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Neuroticism: The Elephant in the Room

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1) Abstract

The term neurosis has a long tradition in psychiatric nosology. It was first introduced by Cullen referring to diseases of the nervous system in which there were no obvious physical lesion. It evolved to a wide use with the assumption of an aetiological meaning in the psychodynamic literature. Partially as a result, it has been removed as an organizing principle in psychiatric classifications subsisting, however, in the heading of one group of disorders of ICD-10.

Nevertheless, in the clinical context, the terms “neuroticism” and “neurotic” are often used as an informal diagnostic for a relatively large group of patients described as presenting both depressive and anxiety symptoms of fluctuating, chronic pattern and frequently associated with underlying maladaptive personality traits.

Most interestingly, a sparking debate subsists among clinicians and researchers on how to categorize such patients. The concept of dysthymia is challenged by several methodological and epistemological issues, along with a raising number of authors sustaining other constructs as better describing the developmental nature of what Schneider called “the aristocracy of suffering”.

The authors address these issues revising the available scientific literature, suggesting that, paradoxically, current classifications on the subject do not effectively describe the core aspects of a common and highly resource-consuming set of patients.

2) Keywords: Neuroticism; Depression; Dysthymia; Depressive personality disorder

3) Introduction

The terms neurosis and neuroticism are widely spread in colloquial language. People use it to describe an episodic or stable way of oneself or others to respond with negative emotions to challenging situations of everyday life. In a psychiatric perspective, however, these concepts have taken different paths, whether they are considered in an investigational or clinical framework. This separation is common to other constructs and represents an obstacle to the evolution and evaluation of psychiatric classifications.

From an investigational and theoretical stand of view, the concept of neurosis remains, since Freud, attached to the assumption of an aetiological meaning in the psychodynamic and psychoanalytical literature. It has long been removed as an organizing principle in psychiatric classifications due to conceptual difficulties and to a dominant perspective of defining classifications purely on descriptive and clinical aspects.

Nevertheless, in the clinical context neuroticism and neurotic are terms used as an informal diagnosis for a considerably large group of patients presenting both depressive and anxiety symptoms of fluctuating, chronic pattern, and frequently associated with underlying maladaptive personality traits. This combination of depressive and anxiety symptoms has been described as affecting about one in seven of the population at any one time in the UK [1], and yet a single diagnosis of both anxiety and depression is not allowed, both in DSM-IV, DSM-5 and ICD-10.

For several reasons to be mentioned, current classifications have not managed to include the large number of patients with mix depression and anxiety and to significantly outrank informal constructs, with a sparking debate subsisting among clinicians and researchers on how to categorize such patients. The concept of co-morbidity in Psychiatry has been challenged by several methodological and epistemological issues, along with a raising number of authors sustaining other constructs as better describing the developmental nature of what Schneider called “the aristocracy of suffering”.

The terms neurotic and neuroticism are underlined to emphasise that they are not taken as more suitable designations, but as the ones informally used and that have been showing an interesting resistance to evolution of psychiatric classifications.

4) Origin of the Term Neurosis and the Coming of Neuroticism

The term neurosis was coined by Cullen in 1769, to mean diseases of the nervous system in which there were no obvious physical lesion. Mental illnesses were a subcategory of neurosis [2]. The concept was developed by authors such as Von Feuchtersleben (1845) and Kraft-Ebing (1872), but it was Freud who generalised it in medical literature, using it from the start to express “disorder” [3].

The rising of standardized international classification DSM eventually abandoned the term neurosis to replace it by disorder, eliminating its use even as an adjective. In ICD classification, reflecting European psychiatric tradition, neurosis still subsists as the heading of the “Neurotic, stress-related and somatoform disorders” [4].

The modern conception of neuroticism, however, is unrelated to psychodynamic models and theories of unconscious conflict, being usually applied in descriptive psychometric terms. It is operationally defined by items referring to irritability, anger, sadness, worry, hostility, self-consciousness and vulnerability [5]. Eysenck, in 1948, argued for a dimensional approach to personality disorders, in which he considered neuroticism as a structuring construct [2] that became a core dimension in his later Eysenck Personality Questionnaire. Individuals who score high on neuroticism are more likely to experience emotions such as anxiety, anger, envy, guilt, and depressed mood, with greater intensity and overall vulnerability to stress [6].

