

## THE COMING OF PSYCHASTHENIA\*

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If the proverbial question, "What's in a name?" were put to any member of this Society, his opinion would hardly accord with that of the poet whose sophistical answer has been leading men into a paradise of fools these many years. From time out of mind psychiatry has suffered greatly from archaic and faulty nomenclature insomuch that the innocent sufferer from the psychoses has been as a reproach among men while his disease has been looked upon as a pariah in nosology. Much as one may regard the *nomen* as a mere *flatus voci*, it is nevertheless true that names, and not alone the things themselves, are to a large extent responsible for the wrongs which the sick of brain have suffered at the hands of unenlightened men. The word "madman," though occasionally heard in England, is happily no longer current in America, but our ears are still affronted with "lunatic" and "lunatic asylum," even in cultured New England, and we must all plead guilty to the unnecessary use of the words "insane" and "insanity" when some more scientific euphemism would serve the purpose of description as well if not better. Neurologists, practising in a populous and fertile border country and making incursions ever and anon into the debatable territory of the psychiatrist, have been wiser than we in appreciating the importance of giving morbid states pleasing appellations. If it be true that an alienist, Van Deusen<sup>1</sup> of Kalamazoo, was the first to describe and name the symptom-complex which for over thirty-six years has been known as neurasthenia, to Beard, the neurologist, belongs the credit of having popularized the name by his larger clinical studies and made it a household word throughout a world now so "civilized" that the conditions under which it flourishes, being well nigh universal, no longer give this country a prescriptive right to its derisive sobriquet, "the American disease." It may well be that some so-called neurasthenics, lulled into a comfortable sense of security by a name that

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was a misfit, might have fared better in health had they been otherwise labelled and undergone treatment in institutions, but I venture to believe that occasional evil therefrom arising has been offset by the countless instances in which men and women have recovered from a psychosis without knowing, or having had it made known, that they had suffered from what is called insanity. Albeit it was inevitable that a term so comprehensive and so universally popular as neurasthenia, and so vague withal, should be made to include from year to year more and more of those cases in which not only the motor and organic energy of the individual are reduced, but in which the "psyche" is too profoundly involved to warrant the all-embracing designation as one still within the bounds of a reasonable scientific exactness. Nothing therefore could have been more timely than the paper read by Dana<sup>2</sup> before this body nearly two years ago on "The Partial Passing of Neurasthenia," a felicitous title, by the way, to which I am indebted for the antithetical caption of this humbler essay. The author's contention was, you will remember, "that a large number of these so-called neurasthenias and all the hysterias should be classed as prodromal stages, abortive types or shadowy imitations of the great psychoses." For in these cases, said he, "it is the morbid mind that dominates the situation, not a weak eye-muscle, a poor stomach, a heavy womb, uric acid, arterial sclerosis, or even an exhausted motor nerve cell. They are not often, to be sure, pure psychoses; the body is also at fault, but the psyche is in main control and it gives the stamp to the syndrome, directs the prognosis and most acutely solicits treatment. Many neurasthenias are only a kind of understudy of some particular type of insanity, or they make the forming stage of some major psychosis which, perhaps, under wise direction never fully develops." The pertinency of this clear-cut statement to my present purpose must be warrant for the full quotation.

To those of us whose activities lie rather in the domain of mental diseases, it was refreshing that one who is primarily a neurologist should have been among the first in this country to suggest so large and important a concession of territory and thereby to have averted the reprisals which otherwise, sooner or later, were bound to have been made, openly or furtively, by men militant on the other side of the line. His paper has gone a long way towards clinching the essential unity of nervous and mental

diseases and establishes a *modus vivendi* whether we profess allegiance to either camp or both.

Whether Dana's "phrenasthenia," a name that has long had a vogue in France, is on the whole as desirable and as likely to survive as that for the recognition and adoption of which it is my business to plead this evening, time will prove. With the backing of its inventor, Janet, *facile princeps* in his chosen field, *psychasthenia* seems to bid fair to prevail against other comers as best descriptive of the grand psycho-neurosis which that investigator has described and named.

