NEURASTHENIA AND PSYCHASTHENIA.¹

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In ordinary life, with or without stress, strain, or accident, in conditions of apparent health, or associated with various degrees of ill-health, we meet with a vast number of symptoms and complexes of symptoms, subjective and objective, which for want of a better name we call hysterical or functional.

So also in an Army composed of individuals of all ages and degrees of susceptibility and subject to all sorts of conditions favourable to their development, there occur an infinite variety of functional manifestations.

With this extensive series of phenomena we shall have little to do. It is better to look upon them as intrusions if they enter at all into the neurasthenic picture. They may exist separately, singly or collectively. I refer to such functional manifestations as constriction of the visual field, amaurosis, aphonia due to adductor paralysis of the vocal cords, deafness with or without mutism, functional hemi- or paraplegia, the analgesias and so forth.

I find it impossible to give a composite word picture of neurasthenia, the picture must be allowed to develop itself as we go along. To take a simple instance: a person is subjected to some sudden shock, mental or physical, without gross injury; in due course a mental state and a train of symptoms show themselves. Something has happened which has for the time being altered the whole tenor of his life, the whole man is changed. It is our business to discuss this change. It is difficult to believe that there is no physical basis underlying so grave a dislocation, and yet we have to use the word "functional" as implying that we know no such basis. Hitherto undreamt of advances in biochemistry may some day give us the light we need.

Meanwhile it may be noted that we are repeatedly coming across men who show some of the indications of Graves’s disease, namely, v. Graefe’s, Stelwag’s and Moebius’ signs, together with tremor and tachycardia, but without thyroid enlargement, a condition of "thyroidism." Possibly one or more internal secretions may be at fault in neurasthenia.

¹ A paper read before a Conference of Medical Officers at Malta, November 24, 1916.
Neurasthenia means nerve weakness, debility of nervous origin implying lack of will power and other nervous changes, as will appear later.

Every acute disease is followed by a longer or shorter stage of debility, but that is not neurasthenia, for there need be no lack of will power, the body is too feeble to carry out the command of the will. The physical powers only are defective.

A neurasthenic, on the other hand, may be muscularly powerful; but so wanting in will power, or so prone to nervous fatigue, as to be unable to drag one foot before the other. In the one case the will is there without the power, and in the other the power is there without the will. That this is so is shown by the fact that a sudden stimulus of excitement may evoke an effort surprising in its results to the patient, and in most neurasthenics the patient can by an effort of volition force himself to perform acts beyond his apparent strength, but owing to the fatigue element this is always done at a cost.

It is therefore obvious that even in the simplest form of so-called neurasthenia, the central nervous system, using the word "central" in its widest sense, cerebral, spinal or neuronal, must be affected. And yet in these simple forms the debility is often so profound and so lasting that one is tempted to use the term myasthenia, or neuro-myasthenia, suggesting that the muscular element of the neuron may possibly be predominantly implicated. This point of similarity to myasthenia gravis is, of course, purely superficial. I do not suggest a common pathogenesis.

In my succeeding remarks, and as the exuberant symptomatology displays itself, I shall have occasion from time to time to draw attention to aspects of the disease, aspects which predominate, but not so sharply as to allow of division into clean-cut types. These aspects help in description, and I think you will recognize the truth of them.

So in the case of the simple nervous debility one aspect is deficiency of will power, and another of chronic fatigue, a fatigue which is increased by exertion, and exertion causes an exacerbation from which recovery is slow. "I used to be able to walk ten to twenty miles with enjoyment; I can now go no more than 100 yards without real fatigue," is a common and true statement.

Ordinary healthy fatigue is nervous or central, not muscular, as Waller has shown. Regular voluntary muscular efforts measured by the dynamometer and recorded on a drum, show in a healthy person a regular steady fall in power to the zero of complete
exhaustion, yet the apparently exhausted muscle reacts briskly to faradism. Compare this with the myasthenic reaction of myasthenia gravis in which faradic stimuli applied directly to muscle produce an intense and rapid exhaustion effect.

Rarely, however, is the case so simple as this; subjective and mental symptoms of great variety intrude and give rise to a bewildering series of clinical pictures. These symptoms, or stigmata, are all truly functional, having no obvious or even possible gross anatomical basis, yet intensely real to the patient.

