Univerzita Hradec Králové
Pedagogická fakulta

PSYCHOLOGY OF HEALTH AND DISEASE

Stanislav Pelcák

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Review: prof. PhDr. Blahoslav Kraus, CSc.

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PSYCHOLOGY OF HEALTH AND DISEASE

Lecturer: **PhDr. Stanislav Pelcák, Ph.D.**

Contact: stanislav.pelcak@uhk.cz

Workload:
Full-time students: 3 hours per week (seminar)
Part-time students: 12 hours per semester (seminar)
Self-study: not specified

Recommended semester for course enrollment: 5th

Prerequisites: none

Rules of communication with the lecturer:
Via e-mail and during consultation hours – for further details, see the department's website

Course overview and syllabus

Course objectives

The aim of the course is to present **the major issues in Psychology of Health and Disease, as well as their application possibilities in prophylaxis, therapy, rehabilitation**, and in health promotion programs in selected groups of population. At the end of the course, the students will be able to design an intervention program for selected group of population, and put it into practice. The course aim is to deepen the understanding of Social Pathology by presenting the topics of present-day Health Psychology and Positive Psychology.

Syllabus

1. Introduction to Psychology of Health and Disease, the development of medical thinking, crucial models of health and disease in the 20th and 21st centuries, holistic approach to health and disease. Salutogenesis. Positive Psychology. The "Public Health for the 21st century" programme.
2. Bio-psycho-social factors of health and disease, stressful situations and adverse life situations, microstressors, high workload, socioeconomic gradient and health, stress-related coping strategies.
3. Psychosocial risk factors, introduction to psychosomatics, multicausal etiology of disease, psychoneuroimmunology, complex treatment of disease, therapeutic community, prevention and rehabilitation.

4. Disease as an adverse life event, chronic disease, coping with disease. Personal resources of coping with disease, resilience, perceived social support, family system, family stress and family resilience, subjective quality of life.
5. Psychosomatic patient in the view of salutogenesis, basic treatment of psychosomatic issues, psychological treatment of psychosomatic patients.
6. Psychological hygiene in helping professionals, risk and protective factors. Psychological consequences of profession, psychological crisis, accute crisis, chronic crisis. Burnout syndrome, chronic fatigue syndrome. Possibilities of prevention.
7. Methods of psychosocial intervention in prevention and health promotion.

Basic literature:

HAVLÍNOVÁ, M. a kol. *Program podpory zdraví ve škole: rukověť projektu Zdravá škola*. 1 vyd. Praha: Portál, 1998, 280 s. ISBN 80-7178-263-7.
HOSKOVCOVÁ, S*. Psychická odolnost předškolního dítěte*. Praha: Grada, 2006. 160 s. ISBN 978-80-24714-24-0
KEBZA, V. *Psychosociální determinanty zdraví*. 1. vyd. Praha: ACADEMIA, 2005. 258 s. ISBN 80-200-1307-5
KŘIVOHLAVÝ, J. *Psychologie zdraví*. Praha: Portál, 2001. ISBN 80-7178-551-2
KŘIVOHLAVÝ, J. *Psychologie nemoci*. Praha: Grada, 2002. ISBN 80-2470-179-0
MAREŠ, J., a kol. *Sociální opora u dětí a dospívajících I.* 1. vyd. Hradec Králové: Nucleus, 2001. 152 s. ISBN 80-86225-19-4
PAYNE J. a kol. *Kvalita života a zdraví*. Praha: Triton, 2005. ISBN 80-7254-657-0
PELCÁK, S. *Osobnostní nezdolnost a zdraví.* 1.vyd.
SOBOTKOVÁ, I. *Psychologie rodiny*. 2. vyd. Praha: Portál, 2007. 224 s. ISBN 978-80-7367-250-8.
SLEZÁČKOVÁ A. *Průvodce pozitivní psychologií*. 1.vyd. Praha: Grada Publishing, 2012. 304 s. ISBN 978-80-247-3507-1
ŠOLCOVÁ, I. *Vývoj resilience v dětství a dospělosti*. 1. vyd. Praha: Grada, 2009. 104 s. ISBN 978-80-247-2947-3.

Recommended literature:

BARTŮŇKOVÁ, S. *Stres a jeho mechanismy*. 1.vyd. Praha: Karolinum, 2010. 137 s. ISBN 978-80-246-1874-6
BAŠTECKÝ, J., ŠAVLÍK, J., ŠIMEK, J. *Psychosomatická medicína*. Praha: Avicenum, 1993. ISBN 80-7169-031-7
BŘICHÁČEK, V., HABERMANNOVÁ M. *Studie z psychologie zdraví*. 1.vyd.Praha:Ermat, 2006. 257s. ISBN978-80-87178-00-3
FALEIDE AO.,LILLEBA BL., FALEIDE, EK. *Vliv psychiky na zdraví. Soudobá psychosomatika*. Praha: Grada Publishing,2010. 240 s. ISBN 978-80-247-2864-3
HARGAŠOVÁ, M. a kol. *Skupinové poradenství*. 1. vyd. Praha: Grada, 2009, 264 s. ISBN 978-80-247-2642-7.
HOSKOVCOVÁ, S., SUCHOCHLEBOVÁ, L. *Výchova k psychické odolnosti dítěte*. Praha: Grada, 2009. 224 S. ISBN 978-80-347-2206-1.
FIALOVÁ, L., KOUBA, P. a kol. *Medicína v kontextu západního myšlení*. 1.vyd.Praha:Galén,2008.978-80-7262-513-0

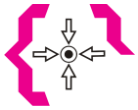
GILLERNOVÁ, I., KEBZA V., RYMEŠ, M. a kol. *Psychologické aspekty změn v české společnosti. Člověk na přelomu tisíciletí.* Praha: Grada Publishing, 2011.256 s. ISBN 978-80-247-2798-1
GURKOVÁ, E. *Hodnocení kvality života*. 1.vyd.Praha: Grada Publishing, 2012. 224 s. ISBN 978-80-247-3625-9
IRMIŠ, F. *Temperament a autonomní nervový systém*. 1.vyd. Praha: Galén, 2007. 195 s. ISBN 978-80-7262-475-1
JANÁČKOVÁ, L. *Bolest a její zvládání*. 1.vyd.Praha:Portál,2007.192s. ISBN 978-80-7367-210-2
KŘIVOHLAVÝ, J. *Stárnutí z pohledu pozitivní psychologie*. 1.vyd. Praha: Grada Publishing, 2012.144 s. ISBN 978-80-247-3604-4
MARCUS, BH., FORSYTH, LA. *Psychologie aktivního způsobu života*. 1.vyd. Praha: Portál,2010.224s. ISBN 978-80-7367-654-4
TÓTHOVÁ, J. *Úvod do transgenerační psychologie rodiny: transgenerační přenos vzorců rodinného traumatu a zdroje jeho uzdravení.* 1 vyd. Praha: Portál, 2011. 256 s. ISBN 978-80-7367-856-2
GRAVE, K. *Neuropsychoterapie.* Praha: Portál, 2007. ISBN 978-80-7367-311-6
CHROMÝ, K., HONZÁK. *Somatizace a funkční poruchy*. Praha: Grada Publishing, 2005. ISBN 80-247-1473-6
OREL, M., FACOVÁ, V. *Člověk, jeho mozek a svět.* Praha: Grada Publishing, 2009. ISBN 978-80-247-2617-5
PAYNE J. a kol*. Zdraví: hodnota a cíl moderní medicíny.* 1. vyd*.* Praha: TRITON, 2002.124 s. ISBN 80-7254-293-1
PELCÁK, S. Psychologie zdraví a salutogeneze. In *Sociální práce a sociální služby*. Hradec Králové: Gaudeamus, 2007, s. 61 – 73.
PELCÁK, S. Nespecifická primární prevence a psychologie zdraví. In KRAUS, B. (ed.). *Sociální patologie*. Hradec Králové: Gaudeamus, 2007, s. 304 – 316.
PELCÁK, S. Psychologická pomoc u pomáhajících profesí. Prediktory psychologické morbidity u zdravotníků. In: *Sociální práce mezi pomocí a kontrolou.* Sborník z konference IV. Hradecké dny sociální práce. Hradec Králové 12. -13. 10. 2007, Hradec Králové: GAUDEAMUS 2008, s. 344–350
PRAŠKO, J. a kol. *Psychické problémy u somaticky nemocných a základy lékařské psychologie.* 1.vyd.Olomouc:UP v Olomouci, 2010. ISBN 978-80-244-2365-4
PRAŠKO, J. a kol. *Chronická únava.* 1.vyd. Praha: Portál, 2006. ISBN 80-7367-139-5
RONEN, T. *Psychologická pomoc dětem v nesnázích: Kognitivně-behaviorální přístupy při práci s dětmi*. 1. vyd. Praha: Portál, 2000. 160 s. ISBN 80-7178-370-6.
SMOLÍK, P. *Duševní a behaviorální poruchy.* Praha: Maxdorf, 2002. ISBN 80-85912-18-X
SVOBODA, M., ČEŠKOVÁ, E., KUČEROVÁ, H. *Psychopatologie a psychiatrie*. Praha: Portál, 2006. ISBN 80-7367-154-9
TRESS, W., KRUSSE, J. *Základní psychosomatická péče*. Praha: Portál, 2007. ISBN 978-80-7367-309-3
TSCHUSCHKE, V. *Psychoonkologie. Psychologické aspekty vzniku a zvládnutí rakoviny*. Praha: Portál, 2004. ISBN 80-7178-826-0
VENGLÁŘOVÁ, M. a kol. *Sestry v nouzi. Syndrom vyhoření, mobbing, bossing.*1.vyd. Praha:Grada Publishing,2011. ISBN 978-80-247-3174-2
VYMĚTAL, J. *Lékařská psychologie.* 3. vyd. Praha: Portál, 2003. ISBN 80-7178-740-X
ZDRAVÍ 21. *Dlouhodobý program zlepšování zdravotního stavu obyvatelstva ČR.* Praha: MZ ČR, 2003

ZDRAVÍ 21. *Výklad základních pojmů. Úvod do evropské zdravotní strategie*. Praha: MZ ČR, 2004

Course completion requirements

Active participation in the seminars, successful fulfilment of assigned tasks, successful completion of the end-of-term test, final essay (10 – 15 pages, any topic related to the subject), successful defence of the essay at the colloquium.

1 PSYCHOLOGY OF HEALTH AND DISEASE: BASIC THEORY



Objectives

The introduction to the development of models of health and disease, and their theoretical background with the focus on salutogenic model of health and disease.

Workload

4 hours

Important keywords

Pathogenic model of disease; biomedical model of health and disease; behavioural medicine; behavioural health; systems model of health; psychosomatics; salutogenesis.

1.1 *Pathogenic model of health*

The role of medicine has been changing not only in the context of human health (specific interventions and treatment) and its determinants, but also in the inspirational, initiation and educational sphere related to other branches, institutions and subjects which anyhow influence the health state of people (Drbal a Bencko, 2005).

The medicine of the 19th and 20th centuries gradually developed the models of disease which reflected the level of scientific knowledge of that time. Biological model of health had become fully-fledged in the 19th century due to the rapid development of scientific research. Biomedical approach is primarily based on Descartes's dualistic view of a human being as a "rational machine". McClelland (1985) considered this view as a mechanistic model which treats human body as a machine which can be fixed by a repair or change of malfunction part, and the destruction of any undesirable element which causes trouble. In this context, a physician becomes the "machine repairman" whose aim is to diagnose a disorder, eliminate, or at least minimalize, it. A major critic of Cartesianism was a neurophysiologist Damasio (2000) who made a revision of the schematic dichotomist approach to a human being.

As a milestone in medicinal thinking, the opinions of a Prussian pathologist von Virchow can be considered. In 1858, he declared that a disease is the disorder of cells, tissue and organs which determine the disorder of their function; a disease is then manifested by various symptoms (Honzák, 2005). All human body processes were then explained on the basis of biochemical, physiological and other biology-

related causes. The opinion prevails in the minds of laymen and even some medical workers, that the “true disease” must have its physiological and somatic correlates.

On one hand, the model made possible the crucial discoveries in the field of “somatic medicine” which, as a result, lowered the mortality and morbidity. On the other hand, it did not view the health and disease in the whole complexity. According to Danzer (2001), the fragmenting specializations of medicine led to the gradual disappearance of the psychological and anthropological aspects of disease from the somatic knowledge and to their classification as special issues of Psychiatry and Psychology. In 1930s, the biomedical approach went through a crisis.

Despite the technological development, research and a wide range of medicinal drugs, the number of diseases which are not manageable by somatic medicine grows (lifestyle diseases, chronic diseases, psychosomatic diseases etc.). Biomedical approach failed especially in searching for the causal factor in diseases which were not brought about by the external factors (physical and chemical factors, microorganisms etc.) and were not considered hereditary. The current terminology refers to such diseases as the *chronic non-communicable diseases*.

In accordance with Křivohlavý (1995), the basic characteristics of the **biomedical model of health** can be summarized as follows:

- the great merit of the model is the decrease in mortality and the improvement of morbidity rate over the past 100-150 years,
- the model focuses solely on the contribution of biological (causal) factor in the onset of the disease (linear causal model of health),
- it considers body and soul (psyche) as two separate and different entities, and focuses on the somatic aspect of health (i.e. ignores the psyche to a large extent),
- the primary interest of the model is a disease which is understood as a malfunction; health is considered as a matter of course – as an opposite of disease,
- to a large extent, the model draws from the assumption that a disease is completely independent of psychological and social factors,
- the primary focus is set on biochemical processes and the somatic aspect of disease,
- its foundation consists in recognizing the disrupted biochemical balance in organism (homeostasis),
- the model pays great attention to neurophysiological abnormalities,
- it strives to describe the nosological units with characteristic etiology which are embedded in organism (disease is manifested by syndromes which are a set of symptoms),
- the patient is not responsible for the onset of the disease and cannot influence the possibility of the disease development,
- the model has difficulties in the objective interpretation of etiological factors of currently prevailing diseases, cardiovascular diseases, cancer and injuries,
- it does not support neither prevention and health promotion, nor an individual’s responsibility for his/her health.

1.2 *Behavioural Medicine and Behavioural Health*

Behavioural medicine broadens the classical medical model of disease by introducing a new model according to which the onset and course of the disease is affected by a patient's behaviour, attitudes and thinking. Current behavioural medicine is a multidisciplinary field comprising a broad model of health and disease which integrates the biological and psychological factors, as well as the environmental factors while the social environment plays the crucial role (Vašina, Záškodná, 1996).

In 1977, Yale Conference on Behavioural Medicine emphasized that the research and practice in behavioural medicine requires the interdisciplinary cooperation of physicians and psychologists. In this context, Matarazzo (1980, 1982) claimed that a single fact that behavioural medicine was established helped in creation of its structure, methods and scope. The emergence of the new branch united several uncoordinated developmental processes which took place simultaneously in medicine and behavioural science, and highlighted prevention and the promotion of good (active) health. Kondáš (1989) states that behavioural medicine is based on the research of psychosomatic aspects of disease and behavioural therapy.

In this context, behavioural medicine is the systematic application of principles and methods of behavioural psychology into the fields of medicine, health and disease. The term "behavioural psychology" refers to the experimental or empirical psychology and, to a lesser extent, physiological psychology.

Schwartz a Weiss (1978) define the Behavioural Medicine as **an interdisciplinary field which deals with the development and integration of behavioural and biomedical science, knowledge and techniques related to health and disease, and their application into the prevention, diagnostics, treatment and rehabilitation**.

Behavioural medicine emphasizes the interaction of biological and behavioural factors in the etiology of disease and its treatment. The basic methodological procedure in behavioural medicine is the search for and the analysis of disease factors which have any relation to a patient's behaviour, for instance smoking, alcohol and drug abuse, harmful habits related to nutrition, coping with stressful situations including the fixed non-adequate forms of lifestyle (Scheme 1).

The aim of behavioural medicine is to apply the psychological methods which may improve the course of disease, using the behavioural and cognitive techniques in order to gradually change a patient's lifestyle and risk behaviour, and to strengthen the ability of coping with stress. In treatment, the behavioural intervention purposely makes use of the principles of human learning, the so-called *cognitive behaviour modification (CBM)*. Preventive measures of behavioural medicine coincident with those of the health psychology include the healthy lifestyle and the change of lifestyle (Boleloucký, 2007 in Vorlíček a kol., 2004).

Scheme 1: SORC Model (**Kanfer a Philips, 1970)**

S – O – R – CR – C

S = STIMULI
O = ORGANISMIC VARIABLE
R = RESPONSE
CR = CONTINGENCY RATIO (consequences of response with regard to the reinforcement /inhibition of "healthy" or "defective" behaviour)
C = CONSEQUENCE (immediate consequences of behaviour which potentially result in the positive or negative reinforcement)

Source: Kaplan a Sallis, 1996

Based on the extensive experts' discussion, the new interdisciplinary field **Behavioural Health** was gradually established which emphasizes the individual responsibility in the use of findings and methods of biomedicine and behavioural science in order to maintain good health and prevent diseases and disorders by means of various individual and collective activities (Matarazzo, 1980). Behavioural Health is thus a branch of Behavioural Medicine which concerns with the maintenance and enhancement of health, and disease and disorder prevention. **Personal responsibility of each individual for one's own health** is newly emphasized, as well as **the active role of patients in breaking dysfunctional habits and the elimination of barriers to healthy lifestyle**.

