Stress and the Disinhibition of Behavior

Todd F. Heatherton, Ph.D., and Rebecca Jo Renn, S.B.

Abstract

This paper examines the causes and treatment of the stress disinhibition effect. Individuals trying to control or restrain impulsive behaviors often become disinhibited when they experience anxiety, depression, or other negative emotional states. This effect is examined from a self-regulatory perspective, and recent theoretic advances are discussed. Disinhibition occurs when individuals lack the personal resources necessary to cope with ongoing stress. Failures to cope with stress and occasional behavioral lapses are attributed to personal weakness, and negative self-appraisals develop. People are motivated to escape from aversive self-awareness and do so through artificial means (such as consuming drugs or alcohol) or by narrowing attentional focus to sensory stimuli through cognitive narrowing. Shutting out painful self-awareness improves mood, but it also increases the likelihood of disinhibition. This paper examines self-control problems in three behavioral domains (addictions, dieting behavior, and self-injury) and makes specific treatment recommendations.

Self-control difficulties are among the most important and perplexing problems facing contemporary society (e.g., drug abuse, unprotected sex for people with AIDS, domestic violence, binge eating, drinking and driving). Moreover, the inability to control health-related behaviors is at the root of many medical problems. Although humans have the capacity to delay gratification and control their appetites and impulses, many people have difficulties with self-control from time to time. One of the primary causes of disinhibition—the release of any behavior being inhibited—is being in a negative emotional state (such as being stressed, anxious, or depressed). A recent review of the literature found that emotional distress was linked to self-regulatory difficulties with alcohol, tobacco, food, gambling, spending, aggression, and many other impulsive behaviors. Thus, when people are upset, depressed, or anxious, they often engage in the very behaviors that they are trying to inhibit. This paper examines the stress disinhibition effect and makes recommendations for treatment intervention.

There are several ways in which self-control and disinhibition problems come into the medical domain. For instance, individuals may seek advice or assistance from physicians in making changes to achieve a healthier lifestyle, such as trying to lose weight, moderate alcohol intake, or quit smoking. Similarly, a physician may prescribe or encourage specific behavioral changes because they are critical for managing or counteracting the effects of a medical illness, such as advising coronary heart disease patients to exercise, lose weight, and stop smoking. Certain patients may also require specific interventions when their out-of-control behaviors become life-threatening (for example, drug addicts, alcoholics, bulimics, or individuals with borderline personality disorder who repeatedly self-injure). Finally, individuals may seek out medical advice and treatment specifically to deal with emotional distress (such as depression or stress) and its attendant consequences (such as disinhibition).

This paper discusses possible mechanisms for the stress disinhibition effect and provides three diverse examples of self-regulation failure that are likely to come to medical attention: alcoholism and addiction, binge eating, and self-injury. These examples vary along many dimensions, including etiology, presence of physiologic addiction, the health risks they pose, and the likelihood that they are accompanied by concomitant psychopathology. All of these factors would, of course, need to be considered in prescribing specific treatment.
However, these and many other forms of self-control failure show remarkable similarity in terms of the processes and circumstances that lead to their unwanted expression. Most importantly for the current paper, all of these behaviors are triggered by emotional distress, such that those who are trying to inhibit these behaviors are more likely to perform them when they are upset, depressed, or anxious. Although people may purposefully engage in these behaviors to alleviate negative emotional states, many times stress leads to disinhibition seemingly against the person’s will.

Irresistible Impulses and Acquiescence

Do people suffer from irresistible impulses for which behavioral control is impossible? This issue has important implications for how self-control failure is seen in both medical and legal realms. Are addicts powerless to control their impulses and cravings? Can the spouse abuser refrain from battering, even when angry? Can individuals be expected to use condoms during the heat of passion? There has been a trend in the past decade to view people as generally powerless to control irresistible impulses. However, in the absence of serious psychiatric illness it is apparent that most people could and would refrain from acting on their impulses if their lives depended upon it (i.e., if someone had a gun to their head ordering them not to succumb to the impulse). Self-regulation failure almost always involves some degree of acquiescence and individuals often make a number of conscious choices in order to engage in forbidden behaviors. Disinhibition is not simply a case of going limp and letting the impulse take over. At the very least, it involves some conscious and purposeful actions such as pouring a drink, raising the glass to one’s lip, and swallowing. Often, much more elaborate planning and activity are involved to satisfy an impulse. One has to obtain money, buy the forbidden substance, travel to an appropriate area, open packages, and finally prepare and consume the substance. For these reasons, self-regulation failure is probably better conceptualized as a process in which situational and intrapsychic factors combine to make the choice to indulge momentarily more attractive or compelling than the motivation to control behavior. However, this is not meant to imply that people always take the time to consciously decide to act on their impulses.

