



A Summary on Anxiety and Phobic Neuroses

Although anxiety and the phobic neuroses are classified as separate entities, most patients with phobic anxiety also suffer from an elevation of their general (free floating) level of anxiety, and nearly all patients with generalized anxiety may experience an aggravation of their anxiety, often to panic intensity.

ANXIETY NEUROSIS.

Mild anxiety is an everyday experience which may be of use to the individual; if severe it is destructive. It is willingly sought by those who engage in dangerous sport and by those who watch them; the neurotic patient attempts to avoid it at the cost of severe handicap of his life style. The applications of this ambiguous word include:

- 1) An emotional state with subjectively experienced fear.
- 2) An unpleasant emotion which may be accompanied by a feeling of impending death.
- 3) Anxiety is directed to the future, implying that there is a threat.
- 4) There may be no recognizable threat, or one which, by reasonable standards is out of proportion to the emotion it provokes.
- 5) There may be subjective bodily discomfort and manifest bodily disturbance.

Anxiety must be considered under the two concepts of trait anxiety (an enduring aspect of the personality structure) and state anxiety (a temporal disorder). This must be considered because the management of the two forms is different, although they often occur together. Trait anxiety may be partly genetically determined and partly the outcome of early experience of the individual. State anxiety may result from stress or conflict (acute or prolonged) or it may arise in the absence of any sufficient stress -- an endogenous affective disorder. It may also be due to some processes such as premenstrual tension, disease of the limbic structures, thyrotoxicosis or tumours leading to overproduction of adrenaline. It may also result from ingesting excessive caffeine or other drugs like amphetamine. Anxiety may be experienced entirely as psychic discomfort characterized by apprehension, diffuse sweating, fear and panic. It may also be somatized: muscular pains, tension headaches, tremor, palpitations, diarrhoea, respiratory distress, feelings of dizziness, swaying and 'walking on cotton wool'. In mild degrees, anxiety may be no more than a slight awareness of discomfort. However, in clinical practice, it may present in an infinite number of variations.

Anxiety, Depression and Affective Disorders.

The feasibility of a true distinction between

anxiety states and depressive illness has been considered in three broad areas: clinical features during the key illness, outcome studies and treatment studies.

Clinical Features

Various independent researches have led to the coinage of the word 'anxiety depression'. Although depreciated by some researchers, there does seem to be a considerable admixture of anxiety and depressive symptoms in most patients examined. One such important investigation used a self-report questionnaire divided up into five main areas of symptomatology: somatic symptoms, obsessions, interpersonal relationships, anxiety and depression. Apart from the somatic scale, it was found that the depressed patients recorded themselves as being severely disturbed on all the scales, including the anxiety scale.

Outcome Studies

An investigation of the outcome of 111 patients presenting with affective illness dominated by anxiety symptoms over a period of up to 2 years was carried out. All patients had received the same treatment; one large group in this sample had suffered from a sudden onset of anxiety without major precipitant stress and the prognosis for this group was much better than for the rest: this form of anxiety state was regarded as being basically depressive in nature. In another study of 112 patients diagnosed as anxiety neuroses, it was found that 44% subsequently suffered from depressive episodes.

Treatment Studies

There is yet the possibility that treatment response will serve to redefine clinical categories, at least in the area of affective disorder, but at present, the observation that some types of anxiety state respond well to several antidepressants, still causes confusion. In a study noting the response of phobic anxiety patients to phenelzine (on M.A.O.I. antidepressant), the following possibilities were considered:

- a) that phenelzine is an antidepressant and phenelzine-responsive patients suffer from a depressive illness.
- b) that phenelzine is an anxiolytic and responsive patients are primarily anxious.
- c) that both depression and anxiety patients may be manifestations of the same core affective illness and that phenelzine is an anti-affective drug.

In other studies, further possibilities were considered:

- 1) Anxiety and depressive states have different

biological substrates, but that much of the symptomatology of the conditions is similar.

- 2) The two conditions represent the same reaction to stress but the characteristic symptomatology reflects the personality structure of the individual.
- 3) Chronically anxious patients become depressed and chronically depressed patients develop anxiety.

PHOBIC NEUROSES

Background to present concepts.

