

Which Diagnostic Approach Is More Valid? The DSM or the Rational-Choice Theory of Neurosis

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Abstract

This article challenges the validity of the DSM-III to exclude neurosis, a decision that has led the DSM to become “an expanding list of disease, from a few dozen disorders in the first edition to well over 200” (Grinker, 2010, p. 169; see also Warelow & Holmes, 2011). It points out the unanimous consensus that the best diagnostic approach would be a theory that can account for the development and treatment of certain diagnostic categories and, at the same time, provide measurable criteria that can distinguish them from other behaviors. Accordingly, it shows that a new theory, the Rational-Choice Theory of Neurosis (RCTN) (Rofé, 2000, 2010, 2016; Rofé & Rofé, 2013, 2015), which despite profound differences is similar to psychoanalysis in several fundamental respects, can offer practical diagnostic criteria that differentiate neurosis from other disorders. Three types of evidence, including a review of research literature, case studies and a new study that directly examined the validity of RCTN’s diagnostic criteria, support the validity of neurosis. The greatest advantage of RCTN’s diagnostic approach is not only is based on empirical evidence instead of the consensus of biased researchers. Rather, their main contribution is that it emerged out of a theory that succeeded to integrate research and clinical data pertaining to the development and treatment of neurosis.

Keywords: DSM, medical models, psychoanalysis, rational-choice theory of neuroses, repression, neuroses

1. Introduction

1.1 Psychoanalytic and DSM’s Diagnostic Approach

Neurosis refers to a group of psychological disorders, such as panic disorder, agoraphobia, Obsessive-Compulsive Disorder (OCD), conversion disorders, Dissociative-Identity Disorder (DID), and anorexia or bulimia nervosa. Freud categorized these disorders into the same class, as they appeared to him senseless and bizarre. He and his followers believed that these behaviors stemmed from repression because patients could not explain the underlying causes for dramatic change in their behavior nor exercise control over them (Fenichel, 1946, p. 1; Freud, 1915a, 1917, pp. 1888-1899). As noted by Shevrin and Dickman (1980), “the clinical phenomena that led to the assumption of unconscious processes often takes the form of a patient describing a bothersome condition that the patient can neither account for nor control” (p. 422; see also Erdelyi, 1985).

Neurosis constituted a major diagnostic category in the DSM-I (APA, 1952) and DSM-II (APA, 1968). However, the DSM-III (APA, 1980) decided to exclude neurosis because the task force could not find operational criteria, which would objectively separate these disorders from other behaviors (e.g., Bayer & Spitzer, 1985). In retrospect, this decision seemingly received further support in light of the fact that numerous studies consistently refuted the existence of repression (see reviews by McNally, Clancy, & Barrett, 2004; Piper, Lillevik, & Kritzer, 2008; Rofé, 2008), the “cornerstone on which the whole structure of psychoanalysis rests” (Freud, 1914, p. 16).

As an alternative, the DSM suggested new diagnostic categories that are supposedly atheoretical. Accordingly, neurotic disorders were separated into different groups of diagnostic categories based on the similarity in one common characteristic, such as *anxiety disorders* that included all types of anxiety behaviors (e.g., panic disorder, agoraphobia, OCD, PTSD and specific phobia), and *somatoform disorders* that consisted of disorders in which there are physical symptoms suggesting “a general medical condition”, such as conversion disorder, hypochondriasis, and pain disorder (APA, 2000, p. 485).

2. Shortcomings of DSM's False Diagnostic Approach

Critics have argued that the DSM is not truly atheoretical as it claims to be, as evidence suggests that its diagnostic categories are implicitly determined by the medical model (e.g., Burstow, 2005; Follette & Houts, 1996). As noted by Pilecki, Clegg, and McKay (2011), the DSM “has not provided a neutral collection of observation-based syndromes and it seems naive to have ever expected such an outcome” (p. 199). Moreover, since the DSM’s task force members had one or more financial ties to pharmaceutical companies, it is possible that their diagnostic decisions, particularly the exclusion of neurosis, were affected by political and economic pressures of both pharmaceutical and insurance companies (Pilecki et al., 2011). Given that Freud’s original writings refer to underlying conflicts, “there was a desire to remove neurosis from diagnostic terminology and focus instead on descriptions of severe pathology that were more rare and justifiable in terms of reimbursement” (Pilecki et al., 2011, p. 196).

