

HLTH 230 Exam I:

1) **Leading Causes of Death:**

- During the 20th century the leading causes of death changed from infectious disease to those that relate to unhealthy behaviors and life style. Treatments were developed but were expensive. Definition of health changed → health as the presence of positive well-being, not merely the absence of disease.
- Chronic Diseases became the leading killers in US (before it were infectious diseases – related to community health problems).
- Last years of 20th century deaths from chronic diseases related to lifestyle began to decrease, while deaths not related to behaviors began to increase (CS and info?). The causes of death that are decreasing are those associated with mortality among young and middle-aged people, whereas those that are increasing are more likely to strike older people.

- Leading Causes of Death 1900 (US):

Pneumonia 11.8%	Pneumonia/flu
Tuberculosis 11.3%	Tuberculosis
Diarrhea and enteritis 8.3%	Gastroenteritis
Heart disease 6.2%	Heart Disease
Liver disease 5.2%	Stroke
Injuries 4.2%	Nephritis
Cancer 3.7%	Accidents
Senility 2.9%	Cancer
Diphtheria 2.3%	Diseases of infancy
	Diphtheria

- Leading Causes of Death 2003 (US):

Heart Disease 28%	Heart Disease
Cancer 22.6%	Malignant Neoplasm
Stroke 6.4%	Cerebrovascular disease
Chronic lower respiratory disease 5.1%	Chronic Lower Res Disease
Injuries 4.3%	Unintentional Injuries
Diabetes Mellitus 3%	Diabetes Mellitus
Influenza and Pneumonia 2.6%	Influenza and Pneumonia
Alzheimer 2.6%	=
Kidney disease 1.7%	=
Septicemia 1.4%	=

- Actual Causes of Death in US 2000:

Tobacco
Poor Diet and Physical Inactivity
Alcohol Consumption
Microbial Agents
Toxic Agents

Motor Vehicle
Firearms
Sexual Behavior
Illicit Drug Use

- **Leading Causes of Death in US among adults (2002):**
 - Cardiovascular disease 3.8% (15 – 24) and 18.6% (35 – 44)
 - Cancer 5.2% (15 – 24) and 17.6% (35 – 44)
 - Suicide 12.1% (15 – 24) and 7.5% (35 – 44)
 - Homicide 15.7% and 3.5%
 - HIV 0.5% and 6.2%
 - Unintentional injuries (accidents) 46.6% and 18.3%
- Within the US ethnicity is a factor in life expectancy, and the leading causes of death even show some variation among ethnic groups. The dramatic life expectancy difference between European and African Americans does not apply to Hispanic Americans, although they have socioeconomic disadvantages similar to African Americans, including poverty and low educational level, both of which have health consequences → poorly understood.

2) Life expectancy – groups with highest and lower

- 20th century life expectancy rose dramatically in US and other industrialized nations (around 30 years).
- Factors → Control of many infectious diseases through vaccination and safer drinking water and milk supplies; healthier life style; more efficient disposal of sewage and better nutrition and medical advances (played a minor role though). The single most important contributor was the lower of infant mortality (when infants die before their first birthday, these deaths lower the population's average life expectancy much more than do the deaths of middle-aged or elderly people – substantial statistical impact).
- Unfortunately, it doesn't apply for all ethnic groups: African American infants are nearly three times as likely as European Americans infants to die in infancy. Again, Hispanic Americans have about the same rate of European Americans despite the social- econ disadvantages.
- People who go to college have lower death rates than those who do not enroll (Education provides an overall health advantage). Factors → higher income, health knowledge, attitudes about the importance of health and positive health habits
- Female has higher life expectancy than males

4) Public Health Surveillance – definition and the 5 D's (6 D's)

- Death – mortality
- Disease – morbidity (Incidence/Prevalence)

- Disability – impairment (total X partial; permanent X temporary)
- Discomfort – pain, distress (e.g. PTSD)
- Dissatisfaction – anger, disillusionment (disappointment/desilusão), stress
- Dollars – direct and indirect \$ value of health problems

5) Prevalence and Incidence

- Prevalence: refers to the proportion of the population that has a particular disease at a specific time.
- Incidence: measures the frequency of new cases of the disease during a specific period, usually 1 year.
- The number of people at risk in the population is divided into either the number of people with the disease (prevalence) or the number of new cases (incidence).
- Short duration diseases: the incidence will exceed the prevalence and vice-versa.

