

## Patterns of Phobic Neurosis: A Retrospective Study

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The published literature in English on phobias has predominantly been from the West; while this has delineated a profile of the illness, it would be worthwhile examining the pattern of occurrence of phobic neurosis in a developing, non-western milieu to discern any differences. As Neki (1973) pointed out, the clinical patterns of psychoneuroses vary far more from culture to culture than do organic syndromes and functional psychoses.

The present report forms an initial part of a multi-stage clinical investigation into phobic neurosis. Stage I comprises a retrospective, case-record review of phobic patients to study their clinical presentation and to explore the association of the condition with various socio-demographic variables. In stage II, we envisage a follow-up of these patients to understand the natural history and course of the disease. Stage III will attempt a prospective study of phobic patients, and will evaluate the efficacy of various therapeutic interventions.

## Method

The study was conducted at the National Institute of Mental Health & Neuro-Sciences, Bangalore, India (NIMHANS). This hospital serves as a specialist referral centre, especially for the state of Karnataka and also for many of the South Indian states. On average, about 30–35 new patients are seen every day in the psychiatric out-patient department. The hospital has a modern case record system.

It was decided to study the case records of adult patients diagnosed as having phobic neurosis (ICD 9: 300.2) during the period 1975–82. The year 1975 was chosen because in September 1974, a fully functioning behaviour therapy unit was established for the first time in the country. It was thought that with the availability of this facility, more phobic patients would be referred for treatment to NIMHANS. With a proforma, information was recorded from the case files about the details of phobic symptoms, the associated clinical features, family and personal history, and socio-demographic variables. The phobic patients were grouped according to the classification proposed by Marks (1970).

## Results

There were 83 patients (66 males and 17 females) with a diagnosis of phobic neurosis during the study period. This forms 0.2% of all the adult psychiatric patients seen in the hospital during that period. A majority of the patients were married (65%), literate (81%), and hailing from urban areas (67%). Hindus formed the bulk (79%) of the study population. There was no family history of phobic illness in the entire sample.

Among the phobic patients, the commonest were agoraphobics (22 males and four females), closely followed by illness phobics (15 males and five females), and social phobics (17 males and one female). There were only two patients with animal phobia, both of them were females. Mixed phobias (four males and five females) and miscellaneous phobias (seven males and one female) constituted the rest of the patient sample.

All types of phobias were noted to occur predominantly at around 25–35 years of age (Table 1). The mean duration

TABLE I  
Ages of onset of phobias

Age in years	Agoraphobia	Social phobia	Animal phobia	Miscellaneous external phobia	Illness phobia	Mixed phobia
<15	1	4	—	2	1	1
16–20	3	2	1	1	2	1
21–25	7	5	—	1	7	1
26–30	3	3	—	2	3	2
31–35	6	2	—	—	2	1
36–40	3	1	1	1	1	2
41–45	1	1	—	—	3	1
46–50	—	—	—	1	—	—
51–55	2	—	—	—	—	—
56–60	—	—	—	—	1	—

of the illness was 4.5 years. Accompanying symptoms were few; spontaneous panic attacks occurred in 21% and depressive features in 10% of the phobic patients.

### Discussion

The prevalence rate of 0.2% for phobic neurosis in our clinic population is rather low in comparison with the figure reported from the West, viz 2–3% (Hare 1965; Errera & Coleman 1963; Marks 1969).

However, this being a hospital-based study, it would be erroneous to infer that phobic neurosis is uncommon in the Indian population. Though there is no study specifically examining the occurrence of phobias in the Indian context, several epidemiological studies have looked into the pattern of occurrence of neurotic disorders in the community in India. In a pioneering effort, Verghese & Beig (1974) studied neurotic disorders in Vellore Town; though they found neurotic disorders to be common (45 per 1000), they could not detect a single case of phobia among them. In the following year, while examining the occurrence of psychiatric disorders in a rural community in West Bengal, Nandi *et al* (1975) detected only a solitary case of phobia. Later, in an epidemiological investigation of a tribal population, the same workers (1980) noted a prevalence rate of 4.4 per 1000 for phobic neurosis, next only to hysteria (6.9 per 1000). In a subsequent study, this time in an urban context, these authors found a much higher prevalence rate of 27.3 per 1000; in their sample, consisting of literate city-dwellers from the upper socio-economic class, this was the commonest type of neurosis—an observation which surprisingly finds no mention in the authors' discussion. In all three studies, these authors had employed the same methods of case detection, diagnosis, and assessment. Hence, the differences they noted in the distribution of neurotic illnesses are predominantly attributable to the different composition of the study populations.

Phobic disorders seem not very uncommon in the Indian context, but perhaps they are more frequent in the 'westernised' segments of society. However, very few out of this affected population report to the clinician. While studying aetiological and demographic variables in 747 adult neurotics attending the out-patient psychiatric clinics of six leading general hospitals in Delhi, Veeraraghavan (1978) detected only two cases of phobia. It is possible that a majority of phobics in the community either do not seek any intervention, due to various constraints, or make use of other

facilities. In a survey of the agoraphobic members of a correspondence club in the United Kingdom Marks & Herst (1970) noted that 15% of them had consulted religious or spiritual healers for their problems. With the number of qualified mental health personnel being woefully inadequate, this figure would perhaps be much higher in our own country. Marks & Herst also reported that phobics who did not consult anybody had symptoms no less severe than those of the rest, but differed significantly on measures of ability to confide in other people. Thus, there is a suggestion that factors other than illness influence the help-seeking behaviour of phobic patients.

