The Functional Psychoses and Neuroses

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PSYCHOSIS AND NEUROSIS

The first two technical terms likely to be encountered in psychiatry are “psychosis” and “neurosis.” Like many psychiatric terms derived from Greek roots, they promise a technical specificity that should help to clear up the confusion created by such terms as “madness” and “nerves.” In fact, countless inconclusive battles have been fought over the implications of each one during the course of a century or more; without further specification, the meaning is still not clear.

The simplest use of these terms is classificatory, but even this use is by no means unambiguous. We talk of the organic, schizophrenic, paranoid, manic, and depressive “psychoses” on the one hand and of the depressive, obsessional, hysterical, phobic, and anxiety “neuroses” on the other. These terms are enshrined in the International Classification of Diseases.1 Some psychiatrists use the terms as a crude indication of severity. A “psychotic” state is one characterized by delusions or hallucinations, in which the subject is unable to differentiate grossly abnormal thought processes from external reality and remains unaware of this deficiency. A “neurotic” state is one in which the psychologic abnormalities are much less severe in the sense that they do not interfere with the discrimination between internal and external worlds and the subject is well aware that he has obsessions or phobias, though this knowledge may not help him to understand them. This can be a useful differentiation as long as it is recalled that states of partial and fluctuating insight occur. However,

This article is based upon chapters 3 and 4 of Reasoning About Madness, to be published in 1977 by Oxford University Press.
it cuts across the descriptive classification in the ICD. People given a diagnosis of schizophrenia (a “psychosis”) may have considerable insight and be well able to cope with their handicaps, while someone with a severe anxiety state (a “neurosis”) might on occasion act in a blind panic and behave totally out of control.

These internal contradictions become even more confusing when a theoretical element is added to the definition. A unidimensional view, in which psychosis is placed at one end of a continuum of regression or severity, may be psychodynamic or organic in nature. In either case, the disadvantage is the same: it is extremely difficult to be precise about the presence or absence of the abnormality. If the essence of psychosis is an “egocentric overinclusiveness,” at what point does this trait fade into everyday selfishness? There is, of course, by definition no such point, and the determination of the clinical significance of the trait in a particular person can be made only by an expert after detailed enquiry. There is an obvious danger that a condition regarded as “psychotic” because of some very subtle and sophisticated interpretation of a person’s modes of thinking might be thought to carry the same implications for action as a grossly abnormal delusional state.

This major disadvantage is shared by multidimensional theories, such as those of Eysenck or Sjöbring. Eysenck postulates that many psychiatric disorders can best be understood in terms of several independent factors, each normally distributed throughout the population. In Eysenck’s system, three such dimensions, with a largely hereditary basis, are regarded as sufficient to explain most of the functional psychoses and neuroses: psychoticism, neuroticism, and introversion-extraversion. Neuroticism is measured by a checklist of items representing, in the main, symptoms of anxiety, worry, and tension. The items composing the introversion-extraversion scale describe sociability and stability of mood. Someone who scores high on both introversion and neuroticism would be likely to be diagnosed as having a neurotic depression, an anxiety state, or an obsessional neurosis. Someone who had high scores on neuroticism and extraversion would be more likely to be classified clinically as hysteric or “psychopathic.” If it worked, the system would replace categorical diagnosis by assigning each person to a unique point at the intersection of the relevant dimensions. Two practical considerations make this system difficult to use. The first is that it is too simple to cope with the great clinical diversity. Several conditions are characterized by a combination of high introversion and high neuroticism, and there is no way of differentiating them. Similarly, “hysteria” and “psychopathy” are terms used for diverse collections of conditions, and by no means all those given these labels are extraverted or neurotic. Adding a dimension of psychoticism has not yet been demonstrated to differentiate between the functional psychoses. A further difficulty arises. It is not possible to derive, from a knowledge of the position of a point in multidimensional space, any useful indications, such as a prescription for treatment or even a prognosis. For example, in one series of patients with anxiety states, only half could be said to have had an introverted personality before the onset of symptoms. These are the two perennial problems of dimensional theories that are not firmly grounded in clinical facts and categories.

Nevertheless, as Eli Robins demonstrated in Part 1 of this symposium, a dimensional approach can have scientific advantages and a categorizing approach scientific disadvantages. Some combination of the two — such as the multiaxial scheme described by Norman Sartorius, in which descriptive clinical classification is classified separately from other factors (such as etiology, personality, course, age, and so on) — may eventually allow clinician and scientist to make the best of both worlds.

