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Suggestion of a New Diagnostic Category: Posttraumatic Embitterment Disorder

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Abstract

Psychological reactions to negative life events have been among the most interesting subjects to researchers for a long time. In recent years post traumatic stress disorder (PTSD), in particular, has been the focus of numerous studies. This disorder is defined as a reaction to an event that is accepted as traumatic by almost everyone, to an extraordinary life-threatening event, or to a disaster. Psychological reaction to events, which are not directly life threatening, is classified as adjustment disorder and is rarely diagnosed in clinical practice. As a result of experiencing such non-life threatening events, PTSD is claimed to be an adjustment disorder as well.

Immigrants frequently report a depressive state in which physical symptoms are in the foreground accompanied by social withdrawal and diminished energy. Negative life events, which are not life threatening and are not experienced everyday, can impair mental health so that the above state may worsen and an immigrant may have a reduction in his performance at work. This state, which is accompanied by such symptoms as embitterment, feelings of injustice, repeated intrusive memories of critical events (injustice at work place, loss of a job, discrimination in a public office, etc.), phobic symptoms, and avoidance behavior towards the place or persons related to the event, might best be described by the term, posttraumatic embitterment disorder (PTED).

This disorder, which was initially described in immigrants from East Germany following the fall of the Berlin Wall, and which does not exactly match the diagnostic criteria of adjustment disorder or PTSD, is presented in a case vignette and its differential diagnosis is discussed.

Key Words: *Posttraumatic stress disorder, adjustment disorder, stress reaction, negative life events*

INTRODUCTION

Psychological reactions in response to negative life events have been among the most interesting subjects to researchers for a long time (Van der Kolk et al., 1996; Fischer and Riedesser, 1999; Maercker, 2005). ICD-10 (World Health Organization, 1992) characterizes mental disorders due to a trauma reaction into 3 groups under the heading, F43: Acute stress disorder (F43.0), posttraumatic stress disorder (PTSD) (F43.1), and adjustment disorders (F43.2). In addition, there is also the category of persistent personality change following a traumatic event (F62.1).

On the other hand, DSM-IV (American Psychiatric Association, 1994) lists PTSD (309.81) and acute stress disorder (308.3) in the anxiety disorders category, and adjustment disorders (309) as a separate category. In recent years PTSD, in particular, has been the subject of many studies (Fischer and Riedesser, 1999; Başoğlu et al., 2001; Başoğlu et al., 2004; Karakaya et al., 2004; Maercker, 2005; Aker, 2006).

PTSD is described as a reaction to a life event that is considered traumatic by everyone, an extraordinary life-threatening event, or a disaster (World Health Organization, 1992). The main symptoms of this disorder are flashbacks, hyperarousal, and avoidance behavior. In recent years there has been an effort to expand the criteria of PTSD, which was previously firmly defined. It has been proposed that PTSD, along with adjustment disorder, can also develop in reaction to life events that are not life threatening (McFarlane, 1992; Amiel-Lebigre et al., 1995; Spurrell and McFarlane, 1995; Fava et al., 2001). It is stressed that psychological abuse in the

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workplace, unemployment, losing a person close to the family, undergoing a severe illness, or separation from a loved one can act as triggers. It was reported that 80% of individuals with PTSD subsequently develop another psychiatric disorder (Hofmann, 2006). Among PTSD cases, the comorbidity of depression was reported as 26%-52% (Kaya, 2000).

Although various studies report a high prevalence of psychological reaction towards life events that do not directly pose a threat to life (Spurrell and McFarlane, 1995; Van der Kolk et al., 1996; O'Brian LS, 1998; Simon G, 2000; Fava et al., 2001; Amiel-Lebrige et al., 1995), it is seen that the diagnosis of adjustment disorder is not used as broadly as required in daily clinical practice. This diagnostic group is also ignored in epidemiological studies (Regier DA, 1988). The reasons for this are (1) the remission of symptoms after 6 months and (2) that when symptoms persist the condition generally fulfills the criteria of another disorder, such as major depression. In this regard adjustment disorders are considered a leftover category (Bronish and Hecht, 1989; Fabrega et al., 1997; Snyder et al., 1990; Despland et al., 1995). If symptoms are adequate for another psychiatric diagnosis the diagnosis is made accordingly, without considering the triggering event. The diagnosis of PTSD is considered by evaluating psychopathology (re-experiencing the event, hyperarousal, and avoidance behavior) and the triggering factor (a life-threatening and an extraordinary threatening event) together.

