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Psychological Trauma: Theory, Research, Practice, and Policy

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EMBITTERMENT IN PSYCHOLOGICAL TRAUMA

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Demoralization and Embitterment

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Objective: Individuals may experience a wide range of psychological reactions in response to negative life events. Even if events that threaten life have been always played a central role in research, recent studies have outlined that experiences, considered exceptional but part of the human existence (e.g., divorce, unemployment, or chronic illness) may also lead individuals to experience enduring emotional states of suffering. Demoralization has been substantially described as an important condition occurring in response to stressful events, while a recent interest is growing on embitterment as a common reaction. ***Method:*** By analyzing the most relevant studies (MEDLINE, EMBASE, PsycLit, and Cochrane Library), this article discusses the main features of embitterment and demoralization, summarizing the similarities as well as the differences detectable between the 2 constructs. ***Results:*** Some authors have described these phenomena as spectrum or gradients that start with normal human responses until getting to pathological conditions, characterized by prolonged intense psychological distress in relation to stressful events. Both have shown distinct psychopathological features than other stress-related mental disorders and have been recognized as predictors of negative outcomes, such as impairment in work and social functioning, reduction of quality of life, risk for mental and physical disorders, and suicidality. ***Conclusions:*** Demoralization and embitterment are multidimensional phenomena, connected to each other by bridge dimensions and in the meanwhile characterized by distinct features. Accurately exploring these clinical conditions is an ongoing challenge to clinicians and researchers, who are called for improving their recognition and proper therapeutic interventions that can ameliorate patients quality of life.

Keywords: demoralization, embitterment, demoralization syndrome, post traumatic embitterment disorder, negative events

Over the last decades, research has considerably focused attention on the great variability of psychosocial responses of individuals who face stressful life events (Schneiderman et al., 2005). It has been demonstrated that significant differences exist in the way people cope and react to stress because of both the specific characteristics of the negative situation, including the severity of the stressful event, and the individual cognitive appraisal, including the subjective meaning and impact of the event and the grade of controllability. With respect to the latter issue, a number of studies have placed increasing emphasis on the factors that may influence the individual emotional response, considering that the role of the interpretation of an event as "traumatic," or with "strong emotional impact" is extremely important. For this reason, experiences that are common in life because part of human existence (e.g., divorce, unemployment, loss loved ones, diagnosis of medical chronic, or life-threatening illness) may become extremely stressful for a certain individual but not for another, with the existing literature and clinical observations showing that various emotional and behavioral reactions or clusters of emotions and behaviors can emerge (Znoj, 2011; Znoj et al., 2016). Many studies have to date defined and proposed appropriate models, attempting to provide explanations of these different responses. Recently, Znoj (2008) has proposed the "circumplex model" to define the emotional states in response to stressful events on the basis of two main dimensions, namely having the potential of changing the situations (hope for change) and locus of control in terms of attributing the situation to internal or external responsibilities (control attribution). According to this model, as a consequence of a negative stressful event, the individual can express one of four emotional states, different from each other for quality and that can be represented on a gradation ranging from a lower intensity to a high level of suffering. More particularly, these factors are represented by "development" (hope for change or internal locus of control), which can lead the person to achieve personal growth; "aggression" (hope for change or external locus of control), which can lead at highest degree to revolution and violence; "depression" (hopelessness or internal locus of control), to the development of clinical depression and suicide; "embitterment" (hopelessness or external locus of control), to hatred and (self-) destruction (Znoj, 2011). This conceptualization of embitterment is in line with the definition formulated by Linden (Linden, 2003; Linden et al., 2007, 2008a), who describes embitter-

AQ: 4

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tapraid5/tra-tra/tra-tra/tra99917/tra0750d17z | xppws | S=1 | 9/22/17 | 4:20 | Art: 2017-0916

ment as a psychological reaction to a stressful event that is perceived as unjust or as a "violation"—caused by others who are identified as the main responsible for what happened—of personal basic beliefs and assumptions. This emotional state is characterized by a long and exhausting feeling of bitterness, defeat thoughts and desire for revenge, intrusive memories and thoughts on the event, feelings of anger, and hostility. Furthermore, perceiving the situation as uncontrollable typically lead persons to experience feelings of helplessness, hopelessness, self-blame, rejection of help, or aggressive fantasies toward oneself or others.

