

The Demoralization Construct in Clinical Practice and Research

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When a stressful situation disrupts assumptions (subjective certainties) and expectations (subjective probabilities) about the present and the future, the stage is set for demoralization to occur. Frank¹ noted that people who sought psychotherapy used similar expressions to describe their suffering. He proposed the term *demoralization* to characterize their state of mind. He noted that the dictionary meaning of “to demoralize” is “to deprive a person of spirit, courage, to dishearten, bewilder, to throw a person into disorder or confusion” and that these terms “well describe the state of candidates for psychotherapy, whatever their diagnostic label.”¹ This concept dovetailed nicely with the observation by Schmale and Engel² that helplessness and hopelessness often precede or complicate medical illness, creating what they called “giving up, given up.” Demoralization may be viewed as involving subjective incompetence, its clinical hallmark, and symptoms of distress. Subjective incompetence refers to a person’s self-perception of an inability to perform tasks and express emotions that are considered appropriate in stressful situations and may be viewed as the opposite of resilience.³ This may result in feelings of entrapment, pervasive uncertainty, and doubts about the future. If demoralization is unrecognized or untreated, the subjective incompetence it involves may escalate into helplessness, hopelessness, a sense of failure, irrelevance, or futility. This can lead to a loss of meaning or purpose in life and may eventually result in demands for hastened death or suicidal thoughts.⁴

Demoralized individuals are sometimes misdiagnosed as having

adjustment disorder. Unlike adjustment disorder, demoralization does not require the clinician to guess the timing of the onset of the stressor, judge that the symptoms are out of proportion to what would be expected from the stressor, and wait up to 6 months for the stressor or its consequences to end.

The development of specific clinimetric criteria, ie, the Diagnostic Criteria for Psychosomatic Research (DCPR), made it possible to recognize and assess demoralization and subjective incompetence in a variety of clinical settings, patient groups, and general populations. Most studies have found that demoralization is correlated with lower income, higher perceived stress, lower perceived social support, lower resilience, higher levels of functional impairment, and lower quality of life.⁵ Clinimetrics⁶ has been widely used in clinical trials in psychiatry to assess response to treatment but had not been used in the diagnostic process until the introduction of DCPR. The use of clinimetrics in DCPR was a major advance in psychiatric research and clinical practice, leading to the discovery of interrelations and overlaps of demoralization with other transdiagnostic entities, such as allostatic load and irritable mood.⁷

Demoralization and major depression may occur together, but it is important to distinguish between the two. Individuals who are demoralized, but not depressed, are willing to take action to improve their situation, but they are uncertain about how to proceed. This uncertainty is called subjective incompetence, the hallmark of demoralization. In contrast, individuals who are depressed, but not demoralized, have a reduced willingness to act, even when aware of

potential solutions. Demoralization always occurs in the context of a past, present, anticipated, or imagined stressful situation (predicament) and is more likely when the stressful situation is relevant to the person’s self-esteem. Depression may or may not be precipitated by a stressful life event. Anhedonia is present in a major depressive episode, but absent in demoralization. Lack of concentration, anergia, insomnia, and anorexia are usually absent in demoralization but may be present in depressive spectrum disorders.^{8–10}

In cancer patients, demoralization, but not depression, carries a significantly increased risk for suicidal ideation after controlling for mental disorders¹¹; in Parkinson disease, demoralization explains disruptions in health-related quality of life better than depression, and resilience favors protection against demoralization over protection against depression^{12,13}; and in inflammatory bowel disease, demoralization persists from baseline to follow-up after 4 years even though mental disorders are no longer present.¹⁴ In cancer patients, as the severity of either depression or demoralization increases, they tend to occur together.^{15,16} Longitudinal use of the DCPR could identify certain unique aspects of individual profiles associated with this co-occurrence that may not be immediately obvious from the use of cross-sectional psychometric measures.

As Giovanni Fava suggested, the recognition of demoralization should be an integral part of clinical judgment in psychiatry.¹⁷ The interview should broaden the clinical focus and assess allostatic load, illness behavior, lifestyle, psychological well-being, resilience, perceived social support, and functional impairment,

in addition to subjective incompetence, helplessness, and hopelessness. The DCPR allows us to perform such evaluation.

The pathophysiology of subjective incompetence and demoralization is incompletely understood. Subjective incompetence may be viewed as a manifestation of a “top-down” process triggered by a failure of cortical mood regulation (emotion modulation). Depression, on the other hand, may be interpreted as a manifestation of a “bottom-up” process precipitated by a failure of subcortical mood regulation (emotion processing).¹⁸ This interpretation is supported by the well-documented role of the dopamine mesolimbic system in depression that explains the anhedonia, anergia, and abulia often present in major depressive disorder¹⁹ but absent in demoralization.

Demoralization is treatable. Psychotherapeutic interventions can reduce demoralization by modifying the perception of stress, restoring hope, and replacing negative cognitive distortions of self and stressful situations with positive and more precise and realistic appraisals. Examples are Well-Being Therapy (either alone or sequentially combined after cognitive behavioral treatment), meaning-centered psychotherapy, and supportive psychotherapy, whereas preliminary evidence suggests a potential role of psilocybin-assisted psychotherapy for demoralization.²⁰

Demoralization is classified as a distinct diagnosis in both *ICD-10* and *ICD-11* but not in the *DSM-5-TR*. It is important to acknowledge demoralization as a separate

diagnosis, rather than merely an additional specifier, because demoralization may occur by itself, in the absence of any other syndrome, disorder, or illness. Identifying and addressing demoralization may help save lives.

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