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On anxiety phobic disorders: single center experience

Dosmagambetova G.

Akmola regional psychoneurological hospital, Kokshetau, Kazakhstan

Borderline mental disorders are weakly pronounced disturbance of human mental activity (neurotical level). They develop on the border between mental health and true mental illness, but they are separate nosological entities. They are polymorphic in clinical manifestations, but at the same time they have common characteristics. Without specific treatment they tend to become chronic with the development of social maladjustment with the development of social maladjustment. This article provides structural analysis of some anxiety phobic disorders

Key words: somatic hospital, psychotic disorders

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Автор для корреспонденции: Досмағамбетова Гульжан Ислямовна, Акмолинский областной психоневрологический диспансер, г. Кокшетау. ул. Абая, 23. Тел.: +7 (7162) 26-58-37. Факс:+7 (7162) 26-58-01. E-mail: giddos@mail.ru

ҮРЕЙЛІ-ҚОРҚЫНЫШТЫ БҰЗЫЛЫСТАР ЖАЙЫНДА: ЖЕКЕ ТӘЖІРИБЕДЕН

Досмағамбетова Г.И.
Ақмола облыстық психоневрологиялық диспансер, Көкшетау қ., Қазақстан

Шекаралық психикалық бұзушылықтар – бұл адамның психикалық қызметінің аса белгілі емес бұзылыстарының шартты белгісі. Олар норма және норма еместің, яғни психикалық денсаулық пен шынайы психикалық аурудың аралығында орналасқан және ауыспалы кезеңмен емес, бөлек нозологиялық формамен бөлінеді. Олар клиникалық көріністеріне байланысты полиморфты, бірақ жалпы тән белгілері бар. Арнайы емсіз әлеуметтік дезадаптацияның дамуымен созылмалы түрге өтеді. Мақалада үрейлі-қорқынышты бұзушылықтың кейбір турлерінің құрылымдық талдауы жургізілген.

Маңызды сөздер: психотикалық бұзушылықтар, соматикалық стационар

К ВОПРОСУ О ТРЕВОЖНО - ФОБИЧЕСКИХ РАССТРОЙСТВАХ: СОБСТВЕННЫЙ ОПЫТ

Досмағамбетова Г.И.
Акмолинский областной психоневрологический диспансер, Кокшетау, Казахстан

Тревожно - фобических расстройства относятся к пограничным психическим (невротическим) расстройствам. Их возникновение способствует к снижению адаптационных способностей человека вследствие воздействия различных внутренних и внешних факторов (личностно-типологические особенности, психогенный стресс, сомато-неврологические заболевания). Важное этиологическое значение в их генезе имеют перенесённые и сопутствующие соматические, неврологические заболевания. «Пусковым механизмом», в возникновении пограничных расстройств часто является психогенный фактор. Они полиморфны по клиническим проявлениям, но имеют общие признаки с наличием тревоги, фобии. При отсутствии лечения приобретают хронический характер с развитием социальной дезадаптации. Знание симптомов этих расстройств могут обеспечить своевременное обращение к специалисту и благоприятный прогноз.

Ключевые слова: психотические расстройства, соматический стационар

Borderline mental disorders are conventional definition of weakly pronounced disturbance of human mental activity. They are on the border between "normal" and "abnormality" [1], i.e. between mental health and true mental disorder. They are separate nosological entities rather than transient phases. Borderline states differ in clinical manifestations, but they have common characteristics. Above all it is their emergence on the background of personality typological features. Past and concomitant somatic, neurological diseases are of great etiological significance in their genesis. The "trigger mechanism' is often for occurrence of borderline disorders psychogenic factor. The clinical picture usually polymorphic, variable, but disorders in the emotional sphere accompanied by somatic-vegetative components are always identified. As a rule, patients are critical of the manifestations of disorder; they are aware of their "absurdity" and adapt "to live with the problem". The most common borderline mental disorders are anxiety and phobic disorders. Anxiety, phobias (fears) are related to the field of human experiences. Subjectively, they are painful, difficult to tolerate and for this reason actual [2].

