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Neurosis:
A Conceptual Examination
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Everything great in the world comes from neurotics.
They alone have founded our religions and composed our masterpieces.¹

Introduction

The term ‘neurosis’ has been described as “that final triumph of the nineteenth century, … an embodiment of pseudo-physiology, unsound metaphysics, and moral condemnation.”² It is a concept which, quite clearly, still has a lot of currency in ‘folk’ psychology and everyday language, but which has gone increasingly out of favour among the expert community. This essay is an attempt to answer the conceptual question, ‘What, if anything, is (a) neurosis?’ What phenomenon, if anything, do we label with the name ‘neurosis,’ and how, if at all, do we describe or explain it?

I shall be dealing with three specific issues. Firstly, is ‘neurosis’ even a coherent concept at all? That is, can the following questions be satisfactorily answered: What does the term ‘neurosis’ classify? What set of things or properties does it group together? Is there a principled difference from the ‘sane’ or from other forms of insanity? If such questions cannot be satisfactorily answered (whatever one means by ‘satisfactory’), then ‘neurosis’ is not a coherent concept—there are no criteria for its correct application, and hence it is meaningless.

The second question concerns whether ‘neurosis’ is a useful classification. Does it capture a particular aetiology of some sort? Does it group together symptoms in a useful and consistent way—that is, does it pick out a certain syndrome or related family of syndromes? Does it group together disorders which all have the same forms of treatment? Is it relevantly theory-neutral, or tied to some particular set of psychological doctrines? Thirdly, I want as I go to make some attempt to briefly survey (and assess) the mooted aetiologies for, or theoretical accounts of, neurosis.

The Concept

Is there any unified notion in ‘the literature’ of what neurosis is? I think the answer is Yes: at some level, there is quite general agreement as to what ‘neurosis’ is. Further, this common notion is reasonably specific and detailed (I put off, for the moment, the question whether it is consistent, applicable, true of the things generally picked out, or useful—I am concerned, for the moment, with asking merely whether such a contemporary notion exists). There are commonly accepted central examples: phobias, obsessive-compulsive disorders, and depression. And there are five traditional, quite widely accepted (though, arguably, becoming outdated) families
of neurotic symptom patterns:3

a) Anxiety Reaction: The physiological symptoms of fear along with strong, pervasive, but inexplicable feelings of apprehension.

b) Phobic Reaction: Symptoms like the above, but elicited only by a restricted class of stimuli.

c) Obsessive-Compulsive Reaction: Obsessions are unwanted, often irrational thoughts that intrude repeatedly into awareness. Compulsions are unwanted, often irrational actions that one feels compelled to perform.

d) Hysterical Reaction: Typically, such reactions involve a large number of bodily symptoms that come and go irregularly, and considerable incapacitation in carrying out social responsibilities. They may be generally either ‘conversion reactions’—primarily involving skeletal musculature and sensory functions—or ‘dissociative reactions’—involving departures from normal states of consciousness.

e) Depressive Reaction: An extension of the normal grief reaction, with strong self-deprecatory tendencies.

Here, then, are some examples of current definitions of the notion of ‘neurosis’:

∞ “Neurosis is a term we often use for behaviour which is associated with strong emotion and which is maladaptive, and which the person giving rise to it realizes is nonsensical, absurd or irrelevant, but which he is powerless to change.”4

∞ The ninth revision of the International Classification of Diseases (ICD-9) defined psychoses as disorders in which “impairment of mental function has developed to a degree that interferes grossly with insight, ability to meet some ordinary demands of life or to maintain adequate contact with reality.” Neurotic disorders are the obverse of this: “disorders without any demonstrable organic basis in which the patient may have considerable insight and have unimpaired reality testing, in that he does not confuse his morbid subjective experiences and fantasies with external reality.”5

∞ “A neurosis is a condition of disorder of the personality characterized by a persistent syndrome of inappropriate physiological or intellectual or aesthetic or motor or emotional or moral responses to life situations; in which the individual instead of adaptively reacting principally in harmony with the total context of present conditions (including consciously-known future goals and consciously-evaluated past experiences) is reacting in a present situation non-adaptively, largely at the mercy of previously acquired psychic processes (of some kind) which intervene while physiologically and psychically isolated from the main body of consciousness and therefore cannot enter rationally into the individual’s present responses and evaluations.”6
"A neurosis is a compromise formation [in the psychodynamic sense] showing itself repetitively in thinking (mentally) or performance (bodily), caused by a preponderant intrapsychic conflict, and the compromise is incapacitating and ineffectual—i.e., the compromise does not accomplish what it sets out to do."

"Any of various usually comparatively mild mental disorders having no demonstrable physical basis and characterized chiefly by anxiety and obsessive behaviour."

