CASE REPORT

What kind of diagnosis in a case of mobbing: post-traumatic stress disorder or adjustment disorder?

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SUMMARY

Over the last decade a consistent increase in stress-related psychological consequences at the workplace, usually called 'mobbing', has been seen. It claimed physical, psychical and social distress as its victims, leading to an increased incidence of many illnesses, such as psychosomatic disorders (ache, high blood pressure, chronic fatigue and insomnia) and psychiatric disturbances (high level of anxiety, depression and suicidal attempts). It was recently demonstrated that mobbing is significantly widespread among healthcare workers, especially among female nurses. In this report, we illustrate the case of a nurse who, after a brilliant career, underwent mobbing at the workplace, showing depression, anxiety and sleep disorders that required hospitalisation and a substantial intervention.

BACKGROUND

Mobbing was identified for the first time in the late 1980s by Leymann[1] who described a severe form of work-related psychosocial distress caused by antagonistic behaviours of one or more individuals that occurs for six or more months until the victims feel forced to quit their job.

It is a widespread phenomenon that involves many sides of modern society but only recently has the importance of mobbing among healthcare workers begun to be recognised. In a study conducted in the health sector in Portugal, 51% of the healthcare professionals had been exposed to verbal abuse in the last year and 60% to bullying.[2] In a study conducted in Australia, 50% of the nurses had been exposed to bullying behaviours once or more in the previous year.[3] Nowadays, international literature gives accounts of many clinical studies about the 'mobbing syndrome', but, despite its economic loss and social importance,[4] it does not have a clear nosological definition. Lacking specific diagnostic criteria, the International Classification of Diseases, 10th Revision (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) indicate just two conditions connected to stress that are not necessarily work related: post-traumatic stress disorder (PTSD) and adjustment disorder (AD). In PTSD, the victim has suffered a tragic event that led to avoiding behaviours of any situation that reminds it, obsessive thinking about the incident, recurrent nightmares, difficulties in concentrating, symptoms of numbing or iperarousal. AD often has fluctuating symptoms that are generally less intense and severe than PTSD, including anhedonia, sadness, mood deflection, anger, polarisation of thoughts, low self-esteem, guilt, anxiety and sometimes somatisation. The clinical features are closely related to the persistence of a stressful situation that triggers an alarm state lasting until the situation persists, tightly associated to the inability to implement coping strategies.[5] Mobbing behaviours can be very covert and subtle, making them hard to recognise as aggression; then it is very important to analyse situations making a correct differential diagnosis to assess the right therapeutic approach.

CASE PRESENTATION

The patient is a 58-year-old woman. She is single and has been working as a nurse since she was 20. She has been working with passion and diligence, with no other hobbies, and some years ago she gained a promotion as charge nurse. When she was young, she had some stressful life events: her father's death, her mother's history of cancer and death, her ex-boyfriend's betrayal and finally, about 10 years ago, her young nephew's sudden death. Despite this, she has always overcome these troubles with fortitude and bravery and describes herself as a strong woman.

In 2011, at the age of 56, she had some disagreement at work with her managers who started to ask her to be their accomplice in carrying out illegal tasks she would not do. Their quarrel triggered a sequence of adverse behaviours against her that started from her managers but soon also involved her colleagues, who became wary and mistrustful; they often talked behind her back, criticising her work, monitoring her movements or ignoring her directives excessively. Hostility towards her was also shown by suddenly changing her timetable and suggesting (verbally or in deed) that she change wards. Initially, she did not care about these behaviours, but this situation insidiously led the patient to a progressive isolation and hindered her from carrying out her work quietly, making her feel unqualified and humiliated. Then she began complaining about insomnia and fatigue and appeared to suffer from headaches and anxiety; so she decided to consult a psychiatrist who prescribed a daily therapy with escitalopram 20 mg, trazodone hydrochloride 75 mg, clonazepam 0.5 mg and

valproic acid 300 mg. After a month, the psychiatrist doubled the dose of valproic acid and trazodone hydrochloride and added venlafaxine 300 mg. The following month she took off clonazepam and added quetiapine 200 mg and alprazolam 1.5 mg. Despite therapy, she had poor response and started to show a progressive mood deflection, a sense of psychological tension and social retirement, until she finally decided to rest at home from work, often crying and spending the most part of her day in bed.

In January 2012, she was admitted as an outpatient: she was downhearted and anxious and showed severe mood deflection, with symptoms of insomnia, anhedonia, hopeless feelings and suicidal ideation; for this reason, she was hospitalised at our psychiatry unit. At the psychiatric examination she was very sad, with a tendency to cry while talking; her depressed mood was predominant in her speech, gestures and facial expression; topics discussed concerned her work-related distress and troubles with her colleagues. She added that the tasks were often illegal and unbearable for her. This caused many clashes with her superiors and made her feel consistently under high pressure; her colleagues also isolated her, causing stress, discomfort, low tolerance and low self-esteem. The anhedonia involved many aspects of her life and she described no longer having interests in taking care of herself and her house, or in going out with her friends, travelling or shopping.

