LESSONS LEARNED AT THE INTERFACE OF MEDICINE AND PSYCHIATRY

The Psychiatric Consultation Service at Massachusetts General Hospital (MGH) sees medical and surgical inpatients with comorbid psychiatric symptoms and conditions. Such consultations require the integration of medical and psychiatric knowledge. During their twice-weekly rounds, Drs. Stern and Maytal, as well as other medical staff and members of the Consultation Service, discuss the diagnosis and management of conditions confronted. These discussions have given rise to rounds reports that will prove useful for clinicians practicing at the interface of medicine and psychiatry.

Dr. Jacobsen is an attending physician in the Division of Palliative Care at MGH. Dr. Maytal is a clinical fellow in psychiatry at the Dana Farber Cancer Institute and Harvard Medical School. Dr. Stern is chief of the Psychiatric Consultation Service at MGH and a professor of psychiatry at Harvard Medical School.

Corresponding author:
Guy Maytal, M.D., Dana Farber Cancer Institute, 44 Binney St., Boston, MA 02115
(e-mail: gmaytal@partners.org).

Demoralization in Medical Practice

Juliet C. Jacobsen, M.D.; Guy Maytal, M.D.; and Theodore A. Stern, M.D.

Do you ever hear a medical term (e.g., *demoralization*) and wonder why it wasn't discussed in medical school? Do you ever wonder whether some words or concepts mean the same thing to all practitioners? If you have, then the following case vignette should provide the forum to discuss the evolution of some terms and help you decide how to apply them.

CASE VIGNETTE

Mr. A, a 74-year-old man with end-stage colorectal cancer, was admitted to the hospital to rule out colonic obstruction. Review of systems revealed poorly controlled low back pain (that persisted throughout the day), poor sleep (which he attributed to pain), and several months of impaired concentration, anorexia, and significant weight loss (that had been attributed to cancer).

Mr. A's hospital course was marked by frustration over a delay in his colonoscopy (caused by his oncologist's out-of-town trip), by persistent pain, and by alternating constipation and diarrhea.

Both the palliative care and psychiatric services were consulted to help manage his pain and to evaluate his cognitive difficulties. Mr. A's back pain (deemed a consequence of a metastatic lesion at L3) was treated with escalating doses of controlled-release oxycodone and as-needed doses of short-acting oxycodone. His psychiatric history was unremarkable. On mental status examination, Mr. A was awake and amiable, but uncomfortable; he denied feeling depressed or guilty. However, he said that he no longer enjoyed his hobbies or spending time with family or friends.

As his hospital stay progressed, he appeared more withdrawn and became less hopeful that his pain, his difficulty maintaining attention, and his bowel problems would resolve. At one visit, he became extremely frustrated, and he complained about the food, his rate of recovery, the delays in testing, and his difficulty walking to the bathroom. When asked about the extent of his frustration, he said that he had been thinking about "smashing his head against the wall."

Mr. A's medical team was uncertain about his diagnosis. They considered an agitated depression and wondered if external factors (e.g., his difficult hospitalization and his poorly controlled pain) adversely affected his mood.

What Is Demoralization?

The term *demoralization* was first used in the psychiatric literature by Jerome Frank in the 1970s (i.e., "the chief problem of all patients who come to psychotherapy is demoralization . . . the effectiveness of all psychotherapeutic schools lies in their ability to restore patient morale")[1(p271)] and represented a persistent failure of coping with (internally or externally induced) stress; Frank believed demoralization left one feeling impotent, isolated, and in despair. This conceptualization was congruent

COPYRIGHT 2007 PHYSICIANS POSTGRADUATE PRESS, INC © COPYRIGHT 2007 PHYSICIANS POSTGRADUATE PRESS, INC

with the psychodynamic approach of the *Diagnostic and Statistical Manual of Mental Disorders*, Second Edition (DSM-II),[2] in which all disorders were considered reactions to environmental events. Frank defined the symptoms of anxiety and depression as direct expressions of demoralization.[1]

However, in 1975, Schildkraut and Klein[3] defined demoralization as a state separate from depression. Whereas patients with depression experienced anhedonia, patients with demoralization lost their sense of efficacy. In the 1980s and 1990s, Frank and De Figueiredo further refined the meaning of demoralization.[4] The term *demoralization* remained distinct from *depression* and was characterized by 2 states: distress and a sense of incompetence that results from an uncertainty about which direction to take. Individuals with depression and those with anhedonia cannot act (even if they know the proper direction to take).

