The more pervasive an archetype type is, the larger is the risk that it becomes a myth that legitimizes itself. —Black M. Metaphor and Thought. 1979.

The aim of this issue is to enhance clinicians’ awareness about the presence of anxiety disorders in psychotic patients and the importance of detection during assessment and treatment.

The general convention in the Diagnostic and Statistical Manual of Mental Disorders (DSM) is to establish a diagnostic hierarchy in various situations, such as when the symptoms of a mental disorder are the same as a medical or substance-induced comorbid disorder, when it is clinically difficult to determine the boundary between one disorder and another (e.g., panic disorder vs social phobia), and when a more pervasive disorder (e.g., schizophrenia) has among its defining or associated symptoms the defining symptoms of a less pervasive disorder (e.g., dysthymic disorder).

With the appearance of the third edition of the DSM in 1980, the classic distinctions between neurosis and psychosis were effectively overcome, which implicitly involved both a hierarchy, whereby neurosis was less serious than psychosis, and also different physiopathological mechanisms—conflict for neurosis and defect for psychosis. This edition did not try to describe mental disorders naturally and did not declare its approach to be atheoretical; however, a number of unstated archetypal concepts still exist, and their pervasive nature has continued to influence the judgements of clinicians. By *archetype*, we mean a theoretical, nonempirically derived influence on the organization of explicitly declared concepts in a hidden, unobtrusive way.1

Such concepts partly explain the slowness to perceive the clinical relevance of anxiety disorders in the so-called psychotic disorders. Especially when the principal diagnosis is an Axis I disorder (indicated by listing it first), the remaining disorders are listed in order of clinical focus, and multiple diagnosis can also be reported in a multiaxial fashion. Because schizophrenia is prevalently a life-long, pervasive condition, the exclusion criterion “does not occur exclusively during the course of” represents a potential diagnostic bias.

Comorbid anxiety disorders and drug-precipitated anxiety disturbances in bipolar and schizophrenic disorders have been extensively reported.2,3 These diagnoses in schizophrenic patients are useful and must be conducted in such a way as to overcome hierarchies in the DSM, because the frequency of comorbid anxiety disorders in schizophrenia is high and can emerge in symptom-free clinical phases, when patients may be able to regain social functioning and resume work and relationships.

Comorbidity for anxiety disorder in schizophrenia requires specific treatments (i.e., selective serotonin reuptake inhibitors) to which it responds, as well as alterations in the therapy of the so-called main disorder. Recent data4 have shown that patients with chronic schizophrenia suffering from comorbid panic attacks tend to be taking neuroleptics in larger doses than patients without comorbid panic attacks.

The close similarity between an obsessive and a schizoid pattern on the Axis II, described in this issue by Rossi and colleagues, makes the importance of the anxiety-schizophrenic spectrum relation both more convincing and more complex, while also generating a broader debate about obsession and psychosis.

Also in this issue, Pallanti and colleagues describe the emergence of social phobic symptomatology with clozapine as an example of pharmacological dissection in the nosographical domain of schizophrenia, and pose the question of the boundary between behavioral extrapyramidal side effects and the medication of the psychological condition.

Lindley and colleagues present the relationship between anxiety and psychosis that is rendered even more complex by the description of psychotic features in patients with posttraumatic stress disorder, which has important nosographic and therapeutic implications. Finally, Gaion and colleagues discuss recent evidence on abnormalities of brain hemispheric organization in panic disorders.

All of these observations have provided us with good reason to title this issue “The Anxiety-Psychosis Spectrum”—a concept that emphasizes, theoretically and clinically, the need to differentiate between the level of cognitive and structural alterations and that of symptomatological expressions.

REFERENCES


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