And here it is pertinent to remark that to Janet, more perhaps than to any living scientist, we are indebted for enabling us to look at mental diseases in a changed and vastly broadened perspective. In a recent address on "The Present Decline of Art in Medicine,"<sup>3</sup> Sir Dyce Duckworth points to the importance of enthusiasm, sympathy and sound judgment in applying principles to the case of each individual. The lesson of the true perspective must be learnt in the school of experience, as well as the harder lesson—an especially difficult one in dealing with mental cases—of getting at the patient's own perspective of his symptoms. The art of practice which Sir Dyce Duckworth had in mind cannot be acquired from books or even in laboratories, but only by long and careful study of individual patients. Such is the art which Janet is helping us to-day to make more and more our own. We recall that in that remarkable paper on "Mental Pathology" read at St. Louis last year<sup>4</sup> he pointed to the tendency of investigators in other countries to separate two branches of study which French alienists are disposed to unite. "They study on the one hand the psychology of the normal individual, or the individual who is regarded as being normal, and on the other hand they are concerned with mental diseases, their analysis, and especially their classification." Frenchmen, however, under the inspiring leadership of Ribot and Charcot "have endeavored rather to throw light upon psychiatry by a study of normal psychology, and to regard mental diseases as experiments which have been cunningly devised by nature to show us such suppressions and modifications of function as the experimental method demands." In other words, they have insisted upon the union of the psychologist and the psychiatrist in a common investigation—a union, the importance of which we in America have but begun to realize within compara-

tively few years. Thanks to that union and the resultant closer analysis of mental symptoms, "psychological experimentation has introduced into psychiatry a rehabilitation and a refinement of the clinical method."<sup>4</sup> Neither may we forget, in estimating our obligation to other students in this field, what we owe to the work of our fellow-member, Dr. Cowles, who was well in the forefront with his studies on "The Mental Symptoms of Fatigue"<sup>5</sup> thirteen years ago and set out bravely to discover a way to reduce the data of everyday psychology to orderly form and to recognize the import of commonly observed mental manifestations by noting their correspondence with recognized bodily conditions. At that time the voice of Dr. Cowles was as of one calling in the wilderness: to-day we recognize him as the earliest American herald of the psycho-neurosis under consideration.

In psychasthenia it will be observed that the deviation from the normal is qualitative rather than quantitative. Loss of memory is not apparent—neither attentive nor recollective. Indeed, memory is often far above the average. Neither is there evident impoverishment of ideas or weakened power of comprehension. There is no stupor and no disorder of consciousness. But there is a reduction of volitional power, as well as that of prolonged and systematic attention. In a word, aboulia is a cardinal symptom. There is a constant intellectual play of a diffuse sort which results in ever-changing imagery and phantasy—an activity that displays itself in brilliant constellations of ideational design which are totally lacking in that orderly succession, arrangement and development which are necessary to productivity. Psychasthenics are dreamers. Their ideational life cannot be brought *en rapport* with the physical and the actual. They have perspicuity but lack the volitional and attentive power to make that keenness of mental vision an available factor in dealing with the everyday problems of life. They stop short of definite delusion, although their dreaming proclivities lead them to the formation of all sorts of delusive and elusive conceptions, the whimsical unreality of which they themselves recognize when brought sharply to book. Similarly there is no sensory disturbance in the sense of true hallucination, although the same ideational activity leads the patient to vivify and objectify his thoughts and so to perceive them as voices and visions, thus leading one to confound the phenomenon with genuine perversion of the special senses. Mental opera-

tions, instead of resulting in co-ordinated and productive activity, find vicarious and devious expression in multiform obsession. In other words, there is a lower order of mental activity, capable, it may be, of dealing with the past, the future, the indefinite, the intangible, but woefully impotent to meet "the various exigencies of times and occasions." Before such realities the enfeebled spirit balks and is constrained to find the line of least resistance. Scruples and diffuse rumination replace decisive judgment and well-balanced logic; phobias and anxieties usurp all useful and legitimate emotions, while tics, mechanical impulsions, mannerisms, stereotypy and motor agitation are the aimless substitutes of energetic behavior. This incapacity reacts again upon the individual consciousness, producing what Janet has so aptly named *sentiments d'incomplétude*. Faced with situations demanding action, the subject is overwhelmed by feelings of incapacity, inutility, indecision, humility, shame, automatism, difficulty, discontent, domination, intimidation and revolt; in the intellectual sphere he feels obscurity, strangeness, unreality, doubt, instability, isolation, disorientation; while his emotional activities are expressed in anxiety, ennui, indifference and restlessness.

