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The relationship between personality organisation and demoralisation in a group of alcohol-dependent individuals

Związek organizacji osobowości z występowaniem stanu demoralizacji w grupie osób uzależnionych od alkoholu

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Abstract

Introduction and objective: The term "demoralisation", which was introduced by Jerome Frank, is used to describe a mental state in which a person has lost the fortitude and strength to endure the hardships associated with carrying out life tasks. According to Otto F. Kernberg's concept, personality organisation is understood as a relatively stable pattern of functioning that determines the maintenance of internal balance and relationships with others. It was assumed that if personality structures become pathologised during development, it may result in the development of mental disorders. All diseases may be accompanied by a state of helplessness, powerlessness, along with a sense of meaninglessness and emptiness in life, which in turn makes recovery difficult. The aim of the study was to assess the relationship between the dimensions of personality organisation and the demoralisation in a group of alcohol-dependent individuals, taking into account the perceived stress. **Materials and methods:** The study used the Inventory of Personality Organization, the Demoralization Scale II, the Restructured Clinical Demoralization scale from the MMPI-2 and the Distress Thermometer. A total of 91 alcohol-dependent individuals were assessed, including 65 (71%) men and 26 (29%) women. The average age of the participants was 43.6 years (standard deviation, *SD* = 12.92). **Results:** Positive correlations were found between personality dimensions and demoralisation and discouragement. Three clusters of people were identified among the respondents, which differed in the intensity of abnormalities in personality organisation and demoralisation. **Conclusions:** The presented results are part of the discussion on the importance of personality for the development and formation of demoralisation.

Keywords: personality organisation, state of demoralisation, addicted to alcohol

Streszczenie

Wprowadzenie i cel: Wprowadzone przez Jerome'a Franka pojęcie demoralizacji służy do opisu stanu psychicznego, w którym osoba utraciła hart ducha i siły do znoszenia trudów związanych z realizacją zadań życiowych. W koncepcji Ottona F. Kernberga organizacja osobowości rozumiana jest jako względnie trwały wzorzec funkcjonowania, warunkujący utrzymanie wewnętrznej równowagi i relacji z innymi. Założono, że jeżeli w toku rozwoju dojdzie do patologizacji struktur osobowości, to może to spowodować rozwój zaburzeń psychicznych. Wszelkim chorobom zaś może towarzyszyć stan bezradności, bezsilności wraz z poczuciem bezsensu i pustki życiowej, co z kolei utrudnia powrót do zdrowia. Celem badania było sprawdzenie związku pomiędzy wymiarami organizacji osobowości a nasileniem stanu demoralizacji w grupie osób uzależnionych od alkoholu przy uwzględnieniu poczucia stresu. **Materiał i metody:** W badaniu zastosowano Inwentarz Organizacji Osobowości, Skalę Demoralizacji II, Skalę Zniechęcenia z MMPI-2 oraz termometr dystresu. Zbadano 91 osób uzależnionych od alkoholu, w tym 65 (71%) mężczyzn i 26 (29%) kobiet. Średni wiek badanych wyniósł 43,6 roku (odchylenie standardowe, *standard deviation*, *SD* = 12,92). **Wyniki:** Stwierdzono dodatnie związki między wymiarami osobowości a stanem demoralizacji i zniechęceniem. Wśród badanych wyodrębniono trzy skupienia osób, różniące się między sobą nasileniem nieprawidłowości w organizacji osobowości oraz stanu demoralizacji. **Wnioski:** Prezentowane wyniki wpisują się w dyskusję o znaczeniu osobowości dla rozwoju i kształtowania się stanu demoralizacji.

Słowa kluczowe: organizacja osobowości, stan demoralizacji, osoby uzależnione od alkoholu

INTRODUCTION

In 1961, Jerome Frank first used the term "demoralisation" to describe the mental state of his patients, characterised by the inability to cope with internal and/or external stressors, which led to a sense of hopelessness and helplessness and contributed to the loss of a sense of meaning and purpose in life (Frank and Frank, 2005). Generally, the research to date (Fava et al., 1995; de Figueiredo, 1993; Frank, 1961; Kissane et al., 2001) indicates that demoralisation is characterised by negative emotionality: depression, anxiety, sense of meaninglessness, hopelessness and helplessness, as well as the sense of alienation from other people and the world. All these difficulties lead to an existential void, which contributes to the inhibition of coping strategies (Clarke and Kissane, 2002).

The chief researchers of the phenomenon have suggested that demoralisation understood as a mental state may vary in intensity, from non-specific mental stress (Dohrenwend et al., 1980) and a normal response to adversities (Clarke and Kissane, 2002) to a syndrome consisting of negative emotional states, cognitive and appropriate behaviour, which allows the use of the term "syndrome", as was done by, among others, a team led by Fava (Cockram et al., 2010; Fava et al., 1995; de Figueiredo, 1993; Frank and Frank, 1993).

