A Lecture
ON
THE MENTAL ORIGIN OF NEURASTHENIA
AND ITS BEARING ON TREATMENT.
DELIVERED AT THE POLYTUNIC, LONDON.
BY DAVID DRUMMOND, M.A., M.D.,
SENIOR PHYSICIAN, ROYAL VICTORIA INFIRMARY, NEWCASTLE-ON-TYNE.

My object in addressing you on the subject selected for to-night's lecture is, if possible, to convince you that neurasthenia is essentially a disorder of the mind, and that it can only be treated successfully when this fact has been recognized.

My time is short, and you are all so familiar with the symptomsology of neurasthenia that I feel it will be unnecessary to describe the condition, but will proceed at once to the view of its origin that I wish to lay before you.

What you will ask, is the evidence that the origin of this chameleon disorder—which is at present at once the backbone and bugbear of general practice—is mental? For I need scarcely remind you that there are some who regard bodily troubles as primary causes. It is clearly of the utmost importance to recognize the cause of the neurasthenic condition, and close inquiry furnishes full evidence that it arises from morbid mental states.

ETIOLOGY.
The first fact I would point to is that in neurasthenia the mental symptoms are without pathological basis (in any individual case this must, of course, be ascertained by careful physical examination). To the patient the symptoms are as real as though some physical lesion existed, and yet the description given of them is so lifelike as to deceive the doctor, who, fearful of being in the wrong, anxious to safeguard his reputation, and destrous of keeping his patient, will, even in cases of considerable doubt, accept the patient's lead, hedge over the diagnosis, and thus with disastrous results confirm the impression that some serious disease exists. The responsibility of the medical attendant in these circumstances is truly great, but to this point I shall return. In some cases the digestive organs are marked out by the patient as the seat of disturbance, or it may be the heart, or the genito-urinary system. What determines the bias of a patient's mind towards a definite organ is seldom of much moment; in some cases it is no doubt a functional derangement of the organ that in the first instance attracts attention, or it may be a hereditary tendency, an incisive professional opinion suggesting, for example, uterine displacement, or kidney morbidty, or weak heart. However, the causes of the real physical symptoms are usually as unimportant as the bias the doctor's aid is sought there little or nothing to combat but the mental state.
The next clinical fact of great importance is to be sought in the mental history of the patient, both family and personal. It may be assumed that with rare exceptions an established nervous temperament has been inherited, though a practical difficulty is often placed in the way of ascertaining this fact through the repugnance on the part of the patient and friends to admitting a family history. It is a real misfortune that most people should confound nervousness with hypochondriacism—apohneaseness—and are likely to resent an inquiry into their mental history lest a charge of cowardice should be established. Most unfortunately there is no word in the language that would be understood by patient, friends, and doctor alike to convey the true significance of the term "nervous." The truth is that a highly-organized nervous system is a most valuable equipment in life; it enables the possessor to be and to do as well as to suffer. But just as you can get a purer tone and more exquisite music out of a fine violin than from a common one, so when injured or badly handled its dissonance is only to be more excessive of the matter is not generally understood; even educated people fail to grasp the difference between the nervous temperament and the state of being easily frightened, and when you begin to make inquiries as to mental antecedents they will fence the question and endeavour to persuade you that there was nothing nervous about them until a certain illness— influenza, for example, or mental shock—developed the disorder. This is easily accounted for, in the mental origin of the neurasthenic disorder; in practice what it points to is the fact that serious dangers threatening the patient have threatened the personal temperament, for whom, therefore, special safeguards in home surroundings and personal habits ought to be observed, just as those who inherit a tendency to tuberculous mischief must observe careful precautions in their surroundings and manner of life if they are to escape harm.

But after all, the player on the violin is the patient himself, and it is with the individual patient that we have to deal. Even when there is an unmistakable family history of nervous disorders, with possibly a case or two of insanity, the patient in early life may exhibit no nervous symptoms. Deviation from the normal may be more than a certain lack of self-confidence. Sooner or later, however, there is shown a tendency to attach undue importance to matters that affect the personal feelings, and this becomes the dominant feature of the neurasthenia. The patient becomes hypersensitive, and gradually surrenders control of his thoughts at will; instead of choosing a line of thought and concentrating upon it, he is dominated by some personal matter, broods over some real or fancied trouble, allowing it to engross attention to the exclusion of all other matters of interest. The habit of indulging in introspection grows upon him, and from being a useful and wholesome practice in the main as exercised by a healthy, well-balanced mind, it becomes a source of danger when it deflects control, and then perverts, hampers, and other hand, a mental weakness. If the neurasthenic is conscious of a struggle to maintain his interest in affairs outside his own personal life, by an effort he can do so, and to this end he is helped by continuing at work, which, even though it be unengaging, serves to distract his attention from himself. Later on he fails to make the effort, or some illness or shock breaks down what little control he still possessed, and so the natural inclination to introspection and self-absorption becomes more self-centred and dissonant, and loses the power of forming an intelligent judgement upon matters that relate to his health. In some cases a certain unimportance is以便性 consequence on giving way to bad habits comes into operation, with further distressing results; others are spared this hope-robbing demoralization because they are recognized by the doctor at an early stage. In any case the outcome of a bad habit, and therefore asquel themselves of all blame. These changes traced from the beginning are essentially mental; the patient abides chief must be recognized, and the path of least resistance.