One prominent example of the medicalization approach of the DSM is the DSM-5’s decision to group conversion disorder, which lacks medical cause, together with a new diagnostic category, “*Psychological Factors Affecting Other Medical Conditions*”, such as diabetes, cancer, and coronary disease that have a clear medical cause but were exacerbated by psychological factors (APA, 2013). Although the DSM’s authors acknowledged that conversion disorder is medically unexplainable, they categorized this disorder together with non-bizarre behaviors that have clear medical causes, only because they didn’t want to reinforce the psychoanalytic theory which maintains the mind-body dualism (e.g., see Carella, 1974; Rofé & Rofé, 2013). As a result of the medicalization approach of diagnosis of behavioral disorders, the DSM became “an expanding list of disease, from a few dozen disorders in the first edition to well over 200” (Grinker, 2010, p. 169), and it “now contains three times as many disorders as it did in 1952, and it is more than seven times longer than the first edition” (Warelow & Holmes, 2011, p. 385).

Some researchers object to the DSM’s approach even if the task force had truly been atheoretical. These authors claim that “the use of theory-neutral criteria goes against a common position in the philosophy of science that scientific progress generally goes hand-in-hand with greater theory ladenness of basic classificatory concepts” (Wakefield, 1999, p. 1002). “Without a theory, categories proliferate, and any atheoretical system will eventually fall of its own weight as will classification systems that are based on inadequate theory” (Follette & Houts, 1996, p. 1122). Similarly, Pilecki et al. noted that since the atheoretical diagnostic approach is, “by definition not guided by a central theory, there is little in the way of an organizing framework by which diagnoses arise” (2011, p. 195). Likewise, Grinker argued that “without the structure of underlying explanations, the manual became a list of symptoms for an expanding list of disease, from a few dozen disorders in the first edition to well over 200” (2010, p. 169). Even Wakefield (1999), one of the strongest advocates of the DSM agrees, “The long-term progress of the mental health field surely depends on knowledge of etiology and on theoretically defined categories” (p. 1002).

Thus, there seems to be unanimous agreement that the best diagnostic approach would be a theory that can account for the development and treatment of certain a diagnostic category and at the same time provide measurable criteria that can distinguish this category from other behaviors. It seems that a new theory, termed the Rational-Choice Theory of Neurosis (RCTN), that already proved its ability to integrate research and clinical data pertaining to treatment of neurotic disorders (Rofé, 2000, 2010), conversion disorder (Rofé & Rofé, 2013) and panic disorder, agoraphobia and other forms of bizarre phobia (Rofé & Rofé, 2015), is the right candidate to meet this goal.

3. The Rational-Choice Theory of Neurosis

3.1 Foundations

The Rational-Choice Theory of Neurosis (RCTN) continues Freud’s framework of thinking in a number of fundamental respects but it completely differs from psychoanalysis. The most important similarity between the two theories, which is directly concerned with the diagnostic category of neurosis, is that both claim that all neurotic disorders share similar etiology and that repression is the common characteristic of all these disorders. In agreement with Freud (1914), repression is viewed as the key for the understanding neuroses.

However, there are fundamental differences between the two theories with respect to the definition of repression and the relation of this concept to neurotic disorders. According to psychoanalysis, as portrayed in Rofé’s (2008) review article, repression is composed of five major components. In addition to the forgetting of trauma (1), psychoanalysis claims that repression exerts pathogenic effects on the individual’s daily functioning (2), it assumes the existence of an unconscious entity that may cause dramatic negative behavioral changes (e.g., leg paralysis) (3), it dictates the specific neurotic disorder that patients develop (4), and the lifting of repression is crucial for genuine recovery (5). A thorough review of relevant studies found no support for any of these

components. Accordingly, Rofé concluded that this comprehensive evaluation reveals little empirical justification for maintaining the psychoanalytic concept of repression (p. 63).

RCTN disassociates itself from these five features and restricts repression to the essence of Freudian repression, defined by Freud (1915) as “Turning something away and keeping it at a distance, from the conscious” (p. 147). Moreover, the unconscious was not a critical theme in Freud’s original conception of this notion. “In his very earliest writings (e.g., Freud, 1894/1962), repression was treated as a potentially conscious mechanism... at least at times, repression is a conscious, deliberate act” (Erdelyi & Goldberg, 1979, p. 365; see also Erdelyi, 2006). Accordingly, RCTN defines repression as a *conscious coping mechanism that deliberately eliminates threatening stimuli from attention through the employment of distractive maneuvers*. This new conceptualization is consistent with the bulk of experimental studies that found that repression is nothing more than conscious distraction (see review by Holmes, 1974, 1990).

