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MODIFYING COPYING WITH STRESS AS A METHOD OF PREVENTING THE RECURRENCE OF MENTAL DISORDER SYMPTOMS

The purpose of this article is to find answers to two questions of practical nature regarding the effectiveness of psychotherapy by referring to research results. These questions are the following: (1) In the case of which mental disorders is there a need to increase the skills of coping with stress in order to prevent the recurrence of symptoms? (2) What would that increase in coping skills be based on? A review of research on the deferred effects of psychotherapy showed that, firstly, studies address only depressive disorders, and, secondly, that teaching different cognitive and behavioral skills is effective in preventing the recurrence of these disorders. A review of studies on the contribution of stress to the etiology of mental disorders showed that in case of 13 disorders the contribution of stress is confirmed by empirical evidence. The theoretical clinical literature suggests that stress contributes to the induction of symptoms in cases of a larger number of disorders. Based on a review of research on coping with stress in representative general populations of adults experiencing stressful situations or traumatic events, it was determined what the ability of effective coping with stress consists in. It consists in adapting appropriate coping strategies aimed at eliminating the stressor or at mitigating the negative emotions associated with stress. In psychotherapy, teaching this skill seems to be a promising method of preventing the recurrence of mental disorder symptoms whose formation is associated with stress.

Keywords: coping with stress, psychotherapy, preventing the recurrence of mental disorder symptoms.

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INTRODUCTION

The theory explaining the etiology of mental disorders (Bennett, 2003) assumes that vulnerability to disorders and mental illnesses is determined by three groups of factors: (1) biological (genetic susceptibility to disorders, viral infections of the brain, and brain damages affecting the biochemical activity of the brain); (2) psychological (nonadaptive cognitive reactions to negative events in the social environment, for example due to a trauma in childhood); (3) social (stress caused by difficulties in relationships with close relatives, a lack of social support, or economic hardship).

Whether a disorder will develop or not depends on whether stressors work in the family or in further social environment and on whether the person affected by them has got mental and social resources to cope with stress. On the basis of this theory, it can be concluded that people with a genetic vulnerability and those exposed to stressors in their social environment can be protected against the occurrence of disorder symptoms if their deficits in the field of stress management skills are remedied.

Behavioral therapists try to prevent the recurrence of symptoms by teaching their patients how to identify the events threatening a relapse and how they should react then (Larimer, Palmer, & Marlatt, 1999). Strategic therapists try to prevent the recurrences of problems by teaching patients to adopt a positive attitude to temporary relapses, strengthening their control over the behavior that perpetuates the problem, as well as strengthening their belief in the ability to solve their problems on their own (Rakowska, 2000). Theories of other psychotherapeutic approaches, such as the psychoanalysis-oriented humanistic systems (other than strategic therapy), do not deal with the issue of protecting patients against the recurrence of disorder symptoms.

The purpose of this article is to search for answers to two questions of practical nature concerning the effectiveness of psychotherapy by referring to research results. These questions are: (1) In the case of which mental disorders is there a need to increase the skills of coping with stress in order to prevent the recurrence of symptoms? and (2) What is this increasing in coping skills supposed to consist in?

A review of research on the deferred effects of psychotherapy, the contribution of stress to the etiology of mental disorders, and coping with stress in adults experiencing stressful situations and traumatic events was carried out. EBSCO databases of psychological articles were searched (e.g., Academic Search Complete, Health Source, MEDLINE, PsycARTICLES). Data for the years 1900-2014 were considered.

DEFINITIONS OF KEY CONCEPTS

Stress is defined as physiological and mental reactions to the assessment related, on the one hand, to the requirements of the environment in terms of a loss, threat, or challenge, and on the other hand – to the available resources, seen as insufficient needed to meet the requirements (Lazarus & Folkman, 1984).