DIFFERENTIAL DIAGNOSIS

According to the DSM-IV-TR criteria, a diagnosis of AD with anxiety and depressive mood was made. The Structured Clinical Interview for DSM-IV Axis I Disorders (SCID I) excluded any other Axis I Diagnosis, such as major depressive disorder or anxiety disorders; the Clinician-Administered PTSD Scale (CAPS) also excluded PTSD.

TREATMENT

During hospitalisation, the patient was given daily pharmacotherapy of paroxetine 20 mg/day, pregabalin 75 mg/day and alprazolam 1 mg/day.

OUTCOME AND FOLLOW-UP

The patient showed a slow but progressive improvement of her symptoms and mood stabilisation; after some days she started to think more positively about her life and showed a wish to resume her interests, taking care of herself and her health. She was discharged after 18 days, following the same therapy and had monthly check-ups at our outpatient department. She also started accessing cognitive-behavioural psychological counselling support. The follow-up has shown the efficacy of this therapeutic setting and the patient reached a full remission of symptoms, even if at work she still had to deal with a pressing situation.

DISCUSSION

Over the last decade, mobbing has become a frequently reported problem in modern societies, showing serious effects either on the employees' health[6] or on the companies' absenteeism rate and staff turnover. These behaviours may be shown either by superiors or by coworkers and subordinates[7] and gradually but inexorably mobbing victims become isolated, exposed to psychological abuse, given jobs inappropriate for their qualifications and paid lower to force them to quit their jobs.[8] As many studies have recently stressed, a large part of the workforce consists of women[4] who are usually employed in healthcare jobs, especially as nurses.[9–11] This is probably due to organisational factors and the hierarchical nature of this kind of job, developed somewhere as a system where submission is expected and encouraged, so that individual consciousness appears blameworthy and reprehensible.[7]

If psychological violence and its duration rise, its effects also increase: at first, victims experience crying, sadness, sleeping disorders and difficulties in concentrating. After a longer period, they progressively display high blood pressure, chest pain and heart palpitations, gastrointestinal problems, excessive weight gain or loss and sometimes alcohol or drug addiction. They experience fear in the workplace and absenteeism from work, depression, anxiety, low self-esteem, suicidal ideation and may act violently towards a third person or attempt suicide.[7]

Furthermore, many studies found a correlation between personality profiles, coping skills and severity of symptoms, which get worse in those patients with a paranoid component and poor adaptability to stressful situations.[12]

According to the DSM-IV-TR criteria, victims of mobbing could be considered either as a PTSD-related syndrome, if there was a risk to the victim's life or very traumatic experiences, or as AD, which is less severe but much more common and is tightly related to the persistence of the stressful situation. Also, making a correct differential diagnosis is essential to assess a proper therapeutic approach.

The treatment should be integrated and should include removal from the workplace and other environmental factors, psychiatric pharmacological intervention and psychological support to obtain a full response and remission of symptoms. In this case, our patient got depressed because of the work pressure and underwent severe troubles at work despite her thoroughness and diligence in performing her duties and probably due to her harsh moral and honesty. She showed mood deflection, anxiety and sleep disorders that required hospitalisation, but after removal from the workplace, her substantial pharmacological intervention symptoms improved. According to the DSM-IV criteria, we can ascribe this case report to AD with anxiety and mood disorder, because of the presence of work-related stress, difficulties in realising coping strategies and depressive symptoms that improved after removal from the workplace with no other relapses after treatment.

Actually, no clear solutions have been found about the incidence of mobbing and only prevention, such as spreading knowledge about the syndrome and making laws to protect workers, can reduce the phenomenon. Mobbing leads to increased sick time, absenteeism and the loss of a lot of money; it creates a negative and tense working environment that impacts on the patient's safety and workers are more likely to leave their jobs[11]; therefore, the international community should pay close attention to this important issue that needs to be better studied and addressed. Lacking specific diagnostic criteria, a correct differential diagnosis ought to be made between the PTSD-related and AD-related forms to have a clear vision of the prognosis, therapy and possible outcomes.

Learning points

- Mobbing is a widespread phenomenon that involves many sides of modern society.
- It does not have a clear nosological definition: the International Classification of Diseases, 10th Revision and the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision indicate just two conditions connected to stress that are not necessarily work related—post-traumatic stress disorder and adjustment disorder.
- There is a correlation between personality profiles, coping skills and severity of symptoms, which get worse in those patients with a paranoid component and poor adaptability to stressful situations.
- Making a correct differential diagnosis is essential to assess a proper therapeutic approach.
- Integrated treatment should include removal from the workplace and other environmental factors, psychiatric pharmacological intervention and psychological support to obtain remission of symptoms.

Contributors CC identified and managed this clinical case. MCC and MC thought of the idea and wrote the manuscript. MSS revised the manuscript critically for important intellectual content and approved the final version to be published.

Competing interests None.

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