

Mental and Physical Health

AP Psychology

Health Psychology and Stress

Health psychology studies how psychological factors affect physical health.

Stress is the process by which people appraise and respond to demands. A **stressor** is the demand itself. Prolonged stress can affect health and immune regulation. This does not mean every stress response causes illness or that stress is the only cause of a disease.

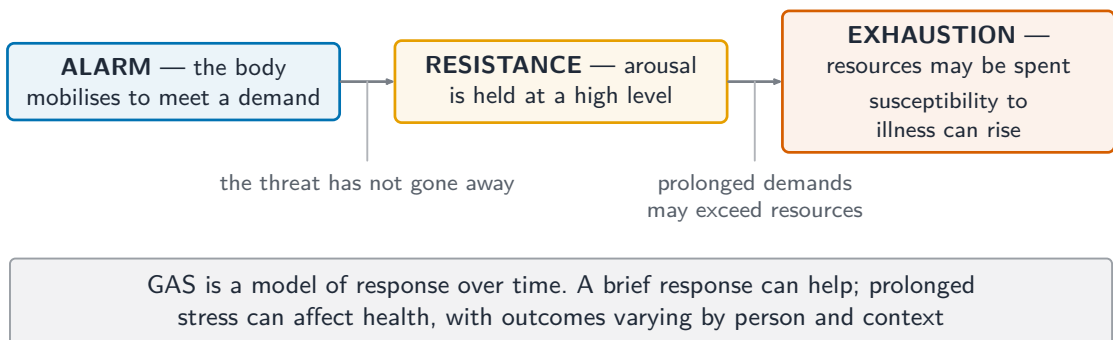
Stressors are not all alike:

- **Eustress** is motivating; **distress** is debilitating.
- Stressors range from **daily hassles** to **significant life changes** and **catastrophes**.

The **general adaptation syndrome (GAS)** describes the body's response in three stages: **alarm** (the sympathetic system mobilises), **resistance** (the body continues responding to a demand), and **exhaustion** (resources are spent and vulnerability to illness can rise).

Not everyone responds by fighting or fleeing. **Tend-and-befriend theory** - proposes that some people respond to stress by caring for others and seeking social support.

Coping takes two broad forms. **Problem-focused coping** treats the stressor as a problem to be solved and works on the cause; it suits situations a person can control. **Emotion-focused coping** manages the emotional reaction instead, which suits situations that cannot be changed.



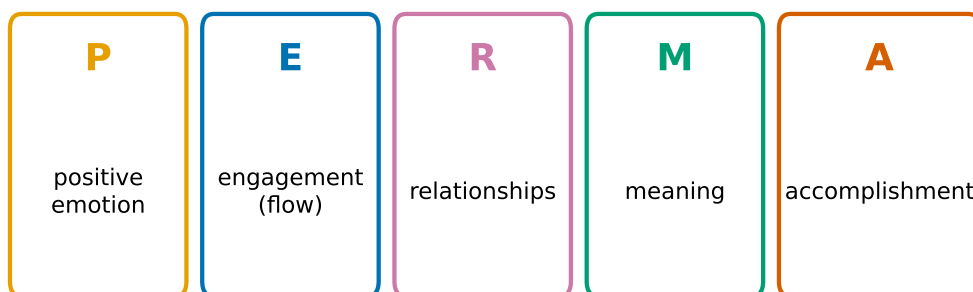
The GAS model traces alarm, resistance and exhaustion; outcomes depend on duration and circumstances

Positive Psychology

Positive psychology studies what makes life go well rather than what goes wrong. It looks for the factors behind **well-being** and **resilience**

Three findings are examinable:

- Expressing **gratitude** can support **subjective well-being**. Assess the design and outcome measure before interpreting a study.
- People who use their **signature strengths** report greater happiness and well-being. A self-report remains a subjective measure; an association alone does not prove causation. The CED groups character strengths around six virtues: wisdom, courage, humanity, justice, temperance and transcendence.
- **Posttraumatic growth** is positive psychological change that can follow a struggle with trauma. It is not inevitable and does not mean the trauma was beneficial or distress has ended.



