American Handbook of Psychiatry

NEURASTHENIA AND HYPOCHONDRIASIS

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e-Book 2016 International Psychotherapy Institute

From *American Handbook of Psychiatry: Volume 3* Silvano Arieti

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Table of Contents

NEURASTHENIA AND HYPOCHONDRIASIS

Neurasthenia

Hypochondriasis

Current Etiological Concepts

Considerations of Social Psychiatry

Management and Therapy

Bibliography

NEURASTHENIA AND HYPOCHONDRIASIS

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Neurasthenia and hypochondriasis are descriptive concepts, dating back to an era when mental disorders were obscure, inexplicable phenomena whose origin was almost exclusively linked to non-psychological aspects. In the intervening years, the discrepancy has widened between the original terminology and our current understanding of neurasthenic and hypochondriacal manifestations. Today, the nosological boundaries of neurasthenia and hypochondriasis have become vague to the point of being more of a burden than a diagnostic help.

Optimally, psychiatric terms serve as sophisticated, professional working tools designed to aid in the task of providing information about the nature and the expected outcome of a particular mental disorder. They represent a coded language pertaining to difficulties in living with the capacity of evoking appropriate thoughts in skilled psychiatrists as to how best to deal with the prevailing situation therapeutically, as well as to offer an educated guess about the prognosis. In addition, the terms are essential for interprofessional communication, as well as for epidemiological considerations. It is mandatory to establish a working consensus about the proper usage of terms, lest one diagnostician's neurasthenia become another

diagnostician’s schizophrenia.

One can appreciate the significance of nosological concepts in realizing the powerful impact on psychiatric theory and practice when Eugen Bleuler rejected the fatalistic term *dementia praecox* in favor of the diagnostic category schizophrenia. In spite of Bleuler’s fundamentally organic point of view, the change of term opened the door to a broad exploration of schizophrenic disorders as a basically human condition, rather than an a priori organic defect. It paved the way for consideration of interpersonal, sociocultural, chemical, hereditary, and other components within the totality of human transactions.

Neurasthenia

When we come to the nosological classification of neurasthenia, we are confronted with a confusing picture. There is not even complete agreement in regard to the definition of the clinical syndrome. It is usually characterized by a wide variety of symptoms. Ordinarily, there are chronic feelings of weakness and fatigue, various aches and pains, as well as strange physical sensations. Insomnia and irritability may occur in conjunction with a feeling of more or less chronic distress in an organ or organic system of the body. Whereas some patients experience vague, general discomfort, others center their attention upon a particular organ. Any part of the body may be affected. However, there is a high percentage of gastrointestinal symptomatology. The clinician who is compelled to arrive at a psychiatric diagnosis does not have an easy task when confronted by a multitude of symptomatic manifestations.

When Freud dealt with the syndrome of neurasthenia, he considered the following symptoms to be characteristic: headache, spinal irritation, and dyspepsia with flatulence and constipation. In regard to hypochondriasis he said, “It is the form favored by true Neurasthenics when they fall victim to anxiety neurosis as they often do.”

In “An Attempt at Analysis of the Neurotic Constitution,” Adolf Meyer stated that the term “neurasthenia” should be reserved for the cases combining the symptoms of great exhaustibility and irritability, depending

largely on the mental attitude of lack of repose and of ready recoverability, frequent head pressures, palpitations and uneasiness of the heart, gastric disorders, phosphaturia and oxaluria, and in men especially, abnormality of sexual responsiveness. He went on to state:

> Frequently, associated with other traits of nervousness, we meet with hypochondriasis, usually built on a feeling of ill-health which leads to self-observation and explanations. These are apt to become the center of thought and interest, are elaborated, or the person merely is troubled with vain fears over trifles, consults quack literature, etc. On the whole, the impressions are apt to become dominating.

Neurasthenia means literally nervous debility or weakness. The notion of weakness of the nerves harks back to the nineteenth-century concepts of mental disorder.

Historically speaking, it is significant that earlier considerations in regard to the etiology of mental disorders did not distinguish between somatic aspects and metaphysical conceptualizations. This mode of thinking gave way to rationalistic and mechanistic models of mental disorders. Thus, in his *Elementa Medicina,* published in England in the eighteenth century, John Brown described the nervous system in terms of eighteenth-century mechanistic concepts, and postulated that “irritability” of the nervous system could cause mental illness. Following this theory, neurasthenia came into existence as a diagnostic syndrome that referred to a weakness or exhaustion of the nervous system. As such, neurasthenia was regarded as the forerunner

of all the more severe nervous disorders, e.g., hysteria, epilepsy, locomotor ataxia, general paralysis, etc.

The term "neurasthenia," to denote nervous exhaustion, was subsequently introduced into American psychiatry by George Miller Beard in 1869. Beard maintained that the nerves might "run down" as a result of overexertion or overwork. Thus, according to Beard's theory, the nerve cells operated in much the same way as a battery: When their supply of stored nutriment was depleted, they lost their natural "charge." As an outgrowth of this concept, S. Weir Mitchell developed his rest treatment which prescribed complete rest to cure "anemia of the brain."