The relevance of such a tendency to experience negative emotions, for rather long periods of time, has been maintained in more recent and well substantiated models of personality, such as the Big Five Model [7]. In addition, neuroscience has brought the evidence for a neural basis of neuroticism, which covers with the volume of brain regions associated with threat, punishment and negative affect [8].

5) Neurotic Patients in Psychiatric Classification

Interestingly, the way modern psychiatrists refer to neurotic patients or neuroticism has also lost, in most cases, any hypothetical dynamic or psychoanalytical orientation. This is certainly due to the progressive downgrading of psychoanalytical thought as the dominant model of modern psychiatry, along with the emergence of supposedly atheoretical and phenomenologically pure classifications of psychiatric disorders. However, the question subsists of why these terms are still at use and if there is a suitable alternative designation in current classifications.

5.1) The era before DSM and ICD classifications

Kraepelin described what he considered being a “depressive temperament”, implying a constitutional origin [9]. Kraepelin considered that depressive temperament was a “fundamental state” predisposing individuals to the depressive aspect of manic-depressive illness [10]. Kretschmer shared this view, while considering that such traits of depressive temperament could be observed in individuals otherwise normal. Interestingly, in the eighth edition of his textbook, Kraepelin considered the construct of psychogenic depression and classified it as one form of “psychopathic disorder”, implying the existence of a form of depression included in the group, at the time, of neurosis and personality disorders, and not within the manic-depressive spectrum of illness [11].

Schneider, in the 1950's, rejected the idea that disorders of personality should be considered as proper mental illnesses [8], but statistical deviations from the norm. In fact, he also rejected the concept of continuum between normality and mental illness. However, describing what he called “depressive psychopathy”, Schneider introduced other new perspectives into the subject, considering, unlike Kraepelin or Kretschmer, that depressive personality could be linked to other personality disorders, rather than major affective disorders [9,12,13].

In our view, Schneider also brought his description of depressive personality much closer to the concept of neurotic patient exposed in this article, when he refers to them as the “aristocracy of suffering” [13]. This expression points out how suffering may be taken as a mark of quality and identity, and how this, along with the relative absence of objectively ascertainable depression, may be distinguishable features of these patients. These features, however, are nowhere to be found in current classifications.

The development of psychoanalytical thought brought the concept of depressive character (developmentally rooted), opposed to the depressive temperament (of constitutional origin) of the German School [12]. Psychoanalytical authors make some useful points on referring characteristics of dependency, obsessiveness-compulsiveness and masochism [12]. The first two also mentioned by Schneider, who compared many depressives to anankastic and sensitive personalities [13]. In general, psychodynamic approaches use three main aspects to describe individuals with a depressive personality structure [12,14]: (1) one appears to be negative and pessimistic in his personal experience and in interaction with others; (2) this style of interaction is attributed to early object loss or frustration, in which the anger and frustration is repressed and redirected toward the self; (3) this pattern is activated in a wide range of situations, in particular when a loss or frustration occurs.

These principles, even if not rooted in theories of unconscious conflict, along with other contributions to be explored further on, may constitute a fertile contribution to a fair description of neurotic patients.

5.2) Development of DSM-I and DSM-II

The early versions of DSM were built under the auspices of psychoanalytic thought [15]. Nonpsychotic depressions were categorized under the sections of neurosis and personality disorders [9]. DSM-I (1952) listed reactive depression as a psychoneurosis and cyclothymic personality - with a depressive subtype – as a personality disorder.

DSM-II (1968) merely proposed new names for those categories, changing depressive reaction to depressive neurosis [10]. Two other related categories were created, namely neurasthenic neurosis and asthenic personality disorder. However, none of these were significantly supported by clinical practice, which favoured depressive neurosis over the other categories [10].

5.3) The emergence of DSM-III

By the late 1970's, there was all but consensus about classification of depressive disorders [9,16]. The most curious aspect that came out of the debate was that eventually, DSM-III brought the end of depressive neurosis as a diagnosis, which was, simultaneously, considered one of the most, if not the single most common psychiatric diagnosis at the time [17].

