the necessary resources to stay awake and alert, and be able to function above their normal level.

During countershock, the body’s resistance to stress is above normal; however, this is not always a positive thing, and can cause some problems. The release of cortisol into the bloodstream can cause damage to the heart and other vital organs, and can make our immune system susceptible to illness.

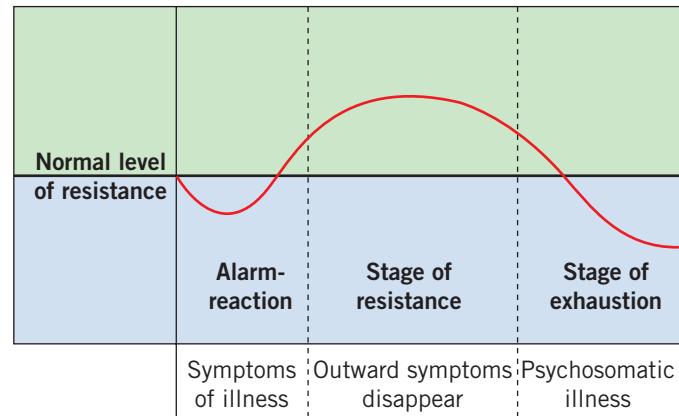
## Stage of resistance

Following the alarm-reaction stage, if the stressor has not been defeated, the body enters the **stage of resistance** as it attempts to stabilise its internal systems and fight the stressor. The ‘stress hormone’ cortisol is released into the bloodstream to help combat the negative effects of stress on the body. When we first move into this stage, the symptoms of the alarm-reaction stage subside. Although the body is better able to cope with the initial stressor, because physiological arousal remains higher than normal, the ability to resist *additional* stressors is significantly lowered. So, the body puts all its resources into fighting the current stressor, but may not have any resources to fight additional stressors. That is why, if we are exposed to additional stressors such as infection during the stage of resistance, we may not be able to cope with them and signs of illness may appear.

During the resistance stage, the student in the critical exam period will continue with the energetic approach to study they achieved in the countershock stage of alarm-reaction; however, after a period of time the student’s resources can become depleted.

## Stage of exhaustion

If we are unable to defeat the original stressor during the first two stages, we reach a **stage of exhaustion**,



**Figure 7.18** The general adaptation syndrome. During the initial alarm reaction stage to stress, resistance falls below normal (shock). It then rises again as bodily resources are mobilised (countershock), and it remains high during the stage of resistance. Eventually, resistance falls again as the stage of exhaustion is reached.

in which the body’s resources are drained and the stress hormones that triggered the fight-flight response are depleted. This leaves us vulnerable to additional stressors such as infection and disease, and we may succumb to illness. As the VCE student undertaking exams enters this stage, they may become sick and physically worn out.

When Selye examined animals in the later stages of the GAS, he found that their adrenal glands were enlarged and discoloured. He also found that there was intense shrinkage of the spleen and lymph nodes and many animals also suffered from bleeding ulcers deep in the stomach. In addition to such direct effects, stress can also disrupt the body’s immune system,

### general adaptation syndrome (GAS)

According to Hans Selye, the body’s typical response pattern in terms of resistance to stress over time, comprising three stages: alarm reaction, resistance and exhaustion

#### alarm-reaction stage

The first stage of the GAS, where resistance to stress first drops below normal, then increases above normal

#### shock

The first stage of alarm-reaction in the GAS, where resistance to stress drops below normal and the body acts as though it is injured; blood pressure and body temperature decrease

#### countershock

The second stage of alarm-reaction in the GAS, where resistance to stress rises above normal levels due to the activation of the sympathetic nervous system

#### stage of resistance

The second stage of the GAS, where the resistance to stress remains above normal levels; cortisol is released to help repair the damage caused by stress on the body

#### stage of exhaustion

The final stage of the GAS, where the body’s resources are depleted and its resistance to stress falls below normal

making a person more susceptible to long-term illness or disease.

How can stress affect health? An answer can be found in the **immune system**, which mobilises defences, such as white blood cells, against invading microbes and other disease agents (Ader & Cohen, 1993). The immune system is regulated in part by the brain. Because of this link, stress and upsetting emotions can affect the immune system in ways that increase susceptibility to disease (Miller, 1998; Pike et al., 1997). The study of links among behaviour, stress, disease and the immune system is called **psychoneuroimmunology**.

Studies show that the immune system is weakened in students during major exam times. Immunity is also lowered by divorce, bereavement, a troubled marriage, job loss, depression and similar stresses (Gilbert et al., 1996; Herbert & Cohen, 1993; Stein, Miller & Trestnan, 1990). Lowered immunity explains why the ‘double whammy’ of getting sick when you are trying to cope with prolonged or severe stress is so common (Biondi & Zannino, 1997).

## Strengths and limitations of the GAS

As an explanation of how the body reacts to stress, the GAS is not without its critics. The GAS successfully contributed to the popularisation of the concept of stress as it relates to physical and mental health in the 1940s and 1950s. It is argued that the GAS placed significant emphasis on the non-specific nature of the stress response and, therefore, placed the adrenal cortex at the ‘centre of the stress universe’ (Fink, 2000). However, different stressors often trigger different patterns of hormone secretion from various organs, demonstrating that a uniform stress response to a non-specific stressor is an oversimplification of the complex way in which the body deals with stressors. Additionally, the differentiation between how you would respond to a particular stressor in comparison to someone else, due to environmental and biological factors, is not adequately explained by this theory. The personal meanings and symbolisms of individual threats would need to be incorporated into why certain issues are

more stressful for some individuals than others and how they manage threat or stressors.

‘Videolink: Selye’s GAS and long-term effects of stress’ gives a thorough overview of the GAS.

### VIDEO

Selye's GAS and long-term effects of stress

## CHECK YOUR UNDERSTANDING 7.4

- 1 What is the term given to the positive experience of stress that helps the body deal with pressure situations?

- A Prolonged stress
- B Super stress
- C Distress
- D Eustress

- 2 The sympathetic nervous system activates the \_\_\_\_\_ response when the body is placed in a threatening situation; the body then chooses to either \_\_\_\_\_ the situation or \_\_\_\_\_ from it.

- 3 For each of the following symptoms, decide whether they are a physiological (Phy) or psychological (Psy) symptom of stress.

- a Skin rashes
- b Irritability
- c Trouble concentrating
- d Colds and flu
- e Heart attacks
- f Changes to sleep patterns
- g Increase in risk-taking behaviours
- h Stroke

- 4 Put the stages and sub-stage of the GAS in the correct order.