In this article I shall consider very briefly the descriptive basis of the main functional disorders. The term “functional” simply indicates that no structural abnormality and no organic cause is definitely known; the syndromes can be formulated descriptively only in terms of impairments of function. The hierarchical principle so widely used by psychiatrists means that the presence of known organic impairments, such as those of dementia or delirium, takes precedence in diagnosis. Postulated organic causes are used in a similar way. For example, characteristic schizophrenic symptoms may
occur as a manifestation of disease of the temporal lobe and be followed by the familiar signs of an epileptic fit. The onset of such symptoms may also be clearly related to excessive intake of alcohol or amphetamine or to some clear-cut cerebral pathology, such as a tumor. In such cases, the diagnosis is based upon the presumed etiologic factor rather than on the syndrome. Depression may occur following the ingestion of the drug reserpine or, occasionally, as a side effect of taking contraceptive pills. In due course, as knowledge accumulates, it can be assumed that the functional group will diminish as more and more precise diagnoses are made, utilizing etiologic and pathologic as well as purely descriptive factors. Even among the functional disorders, the hierarchical principle in classification can be traced. At each level, certain syndromes are picked out as particularly important; these form the basis for classification whatever other syndromes also happen to be present. As a matter of fact, disorders placed higher in the hierarchy are usually accompanied by syndromes from the lower levels.

The significance of this hierarchical element in classification is complex. It may be postulated, for example, that organic lesions can trigger schizophrenic symptoms because schizophrenia itself has an organic substratum. Among the functional conditions, a reactive element may well be a factor. Thus the experience of acute schizophrenia is found by most people to be acutely distressing. It is hardly surprising if they become depressed or anxious in consequence. There may, of course, be a more fundamental association as well, particularly in the case of anxiety, since the processes underlying attention and arousal are known to be disturbed in schizophrenia. The relationship between mania and depression is also more than reactive. However, a reactive element can certainly be implicated in affective conditions as well, since the experience of depression may secondarily induce anxiety just as chronic phobias may well be found depressing. As a result, the differentiation between depressive and anxiety states is often difficult. Every type of psychiatric disorder is likely to be accompanied by the minor syndromes — worrying, tension, poor concentration, and so on — so these come at the bottom of the hierarchy.

THE SCHIZOPHRENIC DISORDERS

The basis of the original concept of schizophrenia was the observation that a severe and permanent deterioration in personality and intellect resembling dementia occasionally occurred in someone who had not had a feverish illness or head injury or other obvious episode to explain it. In 1860, Morel reported the case of an adolescent who had deteriorated in this way. He regarded it as an unusually early dementia. In 1871, Hecker reported his observations about a number of cases in which similar deterioration had occurred at the time of puberty. Because the young people concerned had changed in personality, becoming markedly silly and affected, Hecker called the condition “hebephrenia.” Then, in 1874, Kahilbaum described a condition that he called “catatonia,” because it was characterized by stupor and muscular rigidity. Kraepelin pointed out that these conditions were probably related, and he eventually grouped them together as “dementia praecox,” the name being chosen because of the irreversible intellectual deterioration (dementia) and the early age of onset. Kraepelin did recognize that these features were not unique, that recovery was possible, and that onset could occur later in life; but he thought that emotional deterioration, characterized by apathy and lack of drive, was the common pattern. Another group of cases — in which this feature was less marked and in which more florid traits, such as delusions and hallucinations, were predominant — he called “paraphrenias.” This separation was an uncomfortable one, and when Bleuler suggested the term “schizophrenia” to cover all these conditions, the idea immediately caught on. Moreover, Bleuler argued that all the

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characteristics could be interpreted in terms of the fundamental disorders of affect and thinking. Everyone with schizophrenia was regarded as having emotional flattening and a thought disorder based on "loosening of the associations." Other characteristics, such as delusions, were seen as secondary or accessory. Bleuler in this way broadened the boundaries of Kraepelin's concept, since minor degrees of affective flattening and thought disorder, occurring

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without more obviously recognizable abnormalities, might be detected by eager clinicians in anyone whose behavior was out of the ordinary, such as tramps, criminals, or eccentrics.