It would appear that the most complicated subjective stigmata tend to occur in the more educated and imaginative persons, and that in the lower types the stigmata are of a simple nature, mostly of the cruder sort—pain, for instance. And the picturesqueness of the description is often inversely as the anatomical knowledge of the patient. I must say, however, that highly educated medical men occasionally attempt to explain their symptoms by anatomical descriptions which I am sure they would smile at in their patients.

A run-down hospital medical officer said: "When I bend my head forward I have a sensation in the neck which suggests that there are adhesions between the cervical cord and the theca." So vivid was this impression that it took some argument to persuade him of its absurdity. A short holiday and some strychnine completely removed it. The sensation must have been there, whatever its cause; it was the interpretation that was at fault, and that is what counts.

Many of these stigmata, though possibly originally simple, become extraordinarily complicated and sometimes grotesque. A lady told me that as she lay in bed she had a vivid sensation that the brain was out of her skull and lying on the pillow beside her.

I will now discuss these symptoms in some detail.

Among the most common are those referable to the head, classed by Gowers as "Cephalic Sensations."

The sensation of pain naturally comes first. The neurasthenic headache is conspicuously posterior or vertical as compared with that of migraine, which is frontal or temporal. It generally includes the cervical region and sometimes the whole spine. It is increased by exertion and diminished by rest. It may be described by the patient as a true pain, but more often on close questioning he will admit that the sensation is not comparable with any pain within the range of his experience; "It is much worse than a pain," and there his powers of description break down.

The cephalic sensations that fall short of that of pain, as we
understand it, are of great variety. For instance, a sense of weight, oppression, compression, internal fullness to the sensation of bursting, suggesting to the patient vascular dilatation and calling for much crude anatomical figure. Superficial sensations in the skin of the scalp, suggesting worms crawling under the skin, generally referred to "nerves" supposed to be on the stretch.

Auditory stigmata are also common. Hyperacusis, abnormal sensitiveness to sounds, such as the banging of doors, street music, etc., which may excite intense resentment, this may be a temporary symptom very noticeable in shell shock cases. There may be a mental perversion, so that sounds usually pleasurable become painful and repugnant, such as music, the voice of friends, a mother unable to bear the voices of her children, and so on.

A buzzing in the ears or head is frequently complained of; it must not be confused with true tinnitus. This auditory sensation is not necessarily referred to the ears as in true tinnitus, it is more often than not referred to any part of the head rather than the ear. A patient in his desire for accuracy of description was at pains to indicate four points on the head, and to say that the point of intersection of the imaginary lines joining these points was the exact situation at which he heard the sound.

The eyes are affected in two opposite ways, over sensitiveness to light or diminution in acuity. Photophobia is sometimes intense and the patient welcomes dark spectacles, and shuns the sunlight or any bright artificial light.

On the other hand, and more frequently, there is a temporary want of acuity. Large objects may appear blurred even to an emmetrope. The attempt to read is soon followed by a fusion of the print and a sense of eye fatigue. Testing for glasses should be avoided at this stage. Congenital defects such as refractive errors, astigmatism and the like will be certain to be aggravated temporarily.

This amblyopia need not necessarily be due to constriction of the field of vision, so common a functional or "hysterical" defect, but not proper to the neurasthenic syndrome.

Tremor of the tongue or lips may impart a shivering character to the speech, sometimes closely simulating that of general paralysis. In many cases of shell shock and other soldier neurasthenics there may be profound speech defects from complete mutism to dysphonia, speaking in a whisper: these again are hysterical addenda.

Stuttering in all degrees may occur in any neurasthenic. It is a temporary symptom.
The timbre of the voice may be altered to a high pitched, almost querulous, tone. I recall the case of a lady, a rather severe neurasthenic, who spoke with a marked mincing, foreign accent, so pronounced that I thought she was French. When the excitement of the interview subsided her natural voice reasserted itself, but for a time only.

Visceral Stigmata.—The neurasthenic complains of a variety of abnormal sensations, which may be explained by an acquired abnormal consciousness of visceral movements. The patient has become morbidly alive to internal stimuli which should belong to subconscious existence, such as the heart beat, the carotid and abdominal pulses, the peristaltic movement of stomach and intestines. At first there may be only a recognition of these obtruded sensations, generally any one of them, but as they persist and as the state of anxiety grows, a simple physiological feature becomes magnified into an obsession or fixed delusion.

