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# THE PREDICTABILITY OF DEMORALIZATION FROM STRESS, DEPRESSION AND ANXIETY

**Lalfamkima Varte C*** **Lalbiakzuali****
**Professor, Department of Psychology, Mizoram University, Mizoram.*
***Research Scholar, Department of Psychology, Mizoram University, Mizoram.*

***Abstract***
*The term demoralization is described as a state wherein a person is deprived of spirit, courage and suffers loss of meaning and purpose. This study examines the prediction of demoralization from stress and the mediating role of depression and anxiety. 199 participants with ages ranging from 40 to 84 completed the study. Using the Depression Anxiety Stress Scales-21 (DASS-21) and Demoralization Scale (DS), the results revealed no gender differences on any of the sub-scales of the behavioral measures. The early adulthood as compared to middle and late adulthood has been reported to be marked with significantly higher levels of psychological distress and the resultant demoralization. Closer observation of the analysis revealed large total-effect (beta=.750; p=.000) of stress on demoralization as compared to the direct-effect (beta=.232; p=.003); and the significant indirect-effect (beta=.512; p=.000; 95% CI (BC): .406~.645) revealed the significant multiple mediation from depression and anxiety in the prediction of demoralization from stress.*

***Key Words: Demoralization, Anxiety, Self-Esteem, Hopelessness, Stress, Depression.***

## Introduction

Demoralization is the state of mind of a person being deprived of spirit or courage, disheartened, bewildered, and thrown into disorder or confusion. The person's self-esteem is damaged, and he feels rejected by others because of his failure to meet their expectations (Frank, 1968). Thus, early references to demoralization describe feelings of loss of meaning and purpose in life, a sense of hopelessness and helplessness, symptoms and a sense of giving up or having given up, a persistent inability to cope, subjective incompetence and diminished self-esteem (Engel, 1967; Erikson, 1994; Frank, 1974).

Stress may be operationally defined as the chronic non-specific unpleasant emotional experience of a psychological, social, and/or spiritual nature. Individual experienced distress without the ability to cope effectively with a stressful situation (de Figueiredo, 2013). Demoralization is more likely to occur when the stressful situation is relevant to the self-esteem of the individual. The situation disconfirms assumptions about self and others and about the continuity of the past and present with the future. Individual becomes puzzled, indecisive, uncertain, facing a dilemma, unclear as to ways out of the situation, placed in a deadlock, impasse, quandary, or plight. Thus, demoralization involves a fundamental change in the person's expectations (subjective likelihoods) and assumptions (subjective certainties), i.e., in the person's ambient world (de Figueiredo& Frank, 1982; de Figueiredo, 1993).

Demoralization can be distinguished from passing or transient distress (Mangelli, Semprini, Sirriet. al., 2006), non-specific distress (Clarke, Kissane, Traueret. al., 2005; Wellen, 2010) and sub-threshold depression or anxiety (Cockram, Doros & de Figueiredo, 2010). It can also be distinguished from certain mental disorders such as major depressive disorder, dysthymic disorder, acute stress disorder, posttraumatic stress disorder, and adjustment disorder (de Figueiredo, 2013; Semprini, Fava & Sonino, 2010; Grassi, Mangelli, Fava et. al., 2007).

Anxiety disorders are the most common mental disorders with life time prevalence rates ranging from 13.6% to 28.8% (Kessler& Wang, 2008; Michael et al., 2007). According to a World Health Organization report (Andrade et al., 2000) anxiety disorders generally develop before the age of 35 in 80 to 90% of cases; however, differences do appear between various anxiety disorders. Research also reveals that individuals with anxiety commonly have comorbidity (Gallagher & Brown, 2015; Gros et al., 2013; Kessler et al., 2010) and more than three-quarters of individuals with a life time anxiety disorder exhibit an additional life time disorder (Kessler et al., 2010; Merikangas & Swanson, 2010).

It has also been shown that about 50–60% of depressed individuals also meet the life time criteria of an anxiety disorder (Kaufman & Charney, 2000) and that anxiety disorders can be causal factors for later developing depression (Starr & Davila, 2012; Wittchen et al., 2000). Patients who have an anxiety disorder with comorbid depression have an increased number of suicide attempts compared to those without comorbid depression (Dolnak, 2006).