A further and different possible condition that can be expressed in dealing with stress, that the existing literature on the topic of emotional reactions to negative events has described, is demoralization. According to definition proposed by Kissane et al. (Clarke & Kissane, 2002; Kissane et al., 2001), the demoralization syndrome is a specific clinical entity characterized by a series of symptoms, including existential distress; encompassing hopelessness or loss of meaning and purpose in life; cognitive attitudes of pessimism, helplessness, sense of being trapped, personal failure; absence of drive or motivation to cope differently; associated features of social alienation or isolation and lack of support. By using again as general framework the "circumplex model," even demoralization would seem to lie within the same category of embitterment, in which emotional state is determined by the dimension of hopelessness (no hope of change and pessimism) and the dimension of external locus of control (no possibility to exert control). We can speculate that even within a specific category, the emotional manifestations reported by people exposed to stress may diverge from each other as the degree of a dimension increases with respect to the other. Therefore, when hopelessness reaches higher levels of severity, then the clinical conditions of demoralization outlines, while moving more toward the perception of not being in control of what happened because of others' responsibility, then the embitterment state distinctly emerge. Studies also suggest that both conditions are associated with significant consequences, predicting long-term functioning impairments, reduction of quality of life, risk for mental disorders and suicidality (Linden et al., 2004; Tang et al., 2015).

On these backgrounds, the need to better explore the clinical state of demoralization (or demoralization syndrome) and embitterment (or posttraumatic embitterment disorder) and to clarify the relationship between the two conditions, outlining possible overlap and divergences, emerge as an important clinical and research challenge. Therefore, the aim of this article is to clarify the above-mentioned aspects, both describing the main features of demoralization and embitterment and focusing on some overlap and divergences that are detectable between the two conditions, to facilitate clinicians to identify individuals who suffer from high demoralization or embitterment and provide them appropriate and effectively treatments.

The Construct of Demoralization

Demoralization has emerged as a key concept in the medical psychiatric literature over the past two decades and in recent years several reviews have reassumed the results of the most important studies, contributing for a better conceptual understanding of this condition (Grassi & Nanni, 2016; Robinson et al., 2015; Tang et al., 2015; Tecuta et al., 2015).

The concept of demoralization has been introduced by Jerome Frank (Frank, 1974) in the 1960s through 1970s to define a syndrome of existential distress occurring in patients with severe conditions, such as physical illness or mental disorders, specifically ones that threaten life or integrity of being. Demoralization denotes a persistent failure of coping with internally or externally induced stress and its characteristic features, not all of which need to be present in any one person, are feelings of impotence, isolation, and despair. The person's self-esteem is damaged, and he or she feels rejected by others because of his or her failure to meet their expectations.

In a more articulated conceptualization, de Figueiredo and Frank (de Figueiredo & Frank, 1982) suggested that demoralization includes two core clusters of symptoms, the first related to distress (e.g., anxiety, sadness, discouragement, and resentment), and the second related to subjective incompetence (e.g., feeling of being trapped or blocked because of a sense of inability to plan and initiate concerted action toward one or more goals), which coexist when assumptions relevant to self-esteem are disconfirmed.

In the following years, Fava et al. (Fava et al., 1995) proposed a further definition of demoralization, by integrating both George Engel's giving- or given-up construct (Engel, 1968), including the sense of psychological impotence, hopelessness and helplessness (in which previously used strategies, whether psychological or social, seem no longer effective in dealing with changes in the environment), and Frank's concept of demoralization. The authors empirically proposed a final diagnostic criteria set, applicable in the context of the medically ill: patients with Demoralization Syndrome (DS) must experience feelings of helplessness and hopelessness; perception of diminished competence and control in one's own functioning; relationships with other persons or roles in life are felt to be less secure or gratifying; external environment or one's own performances do not satisfy the subject's expectations given by previous experiences; loss of the sense of continuity between past and future, with diminished hope and confidence in projecting oneself into the future; and proneness to revive previous unsuccessful or frustrating experiences. The latter must persist for at least 1 month and be associated with functional impairment (see Table 1; Fava et al., 1995). T1, AQ:5

More recently, Clarke and Kissane (Clarke & Kissane, 2002), and Kissane et al. (Kissane et al., 2001), by studying patients in oncology and palliative care settings, suggested that the DS is a

Table 1
DCPR Criteria for Demoralization

A through C are required
A. A feeling state characterized by the patient's consciousness of having failed to meet his or her own expectations (or those of others) or being unable to cope with some pressing problems; the patient experiences feelings of helplessness, or hopelessness, or giving up.
B. The feeling state should be prolonged and generalized (at least 1-month duration.
C. The feeling closely antedated the manifestations of a medical disorder or exacerbated its symptoms.

