

# Demoralisation as a Diagnostic Conundrum: Case Reports

## 失志沮喪診斷之謎：病例報告

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### Abstract

Clinical experience and recent research indicate that demoralisation is frequently encountered in medical and psychiatric practice. The three case vignettes reported here illustrate the salient features of demoralisation in psychiatric practice, and are followed by a brief outline of this emerging concept and its significance for clinical practice.

**Key words:** *Adaptation, psychological; Anomie; Depression; Diagnosis*

### 摘要

臨牀經驗及近期研究文獻顯示失志沮喪經常於精神科及其他專科的個案遇到。本文報告三個展示失志沮喪表徵的個案，並簡短地說明這新概念以及其於臨牀醫學的重要性。

**關鍵詞：**精神上適應；失範；沮喪；診斷

### Introduction

The dictionary meaning of ‘demoralise’ is “to deprive a person of spirit, courage, to dishearten, bewilder, to throw a person into disorder or confusion”.<sup>1</sup> The concept of demoralisation was introduced into psychiatry in 1974,<sup>2</sup> initially in relation to psychotherapy. According to Frank,<sup>3</sup> demoralisation was thought to fit well the “state of candidates for psychotherapy, whatever their diagnostic label,” as it was the “chief problem of all patients who come to psychotherapy”. A demoralised person was described as one who “clings to a small round of habitual activities, avoids novelty and challenge, and fears making long-term plans” and is in a state of “hopelessness, helplessness, and isolation ... preoccupied merely with trying to survive”.<sup>3</sup> Anger, resentment, sadness, anxiety, puzzlement, discouragement and a frustrating sense of incompetence are the main emotions characterising demoralisation in its

initial stage, turning into acceptance of fate, inaction and impasse, the “giving-up – given-up” complex.<sup>4</sup>

Demoralisation has rarely been mentioned in the psychiatric literature, even though demoralised patients are frequently encountered in medical and psychiatric practice.<sup>4,6</sup> Earlier investigations indicated that a sizeable minority of the American population is demoralised and clinically and socially impaired,<sup>7</sup> particularly those with medical or psychiatric disorders.<sup>8</sup> Recent studies have confirmed that demoralisation is a significant factor in the psychological distress experienced by medically ill patients.<sup>9-11</sup>

As there is a paucity of studies on demoralisation in psychiatric patients, we present three case vignettes featuring demoralisation in patients referred for psychiatric assessment and briefly summarise the relevant literature.

### Case Vignettes

#### Case 1

Mrs. A is a 51-year-old unemployed woman who separated from her husband 13 years ago. Still generously supported by her estranged husband, she lives alone in a rented flat. The couple married 28 years ago but because of the husband’s infidelity, the marriage was plagued by serious conflict from the very start. Before their separation, two major family crises drove Mrs. A to despair, despondency and insomnia. She was diagnosed with depression in 1990 by a private practitioner and treated with a small dose of antidepressant and ceiling therapeutic doses of anxiolytics

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and hypnotics. She has remained on the same dose of anxiolytics and hypnotics since. Over the past 13 years — since separating from her husband — she has not presented with any psychiatric symptoms. She visited a psychiatric outpatient clinic to have her medication prescribed because she could no longer afford visits to the private practitioner. When seen at the clinic, she was lively, cheerful and talkative, giving the impression of a perfectly normal person with no observable psychiatric symptoms. All that she asked of the psychiatric services was that she be given regular prescriptions of the same medications she has been taking for nearly two decades.

Mrs. A was made redundant 10 years ago and has since followed a rather monotonous daily routine. She sleeps until 3 p.m., buys takeaway food, watches television and listens to music, then buys food again or prepares dinner, takes her evening hypnotics and benzodiazepines and sleeps for 15 hours — “to avoid boredom”, she says. Daily phone contact with her son, his weekly visits and occasional phone calls from her daughter, who lives overseas, have been her only social relations. Although she is lonely, she is basically satisfied with her lifestyle and cannot, and does not want to, initiate any changes.

Mrs. A was brought up in a cohesive, warm family atmosphere, completed high-school education and used to work in clerical positions. She has no significant family or medical history, does not abuse alcohol or illicit substances and has no criminal record. She has probably become addicted to prescription psychotropic drugs; she becomes tense and jittery if she inadvertently misses her medication.

