NEURASTHENIA.

Dr Simon Wessely,
Reader in Liaison Psychiatry,
King's College Hospital and Institute of Psychiatry.

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THE ARRIVAL OF NEURASTHENIA.

The New York neurologist George Beard is widely credited with introducing the term neurasthenia in a brief paper presented in the Boston Medical & Surgical Journal in 1869 (Beard, 1869). However, Van Deusen (1869) has an equal claim to the authorship of neurasthenia, as he introduced the term in the American Journal of Insanity in the same year. The rival claims of Van Deusen, an alienist treating farmers in unfashionable Kalamazoo, and Beard, an East Coast neurologist with clients drawn from the Social Register, mirrored the wider confrontation between neurology and psychiatry at that time (Hale, 1987). As with the larger professional conflict, it was Beard who triumphed, and although the American Journal of Insanity would later resurrect Van Deusen's claim, it was the neurologist who became most credited with the "discovery" of neurasthenia.

The concept of nervous exhaustion was not new, and a few contemporaries took pains to elaborate the history of the disease before Beard, tracing its origins to nervosisme, neurospasm, spinal irritability and so on (ex Huchard, 1883; Arndt,1892) , whilst later historians have pointed out the debt Beard owed hypochondria, spinal irritation and Brownian doctrine of asthenia and esthenia (Fischer-Homberger, 1970:Lopez-Pinero,1983).

Beard's views were not fully articulated until his two books written towards the end of his life (Beard, 1880, Beard, 1881). In them he drew his ideas from several sources including Marshall Hall's discovery of the spinal reflex arc, Edison's electricity and Du Bois Reymond's electrical nervous impulse, Spencer's Social Darwinism and so on (Rosenberg, 1962). His skill lay in mixing scientific advances with social theory and moral exhortation, and constructing out of these sources a single disease entity, designed to appeal to many of the concerns of the age, but couched in what seemed to many (but by no means all) acceptable scientific terminology.

Whatever the provenance of neurasthenia, its rapid spread and popularity owed much to Beard, especially in France and Germany. By the turn of the century a French doctor wrote that "everything could be explained by neurasthenia, suicide, decadent art, dress and adultery" (Certhoux, 1961) - "since the works of George Beard... the name of neurasthenia was on everybody's lips, the fashionable disease" (Dubois, 1909), the "maladie a la mode" (Certhoux, 1961). When Levillain (1891) published his important text he subtitled it " La Maladie du Beard". Many of Charcot's pupils wrote texts on the illness - the most popular was probably

that by Adrien Proust, ironically the father of the most famous neurasthenic of the age, Marcel. Bumke later wrote that there was no instance in the history of medicine of a label having the impact of neurasthenia (Bumke, 1925).

Beard's success was because he articulated his ideas to a receptive audience. For example, a series of investigations during the 1880s had revealed the poor health of much of French youth. This was blamed on the alleged excessive mental demands ("surménage") made by the new education system (Rabinbach, 1990) - similar views could be found on the other side of the Atlantic (ex Ely, 1906 and others). Neurasthenia fitted equally well with degeneration (Nye, 1982), as it could be the "starting point for various kinds of degeneracy" (Bidon,1899)[1] . It weakened the will, and diminished responsibility (and as such could be used to secure acquittal in murder trials (Castin, 1908)). Neurasthenia allowed medical thought to move away from the outdated doctrines of sentiments and passions no longer suitable for a society preoccupied with "La Vie Moderne" (Zeldin, 1980).

WHAT WAS NEURASTHENIA?

Neurasthenia was "a disease of the nervous system, without organic lesion, which may attack any or all parts of the system, and characterized by enfeeblement of the nervous force, which may have all degrees of severity, from slight loosening of these forces down to profound and general prostration" (Bouveret, cited by Deale & Adams, 1894). Authors had their own favourite symptoms - cardiac, gastric, cerebral, ocular, gynaecological and so on, but at the core was "nervous exhaustion, characterised by undue fatigue on slightest exertion, both physical and mental" (Cobb, 1920) or fatigue and muscular weakness (Berkley, 1901; Mitchell, S, 1908). This fatigue had certain characteristics - it "comes early, is extreme and lasts long" (Mitchell, 1883). Hence neurasthenics had "abnormally quick fatigability and slow recuperation" (Jaspers, 1963), their fatigue not being relieved by rest.

Nevertheless, neurasthenia was also "destitute of the objective signs which experimental medicine of our times more particularly affects" (Blocq, 1894). Sufferers looked normal, and were typically "well nourished, muscularly well developed" (Ferrier, 1911) , despite often profound functional disability. It also had no significant mortality (indeed, some claimed the opposite (Beard, 1880)).

[1] Although degeneration is frequently linked with French views on neurasthenia, it also enjoyed considerable respect in Britain - see Campbell Smith (1906) for example.

Neurasthenia was an exceptionally broad church. As Shorter (1992) has shown, at least four different strands can be discerned. First, neurasthenia was male hysteria - "neurasthenia is to men what hysteria is to women" (Gerhardt, 1893). Freud (1888) felt that the "male nervous system has as preponderant a disposition to neurasthenia as the female to hysteria". Many of the neurological and popular writings followed this lead. Second, neurasthenia was simply chronic fatigue- the "fatigue neurosis" (Knapp, 1906; Weiss, 1908). The term should be reserved for "an enfeeblement or fatigue neurosis, its cardinal charcteristics being an inordinate sense of physical or mental fatigue" (Neu, 1920). Third, neurasthenia was depression. Cowles (1893) listed it as a "first rank symptom" of neurasthenia, and Clouston (1892) viewed it as a "minor form of melancholia". Thus could mean depression of "cortical activity" (ex Hartenburg,1907) or latterly depression in a more psychological sense. Déjerine and Gauckler (1911) felt that melancholia and neurasthenia could only be distinguished on the basis of history, previous epsiodes of depression or mania favouring the former diagnosis. Many authors equated neurasthenia with a mild melancholia (ex Berkley, 1901), although the differences remained as instructive as the similarities - thus Friedman (1904) stated that whilst both neurasthenics and depressed patients required treatment away from the family, only the latter should be admitted to an asylum. Fourth, Beard himself viewed neurasthenia as the prototype of many diseases, both physical and mental. In particular it was the forerunner of all the mental illnesses, from neurosis to psychosis (Savill, 1894) It was "the soil from which all mental illnesses spring" (Arndt, 1892) - occupying the "broad borderland between mental health and outspoken mental disease (insanity)" (Barker & Byrnes, 1913). These intermediate stages are "the various anomalies usually combined under the common name of neurasthenia" (Durkheim,1950)

THE AETIOLOGIES OF NEURASTHENIA.