Note. DCPR = Diagnostic Criteria for Psychosomatic Research.
Source: Fava G. A. et al. (2007), Diagnostic criteria for use in psychosomatic research. In Porcelli P. & Sonino N. (Eds), *Psychological factors affecting medical conditions. A new classification for DSM-5* (pp 169–173). Basel: Karger.

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specific clinical entity characterized by a series of symptoms, including: existential distress; encompassing hopelessness or loss of meaning and purpose in life; cognitive attitudes of pessimism, helplessness, sense of being trapped, personal failure; absence of drive or motivation to cope differently; associated features of social alienation or isolation and lack of support; fluctuation in emotional intensity. All these phenomena should persist more than 2 weeks and a major depressive or other psychiatric episode should not be present as the primary condition.

Factor analysis studies have contributed to define the nature of DS, underlined its clinical meaningful dimensions. Using the 24-item Demoralization Scale, Kissane (Kissane et al., 2004) identified five relatively distinct symptom clusters: "loss of meaning," "dysphoria," "disheartenment," "helplessness," and "sense of failure"; subsequently, validation studies has been conducted in different countries, confirming the constitutive symptoms of DS (Grassi et al., 2017; Mehnert et al., 2011; Mullane et al., 2009).

The factor analysis studies, integrating clinical insights with empirical data, have contributed to outline it as a distinct mental disorder, distinguishable from other diagnosis, including Major Depressive Disorder (MDD) and Adjustment Disorders (AD; Caruso, 2017; de Figueiredo, 2013; Robinson et al., 2015; Tang, 2015). However, comorbidity of DS with MDD or AD is possible. For these reason, it may be challenging for a clinician to make diagnostic distinction among these clinical conditions (Jacobsen, 2007; Rafanelli et al., 2013)

The Construct of Embitterment

Recent literature has described embitterment as an emotional reaction to negative life events (Belaise et al., 2012; Blom et al., 2014; Sensky et al., 2015; Znoj, 2011; Znoj et al., 2016) and a wide complex construct that includes affective, behavioral, and cognitive manifestations. It recognize a core relational theme, namely being treated unjustly by others (Belaise et al., 2012; Linden, 2003; Znoj, 2011), for which people experience the bitter feeling of being mistreated and wronged, and to be the victim of a profound injustice. Recently Linden (2003) has suggested that embitterment can be seen as a result of the violation of the individual's psychological integrity, such as personal value systems that encompass religious or political beliefs and values as well as basic definitions of oneself and one's personal goals in life (Linden, 2003).

In some cases, this reaction can become persistent and cause chronically intense suffering, creating the conditions for maladjustment to the stressful event and disability. In accordance with cognitive theories of emotions and clinical observations (Ellsworth & Scherer, 2003), the components of embitterment derive from stress and inconsistency between motivational goals and perceived reality. The embittered individual appraises the undermining of one's values and experiences resulting feeling of shame, whereas the social undesirable manifestations of embitterment (becoming hateful, vengeful, or destructive) may give rise to both guilt and shame (Znoj, 2011). Besides, the subject perceives that others are responsible for the negative situation, either by doing wrong or doing nothing, and this appraisal gives rise to feelings of anger and hostility. Furthermore, perceiving the situation as uncontrollable (resulting in a perceived low coping potential), the individual experiences helplessness and feelings of sadness. Notably, the focus in embitterment is on the past rather than the future, and the fear appraisal that one is at risk of an unfavorable outcome seems to be not relevant. Based on these notions, the hypothesis is that embitterment particularly goes with shame and guilt, anger and hostility, helplessness and sadness, and not with fear (Znoj et al., 2016).

