

# Depression, demoralisation or adjustment disorder? Understanding emotional distress in the severely medically ill

Nikki O’Keeffe and Gopinath Ranjith

**Nikki O’Keeffe**  
MRCPsych, Senior  
House Officer

**Gopinath Ranjith**  
MRCPsych,  
Consultant Liaison  
Psychiatrist and  
Honorary Senior  
Tutor

Department of  
Liaison Psychiatry,  
St Thomas’  
Hospital, London

*Clin Med*  
2007;7:478–81

**ABSTRACT** – As emotional distress is often seen as an understandable reaction to a severe or life-threatening illness, clinicians are reluctant to make a diagnosis of depression and resort to alternative diagnoses such as adjustment disorder (AD) or demoralisation. This paper introduces these concepts and critically examines their clinical utility. It concludes that neither AD nor demoralisation can be clearly distinguished from depression on variables such as clinical symptoms, outcome or treatment response. Since AD and demoralisation are considered transient or understandable reactions, the risk of using these diagnoses as alternatives to depression in a clinical setting is that a simplistic approach of psychological therapies for the former and antidepressants for the latter will be adopted. Instead, a working diagnosis of a general distress syndrome complemented by a personalised formulation is advocated. This would lead to the generation of a problem list and a pragmatic management plan.

**KEY WORDS:** adjustment disorder, biopsychosocial model, demoralisation, depression

## Introduction

Depression is one of the most common reasons for the referral of patients between physicians and liaison psychiatrists in a general hospital.<sup>1</sup> When depression develops in the context of a severe medical illness, it is often seen as an inevitable consequence of the illness or its attendant disability. The attitude of many physicians and psychiatrists when faced with emotional distress in a patient with a severe or life-threatening illness can be summed up by the comment, ‘they have enough reasons to be depressed, don’t they?’.

The reluctance to diagnose clinical depression leads to liaison psychiatrists making alternative diagnoses such as adjustment disorder (AD) and demoralisation.<sup>2,3</sup> Proponents of these diagnoses

argue that a diagnosis of depression runs the risk of the medical labelling of normal emotional reactions and offering unnecessary treatments, usually psychopharmacological with their attendant adverse effects including psychomotor activation and increase in suicidal ideation,<sup>4</sup> to people who may not need them. The downside of using these lesser known diagnostic terms is that they often result in confusion and uncertainty among physicians and patients.

This paper introduces and critically examines the concepts of AD and demoralisation in the setting of a severe medical illness with a particular emphasis on clinical utility. It concludes by offering a framework for the assessment of emotional distress in the medically ill that is not overly constrained by diagnostic labels.

## Making a diagnosis of depression in the medically ill

The diagnosis of depression is fraught with difficulties. The diagnosis is made according to the presence of a certain number of symptoms, their duration and their impact on the individual. The diagnosis of depression in the medically ill poses special problems. Apart from the ‘good reasons to be depressed’ issue discussed in the introduction and the need to exclude depression induced by the medical condition (secondary depression) or its treatment (iatrogenic depression), many of the ‘depressive’ symptoms may actually be symptoms of the primary medical illness. These include sleep disturbance, changes in appetite and weight, fatigue, low energy levels and problems in concentration and memory. Including these as depressive symptoms may lead to over-diagnosis of depression. Three alternative approaches have been suggested to overcome this problem:

- the aetiological approach where the clinician makes a subjective judgement about whether the symptom should be attributed to depression or the medical condition

- the exclusive approach where physical symptoms are dropped from the symptom list and the number of symptoms needed to make the diagnosis is reduced
- the substitutive approach where physical symptoms are replaced by emotional symptoms.<sup>5</sup>

The best example of the latter is that employed by Endicott where, for example, low energy is replaced by brooding and self-pity.<sup>6</sup> Patients assessed for emotional problems in a medical setting may not often fulfil formal criteria for depression. It is usually when faced with patients with sub-threshold depression that other diagnoses such as AD or demoralisation are considered

### Adjustment disorder: trivialising suffering?

Adjustment disorder is conceptualised as a stress-related, time-limited, and non-psychotic disturbance. It is seen as an understandable but maladaptive response to a stressful event, in this context a physical illness, that resolves spontaneously when the stressor is removed or a new level of adaptation is reached. In addition to a state of subjective distress and emotional disturbance, the manifestations include anxiety, depressed mood, and a feeling of inability to cope and plan ahead. The cardinal features are that none of the symptoms are of sufficient severity to justify a more specific diagnosis, and that the symptoms occur in response to an identifiable stressor.