The most difficult stigma, however, to understand is that of chronic pain in a region such as the back or in a limb. There is a group of cases in which there is a persistent pain in, say, the whole limb for which no cause can be found, so real as to enforce an invalid existence for a period of years. I confess to having been completely baffled by some of these cases. Pain may become a delusion, a fixed idea so confirmed as to be beyond the reach of treatment by hypnotism. In dealing with soldiers we are repeatedly confronted by cases in which pain is the only symptom, and if a man for purposes of his own consistently persists in his complaint, I really know of no way in which a simulated can be distinguished from a bona fide pain, whether hysterical or of organic origin.

These allusions to subjective sensations discover another aspect of neurasthenia, hyperesthesias, exaltation of sensibility of special and visceral sensations.

Muscular tremors do not necessarily enter into the picture, but nevertheless we find them almost invariably among war-worn soldiers.

Tremors of the face muscles during speech, and even in voluntary movements as in showing the teeth, have already been alluded to.

Tremor of eyelids when lightly closed is again almost invariable and I hardly think it is likely to be simulated. It is very noticeable when testing for Rombergism.

Regularly spaced, persistent, coarse or fine nystagmus is a true organic sign, often of great value, as in cerebellar lesions, but
occuring also in widely diverse conditions. In some neurasthenics, however, a passable imitation sometimes occurs. It is rarely, if ever, persistent or regular. The commonest form is a slow repeated return of the deviated eyes to the middle line, due probably to the want of power of concentration on the part of the patient, so that he has to be constantly reminded that he is not looking at your finger. Some patients show a marked and characteristic reluctance to deviate the eyes, which waver after two or three attempts with manifest discomfort.

In a severe case, notably after shell shock, there is a coarse or fine tremor of the whole muscular system, visible in standing and walking, such as may rarely be seen in paralysis agitans. In such a case if you lift the leg in bed by placing the hand under the knee a severe thigh clonus is evoked without added stimulus and a coarse irregular ankle clonus can be produced, which must not be mistaken for that of organic disease. There is also a marked extensor rigidity resembling at first sight the hypertonicity of organic disease of the lateral columns, but which is often, if not always, a voluntary spasm evoked by dread of the tremor. In milder cases, and in fact in nearly all soldier neurasthenics, there is a tremor of the extended hands and arms. This is so constantly looked for, and so obvious to the soldier, that one may expect attempts at simulation. The important element of this tremor picture is fine, independent, vibratory tremor of the fingers. A tremor movement of the larger joints, wrist and elbow, might be voluntarily imitated, but I do not think the fine, independent tremors of the fingers can; I am unable to simulate them myself. I have lately seen some excellent involuntary imitations of so-called intention tremor, such as might be seen in disseminated sclerosis.

In a disease which consists so largely of subjective manifestations, for the true interpretation of which we must rely entirely on the statement of the patient, we must welcome any demonstrable objective signs which we can make out for ourselves.

The following objective features seem to me to possess a real value as a test or touchstone of the truth:

1. The tremors, particularly the fine, independent vibratory tremor of the fingers alluded to above.

2. The state of the knee-jerks. These may be normal as regards degree, even depressed, or they may be, and more often are, increased, in fact excessive. These abnormalities are of no significance however. What is important and interesting is that in very many cases the elicitation of the knee-jerk produces a
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wide-spread sensation of discomfort, often excessive, but never amounting to pain.

In its milder manifestations it is often described as an electric shock limited sometimes only to the leg below the knee. But the sensation may be much more extensive than this. It may be described as causing a disagreeable shock felt all over the body, often proceeding up the spine to the back of the head and neck. It is obvious to the observer by the involuntary start that the patient gives, and he often begs that it may not be repeated.

It may be associated with a temporary more or less severe emotional disturbance, fright, tears, sometimes laughter. I have frequently seen a short-lived hysterical state follow the jerk, and in one case, a woman, it was regularly followed by a typical hysterical convulsion. Another curious point is that local stigmata, such as pain areas, posterior headache, are at the same time increased in degree for the moment.

These widespread symptoms accompany the knee-jerk proper, the myotatic (Gowers) stretched muscle phenomenon, not a blow on the patella or ‘bone. They bear no relation to the intensity of jerk, though that is usually exaggerated; they are psychical and not associated, except accidentally, with any disease of an organic nature, however much the reflex may be exaggerated. In a marked case this is a very striking symptom requiring no prompting by the observer, but it may sometimes be induced or suggested in this way. The observer elicits the right knee-jerk, it appears to present no unusual features: he says, “Does that hurt you?” “No.” “Does it produce any discomfort?” “No.” He then proceeds to elicit the left knee-jerk, and the patient now feels the unpleasant sensations and having done so will now feel them on the right side. This is an indication of readiness to suggestion. This peculiar accompaniment of the knee-jerk was first pointed out to me by my late colleague at the National Hospital, Dr. Beevor, some twenty-five years or more ago. I have found it of great value in diagnosis and I have repeatedly demonstrated it in the out-patient room, but I have never seen it mentioned in any text-book.