This picture is not one of true dementia, and if heretofore we have given that name to the symptom group, it is time for us to revise our nomenclature. In the sense that there is a reduction of the energising power to the extent of producing a pervasive disharmony in relation to environment, there may be what, for lack of a better name, has been called dementia, but there is little or no blunting and diminution of the intellectual activity *per se*.

Having thus attempted to describe psychasthenia, let the cases here brought together from the records of Butler Hospital eke out effort by furnishing living pictures of the psycho-neurosis. In presenting these excerpts I desire to make grateful acknowledgment to Dr. Wm. McDonald, Jr., for the thorough studies which they embody.

Since January 1, 1903, there have been discharged from Butler Hospital 270 patients; of these 134 were men and 136 women. Forty-one were diagnosed as *psychasthenics*, i. e., about 15.1 per cent.; of these 18 were men and 23 women. At the present time there are 9 psychasthenics in a population of 162, i. e., 5.6 per cent.; of these 5 are men and 4 women. The difference in the

percentage of psychasthenics discharged and those remaining in the Hospital is readily explained by the comparative curability, or at least improvability, of psychasthenia as compared with the more hopeless diseases that are chronic and accumulate.

Of these fifty psychasthenics the most careful records have been kept and exhaustive examinations have been made of both the physical and mental states. It would be wearying to refer in detail to all of these cases, and, moreover, would necessitate frequent repetition, since they all seem in many ways to have been stamped with the same die. Grouping the symptoms therefore according to the beautiful scheme presented by Janet, we proceed to give illustrations by brief abstracts from the more characteristic case records. We have then to illustrate:

1. Fixed ideas (obsessions, *Zwangsvorstellungen*.)
2. Fixed mental habitudes, or fixed mental processes (*agitations forcées, Zwangsvorgänge*.) These latter are further divided into (a) motor agitations of the systematized form (tics) and of the unsystematized (diffuse agitations), (b) emotional agitations, including the systematized variety (phobias) and the unsystematized (diffuse anxiety), (c) intellectual agitations composed of the more definite and systematized processes (scruples, *manies d'interrogation, manies d'hésitation*,) and the unsystematized diffuse mental agitation (i. e., inability to stop thinking, indefinite and prolonged rumination, etc.)

Case I. P. T. M., an intelligent man of 32. Summary of examination: physically is fairly well nourished, and there is a general appearance of healthy physical tone. The nervous system shows some irritability and instability. There is tremor of the fingers and legs and cardiac irritability and irregularity.

Mentally, the marked symptoms are obsessions, tics, phobias and scruples. The obsessions consist of constant dwelling upon the subject of sexual perversion, and wondering if people might suspect that he might be an invert (patient's sexual life is really normal). Moreover, dwells constantly on the condition of his body, has many hypochondriacal obsessions and is particularly disturbed by constant thought as to the condition of his mouth and quantity of saliva. Associated with this last there is a tic, consisting of a sucking act performed with the tongue and cheeks with the object of drawing saliva into the mouth. As a sequela to this there is constant swallowing of saliva, which is accom-

panied with an occasional slight gurgling sound. There is, moreover, diffuse rumination with tendency to dwell upon past sorrows, upon his own prospects and capabilities. Has diffuse anxiety regarding sleep and the possible recurrence of certain spasmodic movements of the sexual apparatus. There is no evidence of hallucination or delusion. Patient talks well, reasons well, writes unusually well for publication, and shows a high grade of intelligence. There has been no dementia. There is no disturbance of consciousness. Comprehension is excellent. Has no deep grade of depression. With this patient there is considerable admixture of neurasthenic symptoms, i. e., tremor, cardiac irritability, etc., but it is the mental symptoms alone which cause him to seek treatment.