RCTM also distinguishes between *normal repression* and *pathological repression*. Normal repression refers to socially accepted means of distraction, such as reading or social activities. Contrary to psychoanalysis, normal repressive coping styles enhance adjustments among the non-clinical population (see review by Rofé, 2008). Repression becomes pathological when individuals are faced with stress that exceeds their coping abilities, when normal repression is insufficient for warding off stress-related thoughts. Under these circumstances, some individuals will intuitively/unconsciously choose “crazy” behaviors, namely psychological disorders that heavily occupy their attention to the extent that they become unaware of their stressor.

4. RCTN’s Major Criteria of Neuroses

RCTN claims that the DSM’s decision to exclude neuroses was not based on an objective scientific evaluation of the available data. Would the task force carefully examine the relevant data, independent from Freud’s theory, they may have realized that neuroses all share five criteria that can separate them from other behaviors. Moreover, while it is true that psychoanalysis cannot provide an atheoretical framework for these criteria, RCTN, which preserves Freud’s idea that repression in its new version is common to all neuroses, can fulfil this theoretical function. Accordingly, RCTN’s claim that individuals may intuitively choose a mad behavior to heavily occupy their attention, when faced with an intolerable level of stress, indicates that neuroses must have the following five characteristics:

- (1) *Impact on attention and daily functioning*: Given RCTN’s assumption that repression is the major psychological function of neurosis, the symptoms must intensively occupy the individual’s attention and disrupt his/her daily activities to such an extent that stress-related thoughts become inaccessible.
- (2) *Spontaneous onset*: Since mad behaviors are intuitive, patients will display dramatic behavioral changes in the absence of a contingent factor that is uniquely associated with the deviant behavior. The symptom emerges spontaneously in the absence of an observed variable causing the behavioral change, neither by itself nor in combination with other factors.
- (3) *Unawareness*: Despite their conscious involvement, persons exhibiting neurotic disorders must be unaware of the underlying causes of their dramatic behavioral change; otherwise, the symptom would not have a significant distractive value.
- (4) *Rarity*: Since people are rarely subjected to intolerable levels of stress, and madness is just one of several behavioral options, the prevalence of neurotic behaviors must be low.
- (5) *Social stigma*: Given RCTM’s assumption that people deliberately adopt unusual behaviors that severely disrupt their daily functioning in the absence of plausible explanation for the dramatic behavioral change, society stigmatizes the chosen behavior as a reflection of a physical or mental illness.

Differential Diagnosis of Neurosis: While all five criteria characterize both neurosis and psychosis, there are qualitative and quantitative differences between these two types of madness. Qualitatively, only psychotics suffer from detachment from reality as reflected by hallucinations, delusions and illogical verbalizations (e.g., disorganized speech, see DSM-IV-TR, APA, 2000). Quantitatively, psychotic symptoms impact the individual’s attention and daily functioning more profoundly than neurotic symptoms (1); For this reason alone, the prevalence of these behaviors must be lower than neurosis (2); Not only are psychotic patients unaware of the underlying causes of their symptoms, but they are also usually unaware that their behavior is maladaptive (3); The social stigma for psychosis is more derogatory than neurosis (4).

Secondary Criteria of Madness: Since madness is a coping mechanism adopted in response to an intolerable level of emotional distress, stress and depression can be used as additional diagnostic criteria of these behaviors. Usually, these criteria are unnecessary for diagnosing neuroses and psychoses and should be employed to exclude some

exceptional deviant behaviors that seem to meet the five major criteria. For example, while there may be an option for autism to fulfill the five criteria, its onset certainly has no relationship with stress or depression and therefore it will not be classified as madness.

Non-Neurotic Deviant Behaviors: RCTN makes a sharp distinction between **neurotic behaviors** that fulfill all the above five major criteria and **non-bizarre deviant behaviors**, such as depression and suicide, Post-Traumatic-Stress Disorder (PTSD), simple phobias, substance abuse, and antisocial behaviors that fulfill either part or none of these criteria. Thus, contrary to traditional theories that use the same concepts for the explanation of all deviant behaviors, RCTN limits itself solely to bizarre deviant behaviors. Those behaviors that fail to meet RCTM's diagnostic criteria of madness, such as simple phobias, require other theories (see Rofé & Rofé, 2015).

5. Evidence

Three type of evidence in support of RCTM's diagnostic criteria of madness: I) Research literature pertaining to neurosis and psychosis; II) Randomly selected case studies relating to neurotic disorders; and III) A new study where experts were asked to evaluate a list of deviant behaviors on the above five major criteria.