1.3 *Psychosomatics and Psychosomatic Medicine*

Psychosomatic Medicine is usually connected to psychiatric procedures of diagnostics and treatment of disease. It assumes the psychogenic origin of diseases and often explains their cause in accordance with Psychoanalysis. Psychosomatics is a very complex combination of biological and psychosocial approach to a human being in health and disease. According to Baštecký et al. (1993), Psychosomatics can be perceived from several perspectives:

- the *broadest conception* of Psychosomatics assumes that a human being in health and disease represents the unity of the psychological and the somatic with its environment,
- in *narrower conception*, the scope of Psychosomatics includes somatic disorders and diseases in the etiopathogenesis of which the psychosocial factors are involved, and diseases which are connected with unhealthy lifestyle and behaviour patterns,
- the narrowest conception deals with psychosomatic syndromes or diseases in the course of which the psychosocial factors are crucial or characteristic,
- Danzer (2001), Entralgo (1995), Honzák (1993), Poněšický (1999), Špitz (1992), Kebza a Šolcová (2002), Vymětal (2003) and other authors emphasize that every disease is psychosomatic because no disease is free of psychological influences.

Typical of the so-called **integrative psychosomatic medicine** was the gradual revealing and solving of the methodological, diagnostic and therapeutic deficits, and the one-sidedness of biological medicine. The foundations were laid down for the medical science which deals with the "whole" human being. The findings of classical

psychoanalysis, models and theories of holistic medicine of the anthropologically and philosophically oriented physicians of the 20th century still greatly influence the modern Psychosomatics.

Theoretical explanations of pathogenesis of psychosomatic issues have gone through the complex development. Using the original classification of Vašina and Záškodná (1996), the development can be characterized by the following **three groups of theoretical approaches**:

- **historically older approaches to Psychosomatics** based on the findings of Depth Psychology, represented by *Freud's classical psychoanalysis,* Reich (body as character), *Adler* (patient's lifestyle, disordered relationships and communication), *Alexander (*somatic disease as consequence of specific conflict), *Dunbar* (specific personality of patient) and later the so-called Berlin and Heidelberg schools of Psychosomatics (*von Bergmann, Wittkower, Goldstein, von Krehl, von Weizsäcker);*
- **psychosomatic approaches based on the stress hypothesis:** Cannon (fight or flight reaction), Allen (flight–fight), Selye (General Adaptation Syndrome – GAS), Holmes and Rahe (adverse life events), Rosenman and Friedman (Type A and Type B personality), Weiner (X factor);
- **philosophically and anthropologically oriented approaches comprising the salutoprotective mechanisms,** for example Antonovsky (1985, 1987), Kobasa, Maddi (1979), Cohen a Wills (1985), Frankl (1995), and others.

Professional discussion related to Psychosomatics still continues. In relation to the holistic approach to a human being, Frankl's contribution must not be omitted. Frankl criticized the so-called American School of Psychosomatics, as well as the German School, and emphasized the **spiritual (noetic) substance of an individual and the meaning of life**. He presumed that impaired health may become a challenge and the call for spiritual coping by means of courageous resistance to, and endurance of related limitations and suffering (Balcar, 2005). The attention has been also shifting to the psychosomatic health, i.e. from the necessary treatment towards possible preventive measures. Frankl (1999) claimed that in case that a disease cause is related to mental processes it has to be feasible to prevent the disease by affecting these processes.

The **current state of Psychosomatics** is aptly characterized by Honzák (2005) according to whom the Psychosomatics is a scientific and clinical discipline which:

a. studies the relations between the specific psychosocial factors and both the normal and abnormal physiological functions: via research of the interactions between psychosocial and biological factors in the etiology, onset of a disease, its course and consequences,
b. promotes the holistic biopsychosocial approach in the patient care,
c. applies the psychological, behavioural and psychiatric methods in prevention, treatment and rehabilitation of the somatic diseases.

1.4 *Systems / Biopsychosocial Approach to Health and Disease*

The development of modern medical thinking, prevention and treatment was substantially influenced by what is now the established definition of the World Health Organization (1948) according to which "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". In

1977, the definition was complemented by the socio-health level which emphasizes the ability to lead a socially and economically productive life. Even though the definition was not unequivocally accepted by the professionals due to its vagueness and stress on the subjectively experienced quality of health, its **contribution to the multidisciplinary discussion on health and disease** can be summarized as follows:

- the traditional biologizing approach to health as an absence of disease, infirmity and dysfunction has become obsolete,
- compared to the one-sided regard to physiological components of health, the emphasis is put on various dimensions of health status including the physiological, psychological and social aspects (multicausal etiology),
- psychological health and happiness (subjective experience) has become emphasized,
- the importance of social well-being (the ability to hold social roles) has become emphasized as well,
- the new target has been set towards which the effort of all the health professionals should be directed.

According to Brownell and Wadden (1992), the complexity of mutual interactions between the biological vulnerability and psychological and social factors of health and disease requires the integrative biopsychosocial approach to prevention and treatment. These authors were inspired by the concept of *psychological health* by Becker (1982), Albee (1980) and others who emphasized the **mutual interaction of risk and protective factors** which influence the incidence of disease, as well as the necessity of targeted intervention at the level of individual predisposing factors[1]. According to the authors, the resulting risk of disease can be expressed by the following equation:

$$\textbf{Risk of disease} = \text{fn}\ \frac{\text{(organic factors) + stress + vulnerability}}{\text{Ego competences + support from external environment}}$$

In the first half of the 1920s, a crucial role in constituting the biopsychosocial model of health was played by the **general systems theory** which is based on the holistic paradigm (von Bertalanffy a Bateson). According to the systems theory, any

[1]Vulnerability is the disposition to respond to the stressful situation by malfunction. Instead of vulnerability, Albee uses the the term *organic factors* which represent the predisposing factors congenital or developed in early age. Ego competences comprise: needs satisfaction competences, social competences, cognitive competences, competences related to coping with stress and competences related to self-regulation. Vulnerability is considered as the opposite of coping competences. Individual vulnerability is affected by the psychological and social factors; enhancing effects of the external environments therefore comprises the social capital (a system of relationships of an individual which supports the individual in coping with adverse events). The most frequently mentioned external factors are: the standard of living, natural environment, life satisfaction and the lifestyle especially which comprises the salutoprotective and patoplastic factors.

phenomenon can be considered as a distinctive system which comprises a range of subsystems while being a subsystem of the higher-level system.

L. von Bertalanffy (1972) differentiates between the *closed systems* (isolated, autonomously developing systems) and the open systems (which interact with their environment – environment affects them and the other way around; and function as an indivisible complex in which the change of any part brings about the change in other parts)

According to Bertalanffy, an organism is not a genetically determined machine but a self-organising structure the order of which manifests itself by the fluctuation. Its function cannot be understood by the investigation of its actual state but by the observation of its individual history. Multiple interactions with the environment maintain the whole system's constant changeability.

The term **system** is, according to Ludewig (1992), suitable for investigating the relations between the complex qualities of organization of any kind. Human, as an **autopoietic system**, can be thus considered as a complex – i.e. holistic interaction of biological, psychological and social influences. Social systems are structurally united with biological and psychological systems which are simultaneously a condition for their genesis. Mutual relations between organisms and the environment are traditionally a scope of Ecology. Basic findings of Ecology comprise, according to Špitz (1992), the fact that **no living unit represents an organism or a species within the static environment but always a particular ecological system with the reciprocal relations between the organism(s) and its/their natural environment**.

Biopsychosocial framework applies the systems approach to emotional, psychological, physiological and behavioural functioning of a human being (Plante, 2001). The changes at one level of a system most likely cause a change at the other levels. Components, relations and borders of individual systems can be interpreted as mutually conditioned and , at the same time, emerging aspects of the higher-level system.

Inspired by this idea, Mc Daniel (1995) specified that **all human problems are the problems of biopsychosocial system; every biological problem has its psychosocial consequences and every psychosocial problem has its biological correlates**. Even though this theoretical model regards the biological, psychological and social factors as relevant, they need not play the equal role in individual health issues.

According to Vašina (2003), for the onset of any disease, the so-called etiological triad is necessary which consists in the mutual interaction of the three groups of factors:

1. the presence (or absence) of the causative agent (agens),
2. personality as a specific bearer of disease (demographic, psychological, behavioural, physiological and social characteristics),
3. external environment (natural, social and civilizational conditions).

Relations between the individual variables are involved in the mutual interaction in the sense of **circular causality (interdependence)** and thus, their impact is neither unidirectional nor located in a specific point in time. The active adaptation of an individual and the maintenance or renewal of his functional health take place and find response not only within the organism, but also immediately in the closest social environment of an individual (Vymětal a Speirer, 1994). In the context of health, the

interactional systems theory observes the multiple interactions among health status (psychological health, functions of bodily systems and their constitutional predispositions), personality particularities of a person and the influence of external factors (stressors, salutoprotective factors of lifestyle) including time and space.

According to Křivohlavý (1994), current definitions of health which are based on the systems approach most often emphasize the following aspects:

- *Structure of the complex*. The holistic approach to health emphasizes the whole complex which is more than just a set of parts, and deals with the biological, psychological, social and spiritual aspects of the whole complex.
- *Integrity of the complex*. Human system represents an integrated, organic complex at all levels and in between these levels (somatic, psychological, social and spiritual)
- *Process character of health.* Human system is seen from the whole life-span perspective; dynamic character of health is stressed, as well as the process in which the maximal development of all the organism's possibilities is feasible.
- *Social context of an individual*. In definition of health, a person's integration into the family life and social groups is crucial.
- *Respect to the environmental factors*, especially the cultural environment, living conditions and ecological factors.

Bioecopsychosocial approach in medicine means the effort to integrate the biological and psychosocial factors in prevention, treatment/therapy and rehabilitation of health disorders of any etiology. Potential changes in health state are therefore the result of multiple interactions of a wide range of variables, including genetic predispositions, current state of immune system, personality traits, level of psychological resilience, quality of social interactions, and the lifestyle of an individual. The importance of social space, social relationships and quality of life in the whole society should not be underestimated. Currently, the attention has been paid to the type and range of psychophysiological response to the development of abnormal state, i.e. the dependence of the specific disease on the activation level. It can be assumed that the individual emotional reaction and the related physiological manifestation depend on the character and intensity of the stimulus, current state of organism and the long-term characteristics of an individual (genetic predispositions, physiological reactivity, value orientation, social support etc.).

Study questions

1. What is typical of the pathogenic (biological) model of health?
2. What was the subject of Behavioural Medicine and Behavioural Health?
3. What is Psychosomatics? Name the main approaches in Psychosomatics. Which typical psychosomatic diseases do you know?
4. Using professional literature, find examples of the major contributions of any Psychosomatics' representative.
5. Explain the term chronic non-communicative disease.
6. What is typical for the general systems theory? What is autopoietic system?
7. Explain the term biopsychosocial approach to disease (multicausal etiopathogenesis).
8. Name the main aspects of the systems model of health.

Summary

The text describes the main models of health and disease: pathogenic model of disease, behavioural medicine and behavioural health, psychosomatics and psychosomatic medicine, systems/biopsychosocial approach to health and disease, and the salutogenic model of health.

Recommended literature

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1.5 *Salutogenic Approach to Health and Disease*

The change of paradigm in medicine manifested by the shift of attention from pathogenesis to salutogenesis, has analogically taken place in the field of Psychology. Similarly to the biomedical model of disease, the approach in Psychology based on the negative paradigm had greatly enriched the science and clinical practice, especially by the following aspects:

- diagnostic system enabling and facilitating the communication between the clinical workers and researchers,
- data about various psychological diseases and related reduction in suffering which accompanies these diseases,
- efficient treatment of various diseases which require the combination of psychotherapy and pharmacotherapy,
- new findings related to environmental stressors in childhood and their influence on psychological disorders,
- efficient research strategies and statistical methods for the identification of causal relationships between the examined variables and the efficient intervention procedures (Gillham and Seligman, 1999 in Mareš, 2001).

The weakness of the mentioned approach is the one-sidedness of the research, underestimation of the internal resources of an individual in facing threats, overestimation of the role of prevention, preoccupation with victimology etc. This fact was strongly emphasized by Maslow who aptly characterized the orientation Psychology of that time in the following way: “It is as if Freud supplied us the sick half of psychology and we must now fill it out with the healthy half.” He also implied the new horizon of Psychology meaning **the new conception of human health and disease** (optimistic, humanistic perspective on human being):

- each person's inner nature is in part unique to himself and in part species-wide,
- it is possible to study this inner nature scientifically and to discover what it is like,

- since this inner nature is good or neutral rather than bad, it is best to bring it out and to encourage it rather than to suppress it,
- this inner nature is weak and delicate and subtle and easily overcome by habit, cultural pressure, and wrong attitudes toward it,
- if it is permitted to guide our life, we grow healthy, fruitful, and happy,
- if this essential core of the person is denied or suppressed, he gets sick,
- even though weak, it rarely disappears in the normal person, it persists underground forever pressing for actualization,
- the experiences have something to do with a sense of achievement and ego strength and therefore with the sense of healthy self-esteem and self-confidence (Maslow, 1985).

As a response to humanistic psychology and psychotherapy, the new contributions started to emerge which emphasize the holistic, **anthropological approach** to man. Břicháček (2003, 2005) claims that traditionally, life problems and human failures are observed but the opposite pole is examined much less: i.e. a person's successes, coping with difficulties, one's positive relationships to others and their development, and prosocial orientation. Also Mareš (2001) points out the neglect of positive issues and emphasizes the basic idea of **Positive Psychology** – the *examination of a person's positive functioning in the world*. Logically, the multidisciplinary discussion on human health and disease has been enriched by the new theories, constructs, diagnostic procedures and therapeutic methods which stress the salutoprotective factors of an individual's lifestyle.[2]

Salutogenesis examines the conditions of good and invincible health in spite of adversities. Antonovsky (1987) summarized the salutogenic orientation as follows:

- it rejects the traditional medical-model dichotomy separating health and illness and prefers the multidimensional continuum from good health (wellbeing) to disease,
- unlike the one-sided stress on the etiology of dysfunction, it emphasizes *a person* in health and disease,
- unlike the orientation to stressors, it pays attention to the resources of coping,
- consequences of stressors are not considered as pathogens, but as a possible curative factor
- it searches for any resource which facilitates an organism's active adaptation of to the environment,
- emphasis on the ethical aspect of health, health is not the highest value.

[2]The issue of salutoprotective factors of lifestyle (so-called moderators/meliors of health) and their role in the process of health and disease have been systematically researched by a range of authors, for instance Antonovsky (1985, 1987), Cobb (1979), Bakal (1992), Cohen a Wills (1985), Davidson, Shumaker (1987), Ficková (1993, 1995), Heim (1994), Hošek (1979, 1993), Kadlec (1990), Kobasa (1979), Kořán (1986), Koukola (1998), Křivohlavý (1988, 1991, 1990, 1999, 2004), Pelcák and Koukola (1988), Mareš (1997, 2001), Pelcák et al. (2001), Kebza and Šolcová (1992), Šolcová (1994), Šolcová and Kebza (1996, 1998), Balcar (2005), Kebza (2005), Mareš (2003), Vymětal (1997), Lašek (2005), Baštecký and Beran (2003), Bob and Vymětal (2005), Hoskovcová (2007) and others. Monographs, research studies and review articles most often deal with the predispositions of personal resilience, perceived social support, meaningfulness of life, dispositional optimism, sense of humour, personal competency, personal wellbeing, coping, quality of life from the psychological perspective (subjective wellbeing, happiness, flow) etc. For detailed description, see Chapter 2.3

For further comparison between the biomedical (pathogenic) and salutogenic approaches, see Table 1.

Antonovsky's approach differs from the previous theoretical models analysing mutual relations "stress–health" especially in the following aspects:

- it highlights the one-sidedness of pathogenic orientation prevalent in the biomedical and social research of health and disease,
- it strives to define the general factors affecting a person's notional movement towards health,
- it conceptualizes the health–disease process as a biodromal continuum,
- it emphasizes the importance of the so-called generalized resistance resources (GRRs),
- it primarily focuses on the factors which support a person's subjective wellbeing and health,
- it emphasizes a person's freedom of choice and the searching for meaning also in the adverse life conditions,
- it emphasizes a person's active role and responsibility in prevention and health promotion.

Table 1*:* Comparison between pathogenic and salutogenic approaches to health

issue	**pathogenic model**	**salutogenic model**
approach to health and disease	homeostasis, dichotomy of somatic an psychological correlates of health	chaotic imbalance – entropy, dynamic biodromal process of health and disease
examined characteristics	disease, dysfunction, pathology	active health, wellbeing, wellness, quality of life
etiological perspective	why the disease occurs? pathogenicity, virulence, toxicity, diathesis, risk personality traits, risk behaviour	what keeps people healthy? how to prevent disease and facilitate recovery/healing? compliance, mediators and moderators of health
therapy, intervention	elimination of noxious elements, treatment of symptoms, dysfunction	support and enhancement of positive health (prophylaxis), stimulation of self-healing processes, maintenance and enhancement of the quality of life
psychological strain and stress	minimizing of health risks related to the exposure to stressor	proactive coping with stress, posttraumatic growth, personality growth

Source: Pelcák, 2012

The effort of holistic approach to the biodromal process of health and disease brought into the scientific discussion **newly defined issues of subjective quality of life and health of an individual**. According to WHO, the quality of life is generally determined by the way an individual perceives his/her role in the world in the context of culture and value systems in which he/she lives, and in relation to his/her

objectives, expectations, lifestyle and interests (Bártlová, 2005). The dynamic character of subjective quality of life, especially in relation to the changes of a person's health state, is emphasized by Mareš (2005). Similarly, Kožený, Csémy amd Tišanská (2007) highlight the links amongst the rate of wellbeing, psychological and somatic difficulties and the adaptational functioning of an individual.

Multidimensional construct quality of life is a summary of many factors which are difficult to reliably evaluate and quantify. This fact is reflected by the *disunity in terminology and research methods*. Perceived quality of life according to Kebza (2003) is a *personal wellbeing* comprising various emotional and cognitive dimensions, for instance positive and negative affectivity, subjective happiness, autonomy, life satisfaction, self-acceptance, correspondence of expectations and actual life goals, ability to cope with the external influences, meaning of life, psychosomatic symptoms and mood. From the perspective of Psychosomatics, the term is on the boundary among emotions, moods and personal traits, and also includes the important attitudinal component. Grob (1998) in Lašek (2003) defines this construct as a complex term comprising low self-esteem, low satisfaction and negative aspects of life on one hand, and happiness, life satisfaction, slef-satisfaction and positive aspects of life on the other hand.