Case II. A. M. G., a woman of 26. When about twelve years of age whenever she walked around a corner she felt a desire to repeat the process. She finally began to indulge herself in this habit, arriving late at school because of this repeated action. Then she developed a desire to touch objects many times. If she laid a book on the table, for example, she felt impelled to touch it over and over and was unable to draw herself away from it (tics). About this time she had a great fear of comets, was easily influenced by sermons and had much religious feeling. A year before admission, while working hard at bookkeeping, she began to lose sleep and was inclined to weep easily. After reaching home each night would break down and shed copious tears. She was very undecided in her actions; says she lost all will power. For a long time previously had been troubled whenever turning off the gas with the feeling that she must go back and ascertain if she had really turned it off completely; the same with locking the door; these acts had to be done over and over (tics, *manies de précision, vérification*). She began to feel that some one must be with her to tell her that she must not go back and test the door or the gas cock. Soon she found it necessary to go over her columns of figures to verify the addition; began to have hot and cold flashes; in dressing in the morning would put her shoes on, then take them off again eight or ten times, being unable to decide whether she should have put on the right or the left shoe first. A complete breakdown followed, and she remained in bed for two or three weeks. While in bed, inasmuch as she could not arise to perform certain acts over and over, she felt it

necessary that her mother should repeat them for her. If the mother were sweeping the room, she must sweep certain portions frequently, or if she came into the room where the daughter was thinking of something unpleasant, she must go out again and come in a second time. If the unpleasant thought was still in the daughter's mind the mother must repeat her act as many times as might be necessary.

"I don't know how many times I had the medicine glasses changed for various reasons. They offered it to me in a certain glass and I said, 'No, I don't want it in that glass because it's the last of the kind in the house.' " With the next glass there was some other reason for refusing, etc. If the mother went out to buy sugar the daughter insisted that she should take only a five dollar bill and that she must have the sugar done up in two-pound packages and must receive in change two two-dollar bills which the mother must show to the daughter on her return. Always superstitious; would not take the last biscuit for fear of being an old maid; would not count the carriages in a funeral procession; did not like to do anything on Friday or on the 13th of the month, etc. When sewing she found it necessary to rip out the seams as fast as she put them in, the reason being that she had a certain thought in her mind when the work was done and she should have had some other thought. If a certain thought was in her mind when she put the needle through the cloth she must take it out again through the same stitch-hole and put it back again with a different thought if possible (scruples). She gradually became worse, was unable to sleep nights because she must work out certain geometrical forms with her hands (tics). If the hands remained quiet she must imagine the hands drawing out these figures in the air (mental tics; i. e., *agitations systématisées*). She must work out geometrical shapes in her mind, "mental geometrics" as she called them. When walking she conceives these geometrical forms to rise from the feet and to disappear against the opposite wall or trunks of trees; these forms most often have the shape of a tomahawk, so she speaks of them as tomahawks (symbolic hallucinations.) If the form strikes against the wall or something solid she must go back and walk over again and sometimes this must be repeated fifty or a hundred times. Her steps must come out even at the end of a walk, or, if there are figures on a carpet, she must step over them in a certain way.



All her actions she repeated by the square; e. g., if, while blowing the nose she thought of death, she would have to repeat the act twice; if again she thought of death it must be repeated four times; if the same thought again occurred the act must be repeated sixteen times, and so on. She spent all of one forenoon going to and from the dining room because the number of times the act was performed had to be squared each time it was done incorrectly. On going downtown she must always come and go the same way.

At the hospital the same symptoms were in evidence; e. g., she must dress and undress a number of times and it was necessary to have a nurse with her constantly to see that she did not perform these repetitions. The summary of mental state shows consciousness unclouded, good comprehension and excellent intelligence; she is bright, able to converse readily and to intersperse witticisms. There are no delusions and no evidence of hallucinations. Most striking symptom is a compulsion toward certain acts (*agitation forcée*). Characteristic of this peculiarity is the compulsion toward a certain line of action accompanied with intense desire for its accomplishment and a feeling of unrest and anxiety if the action is not performed. There is a moderate degree of depression at times. Power of voluntary attention is diminished by the occupation with the above mentioned morbid processes.

Case III, J. H. Age 50. On the night of admission patient was directed to live so far as possible a natural life in the institution, to obey orders and to desist from talking about his own troubles. He immediately asked, "Must I not talk about them to anyone? Do you mean to the doctors or to the patients?" Having been answered, he proceeded to analyze the problem and to suppose various circumstances under which he might be placed and in which it might be convenient or inconvenient to answer or not to answer certain questions. For two days after admission the same problem bothered him, and he has begged anxiously for a definite answer on every occasion on which he has seen the doctor. The following notes, taken in shorthand, will show how closely he adheres to the same problem.

