

## TREATMENT OF NEUROTIC DISORDERS

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**ABSTRACT**

*Neurotic disorders are commonly encountered in psychiatric outpatient clinics. Treatment of the commoner conditions like the anxiety states, depressive, obsessive-compulsive, hypochondriacal and phobic neuroses will be described. This includes general supportive measures, pharmacological, cognitive, behavioural and psychodynamic approaches.*

*Keywords: Neuroses, cognitive-behavioural, psycho-dynamic, pharmacological, treatment.*

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**INTRODUCTION**

Neurotic conditions form a large percentage of psychiatric outpatient attendances. The more commonly encountered are the anxiety states, depressive, obsessive-compulsive, hypochondriacal and phobic neuroses. Knowledge about their treatment is all the more important in view of their better prognosis when compared with those of the psychotic illnesses. Treatment of the above mentioned disorders will be described.

**GENERAL SUPPORTIVE MEASURES**

Patients experience a lessening of distress when allowed to ventilate their problems to a sympathetic and concerned doctor, who despite the shortage of time must appear calm and unhurried. Having arrived at the diagnosis, the doctor should explain to the patient, briefly and simply, what he is suffering from, the treatment options available and reassure him that he is not suffering from insanity.

**PRECIPITATING/PERPETUATING STRESS FACTORS**

Specific stressors should be looked out for and steps taken to shift or eradicate them. If this is not possible then the patient should be helped to cope with the situation as best as he can. Should there be a need for further advice/counselling on social, financial or marital problems, a referral to a social worker would be indicated.

**ANXIETY STATES**

Pharmacological and psychological therapies are of relevance in the treatment of the anxiety states.

**A. Pharmacological treatment***1. Benzodiazepines*

The benzodiazepines have established themselves as the most widely prescribed medication for anxiety<sup>(1)</sup>. In the case of panic disorders, various benzodiazepine compounds eg Lorazepam (Ativan), Bromazepam (Lexotan) and Clobazam (Frisium) have shown efficacy in blocking panic symptoms as well as ameliorating anticipatory anxiety in the absence of a panic attack.

The triazolobenzodiazepine, Alprazolam (Xanax) has been the most extensively studied compound for treating panic disorder. In the Cross National Panic Study<sup>(2)</sup>, Alprazolam was more effective than placebo and had a quicker onset of action than Imipramine, although the effects of both active drugs were comparable at the end of 8 weeks.

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Safe when taken in overdoses, the benzodiazepines are known to give rise to tolerance and withdrawal symptoms comprising anxiety, tremors, muscle tension, perceptual disturbances, insomnia and sweating upon abrupt discontinuation of treatment after a sustained prolonged period of ingestion. These symptoms are more likely with high dosages of the short to intermediate acting preparations and in severe cases, convulsions and death may result. There is, however, no safe period of treatment before the risk of dependency becomes significant<sup>(3)</sup>. For these reasons it is wise to prescribe these medications over a short duration, at the lowest possible dosages to be taken only when necessary.

A non-benzodiazepine anxiolytic, Buspirone, is said to have no potential for producing withdrawal symptoms and may be useful for those with personality problems or for those with propensities for developing dependency on drugs.

*2. Major Tranquillisers*

Small doses of Chlorpromazine (25-50 mg bd) or Thioridazine (10-50 mg bd) may satisfactorily lower anxiety levels although not as effectively as in the case of the benzodiazepines. They, however, do not give rise to dependency problems but extra pyramidal symptoms eg stiffness, tremors and tardive dyskinesia may develop even in the presence of low dosages<sup>(4)</sup>.

*3. Beta Adrenoceptor blocking drugs*

These are of limited efficacy in generalized anxiety as they do not affect psychological symptoms<sup>(5)</sup>. On the other hand, the somatic symptoms of anxiety eg tremors, sweating and palpitations may be relieved by Propranolol (10-40 mg tds).

*4. Antidepressants*

Tricyclic antidepressants have potent anti-panic properties despite a delayed onset of action as is the case with the monoamine oxidase inhibitors. However, in terms of anti-anxiety potency there is no evidence to suggest that the MAO inhibitors are superior to either the benzodiazepines or the tricyclic group<sup>(6)</sup>.

