

ACTUAL NEUROSIS

Authored by
mohammad looti

November 13, 2025

RECOMMENDED CITATION

mohammad looti (2025). *ACTUAL NEUROSIS*. PSYCHOLOGICAL SCALES. Retrieved from <https://scales.arabpsychology.com/?p=67770>

ACTUAL NEUROSIS

Primary Disciplinary Field(s): Psychoanalysis, Early Psychiatry

The term **Actual Neurosis** (German: *Aktualneurose*) represents a crucial, though now largely obsolete, classification within the early topographic model of Psychoanalysis, fundamentally distinguishing between two categories of neurotic affliction based on their etiology.

1. Core Definition and Classification

As conceptualized by Sigmund Freud in the 1890s, **Actual Neurosis** refers to a group of neurotic symptoms that arise directly and immediately from current, existing physiological or somatic disturbances, specifically disturbances in the individual's contemporary sexual life. This etiology contrasts sharply with the group of disorders Freud termed the **Psychoneuroses** (such as hysteria and obsessional neurosis), where symptoms are rooted in historical psychological conflicts, repressed memories, or traumatic events from early childhood, and possess symbolic, psychic meaning.

The designation "actual" emphasizes the immediacy and contemporary nature of the pathogenic factors. The disturbance is not a product of psychological history or symbolic conflict requiring interpretation, but rather a direct physiological consequence of current sexual practices--often those involving insufficient discharge or frustration of the libido. Consequently, Freud argued that **Actual Neuroses** are essentially toxic or somatic disorders resulting from specific sexual hygiene deficiencies, requiring physical regulation rather than the complex talking cure (analysis) reserved for psychoneuroses. The symptoms are seen as non-symbolic discharge phenomena, representing a purely quantitative build-up of unutilized physical excitation.

The core definition hinges on the distinction between the physical and the psychological. Whereas psychoneurotic symptoms (e.g., hysterical paralysis or obsessional rituals) are understood as distorted, symbolic expressions of an unconscious memory or repressed desire, actual neurotic symptoms (e.g., free-floating anxiety or fatigue) are non-symbolic manifestations of physiological stagnation or accumulation of sexual excitation. This foundational separation allowed Freud to delineate the boundaries of psychoanalytic treatment; only psychoneuroses were amenable to the methods of interpretation, while **Actual Neuroses** fell outside the scope of deep psychological intervention and were often treated medically or through counseling on lifestyle changes.

2. Etymology and Early Development

Freud formally developed the concept of **Actual Neurosis** between 1894 and 1896, primarily articulated in his papers "On the Grounds for Detaching a Particular Syndrome from Neurasthenia under the Description 'Anxiety Neurosis'" (1895) and "Heredity and the Aetiology of the Neuroses"

(1896). This period was crucial as Freud was moving away from the purely physiological models dominant in the late 19th century and beginning to formulate his uniquely psychological approach to neurosis. The initial differentiation served to carve out the specific domain of psychoanalysis.

The term itself, *Aktualneurose*, signifies that the cause is "actual" or present in the current moment, differentiating it from disorders whose causality is historical or "mnemic." Prior to this distinction, various ailments involving anxiety, fatigue, and general malaise were grouped broadly under the popular diagnostic category of **Neurasthenia**, a term coined by American neurologist George Beard in 1869, which attributed symptoms to the exhaustion of the nervous system due to the demands of modern life. Freud's innovation was to rigorously subdivide this broad category based on precise sexual etiology.

This early theoretical move was essential for the subsequent development of psychoanalytic theory. By isolating the conditions caused by current physiological mismanagement (the **Actual Neuroses**), Freud could focus the interpretive power of psychoanalysis exclusively on those conditions resulting from psychological conflict and defense mechanisms (the psychoneuroses). The initial acceptance of a strictly somatic cause for **Actual Neuroses** allowed Freud to maintain a link to contemporary biological thinking while simultaneously establishing the independent science of the unconscious mind and its unique contribution to neurotic pathology.

3. Primary Types of Actual Neurosis

Freud identified two primary clinical syndromes that he categorized as manifestations of **Actual Neurosis**, each linked to a specific deficiency in the conduct of sexual life. These two types were Anxiety Neurosis and the remainder of Neurasthenia, after Freud had conceptually narrowed the latter term.

The first type, **Anxiety Neurosis** (*Angstneurose*), was defined as resulting from the damming up or frustration of the libido. The accumulation of physical sexual tension, which finds no adequate release, is transformed directly into anxiety. Specific etiological factors often cited by Freud included **coitus interruptus** (withdrawal before ejaculation), abstinence, ungratified foreplay, or the practice of "frustrated excitation" where the individual avoids sexual climax. The symptoms were characteristic of sudden surges of anxiety, panic attacks, general apprehension, heart palpitations, breathing difficulties, and various physical paresthesias. These symptoms were considered the direct toxic effect of the accumulated somatic energy.

