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Emotional Responding and Adversity

Tom Buqo

Abstract

The experience of emotions is a ubiquitous human experience, as is the experience of adversity. In the aftermath of an adverse life event, a variety of emotional experiences can occur. This chapter reviews the relationship between emotional responding and adversity within the science of emotion and resilience. Current literature on possible emotional responses to adversity are reviewed, including literature on both resilience and psychopathology. Multiple trajectories following the experience of various types of potentially traumatic events are outlined, including predictors for each of these trajectories. In addition, forms of psychopathology in emotional responding after adversity are discussed, including posttraumatic stress disorder, prolonged grief disorder, adjustment disorders, and other mental health conditions. Information regarding risk and resilience factors for each disorder are discussed, and evidence regarding treatment is briefly summarized.

Keywords: emotion, adversity, grief, trauma, adjustment

1. Introduction

The experience of emotions is ubiquitous to human beings across multiple cultures [1]. While the nature of emotions as biologically determined basic kinds or an epiphonema of language has a lengthy history of debate [2], the fact that emotions allow for human beings to respond to their external environments is not up to debate. One particular area of note is in the human response to adversity, defined as the experience of acute and highly aversive events, especially potentially traumatic events (PTEs) or losses [3]. Many individuals will experience some degree of loss or potentially traumatic, and the vast majority will not go on to develop psychopathology [4]. This chapter will review several of the trajectories of emotional responding to adversity, types of emotional pathology that can emerge in response to adversity, and what is currently known about risk and resilience factors.

2. Trajectories following adversity

Bonanno and Diminich [3] identified four trajectories observed in the data in response to adversity: resilience, recovery, delayed reaction, and chronic distress. In addition, two additional trajectories were mentioned: continuous pre-existing distress and distress followed by improvement. Within each of these trajectories, it is important to note that trajectories such as a resilience and recovery do not mean the global absence of negative emotional experiences. Rather, these trajectories

describe the change in functioning related to emotional experience and the presence or absence of psychiatric symptoms related to emotional responding. Human beings in and out of adversity experience negative emotional experiences with or without the necessary presence of psychopathology. Rather, psychopathological and emotional pathology is a function of the predominance of these negative affective states, associated symptoms, and impact on functioning over time.

Resilience is the most common form of response to adversity [3, 4], though previous clinical wisdom often assumed otherwise due to clinicians primarily interacting with people experiencing various forms of psychological distress. In resilience, when experiencing a potentially traumatic event (PTE) or aversive life circumstance, and individual remains at pre-event functioning and psychological health. While there may be the presence of a certain degree of negative emotion and psychological distress, this distress does not become functionally impairing, resolves naturally, and does not lead to a decrease in functioning when compared with baseline [5]. Bonanno and Diminich [3] also refer to this as *minimal impact resilience*, noting that, while total non-response is uncommon, the emotional stress response in this trajectory is brief and does not lead to functional impairment.

Resilience can be contrasted with a second trajectory following adversity: recovery. Recovery refers to a brief (several months to several years) decrease in functioning following a PTE or adverse event, followed by a return to pre-event functioning [3]. In contrast with resilience, recovery represents at least some degree of immediate impaired functioning whereas resilience represents minimal impact of the PTE or other adverse event. While these trajectories are clearly distinct with single incident PTEs, in those who experience chronic adverse events (e.g., on-going warfare) resilience is less clear and recovery (sometimes called *emergent resilience*) appears to be the most common pathway. Bonanno and Diminich [3] note that this pattern is best referred to as recovery when discussing single incident adverse events, and emergent resilience when following chronic adverse conditions and events.

A third, and somewhat more controversial trajectory, is called delayed reaction or delayed symptom elevations [3]. This pattern is defined as no or low level of symptoms following a PTE or other adverse event, followed by a later appearance of symptoms. While previous clinical wisdom attributed such presentations to theoretical “denial” of trauma and grief, consistent with previous understanding that resilience was rare. Modern understanding of this phenomena recognizes it as rare [6]. Furthermore, these delayed symptom elevations have not been observed in grief after loss [7, 8] and appear to not to occur. With regard to posttraumatic stress (PTS) symptoms after the experience of a PTE, the data suggest that while such reactions may occur, rather than following a period of no distress, such reactions represent initial moderate or subthreshold symptoms that worsen over time [9–11]. Taken together, the evidence does not support the idea that denial of trauma or grief experiences causes delayed expression, but rather that this represents a worsening of an initial psychopathology process over time. Among the trajectories of responses, resilience continues to represent the more common response with delayed symptom elevation being relatively rare.

The fourth of the traditionally common observed trajectories following adversity is chronic dysfunction or distress. This trajectory is represented by a sustained decreased in functioning and increase in psychopathology symptoms following exposure to a PTE or other adverse event. Of note, in defining this trajectory, Bonanno and Diminich [3] identify that this trajectory includes no pre-existing symptoms prior to the experience of a PTE or other adverse event. For these individuals, after a period of relatively healthy functioning, the experience of a PTE

or other adverse event leads to long term psychological dysfunction, captured in the psychopathology discussed later in this chapter. Of note, this course represents approximately 5–30% of individuals rather than the majority of individuals who experience adversity [3].