6) Placebo effect and Nocebo effect

- Placebo effects: is an active substance or condition that has the appearance of an active treatment and that may cause participants to improve or change due to the belief in the placebo's efficacy.
- Placebo is a problem to determine what effects are due to treatment and which are due expectation. Thus, placebo has treatment benefits but research drawbacks).
- Placebo is related to characteristics of the physician: positive expectations, reputation, attention, interest and concern.
- Placebo is also related to the type of treatment: bigger pills, colored pills, more doses, injection or surgery are related to higher placebo effects.
- Placebo has physical and psychological basis. Underlying physiological mechanisms for placebo responses are the same as for drug treatments. Placebo can cure or reduce symptoms, can alter Nt and hormones, producing a variety of perceptual, behavioral and physical effects.
- Placebo is not only improvement but includes any change resulting from receiving a treatment.
- People act in the ways they think they should, which are influenced by their personal histories of treatment and cultural beliefs of what constitutes an effective treatment. Thus, through classical and operant conditioning, people can learn to anticipate certain effects of the treatment. (Both expectancy and learning contributes to placebo effects).
- The placebo can be a valuable adjunct to the treatment and in most situations involving treatment patient's improvements may be a combination of treatment plus placebo effect (indistinguishable).

- For a treatment to be effective, it must show a higher rate of effectiveness than that produced by a placebo → double blind is the strategy of placebo research to distinguish treatment and placebo effects. But sometimes is not possible (ex behavioral treatments), then single blind is the option.
- Use of placebo in clinical studies is controversial and some professionals consider the use of ineffective treatment ethically unacceptable (especially in the cases of surgery).
- Nocebo effects: Placebo is also capable of producing adverse effects, called nocebo effects. Nocebo are, sometimes, the same symptoms as the drug side effects.

7) Research Methods

- When people know how researchers go about establishing which behaviors are healthy and which are harmful, those people become more knowledgeable in evaluating evidence to make personal health decisions.

• Correlational studies:

- Useful especially when scientists are interested in what factors predict or are related to either disease or healthy functioning (relationship between two variables). Do not determine causation between the variables.
- A type of descriptive research
- Small correlations can be statistically significant if they are based in a very large number of scores. However, small correlations offer the research very little ability to predict.
- Shows risk factors for diseases: risk factor is any charact or condition that occurs with grater frequency in people with a disease than in people free form that disease.

• Cross-sectional and longitudinal studies:

- Approaches used to study developmental issues.
- Cross sectional studies are those conducted at only one point in time. Investigator studies a group of people from at least two different age groups to determine the possible differences between the groups on some variable of interest.
- Longitudinal studies follow participants over an extended period. Assess the same people over time, which allows researchers to identify developmental trends and patterns. However, they take time, require a large team of researchers and are more costly.

• Experimental Designs:

- Comparison of at least 2 groups: the experimental group (that receives the IV) and the control group (don't receive IV). To determine the influence of the IV in the DV is important that

experimental and control groups be identical in all the other charact except for the IV, to assure this → random assignment.

- The IV has a cause and effect in the DV.
- Can have ethical issues cause some variables is not ethical to manipulate (especially in humans).

• **Ex Post Facto Design:**

- One type of quasi experimental studies.
- Involve contrast groups to determine differences, but do not involve the manipulation of IV. Instead, researchers choose a variable of interest and select participants who differ in this variable, called a subject variable (or participant variable).
- The groups are not assigned randomly.
- Cannot infer causal relationships between variables, however, can yield useful info, making this type of study a choice for many investigations.
- It's quite common because researchers are often interested in investigating variables they cannot manipulate.

8) Research Methods in Epidemiology

- Epidemiology is a branch of medicine that investigates factors contributing to increased health or the occurrence of a disease in a particular population (study of distribution and determinacy).

• **Observational Methods:**

- Similar to Correlational studies in psyc.
- Used to look at and analyze the occurrence of a specific disease in a given population.
- Do not show causes of the disease, but researches can draw inferences about possible factors that relate to the disease.
- Two types: Prospective studies begin with a population of disease free participants and follow them over a period of time to determine whether a given condition is related to later condition (similar to longitudinal studies); and Retrospective studies begin with a group of people already suffering from a particular disease or disorder and then look backward for charact or conditions that marked them as being different from people who do not have that problem (do not take as much time as money than prospective studies).

