NEUROTIC DISORDERS
(NEUROSES)
=
ANXIETY DISORDERS
ANXIETY

a diffuse, unpleasant, vague sense of apprehension, often accompanied by autonomic symptoms, such as headache, perspiration, palpitations, tightness in the chest, mild stomach discomfort, and restlessness (inability to sit or stand still for long)
ANXIETY

normal anxiety

an advantageous response to a threatening situation

“fight or fly” response

pathological anxiety

an inappropriate response to a given stimulus
The role of Amygdala

Cortical pathway “high road”

Subcortical pathway “low road”

Amygdala reactivity

Hemodynamic responses from amygdala: faces

Figure 7-23

LOCUS COERULEUS

ANXIETY

DILATED PUPILS

TACHYCARDIA

TREMOR

SWEATING
Somatic disorders with anxiety

- Hypoglikemia
- Kaffeine overdose
- Tyreotoxicosis
- Cardiological disorders: arrythmias, valve prolapse
- Abstinence syndrome
- Suprarenal neo
anxiety is an alerting signal, it warns of impending danger and enables a person to take measures to deal with a threat. It is a response to a threat that is unknown, internal, vague, or conflictual.

fear is a similar alerting signal but it is a response to a known, external, definite, or nonconflictual threat.
PATHOLOGY

**psychoanalytic theories**
anxiety as a signal of the presence of danger in the unconscious

**behavioral theories**
anxiety as a conditioned response to specific environmental stimuli

**existential theories**
anxiety as the response to existential concerns (awareness of feelings of profound nothingness in life)
biological theories of anxiety:

**autonomic nervous system**
stimulation of the autonomic nervous system causes symptoms (cardiovascular, muscular, gastrointestinal, and respiratory) – peripheral manifestations of anxiety

**neurotransmitters**
norepinephrine, serotonin, and g-aminobutyric acid (GABA) – the three major neurotransmitters associated with anxiety

**brain-imaging studies**
some patients with anxiety disorders have a demonstrable functional cerebral pathological condition

**genetic studies**
at least some genetic component contributes to the development of anxiety disorders (e.g. a polymorphic variant of the gene for the serotonin transporter)
NEUROSI S the term “neurosis” – W. Cullen, 1776
– functional (no organic basis) disorder
of gnostic, emotional, somatic and
behavioral reactions
of psychogenic origin
CONFLICT SITUATION
  high expectations
  life problems
CHRONIC STRESS
  internal conflicts

ANXIETY – the cue symptom of all neuroses

PERSONALITY
  egocentric, with high self needs and expectation, anxious, easy-frustrated,
  rigid in opinions, with low self-esteem and interpersonal difficulties

“NEUROTIC”

COPING
  isolation, rationalisation,
  intelectualisation, dissociation,
  regression, fixation,
  conversion and somatisation,
  “day-dreaming”, hipercompensation

MECHANISMS
(by prof. J. Aleksandrowicz)

NEUROSIS
ANXIETY

SYMPTOMS

OF NEUROTIC DISORDERS

SOMATIC DYSFUNCTIONS

BEHAVIORAL DISTURBANCES

COGNITIVE AND EMOTIONAL DISTURBANCES

SYNDROMES

OF NEUROTIC DISORDERS
CLINICAL DIVISION OF NEUROSES
(based on clinical presentation of neurotic symptoms)

ANXIETY NEUROSIS

PHOBIC NEUROSIS

OBSESSIVE – COMPULSIVE NEUROSIS

DEPRESSIVE NEUROSIS

HISTERICAL NEUROSIS

HIPOCHONDRIACAL NEUROSIS

NEURASTHENIC NEUROSIS
Classic Neuroses – DSM-IV

Anxiety
- Generalized anxiety disorder

Phobic
- Agoraphobia,
- specific and social phobias

Obsessive-compulsive
- Obsessive-compulsive disorder

Depressive
- Dysthymic disorder

Hysterical (conversion)
- Conversion disorder

Hysterical (dissociative)
- Depersonalization disorder

Hypochondriacal
- Hypochondriasis

Neurasthenic
- Neurasthenia
PANIC DISORDER
AND AGORAPHOBIA

panic attack (as defined in DSM-IV)

"discrete period of intense fear or discomfort,"
accompanied by at least four somatic or cognitive symptoms such as palpitations, trembling, shortness of breath, sweating, and feelings of choking

symptoms develop abruptly and reach a peak within 10 min.
PANIC DISORDER AND AGORAPHOBIA

PANIC DISORDER
the spontaneous, unexpected occurrence of panic attacks, from several attacks a day to only a few attacks per year; panic disorder is often accompanied by agoraphobia

American Civil War – Jacob Mendes DaCosta – DaCosta Syndrome 1985 – Sigmund Freud introduced the concept of anxiety neurosis DSM codified in 1980

AGORAPHOBIA
the fear of being alone in public places (eg. supermarkets), particularly places from which a rapid exit would be difficult in the course of a panic attack from Greek words “agora” - marketplace and “phobia” - fear
PANIC DISORDER AND AGORAPHOBI

EPIDEMIOLOGY

The lifetime prevalence rates – 1.5 – 5% for panic disorder, 3 – 5.6% for panic attacks and 0.6 – 6% for agoraphobia.

