



Michael Linden · Max Rotter
Kai Baumann · Barbara Lieberei

Posttraumatic Embitterment Disorder

Definition, Evidence, Diagnosis, Treatment

HOGREFE



Posttraumatic Embitterment Disorder

Posttraumatic Embitterment Disorder

Michael Linden
Max Rotter
Kai Baumann
Barbara Lieberei

HOGREFE 

Library of Congress Cataloging in Publication

is available via the Library of Congress Marc Database under the
LC Control Number 2006928921

Library and Archives Canada Cataloguing in Publication

Posttraumatic embitterment disorder: definition, evidence, diagnosis,
treatment / Michael Linden ... [et al.].

ISBN 0-88937-344-2

1. Adjustment disorders. 2. Stress tolerance (Psychology) I. Linden,
Michael

RC455.4.S87P67 2006

152.4

C2006-903420-6

© 2007 by Hogrefe & Huber Publishers

PUBLISHING OFFICES

USA: Hogrefe & Huber Publishers, 875 Massachusetts Avenue, 7th Floor,
Cambridge, MA 02139
Phone (866) 823-4726, Fax (617) 354-6875; E-mail info@hhpub.com
EUROPE: Hogrefe & Huber Publishers, Rohnsweg 25, 37085 Göttingen, Germany
Phone +49 551 49609-0, Fax +49 551 49609-88, E-mail hh@hhpub.com

SALES & DISTRIBUTION

USA: Hogrefe & Huber Publishers, Customer Services Department,
30 Amberwood Parkway, Ashland, OH 44805
Phone (800) 228-3749, Fax (419) 281-6883, E-mail custserv@hhpub.com
EUROPE: Hogrefe & Huber Publishers, Rohnsweg 25, 37085 Göttingen, Germany
Phone +49 551 49609-0, Fax +49 551 49609-88, E-mail hh@hhpub.com

OTHER OFFICES

CANADA: Hogrefe & Huber Publishers, 1543 Bayview Avenue, Toronto, Ontario M4G 3B5
SWITZERLAND: Hogrefe & Huber Publishers, Länggass-Strasse 76, CH-3000 Bern 9

Hogrefe & Huber Publishers

Incorporated and registered in the State of Washington, USA, and in Göttingen, Lower Saxony, Germany

No part of this book may be reproduced, stored in a retrieval system or transmitted, in any form or by
any means, electronic, mechanical, photocopying, microfilming, recording or otherwise, without writ-
ten permission from the publisher.

Printed and bound in the USA

ISBN-10: 0-88937-344-2

ISBN-13: 978-0-88937-344-0

“Men are not disturbed by things but by the views
which they take of them”

(Epictetus, *Enchiridion*)

Preface

It is generally accepted in clinical medicine that stressful life events can impair psychological and somatic functioning (Van der Kolk et al. 1994; Van der Kolk et al. 1996; Paykel, 2001a; Paykel, 2001b). In the international classification systems ICD-10 (World Health Organization – WHO, 1992) and DSM-IV (American Psychiatric Association – APA, 1994) such disorders are grouped together as adjustment disorders.

An increase of such reactive disorders was observed in the wake of German reunification, as 17 million inhabitants of the former GDR were faced with reorganizing their biographies, with up to one third of the population still expressing feelings of having been let down a decade later (Schwarzer & Jerusalem, 1994). However, no differences in the rate of mental disorders in East and West were found immediately after the fall of the Berlin wall (Dehlinger & Ortmann, 1992; Achberger, Linden, & Benkert, 1999; Wittchen, Müller, Pfister, Winter, & Schmidtke, 1999; Hillen, Schaub, Hiestermann, Kirschner, & Robra, 2000). Yet ten years later, patients presented with severe psychological reactions to negative changes in their personal biographies, which, for several reasons, could be diagnosed neither as posttraumatic stress disorder (PTSD) nor adjustment disorder nor depressive disorder according to the definitions of ICD-10 or DSM-IV. Instead, these patients showed distinct and characteristic psychopathological features, a marked course, and special treatment needs.

