

Anxiety and Hysterical Symptoms in Schizophrenia

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ABSTRACT

The existence of both anxiety and hysterical symptoms have been described in schizophrenic populations. Various explanations exist. The issue of whether such symptoms represent discrete clinical entities or are intrinsic to the schizophrenic process, requires further research.

Key words

Schizophrenia, Anxiety, Hysterical

INTRODUCTION

Since the end of the nineteenth century psychiatrists have been attempting to describe the relationships between anxiety, hysteria and psychosis.¹ Throughout the nineteenth century opinions varied as to whether obsessive-compulsive disorder was a neurotic or psychotic disorder.¹

In 1875 Legmond du Saule described obsessive-compulsive patients who later developed psychotic symptoms.² Pierre Janet's psychological theories placed obsessive-compulsive disorder in the realm of neurosis, but he describes psychotic symptoms in 7.7% of his patients.¹ Sigmund Freud also conceptualized obsessive-compulsive symptoms as a neurotic illness, but he too described a patient with Obsessive Compulsive Disorder who subsequently developed a delusional disorder.¹

In the early 20th century the diagnoses of hysterical psychosis was often made.³ This diagnosis had since been replaced by the terms: Psychotic Disorder Not Otherwise Specified, and Brief Psychotic Disorder.³

Freud's theory on schizophrenia was that it was due to a fixation occurring at an earlier stage of development than in those cases where neuroses developed.⁴ Paul Federn ascribed schizophrenia as due to an inability to attain self/object differentiation.⁴ Margaret Mahler theorized that schizophrenia developed due to a disturbance in the mother-child relationship.⁴ However, in the psychodynamic model all of these could give rise to anxiety and hysteria as well.⁴

If one looks at the pathophysiology of the conditions under discussion, one finds areas of overlap. Schizophrenia is thought to be a disturbance in dopaminergic function. Whether this disturbance is due to an increased secretion of dopamine or a hypersensitivity of the receptors, is not yet clear.⁴ Serotonin also plays a role.⁴ Serotonin is implicated in anxiety and panic attacks as well as in obsessive-compulsive disorder.⁴

The co-existence of obsessive-compulsive symptoms and psychoses has been scientifically studied from the early twentieth century. Some of the first studies were published in 1926⁵, 1936⁶, and 1945⁷. The comorbidity of psychosis and an anxiety or panic disorder has received much less attention, and study.^{9,10,11} Neither has body image disturbances in psychotic patients been studied systematically or extensively.^{9,10,11}

In studies that were done, the incidence of comorbidity varied a lot. This can mostly be explained by the differences in methodology, and patient selection used in the different studies. One study compared long-term hospital patients with patients living in the community with regards to functioning, diagnoses, treatment, side-effects, comorbid conditions etc. It was found that patients living in the community had significantly more affective and anxious symptoms than long-term hospital patients. Patients in the community tended to be on higher doses of neuroleptic medication with a higher incidence of extra-pyramidal side effects.¹²

Differences in incidence thus occur depending on whether one uses long-term hospital patients or patients in the community as the basis for research. Differences in incidence can also be explained by the diagnostic criteria that were used, by whether the data was gathered using a chart review or patient interview, by whether the study was retrospective or prospective, and by whether schizoaffective disorder was included or not in the schizophrenia groups.¹³

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ANXIETY SYMPTOMS IN SCHIZOPHRENIA

Obsessive-compulsive symptoms

It can be difficult to distinguish obsessions and compulsions from delusions.^{1,13,14} According to the DSM IV definition of obsessions, the patient must recognise that the thoughts, impulses or images are a product of his or her own mind.⁴ Some researchers consider obsessions, overvalued ideas and delusions as lying on a continuum, and not as separate entities.¹

The incidence of obsessive-compulsive disorder in patients with schizophrenia ranges from 3.2% to 46%. Studies using retrospective chart reviews produced the lowest incidence rates.^{13,14,15,16} Studies that were designed around patient or caregiver interviews produced the highest occurrences of comorbid obsessive-compulsive disorder in schizophrenia, with rates of 20% or more.^{13,14,15,16}

All the studies reported that patients with a comorbid diagnosis of obsessive-compulsive disorder worsened the prognosis and course for schizophrenia.^{1,12,13,14,15,16,17} They had an earlier onset of disease, spent more time being hospitalised, were socially more isolated, had a worse work history, were less able to live alone, and had more negative symptoms.^{1,8,13,15} The study by Tibbo et al however, reported a lower incidence of negative symptoms.¹⁴ It is not clear why this should be so, but it is most likely due to a recruitment bias.

