Anxious-Depressive Attack: An Overlooked Condition
A Case Report

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Abstract
Patients with anxiety and/or depressive disorders often experience sudden intense feelings of distressing emotions, including sadness, anxiety, loneliness, gloom and so on, without any apparent psychological reason. Tearfulness often precedes or accompanies such emotional outburst. In addition to these emotional symptoms, mild physiological symptoms similar to those seen in a panic attack, such as palpitations, dizziness, trembling and so on, may appear. Immediately after this emotional outburst, distressing trains of thought or images related to recent or past unpleasant events are experienced and ruminated on repeatedly. They are often manifested as flashbacks with or without visual images. Since these conditions are the bitterest experiences for most patients, they may cope with them in various ways such as deliberate self-harm. These patients generally have a more or less depressive mood. These conditions are considerably different from a panic attack, in that the emotional and cognitive storm dominates the physical one. The author named this condition as an Anxious-Depressive Attack (ADA). In this study, we present five cases of ADA and discuss their psychopathology and differential diagnoses. To the author’s knowledge, this is the first report proposing the term ADA, which is a unique but common syndrome. Awareness regarding ADA may help improve understanding and treatment of the patient.

Key words: anxious-depressive attack, emotional outburst, memory ruminations, coping behavior, social anxiety disorder, depression

[Introduction]
It was aware that patients with anxiety or and depression are attacked by sudden emotional outbreaks of painful feelings incongruent with the patient’s subjective emotional state. At the same time, or just in advance, they move to tears with or without being aware of it. Together with weeping, very mild physiological symptoms, such as palpitation, shortness of breath, sweating and so on, similar to those seen in a panic attack, may be observed. Following the emergence of these emotional outbreaks, the enforced remembering of recent or past regretful memories is manifested repeatedly, with agitation. These memories may appear as flashbacks. Most patients are overwhelmed by these conditions, often forcing them to react in various ways, including extreme behaviors such as wrist cutting in some cases. This episode is not a panic attack, in which the physical symptoms dominate the emotional and cognitive ones. The author named this episode as an Anxious-Depressive Attack (ADA).

In this study, we present five cases of ADA
and discuss their psychopathology and differential diagnoses.

**[Case Reports]**

1. **Case 1**

Ms. A, a 22-year-old student, was in a tense atmosphere with her employment exam approaching. In the interview of the employment exam, she experienced a moment of extreme fear and was unable to speak. Following this episode, she was habitually confused in front of the interviewer in her employment exams, and job hunting did not go well as a result. She wept easily from this time on, and had a gloomy mood at all times. When she was alone in the dormitory in the middle of the night, months after the first employment exam, she had a sudden stream of groundless tears for the first time, following which, she experienced loneliness, a feeling of emptiness, a sense of hopelessness, and a restless and irritable feeling overcame her. This was accompanied by mild palpitation, perspiration, and dizziness, which persisted for several minutes. Regrettable memories of the interview and worries related to the uncertain future came to her mind repeatedly without interruption. The rumination continued for more than one hour, as she wept to sleep. It was her first experience of ADA. She was confused about her being this sentimental and crying every night, but assumed that everyone suffered from such thoughts.

Ms. A experienced sudden palpitation, dizziness, sweating, extreme anxiety, and a choking feeling while on the subway two months after the first employment exam. She endured this without getting off the train. However, she later experienced agoraphobia against the crowd, which aggravated to an extreme degree, such that she was hardly able to go out. When she was alone in the dormitory at midnight, she wept with a feeling of loneliness, distress, and gloom for about 30 minutes every day. She coped with the ADA with a change in place and by going through her favorite books.

Nine months after the first employment exam, as the panic attacks and sudden crying followed by negative emotional attacks became more frequent and occurred every night, Ms. A consulted us as she considered the possibility of a mental illness.

Her clinical interview revealed that she had no history of physical diseases. However, she had a tendency to develop social and generalized anxiety and had trouble in adjusting to her surroundings. She was diagnosed with panic disorder, agoraphobia, and other specified depressive disorder according to the DSM-5 criteria (American Psychiatric Association, 2013).