Moving down the pathway from stress to demoralization through anxiety and depression, the target objective of the study, a person's potential to express a range of morale emerges. At the mild end of this continuum, disheartenment develops, with slight loss of confidence. This would be a comprehensible and non-pathological response to adversity. As the loss of morale worsens, however, and some level of despondency appears, hope begins to diminish, distress increases, and a threshold is crossed in which a morbid mental state arises. Life stressors, multiple losses and medical illness can abruptly change the

individual's sense of hope and meaning in life leading to demoralization. Untreated demoralization can expose individuals to chronic distress, major depression, social withdrawal and impulsive suicidal behavior (Kissane, Clarke & Street, 2001; Clarke &Kissane, 2002).

**Methods**

The data analyzed in the present study are collected by controlled random sampling procedure. The participants completed the background demographic information (sex, age, occupation, educational qualification, marital status, family structure, number of family members, number of sibling, birth order and monthly income of the family), Depression Anxiety Stress Scales-21 (DASS-21; Lovibond, & Lovibond, 1995), and Demoralization Scale (Kissane, Wein, Love, Lee, & Clarke, 2004).

The 199 participants were selected from randomly identified localities in Aizawl, the capital city of Mizoram. The middle and late adult participants ranges in age from 40 to 84 (M=57.58; SD=10.75). Rapport formation was initiated in one-to-one setting. Primary information of the objectives of the study was given. Each participant was requested to complete the background information sheet, DASS and DEMOS in the presence of the researcher. All the data collected were cleaned, screened and coded for analyses. One participant failed to give less than 5% incomplete responses on the behavioral measures and was excluded from analyses.

**Measures**

**Depression Anxiety Stress Scales (DASS; Lovibond & Lovibond, 1995):** is made up of 21 self-report items reflecting a negative emotional symptom of depression (7 items), anxiety (7 items) and stress (7 items). Each of these is rated on a four-point Likert scale of frequency or severity of the participants' experiences over the last week with the intention of emphasizing states over traits. These scores ranged from 0, meaning that the participants believed the item "did not apply to them at all", to 3 meaning that the participants considered the item to "apply to them very much, or most of the time". The internal consistency for the depression (α=.77), anxiety (α=.86), and stress (α=.76) emerged to be acceptable in the present study.

**Demoralization Scale (DS; Kissane et. al., 2004):** is a self-report questionnaire consisting of 24 statements relating to participants' experiences over the last week (for instance 'I no longer feel emotionally in control'). Each item is to be answered on a five point Likert scale ranging from 0 meaning 'never' to 4 meaning 'all the time'. The DS has five subscales describing loss of meaning and purpose (α=.81), dysphoria (α=.77), disheartenment (α=.85), helplessness (α=.79) and sense of failure (α=.64) that emerged to be applicable in the present study.

**Statistical Analysis:** All the quantitative data were entered and analyzed using SPSS and its add-on module AMOS (IBM® SPSS® Amos). To test for differences between male and female participants on the sub-scales of the behavioral measures *t*-test with Levene's test for equality of variances was employed. Multiple mediation analysis with bootstrapping (sample=5000; Bias-corrected confidence interval=95) was employed for the role of depression and anxiety in the prediction of demoralization from stress.

**Results and Discussion**

The preliminary descriptive statistics revealed majority of the participant are employed (66.30%) and maintained regular income (Rs. 5,000/- to Rs. 2, 00,000/- per month). In terms of other background information: 69.80% of the participants completed graduation; 80.90% are married with the remaining reporting to be single, divorced, widow or widower; 59.60% are in extended family with the mean number of family members of 6.12 (SD=2.07); all the participants were with sibling (M=5.92; SD=2.62), except one; and 27.10% of the participants were first born.

The results (Table-1) revealed the analyses of mean differences for 'Sex' (male vs. female) on the sub-scales of the behavioral measures. All the Levene's test statistics and the *t*-statistics failed to emerge significant warranting for more or less similar means for the male and female participants on the stress, depression and anxiety sub-scales of DASS as well as loss of meaning, dysphoria, disheartenment, helplessness and sense of failure sub-scales of DS.

