

The neuroses

- NEUROSES, such as FREE-FLOATING ANXIETY, PHOBIAS and OBSESSIVE-COMPULSIVE DISORDERS are characterized by the emotion of ANXIETY, and are distinguished from the PSYCHOSES by the presence of INSIGHT.
- The TWO-STAGE THEORY of phobias says that they are initiated by classical conditioning of fear to a stimulus and are maintained by operant conditioning, which produces avoidance of the stimulus, thereby preventing extinction.
- Behavioural treatment of phobias uses either SYSTEMATIC DESENSITIZATION or FLOODING, to extinguish the association between the stimulus and fear.
- The personal construct system of a phobic is MONOLITHIC, with a single construct against which all events are evaluated. PERSONAL CONSTRUCT PSYCHOTHERAPY loosens such TIGHT CONSTRUCTS by means of FIXED-ROLE THERAPY.
- In psychoanalytic theory, neuroses arise from FIXATION earlier in psychosexual development, late or early phallic fixation resulting in a predisposition to hysteria or agoraphobia, and anal fixation resulting in obsessive-compulsive disorder.
- Psychoanalytic treatment of neuroses requires a detailed interpretation of the specific events and their appropriate symbolic meanings for the patient, who then works through and eventually accepts those meanings.

NEUROSES must be distinguished from PSYCHOSES, more serious disorders that severely disrupt mental functioning. Although sometimes called MINOR REACTIONS, neuroses can utterly disrupt the life of both patient and family. They are characterized by a single behavioural problem in an otherwise intact personality, with normal perception of the world, normal emotional responses, and normal social sensitivity. Neurotics have INSIGHT, being aware of their problem and asking for help with it. In contrast, the psychotic's more profound problem is a MAJOR REACTION, with personality disorganization or disintegration, which makes it difficult to accept one is dealing with the same person as before the illness. Internal and external events (subjective and objective) become confused, altering the sense of personal identity (EGO DISINTEGRATION). Emotions either flatten or are wildly inappropriate,

social interaction is impaired, and despite the severe problem, insight is absent.

The characteristic emotion of neurosis is ANXIETY, manifested psychologically by needless worrying, particularly about minutiae, intolerance of strong stimuli (shown by wearing sun-glasses on dull days), psychological exhaustion (once called NEURASTHENIA), difficulty in falling asleep, nightmares, and unrealistic fear of physical disease (HYPOCHONDRIASIS); physical symptoms are sweating, goose-pimples, dry mouth, pupillary dilatation, frequency of micturition, diarrhoea, tachycardia, and hyperventilation, sometimes leading to tetany.

Anxiety can be DIFFUSE or FREE-FLOATING, unconnected with specific events, and occasionally causing a PANIC ATTACK. SPECIFIC ANXIETY typically occurs in the PHOBIAS, where anxiety is caused by a particular object (as in the MONOPHOBIAS of spiders, cats, snakes, blood, or syringe needles) or situation (the DIFFUSE PHOBIAS, of CLAUSTROPHOBIA, a fear of enclosed spaces, and AGORAPHOBIA, a fear of open spaces, or more precisely, of *public* places). Fears can GENERALIZE from the original object so that a spider phobic might fear even to go upstairs, because a spider might be in the bathroom, and an agoraphobic might be unable even to leave their house. Specific anxiety also occurs in OBSESSIVE-COMPULSIVE DISORDERS; the OBSESSION is a recurrent mental preoccupation about particular actions (the COMPULSION). The actions are often repetitive and RITUALIZED, as before bed checking each lock, gas tap and electric socket a specific number of times in a particular order, the ritual taking several hours, with any interruption requiring restarting from the beginning. In obsessive cleanliness and hygiene, compulsory hand washing can occur so often that it produces excoriation. Anxiety is not central to the rituals, but occurs when their completion is frustrated.

In phobias and obsessive-compulsive disorder, the symptoms are separate from other mental activities, which are normal, and the patient can hold a job and have ordinary social relationships. The patient recognizes the irrationality of the behaviour, but simply cannot stop it.

Other, less common, neurotic disorders such as CONVERSION HYSTERIA (see Chapter 11) will not be considered here, as phobias and obsessive-compulsive disorders are adequate examples of the application of psychological models.

