The Concept of Neurosis: A Reassessment Is Overdue

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The recent publication of the book *Clinical Neurosis* by Philip Snaith – reviewed by Silvana Grandi in this issue [1] – may be interpreted by post-DSM-III psychiatrists as a reflection of the longstanding British attraction to antiques. Philip Snaith, however, is not an antiquary, but a careful psychopathologist, whose original contributions in the field of irritable mood and mild depression are well known. The concept of neurosis, because of its psycho-dynamic connotations, has been deleted from the American classificatory systems and certainly does not enjoy much popularity nowadays. However, originally introduced by Cullen, an Edinburgh physician, in 1784, it has a long phenomenological tradition that carries important clinical implications [2]. Slater and Slater [3] in 1944 developed a heuristic theory of neurosis, based largely on phenomenological observations, for example in soldiers under stress [4], whereby the neurotic constitution is predominantly determined by a large number of genes of small effect. The neurotically predisposed man is an individual who has more than average susceptibility to environmental stresses of one or more kinds [3]. For instance, factors such as inadequacy, instability and shyness would predict the incidence of neurosis in officers of the Army and the Navy under stress [5]. Several current research trends seem to move along similar lines. Cloninger [6] proposed a general theory of heritable personality traits and their neurobiological basis underlying the development of anxiety states. Paykel [7], commenting on life event research, remarked that it is not merely the event, but the soil on which it falls that is crucial in determining the outcome and form of a disorder. Roth [8] outlined a comprehensive model in which ‘agoraphobia develops as a long period of historical development in the course of which a faulty seam has been introduced in the failure of the personality’ [p. 154]. He stated that one aspect of psychoanalysis has proved of lasting importance: ‘looking before and after’ into the lives of patients. The longitudinal study of mood and anxiety disorders, and in particular of their prodromal and residual symptoms, is also linked to the concept of neurosis [9]. As is the concept of staging, which connotes different phases in the development of a medical illness and which has recently been applied to unipolar depression, bipolar illness and

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panic disorder [10]. The role of mild and subclinical prodromal symptoms in the pathogenesis of mood and anxiety disorders, and of residual symptoms in the occurrence of relapse has been emphasized [9, 10]. Van Praag [11] has outlined the neurotransmitter implications of such pathogenetic processes.

The concept of neurosis encompasses a variety of clinical manifestations that constitute the core of Snaith’s book [1]: depressive symptoms, anxiety, hysterical symptoms, panic, phobic disturbances, hypochondria-sis, depersonalization, irritability, and abnormal eating attitudes. Sims [2] has remarked that what is shared by these syndromes may be as important as the

differences between them. The features held in common may be summarized as emotional and somatic symptoms, disturbances of self-image with loss of self-esteem, problems with social relationships, lack of coping skills. Tyrer et al. [12] have argued that the combination of mixed anxiety and depressive disorders together with a certain type of abnormal personality (excessive timidity, poor self-esteem, avoidance of anxiety-provoking situations and dependence on others) constitute a single syndrome, the general neurotic syndrome. This syndrome was alleged to be associated with a poor response to treatment, to change frequently in symptoms throughout the neurotic diagnostic spectrum and to follow a relapsing course [12].

Even when symptoms and disorders overlap, particularly in a longitudinal prospect, there seems to be a tendency to avoid any unitary frame of reference and to prefer the less binding term of comorbidity [13].

Another term which is avoided is 'affective disorder', used in the European tradition to indicate anxiety and mood disturbances. It was (wrongly) used in DSM-III to indicate mood disorders and was deleted in

DSM-III-R. No substantial agreement about its meaning exists today: it may potentially encompass unipolar depression, bipolar illness, generalized anxiety, panic disorder, phobic disturbances, obsessive compulsive disorder, irritable mood, and depersonalization.

As a result, the bicentenary of the word 'neurosis' passed totally unnoticed almost a decade ago. Yet, in light of current research trends, its reassessment is overdue. I am not advocating its return as a labelling device (the term 'neurotics' is even worse than 'depressives' or 'schizophrenics' applied to patients), but only its renewed and non-committed consideration. General medical practice is a privileged point for observation of neurosis [14], as is the general hospital [2]. A reassessment of the concepts of neurosis and of psychosomatic disorder [15] may unravel new insights into psychosomatic research and practice.

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