Demoralisation may be observed in individuals who experience a disease. It can occur in cancer patients (Clarke and Kissane, 2002; Tang et al., 2020), those with cardiovascular diseases (Basińska, 2022; Liao et al., 2018; Rafanelli et al., 2005) or other severe conditions (Chang et al., 2007; Offidani et al., 2016), as well as in patients with mental disorders (Kohn, 2013; Kohn et al., 2005), including depression (e.g. Grassi et al., 2020; Papakostas et al. al., 2007), schizophrenia (e.g. Basińska, 2022) or addictions (e.g. Basińska, 2021; De Jong et al., 2008). It may also develop in healthy individuals experiencing life difficulties, e.g. emigrants (e.g. Briggs and Macleod, 2010; Hocking and Sundram, 2015) or people exposed to stress at work (Gabel, 2012, 2013; Slavney, 1999).

It is worth emphasising that, in addition to genetic predispositions, positive medical history, personality traits, sense of stress, perceived social support and cultural factors, demoralisation is a risk factor for psychopathological manifestations. Demoralised individuals are more likely to develop anxiety, depression, and substance dependence, as well as to attempt a suicide. Understanding the symptoms of demoralisation allows medical personnel for its identification in patients and implementing proper measures to prevent the above-mentioned abnormalities (Rickelman, 2002). The few studies to date indicate high frequency (61.1%) of demoralisation among substance abusers (Tossani et al., 2013).

From the perspective of practicing clinicians, the demoralisation syndrome is an important construct for assessing the course of the disease, significantly supporting the diagnosis of mood and adjustment disorders. Excluding it from the diagnostic process results not only in inaccurate diagnosis, but also ineffective treatment. In turn, considering this explanation when contemplating the aetiology of the observed symptoms translates into increased diagnostic accuracy and greater efficacy of therapeutic interventions. Identification of the demoralisation syndrome in the clinical picture of the disease requires clinician's insight and readiness to make an effort to take a closer look at the patient. It is necessary to understand not only the symptoms, but also the life situation of the patient, which may be of great importance for the development of demoralisation (Basińska, 2021).

Determining factors that promote demoralisation was an important issue described by researchers in this area. However, no consensus has been reached among researchers as to the nature of this condition, i.e. whether it is only a consequence of the disease representing a difficult situation, or whether some individuals may be predisposed to demoralisation. Current research shows that demoralisation is determined by many factors, including:

- broadly understood stress;
- certain personality traits, including some dimensions of temperament, low self-esteem, cognitive factors (attributional style – expecting events perceived as negative or experiencing the lack of positive life events; poor hope; lack of a sense of meaning in life; pessimism; external locus of control; cognitive rigidity);
- lack of social support;
- female gender;
- severe disease (Basińska, 2021; Clarke et al., 2005; Rickelman, 2002). A study in cardiac patients confirmed the important role of temperament in demoralisation, in particular dissatisfaction, anxiety, perseveration and emotional reactivity (Basińska and Szocińska, 2015).

It therefore seemed important to verify the role of other personality aspects for the development of demoralisation, e.g. the level of personality organisation. The concept of personality functioning proposed by Otto F. Kernberg (2016) is part of the theory of object relations, which places particular focus on the role of the nature of a young child's relationship with their mother and other important persons. Kernberg understands personality traits shaped in this way as fixed ways of mental functioning, which become the basis for the development of the personality structure and formation of interpersonal relationships. In this way, they are also the basis for shaping other personality and social properties and predispositions, and as a result, may either facilitate or hinder future functioning (as cited in: Caligor and Clarkin, 2013). The risk of mental disorders, including alcohol dependence and personality disorders, as well as, among others, the inability to use coping strategies in a flexible manner increases with the growing pathology of personality organisation (Grzankowska and Fabjanowicz, 2023). According to the concept of personality organisation, alcohol addiction is secondary to personality difficulties. It seems that all this is also associated with the risk of strong discouragement and demoralisation, also in addicts,

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Variables		Number*	% of number
Place of residence	Rural, small and medium urban	33	35.48
	Large urban	60	64.52
Marital status	Relationship	47	50.54
	Single	46	49.46
Occupational status	Working	58	62.37
	Not working	35	37.63
* 91 participants were included in the analysis, and all those who declared participation in the study were described in terms of socio-demographic variables, including those who did not complete the forms accurately.			

Tab. 1. Number distribution of sociodemographic variables

who experience mental emptiness in the place of identity, i.e. deprivation of lasting values and meaning in life (Mellibruda, 1997).

