Chapter 2: BIOLOGICAL BASES OF PSYCHOLOGICAL FUNCTIONING

I. STRUCTURE OF NEURONS:

**Neuron**: individual cells in the nervous system that receive, integrate, and transmit information (neural impulses).

**BASIC STRUCTURES OF A NEURON:**

A. **Cell Body (soma)**: contains the cell nucleus & much of the chemical machinery common to most cells

B. **Dendrites**: are branch like parts of a neuron that are specialized to receive information

C. **Axon**: is a long, thin fiber that transmits signals away from the soma to other neurons (or muscles & glands)

D. **Myelin Sheath**: is an insulating material (fatty protection)

E. **Axon Terminals**: end point of an axon where one neuron communicates with the another neuron.
II. FUNCTION OF NEURONS:
A. **Neural Impulse**: a sudden change in the electrical charges within and outside the membrane of a neuron.

B. **Ions**: electrically charged atoms & molecules

C. **Resting Potential**: When the cell is INACTIVE

D. **Action Potential**: a brief change in a neuron's electrical charge (+40 mV)

![Graph showing the change in potential over time]

E. **All-Or-None Principle**: A neuron stimulated will either produce an action potential or it will not.

**Neural Threshold**: the minimum amount of stimulation that a neuron requires in order to fire.
III. FROM ONE CELL TO ANOTHER: THE SYNAPSE

A. Synapse: The junction between the axon terminal and the dendrite of the next neuron.

B. Vesicles: sacs in the axon terminal that hold neurotransmitters.

C. Synaptic Cleft: a microscopic gap between the terminal button of the sending neuron and the cell membrane of another neuron

D. Receptor Sites: where NT is received

E. Neurotransmitters: are chemicals that transmit information from one neuron to another

Agonist:

Antagonist:

1) Acetylcholine (ACh): found throughout the brain & spinal cord
   - Most common EXCITATORY Transmitter

2) Norepinephrine (NE): Involved in MOOD Regulation
   - Implicated in bipolar mood disorders

3) Dopamine: control of voluntary movements
   - Mood

4) Serotonin: involved in regulation of sleep
   - May play a role in depression regulation
5) **Endorphins** (endogenous morphines):

- Family of internally produced chemicals that resemble opiates in structure and effect

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**THE HUMAN NERVOUS SYSTEMS**

**I. NERVOUS SYSTEM = CNS + PNS**

**A. Central Nervous System (CNS):** consists of the brain and the spinal cord

**B. Peripheral Nervous System (PNS):** relay system connecting all parts of the body with the CNS

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1. **Somatic Nervous System:** "outer" functions
   - Critical for generation of motor movement

2. **Autonomic Nervous System (ANS):** "inner" function
   *-> TWO COMPLEMENTARY PARTS: Together, they regulate responses such as heart rate, blood pressure, digestion, and adrenal gland activity.

   a. **Sympathetic Division:** Fight or Flight response prepares body for stressful and/or vigorous action
b. **Parasympathetic Division:** Sustains non-stress functioning, lower heart rate & blood flow to skeletal muscles, enhances digestion

C. **Endocrine System:** consists of glands that secrete chemicals into the blood stream that help control bodily functioning
* Partner to the nervous system

Hormones: Released into blood system

## II. THE CENTRAL NERVOUS SYSTEM

![Diagram of the Central Nervous System]

A. **Spinal Cord:**
Spinal Cord: connects the brain to the rest of the body through the PNS.
**B. LOWER BRAIN CENTERS**

1) **HINDBRAIN:** consists of Medulla, Pons, & Cerebellum
   (* Gerow classifies Medulla & Pons as brain stem Structures)
   (Brain Stem: lowest part of the brain, comprised of medulla and the pons.)
   
   a) **Medulla:** in charge of unconscious but essential functions (breathing, maintaining muscle tone ...)

