

# ACTUAL NEUROSIS

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## Defining Actual Neurosis

The concept of **Actual Neurosis** (Aktualneurose) represents a foundational, yet now largely archaic, component of classical psychoanalytic theory, primarily developed by Sigmund Freud in the late 19th century. Defined as a clinical condition stemming directly from ongoing, current physiological or somatic disturbances, it stands in stark contrast to the vast majority of psychological disorders classified as **Psychoneuroses**. In Freud's original formulation, the symptoms of an Actual Neurosis are seen as the direct, toxic result of a failure in the appropriate discharge or management of sexual libido or anxiety, meaning the etiology is rooted in present-day biological or carnal aggravations rather than complex psychic conflict originating in childhood history or repressed memories. This immediate, physical causation is the defining feature, positing a mechanical or quantitative model where accumulated tension, if not properly dissipated, manifests as debilitating physical symptoms, such as generalized anxiety or chronic fatigue, without the intervention of complex symbolic processes or defense mechanisms.

Within this early psychoanalytic framework, the Actual Neuroses were categorized into two primary forms: **Anxiety Neurosis** (Angstneurose) and **Neurasthenia**. Freud considered these conditions to be primarily somatic disorders with immediate sexual roots, differentiating them sharply from conditions like hysteria or obsessive-compulsive disorder, which he termed Psychoneuroses because their symptoms were meaningful, symbolic representations of underlying, unresolved psychological disputes. The immediate nature of the causation implies that the patient's current lifestyle, specifically the management of sexual excitation and discharge, is the direct producer of the ailment. This reliance on a purely current, physiological imbalance distinguishes Actual Neurosis from all other neurotic classifications which rely heavily on the principle of psychological determinism and the transformation of affective energy through symbolic representation and repression.

Crucially, the terminology of Actual Neurosis, while central to the development of psychoanalysis, has largely faded from clinical use within both psychoanalytic and general psychiatric practice today. Modern diagnostic systems, such as the Diagnostic and Statistical Manual of Mental Disorders (DSM), have absorbed the symptomatic presentations previously categorized as Actual Neuroses into broader categories, including specific anxiety disorders, somatic symptom disorders, or functional somatic syndromes. However, understanding this original distinction remains vital for appreciating the trajectory of Freudian thought, particularly how he initially attempted to bridge neurology and psychology by identifying specific physical pathways for neurotic suffering that lacked the interpretive depth of subsequent psychogenic models.

## Historical Context and Freudian Origins

The concept of Actual Neurosis emerged during a critical period in Freud's intellectual

development, specifically in the 1890s, as he transitioned from a practicing neurologist to the founder of psychoanalysis. His early work sought to provide a definitive, scientific explanation for the physical complaints presented by his patients that resisted traditional medical explanation. This framework allowed Freud to separate neurotic suffering into two distinct etiological groups: those caused by psychological meaning and historical experience (the Psychoneuroses), and those caused by immediate physiological disturbance (the Actual Neuroses). This initial classification was essential, as it provided a clear boundary where purely mechanical, current factors were at play, before the more complex apparatus of psychic defense and infantile sexuality was fully elaborated.

Freud's early publications, particularly "On the Grounds for Detaching a Particular Syndrome from Neurasthenia under the Description 'Anxiety Neurosis'" (1895), solidified this distinction. He observed that many patients presenting with acute anxiety attacks, sudden panic, or chronic physical exhaustion did not exhibit the clear psychological history of trauma or repressed fantasy seen in hysterical patients. Instead, their symptoms appeared directly correlated with specific, often dysfunctional, sexual practices or chronic frustration. By naming these conditions Actual Neuroses, Freud emphasized that the symptoms were 'actual'--meaning immediate and toxic--rather than mediated by psychological processes. This represented a provisional, biological anchor for his nascent psychoanalytic theory, suggesting that some suffering bypassed the psychic sphere entirely, manifesting as a direct, physical overflow of dammed-up energy.

This historical foundation highlights that Actual Neurosis was initially conceived as a quantitative problem of energy management. The sexual libido, which Freud viewed as a quantifiable energy source, was either inadequately discharged (leading to Neurasthenia) or converted into toxic anxiety (leading to Anxiety Neurosis) due to current somatic practices. The clinical importance of this early distinction lay in treatment; while Psychoneuroses required the lengthy process of analysis, interpretation, and uncovering repressed memories, Actual Neuroses, theoretically, required only the correction of the detrimental somatic habit, such as providing satisfactory sexual discharge or modifying frustrating practices. This mechanical view, however, eventually proved too simplistic and contributed to the term's eventual obsolescence as psychoanalysis matured and integrated nearly all neurotic symptoms into a unified psychogenic model.