We believe Mrs. A's persistently demoralised state was induced by repeated, humiliating, marital conflicts that gradually sapped her self-esteem and may have induced a depressive episode many years ago. The depressive symptoms have subsided, but she has passively accepted her fate, lost motivation to do anything beyond carrying on with a simple, self-defeating daily routine, and has settled into a convenient but deficient lifestyle way below her abilities and potential.

### **Case 2**

Mr. B is a 41-year-old single civil servant. He lives with his parents and brother in a rented flat, but has had little communication with them for years. In the past he actively socialised, had three long-term relationships with women and generally led a balanced, happy life.

Mr. B's life started changing for the worse 7 years ago when he had to permanently switch to shift work that led to a chaotic sleeping pattern in which insomnia alternated with normal sleep. His new work schedule, Mr. B claimed, also precluded any promotion. He became disenchanted and unhappy, gradually disengaged from his social circle and broke up with his girlfriend; “I do not even know why”, he stated upon questioning. He still goes to work and discharges his duties but finds no satisfaction in doing so any longer. After work he stays at home, retreating to his room, surfing the internet or watching television, but does not feel lonely.

He hardly communicates, even with his family. He has no specific interests or hobbies. Upon prodding he admitted that he was still resentful about the impossibility of promotion but had given up on that already.

Mr. B was referred to a psychiatric outpatient clinic by his family physician for the treatment of insomnia. On examination he was cooperative but in a distant and reserved way, displaying restricted affect and reporting a neutral mood. His mental state was normal in every other way. He had no somatic symptoms apart from the sleep disturbance. He obliquely admitted that he would not mind early retirement on medical grounds although he could not offer any post-retirement plans. He felt utterly unable to embark on anything else but his rather simple, routine work.

Mr. B has no significant family and medical history, no problems with alcohol / substance abuse or previous contact with psychiatric services. He had a normal upbringing in Hong Kong and joined the civil service after passing his high-school examinations.

We considered Mr. B an able-bodied young man with good average intellectual abilities and no diagnosable psychiatric disorder. He has been leading an isolated, asocial daily life without any direction, goal-directed future plans or orientation commensurate with his potential. The change to his work schedule that had upset his biological rhythm and diminished prospect of promotion — which was a serious blow to his self-esteem — might have triggered his slide into quiet resignation and demoralisation. Neither his physical condition nor his psychiatric status could account for his current plight.

### **Case 3**

Unlike the previous two patients, the 57-year-old, single, unemployed Mr. C has had a hard and mostly joyless life. Born into abject poverty in Mainland China during tumultuous times, he was brought up in a dysfunctional family dominated by an aggressive father. His father severely beat him with an iron rod when he was 11 years old. Mr. C spent only a few years at primary school before he started working, and moved to Hong Kong with his mother and siblings when he was in his late teens. The next 30 years went by quietly without major events; Mr. C worked as a cook in the same restaurant for most of those years. He led a simple life — rising at dawn, working all day with some breaks, going home, having dinner, sleeping and starting all over again. His daily routine was interrupted with the occasional visit to the racecourse or meals with co-workers. He had no close friends and was uncomfortable in social situations. His family was not aware of any sexual relationship or courtship, ever.

Seven years before his first contact with psychiatric services, Mr. C lost his job because the restaurant closed down. For a while he tried to get a new job but failed, became increasingly housebound, and hardly talked, even to his family. He watched television, ate and slept well and generally seemed to be content with life. This very restricted life went on for 7 years until an awkward, bizarre

incident prompted the family to request help from the social services. Mr. C made an unexpected and inappropriate sexual advance toward his elderly mother, which eventually led to his psychiatric assessment and admission.

On admission and over the subsequent weeks, Mr. C was generally distant, emotionless and extremely reticent, answering questions with monosyllables, if at all, and apart from vague complaints of having a headache offered no clues to any psychopathology. He quickly adjusted to the ward routine without asking any questions, and ate and slept well. He seemed to lack interest in the environment or his future. Laboratory tests, including a computed tomographic (CT) scan of his brain and electroencephalography, were all negative. Cognitive tests, including the Mini-Mental State Examination and frontal lobe tests, were all unremarkable.