positive psychology studies what helps people thrive, not only what goes wrong

The PERMA elements of wellbeing

Explaining and Classifying Disorders

The course uses three considerations when discussing disordered behaviour: the level of **dysfunction**, the person's **personal distress**, and **deviation from social norms**. Because norms differ between cultures and change over time, context matters. These considerations are not a checklist requiring all three, and being unusual alone is not a diagnosis.

Classifying a disorder has both benefits and costs. A diagnosis guides treatment and gives access to support, but a label can also carry **stigma** and change how a person is treated. Diagnosis requires specialised training and evidence-based criteria. The **DSM** and **ICD** provide classification frameworks; they do not by themselves establish why a particular person developed a disorder.

Most psychologists take an **eclectic approach** , drawing on more than one perspective:

- **Behavioral** : disorders come from maladaptive learned associations.
- **Psychodynamic** : from unconscious conflict.
- **Humanistic** : from a lack of acceptance and support.
- **Cognitive** : from maladaptive thought patterns.
- **Evolutionary** : considers behavior and mental processes in relation to adaptation and survival; an evolutionary proposal is not proof of a particular disorder’s cause.
- **Sociocultural** : from the person’s social and cultural setting.
- **Biological** : from physiological and genetic factors.

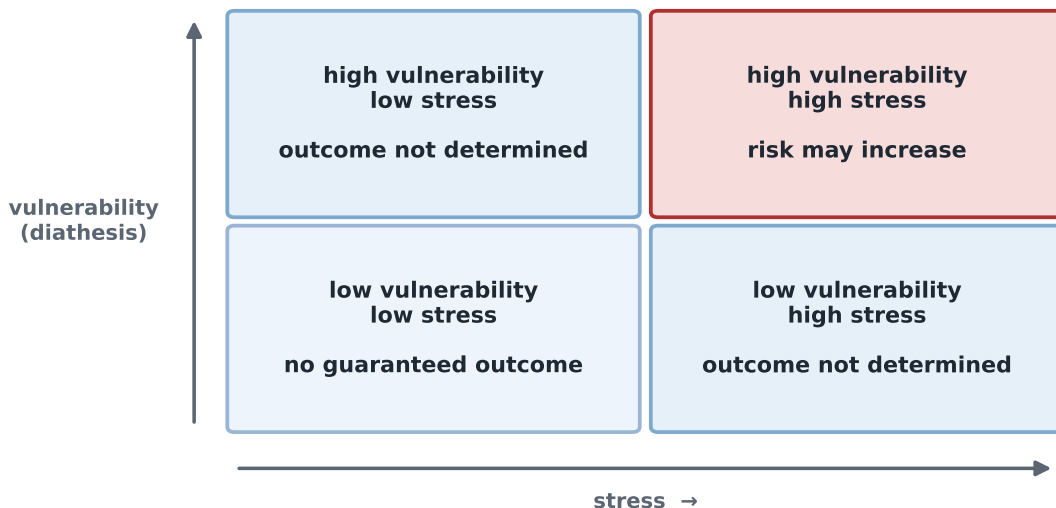
Two integrating models are examinable. The **biopsychosocial model** assumes any psychological problem may combine biological, psychological, and social causes. The **diathesis-stress model** - proposes an interaction between underlying vulnerability and stressful life experience. The CED emphasises genetic vulnerability. It is a model of risk, not a diagnostic formula or a guarantee that a person with both inputs develops a disorder.