The term phobia is derived from the Greek word *phobos* meaning fear. Since antiquity, there have been descriptions of individuals who suffered from a morbid degree of fear of circumstances which would not be expected to call forth such perturbation. When it came to Freud, he divided the group of phobias in 2 classes, common (Exaggerated fears of things which are to some extent, feared by everyone, such as snakes and death) and contingent (fears of special conditions which inspire no fear in the normal man).

Concept of phobias as learned symptoms.

Many experiments have shown that fear responses can be produced by conditioning techniques. Miller (1948) showed that fear itself could act as a drive for further learning, and he demonstrated that escape from fear (drive reduction) served to reinforce learning. Symptomatic behaviour, especially phobias came to be viewed as a learned response to aversive stimuli. In 1958, Wolpe introduced the concept that, if a response incompatible with anxiety was introduced whilst the patient was exposed to the source of his anxiety, then on repeated performance, the fear would be gradually extinguished. On this principle he developed the therapeutic procedure known as 'systematic desensitization'. Neurosis was defined as 'any persistent habit of unadaptive behaviour acquired by learning in a physiologically normal organism'.

Definition, epidemiology and classification of phobias.

Marked fears of certain objects and situations are widespread in the population and there is no clear dividing line between a strong fear of a situation and a phobia. Therefore, a phobia can be defined on the following criteria:

- 1) Fear is out of proportion to the demands of the situation.
- 2) It cannot be explained or reasoned away.
- 3) It is beyond voluntary control.
- 4) The fear leads to an avoidance of the feared situation; or else if unavoidable, leads to extreme discomfort on the part of the individual.

A most informative survey on the prevalence of phobias showed it to be 76.9/1000, and of these 2.2/1000 were considered to be severely disabling. The most common phobias were of illness or injury, followed by storms, various animals and agoraphobia; most of the phobias were commoner in women than in men. A five-year follow-up of this survey showed that in children and adolescents, phobias improved

without specific treatment, whereas more long-standing phobias in adults naturally have a poorer prognosis.

The Phobic neuroses were classified as follows by Marks (1969):

- 1) Phobias of external stimuli.
 - a) Agoraphobia
 - b) Social Phobia
 - c) Animal phobias
 - d) Miscellaneous.
2. Phobias of internal stimuli
 - a) Illness phobias
 - b) Obsessive phobias.

Some difficulties with such a scheme are now to be considered.

Agoraphobia

Means a fear of gatherings of people in the open; however, the term is usually applied when the patient has at least one or more fears: leaving home, wide open spaces, being alone, travelling, narrow confined spaces etc. In addition to the central fears, it is assumed that the patient shows a high level of general anxiety, and may experience panic attacks, somatic symptoms of anxiety and somatic depersonalization. In addition there may be a diffuse collection of other phobias. It is therefore clear that patients may be classified under the label of agoraphobia who in fact suffer from a range of disorders.

Social phobia

Any large group of patients with phobias concerned with interpersonal situations, will be found to suffer from a degree of generalized anxiety intermediate to the groups classed as agoraphobia and those with specific phobias. Many patients with social phobias experience a marked degree of somatized anxiety in their feared situation (either developing the phobia in the setting of a traumatic situation, or else the phobia may originate in a state of depression or anxiety which may have resolved) such as blushing or hand tremors. Social phobia is therefore not a homogeneous clinical entity, but represents the prominent symptomatic manifestations of a wide variety of psychological disorders and psychiatric illnesses.

Specific phobias.

These are seldom so specific as the appellation may signify: there is often a generalization of fear to similar objects, so that the patient with a phobia of cats also dislikes the touch of all furry objects. Mood disturbance is clearly evident in many patients, who thus suffer from generalized states of anxiety or depression.

School phobia.

School phobia is not a homogeneous disorder, since children with this symptom show a varied clinical picture of diverse aetiology. Onset may be sudden or gradual and may or may not coincide with a particular upset at home or at school. There will normally be a marked somatization of anxiety, often abdominal pains and sickness or diarrhoea occurring before the hours of school attendance. When at

home, the child does not appear to be severely anxious. In many cases, a variety of personality disorders, relationship problems, neurosis in the parents and specific problems at school are found in varying proportions.

