

Subjective Incompetence as a Clinical Hallmark of Demoralization in Cancer Patients Without Mental Disorder

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ABSTRACT

Objective: Evaluate the relationship between depression and subjective incompetence at different levels of perceived stress and social support.

Methods: Outpatients with cancer and no previous psychiatric history or concurrent mental disorder completed questionnaires on demographics, perceived stress, social support, depression, and subjective incompetence.

Results: Depression and subjective incompetence were positively correlated when perceived stress was high and social support was low, or both perceived stress and social support were either high or low, and negatively correlated when perceived stress was low and social support was high.

Conclusion: The results are consistent with the view that depression and subjective incompetence are separate components of demoralization and that subjective incompetence is the clinical hallmark of demoralization.

INTRODUCTION

The objective of this study was to test the following hypotheses in cancer patients. First, that when perceived stress is high and/or social support is low, the correlation between depression and subjective incompetence will be positive. Second, when perceived stress is low and/or social support is high, the correlation between depression and subjective incompetence will be negative.

FOCUS POINTS

- Demoralization is the state of mind of many people facing a stressful situation, irrespective of their diagnostic label.
- Demoralization is an overlap of distress and subjective incompetence.
- Clinical depression involves a loss of the magnitude of motivation, even though the direction is known to the person, while the converse is true of demoralization.
- Perceived stress may foster demoralization by bringing depression and subjective incompetence together, while social support keeps them apart.

Numerous studies have assessed depression in cancer patients, reporting widely variable prevalence rates (0% to 38% for major depressive disorder and 0% to 58% for depression spectrum syndromes).¹ The study of depression in cancer patients is quite challenging. This is partly because the symptoms range from sadness to major depressive disorder (MDD); partly because patients are exposed to a life-threatening illness, fatigue, pain, and cancer treatments; and partly because it may be difficult to distinguish what may be a homeostatic response to stress from a mental disorder or a result of cancer or its treatment.² A critical issue is the interpretation of the clinical presentation. Are the symptoms of depression of a cancer patient a sign of normal (“understandable”) reaction to stress, of non-specific (sub-threshold) distress, of clinical (supra-threshold) depression, or of demoralization? These issues were recognized by Coups and colleagues³ when they wrote:

“It is normal that sadness is a response to a diagnosis of cancer, since the implication of potential losses is the usual perception of cancer. But how much is ‘normal’ and when does it become ‘abnormal’? Is there a

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continuum of severity of depressed mood from sadness to [MDD], or are there discrete entities with their own differing etiologies? What is the difference between the depression that is a psychological response to cancer and depression that occurs with pancreatic cancer or with high-dose interferon? These are some of the important and challenging conundrums related to depression in the context of cancer and its treatment."³

In attempting to address these diagnostic issues, the distinction between depression and demoralization brings us closer to an understanding of the psychological distress of cancer patients. Demoralization has been described as the state of mind of a person deprived of spirit or courage, disheartened, bewildered, and thrown into disorder or confusion. Frank and Frank⁴ proposed that these terms describe the state of mind of many people who seek psychotherapy, whatever their diagnostic label.⁵ Demoralization has been documented in numerous clinical settings and in the general population.^{4,5} It is only recently, however, that demoralization has been examined in cancer patients.⁶⁻⁸

To further characterize the concept of demoralization, it has been proposed that the clinical hallmark of demoralization is "subjective incompetence," a self-perceived incapacity to perform tasks and express feelings deemed appropriate in a situation perceived as stressful, resulting in pervasive uncertainty and doubts about the future. Subjective incompetence occurs when a person is facing a stressor that disconfirms assumptions about self and others.⁹⁻¹² Individuals with subjective incompetence are puzzled; indecisive; uncertain; facing a dilemma; unclear as to ways out of the situation; and placed in a deadlock, impasse, quandary, or plight. Demoralization is viewed as involving both subjective incompetence and symptoms of distress, such as depression, anxiety, resentment, anger, or combinations thereof. Furthermore, if motivation is viewed as a vector, with a magnitude and direction, depression would involve a loss of the magnitude of motivation, but not of the direction, the converse being true of demoralization. Subjective incompetence may be viewed as the loss of the directional component of motivation.

A theory of demoralization was developed in which perceived stress is viewed as bringing distress and subjective incompetence together, while social support keeps them apart. Subjective incompetence and distress may occur by themselves. When perceived stress is high and social support low, the stage is set for subjective incompetence and distress to occur together constituting demoralization.^{9,10} From this the following may be predicted. First, when perceived stress is low and/or social support is high, distress and subjective incompetence will be negatively correlated. Second, when perceived stress is high and/or social support is low, distress and subjective incompetence will be positively correlated. By contrast, current psychosocial theories of depression would predict that when perceived stress is low and social support is high, depression and subjective incompetence would always be low, the converse being true when perceived stress is high and/or social support is low.

A scale for subjective incompetence was recently developed and shown to have adequate internal consistency reliability (Cronbach's α of 0.90), test-retest reliability (0.84), and construct validity, thus opening up the possibility of studying the relationship of distress and subjective incompetence to perceived stress and social support.¹² In this study, the particular form of distress examined was sub-threshold depression, ie, depression that does not meet *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition¹³ criteria for mental disorder.