- Exhaustion
- Countershock
- Alarm-reaction
- Shock
- Resistance

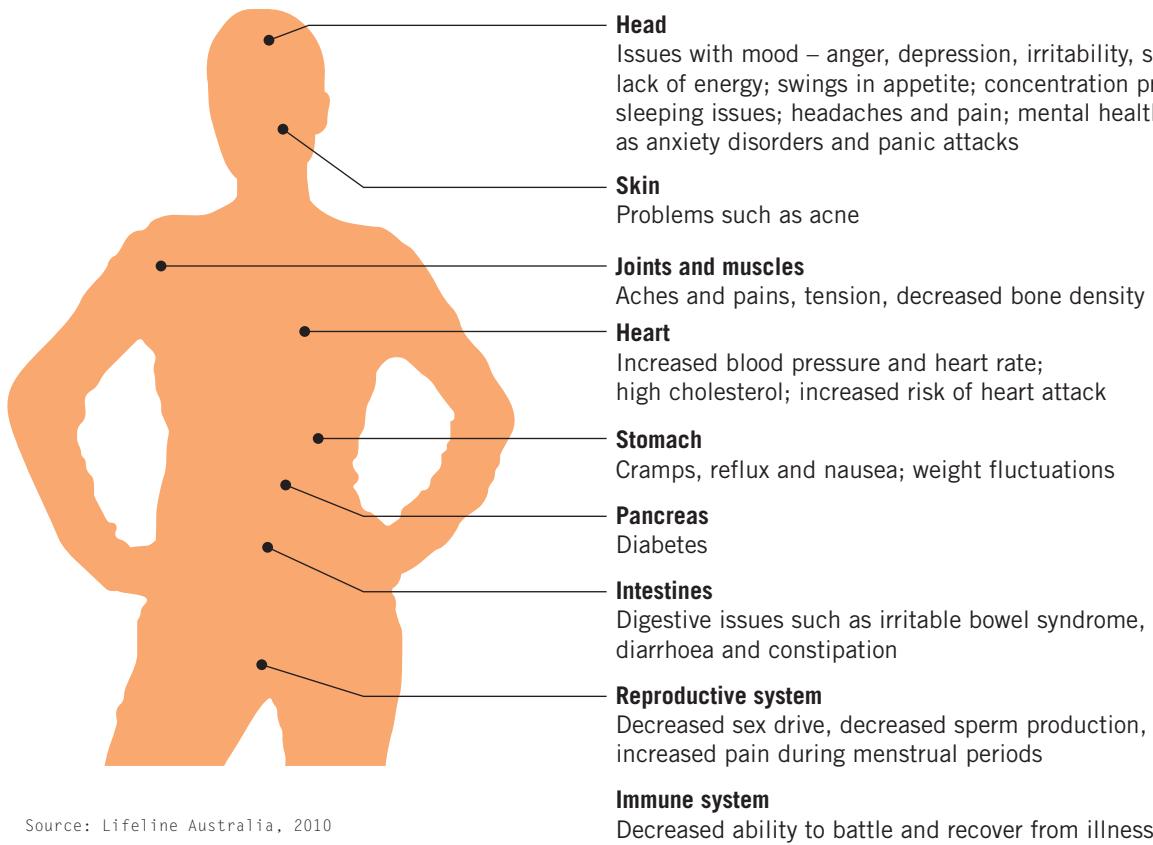
- 5 The study of the relationship between behaviour, stress and the immune system is known as \_\_\_\_\_.

## THE LINK BETWEEN STRESS AND ILLNESS

The GAS shows a typical response pattern of the body’s resistance to stress. Studies investigating the link between stress and illness have shown that there is a relationship between the two: the more intense and prolonged the stress, the more likely the chance of illness. However, stress does not *cause* illness to occur – it just makes an individual more susceptible to illness.

Physiological symptoms and illnesses that are the result of psychological stressors are known as **psychosomatic illnesses**. The term ‘psychosomatic’ comes from the Greek *psyche* (mind) and *soma* (body). In psychosomatic illnesses, psychological factors contribute to actual bodily damage or to damaging changes in bodily functioning. Psychosomatic problems, therefore, are not the same as hypochondria. People with hypochondria believe that they suffer from diseases although there is no evidence of illness; psychosomatic illnesses, however, present with very real physical symptoms as a result of psychological factors. For example, there is nothing imaginary about asthma, a migraine headache, or high blood pressure, but these are some of the physical symptoms that can arise from the psychological condition of prolonged stress.

The most common psychosomatic problems are gastrointestinal and respiratory, but many others exist. Typically, major problems include eczema,



Source: Lifeline Australia, 2010

Figure 7.19 The effect of stress on the body

(skin rash), hives, migraine headaches, rheumatoid arthritis, hypertension (high blood pressure), colitis (ulceration of the colon) and heart disease. Lesser health complaints are also frequently stress-related. Typical examples include sore muscles, headaches, neck aches, back aches, indigestion, constipation, chronic diarrhoea, fatigue, insomnia, premenstrual problems and sexual dysfunctions (Brown, 1980; De Benedittis, Lorenzetti & Pieri, 1990) (see Figure 7.19).

## PSYCHOLOGICAL DETERMINANTS OF THE STRESS RESPONSE

As we know, stress is a subjective experience that depends on how we interpret a stressor and also our own perception of our ability to cope. Richard Lazarus and Susan Folkman attempted to create a framework for evaluating how we cope with stressful events, known as the *transactional model of stress and coping*. Lazarus and Folkman suggested that stressful experiences are transactions between a person and their environment. In comparison to Selye's biological explanation as to how we respond to stress, the transactional model suggests that our stress responses are mediated by our appraisal of the stressor and also by the social and cultural resources at our disposal (Lazarus & Cohen, 1977; Antonovsky & Kats, 1967; Cohen, 1984). As a

result, stress responses are dependent on our emotions and other psychological factors.

Lazarus and Folkman suggest that when responding to stress, we initially engage in a *primary appraisal*, in which we decide if a situation is threatening or positive, or relevant or irrelevant to our situation. This then sets in motion a process of *secondary appraisal*, in which we assess what

### immune system

A system that mobilises the body's defences, such as white blood cells, against illnesses and diseases

### psychoneuroimmunology

The study of links among behaviour, stress, disease and the immune system

### psychosomatic illness

Physiological symptoms that arise as a result of psychological stressors or factors

### transactional model of stress and coping

A model that proposes that stressful experiences are a transaction between a person and their environment; if demands exceed resources, stress is the likely result

### primary appraisal

In the transactional model of stress and coping, when we decide if a situation is threatening or positive, relevant or irrelevant to our situation

### secondary appraisal

In the transactional model of stress and coping, when we assess what resources are available to us to help combat or cope with the stressor

resources are available to us in terms of coping with the situation. For example, most of us would feel stressed if we were asked to deliver a speech at an assembly at school. But how we appraise public speaking will affect how we react to it – is it an intense threat or a challenge? (See Figure 7.20.)

The transactional model focuses on how a person interacts with their external environment and stress is seen as a result of how a person appraises a situation and their abilities to cope with it. Stress is thought to be experienced when the demands on an individual exceed the necessary resources present to deal with a stressor, even if that stressor is not life-threatening or if it poses only a perceived (not an actual) threat.