Recent debates about the definition of demoralization focus on its place in the DSM. Kissane[5] and De Figueiredo[6] proposed that Axis IV be conceptualized as the demoralization axis, with separate ratings given for distress and for subjective incompetence. Given the severe impact that demoralization can have on function, De Figueiredo[7] felt that this state should be recognized as a separate axis, rather than as a V code. In this view, demoralization is always abnormal.[7]

In contrast, Slavney[8] has argued that demoralization is not a psychiatric disorder at all, but a normal response to adversity. He likened demoralization to grief, which is a nonpathologic reaction to stress, but which may be a focus of clinical attention; grief is assigned a V code in the DSM-IV. He cautioned that mistaking demoralization for a psychiatric disorder has the effect of shifting the burden of care from the patient's primary care physician to the psychiatrist, when what the patient needs is understanding, encouragement, and enhanced engagement.[8]

At present, demoralization lacks a readily applicable and standardized definition that is supported by rigorous research in epidemiology. However, a recent factor analysis by Kissane[5] identified 5 relatively distinct dimensions in 100 patients with cancer: loss of meaning, dysphoria, disheartenment, helplessness, and a sense of failure. A subgroup of patients with high demoralization did not meet DSM-IV criteria for major depressive disorder, suggesting that demoralization is a clinical syndrome distinct from major depression.[9]

Further work is needed to distinguish demoralization from other dysphoric states (e.g., major depression and adjustment disorder) and to classify it either as a pathologic condition or as a normal reaction to severe circumstances.

The role of character traits such as optimism and resiliency in the development or avoidance of demoralization also needs to be further defined. Demoralization is negatively associated with dispositional or trait optimism and with trait anxiety,[10] but longitudinal observational studies that could confirm causation have not been undertaken. Similarly, more work needs to be done to understand the relationship between demoralization and the construct of hopelessness, which has been found to be independently associated with the desire for hastened death and the will to live.[11,12] Many working definitions of demoralization contain the variable of hopelessness,[10,13] but it is not clear if these definitions of demoralization have predictive value over the construct of hopelessness alone.

The establishment of a diagnosis and an official acceptance in the *International Classification of Diseases* or the DSM of the American Psychiatric Association requires more data about distinctive symptoms, etiology, clinical course, and treatment outcomes.[14]

What Is the Differential Diagnosis for the Demoralization?

Many medically ill patients complain to their physicians about low mood. However, rather than assume that their patient with depressed mood has depression, the doctor must consider other possibilities for this complaint; 1 possibility is demoralization. The differential diagnosis for demoralization is relatively short and includes mood disorders (e.g., major depression, bipolar depression), adjustment disorders, and other medical illnesses that are known to cause low mood (e.g., endocrinopathies, including hypothyroidism and Cushing's disease, pain syndromes, and degenerative neurologic illnesses). Furthermore, given the controversy in the literature regarding the definition of demoralization (see above), it is likely that demoralization can coexist with other mood disorders. This means that, if a patient is demoralized, he or she may have a separate depressive disorder that would respond to treatment.

For example, Mr. A's diminished frustration tolerance and increased mood reactivity while in the hospital were likely due to a sense of demoralization caused by circumstances beyond his control in the hospital. However, his more chronic symptoms of anhedonia, social isolation, and poor concentration are suggestive of a coexisting depressive disorder.

Lastly, it is worth noting that, although severe and debilitating medical illness can frequently lead to demoralization, chronic and disabling mental illness (e.g., schizophrenia) can also be associated with a demoralized state.

How Is Demoralization Distinguished From a Mood Disorder or an Adjustment Disorder?

Since there is no standard definition of demoralization, diagnostic criteria are lacking. Despite the lack of a formal definition, a consistent description seems to be emerging.[9–12] In general, a patient who experiences de-

© COPYRIGHT 2007 PHYSICIANS POSTGRADUATE PRESS, INC © COPYRIGHT 2007 PHYSICIANS POSTGRADUATE PRESS

moralization has many qualities in common with a patient who is depressed or who suffers from an adjustment disorder. Such a person may experience moods that are sad, apprehensive, or irritable, and his or her behavior may be passive, demanding, or uncooperative. Demoralized patients may suffer from disturbances in sleep, appetite, or energy, and their thinking can be pessimistic or even suicidal.

Unlike the depressed patient, however, the demoralized patient often does not experience a full complement of neurovegetative symptoms—specifically, anhedonia. Furthermore, mood reactivity is usually preserved in demoralized patients.[6] Unlike the depressed individual, the demoralized patient can experience hope and feel enjoyment as adversity is overcome. For example, a patient who is suffering from demoralization can experience an improvement in mood in response to a vacation, to successful pain control, or to a visit from someone important, in contrast to a depressed patient who cannot free him or herself from the dysphoric state.