5.1 Research Literature

1) Impact on Attention and Daily Functioning: Neurotic behaviors intensively preoccupy the individual and severely disrupt one's daily functioning. They also place a burden on the family, community, and on society. For example, OCD is a time consuming disorder (more than one hour a day) and significantly interferes with the individual's daily functioning (APA, 2000; Rofé, 2000, pp. 98-115). Likewise, 49% of eating disorder patients spend more than three hours each day on their eating disorder rituals and 16% of them spend over 8 hours (Sunday, Halmi, & Einhorn, 1995). Similar data can be observed with regard to all forms of neuroses.

2) Spontaneous Onset: Clinical evidence indicates that neuroses develop in the absence of a specific event exclusively associated with the deviant behavior or can account for its development (see also Rofé, 2000, pp. 98-115). For example, a variety of compulsive rituals (Rachman & Hodgson, 1980; Samuels et al., 2002) and conversion symptoms (e.g., see Blanchard & Hersen, 1976; Brady & Lind, 1961; Fukunishi et al., 2001; Griffiths & Ellis, 2007; Pruter, Kunert, & Hoff, 2001) occur in the absence of an event that is uniquely associated with or can account for these dramatic behavioral changes. In some cases, the onset may be gradual, such as in conversion disorder (e.g., Akdemir & Ünal, 2006; APA, 2000; Stone, Warlow, & Sharpe, 2012; Wittkower, Rodger, Scott, & Semeonoff, 1941) and anorexia nervosa, where there is a progressive deterioration that reaches a dramatic point (the sudden onset). This does not however, invalidate the criterion of spontaneous onset, as here too there is no observable event that is exclusively associated with or can account for the behavioral change.

Rival theoretical camps often report findings that seemingly indicate that a certain event is associated with and constitute the cause of a given behavioral disorder. Such evidence, however, violates the criterion of spontaneous onset only if the specific event has been unequivocally proven a sufficient condition for the development of a specific disorder or exclusively associated with this disorder. To date, such proof has not been supplied for by any of the neurotic or psychotic disorders. For example, in an attempt to preserve the behavioral explanation of panic disorder and agoraphobia, and in light of the fact that noxious events (i.e., unconditioned stimulus) do not usually precede the development of these disorders (e.g., Jacobs & Nadel, 1985; Mathews, Gelder, & Johnson, 1981), behaviorists suggested neo-conditioning theory termed "interceptive conditioning" (e.g., Bouton, Mineka, & Barlow, 2001; Mineka & Oehlberg, 2008; Wolpe & Rowan, 1988). According to this theory, the first panic attack, characterized by intense bodily sensations caused by a real or false threat, constitutes the conditioning event (e.g., Bouton, Mineka, & Barlow, 2001; Mineka & Oehlberg, 2008; Wolpe & Rowan, 1988). As noted by Wolpe and Rowan (1988), "Just as electrically elicited anxiety becomes conditioned to contiguous stimuli to produce experimental neurosis... so may panic anxiety become conditioned to contiguous stimuli to produce panic disorder" (p. 446). Consequently, patients may automatically experience a panic attack whenever they are confronted with a situation that causes the increase of bodily sensations, i.e., the reoccurrence of conditioned stimulus.

This suggestion, however, has met serious criticism (e.g., see Clark, 1988; McNally, 1990; Rachman, 1990; Rofé, 2000, 2015), such as the fact that hyperventilation, characterized by intense physiological sensations, does not invariably lead to a panic attack among panic disorder patients (e.g., see Gorman et al., 1994; Nardi et al., 2004; Sanderson & Beck, 1989). Similarly, only a minority of asthmatic patients develops panic disorder (Katon, Richardson, Lozano, & McCauley, 2004; Shavitt, Gentil, & Mandetta, 1992; Yellowlees & Kalucy, 1990), despite their frequent exposure to such intense bodily sensations. Moreover, while the neo-conditioning theory views agoraphobia as the by-product of panic disorder (e.g., Barlow, 2004; Bouton et al., 2001; Mineka & Zinbarg, 2006),

researchers have found that in a substantial number of cases, agoraphobia is “a clinically significant disorder that exists independently of panic attacks and panic disorders” (Wittchen et al., 2008, p. 153; see also Fava, Rafanelli, Tossani, & Grandi, 2008; Goodwin et al., 2005; Hayward & Wilson, 2007). In fact, agoraphobia may serve as an indicator for the development of panic disorder (e.g., Biennu et al., 2006). Furthermore, the etiology of panic disorder and agoraphobia is still disputable among traditional theories of psychopathology, such as cognitive (e.g., Clark, 1986, 1988), medical (e.g., Uhlenhuth, Leon, & Matuzas, 2006), and psychodynamic (e.g., de Poderoso, Julian, & Linetzky, 2005) theories. A recent review article demonstrating the insufficiency of the traditional explanation of fears and phobia, including panic disorder and agoraphobia, was reported by (Rofé & Rofé, 2015).