Peripheral.

During the early years of interest in neurasthenia the prevailing neurological paradigm remained the reflex hypothesis. Excessive irritation of the nervous system led to exhaustion of the peripheral nerves, which could spread to any tissue (see Lopez-Pinero, 1983; Shorter, 1992). One cause of this was over stimulation, which thus fitted easily into Beard's theory. However, the remarkable flourishing of neurophysiology soon discredited the reflex hypothesis, whilst the related belief that female genital reflexes were the cause of nervous disease in women also under pressure by 1870 (Shorter, 1992). Many of the early advocates of neurasthenia in England, such as Reynolds at University College Hospital,

Allbutt at Cambridge and the obstetrician William Playfair at King's College Hospital, were emphatic in their condemnation of reflex theory, and in particular of the practise of "local treatment" of the female genital organs. In ridiculing the reflex theory Allbutt explained that neither muscles nor reflex arc were in a state of exhaustion, nor were the neurasthenic cells too excitable - "to be excitable is their business" (Allbutt, 1899). All these authorities espoused the new central paradigm of nervous disease, which soon replaced reflex theories.

The central paradigm

As views of the nervous system changed, especially under the impact of the new laws of Thermodynamics and Conservation of Energy (Rosenberg, 1962; Rabinbach, 1982; Lopez-Pinero, 1983) so did the nature of neurasthenia. Doctors were beginning to discuss not only the body, but also the mind in terms of heat and energy before the arrival of neurasthenia - George Johnson, the Chair of Medicine at King's College Hospital, wrote about the mind as a "set of complex psychological energies" (Johnson, 1875), and it was only a short step to see neurasthenia as an exhaustion of that supply of energy within the central nervous system. The consequence was "cortical weakness" (Foster, 1900) or "cortical irritability" (Pershing, 1904). Irritable weakness of the brain permitted some remnants of reflex theory to survive, but many other causes of cerebral exhaustion were identified. These were either local to the brain - a failure of cerebral blood flow or a deficiency in energy sources, or arise from distant sources, such as the effect of toxins. The increased demands on the system could result from overwork, or be the result of toxic, metabolic or infective insults. It was in this manner that masturbation was so deleterious to health, both in men (Cleghorn, 1907) and women (Macnaughton-Jones, 1913).

All of the above were acquired in adult life, but individuals could also be predisposed to react to each or all of these factors by hereditary, or could inherit neurasthenia itself. Neurasthenia thus fitted well with concepts of nervous inheritance, or degeneration. As Janet Oppenheim writes neurasthenia could indeed be "all things to all men" (Oppenheim, 1991).

The social paradigm

The doctrine of overwork and nervous exhaustion linked neurasthenia with a variety of contemporary changes in society. Medical authorities viewed overwork, the agent by which the nervous system became exhausted, (which could be purely physical, mental or a mixture of both) as the inevitable consequence of a host of new social ills. Even before the introduction of neurasthenia, a variety of medical authorities were writing about the dangers

of overwork (Poore, 1875; Johnson, 1875; Savage, 1875). Once again, it was Beard, with his facility for similes, who joined together a number of discontents into an explanatory model for his disease. For example, Beard, and many others, ascribed neurasthenia to the new, acquisitive nature of society, singling out, in a famous phrase, wireless telegraphy,science, steam power, newspapers and the education of women, summed up as "modern civilisation" (Beard, 1881). Much of this was conveyed by metaphors drawn from business life, the exhausted businessman overdrawn on his nervous capital, overspent nervous resources and so on (- see Oppenheim, 1991; Lutz, 1991).

The dramatic rise of neurasthenia seemed to confirm its status as a disease of modern civilisation - indeed, its increasing frequency was "as certain as the fact of civilization itself" (Ely, 1906). It was both a consequence, and the cause, of numerous social problems. It was the price to be paid for industrialisation, the rise of capitalism, and the consequent strains to which the business and professional classes were exposed (Haller, 1970). It was "the disease of the century" (Ballet & Proust, 1902; Rankin, 1903; Ash, 1909) or the "Age of Fatigue" (Rabinbach, 1990).

The psychogenic paradigm.

Unfortunately for the organic view of neurasthenia, the central paradigm could not be sustained. Fatigue could only be measured with the greatest of difficulty (White, 1917), if at al (Muscio, 1921), nor could any discrete neuropathological lesion be located. Adolf Meyer later wrote that the "remarkable changes in the nerve cells" which others had found, which were "highly fashionable and a matter of pride to both patient and diagnostician.....could not be replicated. Fatigue exhaustion is no longer tenable" (Meyer, 1919) . The consequence was a loss of faith in simple neurological explanations - Donley (1906), in the first issue of the prestigious Journal of Abnormal Psychology, criticised the previous "mechanical symbolism" of descriptions of neurasthenia, with the false belief that "for every pathological manifestation there must be an underlying, definite 'disease process'", and the "futility of the purely anatomical concept" expressing itself in "apologetic reproductions of nerve cells in a state of fatigue". Two years later neurasthenia could be described as "a state of habitual valetudinarianism with no corresponding characteristic organic lesion" (Tanzi, 1909).

