

The Psychopathology of Posttraumatic Embitterment Disorders

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Key Words

Embitterment · Adjustment disorders · Reactive disorders · PTSD · Stress

Abstract

Background: The posttraumatic embitterment disorder (PTED) was introduced as a new subgroup of adjustment disorders. The trigger event in PTED is an exceptional, though normal negative life event that is experienced as a violation of basic beliefs and values. The predominant emotion in PTED is embitterment. This study presents first data on the psychopathological profile of PTED. **Method:** 48 inpatients were diagnosed by clinical judgment as suffering from PTED. Patients were then interviewed with the standardized Mini International Neuropsychiatric Interview (MINI) and an additional interview section on the diagnostic criteria for PTED. Patients also filled in the Symptom Checklist-90-Revision (SCL-90-R), and the Impact of Event Scale (IES-R). **Results:** According to the MINI 68.8% of the patients fulfilled the criteria for adjustment disorders, 52.1% for major depression, 41.7% for dysthymia, and 35.4% for generalized anxiety disorders. 100% of patients reported that they were suffering from intrusive thoughts about the event. 97.9% of the patients complained about persistent negative mood, 91.7% about restlessness, 83.3% inhibition of drive and loss of interest, 77.1% phobic avoidance of places related to the event, and 75% resignation, but 91.7% reported normal mood when distracted. The SCL-90-R indicated a high load of gen-

eral psychopathological complaints with an average positive symptom total score of 52.26. Characteristic were feelings of injustice (100%), embitterment (97.7%), and rage (91.7%). The IES-R scale indicated a high prevalence of posttraumatic stress, with an average total score of 3.23. The average duration of illness was 31.7 months. **Conclusions:** The PTED patients are suffering from severe, multiform, and disabling symptoms. Their clinical features pose difficult diagnostic problems. The predominant complaints about feelings of injustice, embitterment, and rage and the results of the IES speak for the importance of the critical event for the development and understanding of such disorders.

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Introduction

It is generally accepted in clinical medicine that stressful life events can impair psychological and somatic functioning [1–3]. The ICD-10 [4] lists under the heading of ‘reaction to severe stress and adjustment disorders’ (F43) (1) acute stress reaction (F43.0), (2) posttraumatic stress disorder (PTSD; F43.1), (3) adjustment disorders (F43.2), and (4) enduring personality change after catastrophic experience (F62.0). In the DSM-IV [5] there is the class of ‘adjustment disorders’ with the possibility to differentiate between predominantly depressed mood (309.0), anxiety (309.24), mixed depression and anxiety (309.28), disturbance of conduct (309.3), and disturbance of con-

Table 1. Diagnostic criteria of PTED

A	Core criteria
1	A single exceptional negative life event precipitates the onset of the illness
2	Patients know about this life event and see their present negative state as a direct and lasting consequence of this event
3	Patients experience the negative life event as 'unjust' and respond with embitterment and emotional arousal when reminded of the event
4	No obvious mental disorder in the year before the critical event. The present state is no recurrence of a preexisting mental disorder
B	Additional signs and symptoms
1	Patients see themselves as victims and as helpless to cope with the event or the cause
2	Patients blame themselves for the event, for not having prevented it, or for not being able to cope with it
3	Patients report repeated intrusive memories of the critical event. To some extent they even think that it is important not to forget
4	Patients express thoughts to the effect that it does no longer matter how they are doing and are even uncertain whether they want the wounds to heal
5	Patients can express suicidal ideation
6	Additional emotions are dysphoria, aggression, downheartedness, which can resemble melancholic depressive states with somatic syndromes
7	Patients show a variety of unspecific somatic complaints such as loss of appetite, sleep disturbances, pain
8	Patients can report phobic symptoms in respect to the place or to persons related to the event
9	Drive is reduced and blocked. Patients experience themselves not so much as drive inhibited but rather as drive unwilling
10	Emotional modulation is not impaired and patients can show normal affect when they are distracted or can even smile when engaged in thoughts of revenge
C	Duration: longer than 3 months
D	Impairment: performance of daily activities and roles is impaired

duct and emotion (309.9). Further categories are PTSD (309.81) and acute stress disorders (308.3) which are listed under anxiety disorders.