THE LEARNING THEORY MODEL OF NEUROSIS

Learning theory says phobias result from classical conditioning. Some innocuous stimulus, such as a spider, occurs in association (perhaps accidentally) with an event producing anxiety or fear, so that in future the stimulus also induces fear. This was shown experimentally

by the founder of behaviourism, J B Watson (1878–1958), with a 9 month-old boy called 'Little Albert'. A white rat (the conditioned stimulus), which previously was not a phobic object, was presented to the boy just as fear (the unconditioned response) was induced by a loud noise (the unconditioned stimulus). Subsequently, the boy showed a phobic response to the rat, which induced fear (the conditioned response). Although attractive, this simple theory of phobias has two problems. Firstly, extinction should be rapid when the child subsequently sees the rat without a concurrent noise. It does not occur because of secondary operant conditioning by which phobics avoid the stimulus associated with fear, thereby reducing their anxiety, reinforcing an AVOIDANCE RESPONSE and preventing extinction. In the TWO STAGE THEORY, the phobia is initiated by classical conditioning but maintained by operant conditioning. A second problem is that many stimuli are associated with fearful events, but few produce phobias. Certain objects, such as rats or snakes, induce phobias far more often than do others, such as teddy bears or kittens. BIOLOGICAL PREPAREDNESS is suggested to make certain stimuli more easily conditioned, and more resistant to extinction, this being evolutionarily of selective value.

Learning theory suggests two distinct forms of treatment for phobias. In SYSTEMATIC DESENSITIZATION the patient learns to relax, and then is presented with a graded series of stimuli, from very mildly phobic (a picture of a very small spider), to very fear provoking (a live tarantula). The patient relaxes with each stimulus, and moves to the next only when able to cope with the present one. Two processes are occurring: relaxation is associated with the stimulus, and the association between fear and the stimulus is extinguished. The technique is applicable to a broad range of problems and is widely used (for instance in deconditioning fears of social events). The second technique, FLOODING, appears the exact opposite of systematic desensitization. The patient is placed where they cannot avoid the phobic stimulus, as in a small room with several large spiders. The two stage theory says extinction of classical conditioning does not occur because of avoidance responses. Flooding prevents avoidance and allows extinction of the stimulus-fear association. Exposure may be quite lengthy, perhaps for several hours, but is then very successful.

Learning theory in obsessive-compulsive disorder says that the primary problem is anxiety, either induced by specific objects (such as gas taps) or by specific thoughts (as of disease). The anxiety originates from operant conditioning, the patient discovering, perhaps by accident, that some specific action reduces anxiety, and the anxiety reduction therefore reinforces the action, which then increases in frequency because each production results in further transient decreases in anxiety. In a laboratory demonstration, a hungry pigeon in a Skinner box can be given food automatically at random intervals,

independently of any specific behaviour by the pigeon. If food delivery coincides with a particular action (such as standing on one leg), then this action is effectively rewarded, and subsequently is performed more often. Eventually the animal spends much of its time carrying out SUPERSTITIOUS or RITUALIZED behaviour, mistakenly assuming that the behaviour actually *caused* the reinforcement.

Behavioural treatment of obsessive-compulsive disorder also takes several forms. SYSTEMATIC DESENSITIZATION can reduce the association between an object or thought and subsequent anxiety, although it is not very successful in long established cases. A second approach reduces the association between ritualistic behaviour and anxiety reduction, by associating the behaviour with aversive stimuli, such as mild electric shocks. Although successful, it only treats the compulsion and not the obsession, and therefore is not desirable. The third approach, which is the treatment of choice, is FLOODING combined with RESPONSE PREVENTION. The patient is put in the anxiety provoking situation, is prevented from making the obsessive response (physically if necessary), and learns that the obsessional thought is not genuinely anxiety provoking, and hence can be coped with.

PERSONAL CONSTRUCT THEORY OF NEUROSIS

Personal construct theory sees anxiety as the predominant emotion of the neuroses, the anxiety reflecting failure of the construct system adequately to predict the world. However, construct systems often fail in daily life (and indeed that is essential, for otherwise they could not improve). The neurotic differs in their response to failure of the construct system from normal individuals, who alter constructs to make them more successful. Phobics adopt a different approach. Since the construct system failed to cope with a particular event a solution is to inhabit a world in which the event does not occur, or is not allowed to occur. This 'cooking the books' does not allow events which might invalidate the system. However, phobic objects, by their nature, can occur at any time, and progressively more and more of the construct system is devoted to anticipating the possible occurrence of the object, and avoiding it. Hence the phobic develops a MONOLITHIC or 'one-track' construct system, in which the usual three or four independent clusters of constructs are replaced with a single, massive construct system, with each construct simply implying 'good' or 'bad' in relation to the likely occurrence or not of the phobic object; so-called TIGHT CONSTRUCTING.

