THE STRUCTURE OF NEUROSES

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Ayuntamiento de Madrid

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ABSTRACT

The foundations of the neurotic process are investigated in order to establish why the neurotic fails and becomes frustrated. The reasons for this failure might be constitutional, or biographical, or it might be caused by the convergence of simultaneously operating encounters. These three possibilities are examined in order to find the answer to the question of how the neurotic patient expresses his frustration.

The word "neurosis" was born under an ambiguous sign and this significant ambiguity has continued with it in different forms throughout its history. Cullen was the first to introduce the word to indicate precisely diseases of the nervous system without corresponding anatomical lesion. Among the neuroses described by Cullen there were some, such as epilepsy, Parkinson's disease, etc., which are now enlarging the chapters of neurology. A distinctive note has remained with the neuroses proceeding from the primitive meaning that Cullen gave them: *diseases without a lesion.*

Nevertheless, this negative character is not enough to differentiate them. Nor should we forget that it is not only a matter of language. We are not authorized in clinical work to diagnose a neurosis by a purely negative criterion, that is, by the absence of objective findings in the examination. It is necessary to find a positive note: their psychogenesis. The neuroses have a psychological pathogenesis instead of a physical one. They can manifest themselves symptomatically in the psychic sphere (psychoneurosis) or in the somatic sphere (somatoneurosis, organ-neurosis, psychosomatic syndromes).

The pathogenic factor which triggers the neuroses is the trauma. In relation with the pathogenic value of the trauma there has been an evolution. At first, the neuroses appeared in catastrophic situations *i.e.*, Bird's neurostemia. Charcot indicated the presence of a physical trauma in his hysterical patients. Nevertheless, Breuer and Freud were the ones who confirmed the fact that the traumas causing the neuroses were psychic traumas; later psychoanalysis affirmed that the most important psychic traumas in this respect were sexual ones. Thus hysteria, which for so long was considered a nosological entity, has been absorbed within the perimeter of the neuroses.

The neuroses, then, are characterized by being diseases of psychic genesis (diseases *sine materia*) and by the lack of an anatomic pathological substratum. It is important in this respect to assume that the neuroses, by definition, cannot have any anatomic pathological basis. Parkinson's disease did not have anatomic pathological findings in Cullen's time, but thanks to the progress of scientific knowledge we have discovered its anatomic basis. The neuroses, on the contrary, do not have them nor will they ever have them no matter how far anatomic pathology progresses. This was the affirmation of Hoche with respect to hysteria. But will they have a pathologic neurophysiology ? ** This is the question that is discussed in this paper, which, even if accepted,

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Ayuntamiento de Madrid

will not completely resolve the problem of neuroses.

Owing to the phenomenological analysis during the last 20 years, instead of speaking of neurosis we talk of abnormal affective reactions (abnorme erlebnisreaction). A normal affective reaction is the proper affective response to a life situation (*i.e.*, being afraid or sad when facing some specific event of life). The affective response implicitly carries an attitude, an action or a non-action in facing a determinant fact. All these complexities are integrated in the concept of affective reaction. The affective reaction is not the rational understanding of a situation but something more vital. [1] The individual must be included, immersed, engaged in the situation.

It is necessary that the following conditions be present in a normal affective reaction: [2]

1. The reactive state would not have appeared without the presence of a determinant experience. If one is afraid, it is because something is causing the fear.
2. The content of the reaction has some comprehensible relation with the determinant factor. A frightening event should produce fear and a gay one a certain euphoria.
3. The reactive state has certain temporary relations of duration with the determinant factor. These relations vanish when the determinant factor disappears. For example, a mother is preoccupied about the state of her child's health when the child is ill. Her good spirits return when the disease is gone.

What is called abnormal affective reaction (abnorme erlebnisreaction) in Central European psychiatry is called conflictual reaction in American psychiatry. The neurotic person fails in the face of a conflictual situation, external or internal. Laughlin [4] defines neurosis as: "A disturbance of emotional adaptation due to unresolved internal (*i.e.*, unconscious) conflict." Through the influence of psychoanalytic thought, the internal conflictual situations are considered equivalents in some form to instinctive conflicts. The influence of the external conflictual situations is evident, and thus there exists what is called a sociogenesis of the neuroses. There are no diseases in which the historical situation has so marked an influence as on the neuroses. Every epoch offers a distinctive neurotic style. There is a great difference between the clinical manifestations of hysteria in Charcot's time and in that of Freud. The difference is still greater if we compare the clinical manifestations at the beginning of the century to those at the present time. Times change and the neuroses change, not only because of what the physicians think of the neuroses, but because the neurotic changes his symptoms according to the environment in which he lives.

