https://doi.org/10.69639/arandu.v12i3.1462

# Lymphoma in a Young Patient with Demoralization Syndrome: Case Report

*Linfoma en una paciente joven con síndrome de desmoralización: reporte de caso*

**Jhoan Utria Castro**
utria624@hotmail.com
https://orcid.org/0009-0002-6400-7263
Asociación de Psiquíatras de Argentina
Cali – Colombia

**Luisa María Gaviria**
Luisagaviria1@hotmail.com
https://orcid.org/0009-0007-5471-3902
Universidad de los Andes
Bogotá D.C. – Colombia

**Nicolás López Castellanos**
nicolaslopez@live.com.mx
https://orcid.org/0009-0001-8720-1643
Universidad de Ciencias Aplicadas y Ambientales UDCA
Bogotá D.C. – Colombia

**Paola Andrea Muñoz Ortega**
https://orcid.org/0009-0009-9761-9638
paolam.ortega@gmail.com
Universidad del Cauca
Popayán – Colombia

*Artículo recibido: 18 julio 2025 - Aceptado para publicación: 28 agosto 2025*
*Conflictos de intereses: Ninguno que declarar.*

## ABSTRACT

Introduction: This case illustrates a demoralization syndrome in the setting of palliative care for advanced lymphoma and emphasizes the necessity of a biopsychosocial approach to care. Demoralization is a syndrome of hopelessness, meaninglessness and existential distress that is commonly underrecognized in young adult patients at the end of life. Main Findings: A 21-year-old patient with Hodgkin lymphoma in previous remission presented with tumor reactivation, severe abdominal pain, and profound emotional deterioration. Symptoms included emotional withdrawal, disrupted sleep, and loss of meaning, which were indicative of demoralization. Interventions and Outcomes: Multidisciplinary palliative therapy consisted of advanced analgesia therapy with hydromorphone and infusion of lidocaine, parenteral nutrition, and cognitive behavioral psychological care. Notwithstanding these interventions, the patient experienced an emotional deterioration with no therapeutic comeback possible. Conclusion: This case emphasizes the importance of comprehensive and age-appropriate interventions to identify and

manage demoralization early in the course of terminal illnesses, improving quality of life and preserving patient dignity in end-of-life care.

*Keywords:* hodgkin lymphoma, palliative care**,** demoralization syndrome, mental health, case report

**RESUMEN**

Introducción: Este caso ilustra un síndrome de desmoralización en el contexto de cuidados paliativos para linfoma avanzado y enfatiza la necesidad de un enfoque biopsicosocial. La desmoralización es un síndrome de desesperanza, falta de sentido y angustia existencial que suele pasar desapercibido en pacientes adultos jóvenes al final de la vida. Hallazgos principales: Un paciente de 21 años con linfoma de Hodgkin en remisión previa presentó reactivación tumoral, dolor abdominal intenso y profundo deterioro emocional. Los síntomas incluyeron retraimiento emocional, alteración del sueño y pérdida de sentido, indicativos de desmoralización. Intervenciones y resultados: La terapia paliativa multidisciplinaria consistió en analgesia avanzada con hidromorfona e infusión de lidocaína, nutrición parenteral y atención psicológica cognitivo-conductual. A pesar de estas intervenciones, el paciente experimentó un deterioro emocional sin posibilidad de recuperación terapéutica. Conclusión: Este caso enfatiza la importancia de las intervenciones integrales y adaptadas a la edad para identificar y gestionar la desmoralización en las primeras etapas de las enfermedades terminales, mejorando así la calidad de vida y preservando la dignidad del paciente en los cuidados paliativos.

*Palabras clave:* linfoma de Hodgkin, cuidados paliativos, síndrome de desmoralización, salud mental, informe de caso

## INTRODUCTION

Patients with advanced lymphoma face multiple physical and emotional challenges that can significantly deteriorate their quality of life. Beyond the clinical complications inherent to the disease and the side effects of treatment, the psychological impact associated with prognosis uncertainty, prolonged suffering, and loss of autonomy can lead to syndromes such as demoralization, characterized by feelings of hopelessness and despair. These emotional factors not only compromise the patient's well-being but also hinder their ability to actively participate in the management of their disease (6).

In this context, integrated palliative care, which combines physical, psychological, and social approaches, has emerged as a key strategy to improve the quality of life of patients with recurrent or advanced lymphoma. Several studies have demonstrated that early access to a multidisciplinary team can not only alleviate symptomatic and emotional burdens but also prolong patient survival, underscoring the importance of patient- and family-centered care (4). For instance, the integration of services such as personalized psychological support, regular sessions with palliative care specialists, and effective communication regarding symptom management has been shown to significantly reduce anxiety and depression levels in this population (9).