   Cross Laterality: nerve fibers crossing from one side of the body to the opposite side of the brain.

   b) **Pons** (literally "bridge"): bridge of fibers that connects the brain stem with the cerebellum (concerned with sleep and arousal)

   c) **Cerebellum** (literally "little brain"): Involved in the coordination of movement and is also critical to our sense of balance

2) **MIDBRAIN**
   Reticular Activating System (RAS): complex network of nerve fibers involved in maintaining levels of arousal.

3) **FOREBRAIN**
   a) **Limbic System:** involved in control of emotion, motivation, and memory
      - Collection of structures

   b) **Thalamus:** all sensory information (except smell) must pass through to get to the cerebral cortex
c) **Hypothalamus**: Involved in the regulation of basic biological needs.
   - Lies beneath the thalamus, Hypo means under
   - Controls the AUTONOMIC NERVOUS SYSTEM

d) **Basal Ganglia**: control motor responding - controls slow movements

C. CEREBRAL CORTEX
   1) **Cerebral Cortex**: convoluted outer covering of the brain

   2) **Cerebral Hemispheres**: right and left halves of the cerebrum

D. LOBES
   1) **Frontal Lobes**:
      - Largest lobe
      - Control the movements of muscle groups (primary motor cortex)

   2) **Temporal Lobes** (means "near the temples"):
      - Has an area devoted to auditory processing
      - Language comprehension
      - Language Production
3) **Occipital Lobes**: where most visual signals are sent
   Neurons specialized for
   Damage can result in

4) **Parietal Lobes**: where we register the sense of touch

**E. TWO CEREBRAL HEMISPHERES:**

1) **Corpus Callosum**: structure of nerves that connect the two cerebral hemispheres

2) **Split-Brain Procedure**: the corpus callosum is cut
   - Hemispheres operate independent of one another
Chapter 12: THE PSYCHOLOGICAL DISORDERS

I. ABNORMAL:
   A. Maladaptive Behavior: interfere with a person's normal social or occupational functioning
   B. Deviance “not average”:
   C. Personal Distress: person reports great personal distress

II. NORMALITY & ABNORMALITY

III. MEDICAL MODEL
   A. MEDICAL CONCEPTS:
      1) Diagnosis: Involves distinguishing one illness from another based on a constellation of symptoms.
      2) Etiology: Refers to the apparent causation and developmental history of an illness.
      3) Prognosis: predicted course of the illness
   B. DSM-IV: Diagnostic & Statistical Manual of Mental Disorders (version 4).

Case Histories

DSM-III (Multiaxial system)
C. CRITICISM OF THE MEDICAL MODEL:
   1) Labeling:
   2) Pseudoexplanation:
   3) Patient Role:

D. Diagnosis involves a value judgment:
   - Person must often show DIMINISHED CAPACITY

E. Insanity: not a psychological term but a legal term

IV. COMMON STEREOTYPES ASSOCIATED WITH VARIOUS PSYCHOLOGICAL DISORDERS:
   1) Psychological disorders are a SIGN OF PERSONAL WEAKNESS
   2) Psychological disorders are incurable
   3) People with psychological disorders are often violent and dangerous
   4) People with psychological disorders behave in bizarre ways and are very different from normal people

• A SAMPLING OF PSYCHOLOGICAL DISORDERS •

Neurotic: refer to behavior marked by subjective distress (usually chronic anxiety) and reliance on avoidance coping

Psychotic: refers to behavior marked by impaired reality contact and profound deterioration of adaptive functioning.
A. **ANXIETY DISORDERS**: as a group they are the most common of psychological disorders.
- Feelings of excessive apprehension and anxiety

1) **Generalized Anxiety Disorder**: is marked by a chronic, high level of anxiety that is not tied to any specific threat, often called "free-floating anxiety"

2) **Panic Disorder**: involves recurrent attacks of overwhelming anxiety that usually occur suddenly and unexpectedly.

3) **Phobic Disorder**: is marked by a persistent and irrational fear of an object or situation that presents no realistic danger

4) **Obsessive-Compulsive Disorder (OCD)**: is marked by persistent, uncontrollable intrusions of unwanted thoughts (obsession) and urges to engage in senseless rituals (compulsion).