The obsessive-compulsive is slightly different. Once again the construct system is failing, but not because of uncontrollable external events, but due to being very LOOSE, with very many independent constructs, which do not inter-relate to each other. Such a construct

system should be tightened; however that, of course, would be anxiety provoking. The obsessive-compulsive therefore prefers not to tighten the entire system but instead concentrates on a small portion (see Fig. 30.3 in Chapter 30). The obsessional therefore, as it were, lives in one corner of the construct system, choosing a construct such as safety or health with which to interpret all events.

PERSONAL CONSTRUCT PSYCHOTHERAPY has a range of treatments which try to change the construct system, in the case of neurotic disorders by loosening overly tight systems, by an interactive process between therapist and patient. Kelly said that if an appropriate model of man was of a scientist trying to understand the world, then the appropriate model for therapist and client was that of research student and supervisor; one, the patient, is well-informed about the specifics of their own condition whereas the other, the therapist, has general experience of the problems of patients. Completion and interpretation of a repertory grid can itself be therapeutic for a patient, forcing them to see the limitations of their thought processes and the room for expansion of the construct system. A useful way to promote change is FIXED-ROLE THERAPY; the patient first produces a SELF-CHARACTERIZATION, a description of themselves as written by a friend. Patient and therapist then negotiate a FIXED-ROLE SKETCH describing a person with many opposite attributes to the patient themselves, and the therapist then helps the patient explore what it would mean to *be* such a person. The patient then acts such a role, and thereby realizes the viability of other views of the world and incorporates some into their own construct system. Thus the patient not only explores their own personality but also realizes its mutability, being under their own control, and that other options can be tried and incorporated if beneficial. The 'suspension of disbelief' that occurs when watching a play or film, or reading a book, allows precisely the same acting out and exploration of different ways of being in the world, as we watch and identify with the various characters.

THE PSYCHOANALYTIC MODEL OF NEUROSIS

If the learning theory of neuroses considers a simple association of stimulus and response, and personal construct theory assesses the impact of that association upon the entire adult construct system, psychoanalysis steps further back and views neurosis in relation to the patient's whole life, especially in relation to infancy.

As in other models of neurosis, psychoanalytic theory sees anxiety as the predominant emotion, in this case arising from a CONFLICT between the demands of the ego and the unconscious. The anxiety can be partly reduced by EGO-DEFENCE MECHANISMS (see Chapter 11), but these also restrict the character of the individual and exacerbate

problems. Present conflicts arise out of failure of resolution of conflicts occurring earlier in psychosexual life, causing **FIXATION** at oral, anal or phallic stages, the type of neurosis depending upon the time of fixation: the late phallic stage causes concern with sexual fulfilment and a predisposition to hysteria; the early phallic stage causes avoidance of sexual relations and a predisposition to agoraphobia (and hence avoidance of temptation); and the anal stage causes a concern with **MASTERY**, with a sadistic or masochistic component and a predisposition to obsessive-compulsive disorder. In each case, fixation produces a *predisposition*, or increased likelihood of problems, not a *certainty*. Fixations leave the psyche weakened and vulnerable to subsequent traumas. Freud also emphasized the similarities between obsessive-compulsive rituals and the formal ritual of religion, and argued not only that **QUASI-RELIGIOUS CEREMONIALS** in obsessionals are an individualized religion, but also, and more controversially, that religion itself is a **UNIVERSAL OBSESSIONAL NEUROSIS**, with fixation at a societal level.