The fundamental (though limited) similarity and overlap of these definitions is clear. The central defining elements of ‘neurosis’ today seem to be:

i) The presence of strong emotion; it is widely agreed that anxiety is a core emotion connected with neurosis.

ii) The maladaptivity of associated behaviour; they ‘obviously have something wrong with them.’ (So Barclay Martin writes: “In broad outline it may be conceived as a handicap in psychological functioning that has its locus in emotional and interpersonal aspects of behaviour.”)

iii) That the maladaptivity be ‘comparatively mild’—that is, not so extreme as to very, very severely damage the patient’s ability to deal with life and reality.

iv) That the behaviour be repetitive.

v) The absence of any clear physiological basis.

vi) Some insight and ability to check with reality on the part of the sufferer.

This last characteristic is sometimes supposed to mark out the neurotic from the ‘mad’ (see below). Perhaps it could be said that neurosis is characterised by a break-down in the connection between desires and actions: the neurotic wants to do $A$ but does $B$. She wants to get on with life and get somewhere in her job, but sits all day at home because of some silly fear of cats which makes it impossible to go out in case she might meet one. Or perhaps it would be more accurate to say that the break-down is between desires and second-order desires: the neurotic is bound by a certain powerful emotion (such as the fear of cats), but would prefer not to have this emotion.

Since these characteristics, on the whole, pick out episodes of behaviour, and since (arguably) someone can behave ‘neurotically’ without having ‘a neurosis,’ there must also be the additional stipulation that these acts must be performed by ‘a neurotic.’ A neurotic, presumably, is defined as someone who experiences episodes of neurotic behaviour with a severity and frequency above a certain threshold level.

Again withholding questions about the accuracy and consistency of these definitional criteria for a later assault, I think it is true to say that requirements i) to vi) do adequately sum up a shared notion of neurosis. Some one or two of the clauses might be considered non-essential by some camps—perhaps even false. (For
example, some therapists realize the highly dubious nature of clause iii), and would not include it in their concept of neurosis.) However, I think they include all the central ideas behind the concept, and do not include any which are not widely, if not universally, held.

Let me move on to consider the adequacy of the list. To what extent can it be said to provide necessary and sufficient conditions for the correct application of the word ‘neurosis’? For example, does it differentiate neurosis from the two ‘states of being’ most frequently and centrally contrasted with it: ‘psychosis’ and ‘normality’?

**Neurosis versus Psychosis**

To what extent are the concepts of ‘neurosis’ and ‘psychosis’ separable? Peter Tyrer sums it up this way: “The psychotic patient is very ill and does not realize it whereas the neurotic patient is less ill and realises it almost too well.”¹⁰ The third, revised edition of the American Psychiatric Association’s *Diagnostic and Statistical Manual* (DSM-III-R), like DSM-IV, defined ‘psychotic’ as “gross impairment in reality testing and the creation of a new reality. … When a person is psychotic, he or she incorrectly evaluates the accuracy of his or her perceptions and thoughts and makes incorrect inferences about external reality, even in the face of contrary evidence. The term ‘psychotic’ does not apply to minor distortions of reality that involve matters of relative judgement. For example, a depressed person who underestimates his achievements would not be described as psychotic.”¹¹ (Depression is actually very often taken as a neurotic symptom.) ICD-9, as we have seen above, draws a similar distinction.

Thus, broadly speaking, neurosis is supposed to be a breakdown between (conscious) beliefs and desires and the ability to act upon them; psychosis is the breakdown between reality and the formation of (conscious) beliefs and desires. Perhaps, then, the latter is supposed to be more ‘serious’ because more ‘fundamental’ and, on the ‘average,’ more harmful and dangerous. Hence psychotics are considered ‘mad’ and ‘very ill,’ whereas neurotics are not. However, as a matter of fact, it is simply not true that psychoses are always more disabling than neuroses. An extreme phobia, or obsessive-compulsive disorder can damage a person’s life very severely, preventing them from working, having successful relationships, even adopting hobbies. Obeying the compulsion or dealing with the fear may become the patient’s major life activity. By contrast, people with, for example, mild, grandiose type delusional disorder, can lead perfectly normal lives—certainly appearing completely normal when their particular delusional ideas are not being touched on—and even rise to positions of prestige and authority (!).
Nor is it true that psychotics always believe their hallucinations are reality: certainly, many only lose contact with reality periodically, and in certain situations. Again, this is true of sufferers from delusional disorders, for example, or brief reactive psychosis. Yet those with dysthymia (depressive neurosis) often make and believe unwarranted assertions about the world, such as extreme self-deprecation, or expressions of the hopelessness of situations. Patients with dissociative identity disorder (multiple personality disorder) and dissociative (psychogenic) fugue are labelled ‘neurotic’ by DSM-III-R (these are traditionally considered dissociative hysterical neuroses), yet these syndromes, if anything, surely involve a radical break-down of the connection between ‘ordinary reality’ and their world.

However, there are, apparently, empirical data which generally distinguish neurotics from psychotics, allowing for a more clean conceptual division (and perhaps suggestive both that there may be broadly differing aetiologies, and that psychosis is further from ‘normality’ than is neurosis):¹³

1. The two types of mental illness split themselves up into two great Erbkreise—genetic circles. The families of psychotics contain a high proportion of other psychotics, but very few neurotics; with the families of neurotics, the opposite is found—many neurotics but few psychotics.