The influence of George Miller Beard's hypothetical model is evident in Freud's early formulations concerning the etiology of neurosis. Freud believed that Beard's concept of neurasthenia was too inclusive, and proposed instead the broader classification of "actual neuroses," which would encompass three separate syndromes, namely, neurasthenia, anxiety neurosis, and hypochondriasis. (Hypochondriasis resulted when an anxiety neurosis was superimposed on neurasthenia.) At the same time, however, like Beard, he attributed these phenomena to physicochemical forces, rather than psychological factors. Thus, in Freud's first theory of anxiety, he distinguished between the etiological factors which produced anxiety in specific clinical entities: The psychoneuroses were psychogenic in origin whereas actual

neuroses had a physical basis. More specifically, in the actual neuroses, abnormal sexual practices prevented the adequate somatic discharge of chemical substances, or “toxins.” Concomitantly, there was an interference with the adequate discharge of the psychic component of sexual tension, which gave rise, in turn, to anxiety. In contrast, in the psychoneuroses, the abnormal sexual functioning which produced anxiety was due to psychic factors, specifically, to repression.

Subsequently, Freud recognized the psychological nature of anxiety and neurosis. Throughout his life, however, he continued to believe that psychical and physical processes were closely interrelated and that physical processes preceded psychological manifestations. Accordingly, Freud’s later theory of anxiety did not rule out the possibility that there was a direct somatic relationship between sexual conflicts and anxiety in certain neurotic conditions or, more accurately, that these conditions resulted from the toxic effect of dammed up sexual energy.

He also maintained that there was a potential link between actual and psychoneurosis, that the symptoms of an actual neurosis might precipitate psychoneurotic symptoms in many instances. And, in this connection, he postulated a possible relationship between neurasthenia and conversion hysteria on the one side, and between hypochondriasis and paranoia on the other. For example, initially, the pain which accompanies a

neurophysiological symptom, such as a headache, is “real”; that is, it is somatic in origin and due to sexual “toxins.” This actual physiological disturbance may then become a future source of focal irritation which might serve as the basis for psychoneurotic symptom formation. Freud further postulated that hypochondriasis represents a withdrawal of interest or libido from objects in the outside world; instead, the libido formerly connected with the ideas of objects now intensified all ideas concerning body organs. In paranoia, too, an organ becomes the representative of an external object, as a result of narcissistic regression. Thus, Freud hypothesized that hypochondria is the somatic basis of paranoia, just as the anxiety neurosis, that is, a continual readiness to “explode,” is the somatic basis of hysteria.

Freud’s theoretical foundation for the relationship between the conditions mentioned above is to be found in his concept of narcissism. He distinguished between ego libido and object libido. The former is a withdrawal of interest from object relations and runs counter to the capacity of gaining genuine satisfaction. Freud stated in “On Narcissism:”

> The relation of hypochondria to paraphrenia is similar to that of the other actual neuroses to hysteria and the obsessional neurosis: which is as much as to say that it is dependent on the ego-libido . . . and that hypochondriacal anxiety, emanating from the ego-libido, is the counterpart of neurotic anxiety.

Since Bleuler’s day, there has been an increasing awareness of the

clinical observation that neurasthenia and hypochondriasis may serve as a mask for severe mental illness. Both symptoms occur frequently as precursors of depressions, schizophrenic states, obsessions, and hysteria. In other situations, hypochondriasis and neurasthenia serve as a displacement for a wide variety of difficulties of living, as well as indicating the existence of miscarriages in human relations.

In regard to hypochondriasis, Bleuler stated categorically that "we do not know a disease hypochondriasis." He found the occurrence of hypochondriacal phenomena in schizophrenia, depressive states, in neurasthenia, in early organic psychosis, and in all forms of psychopathy.

A glance at our present psychiatric textbooks does not add much to the picture. Henderson and Gillespie contribute little to our knowledge of neurasthenic and hypochondriacal conditions. They allude to heredity, constitution, autointoxication, and prolonged emotional disturbances as major etiological factors. Noyes is dissatisfied with the term "neurasthenia" which he attributes to deep-lying personal maladjustment. Hypochondriasis is, in his opinion, an organ neurosis. Masserman speaks of neurasthenia as an exhaustive-regressive state, which he believes to be due to unrecognized, cumulative, internal tensions. Harry Stack Sullivan states that, as a student of personality, he finds no virtue in the conception of neurasthenia. From a psychiatric viewpoint, chronic fatigue and preoccupation with fancied

disorders which cannot be explained on an organic basis form merely a panoply, obscuring the nature of various interpersonal events. Although Sullivan rejected the concept of neurasthenia, he referred to certain interpersonal phenomena related to this syndrome. In particular, he described somnolent detachment, apathy, and lethargy in this connection.