Stressors are defined as selective pressures from the physical and social environment that threaten or challenge an organism and elicit compensatory response patterns (Weiner, 1991). In terms of the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5) and on the basis of research, presented below, on the contribution of stress to the etiology of mental disorders, the following stressors can be identified: (1) traumatic events, which include (a) life-threatening events and (b) health-threatening events; (2) stressful situations, which include (a) events that threaten meeting material needs, (b) events that threaten meeting interpersonal needs, and (c) daily difficulties giving rise to a sense of threat; (3) events requiring adaptation to new requirements; (4) the experience of harm; (5) a loss of a significant other; (6) failure to satisfy the essential psychological needs; and (7) an object of phobia.

Coping with stress is defined as activities undertaken in order to remove the stress experience by eliminating the stressor or decreasing the negative emotions associated with stress (Lazarus & Folkman, 1984). It is possible to distinguish a particular style of coping with stress, which means a person's constant disposition to deal in a certain way with stressful situations, and strategies for coping with stress – namely, cognitive and behavioral methods applied by a person in specific stressful situations (Lazarus & Folkman, 1984).

Effective coping with stress is defined as (1) the ability to overcome negative events (an experience of stress and return to the state of normal psychological functioning), (2) the ability not to experience stress in spite of a working stressor, or (3) the capacity for posttraumatic growth (Masten, 2009). Posttraumatic growth means a positive change in the way of understanding the world as well as the purpose and meaning of personal existence as a result of experiencing a traumatic event (Tedeschi & Calhoun, 2004).

The recurrence of mental disorder symptoms means failure to maintain the desired behavior change (Dimeff & Marlatt, 1995). In other words, it means is a recurrence of symptoms after a period of their complete remission or a return of the severity of symptoms after their partial but significant improvement.

PREVENTING THE RECURRENCE OF DEPRESSION SYMPTOMS

Research on the effectiveness of modifying coping with stress in preventing the recurrence of mental disorder symptoms applies only to the symptoms of depression (Zuroff, Blatt, Krupnick, & Sotsky, 2003; Oxman, Hegel, Hull, & Dietrich, 2008; Brunwasser, Gillham, & Kim, 2009; Cheng, Kogan, & Chio, 2012). People with depressive disorders and subclinical depression have been examined. Subclinical depression is a condition in which a person manifests symptoms of depression that do not meet the criteria of depressive disorders but significantly reduce the quality of life, though not to the same extent as depressive disorders do (Cuijpers & Smith, 2008). The results of that research confirm that there is a need for psychotherapy to modify coping with stress in people with depressive disorders or depressive symptoms. They also show that stress management skills can be acquired in two ways. The subjects in the first group gained cognitive and behavioral stress management skills in the course of therapeutic work aimed at eliminating problems related to the occurrence of depression symptoms (Zuroff, Blatt, Krupnick, & Sotsky, 2003) or during training sessions aimed at learning stress management skills (Oxman, Hegel, Hull, & Dietrich, 2008; Brunwasser, Gillham, & Kim, 2009; Cheng, Kogan, & Chio, 2012).

Modifying coping with stress in psychotherapy in people with depressive disorders

On the basis of a study on people with depressive disorders (Zuroff, Blatt, Krupnick, & Sotsky, 2003), it can be stated that when the way of responding to stressful situations has changed under the influence of psychotherapy, the symptoms of depressive disorders do not appear after psychotherapy is finished. At the time of follow-ups 18 months after the end of cognitive-behavioral and interpersonal therapy in people with depressive disorders diagnosed according to DSM-III criteria, it was found that those who were able to maintain positive self-esteem, control the symptoms, and establish relationships with people did not have the symptoms, even if the stressors operating were numerous and assessed by the examined individuals as being of considerable importance. By contrast, those who were not able to do so at the time of follow-ups had symptoms of depression as a result of stressors, even if their number and importance as assessed by the participants were small.

Another study on people with depressive disorders showed that when a change in he manner of responding to stressful situations continues after the

end of psychotherapy, then no symptoms appear after its completion (Oxman, Hegel, Hull, & Dietrich, 2008). Nine months after the end of behavioral problem--solving training it was found that the persistent reduction of avoiding confrontations with problems co-occurs with a reduction of depression symptoms in people with depressive disorders diagnosed according to the DSM-IV. Furthermore, it was found that this phenomenon occurred to a greater extent in people trained in problem-solving than in those subjected to standard medical care – that is, receiving psychological support and pharmacotherapy. The problem-solving training involved defining problems, setting achievable goals, generating solutions, evaluating potential solutions in terms of their strengths and weaknesses, as well as planning the next steps to be taken in order to solve the problem and apply them in life. The training was supplemented with role plays.