Social aetiologies were also changing. It was doubted if neurasthenia really was a disease of modern life (Schofield, 1908), except that "we had become more tender in our ills" (Dubois, 1909). Neurasthenia was more likely to result from idleness than overwork (Brock, 1913; White, 1921), reflected in the increased emphasis on activity and exercise in place of

the classic rest cure. Other aetiologies, considerably less attractive to the potential neurasthenic, were now suggested, such as bad housing (Glorieaux, 1905), and poor dental hygiene, due to the "fashion of eating ice cream .. prevalent among the children of the lower classes" (Savill, 1906).

These last quotes suggest a further change, that of class. Neurasthenia had been sustained by the belief that it was a condition of the most successful people in society. "It is a disease of bright intellects, its victims are leaders and masters of men, each one a captain of industry" (Pritchard, 1905), a view widely shared (Freud, 1887:Kraepelin, 1902) . Many noted the large number of doctors afflicted. The importance of the male doctor who, like Beard, Dowse and Mitchell, willingly admitted he had suffered the illness, and of the male sufferer in general, should not be underestimated (Sicherman,1981; Gay, 1986).

However, the preponderance of the male professional classes amongst sufferers began to alter. Charcot (1889) was among the first to point this out, and by 1906 a series of papers were produced describing the illness in the working class (Leubuscher & Bibrowicz, 1905: Iscouesco, 1905: Savill, 1906). The records of the Vanderbilt Clinic in New York (Jelliffe & Clark, 1903) shows that neurasthenia was now mainly a disease of the lower social classes, and, as most of these comprised Jewish immigrants, it could no longer even be called the "American Disease". In 1906 Stedman pleaded in his presidential address to the American Neurological Association (Stedman, 1906) for more attention to the need for facilities for the neurasthenic poor, and the illness had become the commonest cause of absenteeism among the garment workers of New York (Schwab, 1911). Cobb (1920) noted sardonically that those who continued to believe the disease was restricted to the upper social echelons were those whose commitment was entirely to private practice. Even the excess of male medical sufferers began to alter - it was the female doctor who was particularly vulnerable, because "only the strong can survive" (Burr,1910).

The failure of the organic paradigm, and the change in social class and aetiologies, prepared the way for the psychological model. This took two stages. First, neurasthenia was retained, but viewed as a psychological, rather than a physical illness. The pendulum shifted - rather than psychological symptoms being a consequence of neurasthenia, they first became linked in a vicious circle, with neither having supremacy (ex Tuckey, 1911; Hurry, 1914), and finally were seen as causing the condition - thus Déjerine writes that "many manifestations [of neurasthenia] are by nature purely phobic in origin" (Déjerine & Gauckler, 1911).Second, the category itself was dismembered, and replaced by new psychiatric diagnoses. It is well known that by 1893 Freud considered sexual exhaustion to be the sole cause of neurasthenia,

either directly or indirectly. The following year (Freud, 1894) saw his famous removal of anxiety neurosis from neurasthenia (although he later acknowledged that earlier that Hecker had anticipated his work in the previous year in a paper distinguishing anxiety neurosis ("Angstneurose") and neurasthenia). As important was the work of Pierre Janet. He also regarded fatigue as the key to psychological disorder, and, like his contemporaries blamed modern life for fatigue neurosis (Rabinbach, 1990). However, he followed William James in deriding the conventional economic metaphor of the neurasthenic overdrawing on a limited capital of physical energy, but emphasised instead the emotional demands on the psychic economy (Rabinbach, 1990). Eventually Janet detached obsessional and phobic neuroses from neurasthenia, via the agency of psychasthenia (see Berrios, 1985). Freud, Bernheim and others continued to believe in a physical neurasthenia, not amenable to psychotherapy, labelled by Freud an "actual neurosis" in which sexual energy was lost by masturbation, but thought it was rare - Ernest Jones (1961) later wrote that fewer than 1% of neurasthenics were correctly diagnosed. Janet also believed in a physical neurasthenia for a brief period of time, but then abandoned this altogether.

The organicists countered such observations in two ways. First, the present methods of investigation were too crude to detect the organic changes (ex Oppenheim, 1908). Second, psychological symptoms, if present, were part of the physical neurasthenic state (Starr, 1901; De Fleury, 1901), or were an understandable reaction to the illness. In a speech to the American Neurological Association Weir Mitchell (1908) referred to his own early neurasthenia, and pointed out how depression could not be an explanation for his condition, since he had "no depression that was abnormal or unreasonable". His own illness, and that of other distinguished contemporary medical men, made it inconceivable that neurasthenia could be "a malady of the mind alone".

Nevertheless, these became increasingly minority views. Charles Dana read an influential paper to the Boston Society of Psychiatry and Neurology (Dana, 1904), expounding the "renaissance" in psychiatric thinking, in contrast to the previous antagonism between neurology and psychiatry, and urging adoption of the new classifications. Only two years later the new President of the Neurological Association described an eminent patient as suffering from "neurasthenia or mild melancholia" (Stedman, 1906) -the 'or' being unlikely a decade earlier. When the London Medical Society debated neurasthenia in 1913, Kinnier-Wilson wrote that "it was clear... from the discussion that Beard's original description of "American Nervousness" as a physical and not a mental state was evidently not accepted by several of the speakers" (Kinnier Wilson, 1913). Thomas Horder was sceptical about the ability of "neurasthenia school" to separate it from hypochondriasis, remarking that in his

experience the "mental element" rather overshadowed any physical contribution (Horder, 1903). The successive editions of one important English psychiatric text show how neurasthenia moved from the neuroses (still an organic neurological diagnosis) to the psychoneuroses (Stoddart, 1926) - William White's views showed a similar, albeit less dramatic shift, in only four years (White, 1917; White, 1921). Neurologists at the Massachusetts General Hospital had already done the same (Walton, 1906), as did both Dutil and Déjerine, pupils of Charcot, did likewise - "Beard's illness must now be seen as of mental origin" (Dutil, 1903) .