The presented work is part of the discussion on the role of personality in the development of demoralisation when facing a difficult situation. Its aim was to assess the direct relationships between personality organisation according to Kernberg and perceived stress and demoralisation as measured with the Demoralization Scale II (DS-II) and the Restructured Clinical Demoralization scale (RCd) (H1) in a group of alcohol-dependent individuals. It was further investigated whether dimensions of personality organisation and perceived stress play a role in predicting demoralisation (H2). Additionally, the internal differentiation in the study group was assessed in terms of the severity of personality organisation pathology, followed by verifying whether individuals classified into particular clusters differ in the severity of demoralisation and perceived stress (H3). So far, the research has shown that the more disturbed the personality organisation and higher the perceived stress, the more severe demoralisation experienced by addicts.

MATERIALS AND METHODS

The study included 93 participants; however, due to missing data (incomplete forms), the results of 91 alcohol-dependent individuals, including 65 (71%) men and 26 (29%) women, were included in the analyses. The mean age of the respondents was 43.6 years (standard deviation, *SD* = 12.92). Most of the study participants resided in large cities and were professionally active. About half of participants were married or in a relationship, while the other subjects were single (Tab. 1). The group was internally diverse in terms of perceived stress. The respondents had an average score of 55.81 (*SD* = 22.71), with a range of 0–100 on a 100-point scale.

Written consent was obtained from the subjects to participate in the study, which was conducted in accordance with the criterion of accessibility while respecting the privacy of participants, who belonged to the groups of Alcoholics Anonymous (AA) or were patients staying in closed and open wards of various medical facilities. Those who did not consent to the study were excluded.

The study used the Inventory of Personality Organization (IPO), the Restructured Clinical Demoralization scale (RCd) from the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), the Demoralization Scale II (DS-II) and the Distress Thermometer.

The Inventory of Personality Organization by Kernberg's team (as cited in: Lenzenweger et al., 2001), in the Polish adaptation by Agnieszka Izdebska and Beata Pastwa-Wojciechowska (2013), is a 83-item self-reported tool in which the respondent rates the items on a five-point Likert scale (1 – never, 5 – always). The IPO items are divided into three primary clinical scales and two additional scales. The primitive defences inventory (PD – 16 items) measures the flexibility and maturity of defensive mechanisms used in response to the experienced emotional conflicts and stressful situations. High scores indicate the activation of primary, inflexible and non-adaptive mechanisms that distort the perception of reality.

The identity diffusion inventory (ID – 21 items) measures the consolidation of the sense of self and important others in a differentiated, continuous, realistic and flexible way, as well as the ability to engage in goals, endeavours and relationships that are important to a given individual. Extreme scores indicate a lack of a coherent sense of self/others, which instead is fragmented, unstable, and with extreme, contradictory characteristics.

The reality testing inventory (RT – 20 items) determines the ability to adequately read social signals, understand social conventions and skilfully respond to them. Large deficits in this area may lead to paranoia or fear of abandonment.

The aggression inventory (A – 18 items) measures aggressive attitudes and behaviours, such as aggression towards others, aggressive responses to perceived provocation from others, as well as aggression towards oneself.

The moral values inventory (MV – 11 items) measures hostile and antisocial attitudes and allows for the diagnosis of pathological superego. Those scoring high on this scale introduce abuse, competition, and conflict into their relationships.

The original version of IPO has good psychometric indicators. Studies conducted in both clinical and non-clinical populations (Clarkin et al., 2001) showed good internal consistency ($\alpha = 0.80–0.87$ for PD, $\alpha = 0.84–0.90$ for ID, $\alpha = 0.85–0.87$ for RT). The IPO-PL scales also showed satisfactory reliability (Izdebska and Pastwa-Wojciechowska, 2013). The conducted confirmatory factor analysis showed

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Subscale	Meaning and Purpose	Distress and Coping Ability	Total DS-II
RCd	0.708***	0.738***	0.757***

DS-II – Demoralization Scale II; **MMPI-2** – Minnesota Multiphasic Personality Inventory-2; **RCd** – Restructured Clinical Demoralization scale.
*** $p < 0.0001$.

Tab. 2. Pearson correlation indices between DS-II and its dimensions and the RCd scale from the MMPI-2

the best fit of the five-factor model, which is consistent with American research (as cited in: Izdebska and Pastwa-Wojciechowska, 2013). Reliability results in the presented study were also satisfactory (α = 0.86 for PD, α = 0.92 for ID, α = 0.93 for RT, α = 0.87 for A, α = 0.76 for MV).

The Restructured Clinical Demoralization scale (RCd) of the MMPI-2 by James N. Butcher et al. in the Polish adaptation by Urszula Brzezińska, Marta Koć-Januchta and Joanna Stańczak (Butcher et al., 2012) is an indicator of general emotional discomfort, distress, maladjustment and unhappiness. It is part of the restructured clinical scales (RCs). It is a 24-item true/false self-report questionnaire. The Restructured Clinical Demoralization scale has a high reliability index, i.e. α = 0.85 in the female group (α = 0.93 in my study) and α = 0.93 in the male group (α = 0.94 in my study), and construct validity (Butcher et al., 2012). The letter "d" in the abbreviation RCd stands for demoralisation (Graham, 2015).