2. Neurophysiologically and biochemically, there seem to be some clear differences between the two classes: essentially, abnormalities in blood serum, urine and sweat are found in psychotics which are not found in neurotics or normals. The same is true of studies of neural reactivity in psychotics.

3. Psychological tests (involving verbal and behavioural situations and responses) which differentiate normals from psychotics do not differentiate normals from neurotics; and tests which differentiate normals from neurotics do not differentiate normals from psychotics.

4. Clinically, neuroses do not usually develop into psychoses, or vice versa. Nor are they commonly conjoined.

5. Finally, day-to-day variations in the behaviour of neurotics are usually related to antecedent changes in environmental conditions; by contrast, the controlling factors on the part of psychotics seem internal. This can often differentiate two apparently similar sets of symptoms, such as depression. Further, psychotics hardly respond at all to psychotherapy or behaviour therapy, whilst neurotics seem much more reactive and often do recover (though not necessarily because of the treatment).

Overall, though, the prospects for a hard-edged conceptual distinction between neurosis and psychosis are not too good. And it is very uncertain that there is a clear distinction within the symptomologies: this will be discussed below.
Neurosis versus Normality

What about the distinction between neurotics and ‘normals’? It is estimated that around a third of the population in most countries, at most historical periods, is classifiable as ‘neurotic’:14 does this not cast suspicion on our concept as a useful indicator of anything significant? For example, a Gallup Poll in Britain in the 1970s found that 29% of the population had been treated for ‘worry, depression, or any other nervous complaint,’ and 31% were (very likely to be) suffering from clinical anxiety, according to psychological testing standards.15 It seems the difference between neurosis and normality is very often just one of degree: we can all be at times depressed, boisterous, overly suspicious, compulsive or nervous. “…Few of us are entirely free of some minor ‘neurotic’ reaction. Theories of neurosis play an important part in our understanding of human activity and should not be seen as relevant only to the behaviour of a small number of disturbed individuals.”16

So is neurosis merely a matter of relative deviation from the norm? Simply a somewhat more extreme form of behaviour which is otherwise normal? If so, then it is a matter of degree, which suggests (but doesn’t necessarily imply) that it cannot be rigidly differentiated conceptually from ‘normality.’ However, I am optimistic about the conceptual difference between neurosis and normality, for the following reasons. Firstly, the fact that 30% or thereabouts is such a constant in the measurement of neurosis in populations, both cross-temporally and cross-culturally,17 suggests that some objectively identifiable phenomenon is being measured—otherwise figures would presumably vary according to the researchers’ presuppositions.18

Secondly, there is the element in the notion of neurosis that states the behaviour must be significantly maladaptive: that it seems clear, in the context, that ‘something is wrong.’ This is clearly not a hard and fast distinguishing criterion, but seems to me sufficiently specific as to give the concept meaning; just as we can use the word ‘intelligent’ without having any very clear way of drawing the threshold between the intelligent and, say, the average, so we can use the term ‘neurotic’ because we know, fairly reliably, when someone is ‘ill’ and when they are not. At the least, it gives some sort of shared standard for correct use of the word; if I think Gertrude is neurotic, but you disagree, then at least we know that if we can agree on an answer to the question “is Gertrude behaving significantly maladaptively—is there ‘something wrong’ with her?” then we will know which of us is correct.

Thirdly, and similarly, there is the conceptual criterion of ‘significant insight’ on the part of the patient: with neuroses, it seems that if the patient asserts her own neuroticism this can act to confirm that we are correctly using the word of her; and further this assertion on the part of the patient is supposedly not unlikely. Neurotics
act contrary to their own wishes, and are aware of this; ‘normal’ people do not consciously act against their own desires.

**A Useful Classification in Practice?**

However, now we come to the crux of the matter. Supposing ‘neurosis’ in the abstract to be a conceptually quite clear and meaningful concept, what shape is it in in practice?

1) Does it accurately describe the instances where the word is taken to be correctly applied? If use is the ultimate arbiter (or even, one significant arbiter) of meaning, does the concept of ‘neurosis’ I have spelled out above accurately capture the real meaning of the term?

2) Does it spell out a practical distinction; one that is useful and natural? Does it spell out a ‘true’ distinction, corresponding to a distinction between aetiologies, syndromes or varieties of cure?