CRITERION	WHAT IT ASKS	CONTEXT AND LIMIT
DEVIANCE	is it unusual in this culture?	an unusual talent is also unusual
DISTRESS	does it cause suffering?	some conditions cause the person none
DYSFUNCTION	does it impair functioning?	assess functioning in context
RISK ASSESSMENT	a separate clinical task	not a fourth diagnostic requirement

Consider distress, dysfunction and cultural context. These are not an all-three checklist; risk assessment is separate

Distress, dysfunction and cultural context inform assessment; risk assessment is a separate issue

Categories of Disorders



Vulnerability and stress interact; the diagram illustrates a model, not measured probabilities or a diagnosis

The CED names a limited set of categories, each with its own features and possible causes.

- **Neurodevelopmental disorders** begin during the developmental period. The CED selects ADHD (attention-deficit/hyperactivity disorder) and ASD (autism spectrum disorder); causes may involve environmental, physiological and genetic factors.
- **Schizophrenic spectrum disorders** involve **positive symptoms** - **delusions** (false beliefs), **hallucinations** (false perceptions), **disorganized thinking** - and **negative symptoms**, reductions in typical functioning such as **flat affect**. **Catatonia** concerns movement and responsiveness; do not classify every manifestation as a positive symptom.
- **Depressive disorders** involve sad, empty, or irritable mood with related changes in body and thinking that impair functioning. The CED selects major depressive disorder and persistent depressive disorder; a brief sad mood alone is insufficient.
- **Bipolar disorders** involve episodes of marked mood and activity change. Bipolar I includes **mania**; depressive episodes may occur but are not required for its definition. Bipolar II involves hypomanic and depressive episodes. Episodes need not follow a fixed alternating schedule (NIMH).

- **Anxiety disorders** involve excessive fear or anxiety: **specific phobia**, **agoraphobia**, **panic disorder** with **panic attacks**, **social anxiety disorder**, and **generalized anxiety disorder (GAD)**.
- **Obsessive-compulsive and related disorders** include OCD and hoarding disorder. In OCD, **obsessions** are intrusive unwanted thoughts, urges or images, and **compulsions** are repetitive behaviors or mental acts. They are not interchangeable, and related disorders do not all have an identical symptom pattern.
- **Dissociative disorders** involve dissociation from consciousness, memory, or identity, and can be associated with trauma or stress. The CED selects dissociative amnesia (with or without fugue) and dissociative identity disorder.
- **Trauma and stressor-related disorders** follow exposure to a traumatic event; **posttraumatic stress disorder (PTSD)** is the main example.
- **Feeding and eating disorders** involve altered consumption or absorption of food that impairs health or psychological functioning. The CED selects anorexia nervosa and bulimia nervosa.
- **Personality disorders** are enduring patterns and fall into three clusters: **Cluster A** the odd or eccentric, **Cluster B** the dramatic or erratic, and **Cluster C** the anxious or fearful.

The learning objectives ask for features and possible causes of the selected disorders. Explain the factor relevant to a question instead of attaching the same list to every category. Genetic or physiological vulnerability, learned associations, thinking patterns and social conditions can interact; a brief classroom vignette cannot establish a clinical diagnosis.

Treatment

Meta-analyses generally find psychotherapy effective, but outcomes vary with the intervention, condition, person and study. Evidence-based planning, cultural humility and a therapeutic alliance matter. The rise of effective **psychotropic medication** also changed care, reducing long hospital stays in favour of community treatment.

Clinicians must follow ethical principles such as avoiding harm, integrity and respect for rights and dignity, including **informed consent**, **confidentiality**, and working within their competence.

Therapies follow the perspectives above:

- **Psychodynamic therapies** use **free association** and dream interpretation to uncover unconscious material.

- **Cognitive therapies** use **cognitive restructuring** to examine maladaptive interpretations. **Fear hierarchies** organise feared situations by intensity and can support graduated exposure; the hierarchy alone does not identify a purely cognitive method.
- **Applied behavior analysis** applies conditioning principles, including **systematic desensitization** and **token economies**.
- **Cognitive-behavioral therapies**, such as **dialectical behavior therapy** and **rational-emotive behavior therapy**, combine both.
- **Person-centered therapy**, from the humanistic perspective, uses **active listening** and unconditional positive regard.