• **Randomized, Controlled trials:**

- Similar to experimental studies in psyc.

- Participants are randomly assigned to study group or control group, thus making the two groups equal on all pertinent factors except the variable being studied. Other variables than those being study must also be controlled to prevent them to affect the outcomes.
- Ex: clinical trials, which test effects of new drug or medical treatment.
- Gold standard: randomized, placebo-controlled and double-blind trials.

• **Natural Experiments:**

- Similar to ex post facto designs in psyc.
- The IV can only be selected but not manipulated.
- Study of natural conditions that provide the possibility of comparison.

9) Internal validities – threats:

- Validity is the extent to which an instrument measures what it is designed to measure. It's a true measure of the phenomena.
- An instrument capable of predicting is said to have predictive validity.
- Psychologists determine the validity of a measuring instrument by comparing scores from that instrument with some independent or outside criterion, that is, a standard that has been assessed independently of the instrument being validated (ex. Future event, such as a diagnosis of heart disease).
- In self reports that measures behaviors that involve stigma there is a tendency to over report or minimize the behavior (depending on if it's positive or negative). One of the things that help increasing the validity of self reports is anonymity. However, when you need to identify the participant, because of follow up, then the trust of the institution play a role (credibility) and certificate of confidentiality.
- Types of validity: face (the extent to which the instrument appears to be measuring what it's supposed to measure); content (the extent to which an instrument sample items from the full depth and breadth of the content desired – all the different aspects of the phenomena are being covered); criterion (the extent to which an instrument correlates with another more accurate and usually more expensive → concurrent: criterion administered at the same point in time and predictive: criterion administered at some later point after instrument); *construct* (the extent to which the instrument correlates with other measures in predicted ways, but in this case there's no gold standard → convergent: the measures correlates well with items with which it is predicted to; discriminant: the measure does not correlate with items it's not expected to).
- Threats to internal validity: history (specific events other than the program that could have influenced the change); maturation (natural developmental changes over time); testing (changing someone by pre testing them – e.g. reactive measurements. Ex you can turn from a pre contemplator to a contemplator); instrumentation (change in the sensitivity of the dependent measure – com o tempo o

instrumento tem que ser revisto, pois vai perdendo a sensibilidade); regression (tendency for extreme scores to become less extreme over time – tendency towards the mean).

10) Reliability

- Consistency or repeatability of response. It's the extent to which it yields consistent results.
- Necessary but not sufficient for validity, reliability sets the upper bound for validity.
- High reliability coefficient is from 0.8.
- Examples: Temporal stability (test retest), internal consistency (inter item correlation) and comparing ratings obtained from 2 or more judges observing the same phenomenon (inter rater reliability).

11) Stages of Change Model – Prochaska (Intrapersonal).

- Pre contemplation has no intention of taking action within the next six months (Very common between adolescents).

Potential change strategies: Increase awareness of need for change; personalize info about risks and benefits. (Are you thinking in changing your drinking behavior? Do you think your drinking behavior is a problem). Here is important to personalize the info so the audience can know they are group risk. They need to believe they are personally likely to get this, that it's not an abstraction but reality. A estratégia para intervir aqui tem que ser mais forte, impactante, pessoal.

- Contemplation: Intends to take an action in the next six months. (ex most adult smokers). Health Behavior Model works better in this stage.

Potential change strategies: motivate, encourage making specific plans. Here people are seeking for what can help them. One of the strategies would be giving them the array of options they have.

- Preparation: Intends to take an action within the next thirty days and has taken some behavioral steps in this direction.

Potential change strategies: Assist with the developing and implementing concrete action plans; help set gradual goals, this people are already looking for info (Have you made a commitment to change?).

- Action: Has changed behavior for less than 6 months.

Potential change strategies: Assist with feedback, problem solving, social support and reinforcement (Did you already go to AA meeting?). You wanna get the person into treatment as quick as possible, because the less time between preparation and action the better prognosis. In this stage they need a lot of emotional and social support. Maybe have the help of a peer who already have been in this stage but now is recovered. A significant other may be very helpful.

- Maintenance: Has changed behavior for more than 6 months (o maior problema aqui é continuar por um ano sem o comp, a partir daí já opde dizer que tá mais estável).