The change in the nosology of neurasthenia was also influenced by changing views of treatment. Victorian neurasthenics were treated with a bewildering variety of pharmacological and electrical treatments, but the mainstay of treatment was the rest cure. The introduction and extraordinary popularity of Weir Mitchell's rest cure is well known, and has been described elsewhere (Olson, 1988; Shorter, 1990 ; Wessely, 1994a) [2]. The rest cure has attracted many criticisms over the years. Feminist historians have been influential in highlighting the influence of male stereotypes of women, especially their moral and physical weaknesses (see Wood, 1973; Cayleff,1988). Contemporaries, however, noted other failings. Principal among these was failure of the somatic model. If there was no cellular basis to exhaustion, then what was the purpose of rest? The growing awareness that all the business of the cure, the diet, massage, electricity etc, were just props for the physician to exhort and encourage the patient, meant that they could be dispensed with (see Dutil, 1903; Drummond, 1907; Waterman, 1909). It became increasingly difficult to deny the role of suggestion, of the doctor-patient relationship, upon which "everything depends" (Déjerine & Gauckler, 1911), and ultimately of the newer psychotherapies (see Hale, 1981). Gradually authorities began to suspect that the rest cure might actually make the patient worse. For example, less than ten years separates two contributions on neurasthenia made by Dutil, another pupil of Charcot. In the first (Dutil, 1894) he espouses a standard Weir Mitchell approach, but in the second (Dutil, 1903) Mitchell's regime was condemned the patient to a life of disability and hypochondriasis. Similarly, if electrical treatments were effective, it was more for psychological reasons rather than any "organic modifications of the nerve centres" (Proust &

[2] It is often forgotten that the cure was originally suggested for the treatment of hysteria (Mitchell, 1875), and it was only as the distinctions between the two became blurred, and perhaps as the financial advantages from treating neurasthenia became clearer, that it became popular for neurasthenia. Thus in 1888 Freud was recommending a combination of Weir Mitchell and Breuer's cathartic treatment for hysteria, adding that "in the case of the other neuroses, for instance neurasthenia, the success of the treatment is far less certain".

Ballet, 1902).

The details of the decline of the rest cure, as it gave way to the new occupational and psychotherapies, lie outside the scope of this essay. Its descent into obscurity further weakened the organic models of neurasthenia, and conversely increased the status of the new psychological school of thought. Inevitably, the management of the neurasthenic patient passed from the neurologist to the psychiatrist. By 1944 Karl Menninger's disdainful account of the rest cure reflected this transfer.

THE REACTION AGAINST NEURASTHENIA

What were the consequences of the failures of the simple organic models of both aetiology and treatment,and the rise of the psychological models ? Physicians could either abandon the concept or concede that the patients were best cared for by the psychiatric profession. Many neurologists were soon persuaded that neurasthenia should be abandoned- - Browning (1911) wrote that neurasthenics were rare in his neurological service (although not, he admitted, in his private practise), because "Many of our best neurologists do not now recognise such as disease". Particularly in the United Kingdom, neurology was establishing itself as a scientific speciality and many soon turned their backs on this now discredited diagnosis. This happened with alacrity in the United Kingdom (vide infra), but, although pleas were made for the same process in the USA (ex Dana, 1904), the concept was more deeply entrenched there and in France. As late as 1927 one third of patients seen by American neurologists were still either neurasthenic or psychasthenic (Peterson, 1927). Many physicians retained the diagnosis (and therefore the patients), but began gradually to incorporate the new psychological insights into their treatments - the "rational psychotherapy" of Paul Dubois being particularly influential, perhaps because it so clearly repudiated notions of the unconscious that were often unpalatable to many neurologists.

The rapid abandonment of neurasthenia by British neurologists was because the illness had never found a fertile soil here anyway. Beard himself had a dismal reception when he visited this country in 1880 and 1881, committing one social gaffe after another ([3]). Sir Andrew Clark, an eminent physician at the London Hospital, launched a blistering attack in

[3] See Fourness-Brice J. Medical Etiquette on Board Ship. British Medical Journal 1880; i: 238 and Crichton Browne J. Dr. Beard's Experiments in Hypnosis. British Medical Journal 1881; ii: 378-379.

the Lancet (1886), and , although Playfair made a spirited defence (Playfair, 1886), he was forced to concede that he had been unable to persuade the Collective Investigation Committee of the BMA to take an interest. Neurasthenia was never accepted by the neurological establishment. The giants of the profession, such as Gowers, Gordon Holmes, Ferrier, Buzzard and Kinnier-Wilson based at the National Hospital for Nervous Diseases, declared themselves in various ways against an organic view of neurasthenia, and in favour of psychological interpretations (although hospital records, still readily available, reveal they all made the diagnosis with varying degrees of frequency, whilst contemporary accounts also noted it to be a common diagnosis at the hospital - see Horder, 1903). Gower devoted only one page of his two volume text to the subject (Gowers, 1888), and in the next edition was even briefer - neurasthenia "occurs especially in those of a nuerotic disposition" (Gowers, 1899). This should be contrasted with the extensive coverage given in Oppenheim's equally monumental German neurology text. Unlike the United States, France and Germany, in the United Kingdom the neurasthenic flag was flown by only a few - the most prominent being Clifford Allbutt in Cambridge. Even Allbutt (1899) had to admit that acceptance was at best grudging - in his eight volume textbook Allbutt wrote the section on neurasthenia himself, but felt the necessity of criticising those "medical men who reject neurasthenia as in part a sham, and in part a figment of complacent physicians". Despite such efforts a reviewer conceded that neurasthenia had "not taken deep root in Britain" (Ireland, 1907). The British Medical Journal did not "take quite so serious a view of the prevalence of neurasthenia in modern life" (Anon, 1909), and by 1913 neurasthenia's "servicableness as coin of the realm" was doubtful (Anon, 1913).