There are numerous studies that show a high prevalence of psychiatric disorder, especially adjustment, mood, and anxiety disorders, PTSD, and somatoform disorders in immigrants (Ekşi, 2002; Aker et al., 2002). In addition, another clinical presentation that is observed is a cluster of symptoms accompanied by depressive mood, which does not fulfill the criteria for any disorder in ICD-10 or DSM-IV (Yılmaz et al., 2000). These individuals report a state in which physical symptoms are in the foreground accompanied by social withdrawal and diminished energy (Weiss 2005). This state, which develops over a long period time, is perceived as a natural part of being an immigrant, not as an illness. and work performance of the individual is usually not affected.

A mild accident at the workplace, psychological mobbing in the workplace or in civil offices, diagnosis of a physical illness, illness of a family member, conflict in the family, or a school or child's drug problem might lead to deterioration of the condition more than expected. In addition, other events can negatively affect work performance and produce feelings of injustice and embitterment. When the triggering event is not severe enough to cause trauma, symptoms of the individual are mostly perceived as simulation in the health establishments and this causes the individual to feel alone and misunderstood, accompanied by decreased feelings of trust and the development of hostility.

In this article a condition called posttraumatic embitterment disorder (PTED), which can be considered to exist between PTSD and adjustment disorders, will be defined and discussed in terms of a case presentation.

Posttraumatic Embitterment Disorder (PTED)

PTED was initially described in immigrants from East Germany following the fall of the Berlin Wall in a pilot study conducted in 1999 (Linden et al., 2004). This psychological reaction towards life experiences that are not life threatening, but are exceptional, though normal negative l event, is defined as PTED. Immigration from the east to the west began in Germany after the fall of the Berlin Wall. These immigrants were not welcomed by West Germans and were treated as eastern immigrants. There was no significant increase in terms of psychiatric disorders among those immigrants immediately after the fall of the wall (Acherberger et al., 1999); however, in the following years, psychological disorders followed by significant professional or individual changes were observed. Nearly 30% of these immigrants considered themselves as losers. (Schwarzer and Jerusalem, 1994).

The triggering factor for the development of psychological symptoms was most often an extraordinary experience that was not life threatening, but which led to definite negative consequences, with a high probability of causing disappointment and which could damage the vital or cognitive values of the individual. In turn, these individuals might develop a condition that can be defined as embitterment. PTED patients develop symptoms similar to those seen in PTSD, such as persistent re-experience of the triggering event and avoidance behavior. Emotional fluctuations occur when remembering the event, and depressive mood, diminished energy, and a tendency towards rage and violence might be present. At other times, the patient's mood is stabile and the individual is generally able to carry on with his/her normal life (Linden, 2003) (Table I).

Clinical presentation

The pilot study conducted with the presentation of this disorder revealed the following (Linden et al., 2004):

Table I. (Linden et al., 2004).

PTED diagnostic criteria.

A. Main criteria

1. Presence of a negative life event followed by a mental disorder.
2. The patient consciously holds the negative event responsible for his condition.
3. The patient evaluates the experience as an injustice.
4. The patient feels embitterment and rage when talking about the event.
5. The patient re-experiences the event and it is important for the patient not to forget the event.
6. The ability to regulate mood is intact. When attention is oriented towards other things the mood is normal.
7. There is no history of psychiatric disorders before the negative experience; the current condition cannot be evaluated as a relapse of a past condition.