Let's consider several types of most common disorders in psychiatrist's practice. A total of 286 people were examined in the psychoneurological clinic and Regional Multifield somatic hospital. 180 patients (63%) applied to the reception (without an appointment card from a doctor) on their own initiative; 80 patients (28%) - upon the receipt of an appointment card from the physicians of somatic network; 25 patients (9%) - were taken to the hospital by their relatives. Age of the patients: from 18 years to 52 years, of which 137 people (48%) at the age of 18-28years;106 people (37%) at the age of 29-39 years; 44 people (15%) are older than 39 years; the distribution by sex: female – 203 people (71%); male - 83 people (29%).

Duration of disease before visiting a psychiatrist varies from one day to nine years.

Of all the examined patients:

-86 patients (31%) were taken to the dispensary registration after a year of observation due to disease duration, persistence and severity of mental disorders. 9% of these were listed off the register after a year of treatment and observation with a steady improvement and recovery; 58% of patients (168 people) received consultative follow- up without being registered. 34 patients (11%) applied once. They were advised without filing an outpatient's medical card due to short duration and poverty of neurological disorders.

Past medical histories of 208 patients (73%) have chronic psychotraumatic situations or the effect of intense acute psychogenic stressor.

-34 people (12%) had concomitant somatic diseases;

-26 people (9%) identified brain injuries, neural infections, intoxication in their past medical histories;

-197 people (69%) showed different types of accentuation.

Al of the patients were clinically examined upon their application: psychiatric research, psychological testing, examination of physical and neurological state, instrumental methods were used where applicable.

All of the patients were divided into 5 groups according to nosology form of diagnosed mental disorder. The first group: patients with generalized anxiety disorder – 9 people (10.1%); predominant age - over 35 years; sex distribution male to female is 1:3: 2/3 showed accentuations of asthenoneurotic, labile types. The main characteristic feature of this group was the presence of anxiety with the patients, who noted that they "lived in expectation of something bad." Anxiety apprehensiveness about the "future troubles, failures" followed them always and everywhere (at home, at work, in the street, etc.), ie not limited to specific situations and circumstances. Constantly remaining in the "state of anxiety" they were fussy and irritable. They complained of the "sense of inner tension", "inability to relax", problems with mental alertness, fatigue, sleep disturbance. Patients made complaints of somatic-vegetative character (rapid heartbeat, sweating, etc.); 1/4 of the patients hade patient realized "ridiculousness" of "permanent anxious expectations", wanted to get rid of them as it had a negative effect on their families and work.

The second group: patients with panic disorder - 19 people. (6.7%), predominant age - 30-35 years, sex distribution is 1:1, 1/4 showed accentuation of asthenoneurotic type. Sudden attacks of severe anxiety (panic), the so-called panic attacks, were typical for the patients. They were accompanied by pronounced somatic-vegetative disorders typical for borderline mental disorders. There was a constant feeling of unreality and "weirdness" of their surroundings, the fear of death, or "fear of going mad". The panic attack symptoms progressed rapidly and violently, reaching their maximum intensity within 5-10 minutes, then quickly extinguished. As all the patients noted, they tried to find an explanation for the first two or three attacks relating them to recently experienced psycho-traumatic situations or to their stay in stuffy, cramped rooms, but the patient was "terrified" by repeated in all situations and more frequent panic attacks forming "avoidance behavior". A part of the patients (53%) due to the marked somatic-vegetative disorders assumed they had severe somatic pathology and repeatedly consulted different doctors of physical profile "trying to find the illness". Another part (about 8%) preferred to be "treated" by healers. "With the aim to relieve stress from the attacks" 1/3 of the men started abusing alcohol, using drugs. About 9% of patients due to their "avoidance behavior" condemned themselves to a kind of "house arrest", complete social isolation. Almost all patients addressed for a psychiatric help after 8-9 months of illness in a state of distress and social maladjustment.