In contrast to other axis I disorders adjustment disorders are rather vaguely defined and seen as a category

which only applies if criteria for other axis I diagnoses are not fulfilled. They are furthermore seen as limited in time and should show remission after some months [6–8]. Only PTSD has in the last years received the status of a well-defined disorder [9, 10]. There must be a traumatic event in which a person experiences, witnesses, or is confronted with the threat of death, serious injury or a threat to one's own physical integrity, resulting in intense fear, helplessness, or horror [4]. Characteristic symptoms are intrusion, hyperarousal, and avoidance behavior. As this is the only clearly defined 'reactive disorder' there is now in clinical practice a tendency to use this diagnosis also in cases where instead of a life-threatening event, other negative life events have caused severe changes in the mental status of patients. This speaks for the necessity to further subclassify adjustment disorders.

Modeled after PTSD, Linden [11] described the post-traumatic embitterment disorder (PTED). The trigger event in PTED is not an anxiety-provoking and life-threatening stimulus but an exceptional, though normal negative life event like conflict at the workplace, unemployment, the death of a relative, divorce, severe illness, experience of loss or separation. The illness develops in the direct context of the event. The common feature of such events is that they are experienced as unjust, as a personal insult, and psychologically as a violation of basic beliefs and values. The psychopathological reaction is a prolonged feeling of embitterment. Additional symptoms are intrusive thoughts [12] and avoidance of situations or objects which are connected to the event, self-blame, anger, depression, hopelessness, phobia and somatic symptoms, and suicidal tendencies. If patients are reminded of the critical event they typically react with acute emotional arousal. The duration of the disorder is longer than 6 months and daily role performance is impaired. The symptomatology cannot be explained by preexisting mental disorders or personality disorders. These patients have instead often been functioning especially well before the event. The diagnostic criteria are summarized in table 1.

The predominant emotion in PTED is embitterment, which can be characterized as a feeling of having been let down, of injustice and helplessness together with the urge to fight back and the inability to identify a proper goal. Embitterment is an emotion which in many cases does not cease via self-regulation, and can continue unabated. Although embitterment is a far more impressive and destructive emotion than anxiety or depression, only few scientific studies have addressed this affect. While for example the index of the *Textbook of Psychiatry* [13] shows

42 references related to anxiety and 53 references related to depression, no reference to embitterment can be found. Also, embitterment is not mentioned in established psychopathological manuals [14]. This is surprising, given the fact that prolonged embitterment can lead to impressive psychopathological symptoms. Pirhacova [15] describes embitterment as caused by social injustice. Zemperl and Frese [16] observe this emotion as a reaction to protracted unemployment. Baures [17] mentions embitterment and hate in connection with extreme trauma. Webster [18] addresses bitterness revival as a function of reminiscence. Znoj developed an 'embitterment scale' [Der Berner Verbitterungsfragebogen; unpubl. data] during his work with cancer patients.

Since the first description [11] data from a pilot study have been published [19], which showed that PTED patients are severely impaired and suffering from a variety of psychopathological signs and symptoms. In elaborating this finding a research project has been started to further study these patients. The present paper reports the results of an enlarged study on 48 thoroughly selected patients with PTED and is the first comprehensive empirical description of the psychopathological profile of this disorder.

Method

All participants were inpatients in the Department of Behavioral Medicine and Psychosomatics at the Rehabilitation Centre Seehof, Teltow/Berlin, where patients are treated who suffer from all kinds of chronic mental disorders and who come mostly from Eastern Germany. The majority of patients are sent by their physicians or by insurance companies due to prolonged sick leave. Thus many patients did not come on their own initiative.