Hypnosis is effective for pain and anxiety, but research does **not** support its use to recover memories. Medications include **antidepressants**, **anxiety drugs**, **lithium**, and **antipsychotics**. Biological interventions also include **psychosurgery** and brain stimulation. **Transcranial magnetic stimulation (TMS)** is noninvasive magnetic stimulation; **electroconvulsive therapy (ECT)** induces controlled seizure activity under anaesthesia. ECT can be considered when other treatments fail or a rapid response is needed; it is not restricted to an absolute last resort (NIMH). Drug and procedure mechanisms, benefits and risks differ; medication response does not by itself prove a disorder's cause.

■ Complete original research practice

This is a fictional teaching study and dataset, not a published experiment or a past-paper extract. Eighty adult volunteers consented to a seven-day writing study. Researchers randomly assigned them to write either gratitude reflections or neutral daily descriptions for ten minutes each day. Participants were told they could withdraw, and reports used participant codes. On a 0–10 self-report well-being scale, the mean change was +0.8 in the gratitude group and +0.2 in the neutral group. No variability, significance test or follow-up data are supplied.

Attempt: Identify an ethical procedure using the study evidence. Calculate the difference in mean change. Explain what random assignment supports and one limit on the conclusion.

Worked check: Informed consent is evidenced by volunteers consenting before participation; withdrawal rights and coded reporting are also supplied procedures. The difference in mean change is $0.8 - 0.2 = 0.6$ scale points. Random assignment supports comparing the effect of the writing conditions within this study, but the supplied means alone do not establish statistical significance. Volunteer sampling, self-report and a short follow-up limit wider claims. Do not invent a procedure the paragraph does not report.

■ Applying concepts to scenarios

Coping task: A student has two demands: a revision timetable they can reorganise and a delayed result they cannot speed up. Propose one problem-focused and one emotion-focused response, explaining the target of each.

Worked check: Reorganising the timetable acts on a controllable source of pressure. Managing the emotional reaction while waiting, for example with a calming routine, targets distress. Both kinds of coping can be used together; control is a useful consideration, not a rule that determines one universally best response.

Model task: Two fictional people have similar underlying vulnerability but different stressful experiences and support. Use diathesis-stress and biopsychosocial models to explain why different outcomes are possible.

Worked check: Diathesis-stress considers vulnerability interacting with stress; biopsychosocial reasoning also considers psychological interpretation and social support. These models suggest factors to investigate rather than proving which person will develop a disorder.

Therapy task: In one fictional session, a client tests the prediction “one mistake means everyone rejects me”. In another, a clinician uses planned gradual contact with a feared situation. Identify the main technique in each, and explain why a real treatment plan may combine techniques.

Worked check: Testing an interpretation illustrates cognitive restructuring. Planned contact illustrates exposure and behavioral learning; a fear hierarchy can organise its steps. CBT can combine these approaches. Neither vignette establishes one cause of the client’s difficulties or a guaranteed treatment outcome.

Group and individual therapy: Individual therapy centres on one client and therapist. Group therapy involves multiple clients and can support shared learning and interaction; confidentiality, participation and individual needs still require attention.