Adjustment disorder is frequently seen in the medical setting. In a multi-site study, Strain *et al* found that a diagnosis of AD was made in 12% of consecutive consultations.<sup>7</sup> Despite its high frequency, AD has received little scientific attention. A reason for this is the instability of the diagnosis – Greenberg *et al* found that 40% of patients admitted to a hospital with a diagnosis of AD were discharged with a different diagnosis.<sup>8</sup> The reason for this instability may be because the diagnostic criteria currently used by psychiatrists – the Diagnostic and Statistical Manual, fourth edition, revised (DSM-IV-TR)<sup>9</sup> and the International Classification of Diseases (ICD-10)<sup>10</sup> – are vague and non-specific.

Research findings suggest that individuals with AD have an increased risk of morbidity and mortality. Comorbidity with other psychiatric illnesses is high with Strain *et al* reporting that 39% of adult inpatients in general hospital with AD had a personality disorder and 23% had a substance use disorder.<sup>7</sup> In terms of clinical utility, the key question is whether AD can be differentiated from major depression. A recent large epidemiological study failed to distinguish between AD and depression on variables including symptom severity.<sup>11</sup>

The treatment of AD entails clarifying the meaning of the stressor, developing a means to reduce the stressor and maximising the patient's coping skills. Psychological therapies may involve cognitive behavioural therapy, crisis intervention, supportive therapy and dynamic psychotherapy.<sup>12</sup> There are very mixed views on the role of pharmacological therapy. Though it is generally believed that antidepressants alone are ineffective in the treatment of AD, a recent study, albeit

retrospective and with a small sample size, came out with the counterintuitive finding that patients with ADs were twice as likely to respond to standard antidepressants as patients with major depression.<sup>13</sup> This may, of course, represent a non-specific effect of antidepressants.<sup>14</sup> Regarding prognosis, despite the general impression of AD being a transient disorder compared to major depression, Jones *et al* found that outcome of ADs after six months was no different from other depressive disorders.<sup>15</sup> The prognostic issue is complicated further when the stressor is likely to be ongoing in a chronic or life-threatening illness.

Casey, reflecting the view of many clinicians, has recently called AD an 'afterthought' diagnosis mostly used by liaison psychiatrists.<sup>2</sup> While the advantage of this diagnosis is that it avoids stigmatising the patient the risk is that it implies a transient and spontaneously remitting disorder. This may lull the clinician into therapeutic inactivity and lead to minimisation of the patient's suffering.

### Demoralisation: a useful concept?

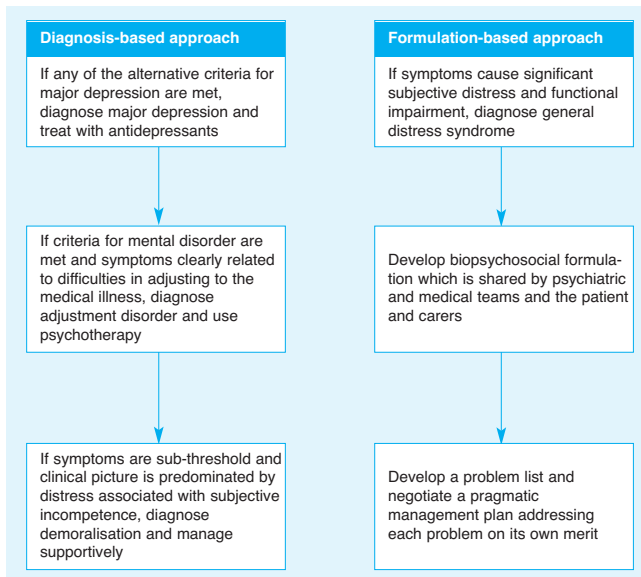
Demoralisation is a concept that was popularised by the late Jerome Frank who described it as a characteristic of all conditions that respond to psychotherapy.<sup>16</sup> There has been much debate about whether demoralisation is a normal reaction to a state of overwhelming circumstances, or a disorder. Slavney supports the former view and strongly advocates distinguishing between demoralisation and AD.<sup>3</sup> Others believe that it is almost always pathological and advocate a separate disorder called demoralisation syndrome.<sup>17</sup> Its criteria are not included in the DSM-IV, but they are listed in the Diagnostic Criteria for Psychosomatic Research (DCPR) that has been specifically developed for use with the medically ill.<sup>18</sup> Using the DCPR, Mangelli *et al* showed that demoralisation is seen in 30.4% of consecutive outpatients seen in medical clinics.<sup>19</sup>