During a period of 20 months all physicians of the department were asked to name patients who might suffer from PTED. 88 patients were reported and examined by one of the authors (B.S.). On the basis of an extensive clinical examination she diagnosed PTED in 48 patients (28 women, 20 men) according to clinical judgment and impression in reference to the criteria as outlined in table 1. The age of the participants ranged from 30 to 61 years (mean = 49.8; SD = 6.99).

Following recruitment, patients were interviewed by another researcher using standardized instruments. The Mini International Neuropsychiatric Interview (MINI) [20] was used to assess psychiatric diagnoses. A standardized diagnostic interview for PTED, which had been developed in the pilot study [19], was used to ask for diagnostic criteria of PTED. Patients also filled in as self-report questionnaires the Symptom Checklist-90-Revision (SCL-90-R) [21] and the Impact of Event Scale (IES-R) in the modification published by Maercker and Schützwohl [22]. The IES-R was subsequently included into the study, so that only 36 of the participants filled in the questionnaire.

Results

Every patient reported at least one critical life event, which he or she experienced as unjust and insulting. All patients saw this event as the direct cause of their present state and of a persistent negative change in their well-being. There were no indications for preexisting mental disorders or personality disorders which possibly could explain the change in the mental status of patients.

According to the MINI diagnostic interview patients fulfilled criteria for many different disorders, i.e. adjustment disorders (68.8%), major depression (52.1%), dysthymia (41.7%), generalized anxiety disorders (35.4%), social phobia (18.8%), agoraphobia (18.8%), panic disorder (12.5%), alcohol abuse (6.3%), obsessive-compulsive disorder (OCD; 4.2%), and PTSD (2.1%). Although the patients complained about multiple somatic symptoms, no diagnosis of somatization disorder could be made, because the diagnostic criteria were not met (age over 30, many somatic complaints over several years, onset of complaints before the age of 30, strong influence on every day life).

The duration of illness ranged from 6 to 144 months (mean = 31.7; SD = 35.5). The critical life events were in 72.9% work related, in 12.5% related to the family or partnership, in 8.3% it was the death of a relative or a friend, and in 6.3% an illness.

Looking at psychopathological signs and symptoms in more detail, all patients reported that they were suffering from intrusive thoughts and memories about the event during the last months (fig. 1). 97.9% of the patients complained about persistent negative mood and 91.7% about restlessness since the critical event. 77.1% of the patients avoided places and persons, reminding them of the event. 75% showed general resignation since the event, and saw no meaning in further effort. 83.3% complained about loss of interest, 83.3% about inhibition, and 79.2% about early awakening, symptoms which are typically seen in melancholic depression. Different from melancholic depression, 91.7% showed normal affect and unimpaired affect modulation when distracted.

In the self-rating SCL-90-R patients showed a high load of general psychopathological complaints, with an average PST (positive symptom total) score of 52.26 (SD = 17.59), and an average GSI (global severity index) score of 1.13 (SD = 0.56). High scores were also seen in the subscales: depression (1.55), obsessive-compulsive (1.48), anxiety (1.22), somatization (1.10), paranoid ideation (1.07), anger-hostility (0.98), interpersonal sensitivity (0.95), phobic anxiety (0.67), and psychoticism (0.61).

Fig. 1. Psychopathological spectrum in connection with the critical event. Assessed by the standardized diagnostic interview for PTED (%).