B. Additional symptoms

1. The patient perceives himself as a victim, and feels helpless and unable to cope.
2. The patient blames himself for not being able to cope with the event.
3. The patient mentions that he is not interested in anything, not even getting better.
4. Suicidal ideation may be present.
5. Mood is depressive, dysphoric, and aggressive, resembling major depression.
6. The patient may present with a series of non-specific somatic symptoms, such as sleep disorders, loss of appetite, or pain.
7. The patient presents phobic reactions towards the place of the event or the event.
8. There is loss of energy, the patient feels powerless and exhausted.

The majority of patients rejected all help; they obtained illness reports from their family physicians, but rejected any kind of treatment; they generally presented to psychiatry clinics long after the initiation of symptoms, mostly in response to pressure from the security companies. Linden et al. examined a patient group composed of 20 women and 2 men. The group included patients referred from different clinics with different diagnoses.

All of the patients reported at least one significant experience that subjectively caused pain. All of the patients stated that this experience was the cause of their illness. These events were (listed from most to least frequent) unemployment, problems in the workplace, loss/death of somebody close, and familial conflict. The majority of patients had feelings of injustice and reported that the situation was irreversible. Above all else, they had feelings of embitterment, rage, and helplessness. Again, the majority of patients reported avoiding the place at which their experience took place. Some of the patients had comorbid major depression-dysthymia, generalized anxiety disorder, agoraphobia, and panic disorder diagnoses.

PTED can be seen in immigrants as a result of different life experiences, such as separation, psychological mobbing in the workplace, or the loss of a job. Although such experiences can occur at any time, they can negatively affect the basic values of the individual when experienced during important periods in life.

This condition will be discussed with a case example.

Case

A 46-year-old Turkish man living in Basel, Switzerland was married, had 2 children, and was unemployed. He did not require psychiatric help until an accident in the workplace 2 years ago. He was hospitalized after falling from a height of 3 meters in the plastic barrel factory that he had been working at for 10 years. He received a medical report after the detection of a crack in his shoulder that stated he was unable to work. As the foremen was absent during the accident, he had to leave the factory without getting permission and was subsequently fired because it was determined that the accident was

unrelated to the workplace and that he was lying about it. This caused the patient great sadness and disappointment. He reported that he could not believe he was fired and that he was disappointed. He claimed that he had never missed a day of work, that the job was his job, and that he had a good relationship with his colleagues. He said that as a result of the passivity of the people he knew for years, especially those who witnessed the accident, his trust in people was shaken, he had feelings of injustice, hated the people he worked with, withdrew from social activities, and could not stand to see anyone. He shyly mentioned that he frequently dreamt of taking revenge and of the foremen and friends who witnessed the accident experiencing a similar accident. He mentioned that in his imagination he had beaten them up a number of times. He reported that he still enjoyed being with his family and closest relatives, and felt happy. If the experience came into his mind while in bed he had difficulty falling asleep and become angrier. He said that he did not want to repeat the same things over and over in his mind, and felt like he was losing control due to his anger. He said that the family physician referred him to a psychiatric clinic, but that he could not accept having a mental disorder and rejected treatment for a long time.

He also reported that he was coming for treatment as a result of pressure from his insurance company. He changed his route when he saw someone from work on the street and avoided the vicinity of his former workplace. He said that his younger son who abuses marijuana (16 years old) and older son, a young adult 22 years old did not ask anything of him, and he felt worthless and useless as a father.

This weakness in the family bond increased after he lost his job and he said that he was totally embittered towards life. He related all his problems to being in a foreign country, saying that if he had not left his home country years ago he would not have had such experiences and discrimination in the workplace, and that his children would have grown up with their own culture and that the family's bond would have been stronger.

Past history: The patient was born in one of the villages of Maraş, Turkey in 1959, the third of 9 siblings. As far as he remembered, he was born under normal conditions with the help of a midwife. He never went to school and worked in the field from the age of 10 years, like his other siblings. Although he had an older brother, he was the one who was responsible for his siblings. He described himself as an honest, helpful, and fair person that hates lying. After the completion of his military service, he came to Basel in 1985 to work to be near his cousin. He started working shortly after his arrival and has not worked since he was fired 2 years ago. He has two son aged 22 and 16 years.