Potential change strategies: Assist with coping, reminders finding alternatives, avoiding slips/relapses (How long have you binge drinking free?). Here you can teach the Behavioral Tailoring: you show the person how to do smtg automatically , part of your life and routine – tornar aquilo um hábito e até uma atividade prazerosa (Ex changing social environment, getting a dog to walk with). Important also to show the person that relapses are common and it doesn't mean that they are not in the maintenance anymore.

OBS: An individual can go back and forth within these stages. And different people need different strategies, that's why is imp to divide the groups intervention in subgroups, according to certain charact (demographic, geographic, psychological, etc). The kind of intervention is always related to the setting (clinical, community health etc).

12) Ecological Model of Health Behavior Theories

- Intrapersonal level: Individual charact that influence behavior, such as knowledge, attitudes, beliefs and personal traits (Ex type A personality).
- Interpersonal level: Interpersonal processes and primary groups, including family, friends and peers that provide social identity, support and role definition. Behavior doesn't exist in a social vaccum, but behaviors influence other people behaviors.
- Organizational (Community level): Institutional factors, rules, regulations, policies, and informal structures, which may constrain or promote recommended behavior (Ex company's policies).
- Community factors: Social networks and norms, or standards, which exists as formal or informal among individuals, groups and organizations.
- Public Policy: Local, state and federal policies and laws that regulate or support healthy actions and practices for disease prevention, early detection, control and management.

OBS: Reciprocal determinants → we influence our social environment and we are influenced by it.

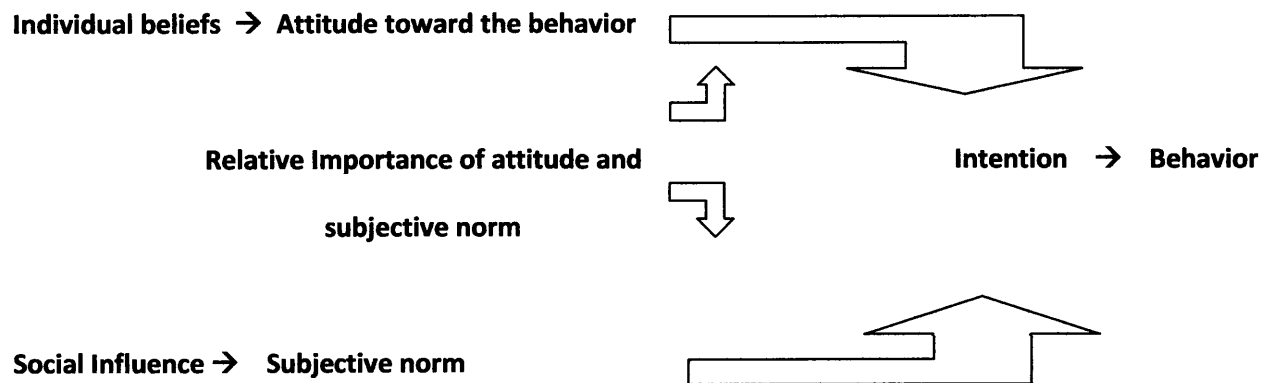
13) Theory of Reasoned Action:

- Assumes that people are quite reasonable and make systematic use of info when deciding how to behave; they think about the outcome of their actions prior to their decision to engage or not engage in a particular behavior. People's behavior is directed towards a goal or outcome and people freely choose those actions that they believe will move them in the direction of that goal.
- The immediate determinant of behavior is the intention to act or not. Intentions, in turn, are shaped by 2 factors: one's attitude towards the behavior (personal evaluation of the behavior) and one's subjective norm (one's perception of the social pressure to perform or not the action).
- One's attitude towards the behavior is determined by beliefs that the behavior will lead to positively or negatively valued outcomes.

- One's subjective norm is shaped by one's perception of the evaluation that a particular individual or groups of individuals places on that behavior and one's motivation to comply with the norms set by that individual.

- This theory is useful to predict unsafe and safe (as effective as health belief model) behavior.

- Beliefs → Attitudes → Intention → Behavior



14) Theory of Planned Behavior

- Extension of theory of reasoned action to include the concept of perceived behavioral control.