In order to go deeper into the nucleus of the neuroses we should ask ourselves two questions:

1. Why does the neurotic fail and become frustrated?
2. How does he express this frustration?

We cannot really compare any failure of life to the failure of the neurotic. If we do, the limits of the neurosis vanish, which paradoxically is not so important in theory as it is in practice because the immediate consequence erases the boundary which separates the need for medical intervention from that which is not (function of psychologists, confessors, spiritual directors, and even friends). Many times we begin with the erroneous concept that the gravest situations in life are the ones that provoke the neurotic reactions. Experience has demonstrated that we cannot generalize. It is true that during wars neuroses increase; but it is also true that in grave situations the neuroses decrease, as experience in concentration camps has shown. In the normal individual, mechanisms of compensation exist to deal with the contingencies of the

** Not referred naturally to the secondary mechanisms of expressions but to their dynamogenesis.

Ayuntamiento de Madrid

external environment. Such mechanisms of compensation operate not on the psychological plane, but on the physical plane. The radius of action on the psychic plane is much greater. Not in vain is man an open structure. The opening is bigger as we ascend from the anatomical planes to the biological and psychological levels.

Clinical experience proves that the neurotic trauma must be a trauma that we should call *appellative* because this trauma awakens or calls something that is in the sick person himself. The psychic trauma is not causal in the sense of logical causality. If a bombardment occurs, not all the inhabitants of a city show a paralysis or an hysterical tremor which lasts longer than the normal reactions of fear; only a few develop such phenomena because of the trauma. Psychoanalysis assumed that the neurogenic traumata were sexual in essence. According to the same doctrine the sexual traumata due to their cathexis, in other words the psychic energy with which they are charged, become insupportable for the conscience; that is why they are directed to the unconscious and their energetic charge is transformed into somatic symptoms (conversion reaction). Later, experience proved that the structure of the conversion reaction is very complex. That is why it is rare that catharsis, the bringing back of the traumata to the conscience, has therapeutic success. Freud realized that many assumed neurogenic traumata were not real in the first place, but were fantasy, imaginary; secondly, he observed that actual traumata were efficacious because they were able to reactivate traumatic situations of the first infancy.

Speer says that the neuroses consist of an abnormal elaboration of affective experience (abnorme erlebnisverarbeitung). In fact, this is the essential point. Why does the traumatic experience penetrate so deeply into the structure of the individual, and why does it leave so deep a mark ? We can think of several possibilities and clinical experience offers us examples of all of them:

1. Perhaps it is a case of a person radically inadequate to face the grave contingencies of life. In this group we must include the anomalous personalities, or even psychopathic personalities. We can also include another type which does not belong to that group, such as mentally defficient persons or certain personalities with various abnormalities (retardations in the development, as described by Kretschmer). These can be classified as constitutionally immature or inadequate personalities.
2. The anomalies may originate from the personal history. In these cases the problem of the neurosis is displaced from the individual present to the individual past, from the trauma to the personality. The foundation for later neurosis is laid during the early phases of infantile development. The immaturity of the personality means a fixation on earlier phases of development. The actual trauma is a reactivation of microtraumata which have been acting from the beginning of life and have impeded normal development.
3. The experience may become abnormal because the subject is simultaneously going through an anomalous situation.

This third possibility is the one I would like to analyze in detail. Many times we see, in effect, that the triggering trauma is not in proportion with the resulting reaction. It occurs this way because the subject is in a specific mood which is pathological *per se* or is on the verge of being pathological. Such a mood is anxiety. Freud said that anxiety was to be found in the nucleus of any neurosis. K. Schneider, [1] when he speaks of abnormal affective reactions, points out that fear, anxiety, and sadness are the fundamental factors. Fear produces a temporary reaction except when it is fear with anxiety. This is the fear that cannot be overcome. The relation between anxiety and sadness is evident as demonstrated by the psychopathology of the depressions.