The appearance of psychogenetic fatigue assumes special significance in regard to the concept of hostile integration. This phenomenon is akin to a sadomasochistic transaction in which both partners relate to each other’s insecurities, rather than to their respective strengths. The integration centers on the mutual capacity to evoke anxieties in the other person and markedly lowers their respective feelings of self-esteem. In a hostile integration, neither party can give encouragement, comfort, or support. A hostile integration is a mutual dependency on undermining each other. The result is frequently a manifestation of security operations, ranging from “not feeling well” to “feeling excessively tired,” “fatigued,” and what have you, as a mask for the malevolent interpersonal atmosphere.

In addition, we have a host of protective devices which are designed to attenuate tension and lower the threshold of painful awareness. Here we encounter the phenomena of apathy, lethargy, and somnolent detachment. Each of the above mentioned manifestations occurs in the face of inescapable and protracted severe anxiety. The result is a decrease in vulnerability to

profound interpersonal stress and strain. In apathy and lethargy, the person is out of touch with his most elementary needs after a state of severe frustration. In other words, fatigue is a complex phenomenon with many different faces. It may reflect a variety of interpersonal malintegrations in which both partners tend to undermine each other's basic security.

From a historical viewpoint, it seems appropriate to include Janet in a discussion of neurasthenia and hypochondriasis. He introduced the term "psychasthenia" in denoting practically all neurotic manifestations which he did not group as those of hysteria. Janet described neurasthenia as a prolonged state of fatigue, without somatic basis. He postulated the notion that neurasthenia was due to a psychic depression in which there is a general depletion of mental energy and a lowering of mental tension.

Hypochondriasis

In its general usage, hypochondriasis or hypochondria denotes the subjective preoccupation with suffering a serious physical illness which cannot be verified objectively on a physiological or organic basis. Hypochondriasis refers also to a chronic tendency of being morbidly concerned about one's health and of dramatically exaggerating trifling symptoms, as if they were a dreaded disease. The name "hypochondriasis" stems from a topographic, anatomical point of view. It was once thought that the soft part of the abdomen below the ribs and above the navel was the seat of the disorder.

In regard to hypochondriasis, Freud was greatly dissatisfied with the obscurity of the concept. He complained to Ferenczi about it in a letter dated March 18, 1912. Freud formulated hypochondriasis as a withdrawal of interest and libido from the objects in the outer world. The relatedness of certain hypochondriacal symptoms to schizophrenia was recognized early. Freud thought that hypochondriasis has the same relation to paranoia as anxiety neurosis has to hysteria.

The concepts of neurasthenia and hypochondriasis have remained relatively unchanged in analytic literature. Fenichel gave a lucid description of these syndromes but stuck closely to the economic concept of libido theory. He affirmed that many an actual neurosis required only adequate sexual

outlets. It is interesting that he recognized alterations in the muscular attitudes of people with neurasthenia. He appreciated the inability of such people to concentrate, because they are unconsciously preoccupied with defensive activities. He pointed to the impoverished life activities leading to restriction of the personality, etc. There were many other important insights offered by him, including the appearance of apathy against aggressiveness. However, he still considered an improved sexual technique to be an adequate treatment in some of these patients. The fact that a change in sexual pattern indicates a reorientation in the total personality was not mentioned.

As far as hypochondriasis is concerned, Fenichel saw it primarily as a transitional state between reactions of a hysterical character and those of a delusional, clearly psychotic one.

Regardless of how misleading the terms may be, the fact remains that neurasthenic and hypochondriacal manifestations are almost ubiquitous in all types of psychiatric practice. Furthermore, the phenomena associated with these concepts are widely represented in our culture, without being given much psychopathological significance. Feeling excessively tired, as well as being deeply concerned about one’s health, are relatively conjunctive aspects of our social pattern.

Many people feel righteous about being entitled to a reactive state of

weariness as a result of labor and exertion. For instance, it is considered quite respectable for a professional person to feel worn out at the end of the day; for the housewife and mother to be exhausted from her many chores; for the businessman, after a day of pressure at the office, to be very tired. On the other hand, we can frequently observe how certain interpersonal aspects can aggravate the fatigue markedly, whereas others can make the person forget how tired he is. I am not talking here about occasional states of overwork, etc. What matters is the recurrent nature of the syndrome—a state of affairs where feeling exhausted forms a more or less consistent pattern. As far as the reaction of the environment is concerned, it ordinarily does not seem to be practical or in good taste to quarrel with people's justification for being tired, regardless of the circumstances. Furthermore, it is to be understood that special allowances are to be made for the person who is afflicted by debility and potential ill health. The victims of neurasthenic and hypochondriacal symptoms can always claim that they wish it were otherwise, but they just can't help feeling the way they do. Obviously, the more absorbed a person is with his mysterious predicament, the less available is he for personal relatedness to others. The "I don't feel myself" preoccupation impoverishes the nature of all other communication and insulates the person from more direct contact with the environment.

Despite this obvious dilemma, the nature of the insulation is such that it still permits a tenuous relatedness to others at a time when more meaningful

contact might not be possible. As long as at least one marginally structured channel of communication is preserved, this may suffice to prevent a disintegration of the personality.