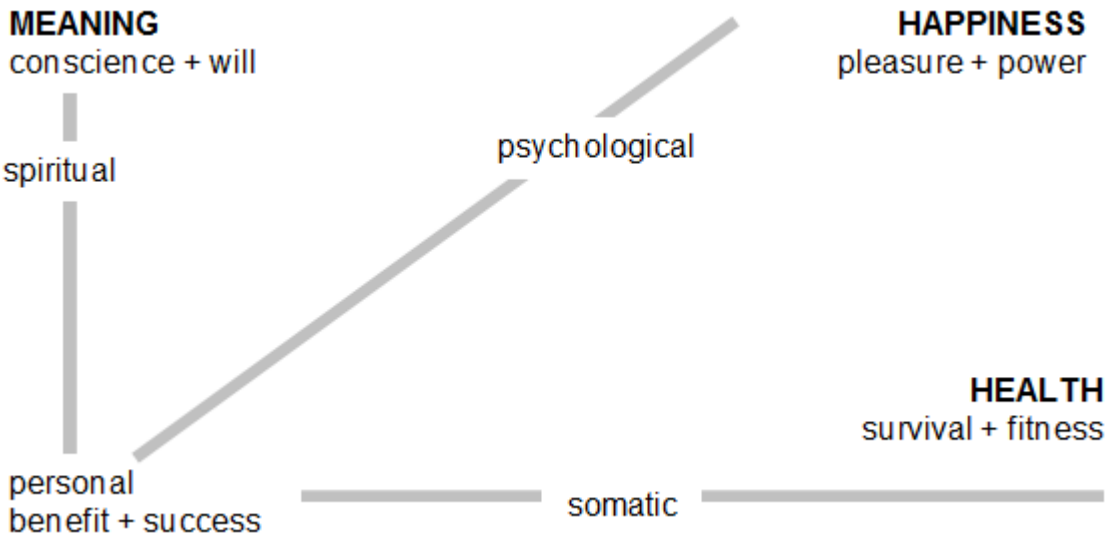
Quality of life construct can be, according to Hnilica (2005), defined by means of the four mutually related components: positive and negative emotions, satifaction with individual aspects of life and general life satisfaction. Positive and negative emotions represent the afective component of quality of life, while satisfaction with the individual aspects of life and general life satisfaction represent the cognitive component. Apart from happiness and satisfaction, medical branches of science include into the quality of life especially *subjective health (self-rated health)* and dimensions which belong to the mutual construct *health-related quality of life*.

According to Mareš (2005), the subjective quality of life construct is constituted by at least three areas: **physiological (somatic), psychological and social area**. A range of subjects also value the spiritual area and/or intimate friendship (sexuality, appearance of one's own body).

In the context of Frankl's logotherapy, Balcar (2005) differentiates the **human health dimensions on the basis of an individual's orientation to world and himself/herself** (Scheme 4) as follows:

- *somatic (physiological) dimension* – ideal norm of physiological harmony and fitness of bodily functions, i.e. traditional conception of human health,
- *psychological (experiential) dimension* – experienced pleasure and power assertion in a person's life, represented by a traditional term "subjective happiness",
- *spiritual dimension* – experience of meaningfulness of one's own life based on responses to value challenges, conscience and activities which an individual wilfully performs in order to reach the value-potential comprised in the present situation

Scheme 4: Life orientation and quality of life



Source: Balcar, 2005

The will to meaning is a desire for, and an effort to reach, the meaningfulness of one's own existence. It is the will to see, organize and interpret individual stimuli as meaningful units. The aim of this organizing tendency is not only the optimal arrangement of perceptional stimuli in order to adapt to external conditions but also the effort of man to search for and find the most adequate and complete explanation which provides him/her with definite target which has to be fulfilled (Tavel, 2007).

The qualitative **shift in view of biodromal process of health and disease** is portrayed, in a simplified way, by Scheme 4. Axis ***x*** represents the classical **health–disease (disorder) continuum** as a dynamic process. The "location" of an individual on the continuum is determined by his/her "somatic" state (wellness, fitness). Axis ***y*** represents the **salutogenic construct of wellbeing** (*personal wellbeing complex*) in the sense of biological, psychological, social and spiritual dimension of health. It refers to a person's subjective experience which can be (in a simplified way) expressed by a "movement" on the axis personal wellbeing–discomfort. The scheme portrays the **subjective health as a person's reflection of his/her own overall health state**. Personal wellbeing implicitly comprises the two almost indivisible components – emotional (present subjective experience) and personality-related (habitual); and many authors consider it as a part of quality of life. Subjective personal wellbeing is constituted by the four components: psychological wellbeing, self-esteem, self-efficacy and personal control.

The continuous biodromal process of health and disease can be portrayed using the four "positions" which come into existence by the intersection of selected planes of health and disease (Pelcák, 2008):

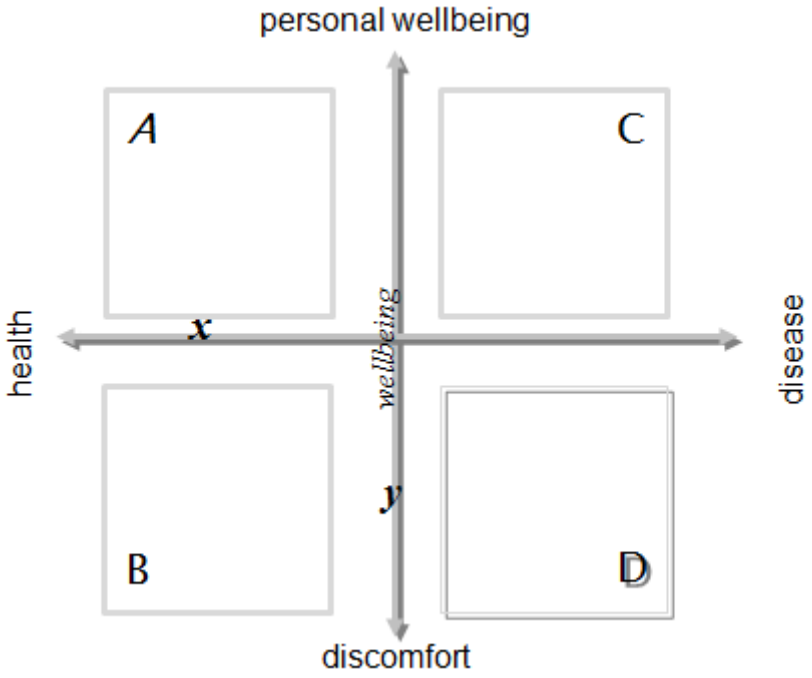
A: *absence of objective symptoms while the level of wellbeing is high* – the state of subjectively experienced complex of health

B: *absence of objective symptoms while the level of wellbeing is low* – e.g. psychosomatic disorder, alexithymia, reaction to an adverse life event etc.

C: *objective symptoms of disease while the level of wellbeing is high* – disease a meaningful challenge

D: *objective symptoms of disease while the level of wellbeing is low* – e.g. learned helplessness, non-compliance etc.

Scheme 5: Two-dimensional model of health



Source:Pelcák, 2008

The presented model of health and disease implies in a simplified way the possibilities of the more complex assessment of a person's health state in relation to possible spheres of psychological intervention in various groups of population. Apart from the traditional, somatic aspect of health which can be examined by objective methods, it also takes into consideration a subjective perspective of health (autoplastic picture of disease, subjective health, coping with disease); interest also rises in relation to factors which emphasize the wider context of human life in health and disease – **salutors**. This is a completely different paradigm which searches the causes of "non-disease", the preconditions of coping with disease in situations in which other individuals fail.

The salutogenic model of health and disease enables in practice to identify and purposefully cultivate the factors of health which help a person maintain and enhance his/her health in the sense of wellbeing. In relation to the new findings of Health Psychology, the application possibilities pf the intervention method in prevention, treatment and health promotion grow in number.

Study questions

1. What is salutogenesis? Which topics did it bring into theory and practice?
2. What is the main contribution of salutogenic model to treatment and prevention?
3. Explain the following terms: quality of life, subjective health, biodromal process of health and disease.

4. Read any book by V. E. Frankl. What is the connection between his work and salutogenesis?

Summary

The chapter portrays the salutogenic model of health in comparison with the pathogenic model; it also deals with health in the sense of wellbeing, treatment and prevention. It serves as a brief review of the "new topics" in health promotion (quality of life, biodromal process of health and disease, coping).

Recommended literature

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2 Psychology of Health and Disease

Objectives

The aims of this chapter are: introduction to Psychology of Health and Disease, present the main theoretical sources of the field and its relations to other sciences, and present the main application possibilities of the Health Psychology in prevention, treatment and rehabilitation.

Workload

2 hours

Important keywords

Health Psychology, Positive Psychology, „Health for the 21st century"

2.1 *Introduction to Psychology of Health and Disease*

The widest conception of Health Psychology defines it as *a systematic application of psychological findings into the sphere of health, disease and healthcare system*. Health Psychology comprises a range of diverse and mutually connected topics on the border between Psychology and Behavioural Medicine (Beam, 2001). Similarly, Kebza and Šolcová (1998) emphasize the combination of stimuli from the psychological, medicinal and borderline sciences which have no clear boundaries.

An example of mutual exchange of information and an effort to reach complementarity in the view of a person in health and disease is the development of psychoneuroimmunology, neuropsychotherapy, sanotherapy and psychooncology as well as the constitution of **Positive Psychology** which is defined as a science

dealing with positive individual traits, positive life experiences, and positive functioning social structures and institutions (Mareš, 2001).

Health Psychology consistently keeps to the **holistic approach to health and disease**, i.e. it respects, both in theory and practice, the biopsychosocial model of health and disease and the **multicausal etiology of individual groups of diseases**. These two starting points imply the multidisciplinary use of the findings and methods. The author does not aim to cover all the possible relations between the sciences, and therefore offers only a simplified review (see Scheme 6).

Formally, the Health Psychology was founded in 1978 by the American Psychological Association (APA) and then, in 1985, defined as a complex of the specific educational, scientific and professional merits of psychology in order to maintain and enhance human health, prevent and treat diseases, identify the etiological and diagnostic correlates of health and disease and related dysfunctions, and to analyse the healthcare system and healthcare policy. The qualitative shift in theoretical thinking about the problems of health and disease at the turn of 1980s and 1990s is reflected by the gradual formulation of the scope of the field. As one of the first authors, Matarazzo (1980, 1982, 1984) emphasizes the necessity and possibilities of multidisciplinary cooperation in maintaining the high quality of health, influencing the factors contributing to the disease onset and alleviating the adverse consequences of disease and its treatment.

Similarly, Kebza and Šolcová (2000) define the Health Psychology as a science which deals with the **influence of psychological dispositions, functions and processes on human health, the onset and development of disease, its therapy, rehabilitation and prevention**. Brannon and Feist (1997) emphasize the role of behaviour and lifestyle in the process of health and disease.

Křivohlavý (1994) generally defines Health Psychology as a science which deals with **the role of psychological factors in health maintenance, disease prevention, psychology of coping with various diseases, the questions of healing process and coping with a chronic disease**.

Scheme 6: Relations of Health Psychology to other sciences

The application possibilities of Health Psychology are roughly implied by Taylor (1995): Health Psychology is a field of Psychology which examines the psychological variables which determine whether a person remains healthy, why a person does not get sick, and how person responses to disease. Health Psychology focuses on the maintenance and enhancement of health, disease prevention and disease treatment. It participates in etiological researches, deals with the issues of health, disease and dysfunction(s), and contributes to the improvement of healthcare system and the formation of healthcare policy.

The main characteristics and objectives of Health Psychology were summarized by Křivohlavý (2001):

- Health Psychology focuses on (relatively) psychologically healthy people who do not suffer from any psychiatric disorder/difficulties.

- it primarily focuses on prevention of health difficulties, maintenance of a good health status, health enhancement, health promotion, and psychological enhancement of health,
- it consistently keeps to the principles of scientific work, draws findings from psychosomatic medicine, medical psychology, clinical psychology, behavioural health etc.

2.2 *Health Psychology in Practice – Perspectives in 21st Century*

As was already implied, Health Psychology comprises both the basic and applied research; practical applications have a clinical, preventive and counselling character (Kebza a Šolcová, 2000). Beam (in Plante, 2001) emphasizes especially the intervention possibilities of Health Psychology which comprise the physiological treatment, education, psychotherapy, social support and social engineering. The current problems of Clinical Psychology are portrayed in the Table 2.

Table 2: The scope of Health Psychology in Medicine[3]

alcoholism	smoking
irritable bowel syndrome	eating disorders
panic disorder	hypertension
coping with disease	asthma
cardiovascular diseases	gastric ulcers
chronic pain	headaches
diabetes mellitus	cancer
spine injuries	epilepsy

[3] The list of topics reflects the fact that in German speaking countries, Health Psychology belongs to clinical sciences. The range of application possibilities of Health Psychology reflects the examined issues at the turn of the 20th and 21st centuries: cognitive aspects if healthcare – vulnerability, optimism; social-cognitive models in Health Psychology; work and health – the sources and possibilities of prevention; protective factors of health; emotions and health (wellbeing); health risks and life events; work and health – coping with stress and strain; cardiovascular diseases, Health Psychology in prevention and rehabilitation; education and training in Health Psychology; carrying out a health screening; AIDS and support of the HIV positive people; organization of training in coping with stress (firms, schools); training of medical staff in Health Psychology; health, sport and physical activity; Psychology and cancer; Psychoneuroimmunology; cardiovascular reactivity to psychological psychotherapeutic interventions; longitudinal research of teenage smoking; application of Health Psychology findings in Stomatology; perception of ecological problems and related coping; accident risk and injury prevention; Odontophobia – diagnostics and treatment; healthy behaviour of school children; quality of life; rehabilitation of patients with vascular diseases; healthy lifestyle; coping with disease; medical staff from the perspective of Health Psychology; predictors of change in health attitude and health behaviour; health promotion; social support; techniques of therapeutic interventions in Health Psychology; socially determined imbalance in healthcare etc.

sleep disorders	cystic fibrosis
AIDS	stress, coping
sexual disorders	substance abuse

Source: Beam, 2004

Concerning the possibilities of enhancement and promotion of health in individuals and the whole population, the Health Psychology assumes that the gradual change in health behaviour can prevent or minimize many future health problems and difficulties. This trend was confirmed by the 19th Conference of the European Society of Health Psychology (2005) the aim of which was to portray the possibilities of change in behaviour in patients or individuals in risk, and to prepare (educate and train) anyone involved in prevention of risk behaviour, health care, i.e. family, school, employers, managers, professional medical staff, individuals responsible for the healthcare in wider communities etc. The conference focused on the four basic issues:

- the use of psychological findings in somatic medicine,
- "healthy" development of personality during the ontogenesis,
- healthy life in various life situations,
- holistic approach to health, healthy lifestyle, prevention of risk behaviour, enhancement of psychological resilience, coping with stress in everyday and/or extraordinary situations, primary prevention of disorders, intervention programmes etc.

WHO European Ministerial Conference on Mental Health (Helsinki 12 –15 January 2005) emphasized that psychological health and wellbeing are the fundamental preconditions of life and productivity of individuals, families, communities and nations; and that they help people experience the meaningfulness of life, creativity and active citizenship. *The primary task of activities in the field of psychological health is thus to promote people's wellbeing and creativity with the focus on their strengths and possibilities, which will lead to the enhancement of resilience and the higher quality of protective external factors*.

The growing influence of salutogenic model of health has been reflected over a long period in public health and healthcare policy. Mental health declaration for Europe "Health 21"[4] emphasizes the health dispositions of an individual, possibility of one's own active care of health and part in decision-making.

[4] Programme "**Zdraví 21"** is the national version of WHO programme Health 21 – health for all in the 21st century which is based on the five mutually related principles: equity, solidarity, sustainability, participation and ethical choice. The programme comprises 21 targets: 1. Solidarity for health in the European Region, 2. Equity in health, 3. Healthy start in life, 4. Health of young people, 5. Healthy aging, 6. Improving mental health, 7. Reducing communicable diseases, 8. Reducing non-communicable diseases, 9. Reducing injury from violence and accidents, 10. A healthy and safe physical environment, 11. Healthier living, 12. Reducing harm from alcohol, drugs and tobacco, 13. Settings for health, 14. Multisectoral responsibility for health, 15. An integrated health sector, 16. Managing for quality of care, 17. Funding health services and allocating resources, 18. Developing human resources for health, 19. Research and knowledge for health, 20. Mobilizing partners for health, 21. Policies and strategies for health for all. Targets 19 through 21 have the highest priority, targets 10 through 13 should be met until 2015, tasks directly related to health state should be carried out till 2020.

The basic target of the programme is the complete health for everybody. This target comprises the two sub-goals: enhancement and protection of people's health during their whole life, reduction in incidence of "main" diseases and decrease in related hardships. Concerning the potential of Health Psychology, target 6 (Improving mental health) is interesting: **"By the year 2020, people's psychosocial wellbeing should be improved and better comprehensive services should be available to and accessible by people with mental health problems."** The attention should be especially paid to:

- reduction of stigma related to mental health problems, prevention and promotion of mental health,
- primary care for individuals with psychological disorder,
- more efficient combination of psychiatric hospital care and services provided within the community care
- continuous education of medical staff with the emphasis on the identification of risk factors and suitable use of modern therapeutic methods,
- decrease in suicide rate by means of timely and correct diagnosis and treatment of depression,
- mental health care especially for the risk groups of citizens.