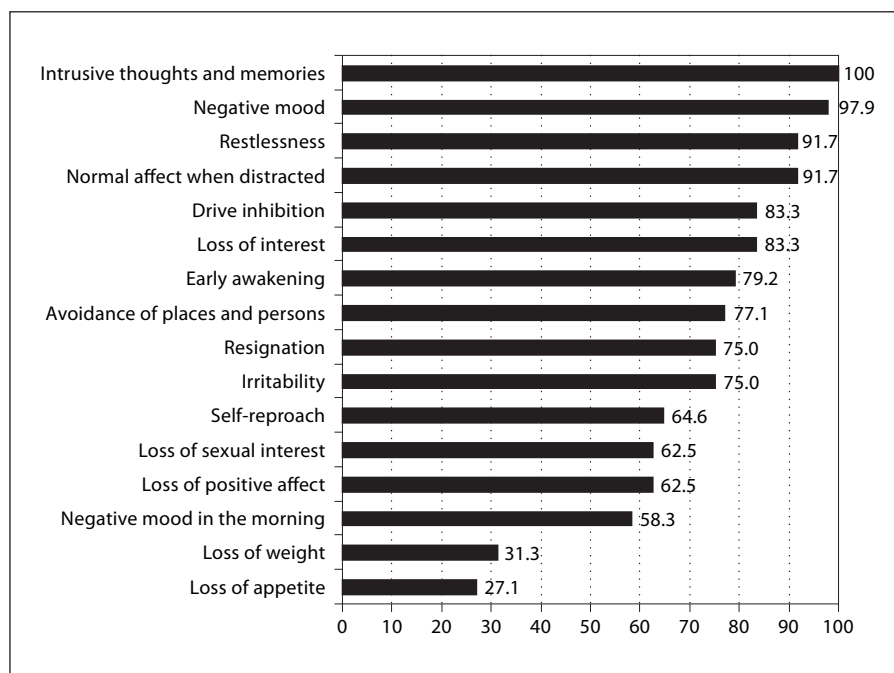
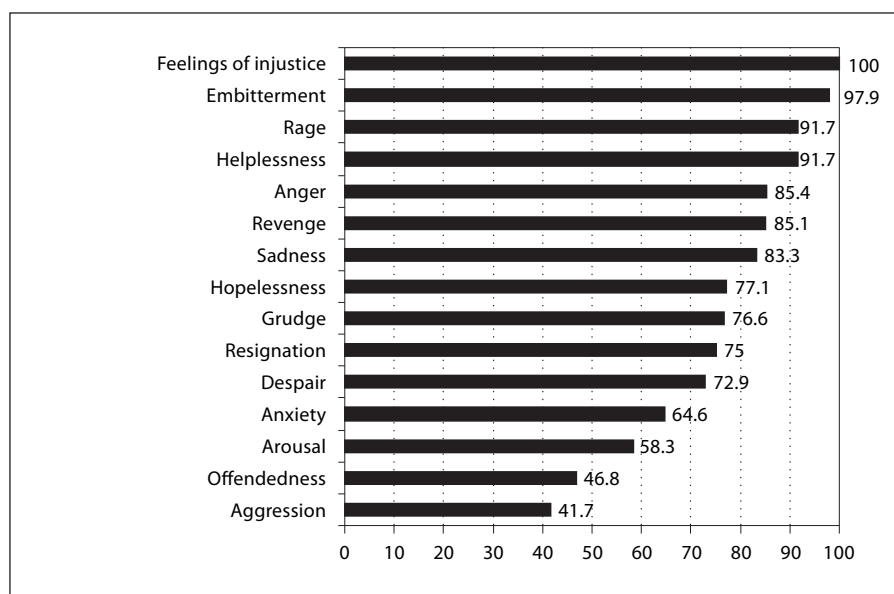


Fig. 2. Emotional spectrum in connection with the critical event. Assessed by the standardized diagnostic interview for PTED (%).



When asking for emotions related to the memory of the critical event, all patients reported to have experienced the critical event as unjust and unfair (fig. 2). Furthermore, they complained about embitterment (97.7%), rage (91.7%), helplessness (91.7%), and anger (85.4%). 85.1% would welcome, if the responsible person would be called to account. Moreover, a general decline in social activities was found. 79.2% of the patients indicated a reduction in their occupational activities, 75% a reduction

in leisure time activities, and 54.2% a reduction in family activities.

The IES-R scale indicated a high prevalence of post-traumatic stress among the patients (fig. 3) with an average total score of 3.23 (SD = 0.64). Particularly high scores could be seen within the subscales intrusion (mean = 3.77; SD = 0.65) and hyperarousal (mean = 3.50; SD = 0.75). The average score in the avoidance subscale was 2.51 (SD = 1.06).