3) Unawareness: An additional central characteristic of neurotic disorders, which motivated Freud to introduce the necessity for the unconscious, is a patient’s unawareness of the underlying cause of the negative radical change in his behavior (e.g., Shevrin & Dickman, 1980; Woody, 2003).

4) Rarity: The prevalence of both neurotic disorders is low, usually below 3%, as shown by the DSM (APA, 2000).

5) Social Stigma: Neurotic behaviors are stigmatized as a reflection of physical or mental illnesses. As noted by Carson, Butcher, and Coleman, “Almost by definition ... abnormal behavior is behavior that is *unintelligible* to the vast majority of persons observing it” (1988, p. 17). Similarly, Bandura states, “the designation of behavior as pathological thus involves social judgments... Consequently, the *appropriateness* of symbolic, affective, or social responses to given situations constitutes one major criterion in labeling ‘symptomatic’ behavior” (1969, p. 3). The fact that the medical community classifies neurotic and psychotic behaviors as a form of mental illness (e.g., APA, 2013; Merck Manual of Medical Information, 2000) indicates that it fulfills the above criterion.

5.2 Case Studies

5.2.1 Neurosis

1) Agoraphobia: This example is an autobiographical account of William Ellery Leonard (1927), a poet, writer and university lecturer, who at the age of 36 developed agoraphobia. Leonard’s disorder, which lasted throughout his life, began a few weeks after his wife, the daughter of a highly respected family, committed suicide. The community, which had come to regard Leonard as demanding and self-centered, almost unanimously blamed him for her death. Shortly afterwards, Leonard experienced a sudden panic attacks while standing alone on a bluff overlooking a quiet lake. As described below, the onset of his symptom was irrational and ridiculous even to him, as there was no environmental incident that could justify the response. Leonard (1927) noted that he experienced a panic attack when he was standing alone, looking out over the silent and vacant water. “Then on the tracks from behind ... comes a freight-train, blowing its whistle. Instantaneously diffused premonitions become acute panic. The cabin of that locomotive feels right over my head, as if about to engulf me ... My subconsciousness knows what the torture is; and makes my voice shriek, as I rush back and forth on the bluffs: My God, won’t that train go, my God, won’t that train go away! I smash a wooden box to pieces, board by board, against my knee to occupy myself against panic...” (Leonard, 1927, pp. 304-307).

Leonard’s symptoms heavily preoccupied his attention and severely disrupted his daily activities (1); the onset of his symptom was sudden in the absence of observable event that could account for the abrupt change in his behavior (2); the patient was unaware of the underlying cause for his dramatic behavioral change (3); his symptom was certainly rare, below 3%, as shown by the DSM (APA, 2000) (4); and his behavior is now socially stigmatized as a mental illness. Leonard himself noted, “I knew I was a “case”. I knew my terrors were phobic. I refused by iron thinking to consider the diagnosis of insanity” (Leonard, 1927, p. 323) (5). Additionally, the patient’s symptoms developed following a stressful life event and high levels of depression.

2) OCD (Neale, Oltmanns, & Davison, 1982): As in Leonard’s case, in a case of OCD (Neale et al., 1982), the patient, Karen, experienced a severe level of depression following a chronically unhappy marital relationship and disciplinary problems in managing her children. Subsequently, she experienced intrusive, repetitive thoughts related to her children’s safety and developed bizarre counting rituals. Thus, the OCD symptoms heavily occupied her attention and severely disrupted her daily functioning (1); the onset was spontaneous, in the absence of an event that could account for the severe behavioral change (2); although the patient rationalized her behaviors as protective measures for her children, she was clearly unaware of the underlying causes of her symptoms (3); her symptoms were obviously rare (the total prevalence of all OCD is less than 2%) (4); regarding social judgment—the mental health system would classify her as bizarre as is the case with OCD symptoms (e.g., see Erdelyi, 1985; Shevrin & Dickman, 1980) (5). Here again the patient’s symptoms were preceded by stress and she suffered from an intense level of depression.