The psychological assessments at the first visit were as follows: Beck Depression Inventory (BDI-II) (Beck et al., 1996): 27; Self-rating Depression Scale (SDS) (Zung, 1965): 54; Liebowitz Social Anxiety Scale, Japanese version (LSAS-J) (Liebowitz, 1987): 15; and Tokyo University Social Anxiety Scale (TSAS) (Kaiya et al., 2004): 15.

All the symptoms including sudden emotional bursts of hopelessness, groundless tears, and rumination of regrettable memories and future worries, that is, ADA, panic attacks, agoraphobia, and depression, subsided with the help of intensive cognitive-behavior therapy and pharmacological intervention administered for 3 months.

1-1. **Summary**

Ms. A first showed ADA followed by panic disorder, which coexisted thereafter and
disappeared with treatment. The ADA was easily treatable since it was acute and in its early stages.

2. Case 2

Ms. B, a 20-year-old vocational college student, visited us with complaints of depression and behavioral difficulties. The psychiatric evaluation revealed that she experienced violent emotional outbursts almost every night for no specific psychological reason. These attacks (ADAs) included depressive feelings, loneliness, self-hatred, and weeping. Within a minute of the emotional outburst, she experienced distressing trains of thought or images related to recent or past adverse events, and flashbacks of several kinds of scenes of past painful events (e.g., being scolded by her mother). The attacks lasted over 3 hours in the most extreme cases. During the attacks, she felt like she was another person. She ruminated on these flashbacks, and coped with her “unendurable” attacks by overeating, wrist cutting, or overdosing on prescribed drugs. She gained 15 kg over 5 years. She withdrew from the school and from meeting friends, hardly went out, and lived in day-night reversal.

The patient was the oldest of three siblings (with a younger sister and brother). As an infant, she was raised by her grandmother and exhibited severe fear of strangers. In junior high school, she experienced social anxiety, avoided public speaking, and was ridiculed by her classmates. In high school, she feared being rejected by her friends and her mother, and experienced groundless anger. Her academic performance declined, resulting in her refusal to attend school and her poor social choices, such as engaging with disreputable peers. She cried on most nights because of the severe emotional bursts and forced ruminations about regrettable memories (ADAs), which began to occur during this time. At the age of 18 years, she met the criteria for a diagnosis of panic disorder.

She was diagnosed with social anxiety disorder, borderline personality disorder, past panic disorder, and major depression with atypical features (mood reactivity, weight gain, and rejection sensitivity).

Psychological assessments at the first visit were as follows: SDS, 45; and LSAS-J, 108.

Psychiatric reexamination at 28 years of age demonstrated that she was almost well and was employed, but experienced ADAs once or twice per month.

2-1. Summary

Ms. B was 17 years old when her ADAs first began. She developed panic disorder 1 year later, on ground of social anxiety disorder and borderline personality disorder. Her ADAs continued chronically, and her atypical depression alternated with panic attacks (seesaw phenomenon). Her ADAs were refractory even after over 10 years.

3. Case 3

Ms. C is a 28-year-old engineer. During high school, she was withdrawn and had few friends owing to social anxiety. She had a history of receiving psychiatric care for depression for almost 3 years between 15 and 18 years of age. At the time, Ms. C had a hard time being hazed by her classmates, showed deterioration of academic performance, and was dumped by a boyfriend. During those 3 years, she suddenly experienced violent fits of sad feelings and related memory ruminations together with severe agitation (ADAs) almost every day, and considered that the ADAs were part of her personality. After high school graduation, she finished graduate school and worked in a
company without great difficulties. During those 8 years, including 2 years of working for the company, the ADAs still continued, albeit with a lower frequency and severity. Three years after beginning work at the age of 27 years, she was stressed due to her inability to get along well with her younger colleagues. Following this, her emotional outbreaks and intrusion of bad memories (ADAs) intensified and she became depressive. Six months following this desperate struggle, she had to take a temporary leave from her job.

She was diagnosed with social anxiety disorder and major depression.

Psychological assessments at the first visit were as follows: SDS, 54; LSAS-J, 88; and TSAS, 95.