While the vast majority of the literature notes that the majority of responses fall into these categories, two additional trajectories have been observed. In continuous pre-existing distress, individuals experiencing high degrees of psychological distress and functional impairment before a PTE or other adverse event continue to experience impairment after such an event [6]. However, in the absence of pre-existing data, distinguishing this category from chronic dysfunction is not possible from a methodological standpoint. A final pattern observed is called the distress-improvement pattern, representing individuals with pre-event psychological distress that improves following an adverse event. This pattern has been observed in grief after loss [12] and combat deployment [13]. Such a response may represent a reduction in stressor related to caretaking in bereavement or removal of anticipatory anxiety to deployment, rather than a stress growth response.

In summary, the current literature on adversity suggests that resilience is the most common psychological response to adversity. While a large degree of clinical focus and attention has been devoted to chronic distress and dysfunction, these represent a smaller subset of emotional response to adversity. However, the emotional pathology that can follow PTEs and other adverse events represent a diverse array of emotional presentations. Comprising both trauma and stressor-related disorders as well as other forms of psychopathology, the various etiologies of these conditions must be considered for a complete picture of emotional responding in adversity.

3. Types of emotional pathology following adversity

3.1 Adjustment disorders

Adjustment disorders represent responses to stress that exceeded what is anticipated for an individual in response to a stressor but represent a particular stress reaction rather than constituting a more persistent mental health condition [14]. Adjustment disorders are characterized by emotional and behavioral symptoms that begin within three months of the onset of a stressor and remit within six months after the stressor or the consequences of the stressor have ended [15]. Adjustment disorders can present with a variety of emotional symptoms, notable depressed mood, anxiety, mixed anxiety and depressed mood, or mixed disturbance of emotions and conduct [15]. These disorders will often resemble a major depressive episode or an anxiety disorder, but their duration is relatively briefer, full criteria for these other disorders is not met, there is a clear adverse event or stressor associated with the event, and they often remit naturally over time [15].

Adjustment disorders are also separated from normative stress reactions by their intensity of symptoms and their functional impairment. As the American Psychiatric Association [15] notes: “When bad things happen, most people get upset. This is not an adjustment disorder” (p. 289). Similar to the pattern of recovery identified in the trajectories after adversity above, adjustment disorders represent a degree of distress and functional impairment exceed what would normally be expected within the individual’s sociocultural context. Treatment of these disorders through psychotherapy most often involves assisting the individual in managing and minimizing the impact of the stressor [14]. These factors can help an individual return to pre-stressor emotional functioning.

3.2 Acute stress disorder/posttraumatic stress disorder

Acute stress disorder and posttraumatic stress disorder (PTSD) represent a particular response to PTEs over the course of time. These forms of adversity-related psychopathology arise in response to exposure of events of actual or threatened death, serious injury, or sexual violence through either direct experience, direct witnessing, or vicarious exposure [15]. These disorders are characterized by the following symptom clusters: intrusion symptoms (e.g., flashbacks, strong emotional reactions), alterations in cognition and mood (e.g., emotional numbing), avoidance symptoms, and arousal symptoms (e.g., hypervigilance) [15]. Of particular note, difficulties in emotion regulation are observed in a number of individuals who meet criteria for PTSD, particularly when exposed to chronic, early life traumas [16], though this may relate to PTSD symptoms severity rather than trauma type [17]. The distinction between acute stress disorder and posttraumatic stress disorder is a matter of time, with acute stress disorder being diagnosed in the timeframe three days to one month posttraumatic event, and PTSD being diagnosed when at least one month has passed [15].

While exposure to PTEs is relatively common, PTSD is relatively rare, and most individuals who experience a PTE do not go on to develop PTSD [18]. The current etiology of PTSD is not fully understood, but a combination of genetic, environmental factors (e.g., trauma type), psychological variables (e.g., appraisals), and coping strategies (e.g., avoidance) seem to influence the likelihood the exposure to a PTE will lead to PTSD. With regard to treatment, while numerous therapies exist for the treatment of PTSD, the most frequently recommended treatments by organizations providing guidance include prolonged exposure (PE) therapy, cognitive processing therapy (CPT), and cognitive-behavioral therapy for PTSD [19].

3.3 Prolonged grief disorder

Bereavement presents a particular subtype of adverse event, and multiple names have been proposed to describe protracted grief responses that involve clinically significant distress and functional impairment, including prolonged grief disorder [20], complicated grief [21], and persistent complex bereavement disorder [15]. For the purpose of this chapter, the most common prolonged grief disorder will be utilized, particularly given its upcoming inclusion in the ICD-11 [22]. Prolonged grief disorder is characterized by continued separation distress and emotional pain following the death of a loved one along with preoccupation with the deceased exceeding a minimum of six months after the loss and characterized by functional impairment [22].