This increase in pathological reactions to critical life events in the aftermath of German reunification made it possible to recognize a distinct reaction type with its own etiology and psychopathological characteristics. This reaction type is universal and frequently seen in patients who have had to cope with events of personal injustice, humiliation, frustration, and helplessness. Within minutes, such events can lead to a change from perfect health to prolonged down-heartedness, hopelessness, embitterment, and impairment in all areas of life. This reaction type can best be described as ‘posttraumatic embitterment disorder’ (PTED).

PTED is a reactive disorder triggered by an exceptional, though normal negative life event such as conflict in the workplace, unemployment, death of a relative, divorce, severe illness, or experience of loss or separation. The common feature of such events is that they are experienced as unjust, as a personal insult, and that psychologically there is a violation of basic beliefs and values. The central psychopathological response pattern in PTED is a prolonged feeling of embitterment.

To further study PTED, a research project was initiated within the Research Group Psychosomatic Rehabilitation at the Charité in Berlin and the Department of Behavioral Medicine and Psychosomatics at the Rehabilitation Center

Seehof, Teltow/Berlin, financed by the German pension fund (Deutsche Rentenversicherung), as many of these patients end up taking prolonged sick leave and early retirement. The objective of the project was to better delineate the clinical features of this syndrome, to develop diagnostic criteria, and to open avenues for treatment. This first monograph on posttraumatic embitterment disorder gives a comprehensive overview of the recent developments in PTED research.

The first part of this book gives an overview of the theoretical background of stress and stress reactions in clinical research. Chapter 1.1. describes how stress reactions to life events and their role in the development of illness found entrance into the psychiatric and psychological nomenclature. Different conceptualizations of stress and life events as stressors and etiological agents are discussed. In addition, methodological aspects of life events research and findings on the connection between life stress and psychiatric disorders are presented. Chapter 1.2. introduces the diagnostic categories of the present international classification systems ICD-10 (WHO, 1992) and DSM-IV (APA, 1994) that refer to reactive disorders. The definition of adjustment disorders, findings on epidemiology and etiology, as well as different treatment approaches are presented. Moreover, the role of adjustment disorders in clinical practice is analyzed, and PTSD is introduced as an example of a well-defined reactive disorder. Chapter 1.3. presents the theoretical concept of PTED as a special form of adjustment disorder, and important aspects of the syndrome are outlined in detail. Chapter 1.4. discusses psychological and etiological models. In particular, “violation of basic beliefs” and “lack of wisdom” are introduced as possible etiological factors for PTED. Chapter 1.5. describes the field of wisdom research and illustrates an approach to operationalizing and measuring wisdom-related performance.

The second part of the book summarizes empirical data on PTED derived from a number of studies on the subject. Chapter 2.1. outlines data on the psychopathological and emotional profile of patients with PTED. Also, PTED patients are compared with patients with other mental disorders as regards quality and intensity of psychopathological as well as posttraumatic symptoms. Chapter 2.2. presents empirically derived diagnostic criteria according to the rules of the DSM-IV and a diagnostic interview for PTED. Chapter 2.3. describes a self-rating scale for PTED. This instrument was developed to measure symptom severity in diagnosed cases of PTED. Data on a principle component analysis of the scale, internal consistency, test-retest reliability, and convergent and discriminant validity are presented. Chapter 2.4. reports data on the epidemiology of PTED in clinical and nonclinical populations. Chapter 2.5. discusses etiological concepts and vulnerability factors with a focus on the psychology of wisdom.

The third part of the book presents first concepts for treatment of PTED. After discussing traditional treatment approaches for reactive disorders and their application in PTED (chapter 3.1.), “wisdom therapy,” a treatment approach specifically developed for PTED, is introduced in chapter 3.2. A detailed treatment guideline for PTED is presented.

The authors hope that this first monograph on PTED will help to introduce and explain this disorder. Patients with mental problems of this kind are seriously ill, they suffer personally and also put severe burdens on family members, coworkers, or friends. They are severely impaired in most areas of life. They are undoubtedly in need of help. But they typically reject help, they do not come to ask for treatment, and if they are seen in psychiatric and psychotherapeutic services they are often misunderstood and wrongly diagnosed. In many cases, treatment ends in failure. Therefore more research is urgently needed. The authors are happy to share their instruments and theoretical and clinical knowledge with all who are interested in working in this field.