The present article describes a clinical case of recurrent lymphoma and aims to emphasize the importance of the multidisciplinary dimension of care, focusing on the need to integrate the physical, emotional and social domains of care based on the principles of palliative medicine. Multidisciplinary approaches to palliative care involving hematologists, palliative medicine specialists, psychologists, and nutritionists, can lead to better control of symptoms, improved quality of life, and greater satisfaction with care, in patients with hematologic malignancies (1).

Additionally, integrated disease-specific multi-disciplinary tumor boards and clinics for lymphoma care all contribute to a better understanding of complex therapeutic decisions, avoidance of unnecessary hospital revisits and are a driving factors towards patient-centered decision-making. Data from intervention studies in metastatic cancer show that multidisciplinary palliative care also increases survival and reduces hospital readmissions by clarifying goals of care and supporting advance care planning (4,10,13)

Highlighting the strength of both interdisciplinary and personalized care, this analysis aims to add to the discussion how the complicated needs of these patients can best be addressed, underlining the need for integrated care models suited for both patients' spectrum of requirements.

In addition, demoralization syndrome has progressively gained consideration as a specific psychological disorder in patients with advanced cancer, different from clinical depression mainly for its existential and meaning-based nature. In contrast to depressive syndromes, which generally respond to antidepressant medication, demoralization requires a targeted psychosocial approach, concentrating on restoring hope, meaning, and a sense of efficacy for the patient via a therapeutic

dialogue and support (3). Prevalence studies report that between 13–52 % of oncology patients experience clinically significant demoralization, with rates particularly elevated in those facing advanced disease and poor prognosis (14).

Early psychological screening (e.g. the Demoralization Scale) allows providing timely psychosocial support, avoiding the development of more severe existential distress (11). By emphasizing the existential roots of suffering, this tailored approach safeguards patient dignity and facilitates more compassionate end-of-life care.

The identification and treatment of this syndrome early in the course of illness is necessary to prevent emotional decline that likely will also compromise treatment adherence and end-of-life decision-making. This case demonstrates the necessity for the intertwining of medical and psychological care in the service of improving quality of life and dignity for those patients with advanced disease.

## CASE PRESENTATION

A 21-year-old woman with a prior diagnosis of Hodgkin lymphoma was treated with chemotherapy and radiotherapy in 2014, achieving complete remission by 2016. She remained on annual follow-up with no evidence of recurrence until August 2024, when she re-entered the healthcare system due to abdominal pain, nausea, and anemic syndrome. At that time, reactivation of the oncologic disease was documented, and she was hospitalized under a palliative care approach. She lived in Bogotá, had a functional family support network, and worked in aesthetics-related fields. During hospitalization, she developed marked emotional distress—feelings of hopelessness, disrupted sleep, and progressive social withdrawal—consistent with a state of demoralization that compounded her clinical condition.

On presentation, her chief complaint was severe abdominal pain associated with symptomatic anemia. Examination revealed generalized pallor and a distended, tender abdomen with signs suggestive of peritoneal irritation, reflecting the multidimensional impact of the disease across both physical and psychological domains. To investigate the cause of clinical deterioration, an abdominal computed tomography scan demonstrated intestinal obstruction with associated peritoneal fluid. Upper endoscopy identified a 10 × 12 mm gastric lesion with irregular borders and neoplastic characteristics, for which biopsies were obtained. Further testing was limited by the patient's declining functional and emotional status. Overall, the assessment confirmed reactivation of Hodgkin lymphoma with gastric involvement, together with a concurrent psychiatric condition of demoralization.

Given advanced disease and the prominent affective burden, management was oriented toward a multidimensional, palliative strategy addressing physical and psychological needs. Severe visceral pain (rated 8/10 on the visual analog scale) was managed with intravenous hydromorphone 0.2 mg every 6 hours, complemented by a continuous lidocaine infusion (5

mg/cc) at 9 cc/h through a correctly placed right subclavian central venous catheter, achieving partial symptom control and improving tolerance to hospital care. Because of obstructive ileus, continuous parenteral nutrition was initiated at 62 cc/h with a standard formulation adjusted to caloric and protein requirements; administration was performed using sterile equipment with continuous monitoring of electrolytes, renal function, and fluid balance.