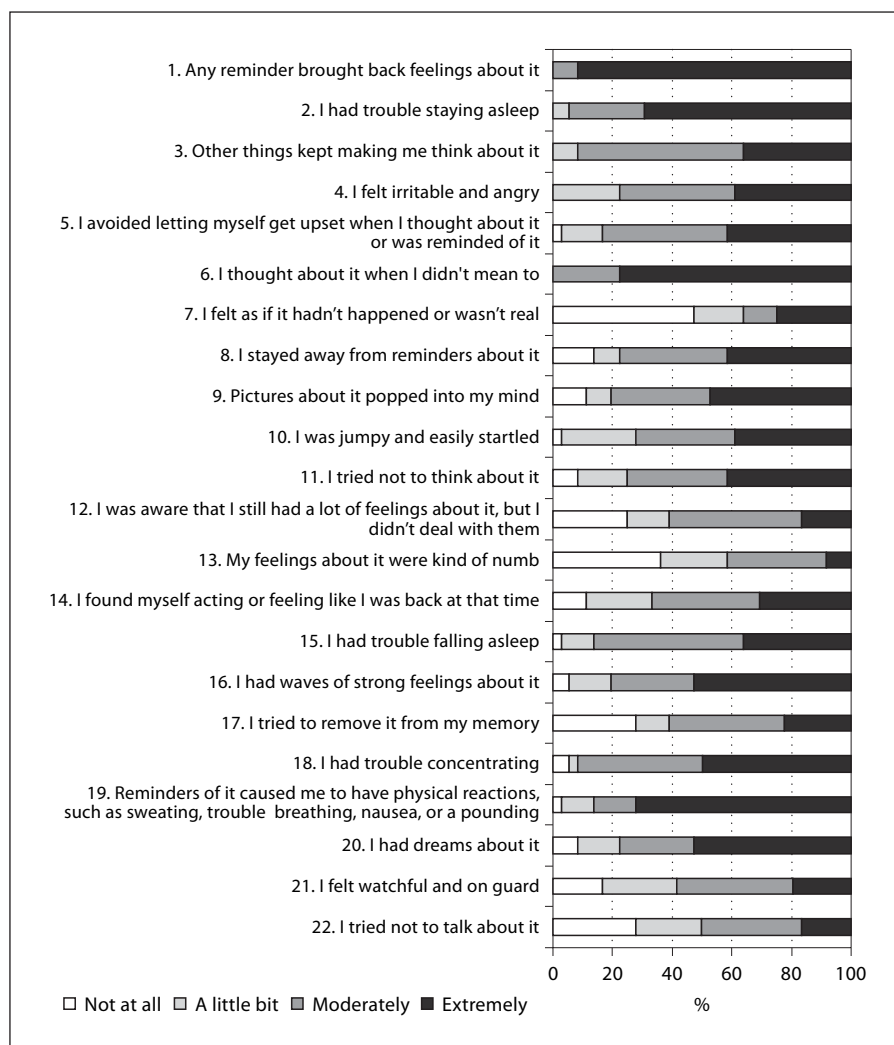


Fig. 3. IES-R (n = 36).

Discussion

The first descriptions of PTED have been based on clinical and theoretical considerations [11, 19], as many such patients are seen in clinical routine and cannot be sufficiently classified otherwise. An additional reason to further subclassify adjustment disorder comes from the observation that the term 'PTSD' is often used indiscriminately for many other reactive disorders without a life-threatening or anxiety-provoking event. This study reports first empirical data on the clinical features of PTED, to describe this disorder and support the concept of an additional subform of adjustment disorders.

