

CARDIAC NEUROSIS

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October 10, 2025

RECOMMENDED CITATION

Mohammed loot (2025). *CARDIAC NEUROSIS*. Encyclopedia of psychology. Retrieved from <https://encyclopedia.arabpsychology.com/?p=13021>

Cardiac Neurosis: A Psychological Perspective on Cardiac Symptoms

The Core Definition of Cardiac Neurosis

Cardiac neurosis, historically referred to as **neurocirculatory asthenia** or **effort syndrome**, is a psychological disorder characterized by the presence of physical symptoms strongly suggestive of heart disease, such as chest pain, palpitations, and shortness of breath, in the absence of any verifiable organic cardiac pathology. It is fundamentally a **psychosomatic** manifestation where severe emotional distress, primarily intense anxiety, triggers real, debilitating physical sensations. While the heart itself is structurally healthy, the patient genuinely experiences the symptoms as life-threatening, leading to cycles of fear and physical exacerbation.

The core mechanism behind cardiac neurosis involves the misinterpretation of normal physiological responses, often driven by the **autonomic nervous system**. When an individual experiences high levels of chronic stress or acute panic, the body releases stress hormones that cause physical changes--increased heart rate (tachycardia), muscle tension, and changes in breathing patterns. For the individual suffering from cardiac neurosis, these benign yet uncomfortable sensations are immediately catastrophized and interpreted as evidence of an impending myocardial infarction or sudden cardiac death. This cognitive distortion reinforces the physical symptoms, creating a powerful feedback loop that sustains the disorder and contributes significantly to functional impairment and reduced quality of life.

Modern diagnostic systems, such as the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, no longer use the term "cardiac neurosis" explicitly. Instead, these presentations are typically categorized under diagnoses like Somatic Symptom Disorder, Panic Disorder with somatic symptoms, or Illness Anxiety Disorder, depending on whether the primary concern is the existence of the symptom itself or the fear of having a serious, undiagnosed medical condition. However, the older term remains clinically useful to describe the specific cluster of symptoms focused entirely on perceived cardiac dysfunction.

Historical Context and Early Conceptualizations

The understanding of cardiac neurosis stretches back over a century, long before the modern division between psychiatry and cardiology became formalized. One of the most significant historical figures associated with this condition is Dr. Jacob Mendes Da Costa, a Union Army physician during the American Civil War. In 1871, Da Costa observed a high prevalence of soldiers presenting with cardiac-like symptoms--fatigue, rapid heart rate, and chest pain--who showed no structural heart damage. He termed this presentation **Da Costa's syndrome**, or sometimes "Irritable Heart." This groundbreaking work established that psychological distress could manifest with profound physical symptoms mimicking severe organic disease.

Following Da Costa's work, similar conditions were recognized under different names, reflecting the prevailing medical terminology of the time. During the early 20th century, particularly around the time of the World Wars, the term **effort syndrome** gained prominence, highlighting the fact that these symptoms were often exacerbated by physical exertion, though they were not purely physical in origin. These early conceptualizations were vital because they forced the medical community to acknowledge the powerful interplay between mental state and physical health, predating the rise of modern psychosomatic medicine.

The shift from the term "neurosis" began in the latter half of the 20th century. Sigmund Freud and his followers had categorized neuroses as emotional disturbances rooted in unconscious conflict. As psychiatry evolved, moving towards more descriptive, observable criteria, the general term "neurosis" was retired in favor of specific anxiety, mood, and somatoform disorder classifications. Nevertheless, the historical context provided by Cardiac Neurosis research laid the foundation for understanding how chronic stress and specific phobias (like cardiophobia) can lead to physiological dysregulation that severely impacts daily functioning.

Etiology: The Role of Stress, Anxiety, and Physiology

The development of cardiac neurosis is multifactorial, involving a complex interplay of psychological vulnerability, acute stress exposure, and physiological sensitization. Individuals prone to this disorder often possess high levels of trait anxiety, are highly attuned to internal bodily sensations (a phenomenon known as **interoceptive awareness**), and may harbor underlying health anxiety or hypochondriasis. When these psychological vulnerabilities meet significant emotional distress, such as high occupational pressure, relationship conflict, or grief, the threshold for triggering a somatic response is lowered dramatically.

