Assessing Demoralization and Depression in the Setting of Medical Disease

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Objective: The aim of this study was to assess the presence of demoralization and major depression in the setting of medical disease.

Method: 807 consecutive outpatients recruited from different medical settings (gastroenterology, cardiology, endocrinology, and oncology) were assessed according to DSM-IV criteria and Diagnostic Criteria for Psychosomatic Research, using semistructured research interviews.

Results: Demoralization was identified in 245 patients (30.4%), while major depression was present in 135 patients (16.7%). Even though there was a considerable overlap between the 2 diagnoses, 59 patients (43.7%) with major depression were not classified as demoralized, and 169 patients (69.0%) with demoralization did not satisfy the criteria for major depression.

Conclusions: The findings suggest a high prevalence of demoralization in the medically ill and the feasibility of a differentiation between demoralization and depression. Further research may determine whether demoralization, alone or in association with major depression, entails prognostic and clinical implications.

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There is increasing interest in the issue of demoralization in the setting of medical disease.[1] A substantial problem of research in demoralization lies in the various ways in which it is defined, ranging from general distress[2] to a specific syndrome characterized by subjective incompetence.[3] Schmale and Engel[4] have provided a detailed account of demoralization, which they defined as the "giving-up complex," involving (1) unpleasant, distressing feelings that are ascribed by the patient sometimes more to failures or deficiencies in his/her environment (helplessness) and sometimes more to his/her own personal failures or inadequacies for which he/she feels nothing can be done (hopelessness); (2) the patient perceiving himself/herself as less competent and less in control, though he/she may continue to attempt to be more competent and more in control; (3) the patient feeling that relationships with other persons or roles in life are less secure or gratifying; (4) the patient perceiving the external environment or his/her own performance as differing significantly from expectations based on past successful experiences; (5) the patient feeling a loss of continuity in the sense of sequence between past and future and a lessened ability to perceive the future with hope and confidence; and (6) the patient being prone to revive feelings, memories, and behavior connected with occasions in the past that had a similar, negative quality of feelings.

The giving-up complex was found to frequently occur in the life setting immediately preceding the onset of disease and can also be exacerbated by the course of illness.[5]

These phenomena cannot be subsumed under the rubric of psychiatric disorders.[6] Criteria for demoralization are indeed not listed in DSM-IV, but have been described in another diagnostic framework, the Diagnostic Criteria for Psychosomatic Research (DCPR).[7,8] The DCPR were developed by an international group of investigators to translate psychosocial variables that were derived from psychosomatic research into operational tools whereby individual patients could be identified.[7] The DCPR criteria for demoralization are detailed in Table 1. These criteria attempt to identify the syndrome described by Schmale and Engel.[4]

The aim of this exploratory study was to determine the presence of demoralization and major depression and

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their interaction in a sample of outpatients with a variety of medical conditions (functional gastrointestinal disorders, cardiovascular illness, endocrine disorders, and cancer).

METHOD

Eight hundred seven consecutive outpatients were recruited from different medical settings in a multicenter effort. The centers included had ongoing studies concerned with the application of DCPR criteria.[9–13] These studies had different aims and sample sizes, but shared a common methodology in the assessment of depression and demoralization.

Patients were recruited in a consecutive way, with the intent of being representative of their respective patient populations:

1. Consecutive outpatients with functional gastrointestinal disorders (N = 190) from the Functional Gastrointestinal Disorders Outpatient Clinic of the Scientific Institute of Gastroenterology (Castellana Grotte, Italy).
2. Consecutive outpatients with heart diseases (N = 351) from 3 different sources: (1) 198 outpatients who underwent heart transplantation from the Heart Transplantation Unit of the Institute of Cardiology at S. Orsola Hospital of Bologna, Italy; (2) 61 consecutive patients with a recent (within 1 month) first myocardial infarction diagnosis from the Cardiac Rehabilitation Program of the Bellaria Hospital in Bologna, Italy; and (3) 92 consecutive outpatients with a recent (within 1 month) first myocardial infarction diagnosis, from the Institute of Cardiology of University Hospital in Modena, Italy.
3. Consecutive outpatients with endocrine disorders (N = 162) from the Division of Endocrinology of the University of Padova Medical Center, Padova, Italy.
4. Consecutive outpatients who had received a diagnosis of cancer within the past 18 months (N = 104) from the S. Anna University Hospital in Ferrara, Italy.