As a result of the changes introduced, DSM-III listed depressive neurosis in axis I, with a new designation of dysthymic disorder, and the depressive subtype of cyclothymic disorder was eliminated and it was classified under axis I as an affective disorder. The other two classifications – neurasthenic neurosis and asthenic personality disorder were simply put aside [18].

It was not without controversy that DSM-III was published [10,19,20]. In our perspective, the most important limitations mentioned were the blending of affective variants with characterologic types of chronic depressions, and considering them as axis I disorders. Not only the former issues pointed out – over inclusiveness and heterogeneity-remained, as also the specific features that Schneider and others have described lose a great deal of importance to biogenetic explanations based on the medical model, as mentioned by some authors [19]. It is not a matter of excluding those explanations, but putting the emphasis on developmental aspects and on specific patterns of behaviour, not compatible with a concept of disorder that transversally affects the patient and susceptible of specific treatment as such.

5.4) H. Akiskal's contribution to the classification of chronic depressions

In 1983, H. Akiskal suggested “a nosological framework for understanding the psychopathology of low-grade chronic depressions”. In a wide picture, Akiskal supported that most part of what was being considered as a dysthymic disorder and before, a depressive neurosis could be actually divided into two subgroups: a sub affective dysthymia and character-spectrum disorder. The first group was characterized by a favourable, sometimes hypomaniac response to antidepressants or lithium, shortened REM latency, family history of unipolar or bipolar affective disorder, unremarkable developmental history and relatively good social outcome [20]. The group of character-spectrum disorder, however, was described in a very different way: poor response to tricyclic drugs; normal REM latency; family history of alcoholism, sociopathy and parental assortative mating but no affective disorder; childhood parental loss, separation or divorce; poor social outcome; greater prevalence among females; onset in childhood or adolescence; a subsyndromal continuous dysphoria punctuated by transient insomniac-agitated, nonmelancholic episodes; and poly substance and alcohol abuse.

Some relevant aspects derive from this classification. First, although some of the criteria were supported by other authors [9], Akiskal was the first modern author, to our knowledge, to frame clinical descriptions in terms of social, family and developmental background, and using it to make important distinctions between groups of patients. Secondly, he consistently distinguishes the personality traits of patients with sub affective dysthymia from those of the character-spectrum group. In the later, Akiskal points out the predominance of a liberal mélange of “unstable” characterologic traits, with dependent, histrionic, anti-social or schizoid features [20]. Also, these patients could be recognized as being somewhat passive-aggressive, manipulative, immature, having a low frustration tolerance, and prone to suicidal [12]. Another important fact is that sub affective dysthymia was first considered the true axis I dysthymia disorder, and later placed in axis II, due to its early onset and to a mediation of traits rather than state [9].

In conclusion, Akiskal demonstrates what clinicians know from everyday practice: a group of patients exists characterized by maladaptive personality traits, and not state, presenting several difficulties of management and with a specific pattern of behaviour and background. Interestingly, Akiskal considers this group a heterogeneous mix of personality disorders with secondary dysphorias that does not warrant categorization as a distinct entity [9]. We believe that is precisely this group, due to its management challenges, high prevalence and resource-consuming follow-up, that is informally designated as Neurotic or with high Neuroticism.

5.5) Where to find neurotic patients in current classifications

Current classifications include dysthymic disorder in axis I and a categorization of personality disorders organized in clusters in axis II. Ironically, the original step of blending former classifications in one entity – dysthymia - in Axis I in DSM-III was supported in Akiskal's research mentioned earlier. However, this does not rigorously reflect what was stated in those studies. In fact, the group of characterologic depressions accounted for 36% of patients in the series reported, and was considered the «most representative of the DSM-III description of dysthymic disorder [20,21]. Of those, two thirds were classified as character-spectrum disorders and only a minority as sub affective dysthymic disorders, which Akiskal considered as an expression of an underlying primary depressive disorder, responsive to thymoleptics.

DSM-III-R attempted to reduce heterogeneity inherent in the diagnosis of dysthymia by adding subtypes concerning early onset versus late-onset and primary versus secondary [13]. DSM-IV eliminated the latter, introducing research criteria for depressive personality disorder (DPD) in Appendix B, fuelling the debate over the validity and relevance of such diagnostic categories [10,12,19].