- The more resources and opportunities people believe they have the stronger are their beliefs that they can control their behavior. Perceived behavioral control is the ease or difficulty one has in achieving desired behavioral outcomes; it reflects both past behaviors and perceived ability to overcome obstacles. People who believe they can easily perform a behavior are more likely to intend to perform that behavior than people who believe they have little control over performing that behavior.

- Predictions of behavior can be made from knowledge of people's attitude toward the behavior, their subjective norm and their perceived behavioral control. All these components interact to shape people's intention to behave.

- Behavioral intention: perceived likelihood of performing behavior.

Measurement approach: Are you likely to perform the behavior (what, where, when → the more specific u are better to predict behavior).

- Attitude: Personal evaluation of the behavior.

Measurement approach: Do you see the behavior as good, neutral, bad, satisfying, acceptable etc?

- Subjective norm: beliefs about whether key people approve or disapprove of the behavior; motivation to behave in a way that gains their approval.

- Perceived Behavioral Control: belief that one has and can exercise control over performing the behavior.

Measurement approach: Do you believe you would be successful trying to change your behavior?

15) Health Belief Model (Intrapersonal model)

- Sometimes people engage in health behavior cause its positive (Positive approached oriented rather than avoidance oriented).

- Assumes that beliefs are important contributors to health seeking behavior. This model includes four beliefs that should combine to predict health related behaviors: perceived susceptibility to disease or disability; perceived severity of the disease or disability; perceived benefits of health enhancing behaviors; perceived barriers to health enhanced behaviors.

- Several factors can reduce the ability of this model to make accurate predictions: perceived health risks may override perceived benefits to prevent people from seeking health care or adopting a healthy life style; another factor that affects people's beliefs about health care is their level of optimism, which is not include in the original model; perceived personal control (= internal locus of control) also affects people's health behavior and it's not include in the model; age is another factor and it's not considered by the model, young people are often unrealistically optimistic about their medical symptoms, but elder people are more likely to attribute their symptoms to age; poverty is also a factor, which sometimes can be more predictive than health belief model and also ethnic background is a factor not considered.

- One way to improve this model and the capacity of predicting who will seek health care is including the influence of unrealistic optimism and irrational beliefs about the risk of health care procedures. Also including concepts such as personal control, perceived risks, intentions to behave, perceived social norms and self efficacy. Some researchers have combined aspects of health belief model with other models, including the theory of reasoned action.

- Perceived risk susceptibility: Beliefs about the chances of getting a condition. People who feel more vulnerable are more likely to engage in protective behavior.

Potential changes strategies: Define what populations are at risk and their level of risk; tailor risk info based on individual's charact and behaviors; help the individual develop an accurate perception of his or her own risk.

- Perceived severity: Beliefs about the seriousness of a condition and its conseq, the more severe the threat is perceived as, the more likely people will engage in protective behavior.

Potential changes strategies: specify the conseq of a condition and recommended action.

- Perceived benefits: beliefs about the effectiveness of taking action to reduce risk or seriousness.

Potential changes strategies: Explain how, where and when to take action and what the potential positive results will be.

- Perceived barriers: beliefs about the material and psyc costs of taking actions.

Potential changes strategies: Offer reassurance, incentives and assistance, correct misinformation.

- Cues to action: factors that active readiness to change.

Potential changes strategies: provide “how to” info, promote awareness and employ reminder system.

- Self efficacy: confidence in one’s ability to take action.

Potential changes strategies: Provide training and guidance in performing action; use progressive goal setting; give verbal reinforcement; demonstrate desired behavior (modeling); show people (visual learning); bake the task down in small units.

OBS: In general, our generation is much more health cs and health is much more a priority issue than in the past.

16) Precaution Adoption Process Model

- Assumes that when people begin new and relatively complex behaviors they go through several stages of belief about their personal susceptibility. People do not move inevitably from lower to higher stages and they may even move backwards.

- People move through 7 stages in their readiness to adopt health-related behavior: stage 1 people have not heard of the hazard (risk, danger) and thus are unaware of any personal risks; stage 2 they are aware of the hazard and believe that others are at risk, but they hold an optimistic bias regarding their own level of risk; stage 3 people acknowledge their personal susceptibility and accept the notion that precaution would be personally effective, but they have not yet decided to take an action. Stages 4 and 5 are critical, in stage 4 people decide to take an action, whereas in the parallel stage 5, people decide that action is unnecessary. Some people who branch off to stage 5 may later return to stage 4 and decide to take appropriate action. In stage 6 people have already taken the precautions aimed at reducing risks. Stage 7 involves maintaining the precaution if needed.