Written informed consent was obtained from all patients. The sample included 377 men and 430 women, with a mean age of 48.7 (SD = 15.4) years. All patients underwent 2 detailed semistructured interviews by clinical psychologists with extensive experience in psychosomatic research: (1) the Italian version of the SCID,[14] leading to current DSM-IV psychiatric diagnoses, and (2) the Italian version of the Structured Interview for DCPR,[15,16] leading to current DCPR syndromes. DCPR syndromes were formulated independently of the DSM-IV diagnostic findings.

Table 1. DCPR Diagnostic Criteria for Demoralization[a,b]

1	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, hopelessness, or giving up.
2	The feeling state should be prolonged and generalized (at least 1 month in duration).
3	The feeling should closely antedate the manifestations of a medical disorder or exacerbate its symptoms.

[a]Based on Fava et al.[7]
[b]1 through 3 are required.
Abbreviation: DCPR = Diagnostic Criteria for Psychosomatic Research.

RESULTS

Demoralization was found in 245 patients (30.4%). There were 43 cases (22.6%) in gastroenterology, 64 (32.3%) with heart transplantation, 51 (33.3%) with myocardial infarction, 53 (32.7%) in endocrinology, and 34 (32.7%) in oncology. Major depression was found in 135 patients (16.7%). There were 39 cases (20.5%) in gastroenterology, 22 (11.1%) with heart transplantation, 19 (12.4%) with myocardial infarction, 42 (25.9%) in endocrinology, and 13 (12.5%) in oncology. While the prevalence rate of demoralization was not significantly different across the patient groups, major depression was significantly more prevalent in endocrinology ($\chi^2 = 19.66$, $df = 4$, $p < .001$).

Fifty-nine patients (43.7%) with major depression were not classified as demoralized, and 169 patients (69.0%) with demoralization did not satisfy the criteria for major depression.

DISCUSSION

In our study, demoralization was found to occur in almost one third of patients (30.4%). Its prevalence was about the same in cardiology, endocrinology, oncology, and gastroenterology. These results suggest that demoralization is frequent across different medical settings. They are consistent with the findings of Feldman et al.,[17] who found the prevalence of demoralization to be in 25% of 556 patients attending secondary health care clinics. They are also consistent with the results of Clarke et al.,[18] concerning demoralization and demoralized grief. The findings are remarkable since much more strict criteria for demoralization were used in this study.

Depressive symptoms are also frequently encountered in the medically ill. However, only a limited number of patients suffer from major depressive disorder. The prevalence of major depression in medical outpatient clinics has a wide range, which is, however, greater than in the general population.[19–23] In our sample, it occurred in 16.7% of patients, with a significantly higher prevalence in endocri-

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nology. In view of the tertiary care settings where the study was performed, the findings are consistent with the literature,[19–23] including the higher frequency of major depression in endocrinology.[24]

Our results indicate that there is a frequent overlap between demoralization and major depression, but that they are not necessarily connected by a hierarchical relationship. Depressed patients do not necessarily meet the criteria for demoralization, and the reverse may also be true. In fact, 43.7% of depressed patients were not classified as demoralized, and 69.0% of patients with demoralization did not satisfy the criteria for major depression. The findings call for the differential diagnosis between demoralization and the DSM-IV diagnoses of adjustment disorder with depressed mood and major depressive disorder.[3,6]