Issues of class and gender were intimately related to those of aetiology and treatment. The more "organic" the account, the more likely was the author to insist on the predominance of upper social classes, the distinction from hysteria (the archtypal disease of women - see Oppenheim, 1991), and the over representation of men and "civilised" races. Physicians were more likely to view sympathetically those whose illnesses had been acquired by praiseworthy rather than contemptible means (as indeed they still do) - neurasthenia, the disease of overwork, came into the former, hysteria the latter (Gosling & Ray, 1986). Groups not subject to such overwork, such as women, lower classes, degenerates, American negroes and all uncivilised races, thus were spared neurasthenia (see Beard, 1881; Althaus, 1898; Mitchell Clarke,1905; Burr, 1910). Playfair, writing in Tuke's dictionary stated that the difference between neurasthenia and hysteria was that the former "give all they possess to be well, and heartily long for good health, if only they knew how to obtain it" (Playfair, 1892). Neurasthenics co-operated with the doctor, unlike hysterics (Brill,1930). The bluntest was Ernest Reynolds, Professor of Medicine in Manchester, who wrote that whereas hysteria was

"purely a mental condition, whose basis is a morbid craving for sympathy and notoriety", neurasthenia was "entirely different", a functional disorder of chronic overuse of neurones" due to "gross overwork and worry" (Reynolds, 1923).

Even within the sexes, such moral judgements were frequent - thus Mott wrote that "neurasthenia ...was more likely to be acquired in *officers of a sound mental constitution than men of the ranks*, because in the former the prolonged stress of responsibility which, in the officer worn out by the prolonged stress of war and want of sleep, causes anxiety less he should fail in his critical duties" [italics in the original].

The consequence was the decline of the diagnosis. This was partially intended, as doctors dismantled the now overstretched concept, that "mob of incoherent symptoms borrowed from the most diverse disorders" (Clark, 1886). However, as the reception accorded Beard in the journals showed, academic disdain was not new. It now vanished for more practical reasons. Neurasthenia had survived academic dissatisfaction because it was "useful to the doctor" (Anon, 1913) as a code for non psychotic illnesses for which the only effective treatments were psychologically based. The diagnosis was made "for the comfort of the relatives and peace of mind of the patient" (Risien Russell, 1913) since it avoided the stigma of psychiatric illness and the necessity to seek treatment in an asylum, where the neurasthenic would "soon be subject to the usual stigma attached to the abode of mental patients... only in a general hospital could the psychic problem be solved under the happiest auspices" (Hallock, 1911). Others commented that even if the symptoms were psychological, it was better to talk about nervous diseases and neurasthenia since "the patients and the patients friends usually have a horror of mental disease" (Barker & Byrnes, 1913). Several anecdotes attest to the consequences of not keeping to these codes.[4]

For a while it was possible for doctors to maintain the old views in public, but statements such as "functional illness means pooh poohed illness" (Anon, 1897) and "neurotic, neurasthenic, hysterical and hypochondriacal are, on the lips of the majority of clinical teachers, terms of opprobrium" (Drummond, 1907) show that the codes were being broken, and the demise of the category a matter of time. In 1868 patients were only too

[4] Drummond (1907) describes a scene he witnessed when a "kindly physician", actually Sir Andrew Clark, during a consultation with a neurasthenic patient, let slip the word "melancholia ". "The outcome of that visit was disastrous, involving serious trouble all round, in which even Sir Andrew himself shared, for he was pestered for weeks with letters to know whether in using the term "melancholia" he had the idea of insanity in his mind".

willing to confess to "weakness of the nerves" (Madden, 1868) , but 30 years later the Spectator observed that neurasthenia was no longer "interesting", it was "discredited and disgraceful...shameful to confess" (Anon, 1894) . The changes in social class, and the rise of the psychogenic school, meant that aetiologies had also changed. Infection remained (vide infra), but in place of overwork came laziness, fecklessness, degeneration and poor hygiene. Neurasthenia, once almost a badge of honour[5], was now considerably less praiseworthy - in place of the hard pressed businessman came the stereotype of the work shy labourer, the Jewish garment worker, or the pampered hypochondriacal upper class female invalid (Edes, 1895). Now doctors who had used the rise of neurasthenia as evidence of the advance of both civilisation and medicine made the same observations on its decline - "the gradual 'passing of neurasthenia' is a sign of the times and of the advancement of medical science" (Ramsay Hunt, 1920). It had "outlived its usefulness" (Clayton, 1926).

Successive editions of the Surgeon General's Index catalogue the decline of the diagnosis. Beard had always argued that neurasthenia was the precursor of a variety of conditions, both mental and physical. As the symptoms were so protean, this was not surprising, but physicians began to see little point in diagnosing neurasthenia in those with conditions adequately covered by other labels (Clayton, 1926). The space devoted to it in the classic neurological texts dwindled, and finally disappeared, or received a brief psychiatric coverage. In the first edition of Cecil's prestigious textbook of medicine neurasthenia has its own chapter (Peterson, 1927). By the third edition it is listed under "The Neuroses or Psychoneuroses" (Wechsler, 1934), and is reduced to a single sentence in the Seventh Edition (Rennie, 1947). One edition later it disappears from the index.

Only in the context of the effort syndromes (Da Costa's syndrome, Soldier's Heart, neurocirculatory asthenia) did it survive, but even there the same process gradually occurred (Paul, 1987). No figure was more associated with these diagnoses than cardiologist Paul

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[5] "It is certain that it is chiefly the people who have a neurasthenic constitution who are the most brilliant, original, energetic and influential. It is they who do the intellectual work of the world" (Robertson, 1919). In "The Guermantes Way", Proust has Dr du Boulbon, the "alienist and brain doctor", who has "special competence in cerebral and nervous matters" , state that "Everything we think of as great has come to us from neurotics. It is they and they alone who found religions and create great works of art. The world will never realise how much it owes to them, and what they have suffered in order to bestow their gifts on it". Marcel Proust, Remembrance of Things Past. Volume 2; The Guermantes Way Trans. C. Scott Moncrieff & Terence Kilmartin. (London, Penguin Modern Classics, 1983), p 315. Haller (1971) uses contemporary texts to show that neurasthenia was also almost a badge of respect in American"society" between 1880 and 1900.

Wood, but by the end of his career he saw them as synonymous with anxiety disorder (Wood, 1968).