Another significant aspect is demonstrated by the fact that almost every practicing psychiatrist has seen patients who seemingly feel tremendous relief when a “real” organic villain is found. The patient who gets X-ray evidence of duodenal ulceration, kidney stones, herniated disk, etc., may be almost pleased. The point is that he has something which he considers to be beyond his personal control. It exonerates him from a peculiar kind of blame by himself or others. Such people often are hounded with the illusion of imaginary ailments. They frequently believe that they can turn symptoms on or off at will, if there is no specific organicity involved. Everything is done to conceal from themselves and others long-standing, unhappy life experiences involving the total personality. The compulsion to negate personal misfortunes is so great that some of these patients readily submit to a surgeon’s knife, painful treatments, prolonged use of medication, etc., in situations that therapeutically do not demand drastic steps.

Here is a situation illustrative of the point made. I saw a sensitive and troubled woman patient in her late thirties who had suffered a transient psychotic episode. Part of this profound upheaval was triggered off by her belated awareness that her husband had much in common with an older

sibling of hers whom she despised. On the surface, it all started with an attack of acute abdominal distress. She was admitted to a general hospital and kept for ten days' observation. There was some idea of a gall bladder disorder. The findings, however, were inconclusive, and she was told that she was severely run down. From the time she returned home, things went from bad to worse. Finally, she accused her husband of having poisoned her food, and of similar uncharitable acts. The situation deteriorated to the point where he felt compelled to institutionalize her. Her hospitalization was relatively short. During her illness, it was brought home to her that she owed deep gratitude to her husband's kindness and thoughtfulness. It turned out later that she had never faltered in her conviction that the mental hospital had been a punitive act on his part. At a later point, when my patient had made major strides toward recovery, her husband began to ail. He had always been known as a hypochondriacal person who suffered from headaches, backaches, gastric ulcers, and neuralgias. Suddenly, he developed an excruciating back pain, which his wife suspected to be psychogenic in nature. Despite her urging, he refused to consult a psychiatrist. After several weeks of acute misery, he had an orthopedic surgeon operate on him for a dislocated *nucleus pulposus.* The result of the surgical intervention was miraculous. Now the dragon's tooth which had been bothering him for years had been extracted. His relief was so great that he did not even complain about having to maintain prolonged sexual abstinence. My patient was not unduly affected by this restriction. It

soon came out that there had been no sexual relations for more than two years prior to the operation. When my patient became fleetingly interested in sex again, her husband's physical symptoms reappeared temporarily.

As the history unfolded in therapy, several aspects in the situation became clearer. In the past, my patient had experienced several spells of depression and ill health, which usually coincided with her husband's feeling on top of the world. There were times when my patient had been highly successful, and her devoted husband almost invariably came down with a physical illness. Furthermore, it became clear that my patient's feelings of wellbeing were usually enhanced by feeling needed. This seesaw pattern had been familiar to the patient within the setting of her own family. In their later years, both of her parents had taken turns in feeling down in the dumps. At such times, the low-ebb marital partner was taken to a shock therapist by the solicitous spouse. As a matter of fact, there had been a similar interplay between the patient and her oldest brother. She always came to his help when he was physically ill or in a jam. Once he was well again, she felt all worn out. He would, however, always make her feel she had not done enough for him. On the whole, he led a glamorous life and had always been his parents' favorite. Anyhow, certain aspects of the hostile integration between the siblings had found their way into the marriage. We can see, then, a highly intricate and morbid interplay in a family setting, where alternating hypochondriasis and neurasthenia occur. By the time the husband seemingly

blew a spinal fuse, a serious crisis had occurred which threatened to break up the old, familiar pattern. The surgical removal of the man's emotionally exaggerated pain served as a *deus ex machina.* An obvious villain for much obscure difficulty in living had been found. Everybody could point to the tangible intervention and the resulting success. One might add sadly that the patient's psychosis had almost been suffered in vain. Nobody talked, however, of mutual suspicions, resentment, power struggles, and humiliations. A cause had been found that could be reactivated if necessary, but which was placed outside of psychological boundaries.

So far, the terms "neurasthenia" and "hypochondriasis" have been used separately. It is not always easy to draw a line of demarcation between these two conditions. However, when we follow the respective roles these two concepts have played in the evolution of psychiatric theory and practice, the situation is somewhat different.

As pointed out previously, the notion of fatigue and overwork as a cause for mental disorders was prevalent at one time. With the advent of psychoanalysis, the etiological focus shifted to the area of sexual behavior. In regard to neurasthenia, Freud wrote that "it arises whenever a less adequate relief takes the place of the adequate one, thus, when masturbation or spontaneous emission replaces normal sexual intercourse." Freud thought that every neurosis has a sexual etiology. However, he postulated a major

difference between the actual neuroses and the psychoneuroses. The former group of disorders has its origin in the here-and-now, while the psychoneurotic conditions relate back to traumatic experiences in infancy. Finally, Freud also contended that the actual neuroses (i.e., neurasthenia, hypochondriasis, and anxiety neurosis) frequently functioned as a focus for neurotic symptom formation.