This model is useful for helping people understand their role in interpretation and appraisal of a stressor. It also distinguishes between the experience of eustress and distress. However, it has been criticised as being too simplistic and not giving due consideration to the uncontrollable factors that underpin our body's response to a stressful situation.

Delivering a talk at an assembly, asking a person out on a date, and sitting an examination are all day-to-day stressors that are not life-threatening, but they are still important issues for us because they challenge our sense of control over these situations. Whenever we cannot (or think we cannot) control our immediate environment, we are vulnerable to feel stressed. Therefore, just the perception of lack of control is as threatening as an actual lack of control (DasGupta, 1992). If the answer to the question ‘What can I do about this situation?’ is ‘Absolutely nothing’, then you will feel emotionally stressed. Sometimes we may also emphasise the threat and make it more of a challenge than it would ordinarily be, by imagining failure, embarrassment and rejection – which often actually invites disastrous consequences (Lazarus, 1993).

It is interesting how a sense of being able to actually reach our goals makes us feel as if we have a sense of control. Whenever we lack a sense

of competency to deal with life's demands, we feel threatened (Bandura, 1986). ‘Focus on research: Yes, a molehill does sometimes become a mountain!’ examines a study that explored the impacts of severity of stressors.

Our personalities also play a role in how we cope with stress. Some people thrive on stress, while

### FOCUS ON RESEARCH

#### Yes, a molehill does sometimes become a mountain!

In a year-long study, Richard Lazarus (1985) and his associates (who researched the transactional model of stress and coping) studied the impact of minor but frequent stresses on the health of individuals. He had 100 men and women keep track of the frequency and severity of the daily ‘hassles’ that they endured. Participants also reported on their physical and mental health. As Lazarus and his co-workers suspected, frequent and severe hassles turned out to be better predictors of day-to-day health than major life events were. However, major life events did predict changes in health one or two years after the events took place. It appears that daily hassles are closely linked to immediate health and psychological well-being (Johnson & Sherman, 1997; Roberts, 1995). Major life changes have more of a long-term impact.

Following up on this, Lazarus found that the personal importance of hassles affects the amount of stress produced (Lazarus et al., 1985). Microstressors (small stressors) that are viewed as central to one's self-worth are many times more likely to cause trouble. For many people, these hassles are linked to work, family and relationships. Psychologist Rand Gruen noted that ‘taking care of paperwork or being organised can be central for some people’ (Fisher, 1984). This observation clearly emphasises that stress occurs in people, not in the environment. The experience of stress is related to personality, values, perceptions and personal resources (Moos & Swindle, 1990).

#### QUESTIONS

- 1 Identify the independent variable in Lazarus' original study.
- 2 Identify the dependent variable in Lazarus' original study.
- 3 Write a possible hypothesis for Lazarus' original study.

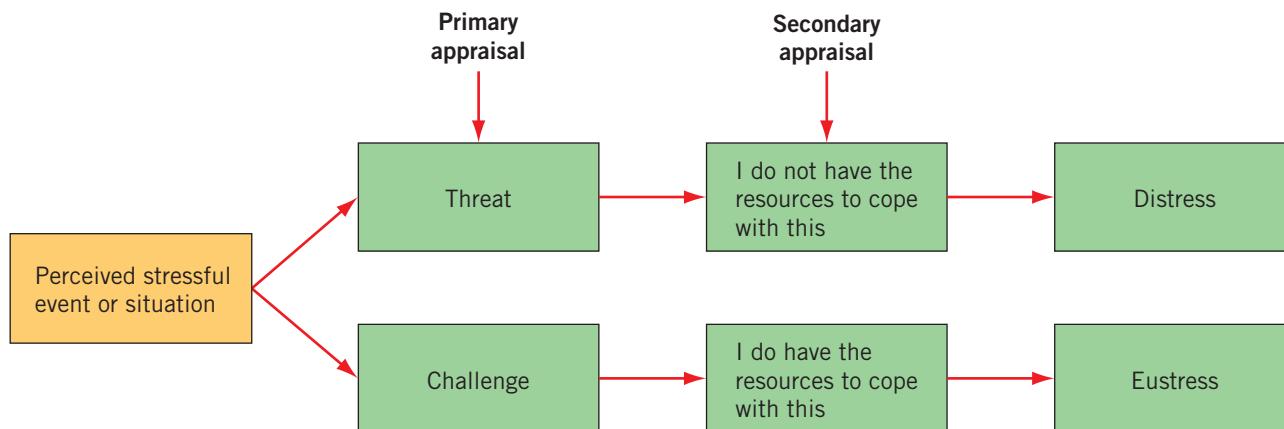


Figure 7.20 How we appraise a situation or event influences how much stress we experience and how effectively we respond.

others thrive in a calmer environment. Complete 'Try it yourself 7.4' to assess the types of things that create stress in your life.

### TRY IT YOURSELF 7.4

#### Appraising your stressors

The transactional model of stress and coping states that stress is about how we appraise the situation.

- List 10 things that have created stress for you in the last week.
- Investigate how each stressor was appraised and how it could have been appraised differently, if necessary.

#### QUESTIONS

- 1 What sort of resources could have enabled you to interpret the stressor as a challenge rather than a strain?
- 2 Is it likely that you will appraise the same situation in the same way in the future? Why or why not?

## SOCIAL, CULTURAL AND ENVIRONMENTAL DETERMINANTS OF THE STRESS RESPONSE

Is it possible to consider the concept of stress through the paradigm of the determinants of health that we examined earlier? Can there be protective and risk factors for stress that alleviate and exacerbate the stress response? Can the stress response be determined by social, cultural and environmental factors?

### Factors that alleviate the stress response

The presence of a secure and established network of friends and family is a protective factor against stress-related disorders. This means that culture itself has a protective role in terms of how we deal with stress. Our social networks provide us with an opportunity to receive support from others. They can align us with coping strategies but also with assistance in our day-to-day activities to make dealing with the stressful situations easier. People within many cultures work together to achieve their goals and as a result the burden of any stressors is often shared with the community.

Environmental factors can also alleviate the impact of stress, its perception and the stress response. Good physical and mental health and a reduction in stress often go hand in hand with a pleasant, clean environment. A predictable and equitable availability of basic resources such as food, electricity and water reduces the perception of stress and helps to alleviate the stress response.

### Factors that exacerbate the stress response

Studies have reported that people who do not have adequate social support are unable to discuss negative feelings and relieve their stress. This stress builds up, and the negative emotions cause frustration, only adding to the stress. Studies have also shown that environmental factors such as poverty, low income, poor housing, and chronic and severe physical as well as mental illnesses can cause significant stress in people. Other environmental factors such as noise, pollution and lack of water resources can all exacerbate the stress response and make the everyday task of dealing with daily life quite stressful.