Rather, situational factors interfere with the cognitive processes that normally inhibit behavior. An understanding of these cognitive processes is useful for illuminating how emotional distress promotes disinhibition.

Self-Regulation

Self-regulation is the process responsible for stopping, controlling, or adjusting ongoing behavior. Although situational cues, learning, physiology, and habit may predispose a given behavior, self-regulation occurs when individuals attempt to override the behavioral inclination by preventing it from happening or by substituting a different behavior. Self-regulation is most difficult in the face of strong impulses, such as when people feel an almost overwhelming desire to behave in a particular way. An impulse occurs when an underlying motive (i.e., hunger) is triggered by some cue from the environment (i.e., a restaurant), thereby resulting in a strong desire to engage in a particular behavior at a particular point in time (wanting to eat a hamburger right now). The intensity of an impulse depends on both individual (degree of hunger) and situational (level of salience) factors. Moreover, although impulses may change in strength or frequency as the result of behavior change (e.g., an alcoholic may have fewer urges to drink after a year of abstinence), impulses themselves are not under conscious control and arise automatically. That is, people are unable to prevent impulses from occurring, although they are able to choose whether to act on the impulse. Note that the colloquial expression “impulse control” is therefore a misnomer, in that people control behaviors, not impulses. People often attempt to regulate behavior either by eliminating environmental cues (such as hiding fattening foods or avoiding situations that trigger impulses) or by regulating their behavior so that they do not act on the impulse once it has occurred. The first strategy may be most effective in the short-term, but long-term success depends on the ability to regulate behavior across a wide variety of circumstances and in the face of a wide variety of temptations.

STRENGTH MODEL OF SELF-REGULATION

There are important individual differences in self-regulatory strength. Self-regulation is a limited resource
that is renewable over time and can be increased or decreased as a result of gradual developments or practice. Some individuals appear to have weaker self-regulatory capabilities generally, and they are likely to have problems across a variety of domains of impulse control (e.g., drugs, alcohol, crime, infidelity, violence). Furthermore, self-regulatory strength appears to be a stable and enduring trait. Children who are able to delay gratification (an important ingredient of self-regulation) as preschoolers showed better academic performance, social competence, and coping ability 10 years later. Thus, self-regulation is an individual strength that has its origins in childhood development.

According to the strength model, the ability to self-regulate varies over time, depending on personal resources and situational demands. For instance, self-regulation is more difficult when people are fatigued (such as late at night) or when situational demands are overwhelming (such as when friends or family apply pressure to engage in the unwanted behavior). Emotional distress interferes with successful self-regulation because it depletes personal resources. Thus, people can become so overwhelmed dealing with the stress in their lives that they have insufficient energy to control or regulate their behavior. Behavioral disinhibition, therefore, may result from inadequate coping strategies or from excessive stress.

An additional implication of this model is that self-regulatory strength can be increased over time. Just as physical exercise strengthens flaccid muscles, effortful self-discipline may promote increased capacity to inhibit or regulate appetites and impulses and assist control of intentional behaviors. Thus, self-regulation should become easier with repeated attempts. Indeed, Prochaska and DiClemente argue that people become more likely to successfully quit a variety of addictions (such as cigarette smoking) after they have made multiple attempts.

Conversely, there is considerable evidence that self-regulation failure often begets self-regulation failure, such that each additional failure makes future success even less likely. For instance, almost all dieters who lose weight will eventually regain the weight (two thirds of them within 1 year) and many will gain even more than they lost. Heatherton and Polivy describe a negative diet spiral, in which dietary failure increases the need for additional dieting but reduces the likelihood of future success. That is, negative affect interferes with successful dietary self-regulation, and yet each failure also increases negative affect. Over time, Heatherton and Polivy propose that dieting leads to heightened negative affect and other psychopathology, and that some dieters eventually engage in more extreme behaviors to lose weight, such as fasting, excessive exercise, or purging.

