Practical Psychiatry in Medicine

Part 12. Neuroses and Personality Disorders

While it is true that the management of persons with severe neuroses often requires intensive treatment that is beyond the available time, interest, and training of the nonpsychiatrist physician, it is also true that persons with these disorders often first turn to their family physician for help.

It is far less common for the individual with a personality disorder uncomplicated by any other difficulty to consult the family physician. It is not rare, however, for maladaptive patterns of behavior which characterize personality disorders to become manifest in those situations in which the patient with personality disorder seeks attention for incidental medical illness.

Definitions

Neuroses

Neuroses are a group of syndromes characterized by some degree of anxiety, often accompanied by other symptoms such as phobias, obsessions, compulsions, conversion reactions, and hypochondriacal complaints.[2,7,8] The latter symptoms arise, at least in part, as a result of conscious and unconscious adaptive processes by which the individual attempts to avoid or reduce anxiety. Anxiety itself, in its acute form, is one of the most painful mental states to which the human being is subject. In this connection it is of interest that anxiety shares etymologic roots with anguish (Latin angere, to strangle).

The several neurotic syndromes are named in accordance with the particular symptoms that dominate the clinical picture. Thus, if the condition is characterized principally by various manifestations of acute or chronic anxiety, it is considered anxiety neurosis. If obsessions and compulsions predominate, the condition is obsessive-compulsive neurosis, and so forth.

It is not rare for neurotic patients to engage in obviously irrational behavior. When this is the case, the neurotic person, unlike a psychotic individual, is apt to recognize the irrationality of his behavior. For example, the phobic patient may avoid elevators, not because he has a delusion about them, but in order to avoid anxiety; as a rule, he himself is mystified by his particular phobia.

In this chapter we will discuss anxiety neurosis at some length, since it is a condition which commonly requires careful diagnostic evaluation and initial management by the general physician. Phobic states and obsessive-compulsive neurosis are discussed more briefly.

Personality Disorders

Personality disorders are characterized by constellations of character traits, attitudes, and patterns of behavior which are deeply ingrained, usually having been present since adolescence or earlier, and which interfere, to some degree, with the individual's adaptation to life.[2,3,8] Individuals with personality disorders may have no symptoms, or only minimal ones of neurosis or other psychiatric illness. On the other hand, the person with symptoms of a neurosis often presents evidence of preexisting personality disorder.

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The following chapter has been selected by the Publisher from its forthcoming book, *Practical Psychiatry in Medicine,* by John B. Imboden, MD and John Chapman Urbaitis, MD, in the hope that it will have immediate usefulness to our readers.

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The salient features of various personality disorders will be briefly described. Most family physicians will not be involved in the psychotherapeutic modification of attitudes and behavior patterns of their patients with these disorders. A sensitive awareness of the patient's attitudes and behavioral patterns, however, may be useful to the physician in the management of medical illnesses in persons with personality disorders.

Anxiety Neurosis

Anxiety neurosis, in common with the other neuroses, usually has its onset in young adulthood. This condition is characterized by one or both of the following: acute attacks of anxiety, or chronic tension state or chronic anxiety.

Acute Anxiety

In an acute attack of anxiety the patient experiences a sudden onset of symptoms, predominant among which is an emotion similar or identical to that of fear. In a severe attack the anxiety may be of such intensity that the patient describes himself as terrified or panicked. In a typical attack there are signs and symptoms of sympathetic discharge: tachycardia, palpitations, sweating, dry mouth, pupillary dilation, and blurring of vision. Transient pain over the precordium or in the upper left quadrant of the chest, not related to exertion, may occur. The patient may show a fine tremor of the hands and usually is restless. He may complain of not being able to get a deep or satisfying breath or of having a suffocating feeling while objectively exhibiting tachypnea. Hyperventilation, in turn, may lead to respiratory alkalosis resulting in paresthesia of the extremities and circumoral region, dizziness, lightheadedness, fullness in the head, or a feeling of weakness or faintness. Frank tetany with carpopedal spasm is unusual.[4]

More often than not, the patient is not consciously aware of any precipitating factor, but once the attack has begun he is apt to focus his apprehension upon something specific. This commonly takes the form of fear that the cardiac palpitations signal an impending heart attack and death. The patient may fear that he is going crazy, that he will suffocate, or that something terrible which he cannot specify is about to happen to him.