Modifying coping with stress in people with subclinical depression

The research on youth and children with subclinical depression suggests that the acquisition of cognitive behavioral skills of coping with stress is related to maintaining reduced symptoms after the end of psychotherapy (Brunwasser, Gillham, & Kim, 2009). A follow-up was carried out 12 months after the end of the intervention that involved teaching 13 skills of coping with stress, in 10 studies involving children and young people aged 8-18 with symptoms of subclinical depression. It was found that in the examined individuals who were taught these skills the symptoms of depression decreased to a greater extent than in individuals not subjected to this kind of intervention. The following skills of dealing with stressful events were taught: (1) increasing the awareness of the emotions experienced, (2) connecting thoughts with the experienced emotions and life events, (3) the identification of the thinking styles – the optimistic or the pessimistic one, (4) the attribution style, (5) developing flexibility and realism in thinking – the study of alternative solutions and finding evidence supporting an interpretation, (6) looking at events from a perspective – considering the consequences of an event from the three perspectives: the worst, the best, and the most likely scenario, (7), assertiveness, (8) negotiation, (9) making decisions – considering the advantages and disadvantages of taking and refraining from action, (10) supporting decision making – generating advantages and disadvantages of taking a particular action, (11) relaxation, (12) regulation and control of emotions – remaining calm in a state of strong emotional agitation, and (13) turning one's attention away in order to deter destructive thoughts and increase the focus on current tasks.

Research on people with subclinical depression shows that flexible coping with stress in combination with cognitive-behavioral skills results in a greater reduction of symptoms after the end of psychotherapy compared with the effect obtained thanks to cognitive-behavioral skills alone (Cheng, Kogan, & Chio, 2012). This regularity was found in the follow-up carried out four months after adults with symptoms of subclinical depression had been taught stress management skills. In the comparison group, a set of cognitive-behavioral techniques was used. In the research group, the same set was applied with an additional one, aimed at teaching flexible coping with stress. It was found that people who were taught flexibility in dealing with stress developed this ability to a greater extent and exhibited weaker symptoms of depression measured by a questionnaire compared with their level prior to the therapy than those from the control group. Teaching flexibility in dealing with stress included (1) differentiation between strategies aimed at changing the situation or at changing the way of thinking and emotions, (2) the identification of stressors according to the degree of their controllability, and (3) the rules for adapting strategies of coping with stress depending on one's control over the stressor – the application of coping strategies that focus on changing one's own thoughts and emotions in a weakly controlled situation, and using strategies focused on changing the stressor in a controlled situation.

THE CONTRIBUTION OF STRESS TO THE ETIOLOGY OF MENTAL DISORDERS

The contribution of stress to the etiology of certain mental disorders is indicated by research and the theoretical clinical literature. In this way, they provide the basis for the inference that since stress contributes to the onset of the symptoms of these disorders, then a change in coping with stress has the potential to prevent their occurrence. This change would allow a person exhibiting these disorders not to experience stress, despite the impact of stressful situations.

Stress in the etiology of mental disorders confirmed empirically

Studies have confirmed the contribution of stress to the etiology of 13 disorders by demonstrating (1) a time sequence between stressors in the form of traumatic events and the development of disorders, (2) a greater frequency of stressful situations or traumatic events experienced by people with disorders than

by persons from control groups, (3) a relationship between the severity of disorder symptoms and the frequency of experiencing stressful situations, and (4) the relationship between a specific disorder and sensitivity to experiencing stress in response to insignificant daily events. The disorders in these studies were diagnosed on the basis of clinical interviews according to the criteria set out in the DSM-IV and DSM-III classifications of mental disorders, on the basis of structured diagnostic interviews according to the criteria set out in the ICD-10 classification system of mental disorders, or on the basis of questionnaires containing diagnostic criteria for the disorders that the research concerned.