3) Dissociative Fugue (Masserman, 1946): In a case study of dissociative fugue by Masserman, a 42 year-old woman, Bernice, suffered severe depression during her unhappy marriage. She tolerated her condition until her youngest child died, and then she suddenly disappeared from home without any explanation, forgetting her past life which is characteristic of dissociative fugue. Here too, the radical environmental and occupational changes in Bernice's life intensely preoccupied the patient's attention (1); the onset of the symptom was sudden; even though it was preceded by the death of her child, this alone cannot account for the development of the disorder in terms of mechanistic cause-effect relationships (2); regarding unawareness, this case was employed by Masserman to illustrate the psychoanalytic concept of repression: "The automatic and unconsciously defensive process banishing dangerous desires, affects or ideas ... from awareness to the unconscious" (p. 296) (3); her dissociative symptoms were rare (4); and although her daily behavior was quite normal, people who knew her true identity and background would have stigmatized her as abnormal (5). Here too the patient suffered intense depression and the symptom followed a stressful life event.

4) Conversion Disorder (Brady & Lind, 1961): This case refers to a 40 year-old man who developed hysterical blindness in response to an unbearable level of stress. Shortly after his marriage, the patient was drafted into the army where he contracted an eye infection that resulted in partial loss of vision in one eye. Consequently, he received a medical discharge and a small pension. Over the next twelve years, the patient found it difficult to hold a steady job and largely depended on financial assistance from the public and his family.

On one occasion, while grocery shopping with his wife and mother-in-law, suddenly, without any immediate precipitating event, the patient became completely blind in both eyes. This blindness occurred at a time when his wife and mother-in-law were unusually demanding, requiring him perform various chores under their supervision. Thus, his conversion symptoms occupied his attention and severely disrupted his daily functioning (1); the onset was sudden and absent of an event that was exclusively associated with such behaviors (2); the patient was unaware of the underlying cause for the dramatic change in his behavior (3); this type of behavior is quite rare (4); conversion symptoms, such as blindness, are categorized by the medical community as a psychological disorder or illness (5). Further, the patient's symptoms were preceded by stress and he must have suffered from significant level of depression, as this often characterizes conversion disorder patients (see Rofé & Rofé's review, 2013).

5) Two cases of Dissociative Identity Disorder: One patient, a 37-year-old male (Witman & Preskenis, 1996), developed this disorder following his impending divorce and the legal proceeding resulting from alleged fraud. He was treated in a mental hospital for 20 days and subsequently for 24 days at a private nonprofit hospital. During the eight days in between, the patient reported increased dissociation; emergences of an additional alter identity, a minor traffic accident, and both suicidal and homicidal ideation. The second case, reported by Gupta and Kumar (2005), concerned a 14 years old girl who developed her disorder following strained relationships among her family members that caused parental separation and the departure of her elder sister, to whom she was strongly attached.

Thus, in both cases, the symptoms severely disrupted the patient's daily activities to an extent that in the former case it required hospitalization (1); the onset was sudden, in the absence of an event that is casually linked with and can account for the symptoms specifically associated with this disorder (2); and both fulfilled the criteria of unawareness of the underlying cause for the dramatic change in their behavior (3); rarity (4); and social stigma, i.e., the classification as suffering from mental illness (5). Additionally, in both cases the symptoms were preceded by stressful life events and both patients suffered from intense depression.

5.3 New Study

In a further attempt to validate RCTM's diagnostic criteria, 15 psychiatrists, and 50 clinical psychologists completed a questionnaire in which they were asked to evaluate a list of twelve randomly arranged deviant behaviors. These behaviors were later classified for the purpose of statistical analysis into *Psychosis* (schizophrenia, paranoia and bipolar disorder), *Neurosis* (agoraphobia, OCD, conversion disorder, DID and anorexia nervosa), *Specific phobia* (extreme fear of animals and of situations, such as flight, height and blood) and *PTSD*. Participants evaluated each of these deviant behaviors on a scale of 1-7 based on the following questions, which measured RCTM's five diagnostic criteria:

- 1) To what extent does each of the deviant behaviors occupy people who suffer from them? [**Criteria 1**]
- 2) To what extent does each of these behavior disrupt people daily functioning. [**Criteria 1**]
- 3) To what extent are these behaviors spontaneous and not exclusively linked with or caused by specific events, as in diabetes, that is specifically linked with the body's failure to produce insulin. [**Criteria 2**]

- 4) To what extent is the individual unaware of the underlying causes for his/her behavioral change when he/she is questioned immediately or shortly after onset? **[Criteria 3]**
- 5) To what extent is the individual unaware that his/her behavior is deviant. **[Criteria 3]**
- 6) To what extent is the behavior prevalent in the general population. **[Criteria 4]**
- 7) To what extent is the deviant behavior perceived by others as a reflection of mental or physical illness? **[Criteria 5]**

The study examined three hypotheses: 1) Neurosis and psychosis are the only disorders that meet all five criteria compared with specific phobias; 2) Psychosis scores significantly higher on all the five criteria compared with neurosis; and 3) PTSD meets only the first criterion: A higher amount of attention and greater disturbances in their daily functioning compared with specific phobias. PTSD will gain lower scores on the remaining four criteria compared with neurosis and psychosis. The means and F values of analysis of variance with repeated measurements are displayed in Table 1.