The attacks may last from a few minutes to several hours. The patient may have a single attack only, an occasional sporadic attack, or a cluster of attacks over a period of several weeks or months.

Chronic Anxiety

Chronic anxiety has also been referred to as Da Costa's syndrome, irritable heart, and neurocirculatory asthenia.

The patient with this disorder is chronically tense, worried, vaguely apprehensive, and sometimes irritable. The content of the apprehension may involve a variety of issues such as his own health, family, or work. The patient typically has a variety of somatic complaints, some of which appear to be secondary to sustained tension of skeletal muscles such as headaches in the occipital or bitemporal regions, backache, or aching in the posterior part of the neck. The palms may be cool and moist. The patient may show a fine tremor of the hands and mild restlessness. He may complain of uncomfortable epigastric sensations such as "butterflies in the stomach" and may occasionally have an episode of diarrhea. Difficulty in getting to sleep is quite common and he may awaken in the morning feeling tired. Chronic fatigue may be present through most of the day and its severity bears no clear relationship to exercise. The feeling of tiredness may be temporarily allayed when the patient becomes absorbed in some activity.

As noted above, the chronically anxious patient may also have an occasional attack of acute anxiety. Symptoms of chronic anxiety, once established, tend to fluctuate in severity from time to time.

Diagnosis

In most instances, the diagnosis of anxiety neurosis, acute or chronic, is readily made on the basis of the characteristic features described above. It is possible, however, for anxiety neurosis to be mimicked by medical disorders.

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Indeed, the patient may make it clear that he himself needs to be convinced that he does not have an organic medical disease.

Hyperthyroidism may closely simulate the anxiety state and indeed may be accompanied by considerable tension and apprehension. The tachycardia of anxiety neurosis is apt to wax and wane with the occurrence and remission of spells of anxiety, as contrasted with the more constantly present tachycardia of hyperthyroidism. However, the clinical features of these two disorders can be sufficiently similar that the physician may want to rule out hyperthyroidism with appropriate laboratory tests.

Caffeinism is by no means rare and is characterized by fine tremor of the hands, irritability, tenseness, restlessness, and difficulty in getting to sleep. The diagnosis is supported by a history of drinking coffee or tea in excessive quantity and by remission of symptoms following abstinence or moderation of drinking caffeine-containing beverages.[5] A somewhat similar picture may be seen with the chronic use of other stimulants such as dextroamphetamine and methylphenidate (Ritalin). It should be kept in mind that patients with anxiety, especially chronic anxiety, may be somewhat prone to drink coffee or tea excessively or to take drugs of both the stimulant and sedative type.

Recurrent, acute attacks of anxiety must be differentiated from other disorders which are characterized by recurrent, acute episodes. Acute episodes of hypertension and tachycardia associated with pheochromocytoma must be considered. Hypoglycemic episodes from whatever cause may mimic acute spells of anxiety. Rather uncommonly, epilepsy may produce recurrent episodes of fear and symptoms associated with sympathetic discharge.

As mentioned above, acute anxiety may be sufficiently severe that the patient can be described as being in a state of panic. In addition to anxiety neurosis, panic states are also observed in association with the ingestion of hallucinogenic substances, such as LSD or mescaline. Panic states may also be observed in dextroamphetamine intoxication and in schizophrenic disorders.

In the early stages of withdrawal from CNS-depressant drugs such as the barbiturates, minor tranquilizers, and alcohol, the addicted person may display symptoms virtually indistinguishable from those of the anxiety state. The recent drug and alcohol ingestion history is thus of crucial importance in ruling out states of both intoxication and abstinence syndromes which may mimic anxiety.