The fact that the contribution of stress to the etiology of these disorders is documented allows to suppose, with a high probability, that in the case of people suffering from these disorders the way of coping with stress contributes to triggering the symptoms. For this reason, a modification of coping with stress in psychotherapy would be helpful in preventing the recurrence of symptoms.

The disorders subjected to research were those in the case of which (1) the contribution of stress to the etiology is a prerequisite – that is, acute stress disorders (Classen et al., 1998), PTSD (Classen et al., 1998; Owens et al., 2009) and adaptive disorders (Kumano et al., 2007), as well as those in the case of which (2) the contribution of stress to the etiology is a risk factor – that is, depressive disorders (Mitchell, Parker, Gladstone, Wilhelm, & Austin, 2003; Kendler et al., 1995; Kendler, Karkowski, & Prescott, 1999; Waldenström et al., 2008; Melchior et al., 2007; Siegrist, 2008; Mc Cauley et al., 1995), social phobia (Marteinsdottir, Svensson, Svedberg, Anderberg, & von Knorring, 2007; Stemberg, Turner, Beidel, & Calhoun, 1995), disorders in the somatic form (Imbierowicz & Egle, 2002; Kotby, Baraka, Sady, Ghanem, & Shoeib, 2003), conversion disorders (Roelofs, Spinhoven, Sandijck, Moene, & Hoogduin, 2005), dissociative identity disorders (Nijenhuis, Spinhoven, van Dyck, van der Hart, & Vanderlinden, 1998), depersonalization–derealization disorders (Miti & Chiaia, 2003), dysmorphic disorders (Neziroglu, Khemlani-Patel, Yaryura-Tobias, 2006; Buhlmann, Marques, & Wilhelm, 2012; Didie et al., 2006), bulimia (Akkermann et al., 2012), psychotic disorders (Latester, Valmaggia, Lardinois, van Os, & Myin-Germeys, 2013), and insomnia (Haeley et al., 1981; Morin et al., 2003).

Stress in the etiology of mental disorders not confirmed empirically

The theoretical clinical literature suggests that stress is involved in the etiology of more disorders than just those for which it has been confirmed empirical-

ly. For example, the DSM-5 classification system of mental disorders (American Psychological Association, 2013), lists additional 19 disorders, apart from the 13 mentioned above in the case of which the role of stress has found empirical confirmation.

In the case of persons exhibiting symptoms of disorders in which the contribution of stress is suggested by theory, it can be assumed that their way of coping with stress contributes to triggering disorder symptoms. However, due to the lack of confirmation in research, this assumption should be treated with caution. There probably is a need to modify coping with stress in psychotherapy in order to prevent the recurrence of the symptoms of these disorders, although this cannot be stated with certainty.

The DSM-5 lists stress-related disorders in the case of which (1) the contribution of stress to the etiology is a prerequisite – that is, reactive attachment disorder in children – and disorders in the case of which (2) the contribution of stress to the etiology is a risk factor, namely: (a) in adults – generalized anxiety disorder, panic disorder, fear of disease, pathological collecting, dissociative amnesia, explosive disorders, anorexia, abnormal sexual desire in women, disorders associated with genital-pelvic soreness/penetration in women, and (b) in adults, adolescents, or children – obsessive–compulsive disorders, specific phobia, agoraphobia, separation anxiety disorders, oppositional–rebellious disorders, behavioral disorders, nightmares and (c) in children – ADHD and stereotypic movement disorders.

COPING WITH STRESS IN REPRESENTATIVES OF THE GENERAL POPULATION OF ADULTS

Research on the skills of coping with stress applied by representatives of all adults experiencing stressful situations provides an answer to the question of how to modify coping skills in psychotherapy in order to prevent the recurrence of mental disorder symptoms. (The general population sample of adults includes people subjected to research among whom persons exhibiting symptoms of mental disorders can be found; Nietzel, Russell, Hemmings, & Gretter, 1987).