List of Tables

Table 1.	Case vignette of PTED.	19
Table 2.	Research diagnostic criteria for PTED.	23
Table 3.	General criteria outlining the nature of wisdom derived from cultural-historical analysis (Baltes & Staudinger, 2000, p. 135)	36
Table 4.	Five criteria characterizing wisdom and wisdom-related performance (Staudinger & Baltes, 1996b, p. 747)	40
Table 5.	Wisdom-related task with examples of extreme responses (abbreviated) (Baltes & Staudinger, 2000, p. 136)	41
Table 6.	Dimensions of cognitive and emotional wisdom-related expertise.	47
Table 7.	Sociodemographic data of PTED and control patients	54
Table 8.	Diagnostic spectrum according to the MINI standardized interview ($N = 100$)	55
Table 9.	SCL-90-R, Bern Embitterment Questionnaire, and IES-R scores.	60
Table 10.	Clinical diagnostic criteria for PTED.	63
Table 11.	Research diagnostic criteria for PTED.	65
Table 12.	The diagnostic interview for PTED	70
Table 13.	Spearman Rho Coefficients (time interval of 6–8 days), rotated factor solution and within-group correlations with the discriminant function	75
Table 14.	Intercorrelations of the PTED Scale with concurrent validity measures assessed with data from the PTED sample ($n = 48$).	79
Table 15.	Sociodemographic data of the train sample for women and men ($N = 158$)	82
Table 16.	Sociodemographic data and occupational situation of the GP sample ($N = 221$)	84
Table 17.	Set of linear nonorthogonal contrasts.	94
Table 18.	List of fictitious life problems that can be used in wisdom therapy	112

List of Figures

Figure 1.	Duration of PTED ($n = 48$)	58
Figure 2.	Psychopathological spectrum in connection with the critical event ($n = 48$)	58
Figure 3.	Emotional spectrum in connection with the critical event ($n = 48$)	59
Figure 4.	Frequency distribution of the unselected inpatient sample for each item of the PTED Scale ($N=100$)	74
Figure 5.	Mean scores of both subsamples of the Seehof sample for each item of the PTED Scale ($N = 96$)	78
Figure 6.	Frequency distribution (in %) of the train sample ($N = 158$) for the five-point answer categories of each item on the PTED Scale	83
Figure 7.	Frequency distribution (in %) of the GP sample ($N = 221$) for the five-point answer categories of each item on the PTED Scale.	87
Figure 8.	Frequency distributions of four different samples on the PTED Scale (mean total scores)	88
Figure 9.	Wisdom-related performance of the PTED sample and the control group ($N = 98$) in connection to fictitious life problems on the nine wisdom scales (pretest assessment).	93
Figure 10.	Wisdom-related performance of the PTED sample and the control group ($N = 98$) in connection to a personal life problem on the nine wisdom scales (pretest assessment).	93
Figure 11.	Mean total scores of each group for the pre- and posttest in the fictitious problem condition.	95
Figure 12.	Mean total scores of each group for the pre- and posttest in the personal problem condition.	96
Figure 13.	Wisdom-related performance of the subsamples of the PTED sample in connection to a personal life problem on the nine wisdom scales (posttest assessment). . . .	97

Table of Contents

Preface.	vii
List of Tables.	xi
List of Figures.	xiii
1. Conceptual Issues.	1
1.1 Reactions to Stress and Life Events.	3
1.2 Adjustment and Reactive Disorders.	11
1.3 Posttraumatic Embitterment Disorder (PTED)	17
1.4 Basic Beliefs and PTED.	28
1.5 Wisdom and PTED	33
2. Empirical Evidence.	49
2.1 The Psychopathology of PTED	53
2.2 Diagnostic Interview and Criteria for PTED	63
2.3 The PTED Self-Rating Scale	72
2.4 The Epidemiology of PTED	81
2.5 Wisdom and Activation of Wisdom-Related Knowledge in PTED . .	91
3. Treatment Perspectives	99
3.1 Cognitive Behavior Therapy for PTED	101
3.2 Wisdom Therapy	107
3.3 A Case Vignette	116
4. References	119
5. Appendix	137
PTED Self-Rating Scale	139
Diagnostic Core Interview and Algorithm for PTED	140
Clinical Semi-Standardized Diagnostic Interview for PTED	142
Wisdom Rating Scale	147
Wisdom Training Outline.	150