The psychiatric profession does not appear optimistic that it does. In both ICD-10 and DSM-IV the definition of ‘neurosis,’ and the subsequent grouping of diseases, has been de jure abandoned, though most of the old-established neurotic disorders in fact appear together in the classification. At the time of the constructing of DSM-III, 1987, there was widespread unhappiness with the concept of neurosis. It was felt that “as a unifying theme for explicating and co-ordinating diverse syndromes it had outlived its usefulness both as a nomenclature designation and as a classificatory principle.” Nor was it considered theory-neutral: it presupposes, researchers felt, intrapsychic conflict as a cause of neurotic symptoms, a central tenet of the psychodynamic school—the symptoms of neuroses are assumed to have deeper psychological significance as being the symbolic expression of a ‘psychological disease.’ Thus in DSM-II there was a category labelled ‘neuroses’; now that is no longer the case. In DSM-III-R the word ‘neurosis’ was largely replaced by the more theory-neutral term ‘neurotic disorder,’ and no mention of ‘neurosis’ is made in the Glossary of Technical Terms (though there is a reference for ‘psychosis’); in DSM-IV even the modifier ‘neurotic’ is eliminated.

I shall consider whether ‘neurosis’ is a sensible notion either aetiologically, symptomologically or therapeutically, looking at the degree to which it captures the way instances are actually (correctly) labelled and the degree to which it marks real borderlines in the phenomena.

**An Aetiological and Therapeutic Notion?**

Does ‘neurosis’ have any real aetiological meaning? Does it carry with it stipulations about the way neuroses are to be cured? Does it matter? Both ICD-10 and DSM-IV try to keep an atheoretical, empirical stance towards
diagnosis. They think of their categories as “simply a set of symptoms that have been agreed by a large number of advisers and consultants … as a reasonable basis for defining ‘typical’ disorders.” On the other hand, psychiatric diagnosis cannot be merely descriptive: to be medically useful it must make a statement about the past and future states of the patient. It must convey more information than simply the patient’s symptoms, if it is to have any power. (Further, one can mention here the by-now philosophical commonplace that observation and classification are theory-laden.) In addition, one assumes that identifying a particular disorder is supposed to be a preliminary to treating it; and that the treatment will be tailored to beliefs about the disorder’s nature.

The aetiological status ‘neurosis’ is supposed to have, it seems, depends on the theoretical standpoint from which you are using the term. Until nearly the turn of the century, the almost universal Western common sense theory of mental illness was that of demonic or satanic possession. The breakdown in usual belief-desire psychology, it was thought, must come from an evil alien force; the cure was to attack the source of the problem by driving out the demon. This account was replaced early in this century by (arguably, primarily Freudian) psychoanalysis. Symptoms were the result of ‘complexes’ laid down in early life; treatment had to address the complexes rather than the symptoms. The cure is to talk at length with the analyst who tries to help the patient remember the incidents which gave rise to the complex and integrate them both intellectually and emotionally with her present life.

More recently, biological factors have been given increasing importance. These fall into two main groups: physiological and behavioural. For example, conditions such as bed-wetting are being seen more commonly now as habit conditions rather than the symptoms of psychological complexes. Here, the cure is often to treat the symptoms: indeed, for the behaviourist, the symptoms are the neurosis.

\[a\) Freud and Psychoanalysis\]

For Freud, and for psycho-analytic theories generally, a neurosis may be defined as a psychogenic condition in which the symptoms are the symbolic expression of an underlying intrapsychic conflict whose origins lie in the individual’s childhood history. The main assumptions of Freudian theory, and the way these relate to an analysis of neurosis, can be summarised as follows:

a) Psychological Determinism. A basic tenet is that human behaviour is never ‘accidental.’ All behaviour is goal-directed, even though the goals might be unconscious. Often apparently peculiar behaviour makes sense in terms of a forgotten event from the subject’s past, usually their childhood.

b) Repression and the Unconscious. The idea of unconscious mental process is central to the psycho-
analytic view of psychology. The term ‘unconscious’ can be used in several ways; in particular it may denote simply the whole class of the non-conscious at any one time, or the specially inaccessible unconscious (in either a dynamic or systematic sense). The common fact of the patient’s resistance to the therapist who is supposed to be helping her is an important manifestation of these unconscious forces. A subset of the unconscious consists of repressed ideas or memories: repression is the purposeful exclusion from consciousness of mental states which are unacceptable to the ego; generally these are sexual or aggressive. This was read by Freud as a defence mechanism; in his later work he held that it was triggered by anxiety.

c) The Structure of the Mind. In his mature work, Freud considered the personality to be made up of three subsystems: the Id, the Ego, and the Super-ego. The Id is the instinctive part; its contents are unconscious, and it is generally represented as a reservoir of instinctual energy. These instinctive drives are based upon the bodily structure of the organism, and are primarily sexual (Eros) and aggressive (Thanatos). These instincts are released according to the Pleasure Principle, pressing for immediate gratification. The Ego is something akin to the ‘self’ and it possesses our conscious attributes: perceiving, understanding, reasoning, feeling and choosing. It is absent from the infant, and is the product of maturation in the adult, by something like ‘precipitation’ from the experiences of the individual in her interactions with the world. It obeys the Reality Principle, and operates principally to reconcile the demands of the Id and Super-ego. A specialised part of the Ego is called the Super-ego; it approximates very roughly to one’s ‘conscience.’ Its censorship may be unconscious. It is based on the resolution of the Oedipus complex, when the child internalises the parental prohibitions; later it is refined by exposure to other social and cultural factors.