What is anxiety neurosis ? The anxiety can be experienced in different ways. One

Ayuntamiento de Madrid

patient speaks of a fear of apoplexy or of spiders. Another cannot cross a street or cannot enter a closed place, such as a theatre. Another patient speaks of a rare kind of headache, strange and difficult to describe, or a slow pain, or that the heart is giving a turn, or a strange bad feeling, vague and indescribable, which is located in the hypochondrium. All these and many more are varieties of an anxiety experience. We can even say that every man experiences the anxiety in an original and personal way. Can we find any common notes among these polymorphous symptoms ? Here briefly are the most important ones:

1. From the psychological point of view all anxiety experiences can be reduced to two fundamentals: fear of death and fear of insanity. The one who suffers from precordial anxiety (soi-disante) is afraid to die. It is an imaginary anxiety because it does not correspond to a lesion of the heart, but it is very real in the way it is felt. The one who speaks of fear of apoplexy or rabies wants to express his fear of the disintegration of his personality. Fear of insanity is the fear of losing control of the personality, letting loose all the aggressive instincts. The hermeneutics of anxiety require one to go at times over difficult paths. The language does not reflect the hidden character because the patient has a radical fear of facing the anxiety experience itself and masks it through his language. Omitting several intermediate steps—for the sake of brevity—I come to the conclusion that anxiety is always the experience of the man who is afraid of annihilation or of becoming nothing. Anxiety is, then, the expression of fear of nothingness, manifested in the consciousness through dark pathological alterations.

2. Another fundamental factor is offered by the patient suffering from anxiety neurosis by the way he expresses it: "I feel", says a patient, "a slow pain pressing here," and he points to the epigastric region, "and it is ascending little by little to my head. Then it feels as though my head was being opened." The picturesque expressions never end. This characteristic is very important as we shall see.

The anxiety of the neurotic is analogous to the sadness of the melancholic. For a long time psychiatry has known about melancholia, one of the most venerable diseases in the history of medicine. Thanks to the phenomenological investigations of the last decades, it has been possible to show that the sadness of the melancholic is not the same as the sadness of the normal individual. It is a sadness which belongs to the stratum of the vital feelings and not to the psychic feelings. These psychic feelings are guided; we are sad or gay because of something. They are reactive. The vital feelings, on the contrary, express how we feel physically. The vital feelings tell us how we are since our "ego" is an "ego anchored in the body," and how we feel in the world. Our moods show oscillations according to the physical and psychological nature surrounding us. The sadness of the melancholic person is a vital sadness. The same occurs with the anxiety of the neurotic; it is also a vital anxiety, in the flesh, corporeal, aside from any psychodynamic structure which is superimposed on this vital anxiety. The difference between the depressive illness and the neurotic illness is that in the neurotic person the affective, reactive, psychodynamic structures are much more important than in the depressed person.

But this somatotropic characteristic of the anxiety means, as I see it, something more. It means that the anxiety of the neurotic is in a large measure not only somatotropic but somatogenic, not only psychodynamic but physiodynamic. To deny the psychodynamics of the neurosis is to deny the neurosis proper. The neuroses are diseases of the personality; but man's personality is not a psychic structure in a vacuum, but in a human body.

Anxiety, then, is not a symptom of the neurosis, but is the neurosis itself. The anxiety of the neurotic is not a normal but

Ayuntamiento de Madrid

an abnormal anxiety, so as soon as the acute picture passes, it leaves an imprint in the form of phobias or autonomic symptoms. As such, the neurotic anxiety is committed to the principle of compulsive repetition (Wiederholungzwang). The importance of the dynamic reiteration of the neuroses has been outlined by Kubie.

This vital anxiety, in a certain way physiogenetic, agrees with the determinism of many neuroses and psychosomatic diseases. The primordial fact is that the crisis of anxiety which emerges from vital planes crystallizes in a symptomatology. In the light of this principle the so-called neurotic trauma acquires a new meaning. Experiences of life which were forgotten more than repressed emerge again with new meaning. The abnormality is not in the initial trauma but in the new resurgence of the same.