APPROACH	MAIN FOCUS	ILLUSTRATIVE METHOD
PSYCHODYNAMIC	unresolved conflict outside awareness	brings it into awareness and interprets it
HUMANISTIC	a self blocked from growing	acceptance and active listening
BEHAVIOURAL	a learned response	exposure and conditioning
COGNITIVE	the way events are interpreted	tests and replaces the interpretation
BIOMEDICAL	biological processes	medication; brain stimulation

A technique reflects a focus, not proof of cause. Evidence, individual needs and combined approaches shape treatment

Approaches emphasise different mechanisms; treatment choice also needs evidence and individual assessment

Exam tips

- Use the three considerations together - **dysfunction**, **distress**, **deviation** - when a question asks what makes behaviour disordered.
- For **diathesis-stress**, explain interaction and uncertainty. The model does not diagnose or guarantee an outcome.
- Keep **positive** and **negative** symptoms straight: positive means something *added* (hallucinations), negative means something *missing* (flat affect).
- Match therapy to perspective. Free association is psychodynamic; cognitive restructuring is cognitive; systematic desensitization is behavioral.
- **Obsessions** are intrusive thoughts, urges or images; **compulsions** can be repetitive behaviors or mental acts.
- Read the task verb. **Identify** wants a name, **Describe** wants detail, **Explain** wants a reason with evidence.

Sources for this lesson

The course scope is College Board's *AP Psychology Course and Exam Description*, Unit 5, PDF pages 121–134 ([syllabi/ap/ap_psychology_CED.pdf](#)). Clinical qualifications use APA: stress effects on the body, NIMH: bipolar disorder, NIMH: psychotherapies, NIMH: brain stimulation therapies, and APA: OCD fact sheet. Practice material is explicitly fictional and carries no official scoring claim.

Vocabulary card meanings

daily hassles: Small, frequent annoyances that add to stress. significant life changes: Major events, welcome or not, that demand adjustment. catastrophes: Large-scale disasters that overwhelm many people at once. general adaptation syndrome (GAS): The body's three-stage pattern of responding to prolonged stress. alarm: The first stress stage, in which the body mobilises its resources. dysfunction: A breakdown that interferes with ordinary daily life. personal distress: Suffering felt by the person, used as one sign that a pattern may be a disorder. deviation from social norms: Behaviour that breaks what a culture expects, used cautiously as a sign of disorder. stigma: Social shame attached to a condition, which can stop people seeking help. positive symptoms: Added experiences in schizophrenia, such as hallucinations or delusions. disorganized thinking: Speech and thought that jump and become hard to follow. catatonia: Marked disturbance of movement, from rigid stillness to agitated activity. negative symptoms: Losses in schizophrenia, such as reduced speech or reduced motivation. flat affect: A marked lack of emotional expression. specific phobia: An intense, persistent fear of a particular object or situation. agoraphobia: Fear of situations that might be hard to escape if panic strikes. panic disorder: A disorder of repeated unexpected surges of intense fear. panic attacks: Sudden episodes of overwhelming fear with strong bodily symptoms. social anxiety disorder: Intense fear of being judged in social situations. generalized anxiety disorder (GAD): Excessive, hard-to-control worry about many everyday matters. Meta-analyses: Studies that combine the statistical results of many earlier studies. confidentiality: The duty to keep a client's private information private, with narrow legal exceptions. Psychodynamic therapies: Treatments that explore unconscious conflict and past relationships. Cognitive therapies: Treatments that work on unhelpful thoughts. Applied behavior analysis: Using learning principles to change socially important behaviour. systematic desensitization: Gradually pairing a feared stimulus with relaxation, from mild to strong. token economies: Systems that give tokens for desired behaviour, later exchanged for rewards. Cognitive-behavioral therapies: Treatments that change both thoughts and the behaviours that maintain them. dialectical behavior therapy: A treatment that combines acceptance skills with change, first developed for emotional instability. rational-emotive behavior therapy: A treatment that challenges irrational beliefs thought to cause distress. Person-centered therapy: A humanistic treatment built on empathy, genuineness, and unconditional positive regard. transcranial magnetic stimulation (TMS): A treatment that uses magnetic pulses at the scalp to affect brain activity. electroconvulsive therapy (ECT): A treatment that induces a brief seizure under anaesthesia, used for severe depression. DSM: The American manual that lists diagnostic criteria for mental disorders. ICD: The World Health Organization's classification of diseases, including mental disorders.