I am of opinion that overwork, mental strain in business, or other ways, the grief of bereavement, or some alarming shock, do not in themselves produce neurasthenia, and cannot be said to be its cause, though by lowering health and weakening mental control they may contribute to the development of the more serious disturbance. On the other hand, I am of opinion that the most distressing and damaging effect on the mind of uncontrolled and bad habits of thought in early life, partly because of its tendency to the mental origin of neurasthenia, and also on account of a growing conviction that to such habits may be ascribed a great deal of the depression and mental discomfort from which nearly every one suffers at times. Care has been taken in this lecture to lay stress on the fact that neurasthenia seems to range from occasional outbursts of uncontrolled temper or fits of gloom—"moodiness," in fact—to obsession by some one false idea, ending perhaps in insanitation. This is a subject which requires much further investigation. If they ever recognized—that the mental horizon of which each individual is the centre may be gloriously wide and embrace the interesting and sunny aspects of life, or may be miserably contracted, to the petty concerns of one personality who lives under the toils, burdens, and
Sorrows of life in a dense shadow that obscures all its joys. Hence the danger of introspection and self-examination in certain minds and to the common wholesome incentives to thought, and who are not spontaneously attracted by things outside their own limited personal sphere; for these habits tend to fix attention of the great circle from which radiations might go forth to an infinitely far horizon. I have more than once said that the disease does respond, and will only respond, to mental treatment.

The Attitude of the Profession.

At this point it may very properly be asked: What has been the attitude of the profession towards neurasthenia, and the influence of policy toward the disease? I am afraid I must say that professional opinion—or at least conduct—has mostly been mistaken and has been fraught with danger to the sufferers and damage to medical reputations. A most interesting—and I mean most encouraging—thing of its kind is the proper professional opinion, or at least conduct, of our patients, and even the most experienced and thoughtful will at times unwittingly fall into error. I remember a very depressing case of a patient who was one of the most respected and estimable of our practitioners; who it must be said, perhaps, consulted the late Sir Andrew Clark, the kindliest and most considerate of physicians; unfortunately, in giving his opinion, which was in the main most encouraging, he dropped the word "neurasthenia." The patient's visit was disastrous, entailing 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 "neurolalia" he had the idea of insanity in his mind.

In framing a diagnosis we cannot, of course, hope to be invariably right, for latent organic disease is prone to mask itself by functional symptoms and to masquerade in a garb of pronounced neurotic character; and, on the other hand, the deceptions practised upon us by hysteria and all functional nervous states in simulating serious lesions, is well known. It is one of the advantages of exercising an exhaustive examination of our patient and institute a thorough search for unequivocal physical signs and symptoms of organic disease; failing to find them, and recognizing that we have a nervous temperament to deal with, we may then give the patient the benefit of the doubt and choose treatment directed to combating the neurotic factor at work.

It may be urged that the doctor's reputation is at stake, and that if not quite certain of his ground he is justified in "hedging" by way of safeguard in the event of something turning up. But this is not the case. The fact is that there is a definite morbid entity deserving of a prominent place in our nosological tables, to be diagnosed and treated like any other disease, and we shall see immediately that our reputations are in much greater peril in consequence of failure to effect a cure than would be from missing a latent organic lesion. A correct diagnosis is, then, of the first importance.

Diagnosis.

We employ the term "neurasthenic" in a very loose and certainly most comprehensive way. It is made to include the most northerly and the most southerly latitudes of functional nervous disease. Anything between the highly-strung, interesting, but irritable young lady who abors the designation "neurotic," and grossly insulted by the slightest hint that she is hysterical when she complains of an abiding cold spot between her shoulders in her spinal column that nothing relieves, and the stupid, depressed, ever-complaining and, indeed, heart-breaking "lunatic,"" is this term neurasthenia, or can we think of her and her friends; anything between the intelligent, vivacious business man with a fixed and altogether uncompromising idea of the importance of a certain sensation in his head or stomach, and the discourse of neurotic impulse as represented by the lifelong depressed hypochondriac, we call neurasthenic, and their name is legion. But the fact that the term is used in a loose and wide sense is only an additional reason why we should be
most careful in working out a diagnosis. Our guiding rules should be to make, if possible at our first interview, a careful search for organic mischief, and, in any case, to give our opinion until an exhaustive examination has been made.