Thus, repeated attempts to regulate behavior may lead to improvement (as in a practice effect or strengthening model) or they may lead to deterioration of self-regulation (i.e., negative spiral). The consequences of self-regulation failure depend on whether failure is attributed to a lack of personal ability or whether the person attributes failure to situational demands and insufficient coping skills. The latter provides room for improvement, whereas the former implies permanent incompetence. Thus, it is critical for patients to understand how specific circumstances provoke disinhibition so that they can develop explicit strategies to cope with situational demands.

LAPSE ACTIVATED RELAPSE

People are rarely completely successful in their first attempts at behavior change (i.e., weight loss attempts, smoking cessation, abstinence from alcohol), and occasional lapses are the rule rather than the exception. The goal of complete abstinence from any behavior is extremely difficult, and most people will fall short of this perfectionistic standard. The first instance of the expression of the inhibited behavior is known as a lapse, which needs to be distinguished from a relapse, in which there is a complete return to the former state in habitually or repeatedly engaging (i.e., having one cookie is not catastrophic to the diet). However, the problem lies in the fact that the unwanted behavior is rarely limited to the initial lapse. Once a lapse has occurred, it often snowballs into a binge and subsequent full-blown relapse.

Marlatt speculates that the goal of abstinence creates all or none thinking in those trying to give up addictions. People perceive themselves as either in control
(abstinent) or out of control (indulgent). Threats to control occur during high-risk situations (such as emotional distress, social pressure, or interpersonal conflict), and if the person is unable to cope with the situation, a lapse is likely to occur. However, a lapse is not doomed to lead to full-blown relapse. Whether people relapse completely depends upon the attributions that are made regarding the lapse. If people attribute the lapse to internal, stable, and global factors that are perceived to be uncontrollable (i.e., there is a lack of willpower or an uncontrollable disease), then the probability of relapse is heightened. People perceive that there is little reason to continue trying to control what is uncontrollable, or they conclude that they do not have the necessary skills to control behavior. However, if the lapse is attributed to temporary, external and specific factors (such as momentary indulgence in a specific high risk situation), then the lapse will not necessarily lead to relapse. Thus, the subjective perception of the likelihood of future control plays a large role in the abstinence-violation effect model.

**SELF-AWARENESS AND ESCAPIST MOTIVES**

Self-regulation is a process that involves setting goals and standards, and then acting in ways that increase the likelihood of achieving those goals or maintaining those standards. To self-regulate effectively, individuals need to attend to their personal standards, and they must also be aware of their own actions, so that they may judge progress toward their goals. In the social psychology literature the process by which one compares the self to an ideal in order to monitor and adjust behavior is called self-awareness. Behavioral inhibition (such as dieting) often breaks down when individuals cease monitoring their activities, and therefore attention allocation is an important component of successful self-regulation. People need to focus on their long-term goals and transcend immediate temptations in order to forego indulging their impulses.

Being able to transcend immediate temptations and inhibit behavior requires what is referred to as high-level thinking. Cognitive processes can operate at multiple levels of meaning. For instance, thinking of long-term goals, broad implications, and values is a relatively high level of processing, whereas low levels of processing entail attention to concrete stimuli in the here and now. Consuming food can be viewed at multiple levels. At the highest level it is eating according to moral standards (vegetarianism) or eating in a manner that will promote longevity or enhance physical appearance. At the lowest level it is biting, chewing, tasting, and swallowing. In general, disinhibition is linked to lower levels of thinking, wherein people focus on sensations and actions rather than on the long-term implications of their behavior.

Self-awareness is generally associated with high-level thinking. People contemplate how they are living up to their goals and standards, and they are mindful of their successes as well as their failures and shortcomings. Although self-awareness is important for successful self-regulation, many times people find it unpleasant and difficult to be highly self-aware. This is especially true when self-awareness reveals a large discrepancy between the current self and the ideal self, or when high-level thinking is otherwise threatening or worrisome because of the meaning that it implies. Under such circumstances, people are motivated to escape from self-awareness. The selective appeal of escapist entertainment is that it allows people to forget about their worries and become absorbed with the object of current attentional focus (such as a book or movie). One process by which people move from high-level thinking to low-level thinking is known as cognitive narrowing. Cognitive narrowing is a shifting of attention away from the self, goals, or meaning and toward immediate stimuli, physical sensation, and mechanical activity. Of particular interest is the effect this has on inhibitions. According to escape theory, inhibitions exist mainly at high levels of thinking. When people escape from aversive self-awareness, or they are otherwise operating at low levels of thought they become vulnerable to disinhibition, primarily because their behavior is guided more by environmental cues and internal impulses than by long-term plans and restraints.