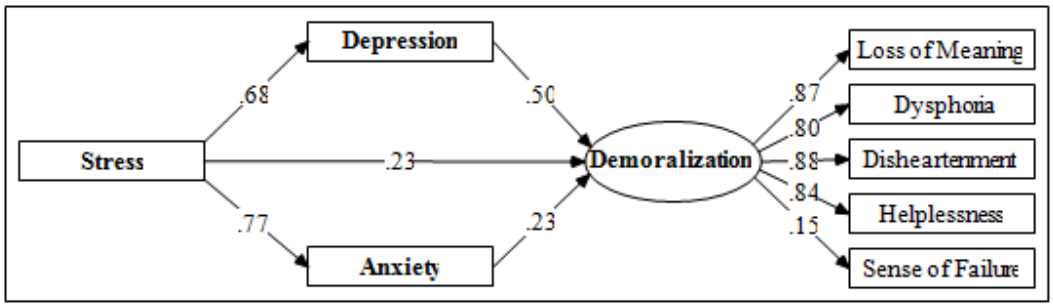
**Table 1: The Mean, SD and *t*-test for the Male and Female Participants of the Study**

| | Male | | Female | | Levene's Test | | *t*-test | |
|---|---|---|---|---|---|---|---|---|
| | **Mean** | **SD** | **Mean** | **SD** | **F** | ***Sig.*** | ***t*** | ***Sig.*** |
| **Stress** | 6.15 | 3.84 | 7.03 | 3.87 | 1.54 | .22 | -1.61 | .11 |
| **Depression** | 3.98 | 4.04 | 4.35 | 3.83 | .00 | .95 | -0.67 | .50 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Anxiety** | 3.75 | 3.49 | 4.31 | 3.34 | .70 | .41 | -1.16 | .25 |
| **Loss of Meaning** | 2.59 | 3.31 | 3.34 | 3.70 | 3.23 | .07 | -1.51 | .13 |
| **Dysphoria** | 8.70 | 4.10 | 9.53 | 4.04 | .00 | 1.00 | -1.43 | .15 |
| **Disheartenment** | 4.59 | 4.46 | 5.62 | 4.53 | 1.07 | .30 | -1.61 | .11 |
| **Helplessness** | 2.68 | 3.34 | 3.46 | 3.25 | .11 | .74 | -1.68 | .09 |
| **Sense of Failure** | 4.57 | 2.23 | 4.41 | 2.48 | .89 | .35 | -1.68 | .64 |

The preliminary analysis of the confirmatory factor analysis of the demoralization scale (Kissane et. al., 2004) revealed satisfactory model fit statistics (CMIN=.841; df=3; *p*=.840; GFI=.998; CFI=1.000; TLI=1.014; IFI=1.004; RMSEA=.000) with all the standardized regression weight emerging to be significant for loss of meaning (*beta*=.88; *p*=.00), dysphoria (*beta*=.79; *p*=.00), disheartenment (*beta*=.87; *p*=.00), helplessness (*beta*=.84; *p*=.00) and sense of failure (*beta*=.16; *p*=.04) sub-scales of DS. The outcomes of the present study find corroborative evidences from the development and validation studies of demoralization (Mullane et. al, 2009; Kissane et. al., 2004).

**Figure 1: Path Diagram in the Prediction of Demoralization from Stress and the Mediating Role of Depression and Anxiety**




The analysis for the role of depression and anxiety in the prediction of demoralization from stress revealed more or less satisfactory model fit statistics (CMIN=25.176; df=15; *p*=.048; GFI=.969; CFI=.991; TLI=.983; IFI=.991; RMSEA=.059). All the path coefficients as depicted in the path diagram (Figure-1) emerged to be statistically significant. Closer observation of the analysis revealed large *total-effect* (*beta*=.750; *p*=.000) of stress on demoralization as compared to the *direct-effect* (*beta*=.232; *p*=.003); and the significant *indirect-effect* (*beta*=.512; *p*=.000; 95% CI (BC): .406~.645) revealed the significant multiple mediation from depression and anxiety in the prediction of demoralization from stress.

**Discussion and Conclusion**

The middle and late adulthood of the present study were selected from the sub-clinical population. The results revealed no gender differences on any of the sub-scales of the behavioral measures subscribing to the empirical findings reported in literature. The early adulthood as compared to middle and late adulthood has been reported to be marked with significantly higher levels of psychological distress and the resultant demoralization (Bayram & Bilgel, 2008; Stallman, 2010; Soysa & Wilcomb, 2015). Besides, findings reported that among youth and younger adults, twice as many women as men are diagnosed with major depression (Kuehner, 2003) and that women are also approximately twice as likely as men to be diagnosed with generalized anxiety disorder (Spitzer, et. al, 2006). In contrast, sex difference in depression and anxiety is not stable across age, implying that the importance of each explanatory factor involved might also vary over the lifespan. The sex difference emerges during adolescence, stabilizes throughout adulthood, and then declines during old age (Jorm, 1987& 2000; Allen, et. al, 2006).