In parallel, the psychology team implemented a psychosocial support program utilizing cognitive-behavioral therapy (CBT) techniques to address recurrent negative thoughts and foster emotional adaptation, with collaborative work involving the patient and her family to strengthen the support network. The psychiatry team evaluated the potential use of anxiolytic and antidepressant medications; however, no specific records of psychopharmacologic administration were found in the clinical notes. As part of comprehensive palliative care, symptomatic measures included ondansetron 8 mg IV every 8 hours for nausea and omeprazole 40 mg IV every 12 hours to prevent gastric complications. Comfort-focused measures, such as bed positioning, meticulous skin care, and pressure-ulcer prevention, were employed to preserve comfort and dignity.

Despite adherence to interventions, clinical monitoring revealed rapid disease progression, with persistent abdominal symptoms and recurrent episodes of dark vomiting (hematemesis). The patient remained oriented and hemodynamically stable for most of her hospitalization but ultimately succumbed to complications associated with the underlying disease.

## DISCUSSION

### Synopsis and contribution

This case underscores the value of early, integrated palliative care in complex hematologic malignancies and highlights the clinical relevance of demoralization as a distinct psycho-oncological syndrome. Comprehensive integration of palliative care across the cancer trajectory is associated with improved symptom control, communication, and alignment of care with patient goals—principles emphasized at global and systems levels (1,5) and supported by evidence syntheses showing benefits for quality of life and, in some trials, survival (4). In hematologic cancers specifically, early specialty palliative care improves outcomes and care processes, yet remains underutilized (13). Our patient's rapid decline, high symptom burden, and marked demoralization illustrate why proactive, interdisciplinary models are clinically important, including in resource-limited settings where collaborative practice can still improve inpatient outcomes (10).

### Demoralization: concept, measurement, and clinical relevance

Demoralization—characterized by loss of meaning, helplessness, and a perceived inability to cope—differs from major depression and merits targeted assessment and management (3,7,11). It is common in advanced cancer and correlates with worse quality of life and psychological distress (2,6,11,14). Validated tools (e.g., DS-II) enable reliable screening and monitoring in

clinical practice (12,14). In adolescents and young adults (AYA), additional developmental and psychosocial needs amplify the impact of existential distress; tailored supportive care and age-appropriate resources are recommended (8,15). In this case, early detection and structured intervention for demoralization would be expected to support coping, decision-making, and engagement with care plans (2,11,14).

**How the case aligns with and expands the literature**

- **Integrated palliative care**: The trajectory and needs observed here are consistent with frameworks advocating concurrent oncologic and palliative approaches from diagnosis through advanced stages, with emphasis on communication, symptom relief, and care transitions (1,5,13).
- **Interdisciplinary delivery**: Evidence from inpatient and outpatient programs supports interprofessional models (oncology, palliative care, psychology, social work, nursing), even where resources are constrained (4,10).
- **Personalization**: Tailored, person-centered interventions, including attention to psychiatric comorbidity and family context, have been associated with improvements in clinical and psychosocial outcomes in advanced disease (6,9).

**Practice recommendations**

1. **Embed palliative care early in hematologic oncology.** Routine, proactive involvement of specialty palliative care to manage symptoms, facilitate goals-of-care discussions, and support complex decision-making (1,4,5,13).
2. **Screen systematically for demoralization** (e.g., DS-II) and **distinguish it from depression** to guide targeted interventions (CBT, meaning-centered strategies, existential therapies) and referral to psycho-oncology (3,7,11,12,14).
3. **Use interprofessional, collaborative pathways** that include nursing, psychology, social work, and spiritual care; these models are feasible and beneficial in **resource-limited hospitals** as well (4,10).
4. **Personalize supportive care plans**: including pain, nutrition, sleep, and family engagement—considering psychiatric comorbidity and patient values; this person-centered approach has documented benefits for distress and quality of life (2,6,9).
5. **Address AYA-specific needs** by integrating age-appropriate informational and psychosocial resources and peer support options (8,15).

**Priorities for future research**

- **Implementation science** on early, integrated palliative care in hematologic malignancies: identifying barriers, facilitators, and equity considerations across diverse health-system contexts (1,5,13).

- **Intervention trials** targeting **demoralization** (screen-and-treat pathways, stepped psychosocial care, digital adjuncts) with standardized outcomes (DS-II, QoL, health-care utilization) (11,12,14).
- **Interprofessional models** in **resource-limited settings**, including scalable training and role delineation, and their impact on clinical, humanistic, and system outcomes (4,10).
- **AYA-focused supportive care** strategies that integrate developmentally tailored resources and evaluate long-term psychosocial outcomes (8,15).