Here are the features of her recent ADAs, as described by her:

“I was attacked by a sudden emergence of loneliness and sadness without any reason, followed by bad memories from the past. My mind was occupied by an idea that I must pay for my sins with my death. I felt my heart pounding. I was looking at my left wrist and visualizing myself cutting it. The image made me cry aloud “No! No! No!” I began to feel that I was nearly going mad.”

“When I came across such an ADA in the train or during mindfulness meditation, I tried to endure the crying, but buckets of tears flowed.”

“I unexpectedly go into a sad mood in the bathroom sometimes, followed immediately by reminiscences of my brain going blank during a speech in an important meeting, and I feel awfully embarrassed. In one such episode, this regretful memory made me feel very agitated and I hit the water in the bathtub while crying aloud. When I returned to my usual self after over half an hour, the water in the bathtub had splashed around and decreased to almost half.”

3-1. Summary

Ms. C had been experiencing ADAs on and off since she was 17. Her ADAs became weaker through 6 years of schooling and 2 years of work. However, stressful events with colleagues intensified her ADAs as well as her depressive mood again.

4. Case 4

Mr. D is a 40-year-old office employee. One year ago, he was diagnosed with an adjustment disorder with depressive mood. The patient developed the illness following an event at work where he was blamed by his superior for unsatisfactory leadership and was later transferred to another position. After this incident, he complained of physical deconditioning, depressive mood, loss of motivation, and sleep disturbance.

Mr. D visited our clinic at the end of his 3-month-long absence from work. His retardation and fatigue interrupted his reinstatement, that is, he was not completely in a remitted state. He experienced sudden feelings of sadness and uneasiness followed by flashbacks of a scene in which his superior scolded him. He took his mind off his agitation by taking to smoking and drinking, and eating plenty of junk food. His wife informed us that he often wept at night.

Psychological assessment at the first visit was as follows: BDI-II, 31; SDS, 54; LSAS-J, 87; and TSAS, 115.

He was diagnosed with major depression with atypical features. His clinical condition met the criteria for post-traumatic stress disorder except for the criterion A.

It took the patient close to 2 years after reinstatement to his job to be free of the ADA
episodes.

4-1. Summary
The feeling of disapproval at work caused Mr. D to develop a depressive state and ADAs continuing for almost 3 years. The ADAs first appeared in the middle age in this case.

5. Case 5
Mr. E is a 38-year-old man. He suffered from separation anxiety and selective mutism during his childhood. He remained absent from athletic meetings in his primary school because of social anxiety. After graduating from university, he had been working as a system engineer, and then as a businessperson in his father's company, which he left because of trouble with his father. Since then, he worked as a personal investor, and lived alone in his secluded home.

Mr. E visited a clinic presenting with depressive mood, irritability, agitation, and feelings of self-hatred since 9 months. Despite considerable improvement in his condition, he continued to complain of irritability, anger, unstable mood, over-eating, retardation, and stranger anxiety. Psychiatric examination revealed ruminations of thinking and flashbacks followed by anger occurring several times a day. The contents of his ruminations included the conflict with his father, those of a college of father's subordinate, and the classmates and teachers that he disliked in junior school.

Psychological assessments at the first visit were as follows: BDI-II, 16; LSAS-J, 88; and TSAS, 87.

He was diagnosed with social anxiety disorder and other specified depressive disorder.

The ADAs significantly improved with pharmacotherapy and cognitive behavior therapy and subsided within a year.

5-1. Summary
Mr. E had sudden ADAs together with a depressive mood, despite the absence of noticeable stress. His ADAs were characterized by ruminations of bad and vexing events from the past. The ADAs appeared frequently, more than 10 times a day, even while driving. Intensive treatment resulted in the disappearance of the ADAs within a year.

[Discussion]

In all the cases reported here, it was common for the ADA to appear spontaneously, irrespective of self-will. ADAs always began with an emotional outburst, followed by unpleasant memory intrusion, and finally, coping behaviors. In reality, an event first provokes cognitive action, followed by emotional and physiological responses, and finally a behavioral reaction. However, the order of these psychomotor actions is reversed in an ADA, in which an emotional outburst appears first, followed by ruminated thinking and coping behavior. In most cases, the emotional outburst is followed or accompanied by weeping. Furthermore, ADAs occur suddenly without any identifiable psychological trigger. This reverse psychomotor course in ADA is possible according to a modern theory of neuroscience. Damasio (2003) stated that certain thoughts evoke certain emotions and vice versa, and that cognitive and emotional levels of processing in the brain are continuously linked in.