1. Conceptual Issues

1.1 Reactions to Stress and Life Events

Early concepts of stress and psychological disorders

In attempting to understand the antecedents of psychopathology, theorists historically have sought explanations from two spheres. On the one hand, the belief has long been held that individuals who develop a psychiatric disorder differ premorbidly from those who do not. Such differences were thought to be constitutional in origin (e.g., Beard, 1881). On the other hand, the belief has also long been held that stress is an important factor in the development of psychological disturbances (e.g., Hawkes, 1857). Stress reactions and coping with threatening events have been at the center of research since the early days of psychology (Reck, 2001; Linden, 2003). Examples of early terms for stress-related illnesses were “railway spine,” “psychogenic or reactive depression,” “traumatic neurosis,” or “abnormal psychological reaction” (Jaspers, 1973; Freud, 1999; Van der Kolk, Weisath & Van der Hart, 2000). A better recognition of the nature and consequences of battle stress followed the experience of the two World Wars, and terms like “shellshock” or “combat neurosis” emerged (Maercker, 2003).

An understanding of the impact of negative life events which lie more in the realm of common experience on the development of mental illnesses was slower to develop (Paykel, 2001b). In the following, research on life events which addresses possible effects of stressful everyday experiences will be reviewed and presented.

Life event research

The subject of life event research are the effects of life events on behavior, experience, and mental or physical health of the individual(s) in question (Filipp, 1995). There is common consent that relevant changes in life are associated with certain demands, which request specific processing, adjustment, and orientation performances (Dittmann, 1991). Petermann (1995; p.53) defines relevant (or critical) life events as a grouping of favorable or unfavorable social circumstances that are psychologically relevant, and which may be verified by their effects (stress, illness). A more general definition has been put forward by Filipp (1995; p. 23), who characterizes life events as changes in the (social) life situation that demand adaptation behavior of the individual concerned.

Filipp (1995) differentiates two major theoretical branches within the field of life event research: The clinical psychological approach, which examines psychosocial causes of physical and mental illnesses, and the developmental psychological approach, which conceptualizes life events as a precondition for developmental change.

The foundation for systematic experimental research on the pathological effects of stressful events was laid by Cannon (1929). His detailed observations of bodily changes caused by stressful conditions and strong emotions provided a necessary link in the argument that stressful events can prove harmful (Dohrenwend & Dohrenwend, 1974a). Thereafter, a vast body of research evolved based on the hypothesis that stressful life events play a role in the etiology of various somatic and psychiatric disorders. This line of research can best be described as clinical life event research.

The early years of clinical life event research were accompanied by a vigorous debate on the causative effect of life events between those supporting a psychological causation of disorders, and those who saw the causes of psychiatric disorders in constitutional, genetic, and biological factors. This polarization in psychiatry has now been put to rest for the most part, as the place of life events in the causative chain of illness development has become generally accepted (Paykel, 2001b).

An early major influence on clinical life event research lay in the views of Adolph Meyer (1951). With his invention of the “life chart,” a device for organizing medical data as a dynamic biography, Meyer (1951) emphasized that various life events within common experience could form an important part of the etiology of a disorder. That is to say, different kinds of events can contribute to the development of an illness, even events that are welcomed, e.g., marriage or winning the lottery.

This view was supported by the findings of Selye (1956), who, in a series of animal studies, observed that a variety of stimulus events (e.g., heat, cold, toxic agents) applied intensely and over a long period of time are capable of producing common effects, meaning not specific to either stimulus event. Based on these findings Selye claimed that all organisms show a nonspecific response to adverse stimulation, no matter what the actual situation is. This response follows a typical three-stage pattern, called the “general adaptation syndrome” (GAS).

