Neuros: Notes by Jason Hancock

Neuroses

One method of classifying Psychiatric disorders is to group them into two main categories: Neurosis and Psychosis.

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<th>Definition</th>
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<td>Neurosis</td>
<td>Abnormal psychiatric features without an organic psychiatric disorder. Neuroses are usually precipitated by stress.</td>
<td>Anxiety disorders; Generalised anxiety disorders, panic disorders, PTSD, Phobic disorders, OCD, Depersonalisation, Derealization</td>
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<td>Psychosis</td>
<td>Loss of contact with reality. Key features include delusions, hallucinations and thought disorders.</td>
<td>Schizophrenic disorders, affective disorders (mania, depression), organic causes (e.g. drug abuse)</td>
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Note that depression can span the Neurosis/Psychosis divide.

Neurosis

A patient suffering from neurosis will usually be exhibiting at least one of the following symptoms: anxiety, fatigue, insomnia, irritability, worry, compulsions, and somatisation. These symptoms are judged to be out of proportion with the stress that has precipitated them and are not a part of a patient’s normal personality (although they may be an exaggeration of one aspect of their personality).

As many of these symptoms can co-exist within one patient the type of neurosis will usually be defined by the main symptom that the patient is experiencing.

Before diagnosing any patient as suffering from a neurotic disorder ask yourself ‘is there any chance this patient is suffering from depression which may benefit from treatment?’

Types of Neurosis

Anxiety disorders

Generalised anxiety disorder

Categorised by excessive anxiety and worry which is present more days than it is absent for at least six months. It occurs following a number of events and activities such as work or school performance.

It is often associated with symptoms such as tension, feelings of impending doom, restlessness, insomnia, fatigue, difficulty concentrating, irritability and a variety of physical symptoms such as headaches, sweating and palpitations.

To be classed as having a disorder the patient must be experiencing severe distress or have problems with important areas of functioning (e.g. work).

In most patients it begins in adolescence and will eventually cause the patient to present in their late twenties. Often patients report having felt anxious their whole lives.

Treatment (Remember BIO/PSYCHO/SOCIAL)
Aim: Help patients to deal with uncertainty or to identify and manage worry.
BIO – In short term intense anxiety states beta-blockers and hydroxyzine may be tried. Treat any underlying depression.
**Specific phobias**

Affected individuals experience a persistent fear of a specific object or situation that is considered to be excessive and unreasonable. Exposure to the object will produce increased anxiety or panic attacks and as such individuals will try to avoid high risk situations.

Most common types; animals, natural environment, blood, injection or situational e.g. social or transport related.

8% of population may have a specific phobia however it only becomes a problem if it interferes with an individual’s life. Around 1% of the population seek treatment for a specific phobia. Phobias usually begin in childhood and disappear or diminish with time.

Treatment usually involves behavioural techniques such as systematic desensitization or exposure techniques. Cognitive therapy can lessen panic attacks.

**Social phobias**

Affected individuals have a constant fear of social situations for fear of embarrassment. Symptoms of anxiety may be experienced when an individual is exposed to social situations, these can include physical symptoms such as blushing and diarrhoea.

Lifetime prevalence of social phobias may be between 3-13%. Males and females are equally affected and 2% of population may be suffering from this disorder at any one time.

Treatment involves in vivo exposure and social skills training. Cognitive techniques can be used to combat low self esteem.

**Panic disorders**

An individual with a panic disorder will suffer from recurrent and unexpected panic attacks. A panic attack is an episode of intense fear or anxiety that consists of the following symptoms:

- Palpitations
- Sweating, trembling, shaking
- Sensations of shortness of breath leading to hyperventilation and sensations of choking, chest pain, nausea, dizziness and paraesthesiae
- Derealization – a feeling as if everyone around you is unreal
- Depersonalization – a feeling of being detached from oneself
- Fear of losing control or dying

Individuals may misinterpret these attacks as being caused by a physical illness such as heart disease. Some individuals change their behaviour in response to these attacks and in severe cases can develop agoraphobia (a fear of being in situations from which escape may be difficult).
People with panic disorders often experience constant or intermittent levels of anxiety between attacks and 50% of those with a panic disorder may also be suffering from depression.

Lifetime prevalence is between 1.5-3.5%, and it is three times more common in women. 20% of the population will experience a panic attack at some point in their lives.

Treatment
BIO – Antidepressants often helpful, depression will co-exist in 50% of cases.
PSYCHO – Relaxation training, cognitive techniques and behavioural exposure training may be helpful.
SOCIAL – anything that improves a patient’s relationships with others will help.

**Obsessive – compulsive disorder**

Obsessions- Stereotypical and purposeless words, phrases and thoughts that an individual finds difficult to control or put out of his/her mind.
Compulsions- Senseless and repeated rituals.

These thoughts are usually unpleasant and concern dirt, harm to self or others, sex and blasphemy. An individual understands that these thoughts are non-sensical (unlike delusions) and despite such thoughts being out of character for that individual they realise that these thoughts are their own (unlike hallucinations/ thought insertion).

An individual will usually initially try to resist such thoughts, however, over time they will either stop resisting or modify their behaviour to try and decrease the anxiety and distress that these thoughts cause. A classic example of this is an individual who has obsessive thoughts about being dirty. To try and reduce the anxiety that these thoughts produce they may develop repeated hand washing rituals. These behaviours (compulsions) may temporarily reduce an individual’s anxiety but it will return. In addition, an individual may develop associated avoidance behaviours, for example avoiding other people’s houses because of the dirt that may be present there.

The lifetime prevalence of OCD is 2.5%. It usually begins in adolescence or early adulthood and gradually increases in severity.

Treatment
Aim: to modify underlying thoughts and the way in which the patients respond to these thoughts.
BIO – SSRI’s (fluoxetine) may help, trial of clomipramine may be considered if SSRI’s fail.
PSYCHO – Cognitive behavioural approach, if prominent rituals and compulsions are present then graded exposure and response prevention may be used.
SOCIAL – encourage good patient relationships with others.

**Post traumatic stress disorder (PTSD)**

PTSD involves the development of a characteristic set of psychological symptoms that occur following exposure to a serious traumatic event that involved actual or threatened injury or death to the self, or others. Initially, the individual will re-experience the event in the form of recurrent or intrusive thoughts, images, dreams or perceptions. Following this they will actively avoid
stimuli that will remind them of the event, and may at this stage feel a sense of detachment from others. Finally, they may experience symptoms of increased arousal such as irritability, poor concentration, sleep disturbance and hyper vigilance.

Symptoms will usually develop 3-6 months after the trauma and the life time prevalence of PTSD is around 1%. 30-40% of women report PTSD following sexual assault.

Although counselling can be offered immediately after a distressing event it can disrupt an individual’s normal method of coping. Most people experiencing trauma do not develop PTSD and therefore treatment should only be offered to those who develop the syndrome.

Treatment – Cognitive behavioural treatments include anxiety management and exposure therapies. Antidepressants may also have beneficial effects.

Further reading