(What do you think of the grounds?) "The grounds are all right, Doctor, and you are all right too. I don't want you to get angry. I was only wanting to ask a little assistance. I don't want to get you angry or anybody angry." (Then why do you

persist in asking that question?) "Well, I tell you I thought it would help me to obey the rules. I don't want to say it if I thought it would go against your rules, but I want to have as much freedom as I can to help myself. When I said I didn't feel so well I only wanted to know if it was against your rules." (Haven't I told you at least forty times to drop that out of your mind?) "If anyone asked me if I was feeling well or all right this morning, if I said I wasn't feeling so well, was that against your rules? What would you want me to say?" (What is your chief trouble?) "Scruples, it seems to be. What would I say in that case to please you? If anyone asked me how I felt this morning, what would I say? Hold my tongue, or what would I say?" (Tell them to mind their own business.) "Well, that would keep a man from being friendly. I am sorry you won't answer me that question, Doctor. I have only tried to ask in a good friendly way." (Let me hear you talk about the weather.) "Yes, of course. It is a nice clear morning. You have nice shade trees. You've got a nice lawn. Do you want me to go on?" (I want to see if you can keep off the other subject for two minutes.) "I was out for a walk with the fellows this morning and they say, 'How are you feeling this morning?' If I am not feeling so well this morning, you have no objection to my saying that?" (No.) "Thank you, Doctor. That's the bottom of that subject." . . . "The doctor said to me, 'Let it go at that,' when I asked him that question. I told him I tried to let it go at that. If anyone asked me how I was feeling I could say, 'Let it go at that.' I might vary it a little—but I will try to do what I can. I might say I didn't feel well this morning; that might—" (I thought you had dropped the subject.) "Well, if they asked me how I was and I said I didn't feel well this morning,—could I say that?" (Didn't we decide that a minute ago?) "Well, well, it's something the same. For instance, if I said I didn't feel well this morning, would there be any harm in that?" (Isn't that the same?) "Well, they are something the same,—I didn't feel *so* well this morning and I didn't feel *well*. If I said I didn't feel *well* or I didn't feel *so* well—could I say either?" (Doesn't it strike you as ridiculous that a man like you should come down to making such distinctions between words?) "Yes, it does. I feel as if I was trying to live a straight life, and it seems the more you try the worse it seems to be. You allowed me to say I didn't feel

so well. For instance, I say I don't feel well this morning. Is there any harm in saying to a patient, 'I don't feel well?' Am I allowed to say that? If I don't feel well am I allowed to say that?" (Yes.) "Thank you, Doctor, I am much obliged. I asked you this morning for a little assistance and now I've got it. They ask if you've got your bath and if you've got your medicine. I said, 'Yes, I've got my bath and I've got my medicine! Now, is there any harm in speaking that way, Doctor?' (Now, drop it.) "Will you just answer me?" (No, I won't answer.) "You might try to help me out just so that I'd be cheerful myself. You allowed me to say I didn't feel well or I didn't feel so well this morning, didn't you? Is there any harm in my speaking about my medicine or the bath? I wouldn't think there was any harm in that." (How much is 8 times 6?) "8 times 6 is 48. If you would tell me what I was allowed to do I could be about more freely, but you won't. 'Did you get your medicine last night?' Is there any harm in my speaking about that? Now, Doctor, don't get angry. I just want a kind of rule to work by."

While the patient was growing very much excited in an argumentative way over these questions, he was forcibly seized and placed before a bench on which worsteds were thrown, and was loudly commanded to sort them. At every attempt that he made to speak he was rudely interrupted and told to keep silent. Finally he became interested in the work and for some minutes refrained from speaking, except concerning the worsteds. Having finished the task, when he showed signs of referring to his scruples again a watch was thrust into his hand and he was commanded to keep absolute silence for seven minutes. He was very uneasy during this period, shuffled about much with his feet and once or twice showed a tendency to break through the silence, but, with encouragement, succeeded, saying finally with a smile, "Here is your watch, Doctor." Thereupon, he began where he left off, saying, "Doctor, when you put that watch into my hand you interrupted something I was saying. I want to know only,"

Case IV, C. S. S., aged 72, chronic psychasthenic. Has had all sorts of diffuse and systematized *agitation forcée* for years. An illustration of this obsessional conduct appeared when the physician was making his physical examination. Just previous to this examination the patient had used his chamber and upon getting into bed was seized by the thought that the carpet had

been soiled. The nurse was called and, after inspection, reassured the patient. This did not satisfy him and he recalled the nurse for a second and even a third inspection. Following this the nurse left the room whereupon the physician was asked to continue the inspection and then the patient himself started on a tour and after repeating this once and attempting a third scrutiny was forcibly made to desist. In the summary of the case there is, physically, little of importance to record, the old gentleman being remarkably well preserved for his age and having retained a fairly strong physique. He is still bright and has a strong memory. There are no delusions or hallucinations, in fact, the mental symptoms can all be summed up in the words *obsession* and *scruple*.