(3) Persistent regular ankle clonus is a sign of some lesion, primary or secondary, of the lateral column. But an irregular clonus does occur sometimes in association with general tremors, and even without, notably after bad shell-shock. There will be no extensor plantar response.

(4) In striking contrast with the tendon epiphenomenon above described is the state of certain skin reflexes. The abdominal
reflexes are generally present, and if anything brisk. But the plantar reflex is notably diminished to complete absence, and this without any true anesthesia.

This is generally a surprise to the patient, who is often extremely apprehensive of sole tickling from past experience.

In most normal persons the sole of the foot is extremely sensitive to tickling, in many painfully so. There are persons, however, who are normally insensitive, and in some tickling is positively pleasant.

The absence of the plantar reflex in functional cases was pointed out some thirty years ago by Dr. Thomas Buzzard at the time when the Weir-Mitchell treatment for hysteria was under trial.

Its value as a sign is enhanced by the fact that the sole sensiveness is increased in most organic diseases, in fact I can conceive of no organic condition in which it could be absent except in complete destructive lesions of the posterior roots or nerves proper to that area of skin, such as may occur in coarse cauda equina lesions at the level of the first sacral root, or in severe neuritis or other lesions of the posterior tibial nerve, and possibly in some cases of tabes.

In primary or secondary lateral column lesions, disseminated sclerosis, and even complete transverse lesion of the cord higher than the sacral region, the reflex is increased.

The term “plantar reflex” applies to the gross effect of stimulation of the sole, and must not be confused with the responses of Babinski flexor or extensor.

Where such response is present it will be flexor with or without the associated contraction of the tensor fasciae femoris, but it is more often absent together with the gross sole reflex, which gives an added significance to this sign.

I must here say that though the absence of the plantar reflex is the rule in neurasthenia there are exceptions, and I have lately seen one or two very severe cases in which the slightest touch to the sole of the foot produces the liveliest distress. A clean, sharp antithesis. As Paget says, every exception to a rule implies the existence of another which has yet to be formulated.

It is not claimed that this is a sign peculiar to neurasthenia itself. Its value lies in the fact that it is a sign of “functional” as opposed to “organic” disease.

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(5) A mild degree of ataxia on toe and heel progression, together with unsteadiness with eyes shut and feet in line, standing, is commonly found if looked for. It resembles the ataxia of tabes.

Psychasthenia.—I now come to consider another aspect of the subject. With few exceptions, every case of neurasthenia may be said to have a mental side. But this may predominate to such an extent as to give rise to a condition deserving of separate consideration, a state in which the more physical stigmata are absent or in abeyance, and the psychical or mental dominate the picture. This has received the name of "psychasthenia."

The mental attitude of the psychasthenic is that of depression, more or less profound, with an underlying aspect of fear and apprehension of undefined evil. There is fear of the present, of failure, of mental breakdown, of the future which colours and disturbs the mental perspective, so that the mind resembles a bad picture, with an ugly ill-balanced background. Among these fears that of death does not usually figure. The idea of death as an end of the state of misery is not unwelcome. The patient becomes introspective, self-centred, looking for and almost inviting symptoms. A minor degree of this state is that of continuous unreasonable anxiety associated with a sense of epigastric uneasiness.

Suicide is sometimes talked about freely, but more as a form of apprehension and as a mode of conveying to other minds the misery of the patient.

Delusions and the suicidal and homicidal impulses do not enter the psychasthenic picture.

The patient may lose all interest in his business; the once keen officer says: "I am absolutely sick of the sight of a soldier," and yet there may be no falling off in acuteness or accuracy. The aspect of fatigue is here as in the neurasthenic, but it is a mental fatigue.

Another common minor shade of the mental state may be described as that of intense boredom, too bored to read a book, or to keep up a conversation, or to meet people. Irritability is generally freely admitted. A symptom which causes, not unnaturally, great alarm is an actual loss of memory for the ordinary affairs of life. It is remarkable how severe this may be and yet pass off with recovery.