The Demoralization Scale II (DS-II) by Sophie Robinson et al. (2016a, 2016b), in my own adaptation, is a tool for measuring demoralisation. This is an abbreviated version of the Demoralization Scale (DS), which was developed by David Kissane et al. (2004) based on knowledge and clinical experience in demoralisation. DS-II consists of 16 items rated on a 3-point scale (0 – never, 1 – sometimes, 2 – often). The DS-II scores allow for assessing overall demoralisation and two subscales – Meaning and Purpose and Distress and Coping Ability. The Meaning and Purpose subscale refers to the loss of meaning and purpose in life. Its reliability index is α = 0.84 (α = 0.89 in my study). The Distress and Coping Ability subscale refers to distress and the ability to cope with it. The reliability index of this subscale is α = 0.82 (α = 0.86 in my study). Australian and German studies indicate that the DS-II shows high internal consistency of α = 0.89 (α = 0.93 in my study) (Koranyi et al., 2021; Robinson et al., 2016a) and validity (Koranyi et al., 2021; Robinson et al., 2016b). The presented study is part of ongoing adaptive research, therefore RCd was used to verify convergent validity. A correlation analysis with the RCd scale was performed (Tab. 2). Since the obtained correlation coefficients were very high, DS-II may be considered an accurate tool.

RESULTS

The analysis of normality tests showed that the distributions of variables for the demoralisation syndrome and its dimensions as well as for discouragement differed significantly from normal distributions. However, their skewness results ranged from –1 to 1, and their kurtosis results ranged from –2 to 2, which allowed to assume that these distributions were consistent with normal distributions for this sample size (Gravetter and Wallnau, 2014). The remaining dimensions had a normal distribution.

The obtained results showed great diversity of the study group in terms of all analysed variables, from the lowest to the maximum values (Tab. 3).

The correlation analysis showed positive relationships between the levels of personality organisation, perceived stress and demoralisation and discouragement (Tab. 4).

Variable	*M*	*SD*	Min	Max
DS-II – meaning and purpose	6.22	4.407	0.00	15.00
DS-II – distress and coping ability	8.26	3.966	0.00	16.00
Total DS-II	14.48	7.985	0.00	31.00
Total RCd	12.89	6.226	1.00	23.00
IPO – primitive defences	43.77	10.606	21.00	72.00
IPO – identity diffusion	57.37	16.461	21.00	102.00
IPO – reality testing	41.82	15.334	20.00	80.00
IPO – aggression	34.70	11.730	18.00	70.00
IPO – moral values	27.66	7.076	13.00	43.00
m IPO* – primitive defences	2.74	0.663	1.31	4.50
m IPO – identity diffusion	2.73	0.784	1.00	4.86
m IPO – reality testing	2.09	0.767	1.00	4.00
m IPO – aggression	1.93	0.652	1.00	3.89
m IPO – moral values	2.51	0.643	1.18	3.91
Perceived stress	55.84	22.947	0.00	100.00

DS-II – Demoralization Scale II; **IPO** – Inventory of Personality Organization; ***M*** – mean; **Max** – maximum; **Min** – minimum; **RCd** – Restructured Clinical Demoralization scale; ***SD*** – standard deviation.
* m IPO – mean score on a given scale, obtained by dividing the sum by the number of items.

*Tab. 3. Mean scores in the study group of alcohol-dependent persons (*N = 91*)*

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Variable	Meaning and purpose	Distress and coping ability	Total DS-II	RCd
IPO – primitive defences	0.472***	0.548***	0.533***	0.609***
IPO – identity diffusion	0.417***	0.524***	0.491***	0.615***
IPO – reality testing	0.398***	0.389***	0.412***	0.493***
IPO – aggression	0.315**	0.275*	0.310**	0.381***
IPO – moral values	0.301**	0.337**	0.333**	0.373***
Perceived stress	0.371***	0.348**	0.378***	0.413***

DS-II – Demoralization Scale II; **IPO** – Inventory of Personality Organization; **RCd** – Restructured Clinical Demoralization scale.
* $p < 0.01$; ** $p < 0.005$; *** $p < 0.001$.

Tab. 4. Pearson correlation analysis between the levels of personality organisation and perceived stress and demoralisation measured with DS-II and RCd

Variable	Cluster 1 $n = 26$		Cluster 2 $n = 44$		Cluster 3 $n = 21$		*F*	*p*
	M	*SD*	*M*	*SD*	*M*	*SD*		
IPO – primitive defences	2.11	0.494	2.77	0.414	3.43	0.525	47.62	<0.001
IPO – identity diffusion	1.87	0.373	2.79	0.406	3.67	0.577	97.45	<0.001
IPO – reality testing	1.40	0.260	2.03	0.446	3.08	0.685	74.62	<0.001
IPO – aggression	1.41	0.377	1.90	0.512	2.63	0.552	36.35	<0.001
IPO – moral values	1.91	0.494	2.55	0.394	3.19	0.509	47.31	<0.001

F – analysis of variance test value; **IPO** – Inventory of Personality Organization; ***M*** – mean; ***p*** – the level of significance of differences; ***SD*** – standard deviation.