A few points seem to indicate the neurotic nature of the symptoms, and to some of these I may briefly refer.

1. It is remarkable that these pains are described as constant; it is said that the pain never ceases, is always present during waking hours. Organic pains of the same type are not described. On close examination for the admission is often made that these functional pains do occasionally cease for a time, but at the next interview the legend that the pains are constant is revived, andculated interrogation has to be instituted before the truth is reached; this lack of accuracy is strongly suggestive of the mental state underlying neuroasthenia. Headache, for example, described as constant, is usually of this nature, and the same may be said of spinal pain and backache generally.

2. A clue may be furnished by the kind of language employed in describing symptoms, this being generally exaggerated, the exaggeration not being to refer to his pain or other abnormal sensation as ever increasing; at every visit it is worse than before—it is "appalling," "painful hearing."

Again, we may learn much from the fact that a neurasthenic patient who comes to see us, and is both able and anxious to describe in detail every feature of his case, is no exception, as a rule, by some one who will and will emphasize his story further—a wife, a sister, or a sympathetic friend.

4. It is important to observe—and many neuroasthenics are prepared to admit the fact, or we may obtain it from an intimate friend—that pari passu with the progress of the symptoms for which we are consulted there is evidence of an ever-increasing nervousness, using the term in a general sense, the type of cases, as a rule, by some one who will and will emphasize his story further—a wife, a sister, or a sympathetic friend.

5. Many neuroasthenics are prepared to admit the fact, or we may obtain it from an intimate friend—that pari passu with the progress of the symptoms for which we are consulted there is evidence of an ever-increasing nervousness, using the term in a general sense, the type of cases, as a rule, by some one who will and will emphasize his story further—a wife, a sister, or a sympathetic friend.

In addition we should become familiar with the special features of neuroasthenic pains and other symptoms, many of which are characteristic. Just as the name of an individual will give us a clue to his nationality, so the special locality or description of a pain will furnish evidence of its nature. For example, a neurasthenic, when asked what is wrong at night, excites but little real alarm in the minds of patients or friends, seldom passes into one arm alone, is accompanied by palpation, and lasts for hours. The neuroasthenic headache is either a diffuse, constant pain, or else is diffuse, a veritable will-o'-the-wisp in the sense that it cannot be located exactly. A headache complained of as constant and referred to the top of the head is a functional symptom. A patient acquires more and more control as the serious mischief advances. In addition we should become familiar with the special features of neuroasthenic pains and other symptoms, many of which are characteristic. Just as the name of an individual will give us a clue to his nationality, so the special locality or description of a pain will furnish evidence of its nature. For example, a neurasthenic, when asked what is wrong at night, excites but little real alarm in the minds of patients or friends, seldom passes into one arm alone, is accompanied by palpation, and lasts for hours. The neuroasthenic headache is either a diffuse, constant pain, or else is diffuse, a veritable will-o'-the-wisp in the sense that it cannot be located exactly. A headache complained of as constant and referred to the top of the head is a functional symptom. A patient acquires more and more control as the serious mischief advances.
by sleeplessness, anemia, dyspepsia, and so on. But even then a true diagnosis and sound advice will do much, coupled with suitable remedies and change of air and scene, for the success of the treatment, to a large extent, depends on the cooperation of the patient. To grapple with this and the various causal factors at work requires all the tact, care, and patience.

Many cases will, however, defy this rational line of treatment, even at the hands of the most experienced, when attempted at home. Adverse circumstances are too frequent for them, and the doctor's efforts are more than counterbalanced by influences outside his control. It is then that isolation proves so valuable, with or without a course of the so-called Weir Mitchell treatment, and I feel that in bringing to a close my remarks upon the treatment of neurasthenia I cannot do better than give you a brief account of my own experience, extending now over many years, of the Weir Mitchell treatment.

This treatment, as you are aware, is a combination of isolation away from home, rest in bed, overfeeding, massage, and electricity. The one item in this list likely to induce a lasting mental effect is the isolation; and although Weir Mitchell himself incidentally speaks of this as giving a valuable opportunity for "moral education," he himself stress upon it from that point of view, while some of his followers openly depurate "preaching," and insist on relying solely on the physical processes.

The great French physician, Dejérine, on the other hand, has evolved a system in which isolation with rest in bed and what he calls "persuasion" play the principal parts; overfeeding is used only in cases of emaciation, massage and electricity are discarded. Dejérine rejects suggestion as formerly used by Charcot and others because it in no way enlightens the patient's intelligence, nor does it help him to exercise his own will; the treatment, so he substitutes for suggestion, means such rational explanation and demonstration to the patient as will communicate enough understanding of the matter to enable him to co-operate intelligently in his own cure.