## CONCLUSION

Overall, this case favors early, integrated palliative care in hematologic oncology to guide treatment based on the patient's agenda and to address treatment-related side effects, including a regular screening for demoralization with targeted psycho-oncologic interventions. Interprofessional pathways are possible even in resource-constrained environments, hold potential to improved patient-centered outcomes, and future efforts can refine operational screen-and-treat strategies for demoralization and determine scalable models of early integration throughout the hematology care continuum (1,4,10,11,13).

## REFERENCES


1. Alcalde Castro, J., Hannon, B., & Zimmermann, C. (2023). *Integrating palliative care into oncology care worldwide: The right care in the right place at the right time*. Current Treatment Options in Oncology, 24(4), 353–372. https://doi.org/10.1007/s11864-023-01060-9
2. Bovero, A., Opezzo, M., & Tesio, V. (2023). *Relationship between demoralization and quality of life in end-of-life cancer patients*. Psycho-Oncology, 32(3), 429–437. https://doi.org/10.1002/pon.6095
3. Clarke, D. M., & Kissane, D. W. (2002). *Demoralization: Its phenomenology and importance*. Australian and New Zealand Journal of Psychiatry, 36(6), 733–742.
4. Hoerger, M., Wayser, G. R., Schwing, G., Suzuki, A., & Perry, L. M. (2019). *Impact of interdisciplinary outpatient specialty palliative care on survival and quality of life in adults with advanced cancer: A meta-analysis of randomized controlled trials*. Annals of Behavioral Medicine, 53(7), 674–685.
5. Hui, D., & Bruera, E. (2016). *Integrating palliative care into the trajectory of cancer care*. Nature Reviews Clinical Oncology, 13(3), 159–171. https://doi.org/10.1038/nrclinonc.2015.201
6. Kaasa, S., Malt, U., Hagen, S., Wist, E., Moum, T., & Kvikstad, A. (1993). *Psychological distress in cancer patients with advanced disease*. Radiotherapy and Oncology, 27(3), 193–197.
7. Kissane, D. W., Clarke, D. M., & Street, A. F. (2001). *Demoralization syndrome—A relevant psychiatric diagnosis for palliative care*. Journal of Palliative Care, 17(3), 12–21.
8. National Cancer Institute. (2025). *Emotional support for young people with cancer* [Internet]. Bethesda (MD): NCI. Recuperado el 8 de julio de 2025, de https://www.cancer.gov/types/aya/support
9. Popa-Velea, O., Cernat, B., & Tambu, A. (2010). *Influence of personalized therapeutic approach on quality of life and psychiatric comorbidity in patients with advanced colonic cancer requiring palliative care*. Journal of Medicine and Life. Recuperado de https://www.semanticscholar.org/paper/Influence-of-personalized-therapeutic-approach-on-Popa-Velea-Cernat/e9b1460d4d15166b28c6785adc90859c734b592e
10. Pornrattanakavee, P., Srichan, T., Seetalarom, K., Saichaemchan, S., Oer-Areemitr, N., & Prasongsook, N. (2022). *Impact of interprofessional collaborative practice in palliative care on outcomes for advanced cancer inpatients in a resource-limited setting*. BMC Palliative Care, 21(1), 229. https://doi.org/10.1186/s12904-022-01121-0
11. Robinson, S., Kissane, D. W., Brooker, J., & Burney, S. (2015). *A systematic review of the demoralization syndrome in individuals with progressive disease and cancer: A decade

of research*. Journal of Pain and Symptom Management, 49(3), 595–610. https://doi.org/10.1016/j.jpainsymman.2014.07.008

12. Robinson, S., Kissane, D. W., Brooker, J., et al. (2016). *Refinement and revalidation of the Demoralization Scale: The DS-II internal validity*. Cancer, 122(14), 2251–2259.
13. Shaulov, A., Aviv, A., Alcalde, J., & Zimmermann, C. (2022). *Early integration of palliative care for patients with haematological malignancies*. British Journal of Haematology, 199(1), 14–30. https://doi.org/10.1111/bjh.18286
14. Tang, P.-L., Wang, H.-H., & Chou, F.-H. (2015). *A systematic review and meta-analysis of demoralization and depression in patients with cancer*. Psychosomatics, 56(6), 634–643. https://doi.org/10.1016/j.psym.2015.06.005
15. Zebrack, B. J. (2011). *Psychological, social, and behavioral issues for young adults with cancer*. Cancer, 117(S10), 2289–2294.