Table 1. Diagnostic validity of RCTM criteria

The diagnostic criteria	Mad Behaviors		Non-Mad Behaviors		F-values
	Psychosis	Neurosis	PTSD	Specific Phobias	
Attention	5.70	5.33	6.03	3.72	84.33
Disruption	5.20	4.09	5.46	3.17	71.1
Onset	4.21	4.10	1.76	3.06	54.05
Unawareness	4.17	3.25	2.32	1.66	94.4
Unawareness of Deviancy	5.75	4.76	2.12	3.27	54.05
Prevalence	0.99	1.09	1.24	1.45	164.12
Social Stigma	6.16	4.29	3.69	2.52	153.02

*All F-values are significant at $p < .000$.

As can be seen in Table 1, all F values were highly significant. As expected in the first hypothesis, Bonferroni statistical analysis demonstrated that both psychosis and neurosis obtained significantly higher scores on the first four criteria and lower scores on prevalence compared to specific phobias. Findings also confirmed the second hypothesis: Psychosis compared to neurosis gained higher scores on all the five criteria. PTSD scored higher on both measures of the first criteria, namely it preoccupied the individual's attention and interrupted his/her daily activities more than psychosis and neurosis. PTSD did not meet the three other criteria of madness. Thus, these findings provide strong support for RCTM's diagnostic criteria.

6. Discussion

In his clinical practice, Freud observed people who displayed bizarre behaviors characterized by three main features: They severely disrupt patients' daily activities; patients were oblivious to the underlying cause for the radical change in their behaviors; and they seemed unable to resume control. Since there was no current event that could justify the severe change in the individual's behavior, Freud arrived at the conclusion that they must have been the consequence of repressed childhood trauma or internal conflicts. However, his theoretical system

collapsed because of the lack of empirical support for his theoretical assumptions, especially studies that consistently refuted the existence of repression (see a review by Rofé, 2008).

Nevertheless, RCTN continues Freud's theoretical adventure by radically changing the concept of repression and linking the development of mad behaviors to current stress. Repression is conceptualized as an active distraction, which is consistent with the essence of Freudian repression, viewed as a withdrawal of attention (Freud, 1915a, p. 147). A more radical change is that, contrary to psychoanalysis, repression is seen as the result, not the cause, of mad behaviors. People consciously adopt a specific madness mainly because they intuitively feel that these behaviors can block the accessibility of stress-related thoughts, thereby alleviating emotional distress. Thus, RCTN succeeded to not only be consistent with the psychological function of Freudian repression, but also disassociate itself from the vast amount of studies that challenged the validity of the conventional meaning of this concept.

Another fundamental difference between the two theoretical paradigms is concerned with the phenomena of unawareness. Freud assumed the existence of an autonomous, unconscious entity that supposedly had the omnipotent ability to control the patient's daily functions. In contrast, RCTN claims that patients become unaware of their deliberate adaption and maintenance of their mad behaviors, both in neuroses and psychoses, as a result of a complex self-deceptive process (Rofé, 2000, 2010, 2016; Rofé & Rofé, 2013).

The inability of psychoanalysis to provide operational criteria for neurosis, the anti-parsimonious approach of the medical models (see Wakefield, 1999) which implicitly affected the DSM, and apparently personal interests as well (Pilecki et al., 2011), motivated the task force to exclude neurosis. Instead, neurotic disorders were separated into different diagnostic groups according to the similarity in one common characteristic, such as *anxiety disorders* that included all types of anxiety behaviors (e.g., panic disorder, agoraphobia, OCD, PTSD and specific phobia), and *somatoform disorders* that consisted of disorders in which there is physical symptoms suggesting "a general medical condition", such as conversion disorder, hypochondriasis, and pain disorder (APA, 2000, p. 485). The DSM's task force did not consider the possibility that neurosis, and in fact abnormality in general, may be a multi-dimensional diagnostic concept requiring more than one common characteristic in order to classify the disorders included in this category into one diagnostic class. The DSM's one-dimensional diagnostic methodology may also explain how the DSM became "an expanding list of disease, from a few dozen disorders in the first edition to well over 200" (Grinker, 2010, p. 169; see also Warelow & Holmes, 2011).