METHODS

The subjects (n=71) were outpatients with cancer consecutively admitted and evaluated at a Consultation Clinic of a Cancer Center from August 2003–February 2004 who agreed to participate in the study and who met the following criteria: age 20–90 years; a diagnosis of colorectal or gastrointestinal cancer; and ability to read and understand English. Subjects near to end of life, as defined by hospice admission, or subjects with a known or diagnosed mental disorder or previous psychiatric treatment or currently meeting the criteria for a psychiatric diagnosis as determined by the administration of the Structured Clinical Interview for *DSM-IV-TR*¹⁴ Axis I disorders, were excluded.¹⁵

All procedures followed the ethical standards of the responsible committees on human experimentation. Approval of the Institutional Review Board was obtained. After complete description of the study to the subjects, written informed consent was obtained.

Subjects completed a questionnaire on background, eliciting information on age, gender, race/ethnicity, marital status, education, occupation, and income; the Impact of Events Scale, measuring perceived stress¹⁶; the Interpersonal Social Evaluation List, Short Form, measuring level of social support¹⁷; the Center for Epidemiologic Studies Depression (CESD), measuring the level of depression¹⁸; and the Subjective Incompetence Scale (SIS), measuring subjective incompetence.¹²

Data were collected on Teleform, entered into an Excel spreadsheet, and imported into a SPSS (version 9.0 for Windows) program for analysis. For each scale, if data were missing, and if at least 80% of the items were completed by the respondent, the mean of the subject's responses was used as a replacement score. Descriptive statistics, including univariate frequency distributions, means, and standard deviations, were calculated to examine the characteristics of the sample. Bivariate correlations with two-tailed tests of significance were run on all scales. Depression and subjective incompetence scores were examined for similarity and differences in the Pearson product moment correlation coefficients under the following conditions: high and low perceived stress and strong and weak social support. A "high" level was defined as a score greater than the median after the scores were arranged in the appropriate direction.

RESULTS

Table 1 provides the sociodemographic characteristics of the subjects. The majority of subjects were male (62%, $n=44$), White (94.4%, $n=67$), married (73.2%, $n=52$), and living with someone (spouse, partner, or child; 76%, $n=54$). The racial and ethnic composition of the sample reflected the population treated at the clinic. Most had graduated from high school or had a higher level of education (84.5%, $n=60$). Most were employed full time (18.3%, $n=13$) or retired (52.1%, $n=37$) and had a professional or managerial position or a skilled craft (59.1%, $n=42$). Self-reported modal income was \$20K–\$39.9K. Age range was 28–85 years (mean: 61.87; $SD=13.5$).

Table 2 shows the correlations between depression and subjective incompetence for high or low perceived stress and social support. With both lower perceived stress and higher social support ($n=17$), the correlation was negative and statistically significant ($r=-.57$; $P=.02$). When perceived stress and social support were either both higher or both lower ($n=34$), the correlation was positive and statistically significant ($r=.41$; $P=.02$). With both higher perceived stress and lower social support ($n=14$), the correlation continued to be positive but it did not reach statistical significance ($r=.25$; $P=.39$). Similar results were found using regression analysis in which depression (CESD) scores were regressed on subjective incompetence scores (SIS) allowing for a different slope for each of the three sub-groups. A marginally significant negative slope was found in the sub-group with both lower perceived stress and higher social support ($b=-.52$; $P=.08$). This means that in this sub-group, to each change of one unit in subjective incompetence scores (SIS) corresponds a decrease in .52 points in mean depression scores (CESD). A significant positive slope was found when perceived stress and social support were either both higher or both lower ($b=.54$; $P=.009$). In this instance, the corresponding change in mean depression scores (CESD) is an increase in .54 points. A non-significant positive slope was found when perceived stress was higher and social support was lower ($b=.38$; $P=.3$). While non-significant, the change in this sub-group is in the expected direction (increase in .38 points).

DISCUSSION

In this study, depression and subjective incompetence are positively correlated when both perceived stress and social support are either high or low, or when perceived stress is high and, at the same time, social support is low, and they are negatively correlated when perceived stress is low and social support is high. The correlations are statistically significant except for one sub-group (high perceived stress and low social support).