## Differentiation from Psychoneuroses

The most pivotal aspect of understanding Actual Neurosis lies in its categorical separation from the **Psychoneuroses**. In the Freudian schema, psychoneurotic disorders--which include conditions like Hysteria, Obsessional Neurosis, and Phobias--are characterized by being psychogenic, meaning they originate from psychological conflicts, typically rooted in early childhood experiences and the repression of unacceptable desires or traumatic memories. The symptoms displayed in a Psychoneurosis are symbolically meaningful; they are compromises between the repressed wish

and the defensive structure of the ego. For instance, a hysterical paralysis symbolically represents a psychological conflict, and interpretation through analysis is necessary to uncover the meaning and alleviate the symptom.

In sharp contrast, the symptoms of an Actual Neurosis are considered non-psychogenic and non-symbolic. They do not represent a compromise formation and hold no hidden psychological meaning waiting to be uncovered through interpretation. Instead, they are the direct physical result of a biological disruption--a chemical or physiological accumulation of undischarged somatic excitation. If a patient suffering from Actual Neurosis experiences chronic headaches or acute anxiety, these symptoms are not symbolic representations of Oedipal conflicts or repressed fantasies; rather, they are the direct, toxic manifestation of currently dammed-up sexual energy. This fundamental difference dictated the original therapeutic approach, where talk therapy and interpretation were deemed largely ineffective for Actual Neuroses, which required intervention at the level of current somatic behavior.

To summarize the crucial distinctions, one can examine the core operational differences between the two categories:

**Etiology: Actual Neurosis** stems from current somatic or physiological factors (e.g., coitus interruptus, chronic frustration). **Psychoneurosis** stems from historical psychological conflicts, repression, and defense mechanisms.

**Symptom Meaning: Actual Neurosis** symptoms are non-symbolic, direct physical results (toxic effects). **Psychoneurosis** symptoms are symbolic representations of underlying, repressed wishes.

**Therapeutic Approach: Actual Neurosis** required correcting the current somatic source. **Psychoneurosis** required psychoanalysis (interpretation, free association, transference analysis).

**Mechanism:** Actual Neurosis involves the direct conversion of somatic tension into physical symptoms (a mechanical conversion). Psychoneurosis involves the transformation of repressed affect into symbolic symptoms (a psychological conversion).

## Core Manifestations: Anxiety Neurosis and Neurasthenia

Freud primarily identified two clinical syndromes that fell under the umbrella of Actual Neurosis: Anxiety Neurosis and Neurasthenia. These two conditions were distinguished based on the nature of the somatic disturbance and the resulting symptom profile. **Anxiety Neurosis** was characterized by the acute manifestation of anxiety symptoms, including sudden, intense attacks of panic, rapid heart rate (tachycardia), difficulty breathing, profuse sweating, dizziness, and generalized apprehension. Freud theorized that this condition resulted from the failure to psychologically

process or physically discharge sexual excitation, leading to a direct, toxic conversion of this accumulating excitation into pure anxiety. The anxiety, in this context, was not fear directed toward a specific object (as in a phobia, which is psychoneurotic), but rather a free-floating, somatic distress.

**Neurasthenia**, a term highly popular in late 19th-century psychiatry, was retained by Freud but given a specific etiological constraint within the Actual Neurosis framework. He linked Neurasthenia specifically to the improper discharge of sexual tension, often stemming from chronic masturbation in youth or, later, chronic sexual frustration leading to depletion. The hallmark symptoms of Neurasthenia were chronic fatigue, generalized weakness, digestive disturbances, headaches, and a subjective feeling of physical exhaustion and inability to concentrate. Unlike Anxiety Neurosis, which resulted from the conversion of dammed-up tension into anxiety, Neurasthenia was viewed as a depletion syndrome--a draining of nervous energy caused by an inefficient or excessive expenditure of somatic resources.

It is important to recognize that both syndromes shared the common thread of lacking psychological determination. A patient suffering from Neurasthenia did not require years of analysis to uncover why they were tired; according to the theory, they simply needed to correct the physical source of the energy drain. The resulting clinical picture was often a blend of somatic complaints that defied specific organic diagnosis, forcing physicians of the era to seek functional explanations. The physical complaints were immediate, visceral, and typically lacked the complex, narrative structure that characterized the symptoms of classic Psychoneuroses, such as the elaborate rituals of an Obsessional Neurosis or the clear psychological triggers of Hysteria.

### **Etiology: The Role of Current Somatic Factors**

The core etiological principle of Actual Neurosis mandates that the disturbance arises from **current carnal aggravations**--practices that disrupt the normal physiological mechanism of sexual tension accumulation and discharge. These aggravations were specifically linked to poor "sexual hygiene." Freud meticulously outlined several specific practices that he believed led directly to the toxic build-up of energy resulting in Actual Neurosis. These factors were not related to childhood trauma or fantasy but to adult, functional behaviors.