There has been considerable debate since then as to which manifestations of schizophrenia are "fundamental," in the sense that they can be used to explain all the others. Gruhle, for example, pointed out that certain delusional experiences were "primary" or "autochthonous," insofar as they could not be understood in terms of other psychologic abnormalities; in fact, many other manifestations could be understood as attempts by the subject to explain his primary delusional experiences. Jaspers adopted this point of view when he defined "true" delusions in terms of experiences that could not be understood by other people. Other types of delusion — for example, ideas of persecution expressed by political refugees — Jaspers called "apparent delusions."

Schneider provided a list of "symptoms of the first rank," which — in the absence of epilepsy, intoxication, or other evidence of gross cerebral damage — he regarded as likely to indicate a diagnosis of schizophrenia. Examples are the experience of hearing one's thoughts spoken aloud in one's head, so loud that it would seem that anyone standing nearby must also be able to hear them; the experience that one's thoughts are repeated after one has thought them; the experience of having alien thoughts inserted into one's mind; the experience that one's own will is being replaced by that of some other agency or force; and the experience that several voices are commenting among themselves on one's thoughts or actions. Schneider did not suggest that these symptoms must be directly related to some underlying biologic abnormality, nor did he think they carried a special prognosis compared with other characteristics of the schizophrenic syndrome. But he did provide the basis for defining a syndrome in a reliable way so that any expert could recognize it.

A somewhat broader set of such symptoms is used in the Catego program to describe a central schizophrenic syndrome that was found, in two large international studies, to be present in about two-thirds of all those who were given a diagnosis of schizophrenia. In a few cases, people with these symptoms were not diagnosed as schizophrenic, and it is instructive to try to analyze the reasons why they were not. Let us examine one particular symptom, "thought insertion." The essence of the symptom is that the subject experiences thoughts that are not his own intruding into his mind. The symptom is not that he has been caused to have unusual thoughts (for example, if he thinks the Devil is making him think evil thoughts) but that the thoughts themselves are not his. In the most typical case, the alien thoughts are said to have been inserted into the mind from outside, by radar or telepathy or some other means. In such a case, there is an explanatory delusion as well. Sometimes the patient may say that he does not know where the alien thoughts came from, although he is quite clear that they are not his own. In very rare instances, he may postulate that they come from his own unconscious mind — while still consciously experiencing them as alien.

There are several ways in which this symptom can be mistakenly regarded as present when it is not. The most obvious is when the patient fails to understand the question or, because of inadequate intellectual or verbal ability, is unable to reply clearly. Several other symptoms can be confused with it, notably those in which the patient believes that other people can
"read his thoughts." This idea may well be based upon an exaggeration of the completely ordinary phenomenon of postulating someone's motives through observing his actions. The patient may come to feel, however, that such powers can be due only to a special ability on the part of others, such as "thought reading" or "hypnotism." In other cases, there may be a strong religious element in such ideas — the patient believing, for example, that God knows what he is thinking. In yet others, a deep intensification of a normal mood, such as depression or elation, may affect a person's experiences, including his thought processes, so that he says that his thoughts are as powerful as the sun's rays or come from the Devil. Such ideas must not be taken to indicate that the symptom of "thought insertion" is present. It should be recognized only when the subject describes an experience of alien thoughts — thoughts that he recognizes as not being his — being inserted into his mind.

This symptom is very rare. One can carry out a large-scale survey in a general population without coming across anyone who has ever experienced it. Moreover, it seems to be invariant with respect to age, sex, family circumstances, class, culture, or nationality. In other words, it comes as close as we are likely to get, in a symptom of this kind, to a nonsocial phenomenon. This is what Jaspers called a "true" delusion, one that can be traced back to an irreducible and nonunderstandable experience — nonunderstandable, that is, except in terms of some post hoc theory made up for the occasion. Of course, it can be faked or imitated on the basis of descriptions by other people who really have had the experience, but no more than physical symptoms can. Rosenhan's experiment has demonstrated that it may also be necessary to consider deliberate faking.4

All the symptoms in the central syndrome can be differentially defined in this careful way and reliably used, anywhere in the world, by psychiatrists who have learned the definitions. Many clinicians, however, do not restrict a diagnosis of schizophrenia to disorders characterized by the central syndrome. If a patient complains that a gang of Communists follows him about, that he has invented the atom bomb but received no credit for it, or that he is a saint or great religious leader, and if these statements are made with unalterable conviction although there is no evidence at all that they are true, many psychiatrists would diagnose "paranoid schizophrenia" even in the absence of any symptoms from the central syndrome. There might be only a single much-overvalued idea — for example, that a person's nose is too large even though no one else can see anything the matter with it. This one preoccupation could ruin the person's life, drive him from one plastic surgeon to another, spoil his personal relations, and deprive him of any peace or satisfaction. Just under one-fifth of all the patients diagnosed as schizophrenic in the International Pilot Study of Schizophrenia5 had delusional symptoms of such kinds, in the absence of a predominating mood of elation or depression that might be held to explain them.