   **Obsessions** (cognitions): intrude on one's consciousness in a distressing way.

   **Compulsions** (behaviors): usually involves stereotyped rituals that temporarily relieve anxiety

5) **Posttraumatic Stress Disorder (PTSD)**: a condition characterized by periodic outbursts of anxiety, panic, or depression provoked by reminders of a traumatic experiences.

   Three clusters of symptoms:
   1: Flashbacks or nightmares
   2: Avoidance of any possible reminders of the event
   3: Increased arousal or "hyper-alertness"
B. SOMATOFORM DISORDER: a class of disorders involving physical ailments with no authentic organic basis that are due to psychological factors

1) Hypochondriasis: involves excessive preoccupation with health concerns and incessant worry about developing physical illnesses.

2) Conversion Disorder: involves a significant loss of physical function (with no apparent organic basis).

C. DISSOCIATIVE DISORDERS: a class of disorders in which people lose contact with portions of their consciousness or memory, resulting in disruption in their sense of identity

1) Dissociative Amnesia: is a sudden loss of memory for important personal information that is too extensive to be due to normal forgetting

2) Dissociative Fugue: condition of amnesia that involves an unexplained change of location.

3) Dissociative Identity Disorder (Multiple Personality): A condition in which a person alternates among two or more distinct personalities.

D. PERSONALITY DISORDERS: a maladaptive, inflexible way of dealing with the environment and other people.

   Antisocial Personality Disorder
E. ALZHEIMER’S DEMENTIA (ORGANIC MENTAL DISORDERS):

1) DEMENTIA: a deterioration in mental abilities that adversely affects the person’s memory and judgment.

2) Alzheimer's Disease: cognitive deterioration: can develop illusions, hallucinations, and delusions - Cholinergic neurons possibly degenerate Acetylcholine (ACh) plays role in encoding memories.

F. MOOD DISORDERS: are a class of disorders marked by EMOTIONAL DISTURBANCES that may spill over to disrupt physical, perceptual, social, and thought processes.

1) Major Depression: a condition in which a person takes little pleasure in life and experiences feelings of worthlessness, powerlessness, and guilt.

Changes in:

2) Dysthymia: essentially a mild case of depression

3) Bipolar Disorder (manic-depressive): alternate between depression and mania

Mania: a condition marked by constant, driven activity and a lack of inhibitions.

Seasonal Affective Disorder: a condition in which the person becomes depressed every winter
Causes of Depression:
Theories suggest that LOW LEVELS of serotonin, dopamine, and norepinephrine cause depression

Biological Factors:
a) Depression:

b) bipolar:

Psychological Factors:

G. SCHIZOPHRENIA: Are a CLASS (GROUP) of disorders marked by disturbances in thought that spill over to affect perceptual, social, and emotional processes.

1) DELUSIONS: are false beliefs that are maintained even thought they are clearly out of touch with reality

2) HALLUCINATIONS: sensory perception that occur in the absence of a real, external stimulus or gross distortions of perceptual input

Two types based on onset:
- Process Schizophrenia: gradual
- Reactive Schizophrenia: sudden onset

Two types based on symptoms:
- Positive Symptoms (adding to normal functioning):
  - Major symptoms are hallucinations, delusions, muscular & rigidity.

- Negative Symptoms: Major symptoms are social withdrawal, reduced energy & motivation
**DSM-IV Types:**
Paranoid Type:

Catatonic Type:

Disorganized Type:

Undifferentiated Type:

Residual Type:

**OBSERVATIONS ON THE CAUSES OF SCHIZOPHRENIA**

* **Hereditary Factors:**
  * One may inherit a PREDISPOSITION to develop schizophrenia

* **The Dopamine Hypothesis:** caused by excessive amount of DA

* **Psychological and Social Factors:**
  * Multifactorial model:
Chapter 13: TREATMENT AND THERAPY FOR THE PSYCHOLOGICAL DISORDERS

I. BIOMEDICAL TREATMENTS OF PSYCHOLOGICAL DISORDERS

I. Psychosurgery: surgical procedures, usually directed at the brain, used to affect psychological reactions.

A) Lobotomy: For DEPRESSION & VIOLENT BEHAVIOR

B) Electroconvulsive Therapy (ECT):
- A treatment usually for severe depression.
- Procedures