Family History: There were no physical or psychiatric disorders in the family.

Mental Status Examination: The patient, a male 1.75 meters tall and weighing 75 kg, had brown skin and masculine-type hair loss. His clothes were clean and neat. His personal hygiene was normal. He talked with a hesitant low voice and was shy, but maintained eye contact. His orientation was intact and psychomotor activity was natural.

He reported that he was embittered towards life and he had responsibilities towards his children and wife who now support him. He had difficulty sleeping when the event came into his mind, and difficulty concentrating. He had feelings of helplessness and rage when he remembered the injustice done to him. He reported re-experiencing the event and felt full of rage each time. He avoided going near his workplace or seeing his friends from work. His mood was mildly depressive and dysphoric, but his ability to regulate mood was intact. He reported that he could feel joyful and happy with his family when there were no problems. His thought content and perception were normal. There was no suicidal ideation. Alcohol and substance anamnesis were absent.

Differential diagnosis: The first diagnosis consisdered was major depression due to his depressive mood and diminished energy. His ability to regulate his mood was intact, ranging from moderate to severe depression; his mood elevated when he oriented his interest to another thing or had fantasies of revenge. He was able to do daily activities, such as shopping, going on holidays with his family, reading newspapers, and watching television. Major depression frequently accompanies PTED, as it does PTSD, and psychopathological symptoms in the patient (depressive mood, diminished energy, difficulty sleeping when remembering the experience, difficulty concentrating) only met the criteria for mild or moderate depression.

Due to his experiencing a traumatizing event, (getting fired), the possibility of adjustment disorder with depressive mood was also considered; however, the patient's complaints specific to PTED (evaluating his experience as unfair, feelings of rage and helpless, avoidance of his workplace, etc.) did not show a tendency towards improvement, as in adjustment disorders; conversely

they worsened over a 2-year period. Due to the existing depressive syndrome, psychopharmacological treatment with an SSRI antidepressant was initiated and approximately 3 months later a significant reduction was seen in the depressive symptoms. Recurrent recollections of the event and re-experiencing the event suggested the diagnosis of PTSD. In addition, he developed an avoidance behavior, as seen in PTSD. The important point in differentiating the diagnosis from PTSD is that the experience was not life threatening or scary, and that it evoked embitterment and rage feelings in the patient. The condition lasting more than 2 years and exacerbating with time was reminiscent of the enduring personality change observed after catastrophic experiences; however, the problem here was the absence of torture, a disaster, or an event that is a persistent threat to life, which are the characteristics of PTSD and sine qua non prerequisite. In addition, symptoms such as permanent hostility and distrust towards all people, feelings of emptiness and hopelessness, and chronic aggressive feelings were not evident.

DISCUSSION

The Turkish term, hayata küsme, was suggested to be the equivalent of the German word, verbitterung, and its English equivalent, embitterment. The dictionary meaning of verbitterung is embitterment, unhappiness, and hostility towards people. The dictionary meaning of embitterment is being sad, to be tired of living. It was believed that the term, hayata küsme, was the best equivalent of the experiences of patients with this clinical presentation.

It was proposed that although they may present simultaneously, the condition of embitterment should be evaluated in a different category than depressive mood, hopelessness, and rage (Alexander, 1966; Baures, 1996). Embitterment arises when an individual is victimized by society (Pirhacova, 1997) or it is defined as a mood reaction towards long-term unemployment (Zemperl and Frese, 1997). The illness value of embitterment is measured by the degree of restriction on an individual's life, as it is in depression or anxiety disorders. If this feeling hinders the daily chores of the individual or is seen together with other symptoms, then it has an illness value. The clinical course of PTED is generally poor. In contrast to adjustment disorders, there is no remission in 6 months and there is a tendency towards exacerbation and chronicity. The diagnosis is not made according to the experienced event, but by considering the type, severity, and course of the presenting psychopathology (Linden et al., 2004). The triggering factor, though, has diagnostic importance. The development of the disorder cannot be understood and treatment cannot be planned without considering the triggering factor. Although the triggering factor is not a life-threatening event, it is also not an ordinary everyday experience. Therefore, another question to consider is whether the experience was traumatic or not. When considered from the patient's point of view, there is no doubt that the event is a trauma. The patient remembers the event and its exact date and time, and feels disappointed and hurt; in other words, traumatized.