Emotional distress is, by definition, an unpleasant experience, and people are motivated to escape from this state through processes such as cognitive narrowing. Becoming immersed in potent sensory actions (such as eating, drinking, exercising, or self-harm) is a particularly
effective means of narrowing attentional focus, and at
least in the short-run, people will experience reduced
negative affect. Unfortunately, often the most com-
pelling escapes are precisely the things that individu-
als are trying to inhibit (such as food for the dieter or
drugs for the addict), and engaging in these behaviors
causes people to be further away from their long-term
goals. When self-awareness returns, therefore, people
probably feel worse than they did before, thereby moti-
vating increased efforts at future escape. Thus, disin-
hbition may result when people seek to escape their
stresses, worries, and troubles by focusing on immedi-
ate sensory experiences.

SUMMARY

Emotional distress interferes with successful self-reg-
ulation in two primary ways. If self-regulation is viewed
as a limited resource (i.e., from a strength model per-
spective); then self-control will fail when resources are
depleted. Just as it is difficult to exercise when one is
fatigued, it may be difficult to control impulses when self-
regulatory strength is exhausted or strained, such as
that which occurs when people are stressed or upset.
Personal resolve is worn down, and people are unable to
muster the necessary effort to override their impulses.
Second, stressful experiences that reflect badly on the
self are unpleasant, and people will be motivated to
escape self-awareness, possibly by narrowing attentional
focus to immediate sensory cues. This low level of self-
awareness might make people feel better (at least tem-
porarily), but it also may lead to disinhibition, and peo-
ple paradoxically may engage in those behaviors that they
are trying hardest to inhibit. The long-term consequences
of such actions can be worse than what caused the neg-
ative emotion in the first place, and resulting negative
feelings about having failed at self-regulation can com-
pound this effect (i.e., drinking to comfort one's sorrows
and then remembering that one's main problem is too
much drinking). Once disinhibition has occurred and the
person experiences a lapse, full-blown relapse will occur
if failure is attributed to personal inadequacies. As will
become obvious, people need to learn specific strategies
to cope both with the stress that causes disinhibition
and with the resulting consequences of performing the
inhibited behavior.

Stress Disinhibition Effect

EMOTIONAL DISTRESS AND ADDICTION

It has been widely noted that negative emotional states
are related to relapse for a number of addictive behaviors,
such as alcoholism, smoking, gambling, and heroin addic-
tion. For instance, emotional distress increases craving for
alcohol and thoughts about drinking among those trying
to control alcohol intake, and drinking in response to
stress has been shown to be especially likely for heavy
drinkers or those trying to control their intake of alco-
hol. Similarly, the single most important trigger for
smoking urges is negative emotional states. Shiffman
found that negative emotional states, including boredom,
frustration, anger, anxiety, and depression, were re-
sponsible for more than half of all relapses in smoking ces-
sation. This effect has also been demonstrated empiri-
cally. Schachter and colleagues found that smokers smoked
more following laboratory inductions of anxiety. Thus,
emotional distress is a leading cause of disinhibition for
those trying to control addictive behaviors.