Aetiology of phobic neuroses.

Many factors contribute, among these being the constitutional liability of the individual to develop fear reactions, the personality structure, the selection and successful employment of coping mechanisms in the early stages of neuroses, the attitudes of family, friends and professional advisors, the potential threat, the presence of a mood disorder, and finally the presence and degree of secondary gain from the neurosis.

Personality structure

Some degree of abnormality of a specific personality trait underlies the liability to develop a phobic neurosis, though this is not universally present. With certainty, it can be said that patients suffering from phobic neurosis show some degree of dependency on others, and the more generalized the neurotic disturbance, the more likely is dependency to be pronounced. Many adults showing phobic symptoms in the setting of a general mood disturbance, are likely to have suffered from phobic problems in childhood, and it is probable that the majority of patients who develop social phobias, do so in the setting of some degree of personal sensitivity to the opinions of others.

Attitudes of the individual and the reactions of others.

The outcome of a fear and whether it hardens into a phobic neurosis will depend to a large extent on the attitudes of the individual and the reactions of others to his fear.

Mood disorder and affective illness.

A temporary disturbance of moods may provide the fertile soil in which the seed of a phobic neurosis may first germinate: the phobia may then subside as the mood returns to normal, or it may persist as a permanent aftermath of the mood disorder. Many phobic neuroses commence during times of unhappiness, insecurity or conflict which causes a reactive anxiety or depressive state, and in this setting, a trivial incident may be sufficient to cause a prolonged phobia. If a severe attack of panic occurs in some non-threatening situation, the patient comes to associate that situation with his panic and his apprehension leads to further panic and eventually to phobic avoidance.

Treatment of anxiety and phobias.

The treatment of anxiety based neuroses must rest upon a careful formulation of the condition of the patient. The correct therapy is selected after a careful assessment of the following factors:

- 1) The degree to which the manifest anxiety is a reflection of the basic trait anxiety of the individual.
- 2) The presence or absence of stress which is related to the occurrence of the anxiety. An attempt should be made to assess how the patient has coped with similar stress at earlier

periods in his life.

3) The present and past life-styles of the patient, the range of his activities and the quality of the relationships with others.

4) The duration of the neurosis and the past history of fluctuation in severity and recurrence of symptoms.

5) The presence of any particular strategies which the patient uses to cope with his symptoms.

6) The attitudes of others towards the patient's neurosis.

7) Apparent secondary gain from the neurosis.

8) The presence or absence of other psychopathological features like depressive symptoms.

9) Response to treatments that have been used for similar neurotic symptoms in the past.

After a formulation of the patient's case, the therapeutic approach must be considered, but sometimes a delay is advisable: it may be necessary to see a relative, special investigations may be required, and moreover, the process of a psychiatric examination may in itself have therapeutic effect.

Psychotherapy.

This should be carried out at weekly sessions each lasting about thirty minutes: time should be spent in considering what elicits anxiety, coping strategies which might be adapted.

Behavioural psychotherapy.

This involves behavioural techniques in a clinical setting. In the treatment of phobic neuroses, systematic desensitization is found to be effective in specific phobias only. The other major behavioural technique for the treatment of phobias has received the name 'flooding' and starts by encouraging the patient to experience anxiety and to confront his neurotic fears more abruptly (exactly the opposite of systematic desensitization).

Pharmacotherapy.

This can often be dramatically successful. In acute generalized anxiety, sedative drugs may be justified for a strictly limited period of time; they may also be effective in helping a patient to overcome a phobic state as long as he clearly understands that the drug is prescribed to help him face up to his anxiety, and should only be taken when he attempts to enter the feared situation. Sedative drugs are ineffective if there is an underlying affective disorder — this requires the prescription of an antidepressant drug. Drugs which are also established as having a role in the management of some anxiety-based neuroses are the β -adrenergic blockers.

Psychosurgery

Patients should only be considered for surgery if they have suffered from chronic anxiety states for many years and who have remained unresponsive to any therapeutic procedure.

Reference:

Snaith Philip: *Clinical Neurosis* (OXF. O.U.P. 1981)