Some psychiatrists prefer to call such disorders "paranoid psychoses" (classifiable separately in the ICD under 297 rather than 295); others regard them as schizophrenic. Nothing is lost by keeping them separate, since there is no difficulty in combining categories. Once they have been included in a more general grouping, however, it is very difficult to separate them again. The term "paranoia" is usually applied to such an "encapsulated" condition, developing gradually over a long period with relatively good preservation of intelligence and personality and relatively little in the way of thought disorder or generalized blunting of affect.

Yet another group of disorders often placed under the general heading of "schizophrenia" are diagnosed only on the basis of various abnormalities of affect, speech, or behavior, in the absence of symptoms of the central syndrome or of the paranoid psychoses. This group is not

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so large as might be supposed, because many patients with such symptoms do have symptoms of the central syndrome as well. However, a few patients do show only catatonic symptoms, only a gradual loss of affective contact, or only a tendency to markedly unusual forms of speech, and none of these symptoms can readily be explained in terms of other diagnostic categories, such as encephalitis, mental retardation, or aphasia. The tendency to use the term schizophrenia in such cases varies in different parts of the world. It is probably greater in the United States and the Soviet Union than elsewhere, although disagreement on the matter can be found within every country. Insofar as such terms as “simple,” “latent,” “borderline,” “pseudoneurotic,” and “pseudopsychopathic” schizophrenia denote conditions that are not characterized by symptoms of the central syndrome or of the paranoid psychoses, they are very difficult to define reliably. The sensible course would seem to be to classify them separately. The empirical question whether they share other characteristics of the central syndrome — for example, the same genetic background, the same response to medication, or the same clinical course — can then be tested empirically. Once they have been included within a general grouping of schizophrenias, however, no such test can be made.

One of the reasons why all three types of disorder have been regarded as belonging to the same class has been the observation that the central schizophrenic disorders are frequently characterized, during the course of time, by symptoms from the other two groups. Probably one-quarter of all those first given a fairly strict diagnosis of schizophrenic or paranoid psychosis develop quite severe long-term hand-icaps, characterized by social withdrawal, poverty of speech, blunting of affect, and unusual processes of thinking. This does not mean, however, that anyone who is socially withdrawn should be given a diagnosis of schizophrenia. The hierarchical principle should not be applied in reverse. Even states characterized by very severe thought disorder and social withdrawal, but where no history of acute schizophrenic psychosis can be obtained, should probably be kept separate from those in which a clear-cut history is obtainable. The rule should be that separate classes of disorder should be formed whenever this facilitates the testing of hypotheses.

**THE AFFECTIVE DISORDERS**

The affective disorders are so called because the primary clinical abnormality is an exaggeration of the normal moods of depression and elation. In some people there is a clear alternation between these affects — hence the terms “manic-depressive” and “circular” and “bipolar” disorders. Others swing only one way, either toward mania or toward depression, but not both.

The manic syndrome, when severe, is characterized by wild elation, gross overactivity, and delusions of grandeur, the affected person believing that he has powers or talents or riches far beyond his actual means. There are lesser variants of the syndrome (hypomania), characterized by ordinary optimism and high spirits. The hypomanic mood is one of euphoria, readily leading to irritability if there is any frustration. One of the most recognizable clinical features is a rapid flow of talk easily diverted from its course by chance associations and punctuated by puns, rhymes, snatches of song, and bursts of loud laughter. There is, however, a painful quality to the mood; it is not happiness. Hallucinations can occur, usually of voices speaking directly to the affected person, saying things that are congruent with the mood, such as “Go to the palace! You are the king!”

The depressive syndrome, at its most severe, in many ways presents the opposite of this picture. The patient may be so deeply depressed as to seem apathetic and so retarded as to be almost in a stupor. Occasionally, there may be extreme agitation rather than retardation. The pa-
tient may express delusions of guilt or inferior-
ity, saying that he has committed appalling
 crimes and deserves severe punishment. He
may hear a voice accusing him of unnameable
sins and telling him that he ought to commit
suicide since he is not fit to live. This is the
classic melancholia.