Alcohol addiction is used here as the prototypical ex-
ample of the stress disinhibition effect. Alcohol is commonly
believed to have specific anxiolytic properties, and many
people report drinking to unwind or drinking to deal with
an impending stressful event. Alcohol in small doses
may indeed improve mood, but larger doses of alcohol are
commonly associated with a worsening of mood. Many
alcoholics have particularly unrealistic positive expecta-
tions about the effects of alcohol, and therefore they con-
tinue to drink even though the alcohol is likely to make
their problems worse rather than better. Alcoholics ex-
perience a great deal of life stress, much of which may be a
direct result of the consequences of their drinking behav-
ior. Rather than attributing their problems to drinking,
alcoholics may paradoxically attribute their problems to
a lack of alcohol. Orford hypothesized that alcoholics
increasingly misattribute all negative states, such as
fatigue, tension, or confusion, to a lack of alcohol. Thus,
any form of negative distress or any unpleasant internal
sensation may increase the motivation to consume alco-
hol, which in turn may exacerbate life problems, thereby
increasing the future motivation to consume even more.
One effect of alcohol is that it tends to reduce self-awareness and interfere with high-level cognitive processing. Thus, alcohol may help people escape from stress and emotional distress by lowering self-reflection (in a manner similar to that for cognitive narrowing). Indeed, heavy drinkers have been shown to be especially likely to consume alcohol when they experience a threat to their self-esteem. For instance, a variety of evidence indicates that heavy drinkers are likely to consume alcohol in response to self-image threats.\textsuperscript{13,24} Thus, alcohol may help people escape from or cope with threats to self-esteem. However, the decrease in self-awareness that accompanies consumption of alcohol may promote binge drinking. As stated earlier, successful self-regulation depends on being able to monitor behavior and compare whether the behavior is in keeping with personal goals and standards. Reduced self-awareness lessens the capacity for self-monitoring, and therefore it is easy for people to lose track of consumption and drink more than was initially planned. Thus, having one or two drinks to cope with stress may promote disinhibition or binge drinking.

Excessive consumption of alcohol has been shown to be related to ineffective or inadequate coping skills. For instance, Cooper and co-workers found that men who used avoidant forms of emotional coping commonly had difficulty inhibiting alcohol intake.\textsuperscript{25} Moreover, teaching effective coping strategies and self-monitoring techniques to those who are at risk for alcohol problems has been shown to lead to significant reductions in drinking behavior lasting for long periods of time.\textsuperscript{26} The development of skills to cope with negative emotional states (especially threats to self-esteem) may be the single most important factor in successful treatment for alcoholism and addiction. Indeed, many of the most successful psychological treatments (e.g., cognitive-behavioral therapy or relapse prevention therapy) emphasize the importance of coping.

**EMOTIONAL DISTRESS AND DIETARY DISINHIBITION**

Emotional distress has also been identified as a major determinant of diet failure and binge eating.\textsuperscript{11,27} Both clinical and anecdotal reports identify negative emotional states (such as anxiety, boredom, frustration, and depression) as the major cause of dietary collapse. Wadden and Letizia note that those who experience a great deal of life stress (such as financial difficulties) are typically not able to follow a weight loss program, and these authors suggest that such individuals “wait for a more propitious time to lose weight.”\textsuperscript{28} More generally, negative emotions have been shown to be potent triggers for relapse among those trying to lose weight.\textsuperscript{29,30} Moreover, such states have been associated with out-of-control eating for those with clinical eating disorders. A recent study of patients with bulimia nervosa revealed that a sad mood was related to increased cravings for food,\textsuperscript{31} and a variety of evidence has identified emotional distress as the main cause of binge eating.\textsuperscript{11}

For most people, emotional distress leads to a reduction in eating, probably because of the effects of stress on the autonomic nervous system.\textsuperscript{32,33} Specifically, fear inhibits gastric motility and promotes the release of glucose and free fatty acids into the bloodstream.\textsuperscript{34} Some individuals, however, eat more when they are stressed than when they are calm. Stress disinhibition of eating is observed in those who are obese, dieting, or who have an eating disorder (such as bulimia nervosa). These groups share the common characteristic of generally trying to restrain or control food intake (i.e., they usually have inhibitions about eating). As noted, stress affects inhibitions generally, and therefore for those who try to inhibit food intake, stress leads to disinhibition and subsequent overeating.

Not all types of distress produce disinhibited eating, only those that involve threats to self-esteem. Heatherton et al exposed chronic dieters and nondieters to either a physical fear threat (fear of electric shock) or to one of two self-image threats (failure at an easy task, or anticipating having to give a speech to an audience).\textsuperscript{35} Fear of electric shock reduced ad lib eating among nondieters but had little effect on chronic dieters. In contrast, the self-image threat appeared to sabotage the restraints of chronic dieters, in that they ate much more in those conditions than in the control condition. Subsequent studies have supported the proposition that only self-relevant emotional distress leads to disinhibition\textsuperscript{36} (Heatherton et al, unpublished manuscript). These findings support the escape from self model of disinhibition, in that only those distress experiences that lead to aversive self-awareness produce binge eating. Moreover, research has shown that
emotional distress does not disinhibit dieters in situations where it is impossible to escape self-awareness (i.e., while people are watching a videotape of themselves). Thus, the authors' research over the past 10 years has demonstrated that three conditions are necessary for stress disinhibition of eating. People need to have inhibitions about eating, the stress experience has to have negative implications about the self, and the situation must allow an escape from self-awareness.