- Before people take action they must first perceive that the relative benefits of the precaution outweigh the costs. Interventions that require low effort tend to be more effective.

- Barrier to health protective behaviors change from stage to stage.

17) Social Learning Theory – Bandura (Social Awareness theory)

- A social cognitive theory that assumes that humans have some capacity to exercise limited control over their lives. That is, they use their cognitive process for self regulation.

- Human action results from an interaction of behavior, environment and person factors, especially cognition.

- Reciprocal Determinism the dynamic interaction of the person, behavior and the environment in which the behavior is performed (I influence and I am influenced by my environment, so the change of both is imp).

Potential change strategies: consider multiple ways to promote behavioral change, including making adjustment to the environment or influencing personal attitudes.

- Self efficacy is the confidence in one's ability to take action and overcome barriers, control over his own functioning and over environmental events. In other words, it is the people's confidence that they can perform necessary behaviors to produce desired outcomes in any particular situation.

Potential change strategies: approach behavior change is small steps to ensure success, be specific about the desire to change. Self efficacy can be acquired/enhanced/decreased in 4 ways: performing or enacting a behavior; vicarious exp or seeing another person with similar skills perform a behavior; verbal persuasion or listening to the encouraging words of a trusted person and physiological arousal states, such as feeling of anxiety, which ordinarily decreases self-efficacy.

- Behavioral capability which is the knowledge and skill to perform a given behavior.

Potential change strategies: Promote mastery learning through skills training.

- Expectations involve anticipated outcomes of a behavior.

Potential change strategies: Model positive outcomes of health behavior.

- Observational Learning (modeling) is the behavioral modeling (seeing other people's behavior). The way other people behave has a huge impact in the way we behave. Ex media is a big power of modeling behavior.

19) Stress – Dr. Hans Seyle

- He researched the effects of stress on physiological responses and tried to connect these reactions to the development of illness.

- He first considered stress to be a stimulus and focused attention on the environmental conditions that produce stress. Just later he changed his focus to stress as a response that the organism makes. To distinguish the two he started using the term stressor to refer to the stimulus and stress to mean the response.

- Stress → nonspecific response (general physical response), no matter what kind of situation prompts the response it will always be the same.

20) General Adaptation Syndrome (Seyle's)

- The body's generalized attempt to defend itself against noxious agents became known as the General Adaptation Syndrome (GAS)

- 3 stages: Alarm reaction (body's defenses against a stressor are mobilized through the activation of the sympathetic nervous system; adrenaline (epinephrine) is released, as a short term response to an emergency situation; these physical reactions are adaptive but many modern stress situations involve prolonged exposure to stress and do not require physical action). Resistance stage is the stage in which the organism adapts to the stressor; how long this stage lasts depends on the severity of the stressor and the adaptive capacity of the organism. If the organism can adapt, the resistance will continue for a long time. During this stage, the person gives the outward appearance of normality, but physiologically the body's internal functioning is not normal. Continuing stress will cause continued neurological and hormonal changes. In this stage people can develop *Diseases of Adaptation*, which are diseases related to continued, persistent stress. Seyle considered peptic ulcers, ulcerative colitis, hypertension and cardiovascular disease, hyperthyroidism and bronchial asthma, changes in the immune system). Exhaustion stage: the capacity to resist to stress is finite and this is the final stage. At the end the ability the organism's ability to resist is depleted and a breakdown results. This stage is charact by the activation of parasympathetic, but in this stage parasympathetic functions at an abnormal low level, causing a person to become exhausted. Seyle believed that exhaustion frequently results in depression and sometimes even in death.

- Evaluation of this model: Focus in the stimulus based view of stress; in considering stress as a set of physical responses, Seyle largely ignored psychological factors, including the emotional component and the individual perception and interpretation of stressful events.

21) Diathesis-Stress model

- Suggests that some individuals are vulnerable to stress-related diseases because either genetic weakness or biochemical imbalance inherently predispose them to those diseases. In other words, some people are predisposed to react abnormally to environmental stressors.

- This predispositions (diathesis) is usually thought to be inherited through biochemical or organ system weakness, but some theorists have also included acquired propensities as components of vulnerability. Whether inherited or acquired the vulnerability is relatively permanent. What varies over time is the presence of environmental stressors, which may account for the waxing and waning of illnesses.