Coping with stress in an uncontrollable situation

Studies revealing that the effectiveness of coping with stress depends on adjusting the strategies of coping with stress to the degree of control over a stress-

ful situation have been identified. These studies concern the experience of loss or traumatic events over which one has no control. A meta-analysis of 20 studies (Suls & Fletcher, 1985) shows this regularity, suggesting that in the early phase of experiencing acute stress (when the impact on a stressful situation is little), avoiding thinking about the traumatic event or stressful situation results in better relief of stress, pain, and fear in patients, for example after a cardiac infarction or a surgical operation, while a problem-oriented solution is more effective at relieving stress at a later stage (when the impact on a stressful situation is greater).

A similar regularity concerning the effectiveness of coping with stress depending on the adaptation of coping strategies to the degree of control over a stressful situation is shown by other studies. The effectiveness of strategies aimed at changing the stressor or alleviating negative emotions associated with the stress experienced in a long-term stressful situation that is not subject to change has been analyzed. One of such studies (Collins, Baum, & Singer, 1983) concerns people exposed to radiation sickness, living near the area near where a breakdown of a nuclear power plant took place. Another one concerns women who have been unsuccessful with in vitro fertilization and the partners of these women (Terry & Hynes, 1998). It turned out that in a long-term stressful situation that is not subject to control, the use of strategies aimed at reducing the negative emotions associated with stress, such as the acceptance of a stressful situation (Terry & Hynes, 1998) or changing the way of perceiving a problem by positive reframing (Collins et al., 1983), reduced the stress and allowed the subjects to adapt to the stressful situation. In contrast, the use of strategies aimed at solving the problem, such as planning how to solve the problem and attempting to solve it, neither reduced stress nor allowed individuals to adapt to the stressful situation. Two of the strategies aimed at reducing negative emotions associated with stress were not effective in relieving stress, namely avoiding thinking about the problem (Terry & Hynes, 1998) and denial understood as a coping strategy, as if one were saying: “I don’t want to believe what is going on” (Collins et a1., 1983). Analyses conducted by Stanton and associates (2000) complete the information on the effectiveness of strategies aimed at reducing stress and negative emotions provided by the studies discussed above. They relate to the expression and mental processing of negative emotions in women suffering from breast cancer. The processing involves deliberate analysis of negative emotions with the intention of understanding them. In this study, distress understood as sensing negative emotional states was measured. Its severity was assessed by aggregating the severity of anger, depression, tension, fatigue, and confusion. The women who expressed negative emotions were experiencing weaker distress and weaker

side effects of medical treatment, had more energy in the course of medical treatment, and after its completion their physical condition was better compared with those who focused on negative emotions with the intention of understanding them.

Studies on persons mourning their partners suffering from AIDS (Folkman, 1997) provide further information on the effectiveness of coping with stress adapted to the degree of control over a stressful situation. Two strategies proved to be effective in relieving stress associated with a loss. They are: positive reappraisal based on redrafting the meaning of a stressful situation so as to see it in a better light and focusing on the problem that is purpose-oriented and consists in setting oneself small, realistic goals, achieveable in a day. Both are related to perceiving positive emotions as well as experiencing a sense of control and fulfillment. It was demonstrated that there is a relationship between these strategies, which suggests that a positive reappraisal underlies focusing on everyday problems and solving them with a sense of satisfaction. Four strategies turned out to be ineffective because they were associated with strong stress and negative emotions. They were three strategies aimed at reducing negative emotions associated with stress. Two of them are based on avoiding thinking about a stressful situation. They are escape behaviors, such as drinking alcohol (which temporarily improves mood), and cognitive tactics, such as imagining that things could go differently. The third one was seeking social support. It is associated with mood deterioration in the dying person's partner at the time of looking after that person and at the time of mourning after his or her death. This relationship is the strongest one month before the partner's death. It is not clear whether seeking support leads to mood deterioration or whether deteriorating mood leads to looking for support. The fourth ineffective strategy was blaming oneself for the stressful situation.