d) Regression and Infantile Sexuality. Infantile sexual impulses commonly persist in an unconscious but active form and exert a powerful effect over adult psycho-neuroses, Freud claimed. Early childhood constitutes the foundations of adult sexuality, and when the unconscious sexual wishes of the adult are thwarted a regression takes place to a more primitive stage of sexual functioning in order to gain satisfaction. The neurotic symptoms provide a substitute satisfaction. “The etiology of the [psycho-neuroses] … is to be looked for in the individual’s developmental history …. Neuroses are acquired only in early childhood … even though their symptoms may not make their appearance until much later.” Neurosis is a form of repetition.

e) The Actual Neuroses. These, for Freud, are the direct result of incomplete sexual satisfaction; he included
among them anxiety neurosis, neurasthenia, and various psychosomatic and hypochondriacal disorders. They have their origins in the adult’s present circumstances, and are somatic rather than psychological. Libidinal energy is directed towards its release in orgasm, and if deprived of this satisfaction it presses for discharge and becomes converted into anxiety.

f) The Psycho-Neuroses. These are of two types: transference neuroses (phobias, obsessions, conversion hysteria) and narcissistic neuroses (manic-depression, (paranoid schizophrenia?)). Their symptoms are symbolic expressions of repressed, unresolved infantile conflicts. The libido is deprived of satisfaction, and seeks new sources of release through regression; this new path must be indirect, because it is opposed by the Ego, and so the neurotic symptoms arise. In all cases of psycho-neurosis, the pathogenic conflict is between the ego and the sexuality, and the ego defends itself through repression, projection, reaction formation, denial, displacement, undoing and rationalisation.

Fenichel isolates the following elements of a psycho-analytic conception of neurosis:25

∞ “In all neurotic symptoms something happens which the patient experiences as strange and unintelligible. … All symptoms give the impression of a something that seems to break in upon the personality from an unknown source.”

∞ “The normal and rational way of handling the demands of the external world as well as the impulses from within is substituted by some irrational phenomenon which seems strange and cannot be controlled. … It can be stated that the common denominator of all neurotic phenomena is an insufficiency of the normal control apparatus. … They can be understood as involuntary emergency discharges that supplant the ordinary ones.”

∞ “The insufficiency can be brought about in two ways. One way is through an increase in the influx of stimuli: too much excitation enters the mental apparatus in a given unit of time and cannot be mastered; such experiences are called traumatic. The other way [psycho-neurosis] is through a previous blocking or decrease of discharge which has produced a damming up of tensions within the organism so that the normal excitations now operate relatively like traumatic ones.”

∞ “We have in psychoneurosis first a defence of the ego against an instinct, then a conflict between the instinct striving for discharge and the defensive forces of the ego, and finally the neurotic symptoms which are distorted discharges as a consequence of the damming up—a compromise between the opposing forces.”

∞ “The symptom is the only step in this development that becomes manifest; the conflict, its history, and the significance of the symptoms are unconscious.”
So the psycho-analytic school generally defines neurosis in terms of the aetiology of the disorder. In principle, neuroses can have any kind of symptomology—the significance of those symptoms is unconscious, and symptoms which could appear highly peculiar and unusual might represent a neurotic aetiology. That aetiology itself is also stubbornly unconscious and unobservable. Disorders, it appears, can count as neuroses purely in virtue of the counterfactual condition that they can be treated by psycho-analysis which tries to bring to light early sexual experiences.

Two main sorts of objections can be brought to this notion of the aetiology of neurosis. The first (a priori) is that it is in some way theoretically inept; the second (a posteriori), that it is not true. Both varieties of complaint seem to me to hit hard against the psycho-analytic conception. Without going into too much detail here, among the first group one can object that the theory is substantially vague and therefore incomplete. For instance, it speaks of ‘instincts striving for discharge’ and, when this is not just metaphor, this is usually cashed out in terms of some sort of psychic energy, like cathexis. But exactly what cathexis is, unless it is merely a new word for the old mediaeval ‘animal spirits,’ remains dark.

The second family of objection includes the claim that the theory is so broadly formulated as to be untestable. The ‘tension’ between ego and libido is ill-defined and apparently unmeasurable; every aspect of the neurosis is inaccessible (to testing and objective observation of any sort as well as to introspection) except for the symptomology, and those symptoms are to be ‘interpreted’ by the analyst. Empirically, too, psycho-analysis has arguably no significant record of success (over and above the rate at which spontaneous remission would anyway occur)—this suggests their efforts are misdirected, and hence that their aetiology of neurosis is likely to be false. Finally, psycho-analytic theory has as a consequence that treating the symptoms of a neurosis alone, without regard to the underlying psychic complex, cannot succeed; at best it will only produce a substitution of symptoms, since the mechanism creating those symptoms is still operating. However, the treatment of symptoms by behaviour therapists and others has in fact been quite successful as a curative method.

b) Conditioning and Trait Models

The behaviourist view of neurotic behaviour is that it is learned behaviour, resulting from personal, individual experiences. It is neither innate behaviour, nor is it due to physiological damage. Neuroses are such in virtue of being maladaptive and yet persistent. The corollary is that the cure of neurosis is precisely the alleviation of neurotic behaviours; remove the symptoms, and you have removed the disease. Hence the historical development of the neurosis is largely irrelevant; treatment concerns itself exclusively with present habits. The
precise symptomologies of neuroses are determined by (probably genetic) individual differences in conditionability and autonomic liability, and by accidental environmental circumstances.