Adjustment disorders are frequently diagnosed by consultation-liaison psychiatrists.[25] The essential feature of this diagnosis is the maladaptive reaction to recent psychosocial stressors, which, in medical settings, can easily be identified with the illness itself. The psychological disturbances that are induced are not specified, however, and once the stressor has terminated, the symptoms do not persist for more than 6 months. Additionally, a demoralized person is no longer able to withstand adversity.[6] However, according to DCPR criteria (Table 1), symptoms should antedate the onset of medical disorders and may persist long after the stress is removed. Further, the clinical picture specifically reflects that of the giving-up reaction.[4,5]

De Figueiredo[3] remarks that we must consider the presence of subjective incompetence, the magnitude and direction of the motivation to act, and the lack of symptoms involving sleep, appetite, energy, and concentration seen in demoralization. A depressed person is incapable of experiencing enjoyment of any sort, whereas a demoralized individual is unable to acknowledge anticipatory pleasure but consummatory pleasure is unaffected.[26] Both demoralized and depressed patients experience a lack of motivation and drive, which influences their ability to interact in daily life. In the depressed person, this inhibition is due to a primary reduction in motivation and drive and not to his/her incapacity to act, whereas in the demoralized person, motivation and drive are usually intact but the lack of confidence and the feeling of helplessness inhibit his/her initiative.[1] Further, in major depression, the perceived source of distress is within oneself, whereas in demoralization the patient may ascribe his/her status to failures or deficiencies in his/her environment (helplessness) as well as to his/her own personal failures or inadequacies (hopelessness). In line with this, breast cancer patients meeting criteria for demoralization according to the DCPR showed higher levels of hopelessness (i.e., feeling that nothing can be done to help oneself, feeling like giving up, feeling that life is hopeless) than patients not demoralized.[27]

In major depression, all areas of psychological well-being tend to be affected,[28] whereas in demoralization, impairments appear to affect specific areas.[29] According to Ryff's conceptual framework,[30] these impairments may be subsumed under the rubrics of environmental mastery, relationships with others, and personal growth.

Further studies on demoralization in the setting of medical disease are warranted in view of the following potential clinical implications. A first, important research question is whether the presence of demoralization in conjunction with a medical disorder has prognostic implications (disease outcome, adverse health behaviors, lack of adherence, physical symptom perception, functional impairment, and medical utilization). The Rochester group had postulated that the giving-up complex may affect vulnerability to disease.[5] Such effects on medical disease have been described with the occurrence of major depression.[19–23] It would also be interesting to know whether the joint occurrence of major depression and demoralization has more severe clinical connotations than each of the conditions alone.

A second important line of research is concerned with treatment of demoralization and the effects of such treatment on the associated medical illness. Antidepressant drugs are effective in treating major depression, and this effectiveness has been tested in placebo-controlled studies and also in the setting of medical disease.[19–23]

It would be interesting to know whether antidepressant drugs can also be effective in demoralization. At present, there are no studies exploring this possibility. Frank and Frank[2] proposed that demoralization is the common denominator of all conditions that psychotherapy attempts to relieve. It would be important to test the effectiveness of specific psychotherapeutic approaches such as cognitive-behavioral therapy, interpersonal psychotherapy,[31] or well-being therapy[32] in DCPR demoralization.

The present investigation has considerable limitations due to the heterogeneous patient population involved. Nonetheless, it has considerable clinical implications. Expressions such as "It's too much," "It's no use," "I can't take it anymore," and "I give up" may be frequently encountered in the medical patient.[4] Lack of symptoms such as early morning awakening, impaired appetite, or diurnal fatigue would rule out the diagnosis of major depressive disorder and would lead to discarding symptoms as part of an adjustment disorder with depressed mood, arising as a consequence of illness. Careful scrutiny of the chronology and quality of symptoms, instead of simple quantity,[33–35] may disclose the pattern of demoralization and that the state antedated the onset of medical disorder. The findings of our multicenter study indicate that demoralization, according to the phenomenological description of the Rochester group,[4,5,24] is indeed common in the medically ill.

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