Beliefs underlying coping with stress in an uncontrollable situation

Studies suggest that the effectiveness of coping with stress in a stressful situation related to a loss or following the experience of a traumatic event depends on the positive or negative connotations of one's existential beliefs. They imply that a modification of coping with stress in such situations in psychotherapy should take such beliefs into account.

The research results mentioned above on people who experienced a loss and were mourning their partners who died from AIDS (Folkman, 1997) illustrate

a relationship between the choice of strategy for coping with stress and the accepted beliefs. The subjects who were able to feel positive emotions despite of mourning after the loss of their partner believed that it was force majeure/God that gave meaning to human life, that human life was a part of a larger plan and a part of a larger entirety. They believed that their partner after death was in a better and safer place and experienced contact with him/her. They also engaged in spiritual practices such as attending institutions related to religion and spirituality, meditation, attending talks on religious and spiritual ideas, reading literature on the subject, and meetings with spiritual or religious leaders. These beliefs were the basis for the participants' positive reappraisal of the meaning of a stressful situation that could not be changed by them and their concentration on "small" everyday life problems in order to solve them. The application of these two strategies in dealing with stress in connection with partners' death was associated with the feeling of positive emotions by mourning partners three months and a month before the partner's death as well as three and five months after his or her death (Moskowitz, Folkman, Collette, & Vittinghoff, 1996).

The relationship between existential beliefs and the effects of coping with stress in the form of either posttraumatic growth or PTSD symptoms is illustrated by the results of research on people who have experienced traumatic events (Gerber, Boals, & Schuettler, 2011). They show that positive existential beliefs are associated with posttraumatic growth, and negative ones – with symptoms of PTSD. The research whose results confirm these relationships concerns people who experienced a threat of death or a physical injury, who were involved in a car accident, a natural disaster, or an assault, who witnessed a serious injury or death of a close relative or a stranger or received information about the death or injury of a close relative, who were victims of a crime, a rape mental or sexual abuse in childhood or adulthood. It was found that having the image of a benevolent God, seeking support in him, having a sense of control over a stressor by counting on the God's help, understanding a stressor as potentially beneficial, forgiving those who do harm understood as liberation from anger and purification from sins is associated with posttraumatic growth. In this study posttraumatic growth means (1) positive changes in the field of interpersonal relationships (a feeling of having support from people, a sense of intimacy with them, the desire to express emotions, showing compassion to people, accepting the fact that one needs other people, a willingness to put effort into building interpersonal relationships), (2) exploring new opportunities (developing new interests, planning new objectives, having a sense being able to make life better, changing what should be changed, a feeling that new opportunities have appeared due to the

trauma), (3) building inner strength (feeling that one can rely on oneself, the feeling that one is able to overcome the difficulties, the ability to accept things as they are), (4) the development of spirituality (understanding spiritual matters and strengthening the faith), and (5) a positive evaluation of life (perceiving things that are important in life, seeing one's own life as valuable, appreciation of each day). When it comes to questioning the love and power of God, the feeling of rejection by God and the religious community, interpreting the traumatic event in terms of punishment for sins or as caused by Satan, or questioning the existence of God, justice, and the purpose of life in response to the traumatic event – these are associated with the symptoms of PTSD.

Based on the results of this study, it can be assumed that positive existential beliefs serve as a frame of reference in the light of which the negative meaning of a traumatic event can be positively re-evaluated. It can be further assumed that the positive meaning attributed to a traumatic event may contribute to a positive change in understanding the significance of one's personal existence. Negative beliefs mean that there are no grounds for a positive re-evaluation of the traumatic event and, as a consequence, they confirm the negative perception of reality. The hypothesis explaining the role of a positive reappraisal of the posttraumatic growth is supported by the results of other research summarized in the meta-analysis.

In the meta-analysis, a comparison (Prati & Pietrantoni, 2009) of the role of coping strategies as factors contributing to posttraumatic growth in people experiencing traumatic events shows their different weight. Coping with stress by referring to positive religious values and positive reappraisal is strongly associated with the size of posttraumatic growth. Instead, strategies such as seeking social support and acceptance demonstrate a moderate relationship with it.