RCTN reverses this situation by referring back to Freud's original approach, which focused on the explanation of bizarre behaviors. This theory also accepts Freud's suggestion that repression is the common characteristic of these disorders and constitutes the key for their understanding. However, while Freud's concept could not provide empirical criteria that would enable us to differentiate these disorders from other behaviors, RCTN offers five major criteria and two secondary, derived from its concept of repression, that allow for the preservation of Freud's original diagnostic categories.

Three types of evidence were presented, even though each alone could validate RCTN's diagnostic criteria and challenge the DSM's diagnostic evaluation method. All three types of data confirmed RCTN's claim that neurosis shares five traits, as well as two secondary characteristics. Accordingly, based on the DSM's own requirement that "classification should be based on shared phenomenological characteristics" (APA, 1976, p. 11), there seems to be sufficient scientific justification to reinstate neurosis as a diagnostic category. Psychosis differs from neurosis by three major characteristics: 1) It has greater negative impact on the individual's attentions and is more costly as it causes greater damage to self and others; 2) Not only are psychotics unaware of the underlying causes of their symptoms, but they are usually oblivious that their behavior is maladaptive; 3) Psychotics suffer from perceptual and thought disorders in the form of hallucinations, delusions and illogical verbalizations. It is important to emphasize that the evidence provided in this article can support Freud's diagnostic approach even in the absence of RCTN. The new theory only provides a theoretical framework for Freud's original diagnostic categorization.

RCTN's diagnostic approach has three main advantages over the DSM. First, its diagnostic categories are based on more substantial scientific ground than the DSM's decision, which was reached through a consensus of one group of experts that was theoretically biased toward the medical model and may have been motivated by personal interests. Second, the DSM's decision to separate neurotic disorders into several categories based on a single criterion yielded heterogamous diagnostic categories. Mad behaviors are classified together with deviant behaviors that seem to be normal and understandable reactions. One example is the classification of OCD that includes bizarre behaviors, such as the compulsive cleaner who washes her hands 200 times per day but leaves her legs and feet unwashed for months (see Rachman & Hodgson, 1980, p. 65), together with non-mad behaviors such as PTSD which is an understandable response to extreme trauma, only because both display observable anxiety

(APA, 2000). As noted by Burstow (2005), in her critique of the DSM categorization of PTSD as an anxiety disorder,

Many of these so-called symptoms are, in fact ... well-documented coping strategies ... it does make sense; and there are times when it is wise and even necessary ... even when they go too far and seriously interfere with a person's other activities and intentions (p. 433).

A second example of a heterogeneous diagnosis mentioned above is the classification of conversion disorder, which, as stated, lacks medical basis along with the psychological factors that affect medical conditions such as diabetes, cancer, and coronary heart disease, into one diagnostic category (APA, 2013).

Third, the DSM's diagnostic approach has little clinical value, since they lack a theory explaining the underlying cause of psychological disorders and insight regarding the mechanisms of therapeutic change. As noted previously, there is a unanimous agreement among researchers that a diagnostic approach guided by a theory, as suggested by RCTN, which already proved its ability to integrate research and clinical data pertaining to neurosis and psychosis (Rofé, 2000, 2010, 2016; Rofé & Rofé, 2013), is preferable over atheoretical, arbitrary diagnostic approaches as proposed by the DSM.

Like the psychoanalytic theory, RCTN opposes behaviorists' and medical model studies, which use animals for the understanding of the underlying causes of neurosis and psychosis. Animals do not exhibit human-like bizarre behaviors. Though harsh environmental conditions (e.g., electric shocks) may produce extreme behavioral dysfunction, as shown in a number of studies on "experimental neurosis" (see Mineka & Kihlstrom, 1978), and learned helplessness (Seligman, 1974, 1975), these behaviors do not seem as senseless as do neurotic and psychotic symptoms. As noted by Mineka and Kihlstrom (1978), given the unusual stressful conditions to which the animals were subjected during the experimental neurosis, it would have been surprising if the animals did not display emotional disturbances. Further, there is no evidence that animals, as opposed to humans, exhibit a variety of deviant behaviors when exposed to the same stressful situations. Unlike humans, the same deviancy displayed by an animal can be experimentally produced among subjects of the same species. Accordingly, it seems that while animals may promote our understanding of the development and treatment of simple phobias and depression, they cannot assist in the understanding of the development of neurosis and psychosis.

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