- Diathetic individuals respond pathologically to the same stressful conditions with which most people can easily cope.

- The disease doesn't flow from an interaction between personality and stress but rather form an interaction of personal physiology and stress.

- The model can predict why event scales are so inconsistent in predicting illness. Person's vulnerability (diathesis) must be considered along with stressful life events in predicting who will get sick and who

will stay well; it allows for a great deal of individual variability in who gets sick and who stays well under conditions of stress.

22) Compliance with medical advice (adherence) – Who is more likely?

I) Disease charact:

A) Severity of illness does not have a strong relationship with medical compliance, but the pain with the illness and the interference in appearance has negative correlation with compliance.

B) Side effects of the medication: negative correlation with compliance.

C) Complex treatment procedures: negative correlation with compliance.

II) Personal factors:

A) Increasing age: curvilinear relationship (children/adolescent and elder people less adherence).

B) Gender: few differences in the overall adherence rates of women and men, but some differences exist in following specific recommendations. However the overall effect for gender is small and not significant in most cases.

C) Personality patterns: noncompliant personality → situations not personality influences adherence, noncompliance is not a global personality trait but is specific to a given situation.

D) Emotional Factors: stressful life events, anxiety and depression decreases compliance. Optimism increases adherence.

E) Personal beliefs: self efficacy and feelings of control increases compliance, no confidence in the treatment decreases.

III) Environmental factors:

A) Economic factors: low income decreases compliance; no health insurance decreases prescription filing and refilling.

B) Social Support: low social support among adolescents, living alone decreases and emotional support increases.

C) Cultural Norms: Belief in traditional healers, physician's stereotype of African Americans and low income patients, physician's disrespect of African Americans, Hispanic Americans and Asian Americans decreases. Acculturation to Western culture increases.

IV) Practitioner/Patient Interaction:

A) Verbal Communication: poor verbal communication, failing to receive expected info and problems with language or terminology decreases compliance. Agreement about treatment increases.

B) Practitioner's personal qualities: patient's confidence in physician's competence and friendliness increases compliance. Practitioner disrespect decreases. Females doctors provide more info.

23) Primary X Secondary appraisal – Dr. Lazarus

- People have 3 kinds of appraisal (avaliação) to assess situations: primary appraisal is not necessarily first in importance but first in time. When people first encounter an event they appraise in terms of its effect on their well being. They may view the event as irrelevant, benign-positive (good implication) or stressful (harmful, threatening or challenging). After their initial appraisal to an event, people form an impression of their ability to control or cope with harm, threat or challenge, this process is called secondary appraisal (What options are available to me? What is the likelihood I can successfully apply the necessary strategies to reduce this stress? Will this procedure work (alleviate my stress)? When people believe they can do something, successfully cope with the situation – stress is reduced. The third kind is reappraisal which is imp cause appraisals change constantly as new info becomes available.

24) Psychosocial factors that influence the stress response and immune function (e.g caretakers of Alzheimer's patients)

- Cataclysmic event: sudden, unique and powerful single life-events requiring major adaptive responses from population groups sharing the exp. Factors that contribute to level of stress: physical proximity to the vent, time elapsed since the event and the intention of the perpetrators.

- Life events: Focus in the change, when people are required to make some sort of change or readjustment, they feel stressed. Life events are not always unpleasant but they require adaptation.

- Daily Hassles: Are part of daily life. Although some hassles are rare and occasional, others are repetitive, chronic, and often beyond personal control. The stress brought on by daily hassles can originate from both the physical (urban life, pollution, noise, crowding, poverty) and the psychosocial environment (discrimination, workplace – high demands, high complexity and low control, personal relationships).

25) Hardy personality

- Grew out of existential personality theory, which emphasizes the idea that authentic, psychologically health people do not passively accept their fate, but rather seize and maintain control of their life.

- Hardiness buffers the harmful effects of stress and thus protects the hardy personality from stress-related illness.

- Stronger sense of commitment to self, demonstrate control over their lives, viewing readjustments as a challenge rather than a stress is charact of hardy personality and decreases the probability of stress related disease.

- Research findings on the health protective power of hardiness have been mixed. The concept may apply to men more than women and to workplace experiences rather than social situations.