Cultural issues can also lead to stress. Australia, New Zealand and Canada are countries that are open to accepting immigrants. Every year, an increasing number of immigrants and refugees coming to Australia must adapt to changes in language, dress, values and social norms (see Figure 7.21). For many of these immigrants, this is a period of culture-shock or **acculturative stress** (stress caused by adapting to a foreign culture).



Figure 7.21 Adapting to a foreign culture can be stressful and cause acculturative stress.

Typical stress responses to acculturative stress are anxiety, hostility, depression, alienation, physical illness or identify confusion (Thomas, 1995). As can be seen from 'A closer look: Strange feeling in a strange land', the perception of stress from being part of a new culture is different for

#### acculturative stress

Stress that is the result of adapting to a foreign culture

## A CLOSER LOOK

### Strange feeling in a strange land

Is it stressful to be a 'stranger in a strange land'?

The severity of acculturative stress is related, in part, to how a person adapts to a new culture. The four main patterns of adaptation are:

- integration – maintain your old cultural identity but participate in the new culture
- separation – maintain your old cultural identity and avoid contact with the new culture
- assimilation – adopt the new culture as your own and have contact with its members
- marginalisation – reject your old culture but also suffer rejection by members of the new culture.

To illustrate each pattern, let's consider a family that has immigrated to Australia from Russia. The father favours integration. He is learning English and wants to get involved in Australian life. At the same time, he is a leader in the Russian–Australian community and spends much of his leisure time with other Russian–Australians. His level of acculturative stress is low.

The mother speaks only Russian and interacts only with other Russian–Australians. She remains almost completely separate from Australian society. Her stress level is high. The teenage daughter is annoyed by hearing Russian spoken at home, by her mother's serving only Russian food, and by having to spend her leisure time with her extended Russian family. She would prefer to speak English and to be with her Australian friends. Her desire to assimilate creates moderate stress.

The son doesn't particularly value his Russian heritage, yet he is rejected by his schoolmates because he speaks with a Russian accent. He feels trapped between two cultures. His position is marginal, and his stress level is high.

To summarise, those who feel marginalised tend to be stressed, and those who remain separate due to a number of uncontrollable reasons are also highly stressed. Those who pursue integration into their new culture are minimally stressed, and those who assimilate are moderately stressed.

Integration and assimilation may appear to be the best options. One can argue that a big benefit of assimilating is that people who embrace their new culture experience fewer social difficulties. For many, this justifies the stress of adopting new customs and cultural values (Berry, 1990; Rogler, Cortes & Malgady, 1991; Ward & Rana-Deuba, 1999; Williams & Berry, 1991). However, others may argue that assimilation means running the risk of losing one's identity, and is not a healthy way to integrate into a new society.

One of the best antidotes for acculturative stress is a society that tolerates or even celebrates ethnic diversity. Nearly everyone's family tree includes people who were once strangers in a strange land and someone had always been there to welcome the immigrants to their new home.

different people. How one acculturates, and whether the new culture is accepting, can determine the stress response. A person who actively attempts to integrate will have less stress, as will a person who is welcomed into the new society even if they have not tried very hard to assimilate. A person who deliberately remains separate from the new culture or who is marginalised when they try to assimilate will experience high levels of stress.

### CHECK YOUR UNDERSTANDING 7.5

- 1 Which of the following is not a major risk factor with respect to health?
  - A Exercise
  - B Cigarette smoking
  - C Stress
  - D High blood pressure
- 2 According to the transactional model of stress and coping, stress tends to be greatest when a situation is appraised as \_\_\_\_\_ and a person does not feel they have the necessary resources to cope with the situation.
- 3 Match each term with its definition.

<ol style="list-style-type: none"><li>a Stress</li><li>b Secondary appraisal</li><li>c Primary appraisal</li><li>d Psychosomatic illness</li></ol>	<ol style="list-style-type: none"><li>i Illnesses in which psychological factors contribute to bodily damage or functioning</li><li>ii Deciding whether a situation is positive or a threat</li><li>iii A state of mental or physical tension that occurs when an individual must adjust or adapt to the environment</li><li>iv Deciding how to cope with a threat or a challenge</li></ol>
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- 4 Which of the following factors would most likely help to alleviate stress?
  - A A natural disaster
  - B Poor housing conditions
  - C A friendship group
  - D Changing schools
- 5 Stress that is the result of adapting to a foreign culture is known as \_\_\_\_\_.

### ALLOSTASIS: HOW DOES THE BODY ADAPT?

After a stressful situation has wreaked havoc on the body, how do we adapt and return to a state of well-being or *homeostasis* (see chapter 2)? We achieve this state through a process called

**allostasis** (Sterling & Eyer, 1988). Within the body, there are ideal levels for biological mechanisms such as body temperature, blood pressure and concentration of chemicals in the blood, and these are disrupted by stress. So, what we experience as signs and symptoms of stress in fact end up causing disequilibrium in bodily systems so that we are not in a state of homeostasis. When the body deviates from the ideal levels of internal functioning, the allostatic systems (including the immune system, autonomic nervous system and neuroendocrine systems) automatically turn on or off in the process of allostasis to restore equilibrium, or homeostasis. Allostasis allows the body to adjust to demands by altering internal systems. These systems must be quickly activated so that the body's functions can return to equilibrium after a stressful event.

However, allostasis is not just dependent on chemicals in the blood stream. Like so many other human responses, it can be influenced by psychological factors. Some people seem to thrive on stress; for example, people might seek out jobs that are highly demanding because they feel bored if they do not have more than one thing happening at once. So, for such a person to achieve their optimal level of functioning, they need a high-stress environment. This would mean that their allostatic systems are working more frequently, but this is not a negative thing because this individual enjoys the high-stress lifestyle.

Of course, social factors can also affect the process of allostasis. The presence of people around us can either enhance or impede our ability to achieve well-being. After a fight-flight response has occurred, a calming environment can help the body to return to normal, whereas a high-stress environment can make it difficult for allostatic systems to return the body to homeostasis.

## COPING WITH STRESS

Could reducing stress or the experience of stress help prevent illness? Various psychological approaches, such as support groups, relaxation exercises, guided imagery and stress management training can actually boost immune system functioning (Kiecolt-Glaser & Glaser, 1992). By doing so, these methods help promote and restore health. There is even evidence that such measures improve the chances of survival following life-threatening diseases such as cancer (Anderson, Kiecolt-Glaser & Glaser, 1994). It is reassuring to know that managing stress can help protect your immune system and your health.

No one is immune to stress; it is an integral part of our lives. Obviously the simplest way of coping with stress is to modify or remove its source, but this is often impossible, which is why learning to manage stress is so important. If we do not learn to manage stress, we will be unable to cope with it. **Stress management** is the use of behavioural

strategies to reduce stress and improve coping skills.

As shown in Figure 7.22, stress triggers bodily effects, upsetting thoughts, and ineffective behaviours. Also shown is the fact that each element worsens the others in a vicious cycle. Indeed, the basic idea of the 'stress game' is that once it begins, *you lose*—unless you take action to break the cycle. We will now look at some ways to break this cycle and cope with stress.