On behavioural accounts there are two families of neurosis. The first kind, which have been called ‘dysthymic,’ are supposed to be caused by conditioned autonomic fear reactions. They include phobias, anxiety states and obsessive-compulsive disorders. They begin with a single traumatic event or a series of sub-traumatic events. These produce unconditioned but strong automatic reactions, mainly of the sympathetic nervous system. A previously neutral stimulus, through association, becomes connected with the unconditioned stimulus that produced the original emotional behaviour: this is a learning process. Because unreinforced, many neuroses gradually die away; they show ‘spontaneous remission.’ Over 90% of severe neurotics recover after five years without receiving any form of psychotherapy. However, not all neurotics recover. In these cases, it is speculated (by behaviourists) that the subjects have avoided the stimulus and so prevented extinction from occurring.

The second variety of neurosis, on this account, constitute the failure of a learning process to occur which would produce socially desirable habits. The best example is psychopathic behaviour; another particular favourite is enuresis nocturna—bed-wetting. A sub-section of this group of disorders consists of those where there has taken place positive conditioning for antisocial behaviours; sexual ‘deviation’ is a good example. All things being equal, there is no reason why spontaneous remission should occur for this group of disorders … and this does more or less seem to be the case empirically. They do tend to call forth ‘negative reinforcement’ from society, and thus bed-wetting, for instance, (usually) dies off during childhood. Learning theory suggests that if a certain stimulus meets with equally opposed positive and negative reinforcement then the one that prevails is the one which came first; making it hard to eradicate homosexuality, for instance, in the bad old days when the state arrogated that immoral ‘duty’ to itself.

One quite prevalent behaviourist theory of neurosis is that it is a disorder of the limbic system, the area of the brain responsible for emotional arousal and which apparently operates largely on the basis of both evolutionary conditioning and straightforward Pavlovian environmental conditioning. A neurosis is in general the activation of some paleocortical mechanism by some conditioned stimulus. By contrast, the neocortex may be supposed to operate according to a rather different, more complex, signalling system: rational, cognitive thought. The curious ‘insightful’ nature of neurosis would appear to be generated by a conflict between limbic and neocortical signals. One possible cure is behaviour therapy though desensitising the patient to the stimulus, ‘flooding’ the patient with the stimulus, and ‘modelling’ to demonstrate to the patient the harmlessness
of the stimulus or giving examples of people successfully coping with trigger situations.

There is also a school of thought which holds that certain people are genetically more predisposed to neurosis; further, that this might be correlated with certain personality types. Using the scales ‘extroverted–introverted’ and ‘stable–unstable,’ studies suggest that neurosis is positively correlated with ‘instability’ (moody, touchy, anxious, restless, rigid, aggressive etc.) and with ‘introversion’ (quiet, passive, unsociable, careful, thoughtful, reserved etc.)—‘Melancholics’ on Wundt’s system. Interestingly, it is thought to be the limbic system which governs the expression of the emotions through its control of the autonomic sympathetic and parasympathetic systems. Introverts have higher habitual levels of cortical arousal, and so are more easily conditioned: they are physiologically predisposed to neurosis.

Like the psychoanalytic theory, this aetiology of neurosis manages fairly well to account for neurosis’ defining characteristics, in particular repetition (as a result of recurring environmental stimuli) and insight (due to the tension between the ‘rational’ and ‘limbic’ systems). However, like the psychoanalytic theory, it is by no means immune to controversy.

∞ Non-trivial, non-circular definitions of stimuli and reactions have proved hard to come by.

∞ It is not easy to explain how the paleocortical system has come to develop such that it will respond in the ways characteristic of neurotic symptomology to certain triggers (e.g. a debilitating fear of furniture, shoe fetishism)—remember, the thesis is not that the limbic system is in any way malfunctioning; just that by an accident of evolutionary design, it is functioning inappropriately.

∞ The myriad differences among symptomologies, and the syndrome-like grouping of those symptoms both elude easy explanation in terms of learning theory.

∞ The second sort of behaviourist neurosis (uncorrected bad habits) seems to include syndromes which are not commonly accounted neuroses—indeed, which a therapist would normally consider clearly incorrect for identifying as a neurosis: for example, sociopathology.

∞ The phenomenon of, say, phobias which persist despite the continued recurrence over a number of years of the conditioned stimulus without any recurrence of the original unconditioned stimulus appears impossible to explain on the behaviourist theory; if someone with a fear of cats is forced to encounter a string of cats over a few years without any actual harmful or fearsome results, then learning theory predicts that the conditioned stimulus (cats) should in fairly short order become unconnected from the original fear.