Physiologically, the central driver is the overactivity of the **sympathetic nervous system**, which controls the body's 'fight-or-flight' response. Chronic anxiety leads to sustained levels of circulating stress hormones, such as cortisol and adrenaline. Even minor stressors can cause an exaggerated release of these hormones, resulting in noticeable physical manifestations. These manifestations include peripheral vasoconstriction, elevated blood pressure, and, most pertinent to cardiac neurosis, erratic heart rhythms (sinus tachycardia or premature ventricular contractions), which the patient perceives as life-threatening palpitations.

A critical component of the etiology is the subsequent **catastrophic misinterpretation** of these normal or stress-induced bodily signals. When the individual feels a skipped heartbeat, instead of attributing it to indigestion or caffeine, they instantly conclude they are having a heart attack. This thought triggers a massive surge in anxiety, which further intensifies the physical symptoms (hyperventilation leading to shortness of breath, muscle tension leading to chest tightness). This escalating cycle ensures that the patient remains trapped in a state of fear and somatization,

regardless of repeated reassurances from cardiologists confirming cardiac health.

Symptomatology and Differential Diagnosis

The clinical presentation of cardiac neurosis is characterized by a specific cluster of symptoms that overlap significantly with actual cardiovascular disease, making the initial diagnostic process challenging. The most common symptoms reported by patients include recurrent bouts of severe, crushing **chest pain** that may radiate to the left arm or shoulder; frequent and often frightening heart **palpitations** or arrhythmias; chronic or acute **dyspnea** (shortness of breath) often associated with shallow, rapid breathing; and episodes of dizziness, lightheadedness, or near-syncope.

A vital step in diagnosing cardiac neurosis is the rigorous process of **differential diagnosis**. Before any psychological label can be applied, comprehensive medical workups must conclusively rule out organic heart disease, including coronary artery disease, valvular defects, myocarditis, and serious arrhythmias. These workups typically involve electrocardiograms (ECGs), stress tests, echocardiograms, and sometimes prolonged Holter monitoring. It is common for patients with cardiac neurosis to undergo multiple unnecessary emergency room visits and extensive testing due to the severity and conviction of their symptoms.

Once organic disease is excluded, the diagnostic focus shifts to the psychological realm. Key distinguishing features of cardiac neurosis include the situational nature of the symptoms (often triggered by emotional stress rather than physical exertion, or occurring predominantly in social settings), the lack of objective findings during symptomatic episodes, and the presence of significant comorbidity, such as Generalized Anxiety Disorder or Major Depressive Disorder. Furthermore, the patient's fear and preoccupation with their heart health often far exceed the objective severity of the physical sensations, indicating a primary psychological distress disorder.

Practical Illustration: Navigating a Panic Episode

To illustrate the destructive cycle of cardiac neurosis, consider the case of "Sarah," a 35-year-old marketing executive who has been recently cleared by her cardiologist after severe, recurrent chest pains. Her symptoms typically begin not during exercise, but during high-pressure meetings or while preparing for a major presentation.

One morning, while Sarah is reviewing her slides, she notices a mild, sharp ache in her left chest muscle--likely tension from poor posture. This seemingly benign sensation immediately triggers a cascade of psychological and physiological events, demonstrating the principle of cardiac neurosis in action:

The Trigger and Initial Sensation: Sarah notices the minor muscle ache. Because she has a

history of health anxiety, her psychological filter immediately interprets this as "heart pain."

Catastrophic Misinterpretation: The thought, "I am having a heart attack right now," floods her mind. This is the central cognitive distortion. Her body responds instantaneously to this perceived mortal threat.

Sympathetic Activation and Physical Symptoms: Her autonomic nervous system shifts into emergency mode. Adrenaline surges, causing her heart rate to jump (tachycardia) and her breathing to become shallow and fast (hyperventilation). The physical symptoms--rapid palpitations and feeling smothered--are now intense and undeniable.