Despite its impressive pathological properties, embitterment, until today, has been neglected in behavioral science. Our study shows how severely impaired patients

with PTED are in respect to psychopathology. Patients who react with prolonged embitterment to a negative life event can develop impressive psychological symptoms. Similar to anxiety or depression, embitterment must be understood as a dimensional phenomenon, which becomes pathological when reaching greater intensities, when it is associated with additional symptoms, and when daily role performance is impaired. Our patients undoubtedly fulfill these criteria and must be called ill!

In contrast to other adjustment disorders the symptomatology found in PTED does not show a tendency of spontaneous remission. On the contrary, patients tend to actively keep memories of the event alive. Given the fact that 52.1% of our patients fulfill the criteria of major depression and that 97.9% reported persistent negative mood, one could argue that a majority of our patients was

suffering from depression rather than PTED. Negative life events can be associated also with depression, be it primary or secondary [23–25], and lead to rumination [26, 27]. There is also some literature on anger, irritability, aggressiveness, and hostility in the context of depression [28, 29]. However, our data point to some important differences between depression and PTED. In contrast to depression, patients with PTED can display normal and positive affect when distracted or engaged in revenge fantasies. More important, the modulation of affect is unimpaired. Furthermore, there is not only a close causal connection between a single negative event and the onset of the illness in PTED, but this is also followed by intrusive thoughts. The full spectrum of symptoms, including aggressive tendencies, intrusive thoughts, phobic avoidance, or anger, can only be understood in relation to the precipitating event. A very difficult question is whether there are pre- or comorbid personality disorders, as one cannot make a valid personality diagnosis while the patient is suffering from another acute mental disorder. The clinical observation is that neither in respect to the history nor to the present status are there indicators for personality disorders as defined in ICD-10 or special personality traits, e.g. narcissistic, which could be seen as linked to PTED.

While traditionally, adjustment disorders have been defined by the negative life event (e.g. pathological grief reaction, mobbing reaction), PTSD opened a new understanding of reactive disorders, as it is defined not by a specified event (rape, car accident, war trauma) but by a psychological process (unconditioned panic reaction) and a specific pattern of symptoms (e.g. intrusion, anxiety). Similarly, PTED is not defined by the critical event, but by a psychological process (violation of basic beliefs) and by the type, severity and course of psychopathology (embitterment, intrusive thoughts, irritability, dissociation, phobic avoidance). Any treatment will have to integrate the trigger event in order to be effective. Therefore, we think that our data support the notion that PTED is a distinct concept with its own etiology and symptomatology.

Due to the fact that the trigger events in PTED are exceptional but usual life events, one could ask if the term ‘trauma’ is appropriate. The patients themselves certainly perceive the event as traumatic. They determine the onset of their suffering to the day and hour. Moreover, they experience themselves as ‘being hurt’ by the event, which is synonymous to being traumatized. From a clinical and scientific perspective the term ‘trauma’ seems to be suitable, because it emphasizes the specific connection

between the trigger event and the psychopathological reaction.

While in PTSD fear of death and panic are specific etiological factors, PTED can be seen as a disorder, in which the pathogenic properties of information are the decisive factors. Thus, PTED is a new clinical concept of general significance for psychopathological research.

The precipitating event is typically perceived as unjust, and many patients want the world to see how bad they have been treated. As a result, many patients are not cooperative in treatment; some fully reject help or even compensation. In our daily clinical work we make the experience that treatment of patients with PTED is difficult. It is hoped that the description of PTED as a distinct subgroup of adjustment disorders will help to develop new treatments.

As PTED is a developing and new concept, further research is needed. The quality of embitterment needs to be outlined more precisely, and its diagnostic assessment must be improved. Also, it has to be stressed that our patients were inpatients. Data from population studies are needed. Furthermore, the characteristics of the critical events need additional exploration. In addition, possible risk factors for the development of PTED should be examined. It must also be stressed that there anxiety like in PTSD or embitterment like in PTED are not the only possible reactions to stressful life events, but these concept can help to better classify at least some patients with respective problems.

In summary, these first empirical results on PTED show that this disorder is associated with severe psychopathological impairment and that it deserves more scientific and clinical attention.

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