Prolonged grief disorder is a relatively new proposed form of psychopathology, with a specific associated symptom profile and response to treatment. In contrast to major depressive disorder, the painful emotions associated with prolonged grief disorder are loss-focused, associated with intense emotional pain and longing with regard to the deceased [20]. For those with prolonged grief disorder, grief-specific interventions have greater efficacy compared with more general interventions [23]. While an understanding of the full etiology of prolonged grief disorder is still the subject of research, attachment [24], identity continuity [25], and integrative [26] models for prolonged grief disorder have been proposed.

3.4 Other psychopathology

While the aforementioned forms of emotional pathology have a direct diagnostic connection to forms of adversity, other psychiatric diagnoses and mental

illness include the experience of adversity as a predisposing factor to the onset of most mental health conditions [27]. In fact, diathesis-stress models of depression [28], generalized anxiety disorder [29], panic [29], and other anxiety disorders [30] generally identify adversity, intense stressors, and exposure to PTEs as common in the etiology of multiple forms of mental health problems. Of note, while the rate of psychopathology is increasing and may bring new more functional perspectives on diagnosis [31], resilience does remain the most common response to adversity. While the research is undoubtedly incomplete, a number of studies have examined factors that are likely to increase the likelihood of resilience rather than pathology.

4. Factors related to resilience vs. pathology

Bonanno and Diminich [3] identified a number of factors that related to increase likelihood of resilience in response to adversity and PTEs. Certain demographic variables frequently correlate with a lower degree of pathology following adverse events, such as increasing age and male gender. These factors are often explained that greater life experience allows older adults to adjust better to adversity [32], and women are more likely to experience a greater number of PTEs than men though some studies have not supported this later explanation [33].

In addition, certain personality factors reliably emerge in providing an increased likelihood of resilience. Bonanno and Diminich [3] identify: higher perceived control, trait resilience, low negative affectivity, a ruminative response style, and trait self-enhancement as particular personality variables that are likely to increase resilience. Low negative affectivity and trait self-enhance are particularly identified by multiple studies (e.g., [9, 34]). Further, other studies have identified emotional intelligence [35], self-esteem [36], extraversion, and conscientiousness [37] as personality factors promoting resilience. In addition, a higher degree of positive emotions has been associated with better adjustment following adversity [38].

In addition to these internal factors, certain environmental factors have also been identified as increasing likelihood of resilience. While the presence of social and economic resources has been identified as particularly helpful in recovery from disaster [39], evidence regarding the role of these resources in recovery from bereavement has been somewhat mixed [3]. In addition, greater degrees of past and present stress and higher frequency of exposure to PTEs has been associated with lower likelihood of resilience following an adverse event. In addition to these factors, the interaction between the individual and their environment plays an important role to the response to adversity.

Individual responses to the environment and resultant emotions can broadly be referred to as coping. Certain forms of coping, particularly avoidance, have long been associated with worse outcomes [40, 41], some nuance has begun to emerge in the literature. For example, in prolonged grief disorder, both approach and avoidance mechanisms have been identified in the development of prolonged grief after loss [42, 43]. Of emerging importance is the role of flexibility in coping strategies [44], emotion expression [45], and psychological flexibility more generally [46] in the human response to adversity, with all of these factors likely to lead to increased resilience in the face of adversity.

5. Conclusion

Adversity, as an environmental event, has a pronounced impact on emotional experiences. While the majority of individuals will return to emotional functioning

before any adverse event, including a PTE or loss, some individuals continue to have difficulties that constitute emotional pathology in the aftermath of adversity, including adjustment disorders, traumatic stress disorders, prolonged grief disorder, and other forms of pathology. Numerous factors modify the likelihood that any given individual under any given set of circumstances will go on to develop chronic dysfunction in response to an adverse event.

With regard to these factors, certain demographic, personality, environmental, and other factors may predict a higher likelihood of resilience including emotional intelligence and psychological flexibility, including both coping and expressive flexibility. In the event that resilience is not achieved, treatments for emotional problems in the aftermath of adversity exist with various degrees of evidence support at this time. While there is no need to provide treatment for the experience of adversity itself (and to do so without emotional pathology may be iatrogenic), treatments exist for the treatment of adversity-related emotional pathology and the accompanying functional impairment.

The experience of adversity, like the experience of emotions, is ubiquitous to the human experience. These two components of the human experience are closely intertwined and understanding their relationship will help continue the understanding of human emotional responding during both situations of stress and in the aftermath of stressful experiences. While this area of research is relatively recent, data continue to accumulate that broaden the understanding of emotional responding and adversity.

Author details

Tom Buqo
Hofstra University, Hempstead, NY, United States

*Address all correspondence to: tbuqo1@pride.hofstra.edu

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