Case V, A. W., a patient aged 52. Summary: patient shows her psychasthenic tendencies in several characteristic directions; both phobia and obsession are well marked. She is extremely hypochondriacal. There are states of marked anxiety, amounting at times almost to anguish, arising from what would be insufficient provocation in a normal individual. Moreover, she recognized the morbidity of her own symptoms. The motor mental compulsions appear in the necessity from which she suffers of constant searching for and dwelling upon quotations referring to hesitancy, selfishness, etc; i. e., verses apropos of her obsession, lack of confidence in herself; e. g., says she could repeat every verse which refers to her characteristics, as, "He who hesitates is lost," "All hope abandon, ye who enter here." etc., etc. Her whole life has been made miserable by her constant desire to change her abode and circumstances of life no matter what these might be. No sooner had she decided upon one course of action and begun it than she was troubled with fears and anxiety that she had chosen the wrong one. There is one characteristic strikingly suggestive of phobia; namely, the fear that in remaining in any place she has moored herself to it for good and all, resulting in the immediate striving to change her abode. She is more than ordinarily influenced by superstition; i. e., as to the number 13, Friday, etc. She is as yet very intelligent. There has been no mental deterioration in the sense of an absolute loss of power although the scope of this power has been greatly narrowed. It is characteristic of her condition that immediately following the examination she be-

came extremely distressed by the fear that she had talked too freely.

Case VI, P. F. L., aged 33, a patient of good intellectual capacity upon whose services as stenographer her employer has put the largest possible value. She is troubled particularly by obsessions of the nature of shame of her body, of her character and of her acts. Says she has such shame in going to the office mornings that she has hesitated many times in going downtown and has often walked out of the way in the endeavor to get up her courage to the point of entering the building. When in the office she had all the shame of a great criminal and suffered veritable anguish of mind. There is some act of childhood over which she worries although she knows that it was not an unusual sin, (i. e., there is an abundance of delusion of sinfulness) feels, however, that she ought to confess this act. Thinks that if she is to get any help in the hospital she must tell all about this and yet she refuses to tell it, deciding to postpone the confession. She talks very well and analyzes her own trouble; realizes entirely the pathological nature of it and its possible disagreeable consequence. She shows no great emotional depression at the time and laughs heartily with the physician at proper provocation though there is an air of weariness and *ennui* about her actions and a similar expression on her face. She attends well and her memory is evidently undisturbed. This patient made three distinct suicidal attempts while in the condition described but, as in each case there was nothing to prevent her completing the act, it may be concluded that her decision and desire in the matter were not positive.

Case VII, M. S., age 29. Has feared for a long time that she might strike someone, though she has never been violent. Said on the day following admission, "I was afraid that I would strike the patients. I went near them and talked to them but all the time I wanted to strike them and was afraid that I would. At home I have got so I think all the time of knives and that I am going to strike my husband with them (phobia). I didn't want to but I was afraid I would so he took them away. I have all kinds of ideas in my head. I've got more ideas now than I had when I was home. Sometimes I feel that I would take my clothes and tear them. I didn't do it and I don't want to do it but I am afraid I am going to. When I see anything I think I

ought to go and hit it though I never had any such idea before (systematized mental compulsions). It seems to me that I am right in my head, I know everything."

Likewise in Case VIII, C. A. P., a married woman, age 48, we see a condition very similar to the last. "Why, it's terrible. I have just the best boys in the world. They are not like many boys. They like to kiss their mother and they are all the time putting their arms about me and kissing me and it seems as though I couldn't stand it. I feel every minute that I would strike them." On account of these thoughts she is unable to read or to do anything. She frequently has distressed feeling, trembles all over, is restless, unable to sit at a table, (diffuse motor and diffuse emotional agitation) "and then there are these awful thoughts; they are all in my own self. How foolish to have to think of your own self all the time and not once of anybody else. I can't think of anyone else. At night when I try to go to sleep and try to think of things it's always myself that I think of" (diffuse mental agitation). Complains particularly of inability to concentrate her thought and of the desire to avoid society and yet a fear of solitude.