Behavioral Response and Fear Reinforcement: Sarah immediately stops working, grabs her phone to call an ambulance, and begins monitoring her pulse obsessively. This avoidance and safety-seeking behavior, while understandable, reinforces the neural pathway that connects the chest ache directly to the belief of cardiac failure.

The Cycle Completes: The fear subsides only when the adrenaline dissipates, but the memory of the terrifying experience solidifies her conviction that her heart is fragile and that she must constantly remain vigilant, setting the stage for the next, inevitable episode.

Therapeutic Approaches and Modern Management

Effective treatment for cardiac neurosis requires an integrated approach that addresses both the psychological drivers of the anxiety and the physical manifestations of the somatic symptoms. Since the underlying issue is the misinterpretation of bodily signals, the gold standard psychological treatment is **Cognitive-Behavioral Therapy (CBT)**. CBT focuses on identifying and challenging the catastrophic thoughts (e.g., "Palpitations mean I am dying") and gradually exposing the patient to the feared internal sensations, thereby demonstrating that these sensations are not dangerous.

A key component of CBT for cardiac neurosis is psychoeducation, where patients learn precisely how the stress response affects the heart (e.g., how hyperventilation causes dizziness or how anxiety increases heart rate). Techniques such as **interoceptive exposure** involve deliberately inducing the feared physical symptoms (e.g., running in place to increase heart rate or breathing into a bag to cause lightheadedness) in a controlled environment. By repeatedly experiencing these sensations without subsequent cardiac arrest, the patient learns to habituate to them and re-label them as non-threatening anxiety responses.

Pharmacological interventions are often used adjunctively, particularly if the cardiac neurosis is complicated by severe generalized anxiety or panic disorder. Medications such as Selective Serotonin Reuptake Inhibitors (SSRIs) or Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

can help normalize overall anxiety levels, reducing the frequency and intensity of the triggering emotional distress. In some cases, low-dose **beta blockers** may be prescribed to physically dampen the somatic response by slightly lowering the heart rate, offering the patient immediate symptom relief and reducing the physiological intensity that fuels the catastrophic thinking.

Significance, Impact, and Related Psychological Constructs

The study of cardiac neurosis holds immense significance for the field of psychology, particularly in the subfield of **Health Psychology** and **Psychosomatic Medicine**. It demonstrates the profound reality of the mind-body connection--that psychological states can exert powerful, measurable, and disabling effects on physiological systems. Furthermore, its prevalence, particularly among patients repeatedly presenting to cardiology clinics, highlights a crucial area for collaborative care between mental health professionals and medical doctors, reducing unnecessary healthcare expenditures and preventing iatrogenic harm from over-testing.

In contemporary psychology, cardiac neurosis is best understood by relating it to the broader category of Somatic Symptom and Related Disorders.

Somatic Symptom Disorder (SSD): Cardiac neurosis aligns closely with SSD, which involves distressing somatic symptoms combined with excessive thoughts, feelings, and behaviors related to the symptoms. In cardiac neurosis, the somatic symptom is specifically focused on the heart.

Illness Anxiety Disorder: This differs slightly as the primary distress is not the symptom itself, but the fear of acquiring or having a serious illness. A patient with cardiac neurosis often shifts between experiencing the symptom (SSD component) and fearing future disease (Illness Anxiety component).

Panic Disorder: Many acute episodes of cardiac neurosis are, in fact, **panic attacks** characterized by intense physiological arousal and the fear of impending doom or death. The specificity of cardiac neurosis lies in the singular focus of the panic on the function and structure of the heart.

Ultimately, the concept of cardiac neurosis reinforces the necessity of holistic patient assessment. Recognizing that a patient's chest pain, though non-cardiac, is a genuine expression of psychological turmoil allows clinicians to move beyond simple dismissal and offer treatments that truly address the root cause of their suffering--the devastating impact of uncontrolled anxiety and subsequent somatic distress.