Successive courses of fluoxetine (up to 40 mg/day) and lorazepam (maximum 8 mg/day) had no appreciable effect on Mr C's mental state. He readily accepted halfway house accommodation, continuing the same isolated life as before.

In Mr. C's case, the diagnosis remains uncertain. Despite the normal CT brain scan and psychological tests, an insidiously progressing organic lesion or psychotic process characterised by predominant negative symptoms cannot be discarded and further close observation is warranted. A slowly progressing organic disorder affecting the frontal lobe or psychotic experiences that were not revealed would explain the ethical blunting resulting in the inappropriate sexual behaviour. Alternatively, the demoralisation of a poorly educated, socially inept and hugely disadvantaged individual is another viable way of explaining his condition. The blow of losing his job and the security and stable daily routine that came with it, combined with his inability to find a new job and order in life due to his meagre social and personal resources, could have triggered the process of demoralisation. It may all have combined to make Mr. C give up hope of a better life, accepting very basic circumstances and retreating into social isolation, essentially doing nothing beyond existing on the simplest level.

## Discussion

All three patients suffered an unexpected serious setback, the successful solution of which exceeded their social competence — in Mr. C's case probably even his intellectual capacity — that eventually caused their lives to grind to a halt. Their situations were aggravated by weak or ineffective social support that further undermined their determination to find a way to adapt to their new circumstances. Instead, they passively withdrew into social isolation, the security of home and a simple daily routine. Initial distress, anger, disappointment and, in the case of Mrs. A, possibly a depressive episode, gradually gave way to acceptance of the situation, and a giving up of hope and the desire to change.

From a clinical viewpoint, it is very important to distinguish psychiatric disorders, i.e., morbid conditions from difficult life situations and human anguish, i.e., existential

concerns or crises.<sup>12</sup> The latter include very similar or even overlapping, complex social and psychological conditions such as demoralisation, burnout syndrome or emotional exhaustion and entrapment ("arrested escape"). Compared to demoralisation, burnout is a more distinct concept, mostly referred to as the consequence of prolonged exposure to chronic work stress.<sup>13</sup> It has 3 dimensions — emotional energy / exhaustion, depersonalisation, and personal accomplishment / competence — and a widely used, standard assessment tool, the Maslach Burnout Inventory.<sup>13</sup> In the psychiatric literature, entrapment is mainly mentioned in relation to depression either internal (feeling trapped in a state of hopelessness) or external entrapment (being trapped in an inescapable situation that may lead to depression).<sup>14</sup> Entrapment usually refers to a concrete situation,<sup>15</sup> whereas demoralisation is a longer process, being rather the consequence of long-term entrapment.

Over the past 30 years, a slowly growing body of research has attempted to define demoralisation as a distinct clinical construct. At this early stage, however, there is still disagreement about the exact nature of demoralisation, specifically over whether it ought to be classified as a psychiatric diagnosis or considered a purely psychosocial phenomenon. At present, demoralisation is not a criterion for any psychiatric disorder in modern classifications. Slavney<sup>6</sup> argued that demoralisation is not a psychiatric disorder but rather a normal response to adversity, a state comparable to grief, which is regarded in the Diagnostic and Statistical Manual of Mental Disorders – 4th ed (DSM-IV) as a non-pathological response to stress. In the DSM-IV, grief is assigned a V code only if it becomes serious enough to warrant clinical attention.

The ever-increasing number of psychiatric disorders found in contemporary classifications raises the danger of medicalising human suffering and misery caused by dire social situations and unnecessarily implementing psychiatric treatment for society's woes.<sup>12</sup> Disagreeing with this notion, de Figueiredo<sup>16</sup> suggested that demoralisation is always abnormal, constitutes an observable clinical entity, and requires some form of therapeutic intervention, most frequently psychotherapy. The development of demoralisation involves the interplay of genetically and socially determined personality factors, environmental stresses, and lack of social support.<sup>4</sup>

It has also been proposed that demoralisation is the result of distress, usually affecting self-esteem and subjective incompetence.<sup>5</sup> Accordingly, it was suggested that Axis IV of the DSM-IV should be re-classified as the demoralisation axis, with separate ratings given for distress and subjective incompetence.<sup>16</sup> A recommendation has been put forward that demoralisation be included in the DSM-V as part of the "psychological factors affecting medical condition" category.<sup>17</sup> Lack of sufficient data on the subject will probably render these suggestions premature.