The relationship between the triggering event and an individual's perception of it is not non-specific, as in depression, but is direct, as in PTSD. In addition, psychopathological symptoms, such as re-experiencing the event and avoidance behavior, are seen as in PTSD.

Fear of death and feelings of terror are specific to the etiology of PTSD, but in PTED the experience evokes rage and embitterment. Although PTED partially overlaps with adjustment disorders, when the timing criterion is considered it is closer to PTSD than adjustment disorders. For all these reasons PTED can be considered a diagnosis between PTSD and adjustment disorders. This condition that was observed in East Germans who immigrated after the fall of the Berlin Wall has also been observed in Turks who emigrated from Anatolia to Europe. In Linden et al.'s (2004) study there was no increase in the frequency of psychiatric disorders in the East Germans with PTED the first few years after immigration, which is similar to the findings among Turks who had migrated to Europe (Weiss, 2005). Sluzki (2001) proposes that the immigration process involves 5 steps: Preparation, immigration, excess adjustment, adjustment disorders phases, followed by a normal adjustment phase, which also includes the next generation. Negative life experiences, such as loss of a job, psychological mobbing in the work place, and the loss of somebody close, during the adjustment disorder phase (when the dream of returning home collapses and the individual realizes that returning home is impossible for various reasons) contribute to the development of psychiatric disorders (Koch, 1995).

Psychological regression, accompanied by lack of self-confidence, helplessness, and anxiety, was observed, especially among first generation Turkish immigrants in Europe that had undergone pressure and abuse for years, worked in bad conditions for relatively low wages, never realized their dream of returning home, were treated as

foreigners in both Europe and Turkey, adopted a individualist life style with the influence of western culture, and who were misunderstood even by their own children (Grinberg and Grinberg, 1999). Therefore, the values that these individuals overestimated and built their lives upon, made them vulnerable to all kinds of wounds. From the cognitive perspective, extraordinary experiences, such as loss of one's job, experiencing injustice at work, divorce, or loss of a loved one, might result in damage to an individual's basic cognitive schemas. Frequent experiences of negative life events can result in a decreased ability to plan or find meaning in life (Schippan et al., 2004). A lack of coping with complex, hard to solve problems is observed in patients with PTED. When an immigrant living with the dream of returning home and a life centered around work loses various individual, social, or familial resources and cannot cope when faced with a relatively less severe negative life experience, they can present with PTED, in addition to mood and/or anxiety disorders and adjustment disorders.

In Turkey, which experienced intense immigration to Europe between 1960 and 1980, the concept of internal immigration based on economic and ideological reasons is also an important public mental health problem.

PTSD, mood and anxiety disorders, and somatoform disorders can be seen in individuals who experience mandatory immigration (Sır et al., 1998; Ekşi 2002; Aker, 2002). It is believed that the diagnosis of PTED, as described above, can be useful in understanding and treating psychiatric problems due to domestic immigration. Variation in the symptoms of immigrants with traumatizing experiences is beyond the borders of DSM-IV and ICD-10 diagnostic systems; therefore, as currently 1 out of every 3 individuals are immigrants, the number of case presentations and population studies in this regard needs to increase, and discussions need to be broadened in order to increase the attention of the issue given by diagnostic systems such as DSM-IV and ICD-10. Additionally, further research is necessary in order to understand if PTED presents independently of immigration, if it should be regarded as a separate diagnostic criteria, or if the diagnostic criteria for PTSD or adjustment disorders should be broadened.

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