Neurotic Disorders
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The symptoms of neurotic disorders are primarily subjective. Nonetheless, neurotic disorders such as phobias and anxiety states can seriously impair an individual's functional ability and are often associated with difficulties in the workplace.

The general classification of neurotic disorders has been abolished in the DSM-III. For convenience of presentation, and also because this classification is still widely used in other diagnostic systems, this classification will be included here.

In neurotic disorders, the primary distinguishing feature is a set of symptoms, which are subjectively distressing to the individual experiencing them and which he or she experiences as being unacceptable or alien. Reality testing is generally intact and behavior does not actively violate social standards.

Neurotic disorders include the broad subclasses of anxiety disorders, somatoform disorders and the dissociative disorders.

Anxiety Disorders

Phobic disorders are a major subtype of anxiety disorder. All phobias have in common the fact that there is irrational and enduring fear of a particular activity, object, or situation which leads to a very strong desire to avoid the dreaded fear stimulus. Usually, phobic individuals recognize that their reaction is unreasonable or excessive in terms of the actual danger.

The most severe and pervasive form of phobia is agoraphobia, which is a marked fear either of being alone or of being in public places from which escape might be difficult. With increasing fear, avoidance behavior may dominate the individual's life to such an extent that normal activities become increasingly constricted. Fear of being in crowds, in crowded stores, in tunnels, elevators, bridges, or on public transportation are among those common situations, which may be avoided by such patients. Many individuals with such fears may insist upon a family member or close friend accompanying them whenever they leave home. Agoraphobia may occur with or without anxiety or panic attacks.

Another common phobia is the subtype social phobia, which is characterized by irrational and persistent fear of being watched and associated compelling desire to avoid those settings in which others may scrutinize the person. An accompanying manifestation may be the fear of behaving in a manner, which will be either embarrassing or humiliating. The person with such a phobia will often experience intense anticipatory anxiety when confronted with unavoidable social situations. Typical examples of social phobias may involve fear of eating in public, fears of having to function in public situations, fear of using public
bathrooms, and so on.

In addition to agoraphobia and social phobia, there are a host of simple phobias, which involve persistent, irrational fear with associated strong desire to avoid settings or situations, which might entail confronting the object of the fear. Typical phobias seen in the general population involve fear of animals, particularly snakes and dogs, fear of closed places or heights, and the like.

**Anxiety States**

Anxiety states include three specific disorders: panic disorder, generalized panic disorder, and obsessive compulsive neurosis.

Panic disorders are characterized by recurrent panic or anxiety attacks which are often unpredictable in their onset and are not associated with phobic stimulation, physical exertion or a life-threatening situation. Individuals experiencing panic attacks report intense apprehension, terror, or fear, frequently associated with the feeling of impending doom. There may be associated physical symptoms, including pounding of the heart, chest pain, choking sensations, dizziness, feelings of unreality, dizziness, fear of dying, or going crazy. Such attacks typically last for several minutes and rarely last for hours.

In a generalized panic disorder, generalized, persistent anxiety occurs, rather than discrete episodes or attacks. Usually, an individual affected by the disorder displays signs of autonomic hyperactivity (sweating, heart pounding, butterflies in the stomach, etc.), apprehensive expectation, vigilant scanning of the environment, and motor tension.

Obsessive compulsive disorders consist of either recurrent obsessions, compulsions, or both. Obsessions are recurring, persistent ideas, impulses, thoughts, or images which are perceived by the individual as repugnant or senseless. The individual may attempt to ignore or suppress such thoughts. Compulsions are stereotyped by seemingly purposive behavior, which may occur with exceedingly high frequency. The individual likely feels the behavior to be senseless and does not derive pleasure from its execution, although it may provide a release of tension.

**Somatoform Disorders**

All somatoform disorders have in common the fact that there are manifestations of physical symptoms suggestive of an underlying physical problem, accompanied by a lack of demonstrable organic findings or known physical mechanism which could account for the phenomenon. Additionally, there is usually positive evidence linking the symptoms to psychological conflicts or factors.
There are three subtypes of somatoform disorder: somatization disorders, hypochondriasis, and psychogenic pain disorder. Somatization disorders, in which there are multiple and recurring physical complaints of several years duration, with complaints not due to any physical disorder, constitute one subtype of somatoform disorders. This subtype merges quite closely with hypochondriasis, which is typically defined as an unrealistic interpretation of physical experiences or sensations as abnormal, with consequent preoccupation with the belief of having a serious disease. Common physical complaints for both of these subtypes may include blindness, paralysis, stomach pain, painful menstruation, back pain, and pain during sexual activity. The affected individual may exhibit considerable bodily preoccupation and frequently seek medical care. In psychogenic pain disorder, the chief complaint is that of pain in the absence of adequate physical findings and usually with evidence suggesting that psychological factors are at work. Associated symptoms may include localized motor or sensory function changes, excessive use of pain medications without pain relief, requests for surgery, and the assumption of an invalid role.

Individuals with somatoform disorders often have difficulty in establishing satisfactory vocational adjustment and frequently miss work or function at low levels of efficiency. They may show substantial interference with their ability to engage in work-related activities. Absenteeism and decreased physical capacity are likely to be the most frequent areas of work disruption. There may be additional interpersonal problems when others become unwilling to listen to the complaints of their co-workers with such disorders.

**Works Cited**