   Good:

   Bad:

II. DRUG THERAPY:

PSYCHOACTIVE DRUGS: chemicals that effect cognitions, affect or behavior

Psychoactive drugs differ in their ability to regulate neurotransmitters (NT):
1) change sensitivity
2) change number of receptors
3) block re-absorption of NT
4) block receptor sites
5) block conversion into inactive molecules

A) ANTIPSYCHOTIC DRUGS: Typically given to treat schizophrenia although can be given to people with severe mood disorders who become delusional
- High likelihood of a relapse

SIDE EFFECTS: drowsiness, constipation, cotton mouth, tremors, impairment of coordination, sexual impotence

SERIOUS EFFECTS: seizures, cardiovascular damage
Tardive Dyskineisa: a NEUROLOGICAL DISORDER marked by chronic tremors and involuntary spastic movements

B) **ANTIDEPRESSANT DRUGS**: these drugs help to bring a person out of depression by **GRADUALLY** elevating their mood

1) **Tricyclics**: Good for **MAJOR DEPRESSION**

2) **MAO Inhibitors**: **GOOD FOR DEPRESSION ACCOMPANIED BY ANXIETY OR PANIC SYMPTOMS**

3) **SSRI**:
   - Serotonin
   - Unrelated to tricyclics

C) **ANTIANXIETY DRUGS** (or tranquilizers):
   Relieve tension, apprehension, & nervousness

Benzodiazepines (Valium, Librium, Xanax):

**PROBLEMS**: Dependency & abuse with antianxiety drugs

**TWO REASONS WHY DRUG THERAPIES ARE CONTROVERSIAL**
1) **Drug Therapies often produce superficial curative effects**

2) **Drugs are OVER PRESCRIBED and many patients are over medicated**

**DEINSTITUTIONALIZATION**: A MIXED BLESSING
Deinstitutionalization: Releasing patients from mental institutions
• THE PSYCHOTHERAPIES •

Clinical Psychiatrist (Ph.D):
  - Psychoanalyst:
Psychiatrist (M.D.):
Licensed Professional Counselor (M.A., M.S.):
Clinical Social Workers (M.A., M.S., BSW):

I. INSIGHT THERAPIES: Involve verbal interactions intended to enhance clients' self-knowledge

A. PSYCHOANALYTIC TECHNIQUES a method of psychotherapy that attempts to bring UNCONSCIOUS THOUGHTS and MOTIVATIONS to the conscious level so that they can be dealt with rationally

1) Free Association: a procedure in which someone reports everything that comes to mind, without omission or censorship

2) Resistance: in psychoanalysis, continued REPRESSION that interferes with the therapy.

3) Dream Interpretation:
   MANIFEST CONTENT:

   LATENT CONTENT:

4) Transference: reacting toward a therapist as if s/he were a parent or some other important figure in one's life
B. **HUMANISTIC TECHNIQUES**: Therapist provides UNCONDITIONAL POSITIVE REGARD and supports the client's efforts to grow and change from within.

**Client-Client-Centered Therapy** (Rogers):

C. **COGNITIVE TECHNIQUES**: emphasizes recognizing and changing negative thoughts and maladaptive beliefs.

1) **Rational-Emotive Therapy (RET)**: replace irrational beliefs with rational ones.

2) **Cognitive Restructuring Therapy**: less confrontational & direct than RET.

II. **BEHAVIORAL TECHNIQUES**: a form of therapy in which the therapist and client agree on specific BEHAVIORAL GOALS and set up LEARNING EXPERIENCES to achieve those goals

A. **Behavior Therapy**: a collection of SPECIFIC TECHNIQUES BASED ON CLASSICAL CONDITIONING aimed at changing specific behaviors.

1) **Systematic Desensitization**: patient relaxes first, then thinks or is exposed to a hierarchy of stimuli that are anxiety producing.