A very serious feature in the case of officers of all commands is an intense reluctance to take responsibility, a form of moral cowardice, and a source of great distress to the sufferer. This is sometimes so acute that the patient is tormented by doubts
as to possible consequences on signing the most ordinary routine documents. Insomnia is a constant and early symptom, in fact enforced broken rest is no doubt a sufficient cause in itself for a breakdown. There may be for a time no sleep at all, but a long night of anxious foreboding. More often the patient goes to bed tired out, gets off to sleep at once, and then wakes up, perhaps with a start, in any time from half an hour to two or three hours afterwards, to lie awake until the early morning. Or more commonly, after a night of poor sleep, sometimes, but not always, tormented by dreams, he may wake about 5 a.m., suffering from the depths of depression, to rise as tired as when he went to bed. Some evil influence colours his whole life and yet there may be no physical symptoms, subjective or objective. The nutrition may be maintained and the more tangible stigmata of neurasthenia may be absent.

This state may be continued for long periods, months even, but generally with intervals, marked by a sense of surprising unexpected well being. These intervals, short at first, may follow a good dinner or the use of stimulants, in fact the "bien aise" of alcohol is to be guarded against.

The periods of remission tend in a favourable case to become longer and those of depression shorter as the case progresses towards recovery.

It must not be forgotten that this state may be the precursor of true insanity, melancholia and general paralysis, in which case it is symptomatic. Pure psychasthenia is not so common among the lower ranks, but unfortunately occurs frequently amongst officers. The features above described enter to a greater or less degree into the complex of neurasthenia.

Classification.—The difficulty in presenting a comprehensive word picture of neurasthenia lies in the vast scope and association of the symptoms and the aspects from which it can be viewed, especially in a short communication like this. I now propose to attempt a short summing up, a grouping of the aspects and stigmata by which certain groups, scarcely worthy to be called prevailing types, may emerge. Whether this can usefully be done I must leave to your judgment.

Group I.—The predominant symptoms are physical: the keynote is fatigue. This fatigue is physiologically nervous, probably central, but the superficial resemblances to myasthenia gravis seems almost to justify the use of a term such as neuro-myasthenia. There will be no mental or psychical stigmata beyond feebleness of will power.
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Group II.—This comparatively simple picture is now enriched by a great number and variety of symptoms, subjective and objective, namely:

(a) Subjective.—Pains, headache, etc. The aspect of hyperesthesia of the senses, hyperacusis, tinnitus, photophobia. Exaltation of and intrusion in consciousness of movements of internal organs which may be physiologically sound, such as the heart and great vessels, the abdominal organs, etc., visceral hyperesthesia.

(b) Objective.—Muscular tremor, general, with or without spasm, fine vibratory, and independent of fingers. Pseudonystagmus, ataxia, and rombergism. Characteristic knee-jerk epiphenomenon. Absence of plantar reflex.

To both of these sub-groups may be added any of the well-known hysterical stigmata, but they are additions not strictly belonging to the picture.

As in Group I there need be no mental symptoms, though such a clean distinction is not common, and, perhaps, almost pedantic. If such a type as this is permissible, it may be called "neurasthenia" proper.

Group III.—To the above groups, together or singly, may be added any or all of the mental stigmata of psychasthenia. This is the largest and most comprehensive group of all into which most of the cases called neurasthenia fall. For the purposes of this classification we may call it "psycho-neurasthenia."

Group IV.—Psychasthenia is a distinct entity, a purely mental state, presenting the following aspects: Depression with fear and apprehension, loss of memory, grasp of affairs and power of attention, irritability, introspection, reluctance to accept responsibility.

Caution.—In civil and military life a more or less obvious cause can generally be assigned, but not always, and speaking generally the more definite the cause the better the prognosis.

Neurasthenia occurring spontaneously may be symptomatic of underlying or impending mental disease.

Certain temperaments predispose to neurasthenia. Persons who have all their lives taken life very seriously, themselves especially, feel all the emotions acutely, are often amongst the most lovable, and even as neurasthenics excite respect. Many are naturally subject to moods varying in degree from elation to depression, from day to day, and even from hour to hour.

Innate selfishness is much too common a temperamental feature, though often concealed under happy and easy conditions.
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of life. The self-centred, introspective attitude is sometimes as much a surprise to the friends as it is to the patient.

Mental degenerates, sometimes brilliant in academic attainments, of good impulses, but nevertheless unstable, and wanting in judgment and sustension of effort, easily break down under strain. Many of these are serving in all ranks.

The abuse of alcohol as a predisposition needs no comment.