From the viewpoint of clinical utility, the crucial issue is whether demoralisation can reliably be differentiated from depression or AD. Patients with demoralisation, de Figuerido noted, lack symptoms characteristic of depression most notably those involving sleep, appetite and motivation.<sup>20</sup> This may be difficult to assess clinically as the majority of hospitalised patients suffering from major physical illness have disturbances in physiological functions such as appetite and/or sleep. Other symptoms said to characterise demoralisation include feelings of hopelessness and helplessness, confusion, loss of meaning, isolation, subjective incompetence, distress and apprehension, most of which are shared with other depressive disorders. Mangelli *et al*, in a mixed medical sample drawn for different specialist clinics, found that not all depressed persons are demoralised and vice versa.<sup>19</sup> But given the significant overlap between depression and demoralisation in the sample, it is difficult to support their conclusion that demoralisation be differentiated from depression and AD in a clinical setting. The suggestion that the distress is relieved by the removal of the stressor in AD as opposed to demoralisation is less useful in the setting of a chronic or life threatening disease. Anhedonia, the

loss of enjoyment of pleasurable activities, has also been suggested as a differentiating feature, being present only in depression while demoralisation is characterised by the absence of anticipatory but not consummate pleasure. Clarke *et al*, using a cluster analysis technique, were able to differentiate demoralisation and demoralised grief from anhedonic depression at a symptom level, but at a person level, the findings favoured

a unitary entity which could be called a general distress syndrome.<sup>21</sup>

Most authors have recommended psychotherapeutic techniques to deal with demoralisation. The role of antidepressants has not been studied in any great detail. Given that subjective incompetence in the face of overwhelming circumstances is the core phenomenon in demoralisation, one might argue that animal models of depression such as the forced swim test,<sup>22</sup> which respond to antidepressants in pre-clinical studies, are actually models of demoralisation. It may be premature to dismiss the role of antidepressants. The research reviewed above does not support using demoralisation as a diagnosis in opposition to depression but there is no doubt that it is an important psychopathological concept and addressing it should be an important part of the management plan.



**Fig 1. Comparing the approaches to understanding emotional distress associated with medical illness.**

**A framework for understanding depression in the medically ill**

Diagnostic labels are useful in aiding communication between professionals and the introduction of diagnostic criteria in psychiatry has advanced research. Distinguishing a depressive disorder from AD or demoralisation may clearly have financial and therapeutic implications. But in clinical practice, where diagnostic criteria are used less rigidly, clinical utility remains the key attribute of a diagnostic concept.

We believe that the terms currently used in diagnosing emotional distress in the medically ill are not very useful in the management of an individual patient and do not lead to clear communication, neither between physicians and psychiatrists nor doctors and patients.

**Case vignette**

A 60-year-old married man with a background history of diabetes mellitus and alcohol abuse developed spinal abscesses following an elective transurethral resection of his prostate gland. His abscesses were drained, however he was left with paralysis of both lower limbs. In addition, histopathology results revealed carcinoma of the prostate. When referred to the liaison psychiatry team, he presented with low mood, feelings of hopelessness and helplessness and subjective incompetence due to his physical disability. He did not have any active suicidal ideation and there were no signs of psychosis or cognitive impairment. He was started on citalopram 20 mg, which was gradually increased to 40 mg and his symptoms improved.

He was transferred to a nursing home, but was readmitted two weeks later, as a result of hypoglycaemia and dehydration after refusing to eat food. He denied low mood or biological symptoms of depression but expressed a strong desire to die and did not want to receive any form of intervention. He reported that he felt very isolated in the nursing home and was of the opinion that his physical needs were neglected. It was also detected that the antidepressant had been discontinued as a result of a prescribing omission. The nursing home was too far for his family to visit regularly and, angered at what he saw as their lack of interest, he forbade them to visit him while in hospital.

Rather than debate whether he fulfilled criteria for major depression or not, it was agreed that his current presentation was a result of anger and frustration at having been placed in an unsuitable nursing home, isolation from his family, the uncertain prognosis about his illness and the reduction in the dose of antidepressant. His family were contacted with his consent and hospital visits were arranged.

A palliative care nurse met with him to discuss issues about prognosis and his desire for end-of-life care during which it emerged that he had thought that his prognosis was worse than it actually was. A referral to the hospital chaplain was offered but declined. A case conference was called and a range of nursing homes identified and the final choice was left to him. Citalopram was restarted and built up to the previous dose. These simple interventions made a significant impact on his mental state and his mood improved. He was transferred to a nursing home of his choice and his mental state remains stable.

The way forward would be to have a working diagnosis of a general distress syndrome which, for the sake of documentation and ease of communication, could be called major or minor depression (depending on the number of symptoms) or placed on a mild to severe continuum based on functional impairment. The principle of watchful waiting, now enshrined in national guidelines for the management of depression, would prevent very transient reactions from being unnecessarily treated.<sup>23</sup>

The diagnosis should be complemented by an individualised formulation of the patients' problems. Such a formulation, stated in non-technical language, could be shared between the medical team, the liaison psychiatry team and the patient leading to clear communication. In this framework, demoralisation and maladaptive adjustment to illness would be considered important dimensions in the formulation rather than diagnostic labels.