Adjustment disorders are, by definition, abnormal responses to a given situation. Although somewhat controversial, demoralization is still considered a normal response to a difficult situation. The difference between demoralization and adjustment disorders appears to be more of a difference of degree than of kind.

Which Factors Contribute to Demoralization in the Medical or Surgical Patient?

Demoralization lies on a spectrum of vulnerability; even the most resilient person may become demoralized under extreme circumstances. In any given individual, multiple factors can contribute to the development of demoralization. However, some adversity is ubiquitous. While many hardships afflict patients (e.g., the disruption of social structure, abject poverty, and discrimination), a physician is most apt to see demoralization as an acute effect of medical illness.[8]

Nearly all types of medical conditions (including traumatic injury [e.g., burns and other disfigurements], acute illness [e.g., myocardial infarction], or chronic illnesses [e.g., rheumatoid arthritis, diabetes mellitus]) can demoralize a patient. Furthermore, demoralization may result from both the illness (and its manifestations) and the treatment of some conditions. For example, the physical discomfort and change of appearance caused by chemotherapy can be just as, or more, demoralizing than the cancer for which chemotherapy was prescribed.[8,13]

Of course, many patients with a potentially demoralizing illness or treatment do not become demoralized. Therefore, other factors must contribute to the development of demoralization. Among these are personality traits, the strength of interpersonal supports, and the existential posture that the patient adopts in the face of illness.[8]

Table 1. Factors That Contribute to Demoralization[a]

Factor
Chronic or acute medical illness
Depressed mood
Past psychiatric history
Diminished functional ability
Younger age
Poor family cohesion
Poor quality of relationships
Avoidant or confrontational coping styles
Trait anxiety

[a]Based on Clarke et al.[10]

A patient whose personality relies on his or her physical integrity will be particularly prone to demoralization when confronted with a debilitating or stigmatizing medical illness. For example, a narcissistic executive who relies on his good looks to influence others may become demoralized when confronted with his own paralysis or facial burns. Or, an individual with obsessive-compulsive traits may become demoralized when confronted by a colostomy for colon cancer and by the requisite colostomy bag (and threats to personal control associated with it) after surgery.[8]

Support from interpersonal relationships helps to deter demoralization. A patient who is isolated from family and friends will have a harder time being resilient in the face of adversity. So too will a patient whose physician is inattentive and patronizing. In the absence of close relationships, patients often find it difficult to make meaning of their medical illness.

Lastly, some patients adopt an existential state that draws them away from goal-directed coping and from engaging with living and toward a state of "giving up."[3] Such psychological states (e.g., confusion, isolation, despair, helplessness, cowardice, and resentment) make a patient more vulnerable to demoralization. By contrast, coherence, communion, hope, agency, purpose, courage, and gratitude characterize and facilitate resilience.[15] See Table 1 for a list of factors that contribute to demoralization.

How Can Demoralization Be Effectively Managed?

Since demoralization in the medically ill refers to the gamut of thoughts and negative emotions experienced by a patient when he or she is unable to cope with life's adversities, treatment should target these unwelcome affects, behaviors, and cognitions. The demoralized patient often adopts an existential position that distances him or her from the challenges of illness. Therefore, help for the demoralized patient targets the alleviation of suffering and the mobilization of his or her resilience. Given the personal nature of sources of demoralization, there is no specific and effective approach for all patients; rather, one can be mindful of broad guidelines that can be applied to each individual case.

COPYRIGHT 2007 PHYSICIANS POSTGRADUATE PRESS, INC © COPYRIGHT 2007 PHYSICIANS POSTGRADUATE PRESS, INC

In essence, the role of the physician is to witness, to validate, and to normalize the patient's experience of illness. This requires timely identification and treatment of symptoms that can be alleviated (e.g., pain, nausea, constipation, depression, anhedonia, and agitation).[3] Exploration with the patient of existential postures that dominate his or her experience is also useful. Physicians can then concentrate their treatment efforts on resilience-building interventions for identified themes.[13] On many occasions, a patient is confused about his or her situation and is left isolated; the patient does not know what to do and is left feeling alienated and in despair. In such a case, a cognitive approach can be helpful. The physician can provide appropriate information and reassurance, explore the meaning of illness to the patient, and identify and challenge distorted thinking about the illness. For the patient who experiences a loss of mastery and feelings of helplessness and cowardice, setting goals will help the patient to regain a sense of purpose and to reengage with meaningful relationships and activities. Perhaps most important, however, is the approach to the patient who feels isolated and ashamed; shame is an affect that most demoralized patients share. The physician can help such a patient by taking the time to listen empathically and by exploring the meaning of the illness. The patient should be reassured that what he or she is experiencing is a normal part of the illness and not a manifestation of a psychiatric illness. Through this connection, a demoralized patient can begin to regain a sense of value as a person and to feel less alienated from the world.

