CHAPTER I

INTRODUCTION
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The relationships among psychological, social, environmental factors and illness have interested medical and social scientists for a long time. This interest has spurred researchers - spanning several academic disciplines - to try and identify the processes by which 'stress' acts as a precursor to a broad range of psychological and physical disturbances. There are, however, "...almost as many definitions of stress as there have been researchers" (Warheit, 1979) and, according to Mason (1975), "... the single most remarkable fact concerning the term 'stress' is its persistent, widespread usage in biology and medicine, inspite of almost chaotic disagreement over its definition". Terms like 'stress', 'distress', 'crisis', 'hardship', 'difficulty' and 'strain' have often been used interchangeably. 'Stress' has been used to denote a stimulus, a response and as an intervening construct. Eisdorfer (1977), refers to stress as a "'riddle, wrapped in an enigma, wrapped in more of the same'".

Historically, the seminal work of Selye (1956) was responsible for popularizing the concept of stress. He
defined stress, from a physiological perspective, as "the
non-specific response of the body to any demand" and postu-
lated the well-known General Adaptation Syndrome (GAS). In
the psychological tradition, to name a few, Cannon (1929)
observed the nature of bodily changes to emotions, Dunbar
(1943) stated that personality constellations were associated
with specific psychosomatic disorders and Alexander (1950)
related specific emotional conflicts to disorders in organ
function. The 'life chart', a device for organizing medical
data as a dynamic biography, was introduced by Meyer (1951).
Life situations, and patients' emotional responses to them,
were considered to have a bearing on the illness. This was
followed by the work of Hinkle and Wolff (1957, 1958) who
studied the links between stress and illness.

The area of stress was first given formal recognition
at the 1949 conference on 'Life Stress and Bodily Disease'
sponsored by the Association for Research in Nervous and
Mental Diseases. It provided the necessary impetus for an
era of research, especially in the fields of medicine and
the social sciences. The effects of 'laboratory-induced'
stress on animals and human beings; acute, discrete stressors
like bereavement and divorce, stress preceding natural
calamities and chronic stressors were extensively studied.

Pioneering work in the development of methodology
for the assessment of life event stress was done by Holmes
and Rahe (1967). Defining stress in terms of life events,
whose advent was indicative of or required "significant change in the ongoing pattern of the individual", they attempted to quantify the impact of these life changes on individuals. Their research culminated in the development of the Social Readjustment Rating Questionnaire (SRRQ) and its variants, the Social Readjustment Rating Scale (SRRS), the Schedule of Recent Experience (SRE) and the Recent Life Change Questionnaire (RLCQ). These scales provide numerical estimates of the average degree of life change and readjustment that subjects assign to life events. Following the Holmes and Rahe model, several other researchers generated life events scales, each adopting his or her own concept of stress in terms of life crises (Antonovsky and Kats, 1967), social exits and entrances (Paykal, Myers, Dianelt, Klerman, Lindenthal and Pepper, 1969) undesirable and uncontrollable events (Gersten, Langner, Eisenberg and Orzech, 1974; Vinokur and Selzer, 1975) and many others (Perkins, 1982). Brown and Harris (1978) developed an elaborate structured interview method of eliciting life events which were rated for degree of 'contextual threat' by independent judges. The life event questionnaire, however, being an easy method of quantifying 'life stress' became increasingly popular and it is estimated that by the 1970's over one thousand publications appeared based on the SRRS alone (Holmes, 1979).

Results of both retrospective and prospective studies provide support for a relationship between life stress and a
variety of health related variables. Life stress, for example, has been found to be associated with sudden cardiac death (Rahe and Lind, 1971), myocardial infarction (Theorell, 1974), as well as other health problems such as tuberculosis, multiple sclerosis, diabetes and a host of other less serious physical conditions (Rabkin and Struening, 1976). In addition, life stress has also been correlated with psychiatric symptomatology (Dekker and Webb, 1974; Paykel, 1974). It has been found to precede the onset of schizophrenia, depression, suicide, anxiety and non-specific psychological distress (Barrett, 1979; Brown and Birley, 1968; Brown, Sklair, Harris and Birley, 1973; Cooper and Sylph, 1973; Dohrenwend and Dohrenwend, 1974; Lloyd, 1980, 1980a; Paykel, 1974). Life stresses, therefore, do not appear to be related to specific disorders, but seem to increase one's overall susceptibility to illness (Norman, McFarlane and Streiner, 1985). Eisler and Polak (1971) suggested that social stressors have generalized effects which may be expressed in varying symptomatology depending on the characteristic of the individual under stress. This viewpoint was supported by Rahe (1979) and Wyler, Masuda and Holmes (1971).