Tab. 5. Descriptive statistics and analysis of variance for the identified clusters of levels of personality organisation in the study group

Variable	Cluster 1 $n = 26$		Cluster 2 $n = 44$		Cluster 3 $n = 21$		*F*	*p*
	M	*SD*	*M*	*SD*	*M*	*SD*		
DS-II – Meaning and Purpose	3.08	3.417	7.30	3.939	7.86	4.607	11.577	0.0001
DS-II – Distress and Coping Ability	5.38	3.430	8.98	3.253	10.33	4.115	13.262	0.0001
Total DS-II	8.46	6.544	16.27	6.701	18.19	8.262	13.829	0.0001
Total RCd	7.88	5.559	13.73	4.948	17.33	5.323	20.176	0.0001
Perceived stress	48.308	21.756	57.11	21.171	62.48	26.282	2.421	0.0948

F – analysis of variance test value; ***M*** – mean; ***p*** – the level of significance of differences; ***SD*** – standard deviation.

Tab. 6. Descriptive statistics and analysis of variance for the identified dimensions of demoralisation and perceived stress due to the level of personality organisation in the group of alcohol-dependent individuals

Multiple regression analysis was then performed. The predictive value of the dimensions of personality organisation and perceived stress for demoralisation was assessed. Explanatory variables introduced into the models for the general dimension of demoralisation measured using the DS-II scale ($R^2 = 0.356$; $F(6,84) = 7.7538$; $p < 0.001$) and the RCd scale ($R^2 = 0.490$; $F(6,84)$) $= 13.453$; $p < 0.001$) showed significance. For the demoralisation measured with DS-II, the dimension of primitive defences ($\beta = 0.312$, $p = 0.031$) and perceived stress ($\beta = 0.214$, $p = 0.028$) played a special predictive role in the study group. However, demoralisation measured with the RCd scale was predicted by the dimension of primitive defences ($\beta = 0.287$, $p = 0.026$), perceived stress ($\beta = 0.201$, $p = 0.021$) and identity diffusion ($\beta = 0.319$, $p = 0.020$). Due to the very large dispersion of results in the study group, a decision was made to analyse its internal structure. Agglomerative cluster analysis of mean scores allowed the identification of three clusters. Then, using the k-means method, the participants were assigned to separate clusters (Fig. 1). Alcohol-dependent persons belonging to particular clusters differed significantly in the severity of abnormalities in all dimensions of personality organisation (Tab. 5).

Then, it was verified whether individuals belonging to particular clusters with varying severity of personality organisation pathology differed in the intensity of their demoralisation and perceived stress (Tab. 6). The results showed significant differences in demoralisation measured with both methods. Post-hoc analyses using the Tukey test for unequal numbers showed significant differences between cluster 1 compared to clusters 2 and 3, and no differences between clusters 2 and 3 in terms of demoralisation and its dimensions measured with DS-II. Measurements using the RCd scale showed statistically significant differences between participants belonging to all three clusters. In terms of perceived stress, cluster 1 differed only from cluster 3.

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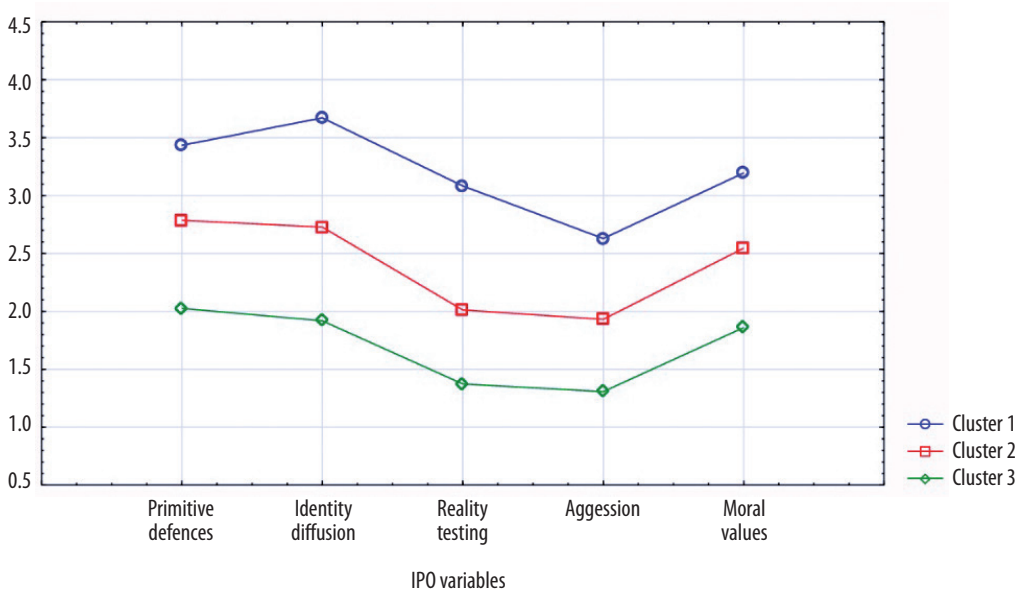