Bleuler, too, rejected Beard's hypothesis that exhaustion of the nervous system caused neurasthenia. On the contrary, he believed that work was beneficial, and he noted that individuals who work hard seldom fall victim to neurasthenia. Bleuler also noted that neurasthenia was frequently a precursor of schizophrenia.

Current Etiological Concepts

Brenner summed up the situation as follows: ". . . the category of the actual neuroses has ceased to be a significant part of psychoanalytic nosology." The same author, in collaboration with Arlow, expressed renewed interest in hypochondriasis, which is the third of the actual neuroses. According to Brenner and Arlow, ". . . hypochondriacal impulses are not properly explainable as the result of libidinal regressions and displacement . . . they are more satisfactorily explained in terms of the conceptual framework of the structural theory, with its emphasis on anxiety, conflict and defense." Otherwise, current psychoanalytic literature has largely ignored the actual neuroses, in spite of the great interest in ego psychology with its emphasis on reality factors. For the most part, references to neurasthenia and hypochondriasis in the current literature do not extend beyond the description of these conditions. Concomitantly, when they are included, discussions of etiology are usually limited to a brief allusion to heredity, constitution, autointoxication, and prolonged emotional disturbances as major etiological factors. There has also been a growing dissatisfaction with outmoded terminology in recent years. Noyes, for one, has taken issue with the concept that neurasthenia represents an exhaustion of the nervous system. Rather, he believes that, invariably, neurasthenia is due to personal maladjustment. On another level, Masserman has described neurasthenia as an exhaustive-regressive state, due to unconscious, cumulative, internal

tensions.

Harry Stack Sullivan’s concern with the etiology of neurasthenia and hypochondriasis reflected his interest in the reformulation of psychiatric syndromes in interpersonal terms. To begin with, he contended that the diagnosis should pertain to an ongoing process which would be considered indicative of the way in which personal situations have become integrated in more or less durable patterns. The integration has its roots in significant interpersonal constellations of the past, as well as of the present. Furthermore, personal encounters in the immediate future are an integral part of the situation, for past and present events tend to determine future experiences. Viewed from this perspective, Sullivan could find no virtue in the diagnosis of neurasthenia as a one-dimensional, somatic concept which made no reference to maladjustments in patterns of living. He postulated, instead, that certain factors, such as deficiency states, malnutrition, and chronic intoxication, might produce neurasthenic symptoms that were purely physiological in origin. On the other hand, psychiatric or interpersonal phenomena might produce symptoms, such as fatigue, apathy, and somnolent detachment, which resembled neurasthenia to some degree. Apathy and somnolent detachment were conceived of as protective operations against a lowering of self-esteem. More specifically, by taking refuge in sudden, overwhelming sleepiness, the individual withdraws from a tension-producing situation and is no longer vulnerable to feelings of inadequacy, worthlessness,

or hostility. In apathy, all the individual’s responses become less intense as a reaction to severe frustration.

Sullivan viewed hypochondriasis as a particular kind of security operation. The self-esteem of the hypochondriac has been organized in such a fashion that bodily phenomena are given a great deal of highly pessimistic attention. For the hypochondriac, an intense, morbid preoccupation with his body serves as a distraction from a stressful interpersonal situation. And, concurrently, the recognition of anxiety is minimized or avoided. The hypochondriacal person has difficulty in achieving any genuine satisfaction, because he is constantly haunted by the shadow of impending doom. Hypochondriasis is further characterized by an implicit symbolism which is body-centered and reflects a regression of cognition. It is this regression of the cognitive operations that links the hypochondriacal thought processes to certain schizophrenic thought processes. Sullivan formulated his ideas on the subject as follows:

> It is as if the hypochondriacal patient had abandoned the field of interpersonal relations as a source of security, excepting in one particular. He has to communicate data as to his symptoms; the illness, so to speak, becomes the presenting aspect of his personality.

It was also Sullivan’s opinion that, in all likelihood, paranoid, algolagnic, hypochondriacal, depressive, and obsessional states were different manifestations of the same maladjustive processes. He observed that in many

patients there was a blending of these conditions and an alternation between one state and another.

Another etiological basis for neurasthenic and hypochondriacal preoccupations may be the existence of unexpressed anger, which leads to concealed resentment. This concept has been stressed in particular by Rado, who believes that hypochondriasis serves to obscure the feelings of repressed rage and hurt pride.

Finally, symbolic feelings of rejection and worthlessness may be communicated in characteristic patterns of nonverbal and verbal communication. For example, Weinstein pointed out that the statement “I am tired” results from a complex interpersonal transaction that expresses a particular relationship to the environment. Similarly, a hypochondriacal preoccupation may be understood as a symbolic expression of feeling disliked, not approved of, and isolated from other people.

It has proved helpful to study human personalities on the basis of mutual activities in a field. By stressing the operational aspects, our interest has turned toward how people affect each other and what impact the social and cultural setting has upon them. This has largely taken the place of being predominantly preoccupied with intrinsic factors. There has been less need to think in terms of strict causality alone. Today, it does not suffice to diagnose

an organic disorder or rule out overt somatic involvement. Even in the predominantly organic disorder there are involved some sociocultural as well as some interpersonal components. The individual and his environment are an interdependent system at all times. Any effort to isolate one or the other produces major artifacts. Every disorder tells something about the persona in terms of specific life experiences. It points to potential vulnerabilities or sensitivities in the total life history. The area which is of interest to the psychiatrist is always of a strictly personal nature. It has to do with personalistic, experiential data which can become communicable in increasingly more meaningful terms.