The third group: patients with phobic disorders

83 people (29.1%); aging from 18 to 39 years; sex distribution male to females is 1:2; 1/3 have accentuations of asthenic or psychasthenic types. 39% of these patients have checked at the doctors to "find out" whether their existing "special manifestation" can be considered as a "pathology"; and 11% - "for treatment, advice". Common characteristic symptom was a phobia (fear) of certain situations, objects. Onset of the disease in 60% of patients was in adolescence; 10% - after psychotraumatic stressful situations. Despite the long duration of the disease (up to 9 years) the manifestations of severe social maladjustment have not been identified. Due to isolation of phobic symptoms the patients have adapted (got adjusted) avoiding psychogenic situation. Phobic disorders being the most common were polymorphic in clinical manifestations. The most common in this group were agoraphobia (fear of open spaces, crowds) – 30 people, (26.1%); claustrophobia (fear of enclosed, tight spaces)

– 11 people, (13.2%); disease phobia (fear of illness: cancer, AIDS or other) – 13 people (15.7%). Other types of phobias were of singular nature, but actual for the patients. I was this category of patients (29 people, 24.9%) sought for the "advice, treatment", by necessity they had to face the phobic situation. They felt anxiety, apprehension that they "would feel as bad as they had felt once before ". Among them there are people with the fear of flying on airplanes, fear of speaking in public, in examinations, etc. It should be noted that such situations were difficult for the doctors, too, due to time for effective treatment (usually the visit were made on the eve of the upcoming event).

The fourth group: patients with acute stress reaction (the first subgroup), and post-traumatic stress disorder (the second subgroup). A total of 76 people (26.5%); of different age, male to female sex distribution is 1:2; 1/4 have accentuations of various types. Typical for the first subgroup of patients was the occurrence of mental disorders in the first minutes, hours after exposure to the massive psychogenic factor (car accident witness, death of loved ones, a rape victim). The clinical picture was confused and rapidly changing: "stunned" state with retardation was replaced with anxiety hyperactivity with disorientation, pronounced vegetative manifestations. In most cases (75%) of mental disorders reduced within 5-7 days. In some patients it was associated with growing anxiety, depression with post-traumatic stress state development.

This type of pathology also occurred in patients 1.5-2 months after experienced stress (delayed response). They are usually delivered to the physicions by relatives, who noted that the patient "lost interest in everything, stopped going to work, communicating with others", i.e. maladjustment state was observed. During the examination the patients were once passive and "detached", once irritable, anxious and fussy. Complained about the intrusive thoughts, images, scenes related to the past stress. Quite often, at night particularly, they noted the state "as if they were back" in a traumatic situation. It should be noted that patients during their visit did not want to talk about the experienced trauma "I don't want to remember", but pointed out that "they can't remember everything". Despite this, they lived out the experienced stressful situation with separate "bright scenes".

The fifth group: patients with obsessive-compulsive disorder (79 people, 27.1%), the predominant age of 18-35 years, sex distribution 1:1; 1/4 had accentuation of various types with a predominance of schizoid and psychasthenic features. This group can also be divided into two subgroups: the first - patients with a predominance of obsessions, the second - with predominantly compulsive (intrusive) activities. Sex distribution is approximately equal. It should be noted that males prevailed in the first subgroup, and females – in the second. Common to the members of the first subgroup were thoughts and images repetitive in a stereotyped form. The patients realized that they were their own thoughts, though weird. Often being unpleasant in content they caused patient's anxiety. The patients noted that in the beginning they managed to "neutralize" them with other thoughts. But over time they became more and more stubborn. The patients were afraid that in some situation they will not be able to "withstand them" and will implement them into action (speaking coarse language loudly in a public place, cause physical or mental harm to their loved ones, etc.). Typical for the second subgroup of patients was the presence of compulsion - annoying actions. Physical compulsive actions are hand washing, cleaning, knocking on the floor before leaving the house, stepping over the fifth step when going down the stairs, etc). The mental ones include praying, repeating any three-digit number, etc. All of these actions were of ritual, protective nature. The patient in such a way kept himself and his family away of troubles. In the early stages of the disease the compulsions were rare and of short duration. But over time the ritual actions were committed repeatedly, continuously for a long time and adversely affect the family and social life of the patient.

CONCLUSIONS

The above states are borderline mental (neurotic) disorders. Their occurrence is promoted by reduce of human adaptive capacity due to various internal and external factors (personality-typological features, psychogenic stress, somatic-neurological disease). They are polymorphic in clinical manifestations, but have common features with the presence of anxiety and phobias. Without specific treatment they become chronic with the development of social maladjustment. Awareness of the symptoms of these disorders can guarantee reference to the specialist in a due time and favorable prognosis.

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