## Biofeedback

Wouldn't it be nice to be able to control some bodily activities, such as sweating before an exam, or your pounding heart rate before a date? Physiologists have discovered that people can learn to control bodily activities once believed to be involuntary. This can be achieved by providing information, or feedback, about autonomic functions, through a process called **biofeedback**. Biofeedback is the process by which a person receives information about autonomic physiological activity in order to learn how to change it to improve health and performance.

Biofeedback uses precise instruments to measure physiological activity such as brainwaves, heart function, breathing, muscle activity and skin temperature. These instruments rapidly 'feed back' this information to the person undergoing the process, so they gain an understanding of how their body responds in various situations and learn how to control a variety of physiological responses. The presentation of this information – often in conjunction with changes in thinking, emotions and behaviour – supports desired physiological changes. Over time, these changes can endure without continued use of an instrument (Association for Applied Psychophysiology and Biofeedback, 2008).

Biofeedback is a promising way to treat some psychosomatic problems. For example, people have been trained to prevent migraine headaches with biofeedback. Sensors are taped to patients' hands and foreheads. Patients then learn to redirect blood flow away from the head to their extremities. Because migraine headaches involve excessive blood flow to the head, biofeedback helps patients reduce the frequency of their headaches (Gauthier, Cote & French, 1994; Kropp et al., 1997).

### allostasis

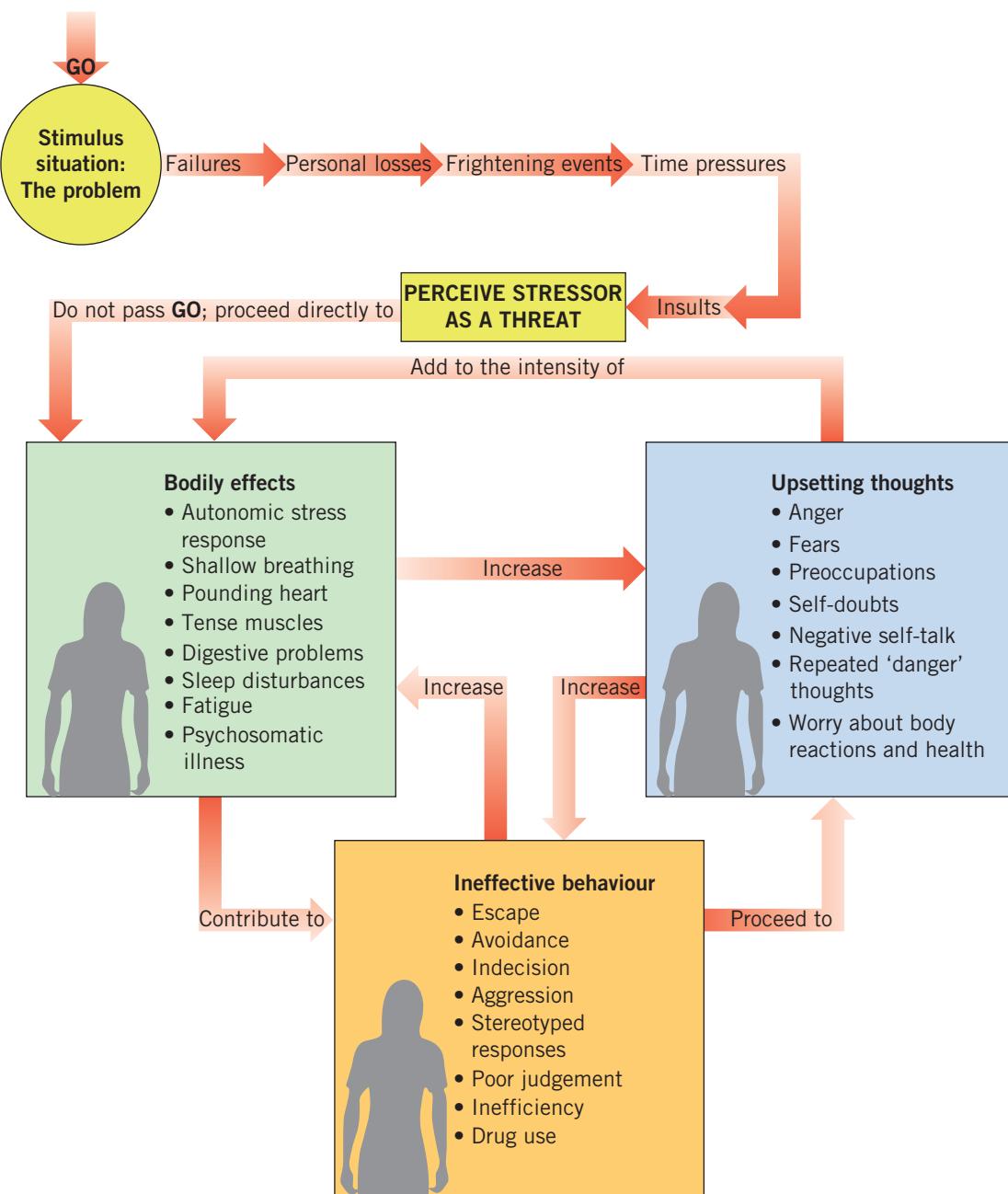
The process of achieving stability of systems inside the body (homeostasis) by the automatic turning on and off of the allostatic systems

### stress management

The application of strategies to reduce stress and improve coping skills

### biofeedback

The process of receiving information about autonomic physiological functions, in order to learn how to control them



Adapted from Rosenthal & Rosenthal, 1980

Figure 7.22 The 'stress game'

Biofeedback can help relieve muscle-tension headaches, migraine headaches and chronic pain (Arena et al., 1995; Buckelew et al., 1998; Gauthier, Cote & French, 1994). It shows promise for lowering blood pressure and controlling heart rhythms (Blanchard et al., 1996). The technique has been used with some success to control epileptic seizures and hyperactivity in children (Potashkin & Beckles, 1990; Sterman, 1996) and insomnia also responds to biofeedback therapy (Barowsky, Moskowitz & Zweig, 1990). Early success led many to predict that biofeedback would offer a *cure* for psychosomatic illnesses, anxiety, phobias, drug abuse and a long list

of other problems. However, in reality, biofeedback has proven at best helpful, but not an instant cure (Amar, 1993).

Some researchers believe that many of the benefits of biofeedback arise from general relaxation. Others stress that there is no magic in biofeedback itself. The method simply acts as a 'mirror' to help a person perform tasks involving self-regulation. Just as a mirror does not comb your hair for you, biofeedback does not do anything by itself – it simply provides information. It can, however, help people make desired changes in their behaviour (Amar, 1993; Weems, 1998).

**VIDEO**

Biofeedback therapy

'Videolink: Biofeedback therapy' examines the use of and processes involved in biofeedback.