When we encounter neurasthenic and hypochondriacal manifestations in our patients, we have to think largely in terms of symbol processes. They tell something about what the patient thinks of himself and of his personal world in his communal existence. There has been increasing interest in denial of illness and bodily feelings in general. The nature of people's self-image ("I and my body," visual, tactile, auditory modes of perception) is a wide-open field for study. As a conceptual scheme, the notion of a nexus (as used by Whitehead), a central relay station where all sorts of things get together, is a fascinating concept.

The clinical study of neurasthenia and hypochondriasis brings another consideration to mind. It is as if the person were attempting to cling to some

reality when the world seems in danger of slipping away. There seems to be a focusing on that which is closest as a means of warding off interpersonal tension or losing oneself. Much of the bodily preoccupation has the appearance of a miscarried effort at finding oneself. The more intrapersonal fear is experienced, the less attention will be paid to interpersonal difficulties. Some of the symptoms found in neurasthenia and hypochondriasis can best be understood in terms of the patient's role in his family constellation, in addition to sociocultural and other factors. It is of interest that certain somatic preoccupations are widely fostered in our cultures. The interest in weight for reasons of health is highly acceptable. To climb on a bathroom scale twice a day is not an unusual occurrence in the American family. For women, the intense interest in the surface measurements and contours of legs, breasts, waist, etc., is encouraged; the way eyelashes are curled, hair-dos are fussed about—all these are deeply rooted in the culture. For this reason, it may be more difficult to detect severe personality disorders in women where there is a camouflage of socially acceptable preoccupations. Some people are aspirin, laxative, patent-medicine, or Christian Science addicts. It may be possible to get by on this basis without showing overt symptoms of hypochondriasis or neurasthenia.

There has been an increasing awareness of the interdependence of environmental factors and personal, adaptational aspects in the continuum of an individual's life space. We have a great number of variables to consider,

and the conceptualization of static units closes the door to meaningful new insights.

We have long been aware that fashions are not confined to the outer wrappings of people, but that neurosis and psychosis, in all their diversity, have something of “a latest look” of their own. The modern way of life in our fast-changing culture will undoubtedly produce relatively novel aspects of human aberrations which are not yet in vogue. It is that much more remarkable how durable the phenomena called neurasthenia and hypochondriasis have remained.

Considerations of Social Psychiatry

We still have a great deal to learn about the intricate relationship between culture and symptomatology. However, several pilot studies by social psychologists and allied scientists have thrown light on possible connections between the Gestalt of psychopathological phenomena and cultural determinants. Epidemiological investigations have been used to focus attention on the occurrence of certain psychiatric manifestations in various cultural and social settings. Much interest has been shown in the part that the traditions of an ethnic group, sex, age, level of social achievement, etc., play in the particular shape and form of mental illness. There has also been increasing understanding of the degree to which the definition of mental disorder constitutes a social phenomenon.

Opler has alluded to how certain ethnic groups tend more toward some symptoms than do others. For instance, he points to the difference in attitude toward illness of Italians and "Yankees." Then we have the New Haven study by Hollingshead and Redlich. This study is limited to people under psychiatric treatment and, accordingly, is not a study of the community at large. It stresses the influence of social and cultural conditions on the development of sundry deviations in behavior. Particular interest is shown in the impact of different class levels of a given society on the type of disorder which can be observed. In the New Haven study the percentage of patients who tended

toward somatizing their complaints was highest among the lowest two classes in the group studied. These two groups consisted mainly of the people whose educational and economic level was at the bottom of the scale. Although the tendency toward somatization is not synonymous with the existence of neurasthenia and hypochondriasis, it seems to be a factor worthy of consideration.

In private psychoanalytic office practice, where patients from middle- and upper-middle-class groups are prevalent, I have encountered a fairly large number of hypochondriacal patients. However, the great majority of these patients suffered from recurrent episodes of preoccupation with their health. There were some patients in whom the symptoms of concern over ill health were more or less constant. These people invariably showed severe pathology and were very slow as far as speed of recovery is concerned. Despite grave distortions in the personality, these patients usually did not create an impenetrable wall by means of their somatic complaints. Similar observations were made in supervising the work of some of my colleagues.

The situation was quite different in consultation work in a community clinic located in a low-income borough of Greater New York. There the incidence of somatic preoccupation as a primary complaint was much higher. In several instances, it seemed most difficult to get beyond the level of neurasthenic and hypochondriacal preoccupation. Many of these patients had

been referred by general practitioners who prescribed psychiatric treatment. Not infrequently, the patient insisted on side-stepping any interpersonal complications and expected to be magically liberated from physical distress.