The text implies that the concrete models of health and disease are always to a certain extent reflected in the state's health policy, healthcare system, and the extent and quality of treatment and prevention. This statement is supported by the policy statement of WHO named **"Health 2020"** (Malta, 10 – 13 September 2012). Sixty-second session of the Regional Committee for Europe defined the main target: **"significantly improve the health and wellbeing of populations, reduce health inequalities, strengthen public health and ensure people-centered health systems that are universal, equitable, sustainable and of high quality."**

Even though it is rather a political declaration, "health as a main social resource and investment" as a target comprises many factors which influence the health of population and individuals (for instance employment and socioeconomic gradient, social capital and community resilience, work environment, healthy behavior, promotion of wellbeing, emphasis on primary prevention, equity in healthcare etc.). During the last decade, these problems have been examined by Health Psychology – both in theory and practice. Health 2020 includes the four mutually related aspects of high priority:

1. **Health investment as a lifelong approach, population's share of power** - increase in average healthy life span and longevity including the important economic, social and individual benefits (improved life conditions, health literacy, support of life independence and accessibility of healthier or easier choices; save childbirth, healthy life-start, promotion of safety in childhood and youth, promotion and support of healthy work environment, promotion of healthy aging). In relation to the obesity epidemic in Europe, the priority is to provide quality and healthy food; highly relevant is the enhancement and promotion of mental health by means of preventive community programmes (every fourth inhabitant of the European region experiences during his/her lifetime any psychological disorder; the most important task is the timely diagnosis of depression)
2. **Solution of the basic health problems of the region related to communicable and non-communicable diseases** – procedure pursuant to the existing strategies, prevention; share of information and common monitoring of communicable diseases and bacterial infections.

3. **Reinforcement of the person-oriented healthcare systems, increase in capacity of the public health service, readiness for the emergency situations, supervision and responses** – response to changing demography and patterns of disease (especially chronic and psychological, as well as difficulties related to aging), regulation of supply-driven increase of prices of prevention and treatment, regulation of wastage; primary care for health as a pillar of healthcare systems in the 21st century; revitalization of public healthcare and transformation of service accessibility requires the reform in education and training f the healthcare professionals.
4. **Establishment of resilient communities and supporting environment** – key factor of health protection, environment protection, protection of population from the risky and contaminated environment; expansion of the interdisciplinary and cross-sectoral cooperation related to human health, environment and fauna.

Study questions

1. What is the scope of the Health Psychology?
2. What is the relation of Health Psychology to other sciences?
3. Specify the relation between the Health Psychology and Positive Psychology.
4. Which are the main domains of the “Healthy school” project? Which tasks concerning the prevention are suggested by the WHO’s policy statement “Health 2020”?

Summary

Recommended literature

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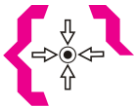
3 Interactional Approach to Psychological Strain and Stress



Objectives

Introduction to interactional approach to psychological strain and stress.

Workload

Important keywords

Psychological strain; stress; adverse life events; microstressors; taxonomy of stressful situations; frustration; deprivation; conflict.

3.1 *Psychological strain and stress in the process of health and disease*

Stress as an organism's complex response to physical or psychological strain ensures the optimal operation of all the organism's functions in new conditions. Severe, especially psychosocial, stressors influence the immune system and may trigger the pathophysiological process which would otherwise not occur or would not occur so soon. In accordance with Vymětal's view (2007), the following equation serves as a means of the individual assessment of the commencement, development, maintenance and termination of complex human activities.

R = fc (S-P-C)

R – **response** (reaction),
Fc – **function** (interdependent relations of the circularly causal nature),
S – **stimulus** (reality which a person imminently and selectively perceives and appraises),
P – **personality** (psychological complex – nature, personality traits, abilities, constitution),
C – **circumstances** (immediate or long-term situation within which other variables exercise their influence).

According to numerous authors, the life is changeable, dynamic and thus implicitly stressogenic. Not even now has the term **stress** uniform content (Smolík, 2002). It is used promiscue to depict considerably unpleasant situations, physiological, behavioural and subjective responses to them, circumstances which mediate the contact of an individual with strain and all the mentioned possibilities together as a system. In this context, Kebza (2005) points out the term stress is used inacccurately as a universal term in order to designate any requirement which needs to be met, or any part of the stress reaction from the stimuli which evoke the stress reaction to the stressors which initiate the process of stress reaction. Similarly, the term strain

implicitly expresses the three aspects: **stimulus, subjective experience and the response to stimulus**.

Interactional model of psychological stress and strain comprises the complexities of the intraindividual and interindividual variability of human reactions and behaviour patterns in situational contexts within the continuum "adaptation, growth and personal development – failing and desintegration of personality".

3.2 *Adverse life events and microstressors*

Life situations and events, demands and actions which require a person's response and active coping during his/her life journey do not represent a homogenous group. Van der Zanden (1990) differentiates between the following *general categories of events/situations*:

- situations and events related to societal processes which determine the "atmosphere" of the era,
- situations intensively experienced by an individual,
- situations and events related to personal growth,
- events which affect the life of group (war, economic crisis)
- events and situations determined by the coincidences in physical world (floods, earthquakes),
- events and situation with strong inner psychological components.

In this context, the traditional life events theory (Holmes and Rahe, 1967) must not be ommited. It is based on the assumption that *every life change or event is connected with some difficulties in the sense of demands placed on the active adaptation over time*. This premise was verified in practice by means of **The Social Readjustment Rating Scale** (Table 1). The advantage of this method are, according to Kebza (2005), the high content validity, suitable system of quantification, inclusion of **distress and eustress** items, and the possibility of choice according to the two versions of retrospection coefficient. Adverse life events are subjectively perceived as intensively negative, usually unxpected, and difficult to control by an individual (Vymětal, 2003).

Praško a Prašková (2003) define the *life event* as anything which happens to a person and makes him/her *change his/her routine way of life*; they emphasize that this does not apply only for the tragedies. According to Baštecký and Beran (2003), life events represent a change in an individual's habitual way of life and require the new, unusual or increased activity, and/or adaptation to the new situation. Life event influence the long-term quality of life connected with fulfilment of life goals, satisfaction of the need for development and growth, making use of one's own potential, and looking for the new meaning of life (Frankl, 1994). According to Vymětal (2003), life situations may have a psychotraumatic nature; decompensation of a health state is often preceded by life event. Higher risk is especially connected with events which are unexpected, undesirable, out of control and subjectively experienced as negative. A range of researches confirm that such life events as the death of a spouse, parent or a child, divorce, job loss etc. have a negative impact on health. The loss of health, status or a close person may be the triggering mechanism of the development of affective disorders. On the other hand, **the presence of life events may be, according to some authors, considered as an indicator of already existing psychological disorder** which affects the subjective evaluation of,

and the process of coping with life events. Not all life events occur sporadically; a number of them may generate a specific chain of changes which result in the radical complete change of one's lifestyle which surpasses his/her adaptability. The onset of disorder often takes place after certain latency.

The spectrum of life events necessarily comprises the so-called **daily hassles** which cause annoyance, irritation and petty troubles. The term refers to petty, every-day difficulties with a long-term effect which may cumulate.

Daily hassles may affect health and disease in two ways – by cumulating or by facilitating the relation between the life events and disease. This relation is not, however, simply linear-causal.

Table 1: **The Social Readjustment Rating Scale**

	Life Event	Value
1.	Death of spouse or child	100
2.	Divorce	73
3.	Marital separation	65
4.	Detention in jail or other institution	63
5.	Death of a close family member (eg parent or sibling)	63
6.	Major personal injury or illness	53
7.	Marriage	50
8.	Being fired from work	47
9.	Marital reconciliation	45
10.	Retirement	45
11.	Major change in health or behaviour of family member	44
12.	Pregnancy of spouse/partner	40
13.	Sexual difficulties	39
14.	Gaining a new family member (e.g. through birth, adoption, etc)	39
15.	Major business readjustment (e.g. merger, reorganisation, etc)	39
16.	Major change in financial state (e.g. a lot worse off or a lot better off)	38
17.	Death of a close friend	37
18.	Changing to a different type of work	36
19.	Major change in the number of arguments with spouse (e.g. a lot more or less)	35
20.	Taking on a significant (to you) mortgage	31
21.	Foreclosure on a mortgage or loan	30
22.	Major change in responsibility at work (e.g. promotion, transfer, demotion)	29
23.	Son or daughter leaving home (marriage, college etc)	29
24.	In-law troubles	29

25.	Outstanding personal achievement	28
26.	Partner beginning or ceasing work outside of the home	26
27.	Beginning or ceasing formal schooling	26
28.	Major change in living conditions (e.g. new house, renovating)	25
29.	Revision of personal habits (dress, manners, association etc)	24
30.	Troubles with the boss	23
31.	Change in work hours and work conditions	20
32.	Change in residence	20
33.	Changing to a new school	20
34.	Major change in usual type and/or amount of recreation	19
35.	Major change in church or spiritual activities (e.g. a lot more or less than usual)	19
36.	Major change in social activities (e.g. clubs, dancing, movies etc)	18
37.	Taking on a small loan (e.g. purchasing car, TV, freezer etc)	17
38.	Major change in eating and/or sleeping habits	16
39.	Holiday or vacation	13
40.	Christmas	12
41.	Minor violations of the law (e.g. traffic or parking infringement)	11

Interindividual and intraindividual variability of responses to mentions situational contexts is affected by the interaction of a number of factors. In vulnerable individuals, the life events represent a risk factor of the organic disease onset by means of the neurohumoural and pathophysiological responses typical with stress. The moderating role is played, apart from the hereditary predispositions (psychosomatic reactivity, psychophysiology of temperament), by especially the attitudes, cognitive styles of personality, previous positive or negative experience with the similar situation, learned ways of coping with strain, one's integration into the world and the perceived meaningfulness of life. The likelihood of morbidity is also connected with the quality and accessibility of social support.

Despite the fact that life events are potential risk factors of the onset and development of health disorders, **the successful coping with them and their solution enhance an individual's personality and accelerates the process of maturation** (Vymětal, 2003). During the biodromal life's journey, the psychological integrity of a person is determined by the person's internal predispositions and external conditions, each time at the newly achieved interactional level (quality).

3.3 *Psychological Strain and Stress*

A person's interaction with escalated life contexts is an active process of restoration of inner integrity and equilibrium with the life environment of different nature, quality and duration (Mikšík, 2005) which ends either by the restoration of integrity, or the psychological failure with diverse consequences for a person's psyche. The process is best expressed by the term psychological strain. In relation to

psychological strain, Štikar (2003) emphasizes the homeostatic process of psychological processing and coping with the demands and influences of the life and work environment. Concerning the evaluation of strain, the author differentiates between the three categories of phenomena:

- demands on the activity (together with the conditions in which the activity os feasible),
- a person's behaviour during the activity reflected in the objective and subjective sphere,
- demands and requirements on a person's traits.

In accordance with Mikšík (2003), the level of subjective psychological strain can be differentiated into the four categories:

1. **regular strain** – the life in usual, habitual contexts,
2. **optimal strain** – stimulates and determines a person's psychological development,
3. **borderline strain** – demands which a person faces with an extraordinary effort; a person is able to solve the stress situation at a subjectively acceptable level of psychological integration,
4. **extreme psychological strain** – an individual is not capable of integrated response to environment, manifests different structures and contents of disintegration, maladaptive behaviour and psychological breakdown.

Depending on the mutual relations between a person's potential predispositions and the situational demands on the psychological resilience, we can distinguish between the five types of stressful situations (Table 2).

The influence of different types of strain (stress) may cause psychological imbalance of a partial or temporary character. The imbalance may manifest itself as changes in subjective experience, thinking and behaviour; in extreme situations, it can even result in the psychological disintegration. Stressful situations can be also distinguished according to the seriousness, potential benefit for the development of new competences or the whole personality. Vágnerová (2008), in accordance with other authors, thus differentiates between frustration, deprivation and conflict.

Table 2: **Taxonomy of stressful situations**

Context	Stimulation of Personal Growth	Disintegrating Effects
1. Demands on activity and performance	enhancement of fitness for work, development of abilities, work habits, procedures, activities and interactions, fatigue resistance and coping strategies	development of the tendency to resign, indifferent attitude to life, tasks and duties, feelings of depression, fatigue and inadequateness, fatigability, lower concentration on performance
2. Problem situation	development of abilities to cope with the new situations, demands on adaptability and creativity	inability to get used to the new reality, development of maladaptive interactional response to the problem
3. Obstacles in achieving goals	development of volitional traits and ability to actively cope with the obstacles on the way to achievement	regression of goal-achieving activities, spontaneous release of tension connected with frustration and deprivation of needs
4. Conflictogenic situations	development of the integrated structure of decision-making processes and behaviour in the ambivalent situations	actualization of subjectively insoluble demands on decision to accept one of the incompatible option of behaviour
5. Stressogenic situations	development of personality resilience against the immediate effects of the new circumstances on realization of habitual activities	disintegration of psychological structures and habitual activities, unusualness and the anticipation of possible consequences of misstep

Frustration is connected with situations in which a person cannot step back from the final decision and his/her effort does not result in the goal achievement (Mikšík, 2009). The described process is accompanied by the development of enormous psychological tension. An individual strives for its reduction by searching for the compromises. The selected ways of behaviour do not lead to the desired effect and the inadequate reactions to dissatisfaction may occur. The frustration intensity depends on the subjective importance of the goal and its substitutability by another, alternate, goal. Intensive frustration is experienced when a person's basic needs are blocked. The resulting situation of frustration can be, according to Švancara (2003), solved in several ways: submissively (inability to action), actively (overcoming the obstacle), by going around the obstacle and searching for an alternative goal, and, finally, by the withdrawal from situation (physically or in phantasy). The ability to endure frustration is also connected with the **frustration tolerance.** Hošek (1997) mentioned the factors which influence the frustration tolerance:

- hereditary factors – specific features of the neural system, temperament
- typological factors – somatotype, personal traits,
- exhaustion, debilitation, injury, disease/illness, handicap,
- age – frustration tolerance increases with the increasing age, the lowest rate is in little children and the elderly; lower tolerance of frustration also occurs in some critical stages of ontogenesis (puberty, menopause, retirement etc.)
- non-adherence to healthy lifestyle habits (sleeping regime, unhealthy food, lack of physical activity and low physical fitness
- mental deficit – lower ability to deal with the demands of environment, unreal aspirations

- upbringing – correct upbringing results in the adequate adaptation to failures and lack of success, hyperprotective upbringing results in the lowered frustration tolerance.

Deprivation is a state in which the basic biological and existential needs are not sufficiently satisfied. Říčan (2011) mentions the following existential needs which were first introduced by Fromm:

1. Relatedness – relations to others, closeness and independence,
2. Transcendence
3. Rootedness
4. Sense of identity
5. Frame of orientation

Contrary to frustration in case of which a person can choose the substitute goals and alternative solutions, deprivation results only in revolt or resignation (Mikšík, 2007). The main types of deprivation are:

- *deprivation of biological needs* (lack of food, sleep etc.),
- *stimulus deprivation*,
- *cognitive deprivation* (lack and neglect of upbringing and education),
- *emotional deprivation* (unsatisfactory emotional relationship with a person's mother and/or any other important person),
- *social deprivation* (lack of adequate contact with other people).

Conflict generally refers to the collision of two or more contradictory tendencies or efforts. In the conflict situation, a person must decide between the two or more contradictory motives the concurrent satisfaction of which is impossible. Conflict is connected with the feelings of indecision, hesitation and helplessness. In the context of interactional approach, Mikšík (2007) distinguishes the conflicts which arise from the contradiction between the external demands on goal-directed behaviour and the internal tendency of a person to decide for a certain content and course of activities. Frequent sources of conflicts are the interiorized conflicts of the two external contradictory demands on decision-making and behaviour, i.e. the way of solving the incurred conflict. Psychological strain is an important factor which affects the job satisfaction, subjective wellbeing and health of an individual and even workgroups. Job risk factors may contribute to the non-specific health consequences in somatic sphere.

Study questions

Explain the terms: stressor, adverse life event, microstressors, daily hassles.

1. Describe the homeostatic process of a person's psychological coping with demands and influences of life and work environment.
2. When does the psychological disintegration take place? What is its nature?
3. Which factors affect the (un)successful coping with environmental demands?
4. What are the possible causes of trauma and posttraumatic growth?

Summary

The text serves as an introduction to the following topics: psychological strain and stress in the process of health and disease, adverse life events and microstressors, taxonomy of adverse life events, possible consequences of the exposition to stressor(s).

Recommended literature

HNILICA, K. Vliv pracovního stresu a životních událostí na spokojenost se životem. In PAINE, J. (Ed.) *Kvalita života*, Praha: Triton, 2005. s. 473 – 488.

MIKŠÍK, O. *Psychologická charakteristika osobnosti*. Praha: Nakladatelství Karolinum, 2003, 256 s.

PELCÁK, S. Proaktivní zvládání psychické zátěže a stresu. In *Sociální práce a sociální služby.* Hradec Králové: Gaudeamus, 2007, s. 44 – 53.

3.4 Mechanism of Stress Reaction (Biological Model of Stress)

Traditionally, the epidemiological research studies of life stress point out the mutual relation of psychological strain, stress and a person's health state. Štikar (2004) performed a comprehensive analysis of mutual relations between the job strain and health problems and emphasizes that **job strain was connected to the immediate manifestations in psychological, physiological and behavioural spheres**. The health relevance of these immediate manifestations is not as striking as it is in the case of stress; however, the long-term cumulation may result in psychological and even somatic consequences. In this context, the risk factor is also such **health related behaviour** as smoking, alcohol consumption, bad eating habits and the lack of physical activity. Other risk factors comprise some personal traits, the style of coping with stress, emotion suppression, excessive rationality (Štikar and Rymeš, 2000). The current approach to the mechanism of stress which implies the possible connection between the stress and health state is the synthesis of principal biological theories of stress and the newer psychological constructs which elaborated them:

- **Cannon proved the heightened sympathoadrenal system (SAS) activity in response to the strain which is perceived as challenge** thus laying the groundwork for the research of catecholamine response called fight-or-flight response.
- **Selye, the author of general adaptation syndrome (GAS), portrayed the activation of the axis hypothalamus – hypophysis – adrenal cortex in situations which comprises uncontrollable chronic stressor(s);** behavioural manifestations include withdrawal, resignation; emotional response is characterized by sadness, depression and apathy.
- **Lazarus** (1966) **and Arnold** (1967) **confirm the importance of cognitive appraisal of situational demands and accessible resources for coping**; they emphasize *the role of anticipation of unpleasant event* in stress response emergence, modification of behaviour and neuroendocrinological aspect of stress response.