The significant direct and indirect paths from stress to demoralization, with the mediation from depression and anxiety, have been accounted in theoretical and empirical findings. Early definitions underscored stress as a response to environmental stimuli. Selye's (1973) physiological model conceptualized stress as a general response to toxic stimuli regardless of the nature of the stressor or characteristics of the individual experiencing the stress (Lyon, 2000). The corresponding general adaptation syndrome views stress as progressing through stages of alarm, resistance and exhaustion that could eventually cause harm to one's physiological system by disrupting balance (Lyon, 2000). More recent analysis defines stress as the process where a person and the environment interrelate, thus individuals' unique response to environmental demands and pressures. Lazarus (1991) described stress as an active, unfolding process that is composed of causal antecedents, mediating

processes and effects. While unhealthy responses develop when the demands of a stressor exceed one's coping capabilities, individuals vary greatly in their response to stressful situations (DeBord, 1996; Garcia, 2010).

Stress indicated by negative affectivity responses, such as nervous tension and irritability are also characteristics of both depression and anxiety (Lovibond &Lovibond, 1995), however, stress is comprised of unique features that are not shared with depression and/or anxiety (Lovibond, 1998). Depression as measured in the present study designates dysphoria, low self-esteem, and lack of incentive, whereas, anxiety designates somatic and subjective responses to anxiety and fear (Gomez, et. al, 2014). Although stress can be distinguished from depression and anxiety, it is important to note that all three syndromes are moderately intercorrelated.

There is an ongoing debate surrounding the degree of separation between depression and anxiety, both in terms of clinical diagnoses, subclinical symptom levels and mood states (Clark& Watson, 1991). However, there are clear indications that the two outcomes overlap (Kessler, et. al, 1996; Kendler, 1996; Mineka, Watson & Clark, 1998). The parallels between depression and anxiety gave rise to similarities regarding the etiology and explanatory factors responsible for the gender disparity in both psychological outcomes (Pigott, 1999; Sprock & Yoder, 1997).Older adults are less likely to describe negative emotions in general than are younger adults(Carstensen, Pasupathi, Mayr, &Nesselroade, 2000). In particular, Gross and his colleagues (Gross, et. al., 1997) reported that, compared with younger adults, older adults were less likely to report anger, sadness, and fear and more likely to report happiness.

More recently, demoralization has been defined as 'a change in morale spanning a spectrum of mental attitudes from disheartenment (mild loss of confidence) through despondency (starting to give up) and despair (losing hope) to demoralization (having given up)' (Kissane, Clarke & Street, 2001; de Figueiredo, 2013). This state of mind always takes place within the context of a past, present, anticipated or imagined stressful situation and accompanied by a state of perceived incompetence, inability to cope, hopelessness, existential despair, and meaninglessness (Frank, 1968; de Figueiredo, 2007).

Demoralization involves hopelessness, subjective incompetence and the inability to cope evidenced with the symptoms of distress, such as depression, anxiety, resentment and/or anger (de Figueiredo& Frank, 1982; de Figueiredo, 2012). Subjective incompetence is a self-perceived incapacity to perform tasks and express feelings deemed appropriate in a stressful situation, resulting in pervasive uncertainty and doubts about the future. Demoralization in the psychiatric nomenclature is often referred to as adjustment disorder (Lloyd-Williams, Reeve &Kissane, 2008). It is the state of mind that psychotherapy seeks to treat and for which many people seek psychotherapy. Bodily disfigurement, physical disability, chronic medical illness, and social isolation are some of the main clinical features associated with the syndrome (Kissane, Clarke & Street, 2001; Clarke & Kissane, 2002; Kissane, 2004).

The most frequent symptoms of people in psychotherapy due to anxiety and/or depression are the direct expressions of demoralization (Frank, 1968). However, demoralization is more than a combination of these symptoms; it is about feelings of inability to 'cope' (usually voiced as 'giving up' or 'depression'), typically accompanied by 'hopelessness and helplessness' and 'suicidal ideation' (Kissane, Clarke & Street, 2001).

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