Anna Freud found that hypochondriasis occurred only rarely in children, unless they were motherless and had been institutionalized. On the other hand, precursors of neurasthenia and hypochondriasis, in the form of “growing pains,” fatigue, and sleep disturbances, are fairly common in children.

Management and Therapy

Earlier reference was made to the frequent occurrence of neurasthenia and hypochondriasis in psychiatric and medical practice, as well as in the culture in general. In some communities, patients with this symptomatology constitute a large number of referrals to the psychiatrists. Others go around and change physicians frequently, or they become more or less permanent fixtures in a doctor's practice. Some of these patients show up in a psychiatrist's office with the challenge, "I have tried everything else, this is my last resort!" The urgent question arises as to what to do with these patients. Should they all be analyzed or tranquilized? Would it be in their best interest to receive mild reassurance by the medical practitioner, or would they do better with expert psychiatric help? Is it helpful to distract them, help them change their environment if possible, stimulate other interests, etc.?

I need not state specifically here that it is not possible to devise one formula for all cases. The management or method of therapy depends on a multitude of factors.

Generally speaking, I have not found tranquilizers given in moderate amounts to be very helpful. Most patients today have tried one kind or another by the time they come to the psychiatrist's attention. It seems that relief is usually not adequate or lasting. There is undeniable merit, however, in having the psychiatrist attempt chemotherapy that does not make the

patient unduly drowsy. (Great care must be taken not to offer the medication as a miracle pill.) I am opposed to all forms of shock treatments in these conditions. In hospital, clinic, and private work, I have seen no indication of even minor improvement in hypochondriasis and neurasthenia as a result of various shock methods. On the other hand, I have encountered distinct difficulties in psychiatric and psychoanalytic treatment with patients who had undergone this procedure. Every neurasthenic and hypochondriacal patient requires individual consideration. In a somewhat schematic evaluation, we might distinguish between the following possibilities: Neurasthenia and hypochondriasis may occur in connection with structural visceral changes. Regardless of whether the organic or the psychic malfunction comes first, by the time there is a demonstrable pre-organic or organic situation, we do not have a primary psychiatric problem at hand.

Occasionally there can be considerable relief, or even cure, as a result of straight medical treatment. In a great many people, however, there is a concomitant disturbance of the personality. This may require attention in its own right.

We may find neurasthenic and hypochondriacal phenomena in conjunction with character disorders, neurotic difficulties, etc. Here we have a different situation. Not all patients have the motivation to change; not all patients have the opportunity to rearrange their lives. There are people who

would have to undergo tremendous changes of the personality. Their pattern of relating to others would have to be grossly modified if they were to become less neurasthenic and less hypochondriacal. The decision as to whether the patient is amenable to treatment should be left to highly experienced psychiatrists. Doubtful cases should be worked up carefully, including projective psychological tests, whenever possible. There is grave responsibility involved in arriving at a thoughtful and adequate conclusion.

Some patients can be found to be preschizophrenic; others to be full-blown schizophrenics, some with delusional ideation. The latter group frequently is markedly paranoid, and some offer a poor prognosis. Among the preschizophrenic or schizophrenic patients (without a fixed delusional system), treatment by a highly skilled analyst in office practice may be successful. Occasionally, a patient has to be hospitalized if all communication is broken off as a result of suicidal tendencies, preternatural preoccupations with somatic symptoms etc.

We may also encounter people with neurasthenic and hypochondriacal complaints who develop the characteristic symptoms after experiencing an acute existential predicament, that is, a state of affairs where professional, marital, or other difficulties have been prominent. Once the crisis is over, these people are apt to suffer from neurasthenic and hypochondriacal symptoms. In other words, it can be observed that pressing reality problems

are capable of obscuring the existence of neurasthenia and hypochondriasis. At the end of an emergency situation, we may find a flare-up of difficulties, which had been at times sub-clinical until then.

Some people are prone to have a chain reaction of highly unfortunate life experience. Once the external pressures subside and life seems to offer more satisfaction and happiness, that is the time when long-standing personal insecurities come to the fore. As long as there is a powerful distraction by more or less constant, external misfortunes, there is less opportunity for coming in contact with unfortunate aspects of the person's self-image. The low self-esteem inculcated early in childhood was always there, but the patient did not suspect his grave personal vulnerabilities and hypersensitivities until actual living conditions became much more promising.

We have to appreciate that there can be actual, current conflicts largely beyond the individual's control. People cannot be expected to undergo excessive stress and strain without showing some after-effects. It should be kept in mind, however, that many situational factors have to be understood in terms of people's character patterns. The vicissitudes of life which call for change of environment, if possible, for less strenuous activity, more rest, and other managerial rearrangements, etc., are not in the realm of psychiatric practice. More often, history tends to repeat itself, and personal difficulties

have to be analyzed, so that there will not be just a shift of symptoms.

I should like to add here that some people in our culture are bored, find their living conditions dull, and entertain themselves with interesting physical symptoms. To some of these patients the psychiatrist has little or nothing to offer. They often go on and on, without improving or deteriorating much.