Adaptation and life events

According to Selye, the organism initially defends itself against adverse stimulation by activating the sympathetic nervous system (*alarm reaction*). This

first reaction to a stressor mobilizes the body for the “fight or flight” reaction. In many cases, the stress episode is managed during the alarm reaction stage. However, if the adverse stimulation continues over a longer period of time, the organism moves on to the *resistance stage*, in which it adapts more or less successfully to the persistent stress. In this stage, the symptoms of the alarm reaction disappear though, according to Selye, an organism in this stage does not function well. Its immune system is impaired, and some typical “diseases of adaptation” (e.g., cardiovascular diseases) develop. Finally, if the stress does not subside, the organism enters the *exhaustion stage*. The adaptation resources are depleted, and breakdown occurs. Irreversible tissue damage occurs, and if the stimulation persists, the organism dies.

In reference to the work of Meyer and Selye, Holmes and Masuda (1974) postulated that life events lower “bodily resistance” and enhance the probability of disease occurrence by evoking dysfunctional adaptive efforts by the human organism that are faulty in kind and duration. This claim initiated a new approach to the investigation of the psychosocial causes of disease. Central to this approach is the assumption that the human capacity to adapt to life changes is limited. Thus, the confrontation with an accumulation of life-changing events within a certain time can have pathological consequences (Filipp, 1995). In this view, life events produce challenges to the organism regardless of their specific (e.g., positive or negative) quality, and therefore increase illness susceptibility.

In accordance with this view, Rahe, Meyer, Smith, Kjar and Holmes (1964) demonstrated that a cluster of social events requiring change and adjustment in ongoing life were significantly associated with the time of illness onset. Subsequently, the *Social Readjustment Rating Scale* (SRRS) was introduced by Holmes and Rahe (1967). The SRRS is an early attempt to quantify the challenge (stress) of specific critical life events to the organism,¹ by assigning predefined values, called life change units, to 43 critical life events (e.g., vacation, jail term, Christmas). It was assumed that the average amount of adaptive effort necessary to cope with an event would be a useful indicator of the severeness of such an event (Schwarzer & Schulz, 2002). By asking for the intensity and length of time which is necessary to accommodate to a life event, independent of the desirability of this event, “change from the existing state” became the pivotal factor and not the psychological meaning of the event, e.g., associated emotions or social desirability (Holms & Rahe, 1967).

Although criticized for methodological shortcomings, the Social Readjustment Rating Scale had a powerful influence on the field of clinical life event

¹ An earlier attempt to quantify life stress was the *Schedule of Recent Experiences* (SRE) (Hawkins, Davies, & Holmes, 1957). The development of the SRRS was based on the SRE. The SRRS is the more refined and better-known instrument.

research by introducing a structured list of stressful life events and a method of stress quantification. A number of interviews and self-report questionnaires have subsequently been developed to obtain information about recent life events. Today, the most prominent and frequently used questionnaires in clinical life event research are the *Interview for Recent Life Events* (Paykel, 1983) and the *Life Events and Difficulties Schedule* (Brown & Harris, 1978).²

Specificity of stressors

Investigations on the effects of specific life events and new findings in the field of endocrinology (Mason, 1975) challenged the assumption of an unspecific impact of critical life events (Holmes & Rahe, 1967). Although the founding fathers of life event research saw “readjustment” as the core feature for the promotion of nonspecific vulnerability to virtually any form of illness, recent research indicates that more specific qualities of life experiences are also of importance (Monroe & Simons, 1991).

In a review of 27 studies, Paykel and Copper (1992) found that bereavement and separation showed a strong connection to depression onset (Reck, 2001). Brown, Bifulco, and Harris (1987) found a connection between depression onset and life events which trigger the experience of role conflict and/or high obligations. For the development of anxiety disorders, threatening events seem to be of special relevance (Finlay-Jones & Brown, 1981; Finlay-Jones, 1989). In contrast to this, no influence of positive life events on the onset of illness has been found (Reck, 2001), and it has not been possible to empirically verify the so-called “depression by success” (e.g., Reimer, 1995). These findings speak against the concept of an unspecific impact of life events and the importance of a general life change factor as suggested by Holmes and Masuda (1974).

The diathesis–stress model

Another theoretical approach in clinical life event research are diathesis-stress models (Reck, 2001), which focus on the interaction of predisposing diathesis and precipitating environmental stress factors. Diathesis can be understood as a tendency to react in a certain way to environmental circumstances. It comprises physiological as well as psychological aspects. An essential feature of diathesis-stress models is the assumption that the diathesis (or the vulnerability) has no consequences as long as no stressful event occurs.