2) **Aversion Therapy**: aversive stimulus paired with undesired behavior.
3) **Flooding**: subject confronted with object of his/her phobic fear while with therapist.

4) **Implosive Therapy**: images one's worst fear in therapist office.

**B. BASED ON OPERANT CONDITIONING:**

1) **Contingency Management**: Rewards & punishments are controlled to change a behavior

2) **Contingency Contracting**:
   - Establish a contract

**III. EVALUATING PSYCHOTHERAPY**

   - Matching therapies with psychological disorders
Motivation comprised of two subprocesses:
(initiates behaviors)

**Arousal:** one's indication of motivation that involves one's level of activation

**Direction:** focus of one's behavior and maintenance of that behavior.

### I. THEORIES OF MOTIVATION:

#### A) **INSTINCTS:** all behavioral patterns that are
1) unlearned
2) uniform in express, and
3) universal in the species.

Imprinting: occurs when an animal makes a strong social attachment during a critical period shortly after birth

#### B) **THEORIES BASED ON DRIVE OR NEEDS:**

[PUSH; motivation within person - motivated to reduce tension

1) **Hull's Theory:**

Need: arises from deprivation

Drive: is an internal state of tension that motivates an organism to engage in activities that should reduce this tension.

**Primary Drives:** based on physiological needs

**Secondary Drives:** drives based on learned experience
2) **Maslow's Hierarchy**: Placed needs and drives in a hierarchy

- Self-Actualization Need
- Esteem Needs
- Love & Belongingness Need
- Safety Needs
- Physiological Needs

Self Actualization: take full advantage of own potential

C) **INCENTIVES**: [PULL; motivation outside the body]
Incentive: an external goal that has the capacity to motivate behavior

D) **THEORIES OF MOTIVATION BASED ON EQUILIBRIUM (BALANCE)**: driven to maintain a state of balance

1) **Homeostasis**: a state of physiological equilibrium or stability.
   - Each physiological process has a SET POINT of operation that is considered normal (optimum)

2) **Arousal Theory of Motivation**: 
AROUSAL: overall level of activation

3) **Cognitive Dissonance**: a state of tension when we hold inconsistent cognitions
   -> motivated to bring about a change in our cognitions
II. PHYSIOLOGICAL BASED DRIVES
A) Temperature Regulation:
   Hypothalamus:

B) THIRST AND DRINKING BEHAVIOR:
   Internal, Physiological Cues
   External, Psychological Cues

C) HUNGER AND EATING BEHAVIOR: INTERNAL, PHYSIOLOGICAL CUES:
   Experience of hunger controlled by hypothalamus
   INTERNAL, Physiological Cues:
   (DUAL-CENTER THEORY)
   1) Lateral Hypothalamus: “feeding center”
      STARTS experience of hunger
   2) Ventromedial Hypothalamus (Ventromedial Nucleus of
      Hypothalamus): STOPS experience of hunger

Blood Sugar Levels:
   Fat Cells:

EXTERNAL, PSYCHOLOGICAL CUES:
1) Learned preferences & Habits can influence WHAT we eat
   and HOW MUCH we eat.
2) Food-Related Cues
3) Stress

D) EATING DISORDERS:
1. Anorexia Nervosa: (literally: loss of appetite - for
   nervous reasons)

2. Bulimia: a condition in which people have periods of
   excessive eating and then purge to remove the just eaten
   food.

3. PROGNOSIS:
• THE SEX DRIVE AND HUMAN SEXUAL BEHAVIORS •

I. SEX DRIVES AND SEXUAL BEHAVIOR:

Internal, Physiological Cues:
Sexual behaviors tied closely to physiology to hormonal levels. These are important in lower animals but as complexity increases role of internal cues become less certain.

External, Psychological Cues:
- Besides hormones, sex desires can be stimulated by a number of environmental cues (pictures, reading material)

II. BIOLOGICAL BASES OF HUMAN SEXUALITY
A. GENETIC BASES:

Zygote: a one-celled organism formed by the union of a sperm & egg. All other cells develop from this single cell.
- 23 pairs of chromosomes; 23rd will determined the sex of the person-to-be.