- In his activation hypothesis, *Mason* (1971) referred to the *neuroendocrinological correlates of psychological states*, and thus elaborated the connection between the cognitive appraisal of situation, experience, psychological response to stressor and the neuroendocrinological manifestations.

From the physiological point of view, stress represents the non-specific, stereotypical response of an organism to the influences which upset its relative balance (physiological, psychological and social). Stress response enables the maintenance of homeostasis in extraordinary conditions and leads to the organism's survival. Stress reaction of human organism comprises three phases:

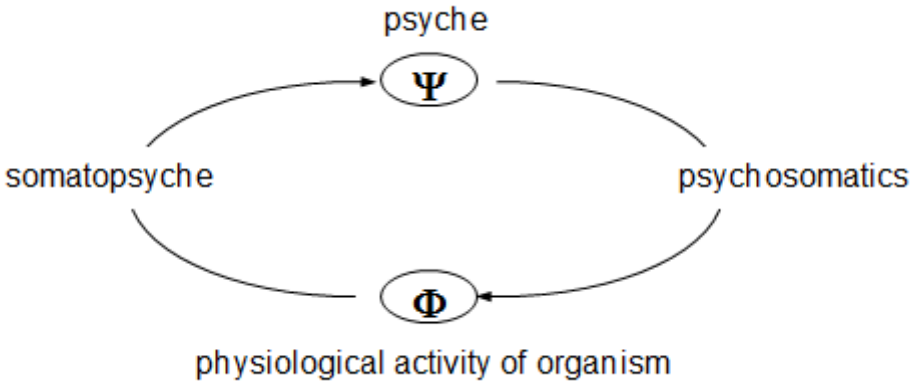
1. **Alarm reaction is typical with the complex mobilization of an organism's energetic resources**. The immediate reaction of SAS with the production of catecholamines (heightened blood pressure, glycogenesis, lipolysis) creates the metabolic substrate (glucose, free fatty acids) necessary for the muscle activity. Concurrently, CRH-ACTH-cortisol system is activated and the secretion of cortisol rises. Other parts of POMC system are activated as well. According to Bartůňková (2010), the alarm phase of stress response includes:
   - quick mobilization of energetic resources
   - increased function of cardiorespiratory system
   - increased muscle tension and muscle strength
   - reduced pain sensitivity
   - increased cognitive and perception abilities
   - mydriasis for the efficient orientation in space
   - faster coagulation (preparation for injury)
   - decreased immunity in order to save energy for the crisis
   - decreased secretion and peristalsis and, at the same time, increased activity of large intestine and bladder
   - increased perspiration
   - reduced function of reproduction system

2. **Resistance (or adaptation) stage is connected with a relative calming down and provides more resources for the energy mobilization**. It is characteristic with the continuous activation of the POMC and CRH-ACTH-cortisol systems which provide substrate for energetic reactions. In this phase, the ability of organism to cope with stress is maximal. In case that the adaptation is not efficient enough, the organism remains in continuous tension. The individual's inability to cope with the chronic character of stress may result in the so-called *psychosomatic disease*.
3. **The exhaustion stage – acquired resistance is inefficient or decreases***.* In situations when that stress is too strong or too long, the cortisol secretion is impaired (impaired adrenal cortex) and the organism succumbs to stress (hypotension, shock, heart failure).

According to the author of this theory (GAS), Selye, the activity of endocrinological and nervous systems influences the resistance against the effects of stress. **An organism strives to reach homeostasis/balance**. Selye highlighted that without stress there would be a lack of positive change and constructive activities because the nature of stress is, in fact, to activate (Selye, 1966). After the process of coping, a healthy organism returns to the state of balance; however, an organism grows by the

adaptation to successfully managed stress. Stress, as an organism's complex response to physical or psychological strain, enables the optimal activity of all the organism's functions in new conditions. It can be evoked by any trauma, pain, infection, feeling of intense cold or hot, injection of noradrenalin or any other sympathomimetic substance, surgery, injection of necrotising substances into skin, immobilization and psychological strain (Křikava et al., 2007). **Grave, especially psychosocial, stressors affect the immune system and may trigger a pathophysiological process which would not emerge that soon, or at all, without the presence stress which functions as a catalyser** (Kebza and Šolcová, 1996). Evans et al. (1997) introduced a hypothesis that *the immune system responses differently to acute and chronic stressors*. Acute stress together with the active effort to manage the situation increases the activity of immune system. On the other hand, a chronic stress combined with the loss of control over the situation decreases the activity and function of the immune system (Scheme 7).

Scheme 7: **Psychological and health consequences of stress**



Source: Pelcák, 2008

Table 3: **The most common symptoms and signs of stress**

Physiological	Emotional	Behavioural
palpitations	mood swings	indecisiveness
chest pain	worries about unimportant things	unjustified lamenting
loss of appetite and flatulence	lack of empathy	increase in absences
indigestion and upset stomach	worries about physical health	frequent illness
diarrhoea	excessive daydreaming	slow convalescence
frequent urge to urinate	reduction in social contact	increased accident rate
impotence	tiredness	low job performance
low libido	attention disorders	task avoidance
menstrual disorders	increased irritation	increased alcohol consumption
tingling in the arms and legs	anxiousness	increased cigarette consumption
back pain and tension	quick temper	sleeping pills abuse

headaches	aggressiveness	loss of appetite
migraine	sadness	overeating
rashes	apathy	changes in biorhythm
stiff neck	disinterest	promiscuity
double vision	depression	drug abuse

Study questions

1 Describe the “biological” conception of stress. Which are the most common symptoms of stress?
2 By means of which mechanisms does stress affect the human health and immune system?
3 What is psychoneuroimmunology?

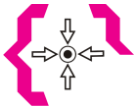
Summary

The text presents a biological conception of stress, basic theoretical models, stages of stress response and the most common consequences of exposition to stress.

Recommended literature

BARTŮŇKOVÁ, S. *Stres a jeho mechanismy*. 1.vyd. Praha: Karolinum, 2010. 137 s. ISBN 978-80-246-1874-6
.

4 Resilience and Proactive Coping



Objectives

- Introduction to the issue of resilience and its factors (resources) at the levels of individual, social groups and society;
- Portrayal of the mechanisms of resilience during the biodromal development of an individual and the stages of family life cycle (family resilience).

Workload

Keywords

Resilience, resilience resources, mechanisms of resilience, resilient family, healthy family functioning, personal resilience, social support

4.1 Resilience as Biodromal Process

The resilience of socio-ecological system is generally determined by the three characteristics: a) **the volume of change** which a system is capable of sustain while its function, identity and feedback mechanism remain the same, b) **the ability of self-organization**, c) **capacity for learning and adaptation** (Quinlan and Allyson, 2003; Stuart and Downing, 2004). According to Adger and Neil (2000), resilience represents **the buffering capacity** or the ability of a system to absorb the disturbing stimuli, until the system changes its structure by changing the variables and processes which regulate its behaviour. According to Dow (1992) is resilience a system's (or its part's) level of capacity to absorb and overcome the occurrence of adverse situation.

Ungar (2004), inspired by the social constructionism, defines resilience as the result of negotiations between the individuals and their environments in order to gain resources so that they can consider themselves healthy in conditions which they, together, perceive as adverse. The topic of resilience is examined also by a range of Czech authors. Paulík (2009), in accordance with the previous definitions, connects resilience with the ability of a system to reduce strain using the previous successful adaptation. According to Hoskovcová (2006), the resilience is an ability to survive a stressor (or a threat) and evade two or more adverse life events in which the majority of comparable group of people would fail/succumb to stress. Mareš (2012) understands resilience dynamically as a process of being resistant in which an individual faces the negative events. According to Vágnerová (2010), resilience reflects the fact that a certain individual has enough of physical and psychological strength, and adequate social skills, to successfully cope with various problems and, moreover, use the skills acquired during the process to his/her advantage. The author emphasizes the ability of quick convalescence and stabilization, including the maintenance of acceptable level of wellbeing.

The brief review of definitions emphasizes the fact that resilience is a multilevel, multidimensional construct which includes the variability of internal and external resources of coping, the adaptive processes at the level of an individual, social groups and society. The Table 4 presents a review of resilience sources and the mechanisms of their protective effects.

Table 4: **Protective factors (sources of resilience)**

Source of Resilience	Protective mechanism
	At the level of individual
Constitutional resilience	positive temperament, strong neurobiological system
Sociability	sensitivity to other people, prosocial attitude, emotional attachment to other people
Intelligence	school performance, planning and decision-making
Communication skills	quality of speech, reading skills
Personality characteristics	tolerance to negative emotions, self-realization, adequate self-efficacy, self-confidence, positive self-concept, internal locus of control, sense of humour, hopefulness, developed coping strategies, system of

	values, balanced view of experience, flexibility, moral strength, strong belief, perseverance, hardiness, determination
At the level of family	
Supporting family (family resilience)	parental warmth, encouragement, help, family cohesion and mutual care, close relationship to caring adults, belief in a child, no accusations, mutual parental support, talent or hobby which is appreciated by others
Socioeconomic status	Material resources
At the level of community	
School experience	supportive friends and peers, positive influence of a teacher, success
Supportive community	Belief in an individual, no punishments
At the level of culture	
	Traditional activities, spirituality, language, traditional medicine

Source: Šolcová (2009, pp. 43 - 44)

Protective factors are, according to Šolcová (2009), those characteristics which, in case of a person's interaction with a hardship or adversity, reduce or eliminate the potential negative effect of the risk factors. The protective factors enhance resilience. The mentioned summary of protective factors which influence an individual's resilience during his/her biodromal development can also include: dispositional resistance against stress (*hardiness*), cognitive style, perceived meaningfulness of life, spirituality, adherence to physical activity and fitness, preventive health behaviour. The process of resilience and its effect are also connected with the presence/absence of the risk (e.g. biological and psychological vulnerability, chronic disease, adverse life events and microstressors, socioeconomic gradient, cultural and environmental factors etc.).

In this context, an important issue is the family resilience which connects the internal and external sources of coping at the level of an individual and the primary social group.[5]

The risk and protective factors exercise their effect in mutual circular interactions and, over time, show a considerable interindividual and intraindividual variability. Related to these factors are also the factors of environment: developmental trumps, developmental activity and developmental assets increase the probability of positive outcomes. The protective factors function as "buffers" against the influence of risk factors; developmental assets have effect irrespective of the presence of risk factors (Šolcová, 2009).

[5] Family resilience refers to the coping strategies and adaptation processes within a family. The majority of research studies emphasize the prevention of problems and strengthening of family system. The basic question, in accordance with the salutogenic conception, is **why some families cope with the situational demands, developmental tasks and adverse life events better than other families the functioning of which is threatened**. The family resilience is affected by the following factors: the gravity of stressor, family vulnerability, type of family functioning, resources, ways of evaluation and interpretation of stress situation, family strategies of managing problems, family coping strategies and the personal predispositions of each member of the family system (Sobotková, 2004).

Regarding the possible outcome of multiple dependent interactions person–stress–health, the intensive attention is paid to **resilience** also in the context of Health Psychology and Positive Psychology. In accordance with Greene (2002), it can be generally defined as a universal ability of a person, group or society to prevent, minimalize or overcome damage or the consequences of hardships and adversities. **Resilience is a life-long process which manifests itself through the mutually connected internal and external factors which are determined by a personality and the interactions with the environmental factors**. Ungar (2004) emphasizes an individual's heading towards health and his/her ability to acquire resources but also the readiness of a family, community and culture to provide these resources. Resilience comprises the resources which are determined socially and somatically, and also by one's personality (personality traits, way of thinking, lifestyle, social attachments and relationships, and physical fitness).

The mechanism of resilience can be portrayed by means of several models:

1. The protective-interaction model assumes the mutual interactions of resilience resources and risk factors which lead to more or less successful coping.
2. The cumulative effect model (compensatory model) presumes the direct effect of resilience factors on coping; the factors of resilience may compensate the risk factors.
3. The challenge model counts with the linear relation between the risk factors and coping. The model presumes that petty hardships strengthen a person and prepare him/her for the more intensive strain and the higher level of risk factors.

According to Schumacher (2000), **on one hand, resilience directly affects the physiological processes and functions thus as a mediator; on the other hand, resilience indirectly participates in cognitive appraisal and the choice of coping strategies, functioning thus as a moderator**. An important factor which affects a person's ability to cope with stress and subjective health is the family resilience. Generally, it represents a family's competence of maintaining the habitual patterns of functioning when facing the risk factors, the ability to quickly recover from a crisis or event which evoked changes in family functioning. Sobotková (2007) states the following **characteristic features of resilient family**:

- *managing problems in family* – communication when solving problems which arose from the normative and non-normative life events is crucial for the creation of family cohesion,
- *equality* – the same possibilities of both men and women,
- *spirituality* – helps find a sense and meaning of grave situations, helps maintain the awareness of connectedness especially in case of tragedies which cannot be processed rationally – logically,
- *flexibility* – maintains a family's stability and helps overcome the adverse consequences of crises,
- *truthfulness* – a sufficient amount of true information is necessary for the successful adaptation process of a family system,
- *hope* – a family's clear view of future is a crucial precondition for a family resilience and successful adaptation to difficult situations,
- *family hardiness* – active inner strength of a family, perseverance, courage and toughness, ability to maintain integrity and search for the meaning of situation,
- *family time and routine* – habits and rituals protect a family's stability, maintain the continuity in family; resilient families spend together more free time which is typical with less control and relaxed relationship between the parents and children,

- *health* – general health of family members belongs to the basic and general factors of the family system resilience,
- *social support* – a family's relationships network and integrity are important in coping with adverse events

Healthy family functioning is sometimes defined as a family's ability to efficiently cope with the adverse or stressful life events, and to adapt to changes. Family adaptability is typical with the ability to creatively response to situations and to solve them, and adequately change the family structure, roles and rules. Besides creativity, the expressed support and interest in mutual conversation and activities are equally important. Probably the most important precondition of adaptability is also a family stability to which a person relates oneself in times of personal volatility (Sobotková, 2004). **The family strategies of coping** include all activities of a family which lead to acquisition and use of the family resilience resources. They are the dynamic processes aimed at gaining a family balance. Existing studies registered the following efficient strategies of family coping:

- strategies focused on reduction of demands in a family (e.g. placement of a grandparent to hospice care)
- strategies focused on acquisition of new resources (e.g. arrangement of care service for a family member with a chronic disease)
- strategies focused on the continuous tension management in a family (e.g. socializing with friend, fun)
- strategies focused on the situation appraisal and the understanding of its meaning (Sobotková, 2007, 78–79)

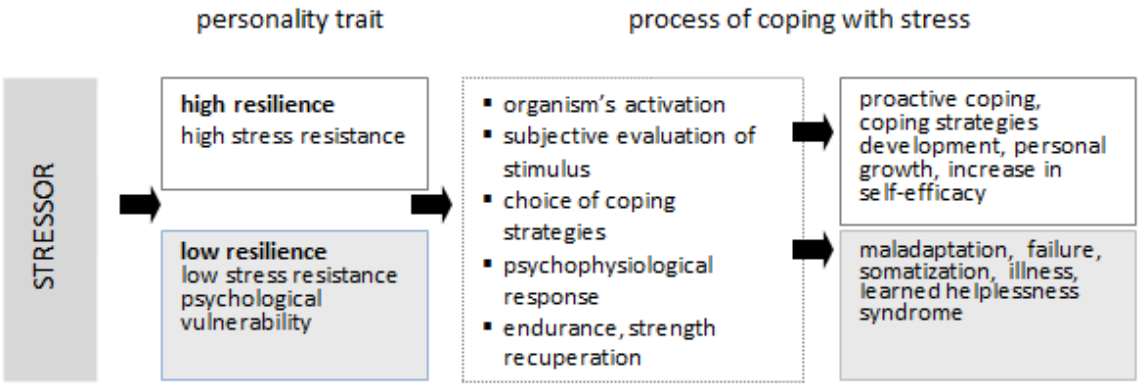
Coping generally refers to the complex of protective factors which help a person cope with the adverse event and endure them while a person's psychological integrity and balance rests preserved. An important role belongs to the internal factors, an individual's personality, one's innate dispositions, experience and abilities which one acquires during the coping with stress situations (*coping resources*). The examination of relations "individual vs. situation" renewed the attention to *personality traits*, implied to view situations as the external environment or processes which are considerably dependent on the subject. **Under the strain, the long-term personality traits are reflected in the coping processes, they affect the choice of coping strategies and subsequently psychological processes including an organism's neuroendocrinological response and the subsequent recuperation of mental strength**. Personality traits may represent an explanation of the variability in vulnerability related to the exposition to stress.

Vulnerability is a disposition to response to stress by a malfunction. Primary vulnerability develops within the first six months of life. Secondary vulnerability develops later and is considerably affected by psychosocial factors. At the psychological level, the influence of stressors may increase an individual's vulnerability against the diseases of both psychological and physiological nature (Kebza, 2005). Primarily, experiences of poor control or no control over the situation development, hopelessness and helplessness have the most negative effect. Interindividual differences in response to stressful situations can be explained by a moderating effect of certain personality traits together with the socially determined factors which arise from the qualitative characteristics of a person's social interactions.

The common feature the protective factors is, according to Kebza and Šolcová (1996), the presumed ability to absorb the impacts of stressful events on a person's

health state. Formally, they share the bipolar characteristics in case of which the positive part of each trait's (factor's) continuum is considered as salutoprotective and the negative part as risk – predisposed to failure of morbidity. The moderating effect of personality is simply portrayed by Scheme 8.