The results have implications for research and clinical practice. Current psychosocial theories of depression would have predicted that when perceived stress is low and social support

is high, both depression and subjective incompetence would always be low. By contrast, the theory of demoralization predicts that in this instance, depression and subjective incompetence could be high or low, but when one is high, the other one is low. The converse would be true when perceived stress is high and social support is low. In other words, with either high perceived stress or low social support, demoralization is likely; with both low perceived stress and high social support, it is unlikely. The findings support the prediction of the theory of demoralization and suggest that not all sub-threshold depression (and, by implication, not all distress) is demoralization, and that the overlap of distress and subjective incompetence (ie, demoralization) is promoted by perceived stress and prevented

TABLE 1
SOCIODEMOGRAPHIC CHARACTERISTICS OF THE STUDY SUBJECTS

<i>Variable</i>	<i>N</i>	<i>%</i>
<i>Gender</i>		
Male	44	62
Female	27	38
<i>Race/ethnicity</i>		
White	67	94.4
Black	2	2.8
Hispanic	2	2.8
Other	0	0
<i>Marital status</i>		
Never married	3	4.2
Married	52	73.2
Separated	0	0
Divorced	11	15.5
Widowed	5	7.0
<i>Education</i>		
Junior high or less	7	9.9
Partial high school	4	5.6
High school	15	21.1
Partial college	24	33.8
College	13	18.3
Graduate degree	8	11.3
<i>Occupation</i>		
Professional	17	23.9
Managerial	13	18.3
Clerical	2	2.8
Other	37	52.1
Missing data	2	2.8
<i>Income</i>		
<\$20,000	26	36.6
\$20,000–\$59,000	32	45.1
\$60,000–\$100,000	11	15.1
>\$100,000	0	0
Missing data	2	2.8

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by social support. When the overlap occurs, the directional component of motivation is lost, the converse being true when the overlap is prevented. In short, distress (in this case, depression) and subjective incompetence are separate components of demoralization. The findings also suggest how distress associated with physical illnesses or mental disorders may or may not represent demoralization. In the sub-group with low perceived stress and high social support, depression could occur without demoralization. In this sub-group, the results are not statistically significant but they occur in the expected direction.

Although the role of psychotherapy was not the focus of this research, the results suggest that depression in the absence of subjective incompetence may resolve itself with psychotherapy or without any intervention. Psychotherapy may relieve demoralization by reducing perceived stress, strengthening social support, promoting the separation of depression (and, by implication, other forms of distress) from subjective incompetence, or reducing either distress or subjective incompetence or both.

The limitations of this study should be recognized. Data came from a single clinical setting, and certain intervening variables known to influence adaptation to stress, such as functional impairment, stage of cancer (primary or metastatic), coping skills, and personality styles, were not measured. The demographics were relatively uniform, however, so that confounding by demographics is unlikely. The number of subjects with both high perceived stress and low social support was relatively small (n=14). Probably for this reason, the association between depression and subjective incompetence in that sub-group is weaker than might be expected and fails to reach statistical significance. Existing scales to measure demoralization were not used because, with one exception, they had not yet been published. The single exception was the Psychiatric Epidemiology Research Interview

demoralization scale which was not used because it appeared to contain items that confounded nonspecific distress with subjective incompetence. The International Criteria for Psychosomatic Research were also not used for the same reason.¹⁹⁻²²

A replication of this study with a more diverse sample from several clinical settings and using available demoralization criteria and scales would be necessary to further clarify this complex association by comparing sub-groups and examining interactions among variables and direction of causality. Additional factors that may be contributing to the variance of demoralization should be examined, such as functional impairment, as assessed, for example, by the Karnofsky Performance Status Criteria and Index²³; whether the cancer is primary or metastatic; the adaptive or coping strategies used by the patients; and personality styles, as assessed, for example, by the Neuroticism Extroversion Openness Revised Scale, that measures neuroticism, extraversion, openness to experience, agreeableness, and conscientiousness.²⁴ Neuroticism, for example, may increase the probability of the overlap of subjective incompetence and distress (ie, demoralization), while openness to experience may reduce that probability. Future studies of the role of psychotherapy in combating demoralization should include separate measures of distress and subjective incompetence.

CONCLUSION

Motivation may be viewed as a vector, with a magnitude and a direction. Clinical depression involves a loss of the magnitude of motivation, even though the direction is known to the person, while the converse is true of demoralization. Faced with a stressful situation, demoralized individuals have

TABLE 2
REGRESSION ANALYSIS OF DEPRESSION AND SUBJECTIVE INCOMPETENCE FOR VARIOUS LEVELS OF PERCEIVED STRESS AND SOCIAL SUPPORT

<i>Group</i>	<i>Slope Estimate</i>	<i>Standard Error</i>	<i>t</i>	<i>P value</i>
Low perceived stress and high social support	-0.52	0.3	-1.73	0.08
Perceived stress and social support both high or both low	0.54	0.2	2.69	0.009
High perceived stress and low social support	0.38	0.4	1.05	0.3

Analysis of Variance				
<i>Source</i>	<i>df</i>	<i>Mean Square</i>	<i>F</i>	<i>P value</i>
Model	5	149.3	2.53	0.04
Error	59	58.9	—	—

Perceived stress (IES): High >15; low ≤15; Social support (ISELF): High >55; low ≤55.

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no clue as to how to proceed even though they are motivated to get out of their predicament. This is to be contrasted with an individual with clinical depression who knows what needs to be done but cannot initiate the necessary actions to deal with the situation. The loss of direction in a demoralized individual is called “subjective incompetence.”⁹⁻¹²

The research presented in this article supports the view that depression and subjective incompetence are separate components of demoralization and that subjective incompetence is the clinical hallmark of demoralization. **PP**

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