It should also be emphasized that the distinction between so-called real and so-called imaginary illness is unfortunate. All symptoms are real, whether or not our methods are adequate in explaining them. We seldom find hypochondriasis and neurasthenia among people who are just plain fakers. Whatever a person feels is based on some perception and some experience. We do not have the right to suggest figments of the mind, precisely because our over-all understanding of the nature of the complaint may be lacking. The assumption that a complaint without demonstrable organic basis is a senseless complaint needs to be dispelled.

In considering therapeutic intervention, we need to keep in mind that neurasthenic and hypochondriacal manifestations are usually a mask for basic personality problems. It is doubtful that the formation of either syndrome is connected with any standard set of circumstances responsible for the syndrome’s existence. There seem to be variable traumatic events

which manifest themselves in more or less circumscribed patterns. As is common with syndromes and symptoms in medicine and in psychiatry, they cannot ordinarily be cured as such. In psychiatry, the elucidation of particular, personal life experiences is a highly skillful and time-consuming procedure. When Mr. Jones complains of always feeling tired, and Mrs. Smith of never enjoying good health, we must assume that common-sense approaches have been tried in most instances. Patients should not be expected to waste good money and time just to be told the obvious. It is not advantageous to be told that the trouble is in the head and not in the body. We have to realize that patients frequently cannot hear us when they are highly defensive about the nature of their actual difficulty. Standard clichés of our common language are often sterile channels, precluding mutually meaningful understanding. The patient who says "fatigue" and the psychiatrist who hears "neurotic syndrome" obviously are not talking in the same tongue. Any attempt to exchange the word "fatigue" for "neurosis," or vice versa, will do nothing to improve communication. As long as there is no common meeting ground, it does not even matter whether the patient nods his head in approval, or shakes it in disbelief.

In discussing therapy, I object strongly to any kind of do-it-yourself manual in psychiatry. At the same time, I recognize the necessity for formulating technical procedure. It seems to me that illustrations are best offered in terms of a particular approach without creating a model for direct

imitation.

Suppose Mrs. Smith consults you with the following story: She has been to many medical doctors for pain around her heart, headaches, backaches, and thyroid trouble; she had been treated for gastric ulcers, but she has always feared it might be cancer. Nobody so far had been able to help her. A chiropractor offers her occasional relief, but it is never for very long. Her family physician has prescribed tranquilizers and barbiturates, but they do absolutely nothing for her. Another physician had recommended a different medication, which helped only in the very beginning. Finally, she had come to see a psychiatrist. She repeats her complaints to him, but the quality of her voice is such that she sounds as if she did not actually expect to be believed. After taking in her recital, with an occasional query here and there, the psychiatrist deliberately changes the focus of the interview. He comments something to the effect, “I hear that you have not been well for some time. Suppose you tell me how it all started.” If there is a more or less definable starting point, he may go on to inquire what life was like at that time. Was fate smiling, or were there hardships or misfortunes? If all goes well, interest may be stimulated in relating experiences of stress and strain of a familial, social, economic, or other nature. The emphasis is not on a single traumatizing event, but on repeated experiences of unhappiness, friction, disappointment, etc. Then, a brief glance is attempted into the past, with such nonthreatening questions as, “How happy a childhood did you have?” If you get a rigidly

defensive answer, then, "I suppose there were at least some fleeting moments of unhappiness, as we find in the life of all children?" Should all answers point to a Hollywood Class C movie with a happy ending, it would be appropriate to say so.

Anyhow, the attempt is made from all directions to get the patient interested in talking about herself in areas which present potential difficulties in living. You may find that you have gently and skillfully helped point to the way in which the patient may eventually find help. Almost invariably, however, such a patient will counter with some sundry version of, "That is all very well and very interesting, but how about my various ailments?" Then it seems appropriate to explain that psychiatrists do not know how to cure tangible or intangible physical disorders as such. They do know, however, something about frustrations, tensions, and anxieties. It is often possible to get a new slant on what gets in a person's way. There can be no promise of the disappearance of the physical symptoms, but it has been found that in some instances discomfort has been greatly reduced when certain difficulties in living were better understood. Under no circumstances can we afford to have the patient sit back while the psychiatrist is expected to do his stuff and melt the patient's complaints away. If there is to be any measure of success, the principle of collaboration has to be stressed from the very beginning.

It is most important that we do not offer things to patients which we

cannot deliver. The reassurance is much more profound when it is made clear that direct verbal communication may lead to a better understanding of one's life situation, but that one cannot assume that bodily complaints will fall by the wayside as soon as insight is gained. The psychiatric facts are often otherwise, and it is our duty to inform our patients honestly and knowledgeably.

I wish to emphasize the fact that successful intervention related to neurasthenic and hypochondriacal manifestations does not necessarily mean a cessation of symptoms. Some people may have acquired a style of life which includes a measure of neurasthenic or hypochondriacal preoccupation. What matters is the capacity not to be unduly distracted by the familiar manifestations, which now assume a peripheral significance, without interfering with constructive aspects of person-to-person relatedness. It is understood, that the ability to sense one's own, as well as one's partner's, feelings of inadequacy provides a more effective protection against an ongoing hostile integration.

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