Blom et al. (Blom et al., 2014), have explored this phenomenon in a sample of patients with a chronic rheumatic disease, confirming the above-mentioned affective components of embitterment. The authors have also found that the social–cognitive determinant of embitterment is the combination of helplessness (provoked by the uncontrollable nature of rheumatic symptoms and referred to the belief that one's coping efforts to master the situation are futile) and the experience of invalidation from the environment (provoked by the relative invisibility and fluctuations of symptoms and linked to the tendencies of others to minimize or deny the seriously of the illness, criticizing the patient, e.g., not to have a tougher attitude). Some authors (Belaise et al., 2012; Znoj et al., 2016) have pointed out that embitterment can become a persistent self-reinforcing condition, in which the person is intensively engaged in ruminations on what happened.

Based on theoretical considerations and clinical observation, Linden (2003) have introduced the concept of Post Traumatic Embitterment Disorder (PTED), describing for the first time the clinical characteristics of this disorder and proposing specific diagnostic criteria (see Table 2; Linden, 2003; Linden et al., 2007, 2008b, 2004). T2

Sensky et al. (Sensky, 2010; Sensky et al., 2015), by studying the relationship between PTED and unemployment and conflicts at work, have suggested the use of the term Chronic Embitterment (CE). The authors hypothesized that the guilt reportedly by the subject has not to be intended as guilt toward themselves, but rather as an attribution of blame to others for being treated unfairly. Then, embittered individual may not have experienced a single negative event triggering the psychopathological condition, but also a series of separated events could have a cumulative effect and intervene in determining this clinical condition.

Other interesting aspects of CE are the fluctuations of emotional symptoms and the potential destructiveness of this state, not only directed to the individual himself but also to the social environment. Thus, embittered persons normally do not seek social support like comfort, but rather attempt to engage others in their problems and request agreement for their position. As a consequence, they often tend to split the social environment in persons who are perceived as enemies or confederates, resulting in high levels of misanthropy and cynicism, social isolation and accentuation of feeling of disappointment, and lack of acknowledgment (Znoj et al., 2016).

The Assessment of PTED and DS

Recent studies have been conducted to develop instrument for the measurement of the afore-described construct and to examine their validity. Regarding DS, a series of instruments have been proposed. Besides some general measures of sense of well-being and life satisfaction (e.g., Demoralization Scale of the Minnesota Multiphasic Personality Inventory (MMPI)-II Restructured Clinical Scales; Tellegen et al., 2003) or nonspecific distress (e.g., Demoralization scale of the Psychiatric Epidemiological Research Interview, PERI-D; Dorehnwend et al., 1980), more specific tools

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Table 2
Diagnostic Criteria for PTED

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 pre-existing mental disorder
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; for some part they even think that is important not to forget
4. Patients express thoughts 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 as well as aggression towards others
6. Additional emotions are dysphoria and down-heartedness, 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 and pain
8. Patients can report phobic symptoms with 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
Duration: Longer than 6 months
Impairment: Performance in daily activities and roles is impaired

Note. PTED = Post Traumatic Embitterment Disorder.
Source: Linden, M., Baumann, K., Rotter, M., & Schippan, B. (2008). Posttraumatic Embitterment Disorder in comparison to other mental disorders. *Psychotherapy and Psychosomatics, 77,* 50–56.

have recently been developed including the Subjective Incompetence Scale (SIS; Cockram et al., 2009), and the Demoralization module within the Diagnostic Criteria for Psychosomatic Research (DCPR; Fava et al., 1995). This is a clinically oriented interview to examine the several psychosocial dimensions affecting the medically ill and not present in the classical psychiatric taxonomy. Also the DS (Kissane et al., 2004) has been shown to be a complete and psychometrically sound instrument that was originally validated among cancer patients. The DS consists of five subscales specifically loss of meaning, dysphoria, disheartenment, helplessness, and sense of failure (Grassi & Nanni, 2016).