² For a comprehensive overview see Reck (2001).

Diathesis-stress models allow the formulation of hypotheses about the probability of illness occurrence. A prominent example for a diathesis-stress model is Beck's (1967, 1983) cognitive theory of depression. Beck assumes that latent depressiogenic schemata are present in individuals vulnerable to depression. However, without the occurrence of negative events (the stress), individuals who possess depressiogenic schemata (the diathesis) are no more likely to become depressed than individuals who do not possess such schemata (see also Abela & Alessandro, 2002). Brown and Harris (1978) found that vulnerability factors for the development of depression in women are: lack of a trusting partnership or marriage, loss of mother before the age of 11, three or more children at home, or lack of a task beyond the household. The existence of one or more of these factors is thought to increase the probability of depression if a stressful life event occurs.

The diathesis-stress model (stress triggers diathesis) was extended by Monroe and Simons (1991), who proposed three alternatives of diathesis-stress interactions:

- a) Both the diathesis and the stress together constitute a necessary condition for illness onset. Neither is sufficient by itself.
- b) The only necessary factor for illness onset is the diathesis. Stress is either a minor factor, a result of the diathesis' expression, or simply a consequence of the emerging illness.
- c) The only necessary factor for illness onset is life stress, the diathesis only increases the likelihood of the stressor to occur.

These different aspects of diathesis-stress interactions represent different approaches to how the interaction between endogenous and exogenous factors and their contribution to illness development can be conceptualized.

Transactional concepts

The clinical psychological/psychiatric perspective on life event research, which, in reference to Meyer and Selye, focuses on the characteristics of life events and the respective quantity of stress that is triggered by these events, has been criticized by health and developmental psychologists (Filipp, 1995; Krohne, 2001; Schwarzer & Schulz, 2002).³

These critics claim that the amount of stress cannot be determined by the objective nature of the stressor alone. In looking only at this, individual differences in perception and interpretation of the same kind of event are neglected

³ For a good example of the clinical psychological/psychiatric perspective see Dohrenwend & Dohrenwend (1974).

(Schwarzer & Schulz, 2002). This criticism emphasizes the importance of subjective interpretation of the stressor for the experience of stress. A major proponent of this conceptualization of stress is Lazarus (1966), who defines stress as a particular relationship (“transaction”) between the individual and the environment that is appraised by the individual as being taxing or exceeding his or her resources and endangering her or his well-being. A major advantage of this concept is that it can explain individual differences in quality, intensity, and duration of experienced stress in environments that are objectively equal. By integrating person variables, such as commitments, personal health or beliefs into the conceptualization of stress, the focus is moved away from the objective nature of stressors to a transactional process between the individual and his or her environment, with both of these components exerting a reciprocal influence on each other (Schwarzer & Schulz, 2002). In this vein, life events are not only conceptualized as possible etiologic agents for illness, but also as tasks that challenge the individual and can further his or her development (Filipp, 1995).

Many factors are involved in determining the type of reaction to a certain stressor. The meaning of stress is affected by “modifiers,” such as ego strength, support systems, and prior mastery (Cohen, 1981). Schwarzer & Schulze (2002) state that societal structures as well as cultural norms and values largely determine the way individuals respond to stress. Several social and personal constructs have been proposed to explain individual stress responses: *Social support* (Schwarzer & Leppin, 1991), *sense of coherence* (Antonovsky, 1979), *hardiness* (Kobasa, 1979), *self-efficacy* (Bandura, 1977), or *optimism* (Scheier & Carver, 1992). As a consequence, many authors have stressed that the vulnerability of the individual (e.g., ego strengths, support system, self-efficacy, sense of coherence, control over the stressors and desirability of the event) needs to be assessed to ascertain the impact of the situation on the individual (Strain et al. 1999).