X and Y Chromosomes: neither do much by itself - work in pairs
Being Female:
Being Male:

B. HORMONAL BASES: sexuality maybe determined by chromosomes inherited at conception, BUT expression of sexuality requires action of sex hormones

Gonads: sex glands
**Testes:** when Y chromosome is present, gonads will be testes in males.

**Androgens:** Hormone produced by testes.
- Helps direct the development of male reproductive organs (penis, testes, & scrotum)
**Testosterone:** most important of the male androgens

**Ovaries:** when Y chromosome is absent, gonads will become ovaries in females.

Hormones Produced by the Ovaries:
- **Estrogen & Progesterone:** hormones produced by the ovaries.
  - Estrogen directs the development of female reproductive organs vagina, uterus, & ovaries

*** BOTH male & female sex hormones are produced by both male & female sex glands

### NORMAL SEXUAL DIFFERENTIATION

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### EXPERIMENTAL SITUATION

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- **Testes Removed**
- **Given Androgens (except for gonads which remain ovaries)**
ORGANIZATIONAL EFFECTS: of hormones produce permanent changes in the organization of sexual characteristics. For O.E. to occur these hormones must be present during a CRITICAL PERIOD in prenatal development.

ACTIVATIONAL EFFECTS: sex hormones activate latent sex characteristics or behaviors

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• THE PSYCHOLOGY OF EMOTION •

I. FOUR COMPONENTS TO AN EMOTIONAL REACTION:

1) Subjective feeling

2) Cognitive Reaction

3) Physiological Reaction - Visceral involving your glands, hormones, and internal organs.

4) Behavioral Reaction

Emotion: the subjective feeling, cognitive interpretation, physical reaction, and behavioral reaction.

II. Facial Feedback Hypothesis:

III. Cognitive Interpretation (Schacter & Singer, 1962)
Subjective appraisal of potentially stressful events

1) Familiarity
2) Controllability
3) Predictability

A. Stress: a response made to a perceived threat to one's well being.

B. Stressors: sources of stress, typically due to a perceived threat

C. THREE TYPES OF STRESSORS:
1) Frustration: occurs in any situation in which the pursuit of some goal is thwarted.

   Environmental: blocking of goal by something or someone in the environment

   Personal: personal or internal reasons for not obtaining a goal

2) CONFLICT:
   a) Approach-Approach Conflicts: a conflict that requires that a choice be made between two attractive goals.

   b) Avoidance-Avoidance Conflicts: a conflict that requires that a choice be made between two unattractive goals.

   c) Approach-Avoidance Conflicts: a conflict that requires that a choice be made about whether to pursue a SINGLE GOAL that has both ATTRACTIVE and UNATTRACTIVE aspects.

   d) Multiple Approach-Avoidance Conflicts: number of alternatives each of which have positive and negative aspects at the same time.
3) **LIFE-CHANGE-INDUCED STRESS**
- Any noticeable alterations in one's living circumstances that requires readjustment

Social Readjustment Rating Scale (SRRS):

D. **HARDY PERSONALITIES:**
1) Challenge:

2) Control:

3) Commitment:

E. **General Adaptation Syndrome (GAS):**
1) Alarm
2) Resistance:
3) Exhaustion:

F. **EFFECTIVE STRATEGIES FOR COPING WITH STRESSORS**
1) Identify the Stressor

2) Remove or negate the stressor

3) Reappraise the situation

   **Cognitive Reappraisal:** rethinking a stressful situation in a more positive way

4) Inoculate against future stressors
5) Learn techniques of relaxation
   - Biofeedback:
6) Engage in physical exercise
7) Seek social Support
INEFFECTIVE STRATEGIES FOR COPING WITH STRESSORS

Fixate

Frustration-aggression hypothesis:

• HEALTH PSYCHOLOGY •

TYPE A behavior Pattern (TABP):

1) Time Urgency

2) Chronic Activation

3) Multiphasia

TYPE B behavior Pattern:

HELPING PATIENTS “FOLLOW DOCTOR’S ORDERS”