Let me give an example: A patient asks to talk under narcoanalysis because in this way he will not be responsible for what he says. He wants to know if what he says has an objective value or if he has tried to exaggerate or hide it with certain finality. Under the narcoanalysis he tells us that when he was fourteen years old, being in bed at college, a boy of homosexual reputation laid with him and tried unsuccessfully to make an anal contact. The patient was dressed at the time, did not take off any of his clothes and the whole incident passed rapidly with little importance. After that he continued to live normally. At the age of seventeen, three years later, one day all of a sudden, without realizing it, the vivid recollection of this incident came to his mind. From that moment he thought of himself as a different being. The recollection made him think his life so impure that he found it hard to continue living. He believed that there was no other solution but suicide to purify himself. The recollection tormented him obsessively. Before, if at any time he remembered the incident, he knew that nothing had happened, that he was dressed; but, when the recollection came to his mind in an obsessive way he started doubting whether he was really dressed or if there had been a hole in his clothing to facilitate the contact. He even thought that after death the recollection would continue tormenting him, and he invoked unknown magic Powers to relieve himself. He wanted to make sacrifices in their honor, give them an arm or leg or anything to calm them and make them stop tormenting him. When in prior years he remembered the incident it was a banal recollection which he was able to dominate and not let it preoccupy him. He had been able to forget it at will; now he was not able. The recollection was overpowering him and he thought that he could not control it, even after death.

The important fact in this case is that years after the occurrence the recollection emerged and this time with pathologic characteristics. Why ? Because his mood was pathologic. He was in a full crisis of vital anxiety. The anxiety made the recollection appear and not *vice versa.* The anxiety stopped and the recollection lost its pathological characteristic, becoming innocuous. It was a case of aphasic, thymopathic, physiogenic anxiety.

Not all the anxieties have a vital origin. In some cases the reactive problems are evident. In others the vital origin has been organized into what we could call neurotic development. Closely related to these neuroses with vital origins of phasic character are the neurotic developments of more permanent character. In some cases we are able to see the process which transforms one neurosis, as a vital crisis, into a neurotic development. Thanks to psychoanalysis and the different psychotherapeutic techniques derived from it, the knowledge of neurotic developments has been very well established these last few years; but, it is necessary not to forget the study of the neurotic crisis as being a crisis of the vital feelings. As in melancholia, we can observe a phasic course with a spontaneous remission of the crisis. I have previously called attention to these

Ayuntamiento de Madrid

problems in various publications, expecially in my book, "La Angustia Vital" (The Vital Anguish).[3]

If the neuroses were no more than abnormal affective reactions or conflictive situations, their treatment might be psychotherapy. In a large measure this is already the situation. Rare is the neurosis produced by an actual conflict, which is not built on a more or less affected personality. It is necessary to study the neuroses as alterations of the personal development. The adequate treatment is psychotherapy. There exist many psychotherapeutic directions; they can be very different, but more different are the personalities of the neurotics. At the base of any psychotherapy transference is found, which is nothing else but the dissolving action that the physician, as a peculiar form of human presence, has over the anxiety. But if, in the neurosis also exists a physiodynamic base, it is natural to think of the possible pharmacological action. Such action will be more efficacious in the neurotic phases built on phasic oscillations of the mood than in the neurotic developments. The drugs which have been used in the treatment of neuroses were used only as symptomatic medications; that is the reason that different medications have been used to regulate the autonomic dysfunctions which at times accompany the neuroses. Nevertheless, it is possible to look for more direct therapeutic approaches.

For several years I have been using autonomic shocks with acetylcholine and other drugs according to the technique that I have described in other papers. The initial idea came from the analogy between the depressive and the neurotic phases as diseases of the mood ("thimopatias"). In the same way that pharmacological and electric shocks are used on the depressive phases, I have thought of the usefulness of other new forms of shock on the neuroses.

The progress of the actual neuropharmacology allowed us to expect new drugs whose action on the neurotic is not just symptomatic. Even Freud admitted that new physical methods might be discovered that would influence the psychological process called mind.

In the actual phase of investigations a new planning of the problem is necessary concerning the structure of the neuroses, analyzing the limits where the neurodynamic and psychodynamic problems of the neuroses converge.

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Ayuntamiento de Madrid

Ayuntamiento de Madrid