Our view, however, is that the main question remains to be answered. Current diagnostic criteria of dysthymia and research criteria for DPD, virtually exclude the group of patients Akiskal called character-spectrum disorders. While dysthymia is considered as a pathological disease state, both fail to describe some of the most distinguishing features of neurotic patients, and therefore not significantly transposed to language of psychiatric practice.

5.6) The issue of psychiatric co-morbidities: depression and anxiety

Perhaps the most simple and linear method of minimizing difficulties such as the ones presented is to consider the existence of multiples diagnosis for the same patient. Evidently, this issue has been one of the most debated in psychiatric field.

The concept of co-morbidity was introduced by Feinstein in 1970, and found a fertile ground in psychiatric nosology [22]. In fact, in the US, in 1994, only 26% of patients with a DSM-III-R/DSM-IV diagnosis of major depression had no co-morbid mental disorder, and on a 2002 Australian national survey, 21% of patients with a DSM-IV diagnosis met the criteria for three or more other psychiatric diagnosis [23,24]. The proliferation of diagnostic entities contributed to the increasing number of diagnosis for each patient and thus diluting the possibility of an holistic and coherent description of a patient's psychopathology.

The issue of co-morbidity considered in the range of patients addressed in this article is patent. Although the battle between “lumpers” and “splitters” is common to virtually any classification system, current status not only fails in uniting under one diagnosis a large group of patients presenting with both anxiety and depression symptoms, with a fluctuating, chronic pattern, often with maladaptative personality traits, but also fails in providing a suitable descriptive framework. A constellation of symptoms and

psychopathological aspects with a coherent architecture is dismembered in different diagnosis and pathologies.

5.7) Comorbidity between depression and anxiety

Comorbid depression and anxiety, despite frequent, is integrated in psychiatric classifications with relative inconsistency. For example, the concomitant diagnosis of major depressive and panic disorders is encouraged in the DSM (quoting, 'one of the most common forms of psychiatric comorbidity), yet Generalized Anxiety Disorder (GAD) is excluded, if the patient is currently depressed [22]. However, it was found that patients with a GAD syndrome that occurred only during major depression, excluding therefore a DSM-IV comorbidity, were indistinguishable from patients with a formal DSM-IV diagnosis of GAD, and both populations differed from depressed patients without generalized anxiety [25].

The mixed state between anxiety and depression is supported, by some authors, to be the stable and deepest core of neurotic symptoms perhaps two different entities with a common psychopathological interface [26,27]. Taking in consideration a tripartite model of depression and anxiety, validated by empirical research, and involving physiological hyper arousal, positive affectivity and negative affectivity, comorbidity is attributed almost entirely to an increase in the latter, which is firmly anchored in the concept of neuroticism [27,28]. Vulnerability to stress can, however, be insufficient to explain most of the liability for depression and anxiety; of interest, gene studies have shown that the genetic diathesis for major depression and generalized anxiety are significantly correlated, yet most of covariance between these results from factors other than neuroticism, responsible by a mere ¼ of such correlation [29].

6) Fundamental Issues in Defining Neurotic Patients

Several questions have been raised on whether it is conceptually possible to distinguish between DPD and dysthymia, inclusively in DSM text review [10,15] and different views are supported with similar consistence. However, some fundamental issues should be present in order to suitably describe neurotic patients.

6.1) Trait versus state distinction

The most important issue is to clarify the notion of neuroticism as a characteriological disorder, regarding of the ideas of Schneider and Akiskal's character-spectrum disorders. This does not mean that one must trip in the still common misconception that axis I disorders are exclusively biogenetic and axis II disorders psycho developmental in origin [5]. However, it is important to emphasize that neurotic patients come from an early-onset of disturbances, frequently developed from adverse early object relationships, and not from a disruption of their life experiences caused by a pathological, disease like, disorder or condition. However, it is crucial to highlight that although personality features have a very important role in describing these patients, they must not be confined to a personality disorder classification, as mentioned further on. Notwithstanding, personality features cannot be excluded from mix anxiety and

depression patients, as Tyrer described in the general neurotic syndrome [30] and other depression classifications, such as the one offered by Parker and colleagues at the Black Dog Institute [25,26].