One of the most frequently cited causes of Anxiety Neurosis was **coitus interruptus** (withdrawal before ejaculation). Freud argued that this practice, common for birth control in the late 19th century, led to intense sexual excitation without adequate physical relief. The excitation accumulated somatically, and since it was prevented from achieving its natural outlet, it was converted directly into free-floating anxiety. The immediate, physical nature of this conversion was key: the excitation was not repressed or symbolized; it simply became toxic due to failed discharge.

Other etiological factors included prolonged sexual abstinence or chronic frustration, where the physical apparatus was constantly stimulated but denied release, leading to a state of chronic somatic tension. For Neurasthenia, the causative factors were sometimes linked to what was considered excessive or inappropriate masturbation, which was thought to deplete the body's finite supply of nervous energy, resulting in physical exhaustion and weakness. Therefore, the treatment for Actual Neurosis was, in its simplest form, the recommendation of a more satisfactory and natural sexual life, allowing the body to process and discharge tension appropriately, thereby eliminating the toxic somatic accumulation responsible for the symptoms. This emphasis on current physiology solidified the Actual Neurosis as the most biologically grounded element of early psychoanalytic theory.

### Specific Clinical Illustrations

To illustrate the practical manifestation of Actual Neurosis, Freud often referenced cases where functional sexual disturbances resulted directly in broader physical ailments. For instance, the original content highlights a common clinical observation: the inability of young males to complete sexual intercourse, often due to premature ejaculation or erectile difficulties, resulting in persistent, generalized anxiety. In this scenario, the current functional failure (the inability to achieve satisfactory discharge) is the mechanical cause of the anxiety, rather than the anxiety being the result of a psychological fear of intimacy or castration complex. The somatic failure feeds the neurosis directly.

Another key illustration involves chronic sexual frustration within a marriage, where one partner experienced intense desire but consistently faced obstacles to gratification. The constant accumulation of undischarged excitation, according to the theory, would inevitably lead to a physiological tipping point, resulting in severe somatic complaints such as chronic headaches, irritable bowel symptoms, or acute anxiety attacks that defied conventional medical explanation. The lack of symbolic content in these presentations meant that the patient could not analyze their way out of the symptoms; they were suffering from a physical malfunction in the drive economy.

Freud noted that the symptoms of Actual Neurosis were often vague and multifaceted, but they always shared the characteristic of being non-specific and lacking the symbolic precision found in Psychoneuroses. They presented as a generalized breakdown of the nervous system--a biological crisis--rather than a psychological compromise. The specific clinical examples served to reinforce the idea that the body's management of sexual drive was a primary, non-psychological determinant of a significant category of human suffering, providing a mechanism for physical distress when psychological conflict seemed absent or secondary.

### The Decline of the Term and Modern Conceptualizations

The concept of Actual Neurosis began to decline significantly in the early to mid-20th century, largely due to two major developments. First, as psychoanalytic theory matured, the focus shifted almost entirely toward the psychogenic model, emphasizing the role of childhood development, psychic conflict, and intrapsychic defense mechanisms (repression, denial, displacement) as the primary drivers of all neurotic behavior. The mechanical, biological explanation offered by Actual Neurosis seemed increasingly isolated and scientifically difficult to verify compared to the rich, interpretive framework of the psychogenic approach.

Second, the rise of scientific medicine and empirical psychology led to the categorization of these somatic complaints into specific, often non-analytic, diagnostic categories. Conditions previously classified as Neurasthenia were increasingly understood as chronic fatigue syndrome, specific anxiety disorders, or generalized psychological distress. The specific Freudian link between coitus interruptus and the toxic accumulation of libido became viewed as culturally and historically specific rather than universally applicable biological truth, especially as societal views on sexuality and birth control evolved. Today, the term **Actual Neurosis** is rarely used in standard psychiatric or psychological literature and holds mostly historical significance within the study of psychoanalytic history.

Despite the obsolescence of the term, the phenomena it described--physical suffering without clear organic cause--persists and has been re-conceptualized in contemporary diagnostic frameworks. The symptoms that Freud attributed to the toxic accumulation of libido are now often diagnosed under categories such as **Somatic Symptom Disorder (SSD)**, **Functional Neurological Symptom Disorder (Conversion Disorder)**, or specific types of generalized **Anxiety Disorder**. While modern theories reject the specific mechanical link to current sexual hygiene, they acknowledge the complex interplay between physical distress and emotional states, recognizing that stress and anxiety often manifest primarily through somatic channels, echoing the initial clinical observations that prompted Freud to formulate the Actual Neurosis concept over a century ago.