At their most severe, these two syndromes
can reasonably be called "psychotic," since
judgment is seriously distorted and the patient
is liable to act against his own interests and
those of people around him. However, such
severity is rare. Depressive disorders are much
more common than manic disorders, and most
of them are unidirectional (not alternating with
manic attacks). At an intermediate level of se-
verity, depression is still characterized by retar-
dation, particularly a subjective feeling that
thinking is difficult and inefficient and that bod-
ily processes are slowed down, even when this
is not apparent to the observer. Quite often re-
tardation is complicated by motor restlessness.
Guilt and self-deprecation are expressed,
though not with delusional conviction. Appetite
is poor, and there may be loss of weight. Sleep
is also affected — particularly early in the morn-
ing, when the depression is worst and is ac-
companied by a dread of getting out of bed to
face the difficulties of the new day. The zest
goes out of life, the edge is taken off all the
appetites, the future appears bleak and hopeless,
and life seems hardly worth living. These symp-
toms often seem to be completely out of propor-
tion to the problems the affected person actually
has to face. Some people experience such de-
pressive swings quite frequently, so that they
and those who know them well come to recog-
nize the prodromal signs and have some idea of
how long the phase will last.

There is yet another level at which depressive
disorders may be manifested — on the whole
milder, though it can occasionally be quite se-
vere. The mood is usually less consistently de-
pressed; there is less retardation or agitation,
less guilt or self-deprecation, and more anxiety.
However, sleep and appetite may still be mark-
edly affected. It is often assumed that this third
syndrome is reactive to environmental pres-
ures of various kinds while the other two are
more "endogenous."

These three syndromes — named, for con-
venience rather than theory, "psychotic," "re-
tarded," and "neurotic" (or "reactive") depres-
sion — seem to be on a continuum of severity.
The first two are encountered most frequently
in people who have had to be admitted to hospi-
tal because of difficulty in carrying on outside a
protected environment. The third type is more
often met in the outpatient department and in
general practice. In all three types, the lesser
psychiatric syndromes, such as worrying and
muscular tension, are very common. There is
yet a further level below these three. In fact, it is
in trying to define the threshold point below
which depression can be said to be "normal"
that the dimension-category dispute can be as-
sessed most clearly. All of us are unhappy from
time to time. What makes us depressed may
vary from one person to another, but someone
who has never had the experience at all could
hardly be regarded as normal. Some people,
however, become more than ordinarily de-
pressed, usually in response to real problems
and pressures, although they do not experience
the various extra symptoms making up the
three depressive syndromes described earlier.
They may well be worried and tense, sleep
badly, and feel unusually irritable. Most psy-
chiatrists would not consider this sufficient
for a diagnosis of depressive disorder in the
sense that they would want to prescribe de-

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tailed investigations, admission to hospital, or
pharmacologic treatment. We can call such con-
ditions "minimal depressive disorders."

It would seem fairly obvious, from a clinical
point of view, that one dimension underlies
these various disorders, from the most severe
"psychotic" variety to the minimal depressive
disorders that most people have probably ob-
served in others or experienced in themselves.

continued
If so, there are also qualitative change points marking the equivalents of the boundaries between ice, water, and steam. The specialist sees mainly the more severe end of the spectrum, and most of the studies that have been carried out with a view to establishing an abnormality in some underlying physiologic cycle, to discover possible causes, and to assess the value of various forms of medication have been concerned with the disorders observed in people referred to specialists, particularly the “psychotic” and “retarded” depressive syndromes. On the other hand, much of the sociologic investigation of environmental precipitating factors and longer-term stresses has been undertaken with general population samples and is, so far, more relevant to “neurotic” (or “reactive”) depression and to the minimal depressive disorders.

Once again, the major reason for separating these conditions is to be able to test hypotheses. It is not clear how far the mainly biologic theories that have been put forward to explain the manic and bipolar depressive disorders can also account for the third group of “reactive” or “neurotic” depressions, and still less how far the mainly sociologic theories that have been put forward to explain the “minimal” group also apply to the others. But we shall never discover unless we can recognize the conditions to begin with:

**ANXIETY AND OBSESSIOINAL NEUROSES**

Kierkegaard thought that the freedom of will that gives human beings the possibility of moral choice must inevitably be accompanied by a feeling of dread.