This important clinical concept, ADA, may have existed and might have been overlooked by physicians for a long time. In general, patients tend not to report inner self-experiences as freely as they would report physiological symptoms such as panic attacks. Some patients go through extraordinary mental states during an ADA;
therefore, they find it difficult to report it without severe emotional distress. In most cases, an ADA should be preserved as a recognition memory, because most patients agree about them experiencing an ADA when they are asked, but they seldom claim ADA spontaneously. When patients who have experienced ADAs were asked why they did not report their symptoms of their own accord, relatively coherent patients gave the following answers: they felt that it would be a nuisance to explain; they believed that everyone experiences similar feelings; they were given over to self-pity; and they did not perceive the ADA to be as severe as a panic attack.

To the author’s knowledge, this is the first report proposing the term ADA and differentiating it from similar conditions. Searching clinical descriptions of symptoms similar to ADA in the literature, the term “anxiety-attack” is found in the book titled “The Anxiety-Neurosis,” authored by Freud (1956). The following excerpt from the book is noteworthy: “Anxious expectation is the nuclear symptom of this neurosis; it clearly reveals, too, something of the theory of it. We may perhaps say that there is here a quantum of anxiety in a free-floating condition, which in any state of expectation controls the selection of ideas, and is ever ready to attach itself to any suitable ideational content. This is not the only way in which apprehensiveness which is not usually present in consciousness without being called forth by any train of thought, and thus brings about an anxiety-attack. An anxiety-attack of this kind either consists of a feeling of anxiety alone without any associated idea, or associated with the nearest interpretation, such as sudden death, a stroke, or approaching insanity; or else the feeling of anxiety combined with parenthesis (similar to the hysterical aura); or finally, together with the feeling of anxiety there is an accompanying disturbance of any one or more of the bodily functions, such as respiration, heart’s action, vasomotor innervations, or glandular activity.” Freud’s description of an anxiety attack does not include depressive feelings like those observed in ADAs, and its associated thoughts are about serious events such as sudden death; in contrast, an ADA primarily concerns troubles related to interpersonal relationships. ADA differs from dissociative disorders, which are characterized by disruption and/or discontinuity in the normal integration of consciousness, identity, or perception of the environment (American Psychiatric Association, 2013). ADAs do not involve a gross disturbance of consciousness. ADA contains all the five symptoms of the so-called agitated depression, which is mentioned as “anxious distress” in Specifiers for Depressive Disorders in DSM-5 (American Psychiatric Association, 2013). However, ADA differs from this condition in two ways: 1) ADA occurs as an attack, while the anxious distress is more gentle and endless, and 2) in anxious distress, the order of appearance of the symptoms is indefinite unlike in an ADA, in which abrupt feelings of distress, painful rumination, and consequent coping behavior emerge in a certain order. Ataque de nervios (attack of nerves) a syndrome among individuals of Latino descent, is characterized by symptoms of intense emotional upset, including acute anxiety, anger, or grief; screaming and shouting uncontrollably; attacks of crying; trembling; heat in the chest rising into the head; and becoming verbally and physically aggressive. Dissociative experiences (e.g., depersonalization, derealization, and amnesia), seizure-like or fainting episodes, and suicidal gestures are prominent in some ataques but absent in others. A general feature of an ataque de nervios is a sense of being out of control. Attacks frequently
occur as a direct result of a stressful event related to the family, such as news of the death of a close relative, conflicts with a spouse or children, or witnessing an accident involving a family member (American Psychiatric Association, 2013). Ataque de nervios shows similarity with an ADA in its symptoms of intense emotional outbursts and occasional fit-like paroxysms of emotionality. Yet, Liebowitz et al. (1994) reported that 41.3% of subjects with ataque de nervios were diagnosed with panic disorder. In ataque de nervios, the attacks frequently occur as a direct result of a stressful event, whereas ADA does not have a direct trigger just ahead of the attack. Moreover, the brash behavior seen in patients suffering from ataque de nervios, seem to be primary symptoms, while various behaviors seen in the ADA seem to occur as a distraction from the primary suffering.