The results of a study concerning the effectiveness of the strategy of expressing and mentally processing emotions in order to understand them in the context of posttraumatic growth (Manne et al., 2004) are complementary to the information provided by the meta-analysis presented above. In this study, the predictors of posttraumatic growth in women with breast cancer and in their partners measured one and a half years after the diagnosis were the different strategies of coping with stress used after receiving information about the diagnosis. In women, the predictor was the expression of negative emotions, and in men the predictors were mental processing of negative emotions and positive reappraisal. On the one hand, the results of this research confirm the efficiency of expression and the ineffectiveness of mental processing of emotions in women with breast cancer, found in the previously presented study (Stanton et al., 2000). On the other hand,

they make it clear that the effectiveness of these three strategies depends on whether they are used by a person directly experiencing the negative consequences of a traumatic event or by a person whom these consequences concern to a lesser degree.

CONCLUSIONS

The purpose of this article was to find answers to two questions of a practical nature concerning the effectiveness of psychotherapy, namely: in case of which mental disorders there is a need to modify the skills of coping with stress in order to prevent the recurrence of symptoms, and what this modification increasing the skills of managing stress would be based on. Referring to research results has provided the following answers to these questions.

Firstly, the effectiveness of modifying coping with stress in preventing the recurrence of depressive symptoms is confirmed empirically, hence the indication for the practice of psychotherapy that in people with depressive disorders or subclinical depression coping with stress should be modified.

Secondly, in the case of the 13 disorders whose etiology involves an empirically confirmed contribution of stress, it can be anticipated with a high degree of probability that in people manifesting these disorders, after a period of remission the symptoms will occur again if the way of responding to the stressors triggering them remains unchanged. Therefore, it seems appropriate to formulate the indication that in the case of these disorders coping with stress should be modified in psychotherapy. Among these 13 disorders there are acute stress disorders. In their case, it is necessary to add that an intervention is needed when they take the chronic form – that is, the form of PTSD. This is because research indicates that about 50% of people with symptoms of these disorders recover over time (Blanchard et al., 1997).

Thirdly, in case of the disorders in whose etiology the contribution of stress is suggested by the theoretical clinical literature, it can be assumed – with a lesser degree of probability than in the case of disorders in which the contribution of stress to etiology has been empirically confirmed – that in people manifesting these disorders, when stressors triggering symptoms work again after a period of remission, they will contribute to the onset of symptoms if the way of reacting to them does not change. Thus, in case of these disorders an indication can be formulated that it is necessary in psychotherapy to diagnose how patients cope with stress and, depending on the needs, to increase their skills in this area.

Fourthly, it has been proved in research that the ability to adapt the strategies of coping with stress to the degree of control over a stressful situation relieves stress. Teaching it in psychotherapy seems to be a promising method of preventing the recurrence of disorder symptoms. Studies suggest that this ability comprises (1) the differentiation between stressful situations that are controllable and those that cannot be changed as well as (2) adapting stress management strategies to them. In a controllable stressful situation, strategies aiming at the elimination of the stressor should be applied, such as planning how to solve the problem and taking an action to eliminate it. A stressful situation that cannot be changed and lasts long requires using strategies that aim at reducing negative emotions associated with stress – that is, a positive reappraisal of the situation and accepting it, expressing negative emotions, planning and implementing small objectives achievable during the day. One should also avoid using ineffective strategies of coping with stress – namely, focusing on negative emotions, avoiding thinking about the stressful situation if it lasts long, and blaming oneself for it. In the case of patients experiencing a stressful situation that cannot be changed or a traumatic event, a reference to the patients' existential beliefs seems to be necessary. Positive beliefs may be used for a positive reappraisal of the importance of such a situation or event. It can be assumed that having this ability, acquired during psychotherapy, would make it easier for patients to handle other stressful situations that cannot be changed or other traumatic events. In cases when patients acknowledge negative existential beliefs in the light of which they interpret the stressful situation or traumatic event, a change of the negative beliefs to positive ones would be needed. No change in this respect would mean a lack of resource to refer to in a positive reappraisal of the meaning of such a situation or event.

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