Anxiety, like depression, is a virtually universal experience. Normal anxiety is even more obviously dependent on everyday environmental or internal stimuli than normal depression. Everyone gets anxious in some situations; it would be regarded as abnormal if the reaction were completely absent. A degree of anxiety actually improves performance by providing a stimulus to attain a desired standard. Thus, normal anxiety functions as a motivating force.

When there is some clear-cut object to be anxious about, the emotion is usually called fear. Many people, perhaps particularly those with a low pain threshold, are afraid of dental treat-
ment. Nearly everyone who experiences an air raid fears injury or death. However, a substantial proportion of people would agree that they avoid certain quite ordinary situations as far as they are able, because they know they will experience anxiety if they enter them. The situation avoided might be a telephone booth, a bus, an elevator, or a room with a spider in it. In most cases, this action is successful and the person avoids the anxiety at small cost to himself.

The criteria for judging “pathologic” anxiety are similar to those used to judge the severity of depressive disorders. The main question is whether the condition has gone “out of control,” producing symptoms that cannot be dealt with by consciously turning the attention to other matters, withdrawing from the anxiety-provoking situation in good order, or simply exercising the will. The symptoms that result—palpitations, muscular tremors, “butterflies” in the stomach, giddiness, sickness, breathlessness, muscular tension, and faintness—can be very severe. In a total panic, there may even be loss of control over bowels or bladder.

In “free-floating” anxiety states, the sufferer experiences such symptoms continuously or in episodes of panic. Situations. Agoraphobia is a common example. (The Greek agora was a public meeting held in the open.) Other situations are enclosed or crowded places, heights, bridges, being alone, and being in the dark. Several such phobias can occur together. Quite often sufferers (young women are particularly vulnerable) have had a minor variant of the condition for a long time, but there is a sudden onset of more acute anxiety following, for example, a change in routine that required the person to stay at home. The symptoms can be extremely severe, chronic, and disabling. Social phobias overlap with these situational anxiety states. The person is afraid of eating or speaking in public, of blushing when spoken to, or of doing something silly when entering a social situation.

There are more specific anxiety states, caused by such objects as spiders, snakes, or fluttery things like birds or moths or bats. These usually begin during childhood, they are restricted to one or a few classes of objects, and there are rarely anxiety symptoms except in the presence or anticipation of the object. Nevertheless, the disablement can be severe if, for example, a sufferer insists on having any room explored by someone else to make sure there are no spiders before he will consent to enter.

In all these types of anxiety state, physiologic tests demonstrate the abnormalities very clearly when the stimulus is present and often even when it is not. There is a high pulse rate, increased palmar sweating, rapid respiration, impaired respiratory efficiency, increased blood flow, and muscular tension. In addition, unusual features in the autonomic response to stimuli can be demonstrated in the laboratory. More sedative is required in order to reach a given “sedation threshold” than in nonanxious subjects; spontaneous fluctuations in the electrical conductance of the skin are more frequent, suggesting a higher level of spontaneous activity in the central nervous system; and anxious patients do not adapt so quickly to a painful or anxiety-producing stimulus.

Occasionally, anxiety states can be extremely severe, and the subjective experiences may be described in very unusual terms: “Cold water is trickling over my spine.” “The roof of my head has been lifted off.” “My stomach is on fire.” There can even be hallucinations, as when a
young woman who was terrified of the dark thought she heard the voices of two men in the shadows, plotting to attack her. Depersonalization and derealization also occur, sometimes as an alternative to severe and prolonged anxiety. The sufferer feels remote or detached from his body, or he feels as though he is floating above the surface of events or seeing things from a distance. Another symptom is fear of illness or hypochondriasis. Both depersonalization and hypochondriasis can occasionally occur, particularly in chronic states, as the most predominant feature, the anxiety symptoms having receded into the background.

Another group of neurotic conditions are termed obsessive and compulsive states. They are characterized by ideas, thoughts, or images forcing themselves into consciousness against the sufferer’s will, so that he finds that he has to be preoccupied with some particular mental content (it might be germs, or knives, or the meaning of the universe) even though he tries to turn his attention elsewhere. These experiences are often severely distressing and disabling. They can occur together with other phenomena in agoraphobic conditions or by themselves. The essence of the difference between an obsessive and a situational or specific phobia is that the former is a direct fear not of a given object or situation but, rather, of imagined consequences arising therefrom. For example, one woman was disturbed more by the notion that she might injure herself on small splinters of glass (and driven to take useless preventive measures) than by possible injury from larger fragments she could actually see and remove.