Case IX, C. A. T., age 64. Patient has never had hallucinations, illusions or delusions. Consciousness is entirely unclouded. There is no impairment of comprehension. The grade of attained intellect is above the average, patient having devoted his life to theological and ministerial duties. The rate of association is prompt. The particular weaknesses noted are those of a chronic and continuous sense of fatigue with vague and various obsessional ideas of physical and mental incapacity, combined with hypochondriasis. For a long time past he had been unable to indulge in mental or physical diversion without the immediate intensification of these distressing complaints. The neurasthenic symptoms in this case are unusually well marked. There is pain across the shoulders. There is weakness, an all-gone feeling in the legs; some loss of weight, indigestion, headache, constipation, sense of fullness and pressure in the head—calls himself "a mere bundle of nerves." This is a case which might, perhaps with justice, lay claim to the diagnosis rather of neurasthenia than of psychasthenia.

Case X, M. W. R., age 43, shows a curious obsession. Has great anxiety as to his present appearance and particularly as to

his neckwear. He exhibited great uneasiness when being undressed for the examination and frequently made motions toward his collar and necktie saying, "I don't like to go around with nothing around my neck. I want my tie on. There was a time when I used to have to wear one of these cravats around on my night-shirt. I thought it looked so much more dressed. Yes, I think I could have left it off but I felt so much more comfortable with it on." This patient also has the fear of hurting people. (How about this fear you have of injuring others?) "I have had that fear, yes." (How did you think you might injure others?) "Well, I suppose—. That is a very painful question to have to answer." (Why so?) "Nothing, just because the very fact that I have such a horror of it that I kept feeling that I was going to do it." (Did you have in your mind any particular way of doing it?) "I suppose with some sharp instrument." Patient has a very marked phobia as to razors and sharp pointed instruments.

Cace XI, C. A. V., a woman, aged 47. (How do you think you were morbid as a child?) "Well, merely in thought that I would have. I have always been blue." (Have any peculiar thoughts as a child?) "I don't know. I do now. I think I was always queer." (In what way?) "I don't know." (As a child did you have any tendencies to wonder if you had done right or wrong about things?) "Yes." (And did you go into little things of life?) "Everything." (On the way to school would you take a certain number of steps around a corner or have to go back and walk around it again?) "About as foolish as that. I have been foolish that way all my life. I never spoke without after I have said it I would wonder how it sounded. I seem to be sort of a double while I am doing a thing mechanically. Seem to be living out a dream or a romance or something like that; doing two things at a time." (That is when you stop to think of it afterwards?) "Seems as though I am all the time, and it seems to me I don't do things and feel as other people do. I wonder what might happen and what is going to come of it." (Does that go back over your whole life?) "I think it goes a good ways." (Were you troubled in childhood by these questions?) "Well, I don't think I thought so much about them. I would look at a tree, for instance, and think what is that tree for and why do they have to have trees. It goes on mentally." (Did you as a child

ask these questions?) "I expect I did." (Do you remember that you did?) "Yes." (Has that been a lifehood characteristic?) "I think it has." (Has it kept you from your work?) "I think it has kept my mind divided. It's 20 years that just as soon as I haven't been pushed actively in teaching I am almost as bad as I am now. My vacations have been just torment. People call it physical trouble. It is physical because I have all this pain and everything the matter that can be—myalgia, sciatica and lumbago."

(When did you begin to break down this time?) "This summer, through July I tried to brace up and tried to pretend I was somebody." (Have you been troubled? What has been the worst thing?) "I don't know; it's indescribable. The worst thing is that I think I am going to be insane. All my friends say I am not, never will be and the doctors say I never will be." (What keeps you awake at night do you think?) "I don't know; things going over and over." (Have difficulty in dropping things?) (Of course I do. One little tune or some little quotation will go on and on and on and my eyelids will droop and I will wake up and it will be going on just the same." (A quotation that applies to yourself?) "No. The chief thing one night seemed to be a little song of some primary school: 'They are coming all humming to their straw-covered home.'" (Do the pictures on the wall bother you?) "Oh, yes. Have to count and count and count." (Are you uneasy unless you finish the count?) "Yes."