## Meditation and relaxation

Much of the immediate discomfort of stress is caused by fight-flight emotional responses. When we are stressed, the body is ready to act, often with tight muscles and a pounding heart. If action is prevented, we merely remain 'uptight'. A sensible remedy is to learn a reliable, drug-free way of relaxing.

Meditation refers to a deep state of relaxation brought about by mental exercises that focus attention and interrupt the typical flow of thoughts, worries and analysis (Wilson, 1986). Meditation takes many forms and has many meanings in various cultures. People who regularly use meditation as a stress-reduction technique often report less daily physical arousal and anxiety. Many stress counsellors now recommend meditation for calming the body and promoting relaxation.



Figure 7.23 Meditation involves focusing on one thing, ignoring everything else, and achieving a state of relaxation.

American cardiologist Herbert Benson proposed that the core of meditation is the **relaxation response** – an innate physiological pattern that opposes activation of the body's fight or flight mechanisms – and indeed others have found that meditation is one of the most effective ways to relax (Eppley, Abrams & Shear, 1989). It has been found that there are several physical benefits of meditation, such as a lowered heart rate, blood pressure and muscle tension as well as a decrease in other signs of stress. As a stress-control technique, meditation may be a good choice for people who find it difficult to 'turn off' upsetting thoughts when they need to relax. In essence, meditation has been found to reliably elicit the relaxation response, which makes it valuable in stress reduction. The keys for inducing the relaxation response include:

- a quiet environment
- decreased muscle tension
- a mental device (such as a repeated word, or a mantra) that helps shift thoughts away from ordinary concerns, and replace them with a passive mindset.

Listening to or playing music, bush walking, enjoying hobbies and the like can be meditations of sorts. Anything that reliably interrupts upsetting thoughts and promotes relaxation can be helpful. You will need an instructor to learn meditation techniques initially, but it is not necessary to take an expensive commercial course – council leisure centres and other community services often run short courses in meditation. Once learnt, this is a lifelong skill that you can use at will whenever required.

We will now explore the two major types of meditation.

### PROGRESSIVE MUSCLE RELAXATION

As we have previously seen, it is possible to relax systematically, completely and by choice. Benson's basic idea of **progressive muscle relaxation** is to tighten all the muscles in a given area of your body (the arms, for instance) and then voluntarily relax them. By first tensing and relaxing each area of the body, you can learn what muscle tension feels like. Then when each area is relaxed, the change is more noticeable and more controllable. With practice, it is possible to greatly reduce tension in this way.

#### relaxation response

An innate physiological pattern that opposes activation of the body's fight-flight mechanisms

#### progressive muscle relaxation

A method of physically relaxing the entire body by progressively tightening and relaxing all the muscles in given areas of your body

'Try it yourself 7.5' provides an opportunity to achieve Herbert Benson's relaxation response.

### TRY IT YOURSELF 7.5

#### Progressive muscle relaxation

Try this relaxation technique for 15–20 minutes.

- 1 Sit or lie comfortably. Breathe slowly. Pay attention to your breathing for 1–2 minutes.
- 2 Continue to breathe slowly and deeply. Contract the muscles in your toes, feeling the tension in your toes. Hold this for 30 seconds. Release and relax the muscles in your toes, feeling all the tension flow out of your muscles. Contract the muscles in your calves. Hold for 30 seconds, then release the muscles, feeling all the tension leave your calves. Progressively contract and relax each of your muscle groups moving up your body: thighs, stomach, arms and hands, shoulders, neck and face muscles.
- 3 All your muscle groups should now be relaxed. Try not to tense them again. As you breathe out, say the word 'relax' to yourself in your head. Do this for 2–3 minutes.
- 4 Imagine an open window with a white lace curtain. Imagine that when you breathe in, a breeze comes in the window and the curtain gently blows in the breeze. When you breathe out, the curtain blows out the window. Imagine this scene, keeping in time with your slow breathing, for 5–8 minutes. If distracting thoughts enter your mind, once again say the word 'relax' in your head each time you breathe out, until the thoughts disappear.

#### GUIDED IMAGERY

In a technique called **guided imagery**, people visualise images that are calming, relaxing or beneficial in other ways. You are usually encouraged to pick several places where you would feel safe, calm and at ease. Typical locations might be the beach, the bush, floating in a warm pool or lying in the sun at a quiet park. To relax using this method, you must vividly imagine yourself in one of these locations. In the visualised scene, you should be alone and in a comfortable position. It is important to visualise the scene as realistically as possible. You should also try to feel, taste, smell, hear and see what you would actually experience in the calming scene.

As with progressive relaxation, this technique takes practice. When the relaxing scenes become familiar and detailed, they can be used to reduce anxiety and encourage relaxation (Rosenthal, 1993).

### Physical exercise

**Physical exercise** is any activity of exerting oneself physically in various ways to keep fit (see Figure 7.24). Regular exercise alters the hormones, circulation, muscle tone and a number of other aspects of physical functioning. Together, such changes can lower risks for disease (Baum & Poslusny, 1999) and be effective in reducing stress-based arousal. Swimming, cycling, dancing, yoga, most sports, and especially walking are valuable outlets (Anshel, 1995).



Figure 7.24 Regular physical exercise helps to maintain good physical and mental health.

A review of the usefulness of exercise in depression showed evidence that exercise did indeed help people recover from depression. It is believed that exercise increases the level of serotonin in the brain, the neurotransmitter that is reduced when a person experiences depression (Sadock & Sadock, 2003).

Exercise is known to not only reduce resting heart rate, but also respiratory rate, blood pressure and core temperature threshold for sweating. It also reduces levels of cortisol (the stress hormone) and norepinephrine in the blood. Exercise is also known to boost the body's immune status. The physiological effects of exercise are surprisingly very similar to those that are induced by the relaxation response and hence help us cope with stress.

You must be careful to choose activities that are vigorous enough to relieve tension yet enjoyable enough to be done repeatedly. Exercising for stress management is most effective when it is done daily (Wheeler & Frank, 1988). Remember, though, that this refers to light exercise, such as walking or biking to school – if you engage in more vigorous exercise to maintain aerobic fitness, you

should allow your body to have rest days to avoid overtraining.

## Social support

**Social support** refers to the close, positive relationships we develop with others (see Figure 7.25). It facilitates good health and morale (Greenglass, Burke & Konarski, 1998). One reason for this is that support from family and friends serves as a buffer to cushion the impact of stressful events (Taylor, 1999). Talking about problems and expressing tensions can be extremely helpful. Research has shown that isolation can increase stress-related bodily changes, including hormones and anxiety symptoms, and that seeking social support to avoid isolation is an important method of coping with stress.



Figure 7.25 The positive relationships we develop with others help us cope with stress.

Although sometimes it is a rite of passage for youngsters to believe that their families do not understand them, it has been found that families are one of the most stable and enduring sources of support for people all over the world. The knowledge that there is support to fall back on enhances the relaxation response in times of stress.