Given these three conditions for stress disinhibition, there are three points of possible intervention. First, those who do not need to lose weight because of medical risks should be encouraged to adopt a healthy eating pattern that does not focus on inhibiting consumption. More than 75 percent of young women diet even though few of them are actually overweight, and many of those who diet are actually underweight. For this group, the health risks associated with dieting far outweigh any possible benefits of food restriction. The medical consequences of inappropriate dieting include malnutrition, nonorganic failure to thrive, heightened risk of eating disorders, and binge eating. Moreover, even for those who need to lose weight, emphasis needs to be placed on healthy nutrition (i.e., low-fat foods) and exercise rather than on caloric restriction. Second, individuals need to learn specific coping strategies to deal with threats to their self-esteem. For instance, individuals need to focus on self-acceptance and learn to be more assertive. Finally, individuals need to learn how to maintain self-awareness so that they might transcend immediate temptations. Self-monitoring of food intake appears to be perhaps the most important element of successful weight loss, with some referring to it as the "cornerstone" of behavioral treatment. However, maintaining self-awareness in times of emotional distress or after an initial lapse may be especially unpleasant, and therefore individuals need to be taught alternative methods of escaping self-awareness (i.e., taking a brisk walk, watching an absorbing movie or television program, or surfing the internet).

**SELF INJURY/MUTILATION AND DISTRESS**

Although it happens infrequently in the general population, self-injury is a serious problem for 7 to 10 percent of psychiatric patients. Self-injury is most often associated with borderline personality disorder, a disorder consisting of labile mood, interpersonal problems, especially anger, various forms of behavioral disorganization, and an unstable sense of self. The most common forms of self-injury include self-cutting, burning, hitting, and head-banging, and such behaviors are most likely to occur following heightened stress or when the person experiences other negative effect. Those who self-injure describe an overwhelming compulsion to inflict pain on themselves, usually with the belief that these actions will relieve their distress. Indeed, many do report experiencing short-term emotional relief after self-injuring.

Although self-injury is a poorly understood behavior, the available evidence is consistent with an escape from self-awareness interpretation. For instance, self-injury occurs among those who have extremely negative self-awareness, such as those with pathologically low self-esteem. Moreover, part of the motivation for self-injury may be that the physical sensations of pain help the person to escape from their aversive self-awareness. Indeed, patients often make statements such as "It's easier to hurt on the outside than on the inside." Liebenluft et al describe self-injury as a multistage process: (1) a precipitating event, such as loss of a significant relationship, (2) escalation of dysphoria of distress, (3) attempts to forestall the self-injury, (4) self-mutilation, and (5) the aftermath, which often includes a relief from tension. Similarly, Baumeister argued that one appeal of masochistic behavior is that pain constricts awareness to physical sensations in the here-and-now. He argues that masochists use pain to escape from self-awareness rather than simply to experience the unpleasant physical sensations.

As with other self-regulatory difficulties, the treatment of self-injury needs to focus on coping with stress and trying to reduce aversive self-appraisals. In keeping with an escape from self-interpretation, effective treatments for chronic self-injury often involve self-monitoring components. For instance, a widely used treatment known as dialectical behavior therapy includes journal exercises, making and keeping a list of alternate responses to impulses, and frequent reviews of impulse related thoughts and behavior.
Although a thorough consideration of the pharmacologic treatment for impulse control problems is beyond the scope of this paper, there is evidence that some drug treatments may be inappropriate or even counterproductive. Common sense might suggest that one method of dealing with stress disinhibition would be to treat the underlying negative emotionality with anxiolytic medication. However, some evidence suggests that this may paradoxically increase the likelihood of disinhibited behavior. In a placebo control trial of several medications for borderline personality disorder Cowdry and Gardner found that benzodiazipine alprazolam (an anxiolytic) increased the incidence of behavioral control problems, including both self-injury and aggression. Other studies have reported similar findings of benzodiazipines disinhibiting impulsive behavior, including increased aggression, criminal behavior, binge drinking, and suicide. The mechanisms for these effects are not completely understood, although the authors suggest that the effects may be attributable to the unintended effects of anxiolytics on inhibitions. Benzodiazipines are known to share some pharmacologic similarity with alcohol, including memory impairment and disturbed cognitive processing. Therefore, such medications may interfere with self-regulation by interfering with cognitive processing in a manner similar to that for alcohol. Clearly, pharmacologic studies are necessary to examine possible unintended effects of anxiolytic medications.