Another predisposing condition is malnutrition and simple loss of body weight. In civil life this is a very subtle question, but in the conditions of military service it is more easy to understand. A loss of body weight caused by improper food, faulty assimilation from whatever cause, diseases, notably dysentery, in some temperaments strongly favours a neurasthenic breakdown, and its successful treatment by diet and rest may be followed by results surprisingly rapid and permanent in young subjects.

Age is a relative term, not to be too strictly measured, as Hughlings Jackson used to say, "by the number of revolutions round the sun"; yet we must not forget that the power to bear responsibilities under service conditions does not improve with age, and stress operates with great effect on the older men.

The most obvious and direct causes of neurasthenia and psychasthenia come under the general terms stress and shock.

These two causes may be accessory one to the other, that is, an apparently inadequate shock may owe its severity to a long preparatory stress.

(1) Stress connotes a prolonged mental strain. Its effect as regards rapidity of onset and severity depends upon predisposing circumstances, temperament, general health, etc.

This strain is practically always psychical; it is doubtful whether prolonged exertion of the purely physical kind can produce by itself the neurasthenic picture in any healthy man without these predisposing circumstances.

But combine over exertion with the constant sense of responsibility and loss of proper sleep in the case of the officer, together with the ever present possibility of death, even if not consciously admitted, the loss of comrades and the eternal clamour of the shells common to all ranks, and sooner or later the most stable mental equipment may give way. Indeed, it speaks well for the mental stability of the British soldier that there are not five times as many neurasthenics as there are.

A large number of the victims of stress received here are non-combatants, on lines of communication, or at the base, clerks,
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mechanics, and quite a number of the Labour Section Army Service Corps, who have never been at any time near the firing line. Most of these are men who are unfit by temperament, training, and age, to bear any extra strain. Most of them have lost weight, whether or not after some disease, such as dysentery.

(2) Shock connotes some event which, though it may be accompanied by bodily violence, is yet essentially psychical, in that there may never be at any time any evidence of organic lesion.

The physical cause may seem in some cases inadequate to produce so serious a sequel, and in many cases it would be inadequate if it were not for a train of predisposing circumstances.

We are all familiar with the so-called traumatic neurasthenia following, say, a railway accident, in which the symptoms declare themselves some three or four days after the event.

Shell shock differs from ordinary traumatic neurasthenia in some important particulars. There is a violence, a commotion and evolution of poisonous gases in connexion with high explosives which, as Mott has suggested, may have much to do with the immediate cerebral symptoms, loss of consciousness and epileptoid convulsions, for instance. It is possible that this “commotio cerebri” is the result of actual disorganization of brain tissue, or perhaps multiple punctate haemorrhages. Moreover, there are other circumstances peculiar to shell bursts, burying under debris, loss of comrades and so on, which add horror to the situation.

These special circumstances may account for the early appearance of the neurasthenic phase, and the absence of the latent period referred to above; patients say that their troubles began immediately on recovering consciousness.

Nevertheless, the ultimate picture is that of traumatic neurasthenia writ large; the severest of all shocks, in which the psychical element must obtain in the highest degree, followed by the most pronounced psycho-neurasthenic state, and the most severe added hysterical stigmata, deafness, mutism, blindness for instance, such as we rarely see in the traumatic neurasthenia of civil practice.

One might say that neurasthenia in its fullest development is almost rarely associated with obvious tangible injuries or wounds. This is so constantly observed as to be more than fortuitous. The reaction on the mind of a wound or injury, with its care, enforced rest and treatment, seems to have a salutary effect, and though certain minor hysterical stigmata, anaesthesias, for instance, may co-exist, the full psycho-neurasthenic picture rarely develops.
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A wound has the effect of diverting the mind from introspection, it offers a satisfactory explanation for all symptoms, hope of ultimate recovery, the kudos of honourable wounds and in civil life the certainty of compensation, perhaps all tend to an attitude of mind unfavourable to the establishment of the neurasthenic state.

An injury is a mental counter irritant. I can suggest no better explanation of what is a well-known fact.

Prognosis.—Generally speaking, in civil experience, a nervous breakdown runs a course roughly of a year's duration, or thereabouts.

I do not mean that the patient is seriously affected for the whole of this period, but that he cannot expect to be free from some manifestation or other for much short of it, and in some cases it may be much longer. A man may never again be fit to assume great responsibilities. Happily these cases are, on the whole, rather exceptional. The periods of depression of the psychasthenic become shorter and the remissions longer until the normal has become established. These remarks apply to many of the cases of soldiers of all ranks, and it is likely that a considerable percentage of the officers affected will be unfit for commands in the field, and especially for the nerve-wracking duties of aviation, for the rest of the War.