Fig. 1. Means for the clusters based on the mean IPO scores (Otto F. Kernberg)

DISCUSSION

Alcohol dependence can take extreme forms and have a highly varied course. In addition to the stereotypical image of an addicted person, there are also the so-called high-functioning alcoholics. Despite regularly abusing alcohol, they do not experience most of the consequences of addiction and, and manage their daily routine and work for a long time (Benton and Rossowski, 2015). Researchers investigating alcoholism also distinguish its various forms depending on the factor that plays an important role in its development (e.g. Jellinek, 1960). The mean, minimum and maximum scores obtained in the presented study are consistent with this clinical observation, as they indicate a great diversity of the study group in terms of the analysed variables, i.e. the level of personality organisation, demoralisation and perceived stress. Confirming this internal differentiation is important from the perspective of planning psychotherapy, which should be individualized in order to be effective.

The inability to cope with a difficult situation, which generates a sense of powerlessness, meaninglessness, and even existential emptiness, is an important feature of demoralisation. It was expected that such properties would be more intense in individuals with a more pathological personality organisation (H1). The obtained results allow for accepting the H1 hypothesis. The strongest correlation indicators, when measured with both DS-II and RCd, were obtained for the dimensions of primitive defences and personality integration disorders. These results indicate the importance of developing coping skills and integrating identity in the therapeutic process in the group of alcohol-dependent individuals, because their lack may result in demoralisation, which significantly impedes recovery. The special importance of these two dimensions of personality organisation was confirmed by multiple regression analyses, which showed that, together with perceived stress, they play an important role in predicting demoralisation. This is important as addiction often coexists with depression (Klimkiewicz et al., 2015), which is distinguished from demoralisation by subjective incompetence (Angelino and Treisman, 2001; Clarke and Kissane, 2002). Therefore, the H2 hypothesis can be partially accepted, because two dimensions of personality organisation and perceived stress are predictive of demoralisation. The obtained results are consistent with previous findings, indicating key factors promoting demoralisation (Basińska, 2021). These include, among others, stressful situations (de Figueiredo, 2013) and some personality dimensions, e.g. temperament, one dimension of which – perseveration (Basińska and Szocińska, 2015), may be of particular importance for the repeatability of maladaptive techniques.

As pointed out by Professor Kernberg during one of the first Conferences of the Polish Society for Psychodynamic Psychotherapy in Krakow, certain cut-off points can be established to assess the severity of personality pathology. A mean score in the range of 1.5–2.4 indicates some abnormal personality tendencies, scores 2.5–3.4 suggest deficits, while scores ranging from 3.5 to 5 are indicative of personality organisation disorders. Cluster analysis for mean results revealed three clusters, and if the levels of dimensions that, according to previous analyses, play a special role in forming demoralisation, i.e. primitive defences and identity diffusion, it can be seen that they fall within the three ranges proposed by Kernberg. Individuals from cluster 1 are characterised by undisturbed personality organisation, slight abnormalities at most. The scores obtained by addicts from cluster 2, apart from the reality testing dimension (which is intact) and aggression (low), indicated deficits in personality organisation. They were related to the

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use of immature defence mechanisms, rigid personality and moderate identity pathology, as well as inconsistent moral functioning. People from cluster 3 are at a level indicating a disorder in terms of identity diffusion. The intensity of the remaining dimensions of personality organisation was higher than in cluster 2, but it did not exceed the cut-off point of 3.5. Therefore, the H3 hypothesis can be accepted, as the analyses confirmed that this is a group that is internally differentiated in terms of the severity of personality organisation pathology. The more disturbed the level of personality organisation and higher the perceived stress, the higher the demoralisation in alcohol-dependent individuals. It is worth noting that individuals from cluster 1, i.e. those whose personality organisation is virtually intact, differ the most from other respondents. A different type of therapy should be offered to this subgroup.

Previous studies using DS-II to assess demoralisation were conducted in a group of cancer patients (Koranyi et al., 2021; Robinson et al., 2016b). The obtained results showed that it is also an important construct in the group of addicts, which may be helpful both in the diagnostic process (differentiation with co-occurrence of depression) and during treatment planning.

CONCLUSIONS

1. The important role of personality organisation in the development of demoralisation was confirmed.
2. The group of alcohol-dependent individuals was internally differentiated in terms of the severity of personality pathology and demoralisation, which should be taken into account in the processes of diagnosis and therapy.

Conflict of interest

The author reports no financial or personal relationships with other individuals or organisations that could adversely affect the content of the publication and claim ownership of this publication.