I shall not take up your time by analysis of the foregoing cases since patient and case are here the voice speaking, as it seems to me, without uncertain sound and rendering unnecessary any echolalia on my part. What has been omitted—and I realize that I have but touched the hem of a rich garment—may be brought out in part by discussion. But I may refer the eager student to Janet's paper on "The Psycholeptic Crises,"<sup>6</sup> as read before this Society and as it appears in the well-fitting English dress fashioned for it by Dr. Courtney in the *Boston Medical and Surgical Journal* for January, 1905. A more recent paper by the same author is "Les Oscillations du Niveau Mental,"<sup>7</sup> in which the attempt is made to show that all the symptoms of psychasthenia are dependent upon oscillations of the mental level.

It seems important to remember that psychasthenia is a condition, not a disease *per se*, and that its interpretation as such



should be widely extended. It is an exhaustion and not strictly a defect psychosis, although it may owe its evolution to inborn weakness and instability. Many of its finger marks may be recognized in the beginning stages of other diseases, e. g., in general paresis and dementia præcox. It is found also in the manic-depressive psychoses in the shape of tics and obsessions, and, as shown in one of the above cases, it may reveal itself in senile dementia.

Finally, by way of summary, it may be well to give here the five main types of psychasthenia which are recognized by Janet<sup>3</sup> in a division based upon the degree of the morbid mental condition. (1) The simple neurasthenic with physical and moral depression, but without any accompanying sense of disease; (2) the patient who feels acutely and suffers from his state of depression and who, in this respect, has very varied sensations of incompleteness (*incomplétude*), as yet fairly accurate, but showing a general tendency to exaggeration and generalization; (3) the patient who to these latter adds diffuse agitations, especially in the affective and motor fields; in other words, one who has crises of agitation and anguish; (4) the patient whose agitations are systematized in such way as to reproduce always the same form of anguish, or the same mental process with respect to the same occurrences; that is to say, the patient who presents tics, phobias, or mental manias; (5) the patient who sums up all the preceding disorders in obsessional ideas of disease, of shame, of crime, of sacrilege, which may express themselves either by crises or more or less continuously, whereby would be determined, of course, varieties in the gravity of the obsession itself.<sup>8 9</sup>

And so far as the form taken by the *evolution* of psychasthenia is concerned, a form which depends greatly upon character and previous education, Janet distinguishes three types according as the symptoms are principally in (1) the motor, (2) the affective, or (3) the intellectual field.

But one word more. We have been witnesses of stirring events in psychiatry during the past dozen or so years. History has been making rapidly. Dementia præcox has come and taken so firm a hold upon the American imagination that a cynical confrère over seas had declared that in our country "everything it dementia præcox from idiocy to general paralysis." Let us beware lest in our Athenian zeal for new things we overload

this latest psycho-neurosis till *ruit mole suâ*. Of us, perhaps, more than of more conservative peoples, it may be said:

"Man wants but little here below,  
Nor wants that little long."

And yet, is in this special plea for psychsthenia, I have seemed to throw dust in the eyes of the jury, there is for the pleader at least a temporary refuge in that other homely saying, "One story is good, till the other is told."

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<sup>1</sup>"Observations on a Form of Nervous Prostration (Neurasthenia) Culminating in Insanity." Supplement to Annual Report for 1867 and 1868. American Journal of Insanity, April, 1869.

<sup>2</sup>Boston Medical and Surgical Journal, March 31, 1904.

<sup>3</sup>The Lancet, Nov. 25, 1905. Editorial.

<sup>4</sup>The Psychological Review, Vol. xii., No. 2-3, March, May, 1905. Translated by J. W. Baird, Johns Hopkins University.

<sup>5</sup>Transactions of New York State Medical Association, 1903.

<sup>6</sup>"The Psycholeptic Crises." Boston Medical and Surgical Journal, Jan. 26, 1905.

<sup>7</sup>"Les Oscillations du Niveau Mental." La Revue des Idées, No. 22, Oct. 15, 1905.

<sup>8</sup>"Les Obsessions et la Psychasthénie," Vol. ii., p. xxii.

<sup>9</sup>"Psychasthenia. Its Clinical Entity Illustrated by a Case." Sidney I. Schwab, M. D. THE JOURNAL OF NERVOUS AND MENTAL DISEASE, November, 1905.