Scheme 8: Personality as mediator of interaction stress–person–health



Pelcák, 2008

Personality factors thus influence the whole process of being aware of the stress and coping with it, and they may function as a protective factor or a factor which enhances the stress risk.

Study questions

1. What is resilience? Name its main factors (sources).
2. Describe the mechanism of resilience.
3. Describe the nature of family resilience.
4. What is vulnerability?
5. Explain the mediating role of personality in interactions stress–person–health.

Summary

The chapter presents a theoretical construct of resilience, sources of resilience and the mechanisms of resilience. The attention is paid to the family resilience, vulnerability and the mediating role of personality in interactions stress–person–health.

Recommended literature

HOSKOVCOVÁ, S. *Psychická odolnost předškolního dítěte*. Praha: Grada, 2006. 160 s. ISBN 978-80-24714-24-0

KEBZA, V. Psychosociální determinanty zdraví. 1. vyd. Praha: ACADEMIA, 2005. 258 s. ISBN 80-200-1307-5

SOBOTKOVÁ, I. *Psychologie rodiny*. 2. vyd. Praha: Portál, 2007. 224 s. ISBN 978-80-7367-250-8.

ŠOLCOVÁ, I. Vývoj resilience v dětství a dospělosti. 1. vyd. Praha: Grada, 2009. 104 s. ISBN 978-80-247-2947-3.

4.2 *Hardiness*

The level of individual resilience against stressful situations is promiscue referred to as frustration tolerance, hardiness and other terms (resistance, toughness, endurance etc.) which express an ability to cope with stress over time. The most general definition is, according to Vágnerová (2004), an ability to cope with adverse life events without inadequate and maladaptive reactions. The protective effect of hardiness most probably consists in the cognitive appraisal of stressogenic situations and their "turning" into the meaningful challenges (Kebza a Šolcová, 1998). **Resilience in the sense of "hardiness" as a personal trait** which moderates the relation between the stressogenic event and disease was first introduced by Kobasa (1972, 1979 and 1982). "Hardiness" construct is based on the theories of existential philosophy and humanistic psychology according to which the task of a person is to live a meaningful life in the generally stressogenic world and to use one's dispositions in order to create the possibilities for self-advancement and self-realization (Šolcová, 1994; Šolcová a Kebza, 1996). Both groups of theoretical approaches emphasize hardy individual's tendency to rely on their own strength, ability to use all internal and external capacities and reserves, and full commitment to performed activities. "Hardy" people subjectively consider the life changes not as threatening obstacles but as exciting, inspiring and meaningful events, and are aware of their own competencies in control of events which take place in their life.

Kobasa (1979, 1982) characterizes hardiness as a variable which moderates the relation between a stressogenic event and disease. The moderating effect consists in the optimistic cognitive appraisal of adverse events and situations, and ability to react adequately and thus reduce the negative impact of stressogenic event. The main feature of hardiness is the ability to struggle hard with all the hardships a person faces during the life journey. According to Czech authors, the individuals with a high level of hardiness generally show positive view of the control over a situation, responsibility and positive attitude towards changes. Other features include:

- the openness to anything new and effort to understand all events and phenomena as interesting and meaningful.
- the understanding of changes as something natural and usual, and as meaningful challenges resulting in further development and self-advancement,
- the positive evaluation of situations leads to the choice of adequate coping strategies which, via feedback, lead to a more favourable cognitive appraisal of situation and the reduction of harmful impact of the stressogenic situation,
- the experience of one's own competency in managing everyday demands, more positive appraisal of one's health state, psychological and physical strengths,
- in the confrontation with adverse life events – the choice of coping strategies which help manage everyday life problems while minimalizing the stress response.

Hardiness is a constellation of personality traits which comprises engagement, commitment, control, coping and challenge. The individual level of hardiness is measurable by the Personal Views Survey (PVS; Kobasa and Maddi, 1982). In accordance with Křivohlavý (1991), Šolcová and Kebza (1996, 2007), the components of hardiness are specified as follows:

Challenge – awareness of the fact that a human life is typical with changeability, not stability; ability to appraise changes in one's environment as challenges and possibilities of further self-advancement. A person who is open to interesting and stimulating experience develops flexible means of coping and certain endurance, and encourages his/her environment to do the same (Šolcová, 1994). People who score high on the challenge scale consider life changes as normal and appraise them as stimuli for growth (Kobasa, Maddi, 1982).

Commitment – people who are highly engaged tend to commit themselves in anything they do instead of performing the activity in a shallow way (Kobasa, Maddi, 1982). Commitment and engagement consist in a person's belief in one's own worth, one's awareness of the purpose, goal and priorities of any activity. An important part is also the feeling of relatedness to other people; activity and effort to face the reality instead of passivity and avoidance; taking responsibility for a task, project or relationship. Life activities are understood as purposeful and meaningful. Low commitment can be understood as alienation – commitment and alienation form a continuum which is measure by an alienation scale.

Control – reflects a person's responsibility for his/her behaviour and trust in his/her own ability to act, take action and manage a situation; persuasion that in managing external events, one can employ his/her imagination, knowledge, abilities and choice. Control is understood as a person's belief that he/she is able to control or influence the course of events in his/her life and environment (Vašina and Záškodná, 1996). The low level of this dimension of hardiness is typical with a destructive belief that a human is subjected to destiny, helpless and unable to defy. The study of predictors of social support in the Czech population by Šolcová and Kebza (2003) confirms significant relations between hardiness and social sources of resilience. Maddi and Kobasa (1996) refer to hardiness as a general level of mental health. The results of regression analysis in a sample of 3988 people showed close relation between hardiness and subjective health (Šolcová a Kebza, 2006). Interesting is that the level of hardiness is independent of sex.

4.3 *Aaron Antonovsky's Sense of Coherence*

In 1979, Antonovsky first introduced his theoretical model of relations between stressors, health and coping with stress. Between the years 1985 and 1987, he systematically elaborated his concept and verified it in clinical practice. **The concept is based on the theoretical foundations of existential analysis, especially V. E. Frankl's logotherapy**. In connection with the meaning of life, the presence of relevant and meaningful goals or values in a person's life is presumed. The term "meaning of life" is related to experiencing life as meaningful and valuable and reflects the answers to such existential questions as: "What is the goal of my life?", "Does my life have a sense?", "What is valuable in my life?" Frankl presumes that a person's physical and mental health must be also saturated by experienced meaningfulness of one's own activity.

A specific human tendency which plays a central role in a person's life is the will to meaning. In a normal everyday life, the meaning is perceived rather latently and gains gravity in cases of stress, frustration and extreme lack of use of one's possibilities (Frankl, 1997). If a person's life is not saturated by the meaning for a long time, a person gradually gets into a spiritual crisis – existential frustration which may contribute to the development of somatic and mental disorders (Frankl, 1995, 1997 and 1999;

Balcar, 2005). The will to meaning is an effort and desire for the meaningfulness of one's existence. It is a will to see, organise and understand individual stimuli as meaningful units. The aim of this organisational tendency is not just an optimal arrangement of perceptional stimuli which enable a person's adaptation to external conditions but also a person's effort to search for and find as adequate and complete explanation as possible which reflects one's purposeful existence (Tavel, 2007). Kováč (2001) emphasizes the intrapsychical nature of the meaning of life which is determined by: ability of self-knowledge, understanding of others, searching for the optimal solutions, well-being, self-control, efficacy, planning of events, searching for goals, and coping with adverse life events.

Also Vymětal (2003), inspired by the salutogenic approach, emphasizes the importance of a person's basic attitude to himself/herself and the world which are characterized by:

- meaningfulness in one's own activity, worldview and life,
- trust and belief in the stability of personal and outer world,
- intelligibility, comprehension, rational orientation based on the existence of principles which direct the world and which are recognizable,
- manageability and control of events of which a person is a participant; personal competency and influence.

In his monograph, Antonovsky (1987) emphasizes that salutogenesis opens the fresh perspective on coping with life events. Sense of Coherence (SOC) is according to the author an answer to the new salutogenic questions and defines it as a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that:

1. the stimuli deriving from one's internal and external environments in the course of living are structured, predictable and explicable,
2. the resources are available to one to meet the demands posed by these stimuli ,
3. these demands are challenges, worthy of investment and engagement.

Křivohlavý (1990) interprets the coherence in two meanings: as a solid group cohesion and as a person's internal integrity. A person who manifests this solid internal integrity and lives in a solid, cohesive social group copes better with life adversities (Křivohlavý, 2001). The opposite of coherence is the incoherence and inconsistence within a group of people as well as the instability and disunity of personality. Sense of coherence thus reflects a person's view and belief that the happenings in his/her internal and external world are predictable, logical and abide by certain rules.

Paulík (2009) claims that a person's level of coherence is affected by the interpersonal relationships, main focus of activity, existential issues and feelings.

According to Antonovsky (1987), SOC guarantees a person's integrity in face of stressful situations. In his recent publication, Křivohlavý (2006) specifies that people with high levels of SOC are exceptionally resistant against the external pressure, do not easily succumb to stress, do not give up in difficult situations, and have their plans for the future. In concrete situations, the sense of coherence affects their cognitive and even emotional appraisal. The central principle of salutogenic model is that the sense of coherence has a key function in successful coping with the omnipotent life stressors, and thus in the health maintenance as well ((Flensborg-Madsen, T., Ventegodt, S., Merrick, J., 2006).

Theoretical construct of the Sense of Coherence comprises three dimensions:

1. **Comprehensibility** – a cognitive tendency to perceive the world and one's place in it. Reflects the level at which a person perceives stimuli from the internal and external environment as the pieces of information which are structured and clear. High comprehensibility is connected with a sense that events will turn out the way which can be reasonably expected (Antonovsky, 1985). The world is understood as a structured complex in which a person is integrated. This is related to the quality of relationships which are characterized by solidarity, credibility and friendship. The opposite process is "chaos" – a person considers all events as coincidental, inexplicable, disorganized and excessively complex. This attitude is connected with rigid prejudices and lower communication competency (especially the inability to understand other people).
2. **Manageability** – a range in which a person appraises the internal and external resources at his/her disposal as adequate to the demands and situational factors. It relates to the resources which are controllable by a person or other people (a person's partner, friends, colleagues, God, doctor etc.). People with a high sense of manageability consider the life demands as manageable and resolvable, feel capable and competent, act with initiative and have an internal locus of control. Manageability is also related to the adequacy of specific resources which are needed for the solution of the problem (e.g. social competency, coping strategy etc.). The other, negative, end of the manageability scale is typical with the feeling that the tasks and situational contexts are uncontrollable, external locus of control (a person expects instructions from others, believes in destiny, does not subjectively dispose of adequate possibilities of influencing situations).
3. **Meaningfulness** relates to the emotional aspect of the overall attitude to life; it is connected with a person's motivational orientation to the life's goal. High meaningfulness is connected with a person's belief that the problems are worth the effort and investment of time and energy in order to solve them; the problems and obstacles are considered as a challenge, a call for action, the work is a source of joy. A person with a high sense of meaningfulness believes that he/she can be initiative and creative and his/her effort will be appreciated by others. The opposite pole of the meaningfulness dimension is *alienation* which is typical with the emotional disengagement in social relationships, social isolation and loneliness.

Study questions

1. What is hardiness?
2. Explain the substance of A. Antonovsky's Sense of Coherence.
3. What is the relation among resilience, process of health and disease and coping with stress? What is the relationship between resilience and other personality traits?
4. Give examples of practical application of the mentioned constructs (prevention, treatment, rehabilitation).

Summary

The text presents the main theoretical constructs of personal resilience: hardiness (Kobasa, Maddi) and the sense of coherence (A. Antonovsky).

Recommended literature

KEBZA, V. Psychosociální determinanty zdraví. 1. vyd. Praha: ACADEMIA, 2005. 258 s. ISBN 80-200-1307-5
KŘIVOHLAVÝ, J. *Psychologie zdraví*. Praha: Portál, 2001. ISBN 80-7178-551-2
PELCÁK, S. *Osobnostní nezdolnost a zdraví.* 1.vyd.Hradec Králové: Gaudeamus, 2013. ISBN

4.4 *Dispositional Optimism and Pessimism*

A subjective appraisal of situation is very important when facing the stressors. Generally, the optimists are characterized as people who expect positive outcomes. Pessimists are considered as people who expect that something bad happens. Peterson (2000) defines optimism as a mental state or attitude connected with expectations of social or material future which an individual considers as socially desirable, useful and pleasing. Optimism is thus an expectation of desirable future. What is desirable for one person in a specific situation may not be, however, desirable for another person in the same situation. In a simplified way, there are two types of optimism/pessimism:

1. *Dispositional optimism* refers to the general expectation that good things are more probable to happen than the bad things in contrast to the dispositional pessimism which is a general expectation of negative outcomes.
2. *Situational optimism* refers to the expectation of good outcomes, rather than the negative ones, in a specific situation; the opposite is the situational pessimism.

Dispositional optimism can be defined as a generalized expectation of the positive course of events, and the positive outcome of event or activity. Dispositional optimism regulates a present mental state and is considered as a mediator of the coping strategy selection in case of stressful event or adverse life event. *Optimism/pessimism as a personal trait and the cognitive style most probably play the crucial role in coping with the stressful situation*. it is assumed that both the situational and dispositional optimism serve to maintain a person's focus, effort and endeavour. Peterson (2000) refers to the so-called "*big" and "little" optimism* and implies that the "big" optimism may be a biologically determined tendency which acquired a socially desirable content in a specific culture; "little" optimism then may be the outcome of learning and a person's experience in a specific situation.

A degree of optimism/pessimism affects the quality of a person's subjective experiencing. Facing the adversities of present situation, optimists expect positive results, whereas pessimists tend to experience such negative feelings as anxiety, guilt, anger, sadness or desperation as a result of their expectation of negative outcomes and doubts about the positive course of events (Carver and Scheier, 2002).

Facing the stressful events, optimists experience less distress than pessimists. The difference lies in the general behavioural tendencies based on the expectations of future events. The individuals who doubt their future tend to postpone unpleasant matters even though they are capable of solving them through positive thinking; they tend more to do activities which bring only a temporary distraction but do not contribute to the solution of a problem and sometimes, they even stop doing anything and run away to wishes and cravings. On the other hand, people who are sure about their future, make a continuous effort even in the cases of severe problems and adversities (carver and Scheier, 2002).

Current research studies confirm that the *optimism is connected with problem-focused coping strategies*, especially when the stress situation is considered controllable. Optimism is also significantly related to the positive reframing and acceptance of the situation in case it is considered as uncontrollable. Optimists are thus more initiative, more resistant to adverse events and situations, decisive, use problem-focused strategies, more assertive than pessimist and anticipate the future realistically. Optimists tend to see something positive even in the adverse event and learn from such situation; **pessimists, however, tend to drop the goals which interfere with a stressor, prefer the emotion-focused strategies which include evasive behaviour** (sleeping, food, substance abuse and avoiding people).

4.5 *Self-efficacy*

The awareness of one's potential plays an important role in the selection and realization of coping strategies. Psychological vulnerability and a tendency to succumb to stress are increased by the low self-efficacy which refers to *an individual's belief in his/her own control of events and his/her own life* (Bandura, 1994). The feeling that we are capable of influencing our own environment has a positive effect on the coping with adverse life events; difficult tasks are considered as life challenges. Higher self-efficacy relates also to the proactive coping with stress, change of bad habits, and regulation of emotional states. People who do not believe in their ability to influence the relevant affairs give up easily, do not believe in themselves, blame themselves, and feel hopeless and doubtful. Low self-efficacy is thus the cause of higher psychological vulnerability and failing under pressure. The loss of faith that a person can actively achieve certain result leads to the loss of motivation and initiative (Hoskovcová, 2006, 65).

Bandura (1994) presents the four information sources which contribute to the development of self-efficacy:

- mastery experience – the experience of success in coping with adversities,
- vicarious experiences provided by social models – symbolic modelling during observation of others' successful behaviour,
- social persuasion – suggestion, encouraging, instruction, interruption of self-blame, interpretation etc.
- awareness and interpretation of perceived signals of one's own body – relaxation, physical condition improvement, being attentive to one's own bodily needs.

The way a person perceives his/her possibilities of coping with stress is connected with a range of other factors at the level of cognition, motivation, emotions, the somatic level and behaviour. At the level of cognition, the self-efficacy correlates especially with attention and its focus. Individuals who estimate

their condition better focus their attention to the character of the task rather than themselves. People with higher self-efficacy also think more analytically and believe that their abilities can be enhanced and changed by learning; they also show a higher level of aspiration (in relation to motivation), are more persisting and resistant to failure. At the somatic level, there is a connection between the efficacy in coping with stressors and the higher resilience of a person's immune system (Hoskovcová, 2006). **Higher level of self-efficacy is related to motivation, affects the formation of optimistic attitudes and contributes to the interpretation of adverse events as life challenges**.

Study questions

1. Explain the term dispositional optimism. What is its relation to coping and quality of life?
2. What is self-efficacy? What does it influence? By means of which mechanism(s)?
3. In which ways is it possible to develop the above-mentioned disposition within the nonspecific primary prevention?

Summary

The chapter introduces some other personality-based factors of coping with stress, dispositional optimism/pessimism and self-efficacy.

Recommended literature

HOSKOVCOVÁ, S. *Psychická odolnost předškolního dítěte*. Praha: Grada, 2006. 160 s. ISBN 978-80-24714-24-0

KEBZA, V. Psychosociální determinanty zdraví. 1. vyd. Praha: ACADEMIA, 2005. 258 s. ISBN 80-200-1307-5

4.6 *Social Support and Health*

Social epidemiologists stress the importance of social support in the process of adaptive coping, during the mitigation of life events consequences, and as a factor which moderates the incidence of diseases and mortality. Social support is most frequently defined as **the existence, accessibility or closeness of people** who are in relationship with us, worry about us, appreciate and love us. Šolcová and Kebza (2003) use the term **social resources** which comprises variables which determine the anticipated social support, obtained social support, social contacts with family and social contacts with friends. Social ties to other people, groups and wider society provide help through social support in coping with life demands and achieving goals. Positive social ties facilitate survival and adaptation to unfavourable environment, and affect the maintenance of the overall health state. Social integration of an individual to a social structure is thus an important determinant of his/her psychological wellbeing and psychological health. The absence of social support, on the other hand, reduces an individual's potential chances in crisis to solve problems adequately and represents a health risk factor. For the detailed review of the functions of social support, see Table 5.