**B. Psychological treatments***1. Cognitive therapy*

Cognitive therapy works on the basis that one's feelings and behaviour are related to one's perceptions, cognitions or interpretations of an event. Perception of a threat to one's sense of well-being will give rise to fearful emotions and may lead to avoidance of the situation. The therapy is designed to reduce anxiety by teaching patients how to identify, evaluate, control and modify their negative danger related thoughts and associated behaviours<sup>(7)</sup>.

Techniques used in the treatment of panic attacks are described elsewhere.

*2. Relaxation Training*

Anxiety produces tensed, aching muscles. Relaxation techniques serve as an adjunct to the other therapies described and pro-

mote a sense of mastery over the symptoms of anxiety, thereby increasing self-confidence.

Controlled breathing can be useful during panic attacks and in restoring normal breathing to hyperventilatory episodes.

For some, the practice of yoga, meditation, tai-chi, biofeedback and being hypnotized appear to be successful in inducing relaxation. Unfortunately, there have been very few methodologically sound controlled studies demonstrating the efficacy of some of these practices<sup>(9)</sup>.

### **OBSESSIVE COMPULSIVE NEUROSIS (OCN)**

The treatment of this fascinating condition involves behavioural and/or pharmacologic approaches.

#### **A. Behaviour Therapy**

The principle of the behavioural approach in OCN is that of "exposure with response prevention"<sup>(8)</sup>. It is postulated that patients perform rituals to lessen the anxiety arising from their obsessional thoughts. By repeatedly confronting feared situations (eg touching "contaminated" objects, and refraining from handwashing) anxiety levels gradually diminish ("habituate") and with it the urge to handwash.

The treatment of obsessional ruminations in the absence of rituals using the "thought stopping" method described by Stern<sup>(9)</sup> has met with little success<sup>(10)</sup>. Another technique, "satiation", requiring the patient to repeat aloud, write down or repeatedly play a tape recording of his obsessional thoughts, has been tried but its usefulness requires further evaluation.

#### **B. Drug Treatment**

Of the many varieties of drugs used in the treatment of obsessional illness, the serotonin reuptake inhibitors have produced the most favourable responses. Clomipramine, the most extensively studied compound, has been shown to be more effective than placebo in 12 controlled double blind trials<sup>(11)</sup>. The efficacy of other serotonin reuptake inhibitors eg Fluvoxamine<sup>(12,13)</sup> and Fluoxetine<sup>(14,15)</sup> were also demonstrated. Dosages should be increased to the maximum the patient is able to tolerate. Should the patient still fail to respond, other medications eg Lithium Carbonate, L-tryptophan, Pimozide can be used to augment the effect of the anti-obsessional drug.

#### **C. Treatment failures**

Non-responders to behaviour therapy were due to noncompliance with the behavioural programme<sup>(16)</sup>, severe depression, overvalued ideas and delusions<sup>(17)</sup> and those suffering from personality disorders<sup>(18,19)</sup>.

#### **D. Psychosurgery**

Stereo-tactic lesions severing connections between the frontal cortex and the limbic areas have resulted in improvements to obsessions and compulsions. These procedures should be carried out when the disorder is severe when all other treatments have failed.

### **HYPOCHONDRIASIS**

Hypochondriasis may be primary or secondary. If secondary, it is usually a symptom of a depressive illness.

#### **Principles of treatment**

The primary condition is difficult to ameliorate and is likely to run a protracted course. Supportive psychotherapy is the mainstay of treatment, as usually drugs or electroconvulsive therapy (ECT) are of little effect. Having ascertained that physical investigations are normal, the doctor should avoid further discussions of the symptoms, choosing instead to focus on emotional issues and any other problems that the patient may be experiencing. The doctor should also refrain from giving repeated reassurances as this will only reinforce reassurance seeking behaviour and in the long run be anti-therapeutic.

Recently, cognitive behavioural techniques have been proposed<sup>(20)</sup> but further studies are required to confirm their efficacy.

When the condition arises secondary to a depressive illness, treatment of the depression should cause the hypochondriacal symptoms to abate.

### **NEUROTIC DEPRESSION**

This condition often occurs in response to an unpleasant life event and differs from the sadness we experience in relation to adverse circumstances in terms of intensity and duration.

#### **A. Psychological treatment**

Psychological treatments are of importance in the management of these conditions.

##### *1. Supportive psychotherapy*

The components of this approach as described earlier are further elucidated by Bloch<sup>(21)</sup>.