Similarly, a network of good friends is also a key to feeling supported. Friends often support us with unconditional positive regard and this enhances our trust that we can rely on them in times of crisis, thereby making the relaxation response accessible. Peer group support is a key mechanism for youngsters to feel accepted and valued. It can be easy to fall into groups that may have an unhealthy influence on your time and values; it is therefore important to seek out those groups that enhance your self-image and contribute positively to your personal growth.

Social support is also found in other community-based activities – for example, at your local football or cricket club. This has the double advantage of providing both physical exercise and social support. Mentorship provided by a teacher or older friend is also a good way of dealing with some stressful issues that you may find difficult to talk about with your parents.

## Other coping tips

### SLOWING DOWN

Remember that stress can be self-generated. Try to deliberately do things at a slower pace, especially if your pace has sped up over the months leading to, for example, VCE examinations. Tell yourself, ‘What counts most is not if I get there first, but if I get there at all’. Slowing down does not mean putting your books back in the shelf, feet up on the table and relaxing by watching TV all the time! It means checking the pace of your progress, so that you have time to recoup and catch your breath.

### BEING ORGANISED

Disorganisation creates stress. Try to take a fresh look at your situation and get organised. Set priorities and ask yourself what’s really important and concentrate on the things that count.

### STRIKING A BALANCE

Work, school, family, friends, interests, hobbies, recreation, community – there are many important elements in a satisfying life. Damaging stress often comes from letting one element (especially work or school) get out of hand. Try to strike a balance between challenging ‘good stress’ and relaxation (Wheeler & Frank, 1988).

### RECOGNISING AND ACCEPTING LIMITATIONS

Many of us set unrealistic goals. Given that no one can ever be perfect, this attitude leaves many of us feeling inadequate, no matter how well we have performed. Set gradual, achievable goals for yourself. Also, set realistic limits on what you try

#### guided imagery

A method of relaxation involving the intentional visualisation of images that are calming, relaxing or beneficial in other ways

#### physical exercise

Any activity of exerting oneself physically in order to maintain or increase fitness

#### social support

Support gained by forming close, positive relationships with other people

to do on any given day. Learn to say ‘no’ to added demands or responsibilities if you know you cannot cope with them.

#### WRITING ABOUT YOUR FEELINGS

If you think you don’t have someone to talk to about stressful events, you might try expressing your thoughts and feelings in writing. You could keep a personal journal or, with the advent of online free publishing by way of blogs, you can maintain your own web journal. Several studies have found that students who write about their upsetting experiences, thoughts and feelings are better able to cope with stress. They also experience fewer illnesses, and they achieve better grades (Esterling et al., 1999; Pennebaker & Francis, 1996).

#### LEARNING TO LAUGH

A good sense of humour can lower your distress or stress reaction to difficult events (Lefcourt & Thomas, 1998). In addition, an ability to laugh

at life’s ups and downs is associated with better immunity to disease (McCelland & Cheriff, 1997). Humour is one of the best antidotes for anxiety and emotional distress (Cann, Holt & Calhoun, 1999).

#### NUTRITION

Does food have anything to do with it? Apparently plenty! What you eat or do not eat can play a big part in your health and emotional well-being, and foods can often differentially contribute to our mood states. Maintaining a healthy and well-balanced diet is important, taking care to eat the right types of foods and consume the right amounts (see Figure 7.26).

Try to limit caffeine if you drink coffee or cola soft drinks, especially when stressed. Alcohol, drugs and smoking are very unhelpful as these can contribute to feelings of anxiousness and discourage sleep, and may adversely impact on your overall health.

‘Try it yourself 7.6’ encourages you to look at some of the things you currently do that hinder and help the experience of stress.



Figure 7.26 Maintaining a healthy diet contributes to emotional and psychological well-being.

## TRY IT YOURSELF 7.6

### Help or hindrance?

Draw a line down the middle of an A4 sheet of paper. Write the word 'Hinder' on one side and 'Help' on the other. Fill the left side of the sheet with different things you do that hinder the experience of stress. For example, do you indulge in soft drinks or energy drinks when you are stressed? Do you bottle up your feelings and not talk about them? On the right side, write down all the coping mechanisms you currently use to help you cope with stress. Examine your lists. What 'hinder' behaviours could you stop doing? What other 'help' behaviours could you engage in?

## CHECK YOUR UNDERSTANDING 7.6

- 1 \_\_\_\_\_ is the achievement of stability by the turning on and turning off our automatic bodily systems, including the immune system, the autonomic nervous system and the neuroendocrine systems.
- 2 The use of behavioural strategies to reduce stress and improve coping skills is known as:
  - A biofeedback.
  - B psychosomatic illness.
  - C psychoneuroimmunology.
  - D stress management.

- 3 The provision of information to a person about his or her ongoing bodily activities, which aids voluntary regulation of these bodily activities is known as \_\_\_\_\_.
- 4 A set of exercises that focus attention and interrupt the typical flow of thoughts, worries and analysis is often called:
  - A biofeedback.
  - B counselling.
  - C meditation.
  - D social support.
- 5 Match each term with its definition.

a Progressive relaxation	i Mental exercises that focus attention and interrupt the typical flow of thoughts, worries and analysis
b Guided imagery	ii The close, positive relationships which we develop with others
c Meditation	iii A method for producing deep relaxation of all parts of the body
d Social support	iv The intentional visualisation of images that are calming, relaxing or beneficial in other ways

# Chapter summary

WORDCHECK

TEST  
YOURSELF

## Normality:

- Normality is defined as patterns of behaviour, or personality traits, that are typical or that conform to some standard of proper and acceptable ways of behaving.
- Approaches to defining normality include the *statistical* approach, the *sociocultural* approach, the *functional* approach, the *historical* approach, the *situational* approach and the *medical* approach.

## Mental illness vs mental health:

- Mental health is characterised as the psychological state of someone who is functioning at a satisfactory level of emotional and behavioural adjustment.
- Mental illness is when the emotional difficulties one faces lead to some level of impairment or disability.
- The scientific and systematic study of abnormal experience, cognition and behaviour is known as *psychopathology*.

## Categorising mental disorders:

- *Categorical* approaches to classifying mental disorders are those that place common symptoms in categories or groups.
- Examples of categorical approaches are the Diagnostic and Statistical Manual of Mental Disorders – IV, Text Revision (DSM-IV-TR) and the International Classification of Diseases – 10 (ICD-10).
- There is a recent push to use or incorporate the use of *dimensional* approaches to classification of mental disorders. Dimensional approaches use a profile of scores on different continuums of diagnoses and symptoms.
- Social *stigma*, and being labelled as having a mental health disorder, are factors that discourage individuals from seeking treatment.

## The biopsychosocial model of health and illness:

- Health and illness outcomes are a result of the interaction between *biological*, *psychological* and *social* factors.

## Stress:

- Stress is a state of mental or physical tension that occurs when an individual must adjust or adapt to the environment.
- The experience of stress may be positive (*eustress*) or negative (*distress*).
- There are physiological and psychological effects of stress, including the activation of the fight–flight response.
- The body reacts to stress in a series of stages called the *general adaptation syndrome* (GAS).