What Treatment Did Mr. A Receive?

Psychiatry and Palliative Care teams identified that Mr. A's lower back pain caused him more discomfort than was previously recognized by his physicians. This was not a surprise, as untreated pain is experienced by as many as 50% of patients with cancer.[16] Mr. A's beliefs about his pain affected his ability to get adequate care from his physicians. Due to fears of narcotic addiction, he had been reluctant to use larger amounts of oxycodone and tolerated his back pain for months. Because he was unable to obtain complete pain relief, he believed that his pain would never disappear. While in the hospital and in severe pain, he failed to ask for extra medication (due to his fears of narcotics and his belief that it would not work).

Once the team understood why Mr. A's pain went undertreated, they were able to address his concerns and to persuade him to take additional medication. The team explained to Mr. A and his wife the difference between dependency and addiction and assured them that fewer than 2 in 10,000 cancer patients with pain develop an opiate addiction.[17] In an effort to rapidly improve Mr. A's pain, he was treated aggressively; his basal rate of pain medication was increased and intravenous preparations were employed until his pain was controlled.

Once his pain was controlled, Mr. A's mobility improved, and he became more self-reliant. With an increased sense of control over his life, Mr. A became less demoralized. He was pleased with the changes made, and his interactions with the medical team and with his family improved. He denied further suicidal ideation. Nonetheless, his cognitive difficulties persisted, as did his weight loss and fatigue. Head imaging revealed no intracranial pathology to account for his cognitive and attentional symptoms. A trial of methylphenidate (with a maximum dose of 20 mg twice daily) did not prove efficacious. And although his physicians suggested a trial of antidepressant medications, the patient declined, saying that he no longer felt depressed. One month after his discharge from the hospital, Mr. A died from end-stage colorectal cancer in an outside hospital.

CONCLUSION

Mr. A's hospital course was complicated; poorly controlled pain induced psychological suffering and suicidal ideation. When his pain was adequately controlled, Mr. A's mood improved, although he continued to suffer from complications of end-stage cancer (e.g., poor concentration, fatigue, and increasing dependency on others). Mood disturbances are common in patients with cancer; 10% to 25% of cancer patients suffer from depression,[18] and Mr. A's medical team struggled with the diagnosis and treatment of his depression. Once his pain was adequately controlled and his mood improved, it became more apparent that he did not suffer from major depression. The term *demoralization* was useful in this context, as it describes a dysphoric mood that can change in response to external circumstances—in this case, improved pain control. By understanding Mr. A to be demoralized, the team was able to address the underlying causes of his psychological state and alleviate the patient's psychological as well as physical suffering.

REFERENCES

1. Frank JD. Psychotherapy: the restoration of morale. Am J Psychiatry 1974;131:271–274
2. American Psychiatric Association. Committee on Nomenclature and Statistics. Diagnostic and Statistical Manual of Mental Disorders, Second Edition. Washington, DC: American Psychiatric Association; 1968
3. Schildkraut JJ, Klein FD. The classification and treatment of depressive states. In: Shader RI, ed. Manual of Psychiatric Therapeutics. Boston, Mass: Little, Brown & Co; 1975:47
4. Shader RI. Demoralization revisited. J Clin Psychopharmacol 2005;25:291–292
5. Kissane DW. The contribution of demoralization to end of life decision-making. Hastings Cent Rep 2004;34:21–31
6. De Figueiredo J. Depression and demoralization: phenomenologic differences and research perspectives. Compr Psychiatry 1993;34:308–311

