

S35. Neurasthenia

HISTORY OF NEURASTHENIA

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Neurasthenia, as the term was used in past times, represented a variety of conditions: chronic fatigue, undifferentiated psychoneurosis, early psychosis, and the male equivalent of "hysteria" in females. In the past, neurasthenia was considered to be a "nervous" rather than a "psychiatric" condition, carrying the implication of organicity. The diagnosis of neurasthenia thus granted patients a kind of "fig-leaf," reassuring them that their problems were truly medical after all. After the 1920s, under the influence of the psychogenic paradigm, this fig-leaf became stripped away and neurasthenia came to be coterminous with psychoneurosis. Patients reacted to this loss of organicity by shunning the diagnosis in favor of other terms, such as chronic brucellosis, hypoglycemia--and latterly chronic fatigue syndrome, multiple chemical sensitivities, and fibrositis. It is suggested that current efforts to reinsert neurasthenia in official psychiatric nosology are ill-advised as long as psychiatry is unwilling to grant the premise that these patients' underlying problems are organic in nature.

A LONGITUDINAL STUDY OF NEURASTHENIA AND ITS RELATIONSHIP TO PSYCHIATRIC DISORDERS

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ICD-10 (1993) gives an operational definition of neurasthenia, as requiring a minimum duration of three months and the manifestation of core symptoms, for instance: exhaustion after minor mental effort, fatigue, bodily weakness after minor physical effort and other secondary symptoms, including the inability to recover from the core symptoms. In the Zurich cohort study carried out with subjects from 20 to 35 years, in a series of five separate interviews, the one year prevalence rates of ICD-10 neurasthenia varied between 1.7 and 3.9%. Considerable morbidity was found under this threshold: extensive neurasthenia (EXN) is a condition which lasts for at least 2 weeks and recurrent brief neurasthenia (RBN) is characterised by shorter, sporadic, at least monthly episodes. The clinical diagnosis of neurasthenia consists not only of the symptoms: exhaustion, weakness, fatigue, the increased need for sleep and loss of concentration, but also of the symptoms: nervousness, irritability, over-sensitivity to external stimuli, an inability to relax, low stress tolerance and a reduced need for social contact. The syndrome corresponds to the original concept of "irritable weakness". There is considerable impairment of subjectivity, a restriction of leisure activities and personal relationships. Extended neurasthenia shows high comorbidity with major depression, recurrent brief neurasthenia with recurrent brief depression. The association with all sub-types of depression over 5 interviews and 15 years is almost complete. There is comorbidity with generalised anxiety, but not with panic, phobias or substance abuse. Subjects do not attribute their syndromes to somatic disorders, but to psychological stress. In this paper the longitudinal stability of neurasthenic syndromes will be discussed.

NEURASTHENIA AND CHRONIC FATIGUE SYNDROME; TREATMENT.Simon Wessely

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This paper will present an account of the development of chronic fatigue syndrome, which I will argue represents a new version of the old concept of neurasthenia. I shall emphasise social and cultural aspects of the new diagnosis. I shall argue that although there have been recent advances in understanding the neurobiological basis of the syndrome, social and cultural factors continue to play a crucial role in the aetiology and perpetuation of disability. I shall argue that many factors contribute to long term morbidity in neurasthenia/CFS. These include depression, anxiety, physical deconditioning, learned helplessness and others. I shall also present data suggesting the effectiveness of a cognitive behavioural treatment package in alleviating disability. Finally, I shall argue that cultural factors, such as modern views on environmental medicine, and the continuing stigma of psychological disorder, continue to intrude on effective clinical management.

NEURASTHENIA AND PRIMARY CAREAS David, H Cope, E McDonald, A Mann

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Complaints of fatigue, lethargy or tiredness are common in primary care attenders. Such symptoms tend not to be taken seriously but may be associated with significant morbidity. In a survey of GP attenders in South London, approximately 10% complained of severe fatigue, defined operationally, for durations of 3 months or more. The effects of sex, age and social class were slight with the exception that women with young children were especially liable to complain of fatigue. When 65 of these chronically fatigued subjects were assessed in detail, approximately three quarters received a diagnosis according to ICD-9, most often depression. Only 5 cases could be diagnosed neurasthenic in the absence of any other diagnosis. Medical investigations did not contribute. These individuals were comparable to those seen in secondary and tertiary care settings except in the conviction with which they held beliefs about illness causation. Regarding illness attributions, most accepted psychological and social explanations for their symptoms or held physical attributions with only moderate conviction. Alternatively, those seen outside primary care tend to have fixed and rigid physical attributions often believing themselves to suffer from a post-viral syndrome such as "ME".

In a separate cohort of primary care subjects diagnosed as having suffered from a viral infection, a slightly higher proportion complained of chronic fatigue after 6 months compared with the earlier study. The prospective design revealed that many of these had in fact complained of fatigue prior to the onset of viral symptoms. Moreover, having a somatising attributional style and receiving a sick certificate were the most powerful predictors rather than influenza symptoms. 'Viral attribution' was found to be distinct from other physical attributions for unexplained symptoms.

IMMEDIATE AND DELAYED RECALL, RECOGNITION AND FREQUENCY JUDGEMENT IN CHRONIC FATIGUE SYNDROME (CFS) PATIENTS, DEPRESSED AND HEALTHY CONTROLSA.J. Wearden, L. Appleby

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In order to explore the question of whether cognitive deficits in CFS are related to depression, four groups of subjects (CFS-depressed, CFS-non-depressed, healthy and depressed), broadly matched for age, education, gender and pre-morbid IQ, were tested on recall, recognition and frequency judgement tasks, using the computerised presentation of words. Additionally, subjects completed questionnaires to assess cognitive complaints, anxiety, depression and fatigue. Subjects in the two depressed groups fulfilled DSM-III-R diagnostic criteria for a major depressive episode or dysthymia.

Preliminary results from the cognitive tests show that in all four groups, the number of words recognised was greater than that recalled, and that judgements of frequency of presentation bear an orderly relation to the actual frequency of presentation. On both recall and recognition tasks, there is a trend towards depressed subjects and non-depressed-CFS subjects recalling and recognising fewer words than the members of the other two subject groups. However, no significant differences have emerged between groups, either on each individual task or in the pattern of results over the three tasks. There is a group effect on response latencies, with healthy subjects performing the quickest and non-depressed-CFS subjects the slowest on the recognition task.

Subjective complaints of cognitive problems differ significantly between the groups and are related to depression but not to objective performance on the cognitive tests. Similarly, neither levels of fatigue nor depression are related to performance on the cognitive tests.

It is concluded that the deficits shown by CFS patients on recall and recognition tasks are slight, and that while the tendency to complain about cognitive problems is related to depression, performance on the tasks in the present study is not.