Women are 2-3 times more likely to be affected than men.

Usually onset during late adolescence or early adulthood.

Panic disorder, in general, is a chronic disorder.

91% of patients with panic disorder have at least one other psychiatric disorder.
PANIC DISORDER AND AGORAPHOBIA

DIFFERENTIAL DIAGNOSIS

TREATMENT

pharmacotherapy

SSRIs (and benzodiazepines)
alprazolam and paroxetine

Psychotherapy:

- cognitive – behavioural
- insight oriented

drugs approved by the FDA
for the treatment of panic disorder
GENERALIZED ANXIETY DISORDER

an excessive anxiety and worry about several events or activities for a majority of days during at least 6 months

the worry is difficult to control and is associated with somatic symptoms such as muscle tension, irritability, difficulty sleeping, and restlessness

the anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
GENERALIZED ANXIETY DISORDER

anxiety – excessive and interfering with other aspects of life

motor tension – most commonly manifested as shakiness, restlessness, and headaches

autonomic hyperactivity – commonly manifested by shortness of breath, excessive sweating, palpitations, and various gastrointestinal symptoms

cognitive vigilance – evidenced by irritability and the ease with which patients are startled
GENERALIZED ANXIETY DISORDER

EPIDEMIOLOGY

GAD is a common disorder – there is a lifetime prevalence of 45%.

The ratio of women to men with the disorder is about 2 to 1.

The age of onset is difficult to specify (“as long as they can remember”).

50-90% of GAD patients have another mental disorder – social or specific phobia, panic disorder, depressive disorder.
GENERALIZED ANXIETY DISORDER

DIFFERENTIAL DIAGNOSIS

TREATMENT

pharmacotherapy

buspirone (5-HT1A receptor agonist), the benzodiazepines and the SSRIs
the TCAs, anti-histamines, and the b-adrenergic antagonists

psychotherapy

cognitive-behavioral
supportive
insight-oriented
phobia (as defined in DSM-IV)

an irrational fear that produces a conscious avoidance of the feared subject, activity, or situation; the presence or the anticipation of the phobic entity elicits severe (and disruptive) distress
SPECIFIC PHOBIA

a strong, persisting fear of an object or situation;
people with specific phobias may anticipate harm,
or may panic at the thought of losing control

animal, natural environment, blood-injection-injury,
situational type of specific phobia

SOCIAL PHOBIA (social anxiety disorder)

a strong, persisting fear of various social situations
in which humiliation or embarrassment can occur
generalized social phobia – phobic avoidance of most social situations (a chronic and disabling condition)
SPECIFIC PHOBLIA
AND SOCIAL PHOBLIA

EPIDEMIOLOGY

the lifetime prevalence rates is about 11 % for specific phobia, and 3 – 13 % for social phobia

specific phobia is more common than social phobia

specific phobia is the most common mental disorder among women and the second most common among men, second only to substance-related disorders

the female-to-male ratio is about 2 to 1

usually onset during adolescence or mid-20s

one third of all phobic patients have depressive disorder
SPECIFIC PHOBIA AND SOCIAL PHOBIA

DIFFERENTIAL DIAGNOSIS

TREATMENT

pharmacotherapy
b-adrenergic receptor antagonists

psychotherapy
exposure therapy
insight-oriented psychotherapy
hypnosis
self-hypnosis
supportive psychotherapy
family therapy
Posttraumatic stress disorder

1. Stressor factor (last 6 months)
2. Ruminations, obsessive thoughts according to stressor factor.
3. Symptoms: sleep disturbances, irritation, attention deficits, memory impairment, narrowing of interests, pessimism.
Subtypes of PTSD

- 1 month – acutestres disorder ASD
- 3 months – acute PTSD
- After 6 months – PTSD of late onset
- Years – chronic PTSD
Depressive and anxiety components

Emotions: Anxiety, depression

General Anxiety Disorder (Benzodiazepine+, SSRI, SNRI)

Big Depression (TCA, SSRI, SNRI)
1. Benzodiazepines
   - short acting (lorazepam)
   - long acting (klonazepam, bromazepam, cloranxen)
2. TCI (clomipramine)
3. SSRI, SNRI, (fluoxetyna, fluwoksamina), (wenlafaksysna)
4. Inhibitors MAO typu A IMAOA (moklobemid)
5. Buspiron
6. Neuroleptics
Common symptoms: anxiety, depression

**Anxiety**
- Anciatory anxiety
- Tension
- Muscle tension
- Irritability
- Muscleaches

**Depression**
- Fatigueness
- Dysphoria
- Irritability
- Sleep disturbances
- Loss of appetite
- Loss of interests
- Apathy
- Psychomotor retardation
- Isolation
- Feeling hopeless
- Daily mood changes
- Mood changes

Nutt i wsp., 1998 (zmodyfikowane)