Our study differs sharply from the published reports on phobic neurosis in reporting a striking male preponderance. Even though all the cases of agoraphobia first described by Westphal were men, subsequent clinical studies, with the sole exception of that of Sim & Houghton in 1966, have characterised phobias as primarily female disorders. However, it would not be appropriate to infer from these clinical studies that phobic neurosis is much commoner in women, for as Agras *et al* (1969) have shown in their community survey, the condition is equally present in both sexes. Agras *et al* also noted that among those affected only a quarter sought psychiatric help, so that even though the condition is evenly distributed in the community, more female phobics in the West seek medical attention than males. This is not surprising, since it is known from the epidemiological data that in the West, females report a higher morbidity in general and, even after correcting for maternity, have a higher rate of utilisation of health services (Andersen & Andersen, 1972). Social psychologists have also emphasised the role of cultural factors in influencing an individual's health-seeking behaviour. The reason why more phobic men in our sample have sought psychiatric help than in the West can perhaps be traced to their social milieu. Nichter (1981) proposed that the type of symptoms most commonly expanded and elaborated are usually in accord with fundamental health concerns, which are related to core cultural and religious values; certain patterns of expression of illness behaviour are socio-culturally sanctioned, facilitated, and reinforced as 'idioms of distress'.

In general, women in the Indian context operate against a wide variety of constraints. In most of the scriptures that govern their lives, there is a very strict code of behaviour laid down for them. While describing the six evils that spoil a woman, Manu, the ancient law-maker, stressed that she should

never go out of the house by herself, nor should she engage in social conversation with men other than her husband, without his permission. Such a view is further reiterated by Sankha (circa 300 BC–100 AD) who wrote, 'a woman should not go out of the house unless she is asked (by her husband and elders)' (Kane, 1941). So by tradition, an Indian woman is mostly housebound, and inability to venture out by herself or to be involved in social transactions without the presence of significant males may not be construed as deviant, aberrant behaviour. Phobic behaviour as an 'idiom of distress' in Indian women has no cultural or religious sanction, and hence is not reinforced.

As the majority of our male phobics were married, it would be interesting to assess the impact of the illness on their spouses. In the literature, there is a suggestion of marital stress in the families of male phobics, contrary to the mixed findings for female phobics (Liotti & Guidano, 1976).

In consensus with the published reports, we found phobias of external stimuli to be much commoner than phobias of internal ones. The only series with which we can compare the frequency of individual phobias is that of Marks (1969). Even though the prevalence rates for individual phobias vary between the two series, the predominant one in both is agoraphobia, animal phobia being least common.

Cases of illness phobia constituted 24.1% of our series. The reported prevalence of illness phobia varies from 15% (Marks, 1969) to 34% (Agras *et al.*, 1969). There are very few published reports on illness phobia, part of this difficulty stemming from its unclear nosological status. Ryle (1948) was perhaps one of the earliest to conceptualise this category. He observed that when there is persistent fear centring round a single symptom of illness in the absence of other psychiatric disorders, the condition could be termed illness phobia, or to use his term, nosophobia. But it is not at all clear how illness phobias relate to hypochondriasis or whether they are not simply a special form of it (Marks, 1969). Mayou (1976) states that fears of illness in most people are probably tentative and transient,

but in a small minority, are more persistent. The term 'illness phobia', he feels should only be reserved for those fears of contracting diseases that are persistent, unfounded, and not allayed by reassurance. But as Marks (1969) states, the definitive status of illness phobia awaits further clinical and psychophysiological studies.

The distribution of age of onset indicates certain interesting trends, especially with regard to agoraphobia: We noticed a bimodal distribution of the age of onset of agoraphobia similar to that reported by Marks & Gelder (1966) and by Mendel & Klein (1969). However, striking a note of discord, Sheehan *et al.* (1981) described an uniform, unimodal distribution of age of onset, and cautioned that the reported bimodal distribution could be an artifact, inherent in a small sample size. It would be worthwhile to follow-up agoraphobics with a bimodal age of onset, to see whether they differ with respect to course, outcome, and response to various therapeutic strategies.

In a majority of our patients, the onset of the illness was gradual, and where it was acute, was ushered in by a spontaneous anxiety attack. As Snaith (1968) pointed out, such patients had usually experienced unexpected attacks of panic in situations which they later came to fear and avoid.

Accompanying psychiatric symptoms, in addition to phobia, were very few in our sample. Spontaneous panic attacks occurred in a proportion of patients, but were evenly distributed among all the different kinds of phobias.

In spite of the limitations and deficiencies inherent in a retrospective design, the present study indicates that the clinical pattern of phobic neurosis in our Indian population is essentially similar to that described in the West. The lower rate of prevalence and the male preponderance in our clinic-based sample may perhaps be due to the impact of various socio-cultural factors.

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## Benzhexol Withdrawal and Cholinergic Mechanisms in Depression

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Anticholinergic drugs are widely used in the treatment of parkinsonism and drug-induced extrapyramidal disorders. Apart from their anti-parkinsonian effects, they also have marked stimulant and euphoriant properties, and may be abused for this reason (Crawshaw & Mullen, 1984; Pullen *et al*, 1984). Anti-cholinergic drugs have been suggested to have mildly anti-depressant effects (Johnson, 1981), and to result in mania-like states (Coid & Strang, 1982). Physostigmine, a cholinergic agonist, is known to result in depressive symptoms

(Janowsky *et al*, 1972), and has been used to treat mania (Davis *et al*, 1978). Because of these reasons, it has been proposed that mania results from a cholinergic deficit, and depression from a relative cholinergic hyperfunction (Janowsky *et al*, 1972). It is interesting that an abnormal Dexamethasone Suppression Test (DST), frequently observed in endogenous depression, can be induced by physostigmine (Carroll *et al*, 1980), and a shortened rapid eye movement (REM) sleep latency, also consistently seen in some depressives, can be