A review of case records showed a predominance of the following categories of symptoms:⁸

- Repeated behaviour that interferes with daily living.
- Indecision/stuckness.
- Repeated behaviour before some goal orientated activity.
- Repetitive behaviour aimed at magically avoiding harm.
- Obsessive and pedantic speech.
- Verbal rituals.
- Repetition of acts that the patient finds repulsive.
- Complaints of recurrent, persistent ideas.

There are good indications that obsessive-compulsive disorder is linked to pathology in the basal ganglia.⁴ Neuroleptic induced movement disorders are also related to basal ganglia dysfunction.⁴ It is therefore possible that patients suffering from both schizophrenia and obsessive-compulsive disorder may have a bigger potential for basal ganglia dysfunction.⁴ Tibbo et al¹⁴ found that patients with both diagnoses did indeed score higher on extra-pyramidal side-effect scores.

There had been reports of obsessive or compulsive behaviour that have emerged after treatment with antipsychotic medication.^{14,17,18} There had been anecdotal evidence that fluoxetine is effective for these cases.¹⁴ A pilot double-blind crossover study done by Berman et al. showed that clomipramine is efficacious for psychotic patients with obsessive-compulsive symptoms.¹⁶

Anxiety symptoms

Symptoms of anxiety and depression can develop at any time during the course of schizophrenia.¹⁰ Anxious symptoms might easily be confused with akathisia. Anxiety and depressive

symptoms often occur together.¹⁰

Anxiety in schizophrenia has not been well researched.^{9,10} It seems to be more prominent in women, to be associated predominantly with positive symptoms, and to occur during a first episode.^{9,10} It is generally present in a moderate degree.^{9,10}

In a study done by Cosoff and Hofner the overall incidence of anxiety symptoms were 43% – 45%.⁹ Patients who had anxiety symptoms were more often hospitalised, subjectively scored their disease as worse than other patients, and were more likely to live alone.⁹ In 50% of these patients the anxiety preceded the diagnosis of schizophrenia.⁹

The following categories of anxiety were identified:⁹

- Social phobia (17%)
- General anxiety disorder (12%)

Seen in light of the fact that anxiety disorders appear to be fairly common in patients with schizophrenia, it might be worth considering the addition of an appropriate antidepressant drugs to the treatment regimen of patients who are not responding to neuroleptic treatment alone.⁹ Alprazolam and cognitive behaviour therapy were described as useful treatment modalities for schizophrenic patients who comorbidly suffer from panic and anxiety.¹⁰

Panic symptoms

Panic disorder is an often unrecognized, but common comorbid illness in schizophrenia.¹⁹ Arieti attributed the etiology of schizophrenia to "...an abnormal way of dealing with an extreme anxiety.²⁰" Waelder describes schizophrenia as a "mega-anxiety".²¹

A study by Argyle in 1990 reported the incidence of panic disorder in schizophrenic patients to be 35%.²² A study by Cutler and Siris in 1991 on patients with schizophrenia or schizoaffective disorder reported an incidence of 24%.¹⁹ The overall morbidity was not significantly increased in patients with comorbid anxiety.²⁴ The National Comorbidity Survey done in New York showed that patients with non-affective psychosis were 7 times more likely than the general population to have a panic disorder.²³ This gives an inferred incidence of 25,2% for panic disorder in schizophrenic patients. (The general population has a 3,6% incidence.)¹⁹ A study by Labette et al on patients with schizophrenia found the incidence of panic disorder to be 43%, and that of panic attacks to be 57%.¹⁹ Cosoff and Hofner found a much lower incidence of panic disorder in their study, namely 5%.⁸ No explanation could be found for this disparity.⁹

Cutler and Siris described the most symptoms in their study as:¹⁹

- Sweating.
- Trembling.
- Palpitations.
- Dizziness.
- Shortness of breath.
- Fear of dying.

They found a significantly higher incidence of depression, negative symptoms, and alcohol and/or drug abuse in patients with comorbid panic disorder.

Further studies are needed, especially with regards to the treatment of patients with both schizophrenia and panic disorder.²⁴

HYSTERICAL SYMPTOMS IN SCHIZOPHRENIA

Hysterical symptoms

The diagnosis of hysterical psychosis was described in 1964 by Hollander and Hirsch.²⁵ They described it as follows:

- It has a sudden and dramatic onset.
- It is related to a profoundly upsetting event or circumstance.
- It seldom lasts longer than 3 weeks.
- It is most common in women with hysterical personality traits.
- It manifests with delusions, hallucinations, depersonalization, grossly unusual behaviour, volatile affect, and transient, circumscribed thought disorder.
- It recedes quickly with no residual symptoms.