##### *2. Cognitive therapy*

Patients whose depression is based upon negative concepts of themselves, their current situation and the future would benefit most from cognitive therapy. Negative automatic thoughts and their dysfunctional assumptions are explored and challenged and the patient is encouraged to think of rational realistic responses<sup>(22)</sup>. Further details are described elsewhere.

Studies assessing post-treatment outcome show cognitive therapy to be at least as effective in reducing depression as tricyclic medication<sup>(23)</sup> and more effective in preventing relapse than anti-depressant drugs<sup>(24)</sup>.

##### *3. Analytic Psychotherapy*

The aim of analytic psychotherapy is to effect a change in the personality structure of the patient by him first gaining insight into himself and his inner world. In the process of therapy, as painful issues are discussed there will be an initial exacerbation of symptoms but in the long term, symptom relief is expected to occur as patients "work through" unresolved conflicts and repressed feelings are allowed to surface.

#### **B. Drug treatment**

Tricyclic antidepressants are more effective in the presence of biological symptoms such as loss of appetite and insomnia and may be of less value in neurotic depression. The more sedative anti-depressants eg Dothiepin and Amitriptyline are useful for anxiously depressed patients. Those with little or no sedative potential, with negligible cardiotoxic or anti-cholinergic properties eg Fluvoxamine would be more suitable for the elderly, or in patients with cardiovascular problems, or for those unable to tolerate the side effects present in the older compounds.

The Mono Amine Oxidase Inhibitors (MAOI) have been shown to be as effective as the tricyclic group in the treatment of neurotic depression. Recently, a reversible MAOI Moclobemide has been introduced with claims that it does not produce adverse drug reactions and avoidance of foods with tyramine content is no longer necessary.

#### **C. Electroconvulsive Therapy (ECT)**

ECT is less effective in neurotic depression but may be necessary if the patient is suicidal, not responding to psychological treatment or unable to tolerate side effects of medication.

### **PHOBIAS**

#### **A. Behaviour Therapy**

The treatment of choice is progressive exposure to the feared object. If this is not readily accessible eg fear of thunderstorms, it is possible to desensitize the patient by imaginal exposure. Spouses or family members may be invaluable as cotherapists in aiding or encouraging patients to practise their exposure programme.

## B. Drug Treatment

Phenelzine and Imipramine have been found to exhibit antiphobic properties but these effects disappear after the medications are stopped. Buspirone and Fluoxetine were both effective in social phobias but the beta blocker, Atenolol, had negligible antiphobic action<sup>(25)</sup>. Despite this, some have demonstrated the success of Propranolol in performance anxiety with such activities as playing stringed instruments and pistol shooting<sup>(26)</sup>.

## CONCLUSION

Treatment of neurotic conditions mainly involve pharmacological, cognitive, behavioural as well as psychoanalytic psychotherapies. Despite the efficacy of some of these methods, supportive measures cannot be over-emphasized as the compliance to and success of treatment will hinge upon a warm doctor-patient relationship.

Where medications are concerned, some have a delay in onset of therapeutic response, may give rise to adverse drug interactions and complications in over dosages may occur, whereas others may cause dependency problems. The psychological treatments require more therapist time and the acquiring of specialised skills but the long-term outcome may supercede that achieved by drug treatment alone.

Given the claims by both behavioural and pharmacologic camps, at present there are no reliable predictors of which patient would benefit most from which method of treatment for OCN<sup>(17)</sup>. While Marks et al<sup>(27)</sup> have argued that Clomipramine is effective only when the obsessional illness is complicated by a depressed mood, this perspective is not held by more recent researchers<sup>(28,29)</sup> who found that Clomipramine exerted its effect even in obsessional patients who were not depressed. My view is that many phobic and obsessive-compulsive disorders can be successfully treated by using a cognitive behavioural approach with the minimum of medication. Anxiety states, unless very mild, would benefit from the use of medication combined with the anxiety management techniques from the cognitive behavioural school.

There is much scope for the general practitioner, working in liaison with the psychiatric service to provide care and follow-up of patients with neurotic illnesses whose conditions have stabilized.

Which treatment to offer will ultimately depend upon the expertise available, the inclination of the doctors concerned, time factor, and careful patient selection. On the other hand the treatment must also suit the patient's needs.

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