Demoralization
In the Palliative Care Setting

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Introduction

- Who am I?
  - SCCA Psychiatry Attending
  - UWMC Psychiatry Consult-liaison Attending

- I have no financial disclosures

- A high number of my current patients are demoralized
Objectives

• To learn the definition of demoralization
• To gain skills in differentiating demoralization from depression
• To learn ways of accurately assessing and treating demoralization
Plan for Lecture:

- Background and Historical info
- Why this matters
- Writing exercise
- Assessment
- Treatment
Demoralization

• Morale: “the mental and emotional attitude of a person or group with regard to their confidence, zeal and willingness, and degree of contentment with their lot or situation”

• to demoralize = “to deprive a person of spirit, courage, or discipline, to reduce to a state of weakness or disorder”

• A human experience, described throughout human existence
Demoralization in Medicine

- 1st proposed as a psychiatric construct in 1970s
- Not in the DSM
- A syndrome of existential distress that features helplessness, hopelessness, loss of meaning and purpose, confusion and subjective incompetence
- Duration of at least 2-4 weeks (per research std)
- Treatable condition!
Demoralization: the Diagnosis

- Not recognized in the DSM
  - We can’t bill for it
  - We use instead “adjustment disorder” or “depressive d/o unspecified” or “anxiety d/o unspecified”
  - Term “demoralization” resonates well with patients

- Lack of recognition in the DSM →
  - under-recognized
  - undertreated
  - excessive and ineffective use of antidepressants
Adjustment disorder criteria

The development of emotional or behavioral symptoms due to a stressor occurring within 3 months of the onset of the stressor.

The symptoms or behaviors are clinically significant, with either or both:

Marked distress that is out of proportion to the severity or intensity of the stressor

AND/OR

Significant impairment in functioning.

Specify whether: With depressed mood, With anxiety or With disturbance of conduct or a combination of these.
Case Example: Treatable Condition

- 66yo man with MDS s/p BMT
- Psych consulted for depression eval
- Physically weak, fatigued, irritable, anhedonic x 2 wks
- “what’s the point? I can’t do anything! I can’t even cook breakfast for my wife.”
- No hx of mental health conditions
- Does not want meds
Risk for Hastened Death

• In general, a sense of hopelessness is more highly correlated with the wish to die than severity of depression.

In studies of cancer and palliative care patients:

• depression, loss of meaning and purpose, loss of control and low self-worth were individual mediators of the desire for hastened death.

• Loss of meaning is the strongest mediator between global distress and suicidal thinking.
The case of Mrs. C

47 yo woman, hx severe JRA and limited mobility, found down at home and admitted after anoxic brain injury causing a stroke

- had new VH and AMS → concern for delirium

- delirium treated and improved → then within 1-2 days develops new SI with plan

- severe hopelessness d/t new blindness & inability to eat
Writing Exercise

This is a confidential exercise. The intent of this exercise is to increase your understanding of demoralization and how you experienced and responded to a time of hopelessness.

- Recollect a time in your life in which you felt temporarily hopeless. You can write down a few notes about this if you choose to.

- you remember this event—What steps did you take in trying to cope?

- What ultimately helped you feel better?
Demoralization vs. Depression:

- Main differentiation between Depression & Demoralization: Consummatory Pleasure
- Past Psychiatric history
- On MSE: affect and mood reactivity
- What about the PHQ9?
- Does it get better if the stressor is removed?

![PHQ-9](image)
Existential Components of Demoralization

- Confusion vs. coherence
- Isolation vs. communion
- Despair vs. hope
- Helplessness vs. agency
- Meaningless vs. purpose
- Cowardice/Fear vs. courage
- Resentment vs. gratitude
Writing Exercise Continued

- Now that you know the existential components of demoralization—which ones were present in your time of hopelessness?

- Did the ways you coped and ultimately felt better correspond with improvement in any of the existential components?
Depression vs. Demoralization

- You can have both!

- The role of antidepressants
  - Not effective in demoralization
  - I will use in certain cases if:
    - current comorbid MDD or Hx of clear MDD
    - Current Anxiety disorder
    - Pt has positive expectations of the med
    - If demoralization is a/w sleep/appetite concerns
Epidemiology of Demoralization

• Prevalence rate of 13-18% in patients with cancer

• Higher risk if:
  • Single, divorced or separated
  • Unemployed
  • Lack of spirituality or with current spiritual problems
  • If fatigue, pain, constipation, mobility issues, breathing problems or cognitive problems are present
In a study of 430 cancer patients with mixed tumor sites:

- 21% were demoralized
- 7% were demoralized AND met criteria for a mood or anxiety disorder
- 14% demoralized alone
- 22% met criteria for depression (using PHQ9)
Assessing demoralization

- First and foremost: Hear their story (decreases isolation)
- What’s the worst part of all this for you?
  - “Right now it’s the pain. I can’t seem to get it under control. I can’t spend the rest of my life like this.”
- Assess the existential components:
  - Confusion vs. coherence
  - Isolation vs. communion
  - Despair vs. hope
  - Helplessness vs. agency
  - Meaningless vs. purpose
  - Cowardice vs. courage
  - Resentment vs. gratitude
Treatment: Palliative Care Team

- Hearing their story
- Active symptom management
- Conduct family meetings to improve family functioning (Communion)
- Explore goals of care with patient, family and in multidisciplinary team meetings (Agency) (Coherence)
- Address spiritual concerns
Further treatment: Supportive Psychotherapy

- Balance stance of support for grief with promotion of hope and acceptance
- Foster search for renewed purpose, meaning and role of life
- Gratitude building exercises
- Legacy interventions
Treatment that Psychiatry/Psychology Provides

- CBT
  - Cognitive Therapy
  - Behavioral Activation
- Mindfulness-based psychotherapy
- Acceptance and Commitment Therapy
- Dialectal Behavioral Therapy
- Meaning-based psychotherapy
- Dignity Therapy
Resources for Improved Coping

For decreasing distress or increasing acceptance:

- Slow, deep breathing
- Progressive muscle Relaxation
- Mindfulness
- Guided meditations or imagery exercises

- Free Phone Apps: Virtual Hopebox, Insight Timer
- UCLA Mindfulness website
- Do these activities IN THE ROOM with the patient
Challenges & Future Directions

- Cognitive impairment and fatigue levels impacting ability to participate in therapy
- Identifying demoralization sooner— is it being captured by our screenings?
- Demoralization among medical team members -effect on patient care and provider burn out?
References


