CHAPTER 28

Emotional Disorders and Medical Illness

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Introduction

The emotional reactions to illness may be more troublesome than the illness itself, particularly if the illness is chronic and results in significant lifestyle changes. These emotional reactions are distressing to the person but do not always meet the criteria set out in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (DSM-IV; American Psychiatric Association, 1994) or the *International Classification of Diseases*, 10th ed. (ICD-10; World Health Organization, 1992) for a specific disorder. In this chapter, we are particularly concerned with chronic medical illness, but much of what is reviewed also applies to acute illness.

It is undisputed that medical illness, especially chronic illness, is stressful and may be associated with emotional disorders. However, the nature of the association, particularly with regard to causal relationships and proper classification, remains unclear. Both the DSM-IV and the ICD-10 classify reactions to stress into three principle groups: (1) acute reactions, in DSM-IV called acute stress disorder; (2) adjustment disorder, classified in both the ICD-10 and the DSM-IV according to predominant symptoms, such as with depression, with mixed anxiety and depression, with disturbance of conduct, and with disturbance of emotions and conduct; (3) posttraumatic stress disorder (PTSD), an abnormal response to a severe stressor with symptoms that involve intrusive recollection, emotional numbing or avoidance, and arousal. Although PTSD and Acute Stress reactions are seldom diagnosed in connection with medical illness, adjustment disorders certainly are, and in patients with cancer, the prevalence may be nearly 50% (Spiegel, 1996).

Coexisting symptoms of anxiety and depression are prominent among the emotional responses in ill patients that are difficult to classify. It has been known for years that these symptoms are commonly present in medically ill patients and are difficult to separate (Lewis, 1956). The ICD-10 has a category called “mixed anxiety and depressive disorder” which is used when symptoms are not severe enough to meet criteria for a specific disorder and where the association with a stressor is not close enough to warrant a diagnosis of adjustment disorder. The DSM-IV has no such diagnosis, but the appendix includes both “mixed anxiety and depressive disorder” and “minor depressive disorder,” either of which could be applicable. The DSM-IV suggests that at present there is insufficient empirical evidence to support including these conditions in the classification. In the *Oxford Textbook of Psychiatry*, 3rd ed. (Gelder, Guth, Mayon, & Cowen, 1996) these symptoms are

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called “minor affective disorders,” and the clinical picture includes anxiety, depression, insomnia, fatigue, irritability, and poor concentration. Such somatic symptoms due, it is thought, to psychological factors, were present in 52% of patients presenting to a primary care practice. However, in such a group of patients, one should not assume that the symptoms are due to psychological factors, and the etiology must be investigated.

Classification is not simple; neither is cause and effect. Notions of cause and effect abound, but they are seldom evidence-based. In the case of psychiatric disorders, three major theoretical constructs relate stress and illness, (although there are many variations) all described by Dohrenwend and Dohrenwend (1981). The first is the innocent victim model, in which there is exposure to some stressful circumstance. If the stressor is severe enough or if there is special susceptibility, illness occurs. This model accounts well for PTSD and adjustment disorders, but is otherwise lacking. Building on the first model, the vulnerability hypothesis says that stress triggers illness in those already predisposed to develop psychiatric illnesses; and the source of the vulnerability can include genetics, social relationships, or early childhood experiences. This model is popular and invoked often for many illnesses, including depression. The third model builds on the first two and is called the interactive model, which postulates that deficient coping skills result in the inability to prevent undesirable events and perhaps even cause undesirable events, which then result in illness.

Having introduced the notion of coping, we will now examine it in some detail, because at least a basic understanding of coping is necessary to work effectively with people who are ill. Traditional psychiatric views of coping and especially defense mechanisms stem from the theoretical work of Sigmund Freud and his followers, and a hierarchical developmental system is usually employed to classify defensive strategies as either mature/healthy (usually called coping strategies and including such things as humor and suppression) or immature/not so healthy (such as projection, psychotic denial, and splitting). George Vaillant has described this system very well (Vaillant, 1977, 1992).

Coping can also be viewed as a process, rather than a hierarchy based at least in part on preconceived notions of health and illness. This approach has been reviewed by Lazarus (1993) who divides coping strategies into adaptive and maladaptive. Adaptive strategies may be further divided into problem solving strategies, which modify some adverse circumstance so as to reduce stress, and emotion-reducing strategies, which enhance one’s ability to deal with stress.

Examples of problem solving include obtaining advice or help, making a plan to deal with the problem, or confronting someone about behavior.

Examples of emotion-reducing strategies include ventilation (expressing emotion), avoidance (not thinking about or dealing with a problem right away), accepting or rejecting responsibility for a problem, and reframing the experience so that it is viewed in a positive light.

In our culture, problem solving strategies are often valued more highly than emotion-reducing strategies, but both may be equally effective.

Horowitz (1997) combined elements of process and hierarchy into a unique scheme for looking at response to stress on an individual in terms of controls that are used to regulate emotional reaction to a stressful life event. Controls maintain an emotional state or mind-set and may also be responsible for the transition from one state to another. The scheme includes controls of mental set, concepts of self and others, and information flow. Table 1, dealing with control of self-concept is reproduced here to illustrate the method.

As an illustration of the advantage of using a process approach to evaluate coping, consider denial, which is a relatively primitive or immature way of coping in a hierarchical defensive system; yet, research clearly shows that denial can be adaptive in some circumstances, and use of denial may actually improve prognosis (Levenson et al., 1994; Ness & Ende, 1994). Note that Vaillant continues to generate data supporting the use of a hierarchical system (Soldz & Vaillant, 1998). The terminology used to describe hierarchical defenses is widely known and will be briefly reviewed.

In Freudian theory, defense mechanisms are considered unconscious processes, that is, they are not employed deliberately, and the person who uses them is unaware of doing so. Common defense mechanisms include

- Regression, or a return to behavior appropriate to an earlier stage of development.
- Reaction formation, or behaving in a way that reflects the opposite of one’s true feelings.