The formulation would lead to the generation of a problem list, each problem being addressed on its own merit. This would move us away from the question, 'Does the patient have depression, demoralisation, or adjustment disorder?' to 'What are the patient's current problems and how can we deal with them?'. In the true spirit of the biopsychosocial model the clinician would be able to use antidepressants for anhedonia, existential or spiritual approaches for demoralisation, psycho-educational or cognitive approaches to deal with maladaptive adjustment and behavioural activation for poor motivation and learned helplessness, where indicated, in the same patient. Patient care would be advanced by such a pragmatic clinical approach rather than by unnecessary wrangling over diagnostic labels. In Fig 1 the diagnosis-based and formulation-based approaches to managing depression in the medically ill are compared and contrasted. A CV based on recently managed cases has also been supplied to illustrate this approach.

## References

- Huysse FJ, Herzog T, Lobo A *et al.* Consultation-liaison psychiatry service delivery: results from a European study. *Gen Hosp Psychiatry* 2001;23:124–32.
- Casey P. The 'afterthought' diagnosis: rehabilitating adjustment disorders. *Expert Rev Neurother* 2006;6:145–51.
- Slavney PR. Diagnosing demoralization in consultation psychiatry. *Psychosomatics* 1999;40:325–9.
- Healy D, Aldred G. Antidepressant drug use and the risk of suicide. *Int Rev Psychiatry* 2005;17:163–72.
- Cohen-Cole SA, Stoudemire A. Major depression and physical illness: special considerations in diagnosis and biologic treatment. *Psychiatr Clin North Am* 1987;10:1–17.
- Endicott J. Measurement of depression in patients with cancer. *Cancer* 1984;53:43–9.
- Strain JJ, Smith GC, Hammer JS *et al.* Adjustment disorder; a multisite study of its utilization and interventions in the consultation-liaison setting. *Gen Hosp Psychiatry* 1998;20:139–49.
- Greenberg WM, Rosenfeld DN, Ortega EA. Adjustment disorder as an admission diagnosis. *Am J Psychiatry* 1995;152:459–61.
- American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*, 4th edn, revised. Washington, DC: American Psychiatric Association, 2000.
- World Health Organization. *The international statistical class of diseases and related health problems*, 10th revision. Geneva: WHO, 1992.
- Casey P, Maracy M, Kelly BD *et al.* Can adjustment disorder and depressive episode be distinguished? Results from ODIN. *J Affect Disord* 2006;92:291–7.
- Gur S, Hermesh H, Laufer N, Gogol M, Gross-Isseroff R. Adjustment disorder: a review of diagnostic pitfalls. *Isr Med Assoc J* 2005;7:726–31.
- Hameed U, Schwartz TL, Kijne B, Johnsen A, Andersen HS. Antidepressant treatment in the primary care office: outcomes for adjustment disorder versus major depression. *Ann Clin Psychiatry* 2005;17:77–81.
- Moncrieff J, Kirsch I. Efficacy of antidepressants in adults. *BMJ* 2005;331:155–7.
- Jones R, Yates WR, Williams S, Zhou M, Hardman L. Outcome for adjustment disorder with depressed mood: comparison with other mood disorders. *J Affect Disord* 1999;55:55–61.
- Frank JD. Psychotherapy: the restoration of morale. *Am J Psychiatry* 1974;131:271–4.
- Clarke DM, Kissane DW. Demoralization: its phenomenology and importance. *Aust N Z J Psychiatry* 2002;36:733–42.
- Fava GA, Mangelli L, Ruini C. Assessment of psychological distress in the setting of medical disease. *Psychother Psychosom* 2001;70:171–5.
- Mangelli L, Fava GA, Grandi S *et al.* Assessing demoralization and depression in the setting of medical disease. *J Clin Psychiatry* 2005;66:391–4.
- di Figueiredo JM. Depression and demoralization: phenomenologic differences and research perspectives. *Compr Psychiatry* 1993;34:308–11.
- Clarke DM, Smith GC, Dowe DL, McKenzie DP. An empirically derived taxonomy of common distress syndromes in the medically ill. *J Psychosom Res* 2003;54:323–30.
- Cryan JE, Mombereau C. In search of a depressed mouse: utility of models for studying depression-related behaviors in genetically modified mice. *Mol Psychiatry* 2004;9:326–57.
- National Institute for Clinical Excellence. *Depression: management of depression in primary and secondary care*. London: NICE, 2004.