Falling between these two diametrically opposite views of the nature of demoralisation, is a compromise<sup>18</sup> hypothesising that demoralisation is a spectrum, a condition

ranging from a normal, logical and comprehensible response to stress to a pathological state that has serious implications for the person's life.

Irrespective of these unresolved issues concerning its conceptualisation, there is a general consensus that demoralisation frequently accompanies serious medical and psychiatric conditions as a superimposed psychological burden. There is compelling evidence that hopelessness, one of the hallmarks of demoralisation, is associated with suicidal acts<sup>19,20</sup> and poor outcomes in patients with psychiatric<sup>20</sup> and medical illnesses.<sup>21</sup> A recent multivariate analysis<sup>22</sup> supports the role of demoralisation in schizophrenia, indicating that patients with schizophrenia with good premorbid adjustment and insight are at increased risk for suicide, as repeated exacerbations, functional deterioration, and awareness of the effects of illness can lead to demoralisation, hopelessness, and depression.

One of the major impediments to widely recognising demoralisation — either as a diagnostic entity or as a separate social and psychological phenomenon — is its considerable overlap with the symptoms of depression. Reduced motivation, hopelessness, helplessness, diminished self-esteem and relative inactivity makes it difficult, but not impossible, to differentiate demoralisation from depression. The diagnostic difficulties are compounded by the fact that, theoretically, demoralisation can co-occur with depression. In a recent study,<sup>11</sup> 30.4% of medical outpatients showed signs of demoralisation while only 16.7% were depressed; 69% of the demoralised patients did not meet the criteria for depression.

A comprehensive review<sup>18</sup> of empirical and observational studies on demoralisation concluded that it was a syndrome separate from major depression. While demoralisation and depression are superficially similar in that both are distressing, anhedonia is more prominent in major depression as are biological symptoms — fatigue, psychomotor changes — and feelings of guilt. In demoralisation, the mood remains reactive, apprehensive or irritable, if it changes at all, and the hallmark feature is subjective incompetence. Other features of demoralisation include the persistent inability to cope, passivity, meaninglessness, fear of loss of dignity, and relative social isolation. Eventually, the demoralised person gives up hope and accepts as inevitable the status quo of a life that is deficient relative to his or her capability, living life on a simple level, which, despite lingering resentment, is still within the person's reach.

As the concept of demoralisation is still in flux, its boundaries are fuzzy and there have been very few clinical studies. No therapeutic intervention has been systematically investigated. There is not enough solid evidence that demoralisation is a separate psychiatric disorder, thus specific psychiatric treatments (e.g. medication) are not warranted.<sup>6</sup> However, if demoralisation is conceptualised as a normal reaction to a difficult life situation, such as grief,<sup>6</sup> then supportive psychotherapy (attentive listening, understanding, sensible advice and encouragement) coupled

with psychoeducation rendered by psychiatrists or other medical practitioners, should suffice. Involving the social services to gain practical help is also important.

Attempts to develop a 'demoralisation rating scale'<sup>23-26</sup> reflect the growing recognition of the concept's significance as a dimension of psychological distress. More prospective studies<sup>10</sup> using structured assessment tools to evaluate demoralisation in the general population and in a variety of medical and psychiatric conditions should either establish or refute the validity of the concept and develop therapeutic interventions. Future studies should be conducted in a cross-cultural context to take into account the socio-cultural determinants of the concept. Wider recognition of demoralisation should contribute to better management for many psychiatric and medical patients.

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## Corrigendum

“Symptoms of Anxiety and Depression in the Perinatal Period: Referrals to the Comprehensive Child Development Service in a Hong Kong Regional Hospital” (September 2009;19:112-6). On page 112, the author list should have read “MYK Miao, GPK Wong, WL Szeto, MGC Yiu” rather than “MGC Yiu, WL Szeto, GPK Wong, MYK Miao” as printed.