In addition to subjective interpretations, variables like gender, culture, ethnicity, and age have been discussed to explain differences in the experience of stressful life events (Schwarzer & Schulz, 2002). Apart from the objective impact of an event, societal structures, cultural norms, and personal values also determine how individuals respond to an incident. Gillard and Paton (1999), for example, found that religious denomination had an impact on vulnerability. Furthermore, there is ample evidence for gender differences in response to stressful life events (e.g., Karanci, Alkan, Sucuoglu, & Aksit, 1999; Ben-Zur, & Zeidner, 1991). Higher situational stress assessment as well as more pronounced stress experience was found among women.⁴ Norris, Perilla, Ibañez, and Murphy

⁴ For a discussion of possible reasons for this gender difference see Schwarzer and Schulz (2002).

(2001) found that women from Mexico were more likely to meet the criteria for PTSD following a hurricane than women from the United States, suggesting that cultural differences influence the way traumatic events are experienced.

Findings on the effect of age on coping with adverse stimulation are rare and contradictory. Some found a decrease of coping abilities with increasing age (e.g., Toukmanian, Jadaa, & Lawless, 2000; Cwikel, & Rozovski, 1998), while others found older people were more resistant to stress (e.g., Ben-Zur, & Zeidner, 1991; Muthny, Gramus, Dutton, & Stegie, 1987).

Another factor that needs to be taken into account is the possible additive impact of a stressor. A recent minor stress superimposed on a previous major stress that has no observable effect on its own may have a cataclysmic effect due to its additive impact. In this regard, the model of a single stressor impinging on an undisturbed individual to cause symptoms at a single point in time appears to be insufficient to account for the many presentations of stress in an individual.

The findings on life events and their effects gathered in the fields of health and developmental psychology show that the conceptualization of life events, as stressors that impinge a quantifiable amount of distress on the organism, is not able to capture the numerous factors which influence the impact and experience of negative life events.

Diathesis-stress models (e.g., Monroe & Simons, 1991) are useful to understand the connections between stressful life events, personal factors, and illness development.⁵ Event-specific factors as well as individual (cognitive and biological) factors are taken into account. However, the importance of social resources as well as cultural and societal variables for stress experience is still insufficiently integrated (Reck, 2001).

Problems with the assessment of stressors

Apart from theoretical conceptualizations of negative life events there are also several basic problems with their assessment. The first is the definition of an event as “critical.” Due to the fact that “critical” life events are defined by their consequences, every definition of a “critical” event is somewhat circular in nature (Reinecker, 2003).

The second problem is that life event data are typically obtained by retrospective history taking. Starting from the observable effect (illness), one tries

⁵ For example, Brown & Harris (1989) account for the demand of integrating subjective interpretations of the event by integrating the context in which an event takes place and the personal understanding of an event into their assessment.

to assess preceding critical events. This method has a number of advantages and disadvantages. An advantage of retrospective studies is that they are able to cover a long life-span. Thus, events that happened a long time ago can be assessed. In addition, the retrospective method integrates individual experiences of events. As a result, it gains indicators about individual ways in which critical events are evaluated or experienced (Petermann, 1995). However, there are a number of methodological problems with the retrospective method, concerning reliability and validity of information. Recollection can be subject to distortion of recall, together with (in the psychiatric patient) misperceptions due to mental illness, such as guilt in depression, or paranoid delusions in schizophrenia (Paykel, 2001b). Furthermore, the patient, psychiatric or medical, may attempt to give meaning to and an explanation for an illness and therefore may overemphasize the significance of events which did occur (Paykel, 1974). An additional problem is the elimination of events that are consequences of illness. The patient may experience events, such as job loss, as a result of his or her disorder. Thus, a confusion of independent and dependent variables can occur (Petermann, 1995). However, many disadvantages of the retrospective approach can be limited by using direct interviews and by confining attention to the period prior to the onset of the illness episode (Paykel, 2001b).

In addition to retrospective studies, there are also a number of longitudinal prospective studies. Here, subjects undergoing a specific event are followed up. Events that have been studied in this manner are bereavement (Lichtenstein, Gatz, & Berg, 1998; Chen, Bierhals, Prigerson, Kasl, Mazure, & Jacobs, 1999), loss of employment (Kasl, Gore, & Gore, 1975; Leino-Arjas, Liira, Mtanen, Malmivaara, & Matikainen, 1999), and mastectomy (Maguire, Lee, Bevington, Kuchemann, Cratebee, & Cornell, 1978). However, these studies resulted in no clear outcome and had only little impact on clinical life event research (Paykel, 2001b).