Similar to other factors affecting the health-disease process, the subjective appraisal of social support is important. The awareness that the others are ready to help forms the feeling of social security which facilitates the risk-taking and encourages a person to solve the problem by himself/herself (Kebza and Šolcová, 1999). Křivohlavý (2002) emphasizes the necessity of an authentic personal relationship of two persons, or a certain group of people (friendly level of relationship, mutual trust and trustworthiness, social closeness, solidarity and sharing). Mareš (2002) stresses the fact that social support the more positive effect the more it is expected and properly focused.

The protective mechanism of social support in coping with psychological strain and stress may be characterized as follows – social support:

- affects the process of cognitive appraisal of the stressogenic demands through the selection and change of strategies used by an individual,
- enhances the feelings of self-esteem and social competence,
- reduces stress through the "buffering" of health-damaging physiological processes,
- and positively affects the ratio of threats (demands of a stressful situation) to coping resources at one's disposal (adequacy).
- Cognitive appraisal of a stressogenic event includes a subjective perception of one's own social anchoring (integration) – an individual appraises the possibilities and accessibility of social support and other resources of coping with stress.

Social support is a dynamic process in which a range of variables coincides; the social support can be instigated, mobilised, enhanced and obtained, as well as refused or provided. The processual character of social support anticipates the quantitative and qualitative changes in the course of the whole biodromal development of an individual; the so-called *convoy model of social networks* is considered. The elderly have objectively more problems related to social support due to the decrease in "constituents" of their social network and the lower tendency to forge new relationships (Šolcová and Kebza, 2003).

Mechanisms of social support

According to Mareš (2005), the general **model of indirect, buffering effect of social support** is interpreted in two ways, both of which are based on psychological and medical findings about distress and coping with stress.

The first approach focuses in research on **the supportive (helpful, helping) behaviour** of people which is observable, describable and objectively registered.

The second approach deals with the recipient of social support and his/her **subjective perception, interpretation and appraisal of experienced distress**. It assumes that social support modifies a person's appraisal of the stressful situation and thus facilitates coping with distress. Other approaches suppose a direct (main) effect of social support on somatic and mental health.

The third approach examines the **mental representations of social support in a person's consciousness** and deals with the effect of social cognition on the process of the recipient's perception and appraisal of provided social support. The model assumes that every individual has a specific idea about the others' willingness to help in case of need. Positively perceived social support enhances a person's self-

concept, his/her willingness to start doing something for his/her health and persevere in the effort (Mareš, 2005, p. 130).

Table 5: **Functions of Social Support – an overview**

Function	Description	Practical examples	Presumed benefits
Emotional support	Mutual reassurance of respect, regard, worth, and importance, Personal, intimate relationship.	A person can express his/her emotions, worries, sympathies, affection, care and acceptance without fear	Shift/change in the subjective appraisal of being threatened by events, growth
Instrumental support	Provision of material support; Practical support; Helping behaviour.	Provide or obtain money, household items; arrange transportation, babysitting, household assistance, service and repairs.	Helps a person solve practical problems; expands the time space for other activities (relaxation); enhances one's effort to cope with strain.
Informational support	Giving advice, recommendation; support in assessing a situation; cognitive "lesson"; problem-solving.	A person is directed to the required information source(s), recommended alternative actions, advised etc.	A person gains access to useful information which he/she needs; direct help in getting the needed services which may lead to the more efficient problem-solving.
Support provided by community	Sense of belonging; togetherness; socialization; integration into community/society.	A person participates in social activities (religious ceremonies, holiday/vacation, dinners, cultural events etc.).	The support evokes positive emotions and may shortly divert attention from strain and rumination about problems, helps cheer up.
Appraisal support	Feedback, social support.	A person reaches consensus in the view of the problem, in/adequacy of behaviour and expression of emotions; his/her status in a particular social group/community of people.	A person feels to be less "outside the norm", that everything he/she experiences is accepted; the support enables comparison with positive outcomes.

(Wills, Shinar, 2000 in Mareš 2002)

The fourth approach is based on the assumption that **the arrangement (organization) of social interactions and their stability evoke a person's wellbeing and enhance his/her mental health**. Social support helps an individual create and maintain identity contributing thus to his/her wellbeing and health.

Accumulation of more roles may thus be beneficial to a person's wellbeing – the resulting benefits may outweigh the feelings of strain, burden or time pressure (favourable self-image, high prestige, affection, attraction, material benefits).

The fifth approach considers the **social support as a specific constituent of general processes which take place within social relationships and social networks**. In this context, the research focuses on the positive and negative relationships among people, dispositional characteristics of individuals which affect their interpersonal behaviour, and needs. Social support has a protective effect regardless of the presence of any adverse situation or subjective distress. The importance of subjective appraisal of social support is also emphasized by Koukola and Ondřejová (2001). Richman, Rosefeld and Hardy (1993) in Mareš (2002) present a more detailed description of mechanisms of perceived or obtained social support:

- **Listening support** – the perception that other person is willing to listen,
- **Emotional support** – the perception that other person is providing comfort and caring,
- **Emotional challenge** – the perception that another person is challenging the support recipient to evaluate his/her attitudes, values and feelings,
- **Reality confirmation support** – the perception of the confirmation of the support recipient's perspective of the world,
- **Task appreciation support** – the perception that another person is acknowledging the support recipient's effort and work he/she does,
- **Task challenge support** - the perception that another person is challenging the support recipient's way of thinking about a task or an activity in order to stretch, motivate and lead the support recipient to greater creativity, excitement, and involvement
- **Tangible assistance support** - the perception that another person is providing the support recipient with either financial assistance, products, and/or gifts
- **Personal assistance support** - the perception that another person is providing services or help, such as running an errand or driving the support recipient somewhere

Social support and social capital

In the field of healthcare (public healthcare, health promotion programmes), there is an intensive discussion going on related to the term social capital (Kawachi, 1997) which, according to Janečková (2007), refers to horizontal relationships among community members characterized by trust, reciprocity and civic engagement. In this context, the socially protective factors are: community empowerment, searching for the internal possibilities of a community, social capital development, enhancement of social cohesion, accentuation of the group performance, the sense of partnership. Psychological empowerment at the level of an individual consists in the awareness of the control over one's own life and participation (Wallerstein, 2002). The internal community capacity comprises the active participation of all members, leadership, rich social networks, abilities and resources, critical reflection, feeling of belonging to the community, understanding of history, articulation of common values, share of power etc.

Social support and negative social exchange

A negative social exchange is currently distinguished from the social support and its unsuccessful expressions. Negative social exchange is defined as affectively unfavourable, stubborn, conflicting, hostile and hurtful transaction (Křivohlavý, 2002,

p. 64). The most frequent social manifestations belonging to this category are, according to the author, the following:

- mocking
- ignoring of another person
- humiliation and cruelty/abuse
- verbal abuse, threatening, accusations
- vulgar gestures
- false and fake information
- tactless criticism
- social conflicts
- quarrels
- coercion
- refusal (e.g. to join the group, party etc.)
- aggravation of another's situation
- prevent a person from participating in discussion
- prevent a person from working individually
- ignoring of another's communication
- cynicism, arrogance

A negative social exchange is often an obstacle in achieving goals; it decreases the efficiency of activity, negatively affects the problem-solving, and threatens one's self-evaluation and self-appreciation. Negative social exchanges may connect with other stressors and thus reduce an ability to perceive and accept social support. Despite the protective role of social support which has been emphasized in the text, there are also examples of **negative** (bothersome, uncalled for) **social support** – a person in stressful situation gets social support which he/she did not ask for, which he/she does not wish to get; the support is unsuitable, inconvenient and/or excessive; the support is provided by people who were not asked for it; in special social situations which threatens a person's need for autonomy and self-determination, self-efficacy and self-image (Mareš, 2003).

Study questions

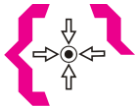
1. Name the functions of social support.
2. Explain the mechanisms of social support.
3. Search the literature for the examples of social support.
4. What is essential for the negative social exchange? What is the unsolicited social support?

Summary

The text presents a dynamic process of social support, its functions and mechanisms (perceived and obtained social support) in relation to the process of health and disease and coping with stress. Possible risks and consequences of the unsolicited and negative social support are mentioned.

Recommended literature

5 Burnout Syndrome – Multicausal Etiology



Objectives

The aim of this section is to present the risk and protective factors of the burnout syndrome, its stages, symptoms and comorbidity.

Workload

Keywords

Burnout syndrome process, risk and protective factors, comorbidity, differential diagnostics, chronic fatigue syndrome.

5.1 *Process of Burnout Syndrome*

The prevalence of burnout is especially high in helping professionals whose job description comprises the contact with other people and dependence on their evaluation. **Burnout is a psychological state characterized by emotional exhaustion, cognitive weariness and overall fatigue**. The syndrome includes a range of symptoms at the psychological, somatic and social levels, as a consequence of exposition to chronic stress. The dominant attribute is especially a psychological exhaustion which manifests in the areas of cognition, motivation and emotions, and affects attitudes, opinions as well as performance and thus the whole patterns of professional behaviour and conduct (Kebza and Šolcová, 1998). The fully-fledged burnout syndrome significantly affects not only a person's subjective quality of life but also his/her health state. Burnout is a consequence of the continuous or repetitive emotional strain which is connected with the intensive empathy, compassion and/or understanding (e.g. health workers, school workers, social workers etc.). **Burnout is a state of complete ransacking of all the energetic resources of a person who was initially a very intensive worker (helping professionals particularly, e.g. GPs, teachers, nurses, lawyers, social workers etc.). It is a consequence of the imbalance between the worker's emotional investment and "profits" which come in the form of appreciation, recognition and the feeling of being successful (Praško et al., 2006)**.

The processual character of the burnout syndrome is portrayed for example by Edelwich and Brodsky's model (1980) which describes the initial above-average work engagement, enthusiasm and ideals, inadequate demands on oneself and others, overestimation of one's energy, excessive identification with work and clients, and perceived meaningfulness of life. Naturally, the initial unrealistic ideas are confronted with the everyday reality of work, and the necessary change in work motivation and correction of ideas of one's possibilities and the sense of profession take place. A person's centre of interest shifts to the satisfaction of material needs, which implies

certain stagnation. Bureaucracy, everyday contact with clients, interpersonal relationships in the workplace, and conflicts which arise from the demanding character of profession and roles' realization within the family system gradually bring disappointment and frustration. A person "awakes" and sees the unrealistic nature of his/her initial requirements on which he/she is forced to compromise. Natural defence strategies include: a reduction in work duties, avoidance to arduous clients (depersonalization), resignation and desperation. A problem is the economic dependence on profession and the necessity to maintain it; a person then does only the necessary tasks (Table 6).

Table 6: The stages of burnout

STAGES OF BURNOUT	
1. enthusiasm	a person is excessively engaged, helps gladly, works overtime, makes sacrifices, expects appreciation and acceptance from the superiors, collective and patients
2. stagnation	a person is becoming more reserved to patients, their demands are becoming bothersome, he/she starts avoiding the contact with patients
3. frustration	"defence" stage – effort changes into resignation and the other way round; request and demands are perceived as bothersome, feeling of time pressure, systematic avoidance to "problematic" patients, annoyance in close relationship – conflicts about petty matters in family, isolation from friends; irritation and belligerence against the colleagues
4. apathy	general resignation in therapeutic relationship, reduction of communication to technicalities without personal engagement, cynicism, labelling, slander, requests of superiors are understood as bothersome, change of behaviour in family (similar trend), resignation in self-education
5. burnout	full disengagement and avoidance to professional demands
Consequences	▪ psychological disorder ▪ somatic disease ▪ disintegration of relationships in family and at work

Understandably, the stated changes are significantly reflected in the personal life and affect negatively not only a person's subjective quality of life, but also his/her health state. The three basic symptoms of burnout include: physical and psychological exhaustion (also called "tedium") connected with depression, internal alienation particularly of work collective and clients, decrease in work engagement (Stock, 2010). In their meta-analysis, Kebza and Šolcová (2010) emphasize the alarming links between the burnout syndrome and acute myocardial infarction, ischemic heart disease, stroke and the sudden cardiac death.

Table 7: Burnout syndrome symptoms

Burnout syndrome symptoms	
Physiological	Psychological
▪ state of overall fatigue and exhaustion ▪ apathy, slackness ▪ respiratory distress	▪ irritation, annoyance ▪ anger and rage outbreaks ▪ increased sadness ▪ overall inhibition and depressiveness

▪ palpitation ▪ headaches ▪ gastrointestinal problems ▪ insomnia ▪ non-specific bodily pains	▪ uncontrollable verbal outbreaks of anger ▪ paranoia, “touchiness” ▪ avoidance to work duties
Work-related	
▪ belief that “it’s not worth it” ▪ decrease or loss of interest in profession-related topics ▪ negative appraisal of situation in which a person had been working ▪ self-pity, intensive feeling of not being appreciated enough ▪ negativism, cynicism and increased irritability in relation to patients ▪ reduction in activity to routine procedures, use of stereotypical phrases and clichés ▪ belief in one’s own expendability and worthlessness	

Source: Ptáček and Čeledová, 2011

5.2 *Risk Factors of Burnout Syndrome*

The main cause of the burnout is the long-term exposure to work stress (distress) which a worker is unable to manage. Daily hassles contribute to the onset of burnout in the out-of-work life together with such life events as, for example, a loss of a close person, a loss or change of work, illness etc. Not inconsiderable role is also played by a person’s internal factors – personal traits, coping strategies, social support etc. (2006). Křivohlavý (1998), Kebza and Šolcová (2003), Matoušek (2003), and Jeklová and Reitmayerová (2006) present the following risk factors of burnout:

- high performance demands, work monotony
- low level of work autonomy
- high level of enthusiasm and engagement
- low level of assertiveness
- type A behaviour with accentuated hostility and competitiveness
- initial high empathy and devotion
- higher frequency of life events and daily hassles
- permanent feeling of time pressure (stress)
- disregard to the needs of staff
- lack of training of the new member of staff within organisation
- wrong or completely absent supervision
- competitive work environment
- overloading of employees, e.g. too many clients on one worker
- high demands on the quality/quantity of work
- continuous negative workplace conditions
- lack of breaks during worktime
- lack of appreciation from superiors or clients
- family and partnership conflicts
- long-term strain in family
- performance-driven culture and society forces a person to work harder and faster, earn money, make a career, provide for one’s family

Table 8: Risk factors in helping professionals

To be a helping professional comprises many paradoxes
▪ Helping other people – dangerous and difficult profession which can deform the professional himself/herself ▪ Exhaustion – a patient does not want to be just an object of help; a patient wants sympathy, empathy, love and attention, not just an impersonal professional advice ▪ Power and control issues ▪ Influence on self-confidence and life values, the profession merges with life ▪ Overlaps in the outside-of-work situations (teachers, lawyers, doctors, nurses) ▪ Disappointments, disillusion and personal "injuries" ➢ treatment is not successful, is stereotypical, boring, too demanding and stressful ➢ patient is refusing, gets worse, comes back again and again, is unappreciative ➢ lack of appreciation and adequate reward from superiors whereas the demands are too high ➢ colleagues punish for the effort ▪ Possible consequences: ➢ excess stress ➢ breaking of personal relationships ➢ burnout ➢ breaking of working relationships ➢ psychological disorder ➢ somatic disorder

Source: Praško et al., 2010

5.3 *Burnout Syndrome and ICD 10 (Differential Diagnostics)*

Problems related to work difficulties are included in ICD 10: **Z73 Problems related to life-management difficulty** and category **Z73.0 Burn-out** which refers to the specific emotional exhaustion typical with a long-term subdepressive mood and irritability. A person has difficulties with focusing on patients, experiences the feelings of resentment and lack of success ("It's not worth it"). Consequences include the minimal (only formal) job performance, loss of the interest in patients and, in extreme cases, substance abuse and addiction, and even suicide attempts. The syndrome is predominantly caused by the gradual loss of satisfaction in work when there is an emotional disproportion between the assets and profit (Boleloucký, 2004).

In case of ambiguities and doubts, a person's state may be classified pursuant to the group of diagnoses **F48 Other neurotic disorders** and it subgroups **F48.0 Neurasthenia** and **F48.1 Depersonalization-derealisation syndrome**. Neurasthenic syndrome is described as irritable weakness; both syndromes may occur at the same time. Hyperexcitability manifests as reduced threshold for the stimuli from sensory organs, and, psychologically, as increased affective reactivity. Excess exhaustion manifests as excess fatigue after no matter how little somatic or psychological strain (Praško, 2007).

Recent literature includes into the nosological unit F48.0 Neurasthenia the Chronic fatigue syndrome (CFS)[6] which is a disorder on the pathogenesis, onset and course of which participate the psychological factors, somatic diseases and disorders, and environmental factors. Excess and poorly managed stress is, too, a contributor to the pathogenesis and further development of CFS.

Table 9: Diagnostic criteria of neurasthenia

Either persistent and distressing feelings of exhaustion after minor mental effort, or persistent and distressing feelings of fatigue after minor physical effort
Accompanied by one or more of the following symptoms ➢ muscular aches or pains ➢ dizziness ➢ tension headache ➢ sleep disturbance ➢ inability to relax ➢ and irritability
Inability to recover through rest, relaxation or enjoyment
Duration exceeds 3 months
Does not occur in the presence of organic mental disorders, affective disorders or panic or generalised anxiety disorder

Similarly, Chromý and Honzák (2005) emphasize the role of stress in the etiology of the disease and consider e.g. flooding, loss situations, relocation, surgery etc. as significant triggers of CFS. One of the frequent triggers of CFS is a long-term feeling of being overworked and overloaded (Praško, 2006).