With respect to PTED, factor analysis studies have contributed to define the nature of this syndrome by using a specific tool, the 19-item PTED Self Rating Scale (Linden et al., 2009). The authors identified two factors, of which one represents general psychological and social malfunctioning and the other is related to the cognitive-emotional pattern that characterizes the specific negative state of embitterment. Basing on observation in the context of life-threatening illnesses, a number of studies have led to the development of a self-report questionnaire, the Bern Embitterment Inventory (BEI; Znoj, 2008; Znoj et al., 2016). The BEI has contributed to underline the clinical meaningful dimensions of embitterment, consisting in "disappointment," "lack of acknowledgment," "pessimism," and "misanthropy." Factorial analysis and empirical data resulting from the studies, contributing to determine the constitutive symptoms of PTED, have been important to outline it as a distinct mental disorder, distinguishable from other psychiatric diagnosis (Dobricki & Maercker, 2010; Linden et al., 2007, 2008a;). However, studies have shown the existence of a high comorbidity with AD, MDD, dysthymia, and other psychiatric disorders (Belaise et al., 2012; Linden et al., 2008b).

The Bridge Between Demoralization and Embitterment: Overlap and Divergences

By analyzing the main features of demoralization and embitterment, it is quite interesting that some points of contact seem to exist between these two clinical conditions, both in terms of psychological processes, symptomatology, and consequences on mental and physical health.

First of all, we can point out that both are characterized by clinically relevant emotional or behavioral symptoms, which arise in response to an identifiable psychosocial stressor. Indeed, they develop in the aftermath of a negative event, described for embitterment as exceptionally negative but common in life (conflicts at the workplace, unemployment, divorce, the death of a loved one, experience of loss or separation, or severe illness), while demoralization has been investigated especially in the context of severe medical conditions that threaten life.

Likewise, demoralization and embitterment can be conceptualized as dimensional phenomena, which become pathological when they reach greater intensity, become prolonged and are associated with additional symptoms, and when daily role performance is impaired (Kissane, 2001; Linden et al., 2007).

Analyzing the various definitions given to date for demoralization and embitterment, they both seem to have underlying ineffective coping skills. Frank has described demoralized individuals as unable to cope, with consequent feelings of being overwhelmed and defeated by one's circumstances and of being unable to effectively engage in problem solving and perform tasks; an inability to cope is also an essential element of "given up-giving up complex," described by Engel as a sense of psychological impotence in which psychological and social strategies seem to be not effective in dealing with changes in the environment. de Figueiredo has finally identified the combination of distress and subjective incompetence as principal components of demoralization. Similarly, embitterment is described as the result of injustice and neglect perceived as threat and the appraisal of a low coping potential (loss of resources, loss of persons, loss of important goals, or bodily functions). In both conditions, this perception is also linked to the appraisal of the stressful situation as uncontrollable and infinite (de Figueiredo, 2013; Znoj, 2011).

Considering the symptomatology, it can be noticed some overlap between the two clinical conditions. Individuals with embitterment may experience feelings of helplessness, shame, hopelessness, negative mood, pessimistic stance, and resentment. Likewise, demoralized persons experience feelings of helplessness, loss of meaning and purpose in life, loss of the sense of continuity between past and future, hopelessness, and proneness to revive previous unsuccessful or frustrating experiences. In particular, helplessness seems to be a very important dimension for both the

APA NLM
tapraid5/tra-tra/tra-tra/tra99917/tra0750d17z | xppws | S=1 | 9/22/17 | 4:20 | Art: 2017-0916

conditions: demoralization people express feelings of impotence, sense of being trapped, absence of drive or motivation to cope differently; embitterment can be characterized as a feeling of injustice and helplessness together with the urge to fight back but the inability to identify a proper goal and define a proper action plan (Linden et al., 2007; Robinson et al., 2015).

Similar considerations apply to the dimension of hopelessness, which is in different ways linked to both demoralization and embitterment constructs. For example, the negative event may foreclose personally significant life goals, or it may cause a loss of trust in ones internal and/or external resources to achieve goals, or may lead to a loss of future orientation (Clarke & Kissane, 2002; Schrank & Hay, 2011).

Because of the sense of impotence and hopelessness, demoralized individuals may predictably progress to a desire to die or to have suicidal thoughts (Fang et al., 2014). The same destructiveness may be recognized in highly embittered individuals, when they have the perception to be cornered and with no way out and when the enemy has full control and life is endangered. In this situation, powerlessness and hopelessness may increase and lead to destructive actions directed to themselves and/or to others (Linden et al., 2007), in agreement with what Alexander (1960) indicated by considering embitterment as an "aggression by self destruction."