The ADA syndrome frequently includes flashbacks, but differs from post-traumatic stress disorder (American Psychiatric Association, 2013). Patients experiencing ADAs do not have past experiences of serious trauma as described in criterion A (DSM-5) in post-traumatic stress disorder, and an ADA is composed of a series of paroxysmal symptoms. The sudden emotional excitement experienced by patients with schizophrenia also appears similar to an ADA, but can be easily differentiated from it because the emotional fit is a reaction to a hallucination and/or delusion in the former case (American Psychiatric Association, 2013).

Anxiety and mood disorders are the most common psychiatric comorbid conditions in patients with epilepsy (Kanner, 2004). As an ADA has a paroxysmal nature, it is important to distinguish an ADA from partial epilepsy. An ADA differs from partial epilepsy in that it is not associated with automatism or impairment of consciousness (Kanner, 2004). Disruptive mood dysregulation disorder is characterized by severe recurrent temper outbursts manifested verbally and/or behaviorally that are grossly out of proportion in intensity or duration with respect to the situation or provocation (American Psychiatric Association, 2013). ADAs are different from disruptive mood dysregulation disorder in the following ways. First, the emotional burst in an ADA is related to anxiety and/or depression, unlike anger in disruptive mood dysregulation disorder. Second, an ADA emerges when a patient is alone in most cases; on the other hand, disruptive mood dysregulation disorder is observed by others. Finally, the onset of disruptive mood dysregulation disorder (<10 years) is earlier than that of ADA (middle to late teens in most cases). Involuntary weeping in ADAs cannot be attributed to pseudobulbar affect, in which patients show emotional eruptions such as outbursts of crying or laughing (Work et al., 2011), as patients with ADA have no neurological disorders such as amyotrophic lateral sclerosis, traumatic brain injury, stroke, and so on as seen in pseudobulbar affect.

A similarity of ADA to the “episodes of abruptly depressive mood in hysteroid dysphoria” reported by Liebowitz and Klein (1979) might be worthy of discussion. Hysteroid dysphoria is now considered as depression with atypical features (Horwath et al., 1992), which we observed in the present study. It is unfortunate that Liebowitz and Klein (1979) did not describe these episodes in detail. Hackmann et al. (2000) reported that patients with social anxiety disorder repeatedly experience excessively negative intrusive images of their past unpleasant social incidents. The intrusion of negative images in their study could possibly correspond to ADA-related rumination. In the present study, three out of the five cases were diagnosed as social
anxiety disorder, while the other two cases showed social anxiety as a symptom. Intrusive thoughts in the ruminations were often linked to adverse interpersonal events, both in their study (Hackmann et al., 2000) and ours. Felker et al. (2003) reported that 21.9% of the patients with depression suffer from comorbid flashbacks and panic attacks. Brewin et al. (2010) mentioned that patients with posttraumatic stress disorder, other anxiety disorders, depression, eating disorders, and psychosis frequently report repeated visual intrusions corresponding to a small number of real or imaginary events, which are usually extremely vivid, detailed, and with highly distressing content. These studies (Liebowitz and Klein, 1979; Hackmann et al., 2000; Felker et al., 2003; Brewin et al., 2010) may provide further evidence for the existence of ADAs in western countries. Self-damage, which is often observed in ADA, is said to be closely related to borderline personality disorder (Evren et al., 2012). As seen in case 2, ADAs could occur in cases of borderline personality disorder.

[Conclusion]

ADA is a syndrome composed of 3 elements, which include sudden outbursts of negative emotions incongruent to the conditions of the place, rumination of intruding unpleasant memories, and finally, behavioral reactions to these painful feelings and thoughts, including self-harm. The three elements appear in that order. ADA is a unique syndrome, which accompanies anxiety and mood disorders. Directly asking patients if they suffer from ADAs during the neuropsychiatric examination has revealed that ADA is not a rare syndrome, as it has been observed to affect 43.2% of the outpatients visiting anxiety clinics (Kaiya, in preparation).

[Additional remark]

Written informed consent was obtained in all the five cases.

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