On the other hand, I have been much impressed by the rapidity and thoroughness of the recovery of many young men after the most serious and unpromising train of symptoms. Mere wrecks, mental and physical, I have seen coming from France, sleepless, unable to bear the slightest sound, or the sunlight, afraid of their own shadow, and yet after a week or two of quiet and rest practically on the road to recovery, and in about two or three months able to rejoin. It is rare to see such rapid recoveries in civil practice. Perhaps they would be commoner if they had always been taken seriously from the beginning.

Healthy young men of clean personal and family history bear severe strains, physical and mental, better than older men, though the strain and stress to which they are subject in this War exceed in severity any that are likely to occur in ordinary life; provided there is no mental heredity or acquired taint, they regain normal conditions with unexpected rapidity.

But men of more advanced age, say 40, and especially alcoholics and mild mental degenerates, having once broken down require long periods for recovery, if they ever do recover completely. It will probably be found also that the apparently simple "stress" cases are really more complex and will be longer and more
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permanently unfit than the initially more serious "shock" cases, for the reason that having broken down under less severe circumstances they are usually weaker types of men. But of course every case must be taken on its own merits, the past and family history, temperament, etc., having been duly considered in forming a prognosis.

Treatment.—To gain the confidence of the patient at the outset is more important in this disease than in most, or any other. This is not always an easy thing to do, but without it we fail. Whatever opinion we may hold as to the value of direct methods of suggestion, I maintain that if any straightforward medical man can gain the complete confidence of his patient, he can and does influence the patient in the way of suggestion. I am sure that a large number of patients date their steady recovery from a prolonged and careful examination, a commonsense explanation of the condition, an assurance that organic diseases may be excluded and a confident prognosis with no attempt to minimize the gravity of the state, the reality of the symptoms, or the length of time necessary for the recovery.

It takes quite a long time to make a detailed neurological examination of exclusion, and longer still to listen to the patient's account. We owe it to the patient to make it, for no man can say what may underlie this complex of symptoms without it; the patient is fully alive to the importance of it and it is the first step in the treatment. Another point, and one repeatedly missed by medical men, is to allow the patient full time to detail every symptom, physical or psychical, and not to attempt to pronounce on the case until the last word has been heard. It is the only way to reduce some patients to silence. Also to receive every statement, however grotesque, with sympathetic gravity, remembering that such statements are not grotesque to the patient, nor would they be to us if we knew all. It is our duty to straighten out a distressed, confused mind, and a chance expression easily missed in a hurried examination frequently throws a flood of light on the mental state. All this takes time and it is time exceedingly well spent. There is no pretence or sham about it, it is good, honest work, it is essential and it is how we would wish to be treated ourselves. Most psychasthenics have in the back of their minds one or two great bugbears, "paralysis"—an indefinite term full of terror to the uninitiated—or insanity, a still greater horror. These are repeatedly kept in the background as too terrible to mention. I never omit to ask "What are you afraid of, do you think you are going to be
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paralysed, or go mad?" and it is almost amusing to see the relief when this dreadful question has been discussed and dismissed with every reassurance.

I need scarcely say that anything like ridicule is not only unkind, but worse than foolish.

You remember the "Rime of the Ancient Mariner" who shot the albatross:

"Oh shrieve me, shrieve me, holy man!"
The Hermit crossed his brow:
"Say quick," quoth he, "I bid thee say—
What manner of man art thou?"
Forthwith this frame of mine was wrenched
With a woeful agony,
Which forced me to begin my tale;
And then it left me free.
Since then, at an uncertain hour,
That agony returns;
And till my ghastly tale is told,
This heart within me burns.
I pass like night from land to land;
'I have strange power of speech;
That moment that his face I see,
I know the man that must hear me:
To him my tale I teach.

Only in this case the listener was not a sympathetic doctor, but an unwilling and hungry wedding guest.

As to the general treatment we must be very sensitive to mental indications.

The state of nutrition, body weight, is a very helpful guide to treatment.

Persons temperamentally predisposed to nervous breakdown begin to show symptoms as soon as they lose weight, even to so slight a loss as half a stone. This is the condition of most of our soldier patients: due to improper feeding, imperfect mastication, bodily wear and tear, or disease such as dysentery or even latent malaria. This class of case is, on the whole, the most satisfactory to treat. Massage and generous feeding on the old rest cure lines may be followed by rapid recovery.