Management

The management of patients with anxiety neurosis depends in part on the symptomatic state of the patient at the time he is seen by the physician.

In the management of an acute attack of anxiety, the physician keeps in mind that the patient probably has one or more specific fears, such as fear that he will die of a heart attack, will suffocate, or is losing his mind. The first task, therefore is to give the patient effective reassurance that will help him to realize that his fears are baseless. Effective reassurance is communicated to the acutely anxious patient in several ways:

1. Through the display of genuine interest in the patient's description of his anxiety experience.
2. By calmly proceeding to take the history, focusing on particularly relevant items such as a history of similar attacks in the past, and so forth.
3. By doing a physical examination in a calm, unhurried manner.
4. By offering the patient one's diagnostic impression that he is having acute anxiety; this diagnostic impression may or may not be qualified by telling the patient that one wishes to do certain further tests or examinations to be certain of the diagnosis.
5. By offering the patient a clear, simple explanation of what an acute attack of anxiety is, including the symptoms associated with the release of epinephrine that occurs with sympatheticoadrenal discharge.

The basic idea of all this is to establish a relationship of confidence and trust, and within the context of such a relationship to offer the patient an explanation, in terms he can understand, of his present condition, ie, to give the patient an opportunity to attain a measure of cognitive mastery of the anxiety experience. The patient needs to be reassured that while anxiety attacks are indeed frightening they do not cause heart attacks,

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Table 1. Personality Disorders

Personality Disorder Type	Salient Features
1. Antisocial personality	Has history of poor adjustment in school: academic failure, truancy, frequent arguments and fights; poor job performance: undependable, quitting without notice, getting fired; frequent conflicts with the law: larceny, robbery, rape, etc; social behavior dominated by hedonism, poor impulse control, lying, charming or "conning" people, defective sense of guilt, shallow relationships, and failure to learn from experience
2. Asthenic personality	Tires easily, is low in energy and enthusiasm, overly sensitive to physical or emotional stress
3. Cyclothymic personality	Has mood swings of depression, elation, or both, which are of moderate degree and short duration, usually occurring without apparent precipitating factors
4. Explosive personality	Tends to react with intense emotion, such as rage, to relatively minor provocation; temper outbursts are often followed by remorse
5. Hysterical (histrionic) personality	Tends to be excitable, histrionic, self-centered, attention-seeking, and seductive
6. Inadequate personality	Tends to be inept and ineffective, has poor judgment, frequently fails socially and at work, in spite of average educational opportunity and intelligence as measured by psychologic tests
7. Obsessive-compulsive personality	Tends to be unusually conscientious, dutiful, perfectionistic, inhibited; is often ambivalent and tends to doubt his own opinions and decisions
8. Paranoid personality	Shows behavior characterized by tendency to be rigid, opinionated, jealous, resentful, suspicious; is quick to blame others for his problems
9. Passive-aggressive personality	Tends to express aggression passively by procrastination, pouting, stubborn withholding, and obstructionism
10. Passive-dependent personality	Tends to lack self-confidence; often feels indecisive and clings to others for guidance, reassurance, and support
11. Schizoid personality	Feels vulnerable and therefore avoids close or competitive relationships; tends to be seclusive, aloof, does not display feelings readily, daydreams

From Harvey et al: The Principles and Practice of Medicine, 19th ed. New York, Appleton, 1976

sudden death, insanity, or whatever the patient's specific fear happens to be.

In our opinion, it is preferable to manage the acute anxiety attack by means of a psychotherapeutic approach such as that described above, without recourse to an antianxiety drug. If, however, the physician decides a medication is necessary, the best choice is an oral preparation such as diazepam (Valium) 10 mg, rather than a parenteral one. The patient can easily use the tablets to help control future attacks of anxiety. The patient who has recurrent anxiety attacks should be actively encouraged to recall the physician's description of the physiology of anxiety and his assurance that acute anxiety will not cause the patient's fears of medical catastrophe to be realized.