My own experience, independently worked out and extending now over many years, goes to show that the point of chief importance is mental treatment administered under the most favourable conditions, of which the first essential is isolation under the doctor's control. The mental treatment is, in fact, a sort of education with emphasis on the part of the patient. The plan adopted should not be too rigid; each case needs to be separately considered and treated on its own merits—one will require stern insistence, another gentle coaxing. By countless varying methods the treatment is always directed to the one end of leading the patient away from the constrected, self-centred attitude of mind in which attention is absorbed in narrow personal feelings, and substituting for this a broader or wider interest in life, which will in turn endow him with a new and larger and perfectly healthy self. To this main object the various helps of rest, over-feeding, "parasite exercise" or massage, electricity, etc., are, when used at all, regarded only as subordinate accessories. And I may add, in conclusion, that the number of lasting cures secured in this way year by year strengthens my conviction that the theory is true and the practice sound.

Clinical Remarks

ON TUBERCULOUS CHLOROSIS.

By ALEX. JAMES, M.D. EDIN.,

CONSULTING PHYSICIAN TO THE EDINBURGH ROYAL INFIRMARY.

When we meet with a case which presents in a more or less marked degree all the ordinary appearances of chlorosis, and which yet on examination of the blood reveals the number of red corpuscles and the percentage of haemoglobin to be practically normal, we are very likely to find in it a history of past or present tuberculosis disease. This condition, often occurring in young women, is one which long ago Troussseau recognized and called false chlorosis or tuberculous anaemia; and although in recent times, when blood examination has become more of a routine procedure, the co-existence in tuberculous disease of an anaemic appearance without a definitely abnormal blood count is quite recognized, it seems to me that in cases apparently of chlorosis this possible association of tuberculous disease often passes for being unrecognized. Inasmuch as the recognition of such cases is important from points of view alike of diagnosis, etiology, pathology, and treatment, I believe that the following are well worth recording.

CASE I.

A. H., aged 16, a French polischi, was admitted to Ward 31, April 9th, 1907, as a case of chlorosis. She complained of shortness of breath, palpitation, and swelling of the ankles, and stated that she had been ill for three weeks.

History.

Her family history was not very good. Her father had died, aged 55, from Bright's disease; her mother is alive and well. Of a family of four, two brothers had died, causes unknown; one sister was alive and well. Her surroundings were so poor that it was not at all satisfactory; at work, however, she had been in a room, the walls of which were marked by year after year. The temperature was unbearable. In the last two years, she had been troubled with emaciation, massage, and others because it was not abnormal could be detected. The heart was not markedly enlarged, the sounds were quite clear. On palpation, the bruit de diable was not well marked. The red blood corpuscles numbered 5,200,000, haemoglobin 70 per cent, white corpuscles 7,187, differential count shows polymorphs 57 per cent, lymphocytes 39 per cent, basophiles 5 per cent, eosinophiles 1 per cent; the eosinophile index was 0.9.

Circulatory System.—The pulse was usually about 90 or 100. She had complained of shortness of breath, faintness, and palpitation. As regards physical signs, the liver and lungs were normal; from the neck the heart could be heard. Adverse symptoms were a feeling of warmth in the chest on coughing and breathing. On careful examination of the lungs, slight shrinking of the left apex with a slightly impaired percussion note was made out. On auscultation, nothing was detected except slight harshening of the breath sounds. With the exception of the slight abnormal corroboration of the physical signs, for the left apex lighted up much less distinctly on inspiration than did the right. The urine was of the same cast, and there was no evidence of cystitis. As regards the integumentary system, all that had to be noted was that there existed slight oedema of both ankles.

In this patient, then, we had presented all the appearances of chlorosis, and yet a practically normal blood count. The differential count of the white blood corpuscles showed, as was to be expected, a relative increase of lymphocytes, and the eosinophile index, for the estimation of which I have to thank Dr. Ian Stewart, was within normal limits. Dr. Ian Stewart also tested in this patient the effect of tuberculin inoculation on the eosinophile index, and found a rise on the third day, without, any previous fall. All this may be regarded as indicating that there is present no active tuberculous mischief going on. But the evidence of the old tuberculous neck glands, and the condition of the left apex under the co-existence of tuberculous disease, whilst the occurrence from time to time of cough, expectoration, and chest pain, make this all the more manifest. The case is therefore one of tuberculous chlorosis.

CASE II.

Constence H., aged 15, domestic servant, was admitted to Ward 35, on December 19th, 1907, complaining of breathlessness, palpitation, stomach pain, and swelling of the legs, and stating that she had been ill from this for the last two years.

History.

Her family history was not very good; her father died of Bright's disease, her mother of childbirth. She had one sister alive and healthy, and one brother healthy; but of her other three brothers, one had tuberculosis, another some form of paralysis, and another had died from consumption. She had been in service for three years, and as regards food and home surroundings had been well placed.