∞ The role of society and the cognitive sphere of the self seem to be drastically underestimated in this theory.
c) **Social and Cognitive Models**

These theories see neurotic disorders as being, at least in part, a function of the social environment, and place more stress on the human capacity for self-direction than conditioning theorists. For example, Katz et al. found that simply informing their subjects of the conditioned–unconditioned stimulus pairing actually established a conditioned response just as efficiently as actual exposure to such pairings. Further, people in large part produce the environmental conditions which surround them, and which in turn affect their behaviour. A. Bandura calls this ‘reciprocal determinism.’

D. Rosenhan has extended this into a strong thesis about the effects of the social context upon the perception of ‘abnormality.’ The social context and the meanings attributed to the person labelled mentally ill are so powerful that they determine our perceptions of mental illness. In his study, eight pseudo-patients were admitted to twelve psychiatric hospitals in America complaining of hearing voices; on admission they ceased simulating this symptom, and behaved normally. Nevertheless, all were diagnosed as schizophrenic or manic-depressive and in none of the cases was the diagnosis reversed. Other studies suggest that the diagnosis of neurosis is affected by such factors as self-concept, attitude on the part of the patient towards the label ‘neurotic,’ the social interaction between patient and therapist (including, apparently, factors like class difference), past social experiences, and so on.

Mental illness may be seen as an ascribed social role. Neurotic behaviour is maladaptive in its failure to meet the expectations held by the patient and / or others for someone in their role. This is a social model; it does not rely on an inherent psychopathology. Neurosis may not, in some cases, have anything to do with the personal attributes of the individual. “The neurotic disorders cannot be reduced to objective, natural phenomena. … From the psychological perspective, and particularly from a social and cognitive viewpoint, a neurotic disorder is best seen not merely as a behavioural response, but as a form of *social action.*” The implication of this variety of theory is sometimes that neurosis has no aetiology and no cure; it is simply the case that people behave in certain ways, and the more unusual of these ways get labelled ‘neurosis’ (as long as they are not too unusual, when they become ‘psychoses’). At most, as far as treatment is concerned, one can rejuggle the patient’s social relationships and belief-desire set so that they perform less socially unacceptably.

There is a point up to which this notion seems reasonable; mildly over-excitability or socially inept people quite plausibly have no physiological disorders, and no psychological states one would want to label a disorder either. However, surely there are very many cases in which behaviour is so bizarre, so upsetting, and so unstoppable that it cannot be a ‘socially imposed role’ but must have something to do with malfunctioning
personal attributes of the individual: that is, surely most neuroses have a physiological or psychological cause (or set of causes). In addition, the social / cognitive methodology has a hard time differentiating neurosis from other forms of mental disorder: it cannot do so on the basis of aetiology, and it cannot do so on the basis of the symptomatic characteristics of the individual.

Having considered the three main candidates for aetiologies of neurosis (not including neurophysiology, which is not yet sufficiently advanced to even begin to confidently theorise in this area), and found serious flaws with all of them, I conclude that there is no really good account of the aetiology (and therefore guided treatment) of neurosis. The abstract concept can be ‘explained’ in various speculative ways, but none which seem theoretically or empirically substantially correct at the moment. The possibility remains that ‘neurosis’ is not a term that picks out anything with a unified underlying cause: it could deal only with a group of symptoms which have many different, disparate causes (possibly more than one cause for the ‘same’ neurosis, even).

Neurosis as a Syndrome

So, finally, how far does the concept of neurosis fit any well-defined syndrome, any coherent group of symptoms? I shall answer this with reference to DSM-III-R (the latest manual in which the concept of neurosis plays any significant part). There is no section of ‘neuroses,’ but 15 disorders are indexed under ‘neurosis’ in the back of the book. These are: panic disorder, generalized anxiety disorder, dysthymia, major depression, adjustment disorder with depressed mood, hypochondriasis, conversion disorder, somatoform pain disorder, multiple personality disorder (dissociative identity disorder), psychogenic fugue (dissociative fugue), psychogenic amnesia (dissociative amnesia), depersonalization disorder, dissociative disorder NOS, sleepwalking disorder, obsessive compulsive disorder, simple phobia (specific phobia), social phobia and separation anxiety disorder. These make up the bulk of the sections on anxiety, depressive, somatoform and dissociative disorders—which are next to each other in the text. However, three disorders—separation anxiety, sleepwalking and adjustment disorder with depressed mood—are widely separated in the text.