The inclinations even of the patient may guide us quite usefully. If he takes kindly to and welcomes the idea of seclusion and rest in bed, it will probably be found to be the right course, and it should not be of less duration than a month or six weeks. The rigours of the old Weir-Mitchell treatment are never, in my opinion, justified in this class of case.

But when a man is well nourished and, as often is the case, intensely averse from a course on the lines suggested, this may be
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quite the wrong treatment. Massage is probably unnecessary, though it may not be actually harmful, but rigid seclusion and even enforced rest in bed seem in such cases to produce or foster unexpected mental states. I have seen cases brought to the border line of insanity by a rigid routine of this kind. Such cases are best among their friends or even lightly employed.

A period of complete idleness is grateful and beneficial to some minds, positively harmful to others. There are men and women who are possessed of no resource, mental or bodily. Take them from their routine work and they are miserable. They do not read, they have no hobbies, no amusements and play no games. I have met many who have not a friend in the world and have never had one. What is the sense of telling such a person to take a holiday? he does not know how to set about doing it. These are among the people who gravitate to "hydros," and certainly afford one justification for the existence of such institutions.

Many a business man has been ruined mentally by such advice, he does not know how to be idle, he only tends to become more and more introspective. Let him go back to his work on a low scale, ever so little, and in doing so he keeps his self respect, and the neurasthenic phase, for a phase it is, will eventually pass. Work in this case is part of the treatment, paradoxical though it may appear. These remarks apply strongly to the cases of some officers, and even men.

Happily these are exceptions, most of our patients may be trusted to make the best use of a period of rest and idleness.

A real danger, however, to some active minds is that they may overdo their amusements. You cannot bluff neurasthenia. Long walks, too much golf and tennis, late hours at bridge, with the idea of shaking off "nerves" invite trouble and delay recovery. There still survive doctors who give the silly advice—"Buck up, take plenty of exercise, its only 'nerves.'"

Symptomatic Treatment.—Hypnotism is a treatment of stigmata, and not of the state that produced them, or on which they are grafted. This treatment may almost miraculously remove stigmata and so contribute to recovery, but the neurasthenic phase must run its course.

Insomnia calls for treatment urgently. Good nights are followed by good days. Rarely, if ever, should opium in any form be used for pure insomnia. Trional or veronal given not oftener than every other night are generally the most useful and should rarely be used for more than a fortnight. Bromide ten grains and tincture of
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digitalis five minims in three doses repeated at half-hourly intervals is very useful where there is subjective pulsation in the vessels.

Headache may be treated by aspirin, valerianate of zinc five grains, phenacetin "et hoc genus omne."

Electricity must be used tentatively. Faradism seems to be of little use. Galvanism in the form of baths has a stimulating effect in some and soothing in others. So also if applied locally to the neck for the characteristic headache. High frequency currents are very varied in their effect.

The late Dr. Lewis Jones, an accomplished electro-therapeutist, used to say that the state of the blood pressure gives some broad indication as to the use of electricity, in that neurasthenics with a low blood pressure usually took kindly to it and derived benefit, whilst those with a high mean pressure seem to be the worse for it.

Alcohol has an almost magical effect in the depressed periods of psychasthenia. It is therefore to be used with much discretion. As a routine it is perhaps better to rely on some general tonic and the most generally useful is strychnine.

In conclusion, I must anticipate a probable criticism, namely, that my remarks are based largely upon civil experience and at the present time it is the military that is wanted. That is so, but I must repeat that I have up to now learned practically nothing new from soldier cases. I have seen the counterpart of most of them times and often at home. Even such "shell shock" cases as I have met with, and read of, seem, in their most important general characters, to differ from the severe traumatic neurasthenia of civil life more in degree than in kind. As I am not a psychologist, I have used the language of, and tried to handle the subject as, a practical physician.

From being at first, and even now perhaps, looked upon askance by military medical officers, neurasthenia is now in danger of being overloaded, so that every man who has a functional symptom or two, which might be cured by hypnotism, or electricity, may be sent home unnecessarily labelled with that formidable diagnosis.

My object has been rather to constrict the field than the reverse, and by attempting to define its limits and the true stigmata of the disease to help towards such an understanding of it, that the real neurasthenic may be justly appreciated on the one hand, and that the Army may not be unduly depleted on the other.
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