Author contributions

Original concept of study; collection, recording and/or compilation of data; analysis and interpretation of data; writing of manuscript; critical review of manuscript; final approval of manuscript: MAB.

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References

Angelino AF, Treisman GJ: Major depression and demoralization in cancer patients: diagnostic and treatment considerations. Support Care Cancer 2001; 9: 344–349.

Basińska MA: Funkcjonowanie w chorobie przewlekłej. In: Brudek PJ, Mącik D, Kuncewicz D (eds.): Psychologia kliniczna w trosce o godność człowieka. Księga Pamiątkowa dedykowana Profesor Stanisławie Steuden w podziękowaniu za całokształt pracy naukowo-dydaktycznej w Instytucie Psychologii Katolickiego Uniwersytetu Lubelskiego Jana Pawła II. Towarzystwo Naukowe KUL, Lublin 2022: 539–554.

Basińska MA: Syndrom demoralizacji w zmaganiu się z chorobą: rozumienie, kształtowanie się i pomiar. Wydawnictwo Uniwersytetu Kazimierza Wielkiego, Bydgoszcz 2021.

Basińska MA, Szocińska A: Temperament a występowanie syndromów psychosomatycznych wg The Diagnostic Criteria for Psychosomatic Research – DCPR u pacjentów z chorobami kardiologicznymi. Psychol-Etol-Genet 2015; 32: 29–46.

Benton SA: Alkoholicy wysokofunkcjonujący z perspektywy profesjonalnej i osobistej. Wydawnictwo JK – Feeria, Łódź 2015.

Briggs L, Macleod S: Demoralization or clinical depression? Enhancing understandings of psychological distress in resettled refugees and migrants. World Cult Psychiatry Res Rev 2010: 86–98.

Butcher JN, Graham JR, Ben-Porath YS et al.: MMPI®-2. Minnesocki Wielowymiarowy Inwentarz Osobowości®-2. Podręcznik stosowania, oceny i interpretacji. Wersja zrewidowana. Pracownia Testów Psychologicznych Polskiego Towarzystwa Psychologicznego, Warszawa 2012.

Caligor E, Clarkin JF: Model osobowości i patologii osobowości oparty na teorii relacji z obiektem. In: Clarkin JF, Fonagy P, Gabbard GO (eds.): Psychoterapia psychodynamiczna zaburzeń osobowości. Podręcznik kliniczny. Wydawnictwo Uniwersytetu Jagiellońskiego, Kraków 2013: 23–60.

Chang VT, Sorger B, Rosenfeld KE et al.: Pain and palliative medicine. J Rehabil Res Dev 2007; 44: 279–294.

Clarke DM, Kissane DW: Demoralization: its phenomenology and importance. Aust N Z J Psychiatry 2002; 36: 733–742.

Clarke DM, Kissane DW, Trauer T et al.: Demoralization, anhedonia and grief in patients with severe physical illness. World Psychiatry 2005; 4: 96–105.

Clarkin JF, Foelsch PA, Kernberg OF: The Inventory of Personality Organization. The Personality Disorder Institute, Cornell University, New York 2001.

Cockram CA, Doros G, de Figueiredo JM: Subjective incompetence as the clinical hallmark of demoralization in cancer patients without mental disorder. Prim Psychiatry 2010; 17: 54–58.

De Jong CAJ, Kissane DW, Geessink RJ et al.: Demoralization in opioid dependent patients: a comparative study with cancer patients and community subjects. Open Addict J 2008; 1: 7–9.

Dohrenwend BP, Shrout PE, Egri G et al.: Nonspecific psychological distress and other dimensions of psychopathology. Measures for use in the general population. Arch Gen Psychiatry 1980, 37: 1229–1236.

Fava GA, Freyberger HJ, Bech P et al.: Diagnostic criteria for use in psychosomatic research. Psychother Psychosom 1995; 63: 1–8.

de Figueiredo JM: Depression and demoralization: phenomenologic differences and research perspectives. Compr Psychiatry 1993; 34: 308–311.

de Figueiredo JM: Distress, demoralization and psychopathology: diagnostic boundaries. Eur J Psychiatry 2013; 27: 61–73.

Frank JD: Persuasion and Healing: A Comparative Study of Psychotherapy. Johns Hopkins University Press, Baltimore 1961.

Frank JD, Frank JB: Persuasion and Healing: A Comparative Study of Psychotherapy. 3rd ed., Johns Hopkins University Press, Baltimore, London 1993.

Frank JD, Frank JB: Perswazja i uzdrawianie. Analiza porównawcza psychoterapii. Instytut Psychologii Zdrowia, Polskie Towarzystwo Psychologiczne, Warszawa 2005.

Gabel S: Demoralization: a precursor to physician burnout? Am Fam Physician 2012; 86: 861–862.

