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EDITORIAL

IS NEUROSIS DEAD ?

By

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In 1980, the American Psychiatric Association published a revised system of classification (DSM III), from which it had removed the category of neurosis. This is not the first time that the obituary of neurosis has been written. In 1923, Schneider remarked that neurosis is an erroneous and unfortunate expression, arguing that all the conditions it denoted were abnormal reactions of the personality, and should be classified as such. What reasons are now being suggested for giving way to such a widely used term? There are three main arguments:-

(1) It groups together conditions that would be classified better in other ways.
(2) It introduces unsubstantiated ideas about etiology into the system of classification.
(3) We can do perfectly well without it.

There are two main arguments in favour of retaining the group of neurosis:

(1) With the possible exception of depressive neurosis, the conditions classified this way have general factors in common, such as difficulties in personal relations, and bodily symptoms without an organic cause, (2) a common element in treatment, notably: psychological procedures to deal with poor self esteem, and problems in relation with others.

Since Freud's early papers, it has become customary to classify neurotic disorders according to their major symptomatology. Thus in the ICD 9, anxiety, hysteria, phobia, obsesssion, depression, and neurasthenia, qualify for separate labels, and differ mainly in the predominance of their primary symptoms. In DSM III, the major changes have been in the abolition of hysteria, and the re-labelling of somatoform disorder,

and the addition of panic disorder in the anxiety group, both as a separate disorder, and combined with agoraphobia. Although it is customary to regard ICD and DSM III diagnoses as quite independent, there is still a high correlation between the two methods of classification.

Previously, treatment was covered by the blanket term 'psychotherapy', for all neurotic disorders. Now we realize that psychotherapy is ineffective with all, except the milder forms of anxiety disorders.

Behaviour therapy is of specific value in phobic and obsessional disorders, and drug therapy has a broad range of activity, but is specifically indicated for panic disorders. Both hysteria and somatoform disorders are unreliable in their response to treatment, and can be distinguished accordingly. The separation of different neuroses looks decidedly a suspect. These disorders impress by their lack of consistency. Follow-up studies indicate that these group changes in nature, more than any other psychiatric diagnosis. For example, the most common change is for anxiety disorders to be classified as depressive ones, and vice versa. Patients with panic disorder and agoraphobia, can become depressed; depressed patients can become anxious and phobic, and almost any other combination of diagnosis can occur over a time scale of five years. The only way it is possible to retain the original diagnosis, is by adopting a longitudinal hierarche that states for example: that when patients have had three panic attacks, in the course of a three week period, they suffer from panic disorder, and will retain that label for life. Rather than regard the appearance of new symptoms as secondary development, it would be more honest to say that the original diagnosis has changed. The different neurotic disorders merge and interchange, and serve only to confuse. By taking the aetiology symptomatology, prognosis, and treatment of different neurotic disorders, only two groups consistantly stand out:-

(1) Adjustment reaction, a group with short-lived acute

symptoms, occurring in a setting of major stress, and carrying a good prognosis.

(2) General neurotic syndrome, a second chronic group with variable symptomatology at different times, which often continues in the absence of any specific stressors. The most persistent symptoms appear to be that of anxiety, which was described as the 'anxiety disease', and described how it progresses from panic attacks, to limited and social phobias, later generalizing to agoraphobia, and then depressive symptoms.

Patients seen in psychiatric out-patient clinics with neurotic disorder, include a high proportion with the general neurotic syndrome, have a high proportion with abnormal personalities, predominantly those with obsessional, dependent, anxious, and hypochondriacal features. By contrast, a similar population of neurotic patients seen in the primary care, only included 13% with abnormal personality. Patients with sociopathic and schizoid personality features are rare in those with neurotic disorders. It therefore seems sensible to combine assessment of personality and clinical status in assessing patients with neurosis, and to use the assessment as an important means of distinguishing between the two major groups of disorders.

Should we, therefore, throw away the existing classifications of neurosis? This would be unwise at this stage, recognition of phobias, obsessions, panic and somatoform disorders have been valuable in many ways, and may justify separate diagnosis at times. However, what is needed is the abandonment of a constricted diagnostic system into a single diagnostic category, if a single major neurotic syndrome were allowed in diagnostic systems, many patients would qualify, and in some others, diagnosis might disappear altogether.

Neurosis is not dead, it has merely retreated, and been re-labelled as a disorder. None of the arguments for or against the abolition of neurosis

is compelling. On balance, it seems best to be conservative, and to make changes only when there are strong reasons for doing so, and preferably when any new classification can be based more firmly on etiology. For the present, there seems to be enough common ground among these conditions, to keep them together in our system of classification, either as neurosis or neurotic disorders or emotional disorders or under some broader rubric, such as neurosis and adjustment disorders. In any case, clinicians are unlikely to stop using the word neurosis in their every day work as a useful collective term for a common group of problems.

Indeed, these current disputes about the term neurosis, are reminders of a debate some years ago, about another controversial word, 'hysteria'. It was mentioned, 'a tough old word like hysteria dies very hard, it tends to outlive its obituarists'. Though neurosis is not as old a word as hysteria, it's likely to prove to be no less tough.

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