© COPYRIGHT 2007 PHYSICIANS POSTGRADUATE PRESS, INC © COPYRIGHT 2007 PHYSICIANS POSTGRADUATE PRESS

7. De Figueiredo J. Diagnosing demoralization in consultation psychiatry [letter]. Psychosomatics 2000;41:449–450
8. Slavney PR. Diagnosing demoralization in consultation psychiatry. Psychosomatics 1999;40:325–329
9. Clarke DM, Mackinnon AJ, Smith GC, et al. Dimensions of psychopathology in the medically ill: a latent trait analysis. Psychosomatics 2000;41:418–425
10. Clarke DM, McLeod JE, Smith GC, et al. A comparison of psychosocial and physical functioning in patients with motor neurone disease and metastatic cancer. J Palliat Care 2005;21:173–179
11. Breitbart W, Rosenfeld B, Pessin H, et al. Depression, hopelessness, and desire for hastened death in terminally ill patients with cancer. JAMA 2000;284:2907–2911
12. Chochinov HM, Wilson KG, Enns M, et al. Desire for death in the terminally ill. Am J Psychiatry 1995;152:1185–1191
13. Clarke DM, Kissane DW. Demoralization: its phenomenology and importance. Aust N Z J Psychiatry 2002;36:733–742
14. Ganzini L, Prigerson H. The other side of the slippery slope. Hastings Cent Rep 2004;34:3
15. Griffith JL, Gaby L. Brief psychotherapy at the bedside: countering demoralization from medical illness. Psychosomatics 2005;46:109–116
16. Hallenbeck J. Palliative Care Perspectives. Oxford, England: Oxford University Press; 2003:110
17. Abrahm J. A Physician's Guide to Pain and Symptom Management in Cancer Patients. Baltimore, Md: The Johns Hopkins University Press; 2005:47–50
18. Pirl WF. Evidence report on the occurrence, assessment, and treatment of depression in cancer patients. J Natl Cancer Inst Monogr 2004:32–39

ANNOTATED BIBLIOGRAPHY

Clarke DM, Kissane DW. Demoralization: its phenomenology and importance. Aust N Z J Psychiatry 2002;36:733–742
–This narrative review of demoralization discusses the role of hopelessness and the meaning of this construct. The authors review a variety of empirical and observational studies, as well as the theories of Jerome Frank among others. They put forward the idea that demoralization is a valid descriptive and predictive construct, whose place in the psychiatric nomenclature is not yet known, but should be established.

Ganzini L, Prigerson H. The other side of the slippery slope. Hastings Cent Rep 2004;34:3
–The authors respond to Kissane's hypothesis that demoralization is a separate psychiatric diagnostic entity. They argue that such a claim is premature due to the lack of data about distinctive symptoms, etiology, course, or treatment outcomes. They express concern that labeling demoralized patients as psychiatrically ill, particularly in terminally ill patients, could be used coercively and paternalistically (e.g., by refusing terminally ill patients the choice of stopping life-sustaining treatments).

Griffith JL, Gaby L. Brief psychotherapy at the bedside: countering demoralization from medical illness. Psychosomatics 2005;46:109–116
–The authors describe a technique for brief psychotherapy at the bedside to help moderate demoralization in medically ill patients. They discuss the fundamental components of demoralization and describe how a psychotherapeutic approach can address each of them.

Kissane DW. The contribution of demoralization to end of life decision-making. Hastings Cent Rep 2004;34:21–31
–This exploratory article published in the quarterly journal of the Hastings Center for Biomedical Ethics explores the nature of demoralization as a separate syndrome in which coping breaks down. Kissane discusses how demoralization can adversely affect decision making of patients at the end of life and how their caregivers should address the demoralization.

Pirl WF. Evidence report on the occurrence, assessment, and treatment of depression in cancer patients. J Natl Cancer Inst Monogr 2004:32–39
–In this comprehensive, evidence-based review of the literature on the occurrence, assessment, and treatment of depression in cancer patients, the author reviewed over 350 studies from 1966 through 2001. The evidence shows that the rates of major depressive disorder comorbid with cancer range from 10% to 25%. Although some evidence exists to support psychosocial and pharmacologic treatments for depression, the data remain limited—particularly for selective serotonin reuptake inhibitor medications.

Shader RI. Demoralization revisited. J Clin Psychopharmacol 2005;25:291–292
–In this editorial, the author discusses the current limited evidence about the comorbidity of depression, pain, and demoralization and when antidepressants should be used for demoralized patients.

Slavney PR. Diagnosing demoralization in consultation psychiatry. Psychosomatics 1999;40:325–329
–In this case series, in which the author argues that demoralization is a normal response to adversity rather than another pathologic syndrome, Slavney posits that, in the clinical setting, demoralization should be approached with this understanding in mind.

COPYRIGHT 2007 PHYSICIANS POSTGRADUATE PRESS, INC © COPYRIGHT 2007 PHYSICIANS POSTGRADUATE PRESS, INC