DOI: 10.15557/PiPK.2023.0035

Gabel S: Demoralization in health professional practice: development, amelioration, and implications for continuing education. J Contin Educ Health Prof 2013; 33: 118–126.
Graham JR: MMPI-2. Ocena osobowości i psychopatologii. Wyd. 5, Pracownia Testów Psychologicznych Polskiego Towarzystwa Psychologicznego, Warszawa 2015.
Grassi L, Pasquini M, Kissane D et al.: Exploring and assessing demoralization in patients with non-psychotic affective disorders. J Affect Disord 2020; 274: 568–575.
Gravetter FJ, Wallnau LB: Essentials of Statistics for the Behavioral Sciences. 8th ed., Wadsworth Cengage Learning, Belmont 2014.
Grzankowska IA, Fabjanowicz A: Organizacja osobowości a elastyczność w radzeniu sobie ze stresem w grupie osób uzależnionych od alkoholu. Psychiatr Psychol Klin 2023; 23: 268–279.
Hocking D, Sundram S: Demoralisation syndrome does not explain the psychological profile of community-based asylum-seekers. Compr Psychiatry 2015; 63: 55–64.
Izdebska A, Pastwa-Wojciechowska B: Organizacja osobowości i jej pomiar – polska adaptacja kwestionariusza IPO Kernberga i współpracowników. Czas Psychol 2013; 19: 17–27.
Jellinek EM: The disease concept of alcoholism. Hillhouse Press, New Haven 1960.
Kernberg OF: What is personality? J Pers Disord 2016; 30: 145–156.
Kissane DW, Clarke DM, Street AF: Demoralization syndrome – a relevant psychiatric diagnosis for palliative care. J Palliat Care 2001; 17: 12–21.
Kissane DW, Wein S, Love A et al.: The Demoralization Scale: a report of its development and preliminary validation. J Palliat Care 2004; 20: 269–276.
Klimkiewicz A, Klimkiewicz J, Jakubczyk A et al.: [Comorbidity of alcohol dependence with other psychiatric disorders. Part I. Epidemiology of dual diagnosis]. Psychiatr Pol 2015; 49: 265–275.
Kohn R: Demoralization and the longitudinal course of PTSD following Hurricane Mitch. Eur J Psychiatry 2013; 27: 18–26.
Kohn R, Levav I, Garcia ID et al.: Prevalence, risk factors and aging vulnerability for psychopathology following a natural disaster in a developing country. Int J Geriatr Psychiatry 2005; 20: 835–841.
Koranyi S, Hinz A, Hufeld JM et al.: Psychometric evaluation of the German version of the Demoralization Scale-II and the association between demoralization, sociodemographic, disease- and treatment-related factors in patients with cancer. Front Psychol 2021; 12: 789793.
Lenzenweger MF, Clarkin JF, Kernberg OF et al.: The Inventory of Personality Organization: psychometric properties, factorial composition, and criterion relations with affect, aggressive dyscontrol, psychosis proneness, and self-domains in a nonclinical sample. Psychol Assess 2001; 13: 577–591.
Liao HY, Chiu CC, Ko YY et al.: Factors associated with demoralisation syndrome in patients before and after cardiac surgery. J Clin Nurs 2018; 27: e559–e568.
Mellibruda J: Psycho-bio-społeczna koncepcja uzależnienia od alkoholu. Alkohol Narkom 1997; 28: 277–306.
Offidani E, Del Basso D, Prignago F et al.: Discriminating the presence of psychological distress in patients suffering from psoriasis: an application of the clinimetric approach in dermatology. Acta Derm Venereol 2016; 96: 69–73.
Papakostas GI, Petersen T, Homberger CH et al.: Hopelessness as a predictor of non-response to fluoxetine in major depressive disorder. Ann Clin Psychiatry 2007; 19: 5–8.
Rafanelli C, Roncuzzi R, Milaneschi Y et al.: Stressful life events, depression and demoralization as risk factors for acute coronary heart disease. Psychother Psychosom 2005; 74: 179–184.
Rickelman BL: Demoralization as a precursor to serious depression. J Am Psychiatr Nurses Assoc 2002; 8: 9–19.
Robinson S, Kissane DW, Brooker J et al.: Refinement and revalidation of the demoralization scale: the DS-II – external validity. Cancer 2016a; 122: 2260–2267.
Robinson S, Kissane DW, Brooker J et al.: Refinement and revalidation of the demoralization scale: The DS-II – internal validity. Cancer 2016b; 122: 2251–2259.
Slavney PR: Diagnosing demoralization in consultation psychiatry. Psychosomatics 1999; 40: 325–329.
Tang L, Li Z, Pang Y: The differences and the relationship between demoralization and depression in Chinese cancer patients. Psychooncology 2020; 29: 532–538.
Tossani E, Ricci Garotti MG, Cosci F: The use of the diagnostic criteria for psychosomatic research in substance use disorder patients. Psychother Psychosom 2013; 82: 195–196.