Conceptual issues and methodological problems have posed innumerable difficulties in the study of life events (Cleary, 1980, 1981; Dohrenwend, 1974; Monroe, 1982; Perkins, 1982; Tausig, 1982). Schroeder and Costa (1984) stated that substantive relationships that may exist between stressful
events and illness, are confounded by various forms of criterion-related and other measurement contamination in life event lists. Life event scales routinely contain items that reflect the physical and psychological condition of respondents. Items are often ambiguously worded and require subjects to exercise a considerable amount of recall and judgement in deciding, whether or not, a given event occurred. Moreover, individuals who are psychologically distressed may attribute their distress to external events and interpret, recall and report events in support of this attribution. Bartlett (1932) referred to this retrospective bias as an "effort after meaning". In spite of these and other methodological flaws, most studies have reported correlation coefficients between stress and illness in the range of .20 to .30. This sobering fact suggests that life stress accounts for approximately 10 per cent of the variance in the dependent measures (i.e., illness) employed. Rutter (1981) commented, that although it was "... still too early to completely bury the concept of stress. Nevertheless, it does seem that it has little use (and indeed is obfuscating) in its more general form ... it has served a purpose in drawing our attention to important phenomena, but now it is time to undertake a more discriminating analysis of the probably rather different effects of the various contrasting types of life event sometimes considered stressful...". Differential patterns and processes of reactions of individuals to apparently identical stressful stimuli pose an intriguing problem.
Antonovsky (1973) in a position paper, presented at the conference on 'stressful life events: their nature and effects', argued that if anything has been learned in the study of stressful life events, '...it is that what is important for their consequences is the subjective perception of the meaning of the event rather than its objective character'. He proposed that stress outcome was determined by an individual's psychological, social and cultural resources. Marked individual differences in susceptibility to stress made investigators realize the need to study the role of moderator or mediating variables in the stress-illness process (Harder, Strauss, Kokes, Ritzler and Gift, 1980; Johnson and Sarason, 1979; Rabkin and Straening, 1976; Rahe, 1978; Tennant and Andrews, 1978). The World Health Organization (W.H.O., 1981) working group which met in Sofia, Bulgaria in 1981 highlighted this aspect in its discussion.

From a simplistic, stimulus-response (S-R) model postulating a linear cause-effect relationship between stress and illness, the emphasis has shifted to a more complex stimulus-organism-response (S-O-R) model, wherein organismic variables provide a means for exploring and explaining individual differences. Personality resources, defined as the "'personality characteristics that people draw upon to help them withstand threats posed by events and objects in the environment'" (Pearlin and Schooler, 1978), and coping behaviour, "'the things people do to master, tolerate and
reduce "stress (Folkman and Lazarus, 1980), are but two of the numerous variables caught in the complex web of relation-

between stress and illness. According to Lazarus (1981)
stress itself as a concept, "pales in significance for adaptation" as compared to coping. How people cope with stress is more important than the frequency or severity of stress. Moreover, personality characteristics may predispose people to experience more stressful life events or to prefer certain ways of coping with stress.

In an attempt to accommodate the notions of person-
situation interaction, cognitive appraisal and individual differences within a coherent, interconnected and inter-
dependent theoretical framework, Lazarus, Averill and Opton (1974) have proposed a "three-way sources of variance model" to disentangle the complexities of individual variability in coping with stress. According to this model, the variation in coping behaviour is a function of three main sources: (a) types of coping responses (avoidance, information-seeking, etc.), (b) types of personal disposition (anxiety, belief, etc.) and (c) types of situational variables (physical danger, ego threat, etc.). Personality and coping are no longer "footnotes to stress theory", but have emerged in their own right as important variables determining the outcome of health

in response to stress.

No single personality characteristic can be the sole source that influences coping and, it seems reasonable to
assume that, several characteristics acting in conjunction, affect the resultant coping responses. At the same time, coping is not an unidimensional phenomenon, but includes diverse behaviours. Although, no clearcut taxonomy of coping exists, distinction among types of coping are important, for different styles of coping may differ in their antecedents and consequences. Studies to explore personality and coping behaviour are, therefore, essential to further our knowledge and understanding of the reciprocal influence of the person and the situation (Bandura, 1978).

Stress, then, is an universal phenomenon and change an inevitable part of modern life (Toffler, 1970). According to Selye (1974) 'life without stress is death'. All stresses, however, do not inherently possess a pathogenic quality. Caplan (1964), in his crisis theory, postulated that various life stressors provide pivotal points for mental health. If the crisis or stressful life event is managed by effective coping, the individual learns new coping behaviours and strengthens his emotional and problem-solving abilities. If inadequate coping methods are involved, deterioration in psychological functioning is likely to ensue.

Ilfeld (1976) suggested that current life events have great clinical and therapeutic potential as they are more amenable to change and correction. This viewpoint, shared by other clinicians, has gained wider acceptance by being incorporated into the Diagnostic and Statistical Manual (APA,
1980). Axis IV on the multiaxial classification is coded for 'severity of psychosocial stressors' and it is felt that 'this information may be important in formulating a treatment plan that includes attempts to remove the psychosocial stressor or to help the individual to cope with it'.

Stressful circumstances, do not take their toll on a passive individual, but on one who is struggling to control and master it. Efforts to understand the impact of stress on human adaptation will be heavily dependent upon the success with which mediating psychological processes are conceptualized (Holroyd and Lazarus, 1982). According to Andrews and Tennant (1978), the study of stressful life events alone is a 'doomsday exercise' because the loss of loved ones and reverses of fortune are life experiences that cannot be remedied by health services.

The study of personality and coping behaviour in relation to stressful life events, although fraught with methodological problems, seems to have considerable therapeutic utility. An attempt to explore the nature of these variables in an Indian sample is made in the present study.