6.2) Depression as a secondary feature

Another misleading aspect of current classifications is the focus on depression and depressive symptoms. This has contributed to the incongruencies of conditions such as Major Depressive Disorder, which certainly includes an important part of neurotic patients. In addition, important distinctions have been made based on criteria of duration and severity.

Neurotic patients have frequent episodes of depression and dysphoria which observed in a transversal perspective would undoubtedly be considered a major depression episode. However, this is not a core characteristic, nor underlines the coherent structure of the pattern of symptoms so clearly expressed by Schneider by “aristocracy of suffering”. Expressions like “I was born depressed”, referred by Akiskal (1983), are very frequent in these patients, and far different from the pervasive depressive complaints, blocking patients functioning seen, for example, in bipolar depression or major depressive disorder. In neurotic patients, instead, depressive symptoms, paradoxically, often have an organizing role in patients’ lives, in a status-like fashion. Thus, the clinical profile of neurotic patients is the core feature that makes the difference to other patients presenting depressive symptoms or conditions [11].

The issue of severity is also a matter of debate. Usually, depression in dysthymia or DPD is considered less severe [10,15]. However, neurotic patients often present with serious depressive crisis which, due to a particular profile, may lead to anger bursts, family disruptions and impulsive actions including suicide attempts and risk behaviour.

Furthermore, chronicity represents another decisive feature when considering dysthymia and DPD which, to our view, may not be consistent. In fact, what it is most seen in neurotic patients is a pattern of recurrent crisis with periods of remission of variable duration. Also the clinical course, severity and response to treatment are highly susceptible of being influenced by life events and variable circumstances surrounding the patient.

These characteristics, along with the next item to be considered, may lead to a wrong conclusion that the patient is malingering, or that the case is of less severity.

6.3) Main trait characteristics

Perhaps one of the most difficult issues in the management and follow-up of neurotic patients is the counter-transference that may exist in therapist-patient relationship. Many patients are non-assertive, burdening the therapist with complaints and a never-ending cycle of undermining any attempt, either through the use of medication or counselling, of improvement. Other patients, however, may be sarcastic, cynical or nihilistic [19] questioning the therapist’s role, demanding specific treatments, medical exams or putting down any previous approaches.

Like mentioned before, neurotic patients may also be pathologically dependent, object driven, highly manipulative, impulsive and unstable. Passive-aggressiveness, immaturity, low frustration tolerance and frequent suicidal gestures are also common. Naturally, these characteristics, presented with a set of depressive complaints, often dissonant from what may be objectively observed, may alienate the therapist

and triggering even further inadequate responses from the patient, further reinforcing his/her behaviour and beliefs.

All these features may not distract from the fact that this kind of personality organization indeed have the potential of a great deal of impairment and suffering, like eventually all types of disordered personalities. Neurotic patients are rigid and with deficient skills of adapting to new situations. Again, on this subject, we disagree with views that consider dysthymia or DPD as less severe forms of depression [9].

This topic brings about the challenging question of determining the nature of personality disorders and ways they correlate with “pure” axis I disorders. Research has led to a growing consensus towards a five core dimensional domains of personality, namely Neuroticism, Extroversion, Openness, Conscientiousness and Agreeableness, that may organize classifications of personally disorders in a dimensional, less artificial approach [31-33]. However, it is not the aim of this article. Again we make clear that we do not argue in favour of a Neurotic category; instead we analyse its use outside official classifications. Unfortunately, DSM-IV not only have not reduced ambiguity, but also increased it by introducing a trait version of dysthymia in Appendix B – Depressive Personality Disorder.

Interestingly, the dimensional trait model proposed for DSM-V is consistent with five-factor models of general personality, including neuroticism [34,35].

6.4) Cognitive versus somatic symptoms

Another frequent aspect referred in the dysthymia versus DPD debate is the hypothetical distinction based on psychological features, more present in DPD, versus somatic and/or vegetative of dysthymia [9]. Again, we believe that these differences, to exist, are not a core question. Neurotic patients are generally heavy consumers of primary care services, often presenting a wide range of somatic symptoms, ranging from headache to subjective memory complaints, palpitations, and joint pain, among others, with little or no evidence of underlying medical disease [20]. Again, this tends to produce counter-transference incidents and the tightening of the maladaptive thread. Somatic symptoms are frequently used by patients as function in their communication pattern. Frequently there are ways of avoiding conflicts, uncomfortable situations or as retaliation, especially with partners, family or labour relations. As these strategies become less efficient in capturing other’s attention and sympathy, patients tend to hyperbolize handicaps and the expressions of suffering and desperation in an ascending scale that often end up in suicidal behaviours, serious family or labour disruptions and even physical aggression.