Because the objects of anxiety are less definite in the case of the obsessive phobias, there is a greater likelihood of generalization, so that protective rituals spread to encompass the whole of a person’s life and the lives of people around him (though this is a risk in all anxiety states). One young man could never decide whether he had seen every possible source of danger when beginning to cross the road. He was afraid that a cyclist, for example, might have escaped his attention and that by stepping out incautiously he might cause an accident. Thus he stood hesitating on the curb for hours at a time, unable to cross. Obviously, his whole life became dominated by this obsession. He was unable to work, and he had no social life; even his close relatives were finally unable to tolerate this bizarre behavior, and he had to go into hospital.

The reactive element in the depressive and anxiety disorders leads to difficulties in differential classification. On the one hand, depressive states often seem to induce anxiety. A characteristic symptom is the dread experienced by someone first thing in the morning before getting up, when all the difficulties and pain of the day to come are considered. The feeling that “something awful will happen” is also typical in depression. On the other hand, someone with chronic phobias may become very depressed because of the accompanying impairment of social functioning.

Sometimes, the problem can be solved by asking the subject which affect is predominant. If not, a useful working rule is to treat the depression first. This implies that mixed states should usually be classified with the depressions (i.e., as “neurotic” depressions); this leaves only a rather small group of relatively “pure” anxiety and obsessional states for separate classification.

**Hysteria**

Hysteria is one of the oldest concepts in medicine; it has contributed more than any other to the powerful controversies that have always raged around the psychiatric disorders. This is paradoxical, because it is generally accepted today that disease theories of hysteria are only of very limited practical use, though they may yet turn out to be valuable pointers towards an understanding of the neurophysiology of mental processes. The term itself dates from the time of Hippocrates. The traditional theory was that hysteria was a disease of the
uterus that wandered about the body causing a multiplicity of complaints, though such physicians as Aretaeus realized that it could occur in men as well as women. “Hysteria” was probably used then, as now, as a sort of catchall for those complaints that no other diagnosis would fit.

The concept was resuscitated in new guise by Janet and Freud, both of whom were impressed by the work on hypnotic phenomena of Bernheim and Charcot. Janet’s work has not been influential outside France, and Szasz has argued that Freud’s contribution was not to discover that hysteria was a mental illness but to advocate that so-called hysterics should be called “ill”.

Although it is well established that hysterical phenomena — such as catalepsy, somnambulism, and multiple personality — were often induced by doctors rather than spontaneously produced by patients, during the era when magnetism and hypnotism were being investigated, similar phenomena often occurred in nonmedical settings. States of “dissociation” are regarded as desirable in certain societies and are often connected with religious ceremonies. There are similarities in the methods used in different countries to induce trances or states of possession. “Epidemics” of hysterical phenomena indicate that some persons are much more susceptible than others. It may therefore be useful, on occasion, for the doctor to be able to recognize those most at risk — i.e., to be able to classify them. Jaspers’ description of the central traits of the predisposed personality is as follows:

Far from accepting their given dispositions and life opportunities, hysterical personalities crave to appear, both to themselves and others, as more than they are and to experience more than they are ever capable of. The place of genuine experience and natural expression is usurped by a contrived stage-act, a forced kind of experience. This is not contrived “consciously” but reflects the ability of the true hysterical to live wholly in his own drama, be caught up entirely for the moment and succeed in seeming genuine. All the other traits can be understandably deduced from this. In the end, the hysterical personality loses its central “core” as it were, and consists simply of a number of different exteriors.

CLASSIFICATION AND DIAGNOSIS

This article has been concerned primarily with describing the syndromes that form the main body of material that is used in any classification of the functional psychoses and neuroses. However, the process of diagnosis implies a good deal more than mere description, since many other factors need to be taken into account, including age, sex, intelligence, personality, clinical history, and etiology. The concept of multiaxial classification, discussed by Norman Sartorius in Part 1 of this symposium, provides a possible means of dealing with this complexity in a reliable and communicable way, but a great deal of international development work will be necessary before such a scheme can be used in practice.

In the next two articles, the way in which various factors are taken into account to reach a clinical diagnosis is illustrated. The chapter by Martin Roth deals in detail with diagnostic problems that arise in the context of geriatric psychiatry, while that by Donald Cohen discusses examples from child psychiatric practice.

BIBLIOGRAPHY