- The stages of the GAS are *alarm-reaction* (shock and countershock), *resistance* and *exhaustion*.
- *Psychosomatic illnesses* are physiological symptoms that are experienced as a result of psychological stressors.
- Studies of *psychoneuroimmunology* show that there is a relationship between stress and disease. Stress does not cause disease; it just makes an individual more susceptible.

## The transactional model of stress and coping:

- Stress is intensified when a situation is perceived as a threat and when a person does not feel competent to cope with it.
- The *primary appraisal* of a situation involves deciding whether the stress is threatening or challenging.
- During a *secondary appraisal*, some means of coping with a situation is selected. Coping may be problem-focused, emotion-focused, or both.

## Social, cultural and environmental effects on the stress response:

- These factors may alleviate the stress response, through having strong friendships and relationships.
- These factors can exacerbate the stress response through problems such as low income and social stigma.
- *Allostasis* is influenced by these factors – it is the process of achieving stability by turning on and turning off the allostatic systems, including the immune system, the autonomic nervous system and the neuroendocrine systems.

## Strategies for managing stress:

- A sizable number of coping skills can be applied to manage stress. Most of these focus on mitigating the stress response.
- During *biofeedback* training, autonomic processes are monitored and converted to a signal that reveals what the body is doing. With practice, biofeedback allows alteration of many bodily activities.
- *Meditation* can be used to reduce stress. Two major benefits of meditation are its ability to interrupt anxious thoughts and its ability to elicit the relaxation response.
- *Physical exercise* alters the hormones, circulation, muscle tone and a number of other aspects of physical functioning to help lower our likelihood of disease.
- *Social support* is the support gained through forming close, positive relationships with others. It facilitates good health and morale and the reason for this is that support from family and friends serves as a buffer to cushion the impact of stressful events.

## Apply your knowledge and skills

### SECTION A: MULTIPLE-CHOICE QUESTIONS

- 1 Health is a state of complete:
- A cultural well-being.
  - B spiritual well-being.
  - C physical, mental and social well-being.
  - D environmental well being.
- 2 The fight-flight response is activated by which nervous system?
- A The stress nervous system
  - B The somatic nervous system
  - C The parasympathetic nervous system
  - D The sympathetic nervous system
- 3 If John's parents both have diabetes, but neither of Sam's parents have diabetes, John's risk of developing diabetes is higher than Sam's. Which of the determinants of health does this represent?
- A Social
  - B Cultural
  - C Biological
  - D Environmental
- 4 The hormone that is released into the bloodstream to help repair the damage done to the body from stress is known as:
- A adrenaline.
  - B cortisol.
  - C dopamine.
  - D serotonin.
- 5 In some countries it is unacceptable to be married to more than one person at a time. In Australia, this practice would be defined as abnormal in the \_\_\_\_\_ approach to normality.
- A sociocultural
  - B statistical
  - C situational
  - D functional
- 6 Tom was walking to the bus stop one morning. When he reached the bus stop, he met a man dressed as a clown. This man wore a red nose and a bright curly wig, as well as a coloured jumpsuit and big red shoes. Which approach to normality would best classify this man's behaviour as abnormal?
- A Functional approach
  - B Medical approach
  - C Historical approach
  - D Situational approach
- 7 An example of a stressor is:
- A learning to relax from a trained professional.
  - B an examination.
  - C meditation.
  - D regular exercise.
- 8 Sheri is late for a dinner with her family. While she is sitting in traffic in her car on the way to the restaurant, she realises she has an increased heart rate, increased respiration rate and muscle tension. This is best described as:
- A an anxiety disorder.
  - B a panic attack.
  - C a stress response.
  - D post-traumatic stress disorder.
- 9 The three stages of the general adaptation syndrome are:
- A shock, resistance and exhaustion.
  - B alarm-reaction, resistance and exhaustion.
  - C shock, countershock and resistance.
  - D alarm reaction, shock and countershock.
- 10 The two processes that individuals undergo according to the transactional model of stress and coping are:
- A primary and secondary appraisal.
  - B alarm and resistance.
  - C depression and anxiety
  - D stress and stressors.
- 11 Integration, separation, assimilation and marginalisation are four main patterns of adaptation to a new culture. This is known as:
- A acculturation.
  - B cultural neglect.
  - C immigration.
  - D displaced culture.
- 12 The study of links among behaviour, stress, disease and the immune system is called:
- A psychopharmacology.
  - B psychoneuroradiology.
  - C psychoneuroimmunology.
  - D immunochemistry.
- 13 Which of the following categories of stress reactions are not considered psychological?
- A Biological
  - B Behavioural
  - C Emotional
  - D Cognitive

- 14** Which of the following statements best describes allostasis?
- A** The maintenance of bodily functions while resting
  - B** The achievement of body stability after change
  - C** The activation of the sympathetic nervous system
  - D** All of the above
- 15** Which of the following is not considered a technique to help you cope with stress?
- A** Meditation
  - B** Exercise
  - C** Guided imagery
  - D** Over-eating

## SECTION B: SHORT-ANSWER QUESTIONS

- 1** Explain how the biopsychosocial approach seeks to explain mental health.
- 2** What is the statistical approach to defining normality? Provide an example to support your answer.
- 3** Explain the difference between a stressor, stress and stress reaction.
- 4** What is an advantage of classifying mental disorders using a dimensional approach rather than a categorical approach?
- 5** Name two different categorical approaches to classifying mental disorders.
- 6** Explain what the term eustress means and provide an example.
- 7** Explain the role that allostasis plays in maintaining physical health.
- 8** Name and explain two reasons that may prevent people from seeking treatment for mental disorders.
- 9** Explain two ways that you can cope with stress.
- 10** List three physiological effects of prolonged stress.

## SECTION C: EXTENDED-RESPONSE QUESTION

Give an example of a situation that is personally stressful to you. With reference to the Transactional Model of Stress and Coping, explain why you might interpret this situation as stressful. Explain how your body will attempt to deal with the stressor by referring to each stage of the General Adaptation Syndrome.

*This question is worth 10 marks.*

## SECTION D: ASSESSMENT TASK

### Visual presentation

In this task you will use a visual presentation format to demonstrate your understanding of the relationship between stress and physical and mental well-being.

Your presentation should demonstrate your understanding of the following:

- The relationship between a stressor, stress and a stress reaction, with reference to an everyday example
- The general adaptation syndrome
  - What it is
  - How the body reacts during the three stages of the GAS
  - Its relationship to the fight-flight response
- Stress
  - What it is
  - The physiological and psychological effects of eustress and distress
- The biopsychosocial approach to stress
  - How biological, psychological and social factors can contribute to an individual's response to stress

You can use one of the following forms to present the information:

- Create a poster showing a flow chart or concept map
- Design a multimedia presentation