6.5) Social performance

Akiskal mentions social outcome of patients with chronic depression, adding it as one of the differences between sub affective dysthymia and character-spectrum disorders, considering that the latter had worse performances. It is interesting, however, to notice how neurotic patients do in fact have a social network and many of the ingredients of what may be called a “normal” life, and that is utterly different from patients with personality disorders. What are striking are the difficulties presented in acute stages, usually in the context of adjustment to life events perceived as negative and adverse, which may imply emotional instability, quarrels and conflicts held with significant ones and heavy disturbance of global personal functioning. This frequently overloads psychiatric emergency consultations, where psychiatrists and

therapists are dragged to take side, or to attest the specific needs and vulnerabilities of the patient. All this implicates a heavy burden to families and, in particular, to the offspring of neurotic patients, which may be often seen imitating and reflecting such conducts.

6.6) Management and treatment

It is relevant that the efforts made by some [19,20,36] to put neurotic patients in a biological framework by considering dysthymia as a subdepressive trait disorder have been focused on the response to pharmacotherapy.

We sustain that one of the motives that make neuroticism a popular informal category is the same one that makes drug trials for depression have contradictory results [37]. In fact, clinicians know from everyday practice that neurotic patients present poor response to anti-depressant treatment, unlike other depressive patients, and that a more symptom-oriented prescription often has better results. Clinicians also know that neurotic patients account for a greater part of the psychiatric practice, and that these same patients are not likely to integrate randomized controlled studies [37,38]. Treatment of neurotic patients must go beyond pharmacological management which, while mandatory, is inefficient if not done along with the therapeutic approach to patient's personality features, personal adjustment and coping strategies. The training and skills necessary to do so is, in the end, what is expected from psychiatrists, and the knowledge to support it needs to find its way in the modern scientific methodology and investigation.

7) Conclusions

The purpose of this article is to shed some light over the reasons why, in spite of current psychiatric classifications, the terms neurotic and neuroticism are still being used, in an informal way, outside its former meaning or any psychometric context, and why so many doubts remain regarding classification of depression and anxiety.

Comorbid depression and anxiety is frequent, as any clinician would state, taking into account the significant number of patients presenting with 'anxious depression' in daily practice, perhaps more frequently than so called pure depression [27].

DSM-5 has made some remarkable efforts regarding previously discussed issues: besides stating neuroticism as one of its personality dimensions, a specifier for anxious distress is allowed on affective disorders, namely of the bipolar spectrum, recognizing the high prevalence of anxiety symptoms in its natural history.

However, the persistent failure to allow a formal diagnosis of mixed anxiety–depression (a comorbid sub-threshold major depression and sub-threshold anxiety disorder) could deprive a significant cohort of patients, namely in the primary care setting, of adequate diagnosis and intervention.

The analysis of the evolution of classifications of depression - and chronic depression in particular - shows that some of the basilar aspects of those concepts got dispersed and oversimplified. This process took place biased by the effort of favouring an atheoretical perspective of psychiatric classifications and clinical descriptions over interpretation. In the case of neurotic patients, as surely in other diagnostic

entities, classifications got trapped by the facial value of the symptoms and complaints presented, losing perspective of the wider frame.

Neurotic patients are scattered through several diagnostic entities, including Major Depressive Disorder. This may represent a relevant factor of bias in studies addressing treatment response, clinical profiling and symptom presentation, among many other variables. It is important to reaffirm, however, that this article does not stand for a definition of a new personality disorder category, nor to the appraisal of the return to the old definition of neurotic depression. Instead, Psychiatry faces the challenge of stepping outside the rigid medical illness boundaries and integrating reality of the everyday practice and the knowledge of the past in a scientific framework.

Further knowledge on mental disorders and of normal function of the mind will hopefully, in the future, clarify the complex boundaries of mental illness and personality that Psychiatry, so far, was only able to grasp.

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