AQ: 6

Comparing now demoralization and embitterment with clinical depression, both include symptoms in common with it, specifically a negative, unpleasant affective tone, and feelings like sadness, helplessness, hopelessness, and worthlessness (Belaise et al., 2012; Linden et al., 2008). Some evidence arising from the literature suggest also that, similarly to depression, they are related to lower levels of psychological well-being and functioning (Blom et al., 2014; Robinson et al., 2015). Furthermore, we can notice that several studies have shown a closely linkage existing between symptoms such as tension, irritability, anger, and hostility to diagnosed unipolar depression, suggesting the "disphoric" dimension as a clinical marker of a more severe, chronic, and complex depressive illness (Biondi et al., 2005; Judd et al., 2013). Despite this, links and boundaries between these dimensions are still debated and require further studies that can shed some light on the subject.

Despite the possibility of co-occurrence and the partial overlapping, several authors suggest that demoralization and embitterment may constitute psychopathological conditions that are distinct from depression, and point some features that may help clinicians to differentiate them. First of all, while patients with major depression perceive the source of distress within themselves, those with demoralization and embitterment perceive the source of distress outside the self and, for this reason, they do not feel guilty (but, respectively, subjective incompetent to cope and with feel of blame to others for being treated unfairly; de Figueiredo, 2013; Caruso et al., 2017; Sensky et al., 2015). In contrast to depression, they also may both present a preserved reactivity of mood. Demoralized individuals can experience an improvement in mood level as adversity is overcoming or in response to a positive event (e.g., vacation, successful of somatic symptoms control, or a visit from a significant one). In a similar way, embittered persons may show fluctuated emotional symptoms and, in some cases, normal mood, especially when distracted or engaged in revenge fantasies (Jacobsen et al., 2007; Sartorius, 2011). Moreover, demoralized and embittered people do not have anhedonia, and they report a remarkable uncertainty about the direction one's actions should take, even if the magnitude of motivation is intact (de Figueiredo, 1993; Linden et al., 2008).

Focusing on the constructs of demoralization and embitterment, we can find existing differences between the two in terms of psychological processes and phenomenological domains (see Table 3). The distinction become more evident when these conditions reach high levels of emotional suffering, particularly when we refer to the symptomatology of the pathological forms, namely DS and PTED. In fact, anger, disdain and hatred, as well as persistent resentment and thoughts of revenge are important components of embitterment and PTED but they are not typical for demoralization and DS. Shame and guilt are also typical painful affects in embitterment, which contribute to reinforce rumination and defensive behaviors such as externalizing blame and devaluation of others,

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Table 3
Demoralization and Embitterment: Divergences

Embitterment	Demoralization
The patient experiences feelings of anger, disdain and hatred, persistent resentment, and thoughts of revenge most of the time	Anger, disdain, hatred, and thoughts of revenge are not typical components
Feelings of shame and guilt, with externalizing blame and devaluation of others	The patient feels not guilty but incompetent to cope
Neurovegetative symptoms (related to hypervigilance to threat) are frequent	Neurovegetative symptoms are not usually present
Trigger event experienced as an unjust personal insult, and psychologically as a violation of basic beliefs and values	Trigger event that threatens a personal sense of independence and competence (including both physical and mental illnesses)
Rumination and intrusive thoughts as constant reminders on the negative life event. These are indicated to be responsible for the prolonged emotional reaction and the progressive worsening of the embittered state	Steadily perception to have failed to meet own or others' expectations. This is responsible for the strengthening of the reaction and the progressive worsening of the emotional state
The embittered state is attributed to other (e.g. persons or circumstances), and not because of own failure	The patient perceives to be unable to resolve the situation and experiences feeling of impotence, loss of sense of mastery and control over life, and diminished esteem
Intense externalizing affects and behaviors, with typical manifestations of misanthropy, cynicism and aggressive tendencies to others	Intense internalizing affects and behaviors, which can more easily lead to aggressive tendencies directed to themselves (desire of hastened death or suicidal thoughts)

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leading to a worse persistent state. In contrast, they are not common in demoralized states, even if they can, in some cases, arise secondarily to the feeling of subjective incompetence to cope. Moreover, neurovegetative symptoms in PTED are frequent and related to hypervigilance to threat, whereas in demoralization these symptoms are not usually present (Belaise et al., 2012; Caruso et al., 2017).