The basic principles of management, as outlined above, also hold for the patient with chronic anxiety, the difference being that the chronically anxious patient's need for effective reassurance is not so immediately pressing or dramatic. The effectiveness of the physician's reassurance may hinge in good part on the patient's being convinced that the physician is conducting a thorough examination and is being open and candid with him as the medical evaluation proceeds.

The recurrently or chronically anxious patient should be encouraged to make observations about himself and his everyday experiences in order to see if he can detect some correlation between life events or reactions to events

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and the waxing or waning of his symptoms. Such perception on the part of the patient will not only afford him increased opportunity to discuss anxiety-provoking experiences or concerns with others, including the physician, but may also have the effect of making his anxiety symptoms seem less mysterious and foreign. Further, such an approach will help the patient to accept referral to a psychotherapist when, in the physician's judgment, such a referral is indicated. The physician should consider referral for psychotherapy when the patient's symptoms persist or persistently recur beyond a few weeks in spite of the physician's supportive treatment.

The above approach to the chronically anxious patient may be supplemented, when necessary, with the administration of antianxiety drugs such as diazepam or chlordiazepoxide (Librium). It is advisable to prescribe such agents for specified periods of time, such as four weeks, rather than on an open-ended basis. During the specified time period, the patient may be instructed to take up to a specific daily amount on an as-needed basis. These drugs, while useful in reducing anxiety, do not appear to be effective in preventing attacks of acute anxiety.

Phobic Neurosis

In phobic neurosis the patient has a fear of an object or situation even though he recognizes that the feared object or situation does not pose a realistic threat to him.[1] Common examples are fear of heights (acrophobia), fear of going out in open areas alone (agoraphobia), and fear of closed places (claustrophobia). The not uncommon fear of airplane travel may combine elements of fear of an enclosed place, heights, and fear of falling or crashing. The phobic patient naturally avoids the feared object or situation and, when deliberately or inadvertently exposed to it, experiences severe anxiety. A frequent accompaniment of the fear of going out or traveling alone is fear of fainting or of becoming ill in a situation when there will be no one to take care of the patient.

Occasionally the origin of the phobia is directly traceable to a conditioning experience. Probably the most common example of this is afforded by the patient who reports that his phobia began when he had a acute attack of anxiety in a certain situation, such as while driving a car, and that since that experience he has been afraid to drive a car lest the dreadful experience (anxiety) recur. On the one hand, such a patient has developed a fear of fear. On the other hand, he now has the feeling of being able to avoid anxiety by avoiding a specific situation, ie, a feeling of having control over a sudden attack of anxiety that strikes with no apparent warning. It can thus be seen that the phobia has a certain psychologic value for the patient.

Less commonly, the phobic patient has a history of some other kind of conditioning experience that initiated the phobia, such as a fear of animals following a frightening experience with a specific animal.

It is typical for the phobia, once established, to spread beyond its original circumstances, eg, from fear of traveling by car alone to fear of any mode of travel alone. Further, the avoidance of the feared situation serves to intensify the patient's dread of it.

More often than not, the patient cannot recall a conditioning experience from which the onset of the phobic neurosis can be dated. Psychiatric theories hold that in such instances the phobic object or situation is the symbolic representation of an unconscious, anxiety-laden conflict.

Diagnosis and Management

Diagnosis does not usually present a problem. However, it should be remembered that like any neurotic symptom, phobias can occur in the course of schizophrenic illness. Occasionally, the fearfulness of depressed patients may bear some resemblance to phobic neurosis. It is not uncommon for the person whose life has been severely restricted and impoverished by a phobic neurosis to become secondarily depressed.

It is advisable to refer the patient with a phobic neurosis producing significant disability for psychiatric treatment, which may consist of supportive therapy with encouragement gradually to confront the feared object or situation, a more systematic behavioral therapy such as desensitization, psychoanalytic psychotherapy, or some combination of these. The judicious use of antianxiety drugs may usefully supplement psychotherapy.

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