Psychoanalytic understanding of a patient's neurosis requires detailed analysis of their specific problems. The strengths and weaknesses of the analytic approach are best seen in a case history described by Freud in his *Introductory Lectures on Psychoanalysis*. The patient was a 19-year-old girl who was the only child of parents of lesser education and lower intellectual ability than herself. In her childhood she had been wild and high-spirited, and over the previous three or four years had become progressively affected by her neurosis. The principal symptoms were irritability, particularly expressed at the mother, and a continual sense of dissatisfaction and 'depression'. She had problems in being unable to walk by herself across squares, wide streets or other public places; an agoraphobia. She also had an obsessive-compulsive disorder, involving an elaborate 'sleep ceremonial', taking one or two hours each night, and seriously disrupting her and her parent's life. The rest of this account will consider the sleep ceremonial, and use the general psychoanalytic principle that symptoms are not random but have specific meanings, which might require interpretation, the symbolic value not being apparent at first. Successful treatment will require the patient's insight into those underlying meanings, and hence resolution of the conflicts.

The sleep ceremonial is typical of the rituals seen in such patients. Their ostensible purpose was to produce quiet, so the patient could sleep better, all sources of noise being removed. Specifically:

- i. the big clock in the bedroom was stopped.
- ii. all small clocks and watches were removed.
- iii. the flower pots and vases were put on the writing table 'so that they might not fall over and break', and hence disturb sleep.
- iv. the connecting door with the parents' bedroom was wedged in the *half-open* position (even though this would clearly *not* prevent disturbing noise).

- v. the large pillow on the continental bed was placed so that it did not touch the wooden bedstead.
- vi. the small square pillow was placed in a diamond shape on the long, lower pillow.
- vii. the duvet was first shaken so that all the feathers were in a bulge at the bottom, and were then ritualistically smoothed out.

Using psychoanalytic techniques, Freud explored the symbolic meaning of the various components of the ceremonial. Clocks and watches frequently symbolize the female genitals through their periodicity (and many women describe their menstruation as 'regular as clockwork'). However, the girl associated the ticking of the large clock with the throbbing sensation found in the clitoris during sexual excitement. Flower pots and vases are also female symbols, and the breaking of a pot is symbolic of a loss of virginity (and at some Mediterranean weddings, men smash vases or plates to show renunciation of the bride as a possible sexual partner). The soft, yielding pillows are also female symbols, whereas the firm, upright bedstead is a male phallic symbol.

By now the elements of the ceremonial are seen not to be just random but to have a systematic meaning, with a recurrent theme of prevention of sexual activity (stopping the clocks and watches), and with protection of virginity (symbolized not only by the unbroken vases, but being supported by a childhood recollection when she had fallen, dropped a vase she was carrying, and cut her finger which bled profusely, and which she associated with the metaphorical falling of loss of virginity and haemorrhage). The male and female symbols, pillow and bedstead, were kept apart, and these symbolized the parents who were also kept apart, not least by the girl keeping open the door to their bedroom. As a girl she recalled simulating nocturnal fears in order to be taken into her parents' bed, and when older had slept in the parental bed with the father, while her mother occupied the daughter's bed. The girl was an only child, and had been frightened of her parents having another child, and that fear was still seen in the ruffling of the duvet to produce a pregnancy-like swelling, followed by its smoothing away and thus the abolition of her fears. The large and small pillows represented mother and daughter, and placing the small pillow over the large represented an Oedipal wish to replace the mother in the father's affections. The sexuality of this wish was seen by the diamond-shape placing of the pillow, the diamond being a well-known, if crude, graffito for the female genitals (as can be verified in many public toilets). The ceremonial ended with the girl's head being placed on the pillow (i.e. over her own symbolic genitals) rather than against the male bedstead, to demonstrate the ego-defence mechanisms which had produced the elaborate ritual. Freud interpreted the case as representing an unresolved Oedipal conflict at the

phallic stage, resulting in the girl developing an erotic fascination with her own father.

At this point you may well feel that the case has been heavily over-
 interpreted, and is highly unlikely, perhaps even impossible, for a
 young girl in late nineteenth century Vienna. Perhaps so, and Freud
 himself was aware of such criticism. Nevertheless the story has a
 unity and a completeness which would be difficult to derive from,
 say, a learning theory account of the patient. Freud concluded his
 own description of the case thus:

'Wild thoughts, you will say, to be running through an unmarried
 girl's head. I admit that this is so. But you must not forget that I
 did not make these things but only interpreted them. A sleep-
 ceremonial like this is a strange thing too, and you will not fail to
 see how the ceremonial corresponds to the phantasies which are
 revealed by the interpretation.' Freud, S, *Introductory Lectures in
 Psychoanalysis*, Standard edition, **16**, 268-9.