Neurasthenia was replaced mainly by the new psychiatric diagnoses. The symptoms were now listed as psychological - painful fatigue became anhedonia (Myerson, 1922) whilst a textbook of anxiety could include the symptom "fatigue on slightest exertion" (Ross, 1937). For a period of time psychasthenia contained much of obsessional and phobic neuroses (Blumer, 1906), but by 1927 a typical textbook would restrict psychasthenia to illnesses characterised by morbid fears (Peterson, 1927), and soon this concept gave way to the current classifications. The greatest beneficiary was the new concept of depression. Even De Fleury acknowledged the change. In 1901 he used the title "Les grands symptômes neurasthéniques", but twenty years later this had changed to "Les états depressifs et la neurasthénie". With the support of such figures as Jaspers and Bleuler (1924) ("What usually produces the so-called neurasthenia are affective disturbances") the view became widespread that "all neurasthenic states are in reality depression, - perhaps minor, attenuated, atypical, masked, but always forms of anxious melancholia" (Tinel, 1941). In current neurological practice, neurasthenia, when mentioned at all, is seen as synonymous with depression (Adams & Victor, 1985).

In conclusion there were a number of reasons for the decline in neurasthenia. First, the neuropathological basis of the illness was discredited. Second, rest cure was seen either to be unsuccessful, or to be efficacious principally for psychological reasons. Third, the social class distribution of the illness altered. Finally, the interest and optimism shown by the neurologists was transferred to the new profession of psychiatry.

THE DISEASE THAT DID NOT DISAPPEAR.

The consequences of the psychogenic explanations of neurasthenia were not entirely as intended. Buzzard (1930) had warned that although the advances in both neurology and psychiatry had illuminated the plight of the neurasthenic, the same could not be said of the exclusively psychogenic theories, which would lead to a polarisation among doctors. "On the contrary, Freudian doctrines have produced a reaction in the minds of medical men which has taken the form of a desire to ascribe all mental disorders, including neurasthenia, to some physical or chemical agent the result of disturbed glandular secretions, of septic tonsils or teeth, of intestinal stasis or infection, or of a blood pressure which is too high or too low"

Buzzard was right. Before the acceptance of the psychogenic paradigm neurasthenia served a purpose - "At a time when physicians felt comfortable only with clearly organic

disorders, a diagnosis of neurasthenia permitted some to address themselves to tangible clinical issues and to provide an essentially psychological therapy under a somatic label" (Sicherman, 1977). With the rise of the psychogenic school, this ability, acquired by physicians with difficulty, was lost. For a time the good physician now "wanted to study all sides of the question" (Meyer, 1930), which meant attention to emotional issues, but "without overlooking the possibilities of infective and organic factors". Conversely, the informed psychiatrist also accepted the possible role of organic factors, hence Tredgold (1911) doubts the existence of a structural basis to neurasthenia, but accepts the probable role of a cerebral "bio-chemical" abnormality.

However, the introduction of psychoanalysis to the USA, with its exclusive emphasis on mental origins, ended this appropriately labelled "holistic" approach (Gosling, 1987). Narrow somaticism had failed, but in its place came "belligerent Freudianism" , as illustrated by statements such as "there is only one certain cure for neurasthenia - viz psychoanalysis" (Stoddart,1926). Ironically, this treatment attracted criticisms reminiscent of those of the rest cure, namely questionable efficacy, but unquestionable expense (Anon, 1913; Buzzard, 1930; Hale, 1971). Others disliked the new approach because it appeared to encourage introspection, the quality which the neurasthenic apparently already possessed to excess (ex Peterson,1927).

Paradoxically, it was the solely psychological explanations in the new "official" consensus on neurasthenia that ensured the survival of a contradictory view familiar to Beard and Mitchell. One reason was financial. Beard had made a virtue out of the predominance of upper classes among his patients, claiming that "the miseries of the rich, the comfortable and intelligent have been unstudied and unrelieved" (Beard,1881) - forty years later A J Cronin (1952) was still making a decent living in fashionable London by treating society ladies for the illness. American physicians and neurologists were particularly reluctant to abandon it -as late as 1927 Adolf Meyer was writing to Abraham Flexner complaining that neurologists continued to see neurasthenics in their clinics, although it was psychiatrists who had the necessary training (Grob, 1985)[6]. However, as important as the financial rewards was the rejection by sympathetic physicians of what they perceived as the implications of the now

[6] Nevertheless, neurasthenia was on the decline, albeit with less speed than in Britain. Diller (1917) noted that the between 1894 and 1916 the proportion of neurasthenics and hysterics in his case load had halved, an even more preciptious decline occuring at the New York Neurological Institute. This should be contrasted to the predominance of the diagnosis at the Vanderbilt clinic in the previous decade.

ascendant psychological views. Such physicians often endorsed a division between organic and psychological, usually synonymous with a division between real and unreal illnesses. The argument would thus revolve around the status to be accorded neurasthenia. Those continuing to diagnose the condition would thus energetically refute "the idea, now strongly held that neurasthenia is basically psychiatric, almost imaginary in nature" (de Fleury, 1901). Only by continuing to affirm the organicity of neurasthenia could many doctors continue in their dealings with nervous patients. It was the survival of such attitudes which prolonged the survival of neurasthenia, and prepared the way for its modern re emergence.

The result was that despite the obituaries, and the consignment of the condition to the "garbage can" (Brill, 1930) , "rubbish heap" (Culpin,1931) or "waste basket" (Kinnier Wilson,1913), neurasthenia survived. "Everywhere we meet with the statements that it is rare... yet no name is more often on the lips of both our profession and the laity" (Dicks,1933). Buzzard (1930) noted with regret that although he felt that most of the patients referred to him were depressed, nearly all came with a label of neurasthenia. Brill (1930) commented "inspite of all that was said and done about the inadequacy of the name, as well as the concept itself, neurasthenia is still very popular with the medical profession" .

MODERN NEURASTHENIA.