Other researchers also studied this phenomenon, but not much was added to the description given by Hollander and Hirsch.³

There are parallel, overlapping descriptions between hysterical and schizophrenic symptoms. Most notable are emotional detachment, social inappropriateness, dissociative states and self-mutilation.²⁶

Cernovsky and Landmark studied the incidence of hysterical symptoms in schizophrenia²⁶. A symptom was only noted as present or absent. They found an overall incidence of 37,5% for hysterical symptoms, with 45.7% of female and 23.8% of male patients having hysterical symptoms.

Somatic symptoms

The presence of delusional thoughts forms part of the A criteria for Schizophrenia in the DSM IV.⁴ Body image disturbances in psychotic patients have however, been little studied.¹¹

McGilchrist and Cutting did a study in an attempt to classify this phenomenon, and to look for evidence of localization of pathology.¹⁰ They found that 68% of chronic schizophrenic patients, and 60% of acute schizophrenic patients held abnormal beliefs about their bodies. They also found that certain delusions were significantly positively related to the diagnoses of both chronic and acute schizophrenia. Schizophrenic patients were usually very specific about the body part affected, and tended to lateralise to the left side, e.g.: "My left arm is empty." Male patients were more likely to lateralise than female patients.¹⁰

CONCLUSION

The comorbidity of anxiety and so-called hysterical symptoms in schizophrenia has not been extensively or conclusively studied. The studies to date usually did not use large patient samples. Furthermore, the treatment of these conditions requires further study given that comorbidity tends to impact on treatment response and

outcome. Anxiety and hysterical symptoms may not simply be an epiphenomenon of the schizophrenic process but discrete features requiring definitive treatment.

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COMMENTARY

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The first part of this article by Scribante and Joubert highlights an aspect of schizophrenia that is important, but generally under-recognised by clinicians. Anxiety symptoms are frequently encountered in patients with schizophrenia, and while often regarded as non-specific and insignificant, there is now increasing evidence that these symptoms are of considerable clinical importance. Estimates of the frequency of anxiety symptoms and syndromes in schizophrenia vary widely, depending on the populations studied and the instruments used to assess the anxiety. But most patients experience anxiety to some degree.

The presence of anxiety symptoms may alert the clinician to environmental stress-factors causing anxiety, co-morbid psychiatric conditions or untoward effects of medication. There are a host of possible causes of anxiety in patients with schizophrenia, and the majority are amenable to therapeutic intervention. For example, patients with schizophrenia may become anxious in response to adverse life-events, of which they have more than their fair share. This would include events such as involuntary hospitalisation, enforced treatment, unemployment and broken relationships. Anxiety symptoms could also be expected to occur in reaction to the terrifying psychotic experiences accompanying acute exacerbations of schizophrenia. Anxiety symptoms may also be a symptom of substance intoxication or withdrawal. (There is a very high incidence of co-morbid substance abuse in schizophrenia.) They may also develop in association with antipsychotic medication. This may occur as a direct side effect (akathisia), or indirectly, in reaction to distressing adverse-effects such as dystonic reactions. Akathisia has been rated by patients as the most distressing of all antipsychotic side effects, and is associated with increased suicidality. Treatment-emergent specific anxiety disorders such as obsessive compulsive disorder and social phobia have been described, particularly in asso-

ciation with the potent serotonin-blocking atypical antipsychotics.

Furthermore, anxiety symptoms may indicate the presence of a co-morbid anxiety disorder. Anxiety syndromes feature prominently as co-morbid disorders in patients with schizophrenia, and there is an emerging literature showing a higher than expected by chance incidence of anxiety disorders such as obsessive-compulsive disorder, panic disorder, posttraumatic stress disorder and social phobia in schizophrenia. Finally, a depressive syndrome occurs in up to 50% of acutely psychotic schizophrenics. This may occur at any stage of the illness. Frequently, prominent anxiety symptoms are associated with the depression. Anxiety and depressive symptoms in schizophrenia are of considerable clinical importance. Their existence may compromise social and vocational functioning, they may detrimentally effect compliance, and they are associated with an increased risk of relapse and suicide. The numerous and varied associations between schizophrenia and anxiety indicate that this might be a very important subset of patients to investigate in order to further elucidate underlying pathological mechanisms of both schizophrenia and the anxiety disorders. Of clinical importance is the fact that associated anxiety symptoms and syndromes in schizophrenia are frequently not recognised, in spite of the fact that they are likely to respond favourably to therapeutic intervention.

The second part of this article deals with so-called hysterical symptoms in schizophrenia. This section is largely of historical interest, and underlines the progress that has been made in terms of the nosology of psychiatric disorders. Hysteria, a non-specific term was at one stage used to describe strange clinical presentations that were thought to be mainly psychological in nature. The disappearance of the word hysteria from the Diagnostic and Statistical Manual of Mental Disorders is has simplified matters, and conversion and dissociative disorders are considerably more understandable.

As emphasised in this article, more research is required in this field. **SAPR**

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