The second type was **Neurasthenia** (as redefined by Freud). Freud retained this diagnosis specifically for symptoms arising from excessive or irregular masturbation, or spontaneous seminal emissions. The symptoms of Freudian **Neurasthenia** were centered around physical exhaustion, difficulty concentrating, general fatigue, headaches, and digestive problems. Unlike the anxiety associated with blocked energy, neurasthenic symptoms were attributed to the expenditure and

depletion of vital energy (somatic exhaustion). It is critical to note that Freud considered the symptoms of both **Anxiety Neurosis** and **Neurasthenia** to be primary, toxic, and non-psychic, meaning they were impervious to the psychoanalytic method of uncovering repressed memories or unconscious fantasies.

4. Somatic Causation and Lack of Psychic Meaning

A defining feature of the **Actual Neuroses** is the direct, non-symbolic link between the cause and the symptom. In the model of **Actual Neurosis**, the libido is viewed primarily as a physiological force or energy. When the path for the normal discharge of this energy is obstructed (as in Anxiety Neurosis) or when the energy is depleted (as in Neurasthenia), the somatic excitation is immediately converted into clinical symptoms. There is no intervening psychological process of repression, defense, or symbol formation, which characterizes the psychoneuroses.

This reliance on somatic causation meant that the symptoms of **Actual Neurosis** were not meaningful in the same way dreams or hysterical symptoms were. A typical psychoneurotic symptom, such as an obsessional hand-washing ritual, could be traced back through free association to a specific repressed thought or desire, allowing the symptom to be interpreted and dissolved. Conversely, the heart palpitations experienced during an anxiety attack related to **Actual Neurosis** were simply the physiological manifestation of undirected or dammed-up sexual energy; there was no secret message or symbolic content to unlock.

The implication for treatment was profound: if the symptoms lacked psychic meaning, they could not be treated by psychological means alone. Freud suggested that treatment for **Actual Neuroses** must involve changes to the individual's sexual habits--such as ensuring adequate release of tension through satisfying sexual activity or reducing excessive depletion. This focus highlights the transitional nature of the concept, bridging the gap between the purely neurological psychiatry of the 19th century and the developing depth psychology of the 20th century, placing one foot firmly in the biological domain.

5. Decline and Transition within Psychoanalysis

Although central to Freud's early theoretical scaffolding, the concept of **Actual Neurosis** began to diminish in importance within psychoanalysis as Freud developed more sophisticated models of psychic structure, particularly the structural theory of the mind (Id, Ego, Superego) and the later emphasis on anxiety as a signal (1926). The later understanding of anxiety, outlined in *Inhibitions, Symptoms, and Anxiety*, recast anxiety not merely as a direct toxic transformation of dammed-up libido, but primarily as a signal of danger generated by the Ego in response to internal threats (such as repressed desires).

As the psychoanalytic framework matured, the rigid separation between somatic and psychic

causality became increasingly difficult to maintain. Most clinical manifestations previously categorized as **Actual Neuroses** were re-integrated into the broader categories of anxiety disorders or somatization disorders, where psychological factors were understood to play an integral, rather than secondary, role. The idea of a purely non-psychic somatic conversion became less compatible with the holistic view of the psyche.

By the mid-20th century, the term **Actual Neurosis** had largely disappeared from standard psychoanalytic terminology, supplanted by more nuanced understandings of anxiety and defense mechanisms. While historical psychoanalysts still study the concept to trace the evolution of Freud's thought, it holds virtually no diagnostic validity in contemporary psychiatry or clinical psychology, having been replaced by categories within the Diagnostic and Statistical Manual of Mental Disorders (DSM) such as Generalized Anxiety Disorder, Panic Disorder, or Somatic Symptom Disorder.

6. Criticism and Modern Assessment

The concept of **Actual Neurosis** faced significant criticism, both internally within the psychoanalytic movement and externally from empirical psychology and medicine. One primary criticism revolved around its **reductionist view of sexuality**. By linking specific neurotic symptoms directly to particular sexual practices (like coitus interruptus or masturbation), the theory risked oversimplification and moralistic judgment, failing to account for the complex interplay of relationship dynamics, personal history, and genetic predispositions in the development of anxiety and fatigue.

Furthermore, the empirical distinction between symptoms caused by physical stagnation versus those caused by psychological conflict proved virtually impossible to maintain clinically. Critics argued that even symptoms labelled as "actual" invariably carry psychological meaning and are influenced by unconscious factors, defense mechanisms, and psychic history. The strict boundary Freud attempted to draw between the physical and the psychological was seen as artificial and unsustainable, especially in light of advances in psychosomatic medicine which demonstrated the deep interconnectedness of mind and body in neurotic symptom formation.

In modern terms, **Actual Neurosis** serves mainly as a historical footnote. It demonstrates Freud's initial struggle to transition from a neurological explanatory model to a psychological one. While the specific categories of Anxiety Neurosis and Neurasthenia based on purely toxic somatic etiology have been abandoned, the underlying question of how current physiological states intersect with psychological history remains central to fields like neuropsychology and psychopathology, even if the strict conceptual dichotomy of the 1890s is no longer employed.

Further Reading

[Actual Neurosis \(Wikipedia\)](#)

[Sigmund Freud](#)

[Psychoanalysis](#)

[Neurasthenia](#)

ARABPSYCHOLOGY.COM