1.2 Adjustment and Reactive Disorders

Stressors and the onset of mental disorders

Since the late 1960s, researchers have documented the influence of stressful life events on a number of psychiatric disorders. It has been shown that life events tend to occur to an extent greater than chance expectation before a variety of psychiatric disorders, including depression, schizophrenia, and anxiety disorders (Paykel, 1974; Finlay-Jones & Brown, 1981; Paykel, 2001b). The effect is moderate in magnitude but varies with disorder. The influence of stressors is less pronounced in schizophrenia than in depression, probably less strong in bipolar affective disorder than in unipolar, and within unipolar depression stronger in first episodes and milder disorders than in severe recurrent disorders (Paykel, 2003). When looking at these findings, one needs to take into account that the revealed connection between life events and psychiatric disorders is correlative only. Nothing can be said about the causal direction and mechanisms of life events on psychiatric disorders on the basis of these findings.

Even though it has been shown that life events are important in determining the onset of an illness, they are not a sufficient explanation. Life events are only one link in a complex multifactorial causative chain. Whether an event is followed by a disorder must be attributed to other modifying factors, both genetic and environmental, ranging from biochemical through personality and coping mechanisms to social experiences, early or recent (Paykel, 2001b).

Adjustment disorders

Exceptions are adjustment or reactive disorders. In international classification systems for mental disorders, such as ICD-10 (WHO, 1992) and DSM-IV (APA, 1994), there are special chapters for disorders which are defined as responses to a variety of causal stressful events, the symptoms representing an adaptation to these stressors or to their continuing effects (Casey, Dorwick, & Wilkinson, 2001). Under the heading of “Reaction to severe stress and adjustment disorders” (F 43), ICD-10 lists: (a) “acute stress reaction” (F 43.0); (b) “posttraumatic stress disorder” (PTSD; F 43.1); and (c) “adjustment disorders” (F 43.2). Furthermore, there is also the category “enduring

personality change after catastrophic experience” (F 62.0)⁶. In the DSM-IV, the chapter on adjustment disorders differentiates between “adjustment disorders with predominant depressed mood” (309.0), “anxiety” (309.24), “mixed anxiety and depressed mood” (309.28), “disturbance of conduct” (309.3), and “disturbance of conduct and emotion” (309.4). Further categories are “PTSD” (309.81) and “acute stress disorder” (308.3) that are listed under anxiety disorders.

The adjustment and reactive disorders are unique within the classification systems, as they are diagnoses with a known etiology and in which the etiological agent is central to the diagnosis. This contradicts the concept of a strictly atheoretical and phenomenological approach to the classification of mental disorders (Strain, Newcorn, Fulop, & Sokolyanskaya, 1999). The essential feature of an adjustment disorder is the development of clinically relevant emotional or behavioral symptoms in response to an identifiable psychosocial event that occurs within 3 months after onset of the stressor. The disorder should by definition resolve within 6 months of the termination of the stressor. If the symptoms last longer, the diagnosis should be changed to chronic adjustment disorder (DSM-IV only) or to another Axis I disorder, if the necessary criteria are fulfilled (WHO, 1992; APA, 1994).

In contrast to other DSM-IV and ICD-10 disorders, there is no clear and specific profile of symptoms for adjustment disorders (Strain et al. 1999), which makes this a vague diagnostic category. Also, it is unclear how the concept of ‘clinically relevant reaction’ can or should be operationalized. The social, emotional, and vocational dysfunctions which indicate the pathological reaction, are qualitatively and quantitatively unspecified. Hence, they lend themselves neither to reliability nor to validity. By the indication that the distress must be greater than would normally be expected from the stressor, the concept of a maladaptive reaction is further confounded by elements of culture. Expectable reactions to an event can differ within specific cultural environments. Gender responses, developmental level differences, and the meaning of events to an individual are all factors that determine an ‘expectable’ reaction (Strain et al. 1999).

Another important shortcoming of present diagnostic criteria is that no criteria are offered to quantify stressors for adjustment disorders or to assess their effect or meaning for a particular individual at a given time.

⁶ The diagnostic category of enduring personality change after catastrophic experience (F 62.0) will be discussed in more detail in chapter 1.3.