Summary and Clinical Implications

This model has many implications for clinical treatments. The most obvious is that people need to avoid situations that trigger extreme levels of stress. Trying to remove the source of distress may be the most direct solution, but in many cases it is difficult if not impossible (i.e., if the stress comes from work or from family). Thus, people should be encouraged to develop other, more constructive ways of coping with the distress that they do experience. These might include relaxation techniques or stress reducing activities that take place in environments devoid of cues that trigger impulses to perform unwanted behavior. As stated earlier, teaching people alternative ways to escape from aversive self-awareness may help them deal more effectively with the stress that they experience.

Even benign forms of escape are only a temporary reprieve from perpetual and enduring life stress. Thus, people need to be encouraged to use coping strategies that are problem focused rather than emotion focused. They should be encouraged to take direct action to at least minimize the stress that they experience, and they should be encouraged to seek out and accept social support from friends and relatives. From a strength perspective, they might be encouraged to practice dealing with small stressors so that they can later challenge and conquer major stressors. Gaining experience fixing small problems eventually helps one to solve more serious problems. People need to realize that some level of stress is a normal part of daily existence, and they also need to learn to tolerate some unpleasantness, pain, and discomfort. Many people fear that they might not be able to handle stress, and so they try to avoid all potentially threatening situations. Unfortunately, this is analogous to parents who do not let their child engage in any physical activity because of fear of injury, and therefore the child becomes weak and out of shape. People need to build up self-regulatory strength by exercising small amounts of self-discipline. Over time, self-regulatory capacities will increase, and people will find that they have the necessary resources to handle even major life stressors.

Since no amount of coping will completely eliminate distress, successful self-regulation depends on maintaining some level of self-monitoring. People need to keep track of their goals and monitor their progress...
toward achieving those goals. Some techniques that have been used to increase self-monitoring include keeping a journal, keeping careful track of behavior (i.e., counting number of drinks, cigarettes, calories), carrying a list of coping strategies at all times, restricting the behavior in situations that promote reduced self-monitoring (i.e., avoiding eating in front of the television).

Successful self-regulation also depends on setting realistic goals with the full knowledge of personal skills and abilities. The extremely obese person whose goal is to look like a fashion model will be unlikely to feel any real progress toward achieving that goal. Moreover, people need to be extremely careful with goals that require complete abstinence, lest small lapses be viewed as catastrophic and thereby lead to full-blown relapse. Especially when self-regulatory strength is weak, individuals may need to start small and practice achieving small goals. Once these are achieved, the person can set more challenging goals or work on increasing the rate of progress.

Finally, people need to work on developing self-acceptance. The distress that arises from a negative self-image is the most consequential for disinhibition. People need to focus on their positive qualities rather than dwelling on their weaknesses and inadequacies. For instance, people who motivate themselves to lose weight by constantly thinking about how fat and ugly they are may find that the strategy backfires by making self-awareness especially distressing, thereby promoting escape from self-awareness and disinhibiting eating. Thus, focusing on positive qualities may forestall the motivation to escape and thereby avoid the negative consequences associated with low self-awareness.

In summary, physicians can help patients develop self-regulatory strength by encouraging them to develop suitable and useful coping strategies for dealing with life stress. Patients might be offered specific coping strategies and exercises to assist them in facing and dealing with their stressors and problems. Moreover, patients should be told that occasionally escaping from their problems, through healthy means, can preserve their strengths and positive characteristics rather than dwelling on their shortcomings and weaknesses. Building a healthy sense of self-regulation will do much to inoculate patients from experiencing stress-related disinhibition.

References