Nevertheless, neurasthenia did gradually disappear. In the USA and United Kingdom formal interest in had virtually disappeared by 1960 (Chatel & Peele, 1970). However, the term does survive in other parts of the world, and is retained in the International Classification of Diseases (ICD-9 and ICD-10). It is a common neurotic diagnosis in the Netherlands, Eastern Europe and the old Soviet Union and flourishes in parts of Asia, especially China, where it is seen as a physical illness, without stigma, describing what Western observers label as depression (Kleinman, 1982). There are even signs of a revival, perhaps stimulated by the rise of CFS, with a series of recent publications from transcultural psychiatry [7] and the diagnosis has reappeared in modern epidemiological studies (Merikangas & Angst, 1994; Ormel et al, 1994).

After the demise of neurasthenia, general physicians continued to encounter the patient with chronic fatigue, often arising after a variety of insults, including infection. Perhaps mindful of the neurasthenia experience, rather than develop specific nosological

[7] A special edition of Transcultural Psychiatric Research Review (Volume 31, Issue 4, 1994) was devoted to the subject.

entities physicians generally resorted to descriptive labels, such as "chronic nervous exhaustion" (Macy & Allen, 1934), "tired, weak and toxic" (Alvarez, 1935),"Fatigue and weakness" (Allan, 1945) or "Fatigue and nervousness" (Wilbur, 1949). However, the main emphasis was on psychological mechanisms. Illnesses closer to classic neurasthenia included the succession of diagnoses such as candidiasis, hypoglycaemia and total allergy syndrome, but none attracted the professional support necessary to become an established part of medical practise. This would not be forthcoming until the recent re-emergence of the post infective fatigue syndromes (Wessely, 1994a).

Even the first descriptions of neurasthenia included a link with febrile illness. Van Deusen (1869) highlighted malaria , since he worked in an area in which the disease was endemic, whilst Beard drew attention to wasting fevers. The link with infection persisted in the earliest accounts in France (Huchard, 1883), whilst one of the first cases to be treated in this country by the Weir Mitchell regime was a woman with a fourteen year history of neurasthenia, confined to bed in a darkened room, whose illness had begun with a persistent cold (Young, 1884).

By 1914 the observation that neurasthenia frequently followed an infection was widely acknowledged [8]. For most, including Osler, Ely, Oppenheim, Cobb, Horder, Ladova, Clarke, Kraepelin, Althaus and Arndt the principle candidate was influenza, but claims were also made for many others, especially typhoid, and latterly the effects of vaccination (Craig, 1922). As the microbiological revolution spread, each organism was linked with neurasthenia. Everybody had a favourite culprit, until it was conceded that any infective agent could produce the state of chronic exhaustion (Oppenheim, 1908; Dubois,1909; Dicks, 1933), especially in combination with depression (Lane, 1906) or worry (Ash, 1909). To a generation schooled on Virchow and Koch this was a major hurdle.

Such efforts did not cease after the decline of neurasthenia, since, starting with Reiter's disease (Reiter, 1916), attempts to link infective organisms with previously mysterious clinical conditions had reaped dividends, and the list of bona fide post infective conditions was growing. Specific post infective syndromes identical with neurasthenia continued to be describe as each new infection was discovered, although many continued to be noticeable for their psychological flavour.

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[8] Much the same applied to effort syndromes/Soldier's Heart - see Sir James MacKenzie (1916),

The story of chronic brucellosis is another link between neurasthenia and CFS. Although by 1930 the diagnosis of acute brucellosis was well established, there was less certainty about chronic brucellosis. One of its chief supporters was the public health specialist Alice Evans, who noted the similarities between neurasthenia and chronic brucellosis, but only in order to highlight the plight of the large numbers of those afflicted who suffered the indignity of receiving the erroneous, "dishonourable" diagnosis of neurasthenia (Evans, 1934). Thirteen years later she was still championing the disease, which remained "extremely difficult to diagnose.... however, an unrecognised mild form of brucellosis is a common ailment in this country" (Evans, 1947).

The end of the syndrome encapsulates on a smaller scale the eclipse of neurasthenia. Spinks (1951) studied a series of patients with acute brucella infection, and noted that a proportion failed to recover - the chronic brucellosis group. However, he found no objective evidence of disease, and instead noted high rates of psychological disorder. Researchers from Johns Hopkin Hospital, in the first of a series of papers on the relationship between infection and psychological vulnerability, studied subjects with the label of chronic brucellosis in greater detail. They found no evidence of chronic infection (Cluff et al, 1959), but high levels of psychiatric morbidity, coupled with reluctance to discuss psychological issues and a strong attachment to the "organic" diagnosis (Imboden et al, 1959). Once this evidence became widely disseminated, chronic brucellosis largely disappeared, reappearing in an editorial on the social construction of mental illness (Eisenberg,1988).

Chronic brucellosis never made a substantial impact on the medical scene. However, events took a different course with the emergence of the next generation of post infective syndromes during the mid 1980s, with "chronic Epstein Barr infection" in the United States, and "post viral fatigue syndrome" in the United Kingdom, where it is popularly known as "ME" ("Myalgic Encephalomyelitis"). All these conditions are essentially similar, and are grouped together as "chronic fatigue syndrome" (CFS).

These illnesses have all the characteristics of neurasthenia in its heyday. All the symptoms, from delayed fatigue, exhaustion after minimal effort, and mental confusion [9] .

[9] The resemblances between chronic fatigue syndrome and neurasthenia have been previously elaborated elsewhere. The current essay is based on two earlier papers, (Wessely, 1990: Wessely, 1991). Wessely (1994a) brings this essay up the modern era, adding the more recent literature on CFS. Social and epidemiological aspects of modern neurasthenia are discussed in Wessely (1994b). Greenberg (1990) and Abbey & Garfinkel (1991) independently observed similar historical parallels. However, Shorter (1992), contains an analysis critical of

The earlier forms of "ME" were divided into cerebral, brainstem and spinal varieties, as in the first series of neurasthenic texts. Upper social classes appear to be over represented among sufferers, and medical and paramedical professionals are particularly affected. These conditions are frequently labelled "yuppie flu" in the media, reflecting the stereotype of the over stressed, over achieving urban professional, a characterisation more than familiar to the readers of Beard and Kraepelin. Adherents of the conditions emphasise the impeccable moral stature of those afflicted, in order to prove that the illness is not psychological.