1. Do these instances of ‘neurosis’ consistently fit the conception defined above?
   i) Strong emotion. All instances involve marked distress.
   ii) Maladaptivity. All instances involved are maladaptive … but this is true of all mental disorders (hence the label ‘disorder’!).
iii) Mildness. Not all neuroses are mild, by any means. For example, separation anxiety can be very incapacitating in that it prevents independent functioning. Depressive episodes may leave the sufferer “totally unable to function socially or occupationally, or even to feed or clothe himself or herself or maintain minimal personal hygiene.” Conversion disorder not only can seriously impede the normal life functions of the patient, but prolonged loss of function may produce serious physiological and other mental complications. Somatoform pain disorder typically leads to the patient adopting the form of life of an invalid. Multiple personality disorder, psychogenic fugue and depersonalization disorder (‘dissociative hysterical neuroses’) involve a radical breakdown of personality.

iv) Repetitive. Major depression, conversion disorder and somatoform pain disorder can be non-episodic and non-recurrent. Multiple personality disorder, too, is hardly ‘repetitive.’

v) Non-physiological. All instances involved as yet have no identified physiological cause … but this is true of all the non-organic mental disorders.

vi) Insight. Children suffering separation anxiety appear to have no necessary insight into the irrationality of their fears. Conversion disorders are not conscious: the patient is not aware of intentionally producing the symptom. Somatoform pain disorder may very well not be linked with any insight into the fictional nature of the pain.

2. Do the DSM-III-R instances of ‘neurosis’ exhaust the disorders covered by the definition in section 2 of this paper?

It appears not. Impulse control disorders seem to meet the conditions pretty well: in particular, they are repetitive, on the whole fairly mild (e.g. kleptomania, trichotillomania), and involve a temporary loss of control to a particular desire which is often followed by regret and self-reproach. Likewise the sexual paraphilias involve recurrent struggles with desires not endorsed by the subject.

3. Is there some plausible definition of ‘neurosis’ (i.e. not, for example, simply the conjunction of actually ‘neurotic’ syndromes) which does capture all and only those DSM-III-R instances of neurosis?

I confess, I cannot find one which does not sound ad hoc. The conditions of maladaptivity, emotion and non-obvious physiological cause seem worth retaining as they do a good, partial job of differentiating neurosis from other medical, non-‘insane’ conditions, and from normality. Beyond that, even constructing a plausible set of sufficient conditions seems impossible: there are few aspects which the 15 neurotic disorders have in common which are not hopelessly vague. It is not even true that they all involve anxiety concurrent with the symptoms:
MPD or conversion disorder need not, for example. It is true that a sort of family-resemblance concept could perhaps be constructed, in which neuroses would have only to possess a certain number of the set of defining qualities, not all of them. But still, the problem now becomes finding candidates for necessary conditions. Anxiety, for example, is present in brief reactive psychosis or manic-depression.

**Conclusion**

The picture which has emerged of neurosis is this:

a) As an abstract notion, ‘neurosis’ is fairly well-defined and agreed upon, though even at this level there is a problem with distinguishing neurosis from other forms of mental disorder, and with stripping the notion of theoretical presuppositions (such as that neurosis results from a psychological conflict of some sort). The notion of ‘neurosis,’ as it is used today, is a coherent, meaningful concept *in the abstract.*

b) As a concept which picks out a certain variety of aetiology the concept fails. Connected with this failure is its failure to specify a particular defining sort of treatment for neuroses as a way of picking out the group. ‘Neurosis’ neither serves to identify a *generally agreed upon* aetiological story, nor a particularly *plausible* story held by any sub-section of its users. However, it can be said that the psycho-analytic school at least *has* an aetiological theory which seems to uniquely define neuroses.

c) As a concept which in fact picks out a unique, definable class of phenomena, ‘neurosis’ fails again. Given the instances to which the term is actually correctly applied, there appears to be no interesting way of abstracting out an explicit set of criteria which specify the necessary and sufficient conditions for its correct application. Certainly, the concept to be found in the literature does not successfully do so.
Notes


5 World Health Organization, *Mental Disorders: Glossary and Guide to their Classification in Accordance with the Ninth

6 Adapted from C. P. Oberndorf, “Diagnostic and Etiological Concepts in the Neuroses,” in Paul H. Hoch and

7 Oberndorf, *ibid.*, p. 83.

8 *Gage Canadian Dictionary*, Toronto: Gage, 1983.

9 Martin, *op. cit.*, p. 3


11 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (Third Edition, Revised)*,
   Washington: American Psychiatric Association, 1987 [DSM-III-R], p. 404. My emphasis. The *Diagnostic and
   Association, 1994) is less garrulous on the point, but defines ‘psychotic,’ at its narrowest, as “delusions or
   prominent hallucinations, with the hallucinations occurring in the absence of insight into their pathological
   nature.” (273)

12 The definitions of these disorders are not substantially different in DSM-IV but, interestingly, the new
   manual seems to have dropped all mention of the term ‘neurosis.’


15 Cited in Eysenck, *op. cit.*, p. 34.


17 See, for example, the studies cited by Eysenck, *op. cit.*, pp. 25–36.

18 Though I suppose that what could be being measured is a relative quantity, something like ‘being in the top
third most anxious and depressed in the society.’


29 Eysenck and Rachman, *ibid.*, p. 5.


37 DSM-III-R, p. 221.