A further analysis of the psychopathological models proposed for the two disorders can contribute to explain the possible causes of the different phenomenology. The above-mentioned symptoms of embitterment testify to the reactive nature of the disorder, which, in line with the model proposed by Linden (2003), develops from a trigger event with specific features. It is experienced as an unjust personal insult, and psychologically as a violation of basic beliefs and values. The rumination of the negative life event is indicated to be responsible for the prolonged emotional reaction and the progressive worsening of the embittered state. The intrusive thoughts act as constant reminders of the insult and entail a precise visual recollection of the situation in which the insult was uttered. Thus, the negative event represents a constant threat to fundamental assumptions and beliefs, and at the same time is too vivid and powerful to be discounted. Because this state is attributed to other (e.g., persons or circumstances), and not because of own failure, this could explain the expression by embittered individuals of intense externalizing affects and behaviors, so even the typical manifestations of misanthropy, cynicism, and aggressive tendencies to others (Linden et al., 2008; Sartorius, 2011; Znoj, 2011).

Demoralization, in line with the model of a number of authors (de Figueieredo, 2013; Fava et al., 1995; Kissane et al., 2001), may occur in the aftermath of stressful event that threaten a personal sense of independence and competence, including both physical and mental illnesses. When the individuals have the self-perception to be incompetent to deal effectively with the stressful situation, then they no longer "know what to do" and feel of being trapped, becoming distressed and helpless. If the concern persists, being unable to resolve the situation him/herself, the subject experiences feeling of impotence, loss of sense of mastery, and control over life and diminished esteem. If help seems unavailable (or the person feels unable to ask for help), a sense of hopelessness can ensue. Therefore, demoralized individuals steadily perceive that they have failed to meet their own or others' expectations and that seems to be responsible for the strengthening of the reaction and the progressive worsening of the emotional state, until getting to loss of meaning and significance of life and existential despair. Based on the psychological processes that underlying demoralization, we can assume that this model could explain the development in demoralized individuals of intense internalizing affects and behaviors, which can more easily lead to aggressive tendencies directed to themselves (desire of hastened death or suicidal thoughts; Clarke & Kissane, 2002).

Conclusions

Experts in the field of psychological reactions to negative life events agree in recognizing DS and PTED as new diagnostic entities, which have been proposed for inclusion in current psychiatric diagnostic manuals or, at least, to be seriously considered as clinically significant syndromes to be taken into account for their negative consequences in patients functioning. Current literature reveals advancements in research consistency regarding DS, which appeared characterized by distinctive phenomenology, etiology, response to treatment, and adverse outcomes. More recent evidences have been gathered on chronic state of embitterment in response to negative life events, particularly in terms of symptom characteristics, vulnerability factors, and effects on mental and physical health.

The clinical observations and the reflections summarized in this article seem to suggest the necessity and utility to keep separating the two clinical entities because of the differences highlighted in relation to psychopathological processes, clinical manifestations, and consequences.

The constructs of demoralization and embitterment could indeed have profound implications not only for clinical practice, but also for public health, psychosomatic medicine, and transcultural psychiatry. First of all, it would be important that health care professionals early identify the subset of DS and PTED, reducing the psychological impact of modifiable risk factors and providing them adequate psychosocial support. Furthermore, agreement on standardized criteria for the disorders may allow clinicians and researchers to identify embittered or demoralized individuals, directing them to receive specific opportune treatments and preventing negative consequences.

For these reasons, future research should aim to outline more precisely the quality of the emotional suffering in demoralized and embittered individuals, particularly by studying patients who do not show concomitant depressive or adjustment disorders. This could be a significant contribution in increasing knowledge and improving diagnostic assessment. It is important to carefully consider the dimensions underlying the constructs, contemplating the possibility that such dimensions may be part of the same psychological spectrum, within which clinical manifestations of emotional suffering can in some cases approach and show evident overlap areas, while, in other cases, different specific dimensions may emerge.

Moreover, it would be interesting for both conditions to examine variables or personality traits that can be predisposing for their development, making people particularly devoid of the ability to manage critical life situations and difficulties that arise.

In conclusion, ~~the need for~~ further research is urgently needed to study in deep these suffering states, enriching the currently available literature, and to identify the most effective treatment modalities.

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