The aetiological theories advanced have seen a similar progression from peripheral (neuromuscular), via central (central nervous system) to psychological hypotheses. As with neurasthenia, various medical writers have claimed that CFS is either hysteria, effort syndrome, depression or anxiety, whilst supporters either deny any psychological involvement, or claim that psychiatric disorder is simply the normal reaction to physical disease.

In the popular literature one does not have to search hard for metaphors well known to Beard and the Victorians, as authors use concepts such as limited energy resources, lack of nervous energy, life on a flat battery and so on. Once again, the consequence of such theories is to advocate a treatment not dissimilar to rest cure, with forced inactivity to marshall limited supplies of energy, often accompanied by strict diets, albeit to deal with allergic conditions.

One popular characterisation of neurasthenia was of the body giving way under attack from outside, becoming, as Beard described it, "overloaded" (Beard, 1881). Contemporary observers ascribed this overload to the deteriorating quality of life, to new organisms, new stresses, new ways of working, the decline of leisure and the increasingly decadent and acquisitive nature of society. All of these ideas reappear in the current theories of immune dysfunction in CFS, and parallels between CFS and AIDS are frequently drawn in many of the popular books. Abbey and Garfinkel have written that "just as neurasthenia was a compilation of ideas which captivated the imagination of both public and medical professionals, so too is CFS built upon two of the most interesting themes in modern medicine, infectious disease and immunology" (Abbey & Garfinkel, 1991) in which the new "overload" is from viruses, pollution, stress and so on. Writers on both neurasthenia and CFS thus use the prevailing scientific discourse to express wider social concerns, but, as Peter Gay observed, "the symptoms of contemporary culture they liked to adduce in proof were, though

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the simplistic equation of CFS and neurasthenia.

plausible villains, not easily demonstrated agents of nervousness" (Gay, 1986).

CONCLUSION.

One of the striking features of both neurasthenia and latterly CFS is their capacity to cause dissent. Non believers have consistently attacked the gullibility of those who willingly accepted neurasthenia or its successors in toto - the reviews that greeted Beard's books between 1880 and 1882 were extraordinarily vituperative[10]. In return believers were hardly less tolerant - Weir Mitchell once reacted to a copy of Freud by saying "Throw that nonsense on the fire" (Earnest, 1950). The accounts of the "Congrès des Médicin Aliénists et Neurologist de France" [11], the American Neurological Association on numerous occasions between 1880 and 1914, the American Medical Association in 1944 (Allan, 1944) and many others, including most modern meetings of CFS, were characterised by arguments of varying degrees of intensity. Disputes also split the two camps - on the one hand Dubois and Déjerine devote much space to criticising Bernheim and Freud (and vice versa), whilst on the organic side the arguments between Althaus and Arndt, and between Beard and Hammond, were even more ill tempered. Doctors have always found it easy to disagree about chronic fatigue.

After dissent came dismissal, as the personal scorn about which Beard and Mitchell so often complained became transferred to the patients themselves. Sir Andrew Clark (1886) called neurasthenics "always ailing, seldom ill" - whilst the "wealthy neurasthenic will be a useless, frivolous, noxious element of society" (Urquhart,1889). Charles Beevor (1898) joined Clifford Allbutt in reminding doctors that "on no account should the patient's symptoms be laughed at", but to little avail. At the Johns Hopkins Hospital "the neurasthenic patient is treated by physicians .... with ridicule or a contemptuous summing up of his case in the phrase "there is nothing the matter, he is only nervous" (Mitchell,J., 1908), views echoed in the popular press - "The majority of sufferers have better reason to complain of the weakening of their moral fibres than of either their mental or physical ones" (Anon, 1894). In the USA Jelliffe described them as "purely mental cases. Laziness, indifference, weakness

[10] See for example the reviews in the St Louis Clinical Record (1880; 7 : 92-94), American J Insanity (1880;36: 520-526), St Louis Clinical Record (1881; 8 :122-124), J Nervous Mental Dis (1881; 8 773-777), Medical Record (1881; 20 : 296-297), Boston Medical Surgical Journal (1881; 105: 162-163).

[11] La Psychotherapie chez les neurasthenique. L'encephale 1907: 2 : 266-267, and Pathogenie des etat neurasthenique. L'encephale 1908; 3: 525-531.

of mind and supersensitiveness characterise them all. They are .. ill because of lack of moral courage" (Jelliffe, 1905). Even those sympathetic to neurasthenics could not avoid a note of irritation and condescension. Patients were "the terror of the busy physician" (Rankin, 1903) "occupied by their symptoms beyond reason" (Blocq, 1894), going from physician to physician (even Beard called them "rounders") where they "write down their sensations in long memoranda which they hasten to read and to explain " (Blocq, 1894).

This dissent largely revolves around differing interpretations of the physical and psychological. The commonest dialectic in both neurasthenia and chronic fatigue syndrome is that these must be physical illnesses, not because of the evidence, which remains inconclusive, but because psychological illnesses are unreal, malingered or imaginary. This tendency of those committed to an exclusively organic view of such illnesses to juxtapose psychiatric and imaginary was criticised by both Dutil (1903) and Tinel (1941), both of whom also denied that neurasthenia was a "malade imaginaire". Drummond (1907) attacked with equal vigour those who viewed neurasthenia as a solely physical illness, and those who regarded it as a thinly veiled excuse for malingering. Neurasthenia provided a haven for those uncomfortable with the psychological aspects of illness, who either insist on its solely organic basis, or see it as a refuge for the mentally infirm. Similar themes can be identified in the modern literature of CFS (Wessely, 1994b). The passions that these arguments create is because what is at stake is the issue of legitimacy - what constitutes an acceptable disease, and what is legitimate suffering, deserving of support and sympathy?. It is each generation's answers to these questions that permit the survival of neurasthenia, and the survival of the disputes that inevitable accompany it.

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