The signs of CFS are often similar to the signs of other diseases and disorders, e.g. depressive disorder, prolonged depressive reaction, somatization disorder, somatoform pain disorder, hypochondriac disorder, posttraumatic stress disorder, seasonal affective disorder etc. (e.g. Nouza and Svoboda, 1998). The most common sings of the disease are included in the Table 10.

One of the main factors affecting the onset and duration of the disease is the psychological predisposition. Praško (2007) mentions the following psychopathological concepts as mechanisms leading to the CFS: somatization, attribution style, evasive and safeguarding behaviour, and fear of stigma. Personality traits also play a crucial role, e.g. perfectionists with excessive demands on performance, evasive people with exaggerated worries about health, and passive or dependent people, histrionic people who tend to exaggeration and excessive self-observation.

The term CFS was coined in 1988; it is a syndrome without a clearly determined cause. At one hand, it comprises symptoms of psychological disorder and, on the other hand, it comprises symptoms of an immunity disorder and infections (Chromý and Honzák, 2005, p. 192). Some specialists and patient's clubs in USA prefer the predominant role of immunity disorder in the onset of the disease (CFIDS - **chronic fatigue and immune dysfunction syndrome**). The CFS refers to the state typical with significant, long-term and debilitating fatigue connected with a range of related symptoms and subjective difficulties: reduced ability to concentrate, muscle and joint pain, cephalea, sore throat and sleeping disorders. All symptoms are modulated by and experienced through psyche (Janů, 2003).

Table 10: Health problems of patients with CFS

Problem	questionnaire-based data (%)	reported by patients (%)
Fatigue	100	100
Muscular pains	75	55
Gastrointestinal problems	67	48
Concentration issues	65	34
Allergy	65	–
Muscle weakness	60	29
Sleep disturbance	48	29
Memory issues	48	19
Joint ache	44	32
Headache	39	47
Irritability	33	14
Vertigos	31	24
Sore throat	22	13
Depressiveness	16	11
Polyuria	17	–
Recurrent infections	16	15
Blurred vision	14	–
Lymphadenopathy	14	5
Subfebrilia	8	11

Source: Janů et al., 2003

Study questions

1. Name the protective and risk factors of burnout.
2. Characterize the individual stages of burnout and the most common symptoms.
3. Characterize the Chronic Fatigue Syndrome.
4. In what way may the risks of burnout syndrome onset be diminished?

6 Methods of Psychosocial Intervention in Prevention and Health Promotion

6.1 *Historical development of methods and forms of social-psychological training: brief review*

Training groups (T-groups) were initially designed as groups for the training of social-psychological skills, the members of group were led to observe the group processes and own interactions with other people. The beginnings of the continuous interest in T-groups took place at the turn of the 1950s and 1960s. Many groups of various names started to emerge which focused on a deep encounter of a person with another person, and assumed that an everyday life put such demands which a person's psyche became incapable of managing. A great influence on the development of these groups had especially Psychiatry; the development led to a better understanding of one's own behaviour and influence on other people increasing thus the readiness to solve complex interindividual situations. The clientele of T-groups gradually extended from executives to other groups of professionals (pedagogues, social workers, instructors and other helping professions).

In Psychology, the origins of group methods are dating back to 1910 when J. L. Moreno established the first therapeutic groups for children, prostitutes and immigrants in Wien. Another pioneer of group work was J. Pratt who had organized groups for patients with tuberculosis in Boston since 1906 (Tax, 1989). The crucial role was played by the Palo Alto school of family therapy and its systemic view of an individual's interactions with his/her environment, and of an individual's family (Kratochvíl, 1997). One of the resources of the techniques which have been used in the social-psychological training were the military games (Hermochová, 1988) initially designed for the modelling of war situations solving. After the World War II, a range of these techniques have been utilised in economics to prepare managers, in clinical practice and social work. Social-psychological training as a method-based training of specific skills of social interaction (Nakonečný, 1999) has gradually spread to the fields of Psychotherapy (encounter groups), Organizational Psychology and Practical Pedagogy.

In the context of the development of training methods, the work of C. R. Rogers and his colleagues is of great importance. At the University of Chicago, they organized an intensive course for the professional who had been preparing for the counselling and psychotherapeutic work with the veterans of WWII. Rogers' approach connected the emphasis on the experiential and cognitive learning with the process of therapeutic character, providing thus the participants with the ability of a more accurate self-reflection and self-acceptance by means of realization of one's own attitudes during the group work.

At the turn of 20th and 21st century, the group techniques developed greatly. According to (1985), the most important schools of present-day intensive groups are the following:

- T-groups focused especially on the development of social skills,
- Encounter groups focused on the personal growth and improvement of interpersonal communication,
- Sensitivity training,
- Task oriented groups – combine elements of T-groups and encounter groups,
- Experiential groups focused on the realization of physical processes and expression
- Creativity workshops
- Organizational development groups oriented on the improvement of management skills
- Team-building groups
- Synanon groups or games.

6.2 *Objectives and methods of social-psychological training (SPT)*

A determination of goals which we want to achieve by means of the group training in a specific population/group is a very important aspect of the social skills training. Within a social interactional learning, there are the following general goals, regardless the school or group specifics:

- enhancement of the ability to perceive social reality,
- improvement of the effort of self-regulation,
- change of the undesirable stereotypes,
- authentic and functional expression of one's emotions,
- clarification of one's own behaviour motives,
- enhancement of self-acceptance and acceptance of other people,
- development of the group values and norms,
- enhancement of the interpersonal openness.

Kožnar (1992), determines the goals of SPT according to its focus and mentions the following: enhancement of social skills, improvement of self-knowledge and achievement of the insight into one's own attitudes, experiences and reactions, realization of consequences of one's behaviour in the interpersonal situations, enhancement of empathy, learning to constructively solve the interpersonal and group conflicts, understanding of group processes, group dynamics and learning how to efficiently influence it, optimization of one's own organizational behaviour and work (educational) activity.

Similarly, Sedláček (1985) considers as the main goals of SPT the development of creative attitude towards the world (discovering, experimenting), enrichment of one's own behaviour repertoire, acquisition of important knowledge, authenticity and openness in social relationship, clarifying of vertical relationships and the ability of mature reactions, self-knowledge and self-development, cooperation with other people and the ability to solve conflicts.

Methods of social-psychological training

Within the SPT, there are many group techniques adopted from various fields of Social Psychology and Group Psychotherapy. Other sources of inspiration are, for example, psychogymnastics, transaction analysis, training of assertiveness, music therapy, art therapy, autogenic training, and yoga. Sedláček (1985) differentiates between *techniques according to the functions on improvement of which they are focused*:

- relaxation and free expression techniques
- techniques aimed at self-reflection and meeting other people
- techniques aimed at the training of the new forms of social behaviour
- techniques aimed at efficient communication
- techniques aimed at the training and analysis of the cooperative forms of behaviour.

According to the means and the main method which determine the action, the methods can be differentiated as follows:

- role-playing (closely related to psychodrama)
- interview techniques (e.g. non-directive interview)
- sociogramatic techniques which enable the social structure diagnostics
- non-verbal techniques (perceptual and motoric techniques – pantomime; communicative non-verbal techniques - encounter)
- drawing techniques
- musical group techniques
- group task techniques (cooperation skills and competitiveness)
- simulation games
- relaxation techniques

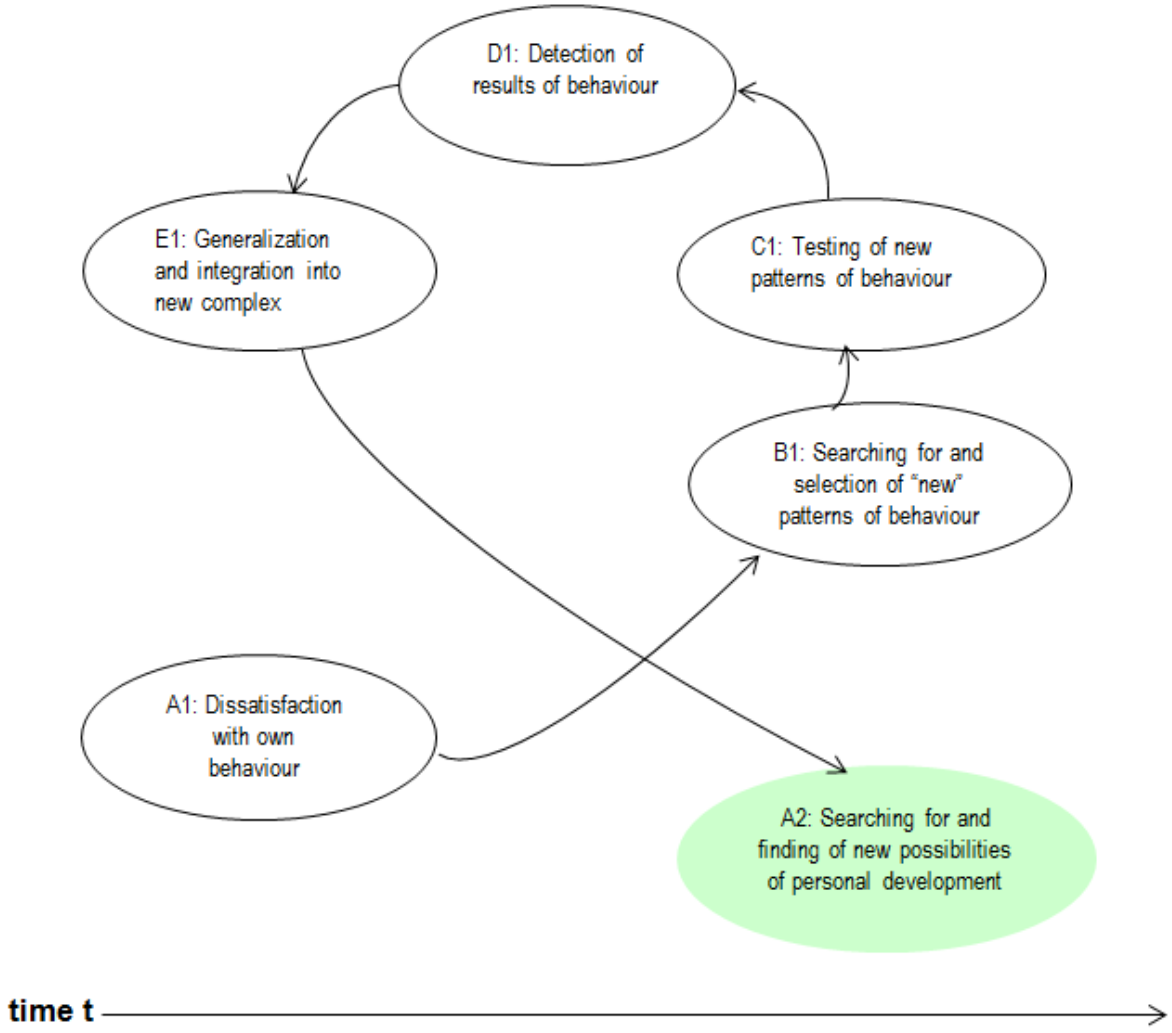
6.3 *Social-psychological Training and Process of Change in Group*

In accordance with Hermochova (1988), the course of SPT can be characterized as a process which includes three stages:

1. participants try to learn new forms of behaviour, enter the socially safe situation, and relax which helps them behave in other way than they are normally used to;
2. in a relaxed state, participants explore and try the new forms of behaviour because in the socially safe atmosphere, they managed to remove obstacles and make more effort;
3. integration of the new forms of behaviour or at least disposal of those forms which lead to the undesirable effects (Scheme 9).

When the training is successful, the spiral in the Scheme 9 moves in the direction of the more efficient group and individual behaviour. In each of the mentioned phases, a participant faces a range of emotional problems and stress. Changes take place over time with a significant interindividual variability which may be related to a participant's current life situation, motivation to change, self-concept and his/her social-psychological competence.

Scheme 9: **The process of social-psychological training**



Pelcák, 1985

In this context, Labáth a Smik (1991) emphasize that participants of training realize and experience the present time, that it is possible to change their own behaviour in a certain direction despite the difficulties arising from the changing of long-term, fixed stereotypes. *Within a group work, the correct as well as inefficient stereotypes of interpersonal behaviour is projected and reflected by means of confrontation and feedback, which leads to the insight (understanding) of what a person does wrong in interpersonal relationships, by what one does evoke a reaction which may then traumatise him/her etc. Apart from the insight, the group can also provide an emotional adjustment, safe space for the testing and training of the new, more efficient patterns of behaviour. Also a certain ambiguity and a lack of structure in the training situation has a positive influence – facilitates the change of behaviour stereotypes, opens new possibilities to bring into the situation one's own meaning and motives, and compare them with the other participants of the group etc*.

The group processes take place also during the time when the members are not together; they also take place in situations when the group may not be ready to analyse them and affect them. During the training, the tolerance among the participants grows as well as the effort to help each other as a consequence of getting to know each other.

Positive relationships among the group members also facilitate the mutual satisfaction of various needs (e.g. the need for affiliation/group membership, acceptance, the need for an active influence on the group dynamics, the need of being positively appraised etc.). The mutual position of individuals in the group also gets more specific. **The SPT stimulates the optimal development of a person's potentialities in an optimal social interaction, creating thus specific conditions suitable for the saturation of needs, integration and a person's self-realization**.

An important factor of the group training is the possibility to obtain information about oneself and one's behaviour, which positively affects the development of healthy self-concept. A person's self-esteem is largely related to the appraisal that he/she gets from other people. From this perspective, a group membership may trigger a very helpful change. This fact, however, brings a variety of risks which are continuously underestimated.

6.4 *Relation between social-psychological training and psychotherapy*

The training situation clears the way for an active participation of any group member. It is allowed to express feelings and examine them there, to observe oneself and other members, communicate together, play various roles, move, clarify mutual relationships and contribute to the group decision-making.

Despite the fact that in SPT is the emphasis put on a person's external behaviour or expression rather than his/her internal motives, the positive changes which are accessible within a group work have also psychotherapeutic aspects.

Frequently discussed issue is the difference between the group training and group psychotherapy. Despite significant similarities between the two mentioned types of work with groups (especially the factors of group dynamics and the methods and techniques), the significant conceptual difference depends on the target group.

Hermochová (1988) and Bratská (1985) both claim that sometimes it is hard to determine the exact boundary between the group within which a process of therapy takes place, and the group within which there is an intensive social-psychological training. Kožnar (1992) deals with the strengths and weaknesses of both types of training and according to him, the greatest advantage of social-psychological training is the emphasis on skills, practice of communication and specific interactional abilities.

Both procedures emphasize a development of personality, its creative potential, the support of similar ways of behaviour, e.g. comprehensible and exact communication – the ability to create new, fully-fledged relationships, ability to take a risk and responsibility for one's own decisions, ability of self-regulation while maintaining one's own authenticity, deeper social perception and ability of realistic interaction and cooperation, acceptance of other people (sensitivity to group dynamics, insight into one's motives and incentives etc.). The similarities also include some techniques and learning mechanisms and principles (openness, feedback, present behaviour analysis, emphasis on "here and now" as a primary source of information about anyone etc.).

Psychotherapeutic changes are usually more significant, deeper and especially related to the emotional layers of personality. Changes mediated by the SPT are clearer, practical, directly observable and usable in social interactions.

In the context of encounter groups, Rogers (1974, p. 115) claims that within the intensive training which is oriented on personal growth and the growth of one's therapeutic potential, the goal of this training merges with the goal of the SPT. There

are thus practically no clear borders between the SPT and psychotherapeutic group. Due to their positive influence on the group members' personal development and growth, the methods of SPT can be efficiently utilised within the programmes of non-specific primary prevention in the risk groups of population (Pelcák, 1992). Functional interconnection of the SPT techniques and psychotherapy can be considered as possible, helpful and desirable. Efficient interconnection of the both levels of work with group however places considerable qualification demands on trainers.

Trainer's personality in social-psychological training

Interpersonal relationships contain a huge psychotherapeutic potential. The power of true and deep interpersonal relationship, especially the acknowledgement of a person by other people, is an important prerequisite for his/her psychological stability, integrity and development.

The SPT leader (trainer, instructor, facilitator) is practically a teacher who focuses on the analysis of what happens during the process of learning and social learning; he/she is neither an authoritative, nor a protectionist type of a leader; however, in case of need, he/she may make use of such forms of leadership. A facilitator is neither a group member in the true sense of the word, not does he/she stands outside of it. His/her role consists in the facilitation of group dynamics and the ongoing interactions, i.e. stimulation of emotions, expression of personal attitudes, interpretation and structuring of situations. According to Tax (1989), the leader/trainer/facilitator should:

- ensure compliance with the group norms,
- provide help to participants by means of suitable techniques,
- lead the analysis of the group dynamics (via commenting, generalizing, discussing, or interpreting of the group phenomena),
- facilitate the group and individuals' experiments with behaviour,
- check the group interactions while maintaining a certain form of group membership,

A good fulfilment of the trainer's role is not easy and requires a range of specific skills as well as personal predispositions. Hermochová (1981, p.27-28) emphasizes the following traits:

- openness to changes and innovation (even concerning himself/herself)
- inner "relaxedness" (ease), life optimism, positive relationship to himself/herself and other people and thus a certainty in reactions to the new and unusual situations,
- effort to help other people as a real motive for the role of the trainer,
- ability to signal the group his/her readiness and qualities suitable for the positive influence on the group interactions,
- flexibility,
- sensitivity towards group dynamics,
- and very good knowledge of social psychology, SPT theory and a previous quality practice with groups.

These predispositions may be developed within the lifelong education, training focused on self-experience, supervisions etc.

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Author: PhDr. Stanislav Pelcák, Ph. D.

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