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PSYCHODYNAMIC FACTORS IN NEURASTHENIA OR NEURASTHENIC NEUROSIS A SURVEY OF THE LITERATURE

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A Survey of the literature about the role of psychodynamic factors in the development of neurasthenia is presented. Freud denied the role of psychic factors in the elaboration of the neurasthenic symptoms. Subsequently, authors as Reich and Schilder tended to describe neurasthenia much more as a pregenital psychoneurosis, while others conceptualized neurasthenia in the same way as psychosomatic diseases. — Today, neurasthenia is mostly considered as a neurosis with strong narcissistic roots. It seems more regressive than classical psychoneuroses, but less than psychosomatoses or psychoses, and it is related to depressive and anxiety neuroses. Some empirical personality studies confirm these theoretical concepts. — The views of the described authors are then summarized with regard to the specific diagnostic position, developmental level, typical symptom formation, character structure, psychodynamic conflicts and defence mechanisms in neurasthenia.

INTRODUCTION

In psychiatric practice patients complaining about fatigue, exhaustion and associated functional vegetative somatic complaints — and thus presenting a so-called neurasthenic neurosis — are quite frequent. In contrast, there is little interest for this category in the psychiatric and psychological literature. Whereas much has been written about the role of psychodynamic factors in psychoneuroses, depression, psychosomatic diseases and psychoses, this is virtually not the case for the neurasthenic neurosis and other so-called actual neuroses.

To prevent any mistake it should be clear that we are not talking about a neurasthenic syndrome in the meaning of an hyperaesthetic-emotional syndrome in patients with predominantly organic diseases, but about patients without predominant organic disease. Once this stated, it is of course so that, on the one hand, an organic disease, e.g. a flue, can often be the eliciting factor for a neurasthenic decompensation and, on the other hand, psychic factors can play a very important part in some predominantly organic neurasthenic syndromes.

The literature can be chronologically divided as follows. First, authors as Freud (1895) and Ferenczi (1908) tend to deny the role of a psychic elaboration of the symptoms in the etiology of neurasthenia. Neurasthenia is conceptualized as a biological-somatic intoxication. Reich (1926), Schilder (1930-1931), Federn (1930), De Saussure (1931)

formulate the first psychodynamic concepts and consider neurasthenia as a pregenital psychoneurosis. Later on, authors tend to consider neurasthenia as a psychosomatic disease or as a narcissistic psychoneurosis. A survey of these opinions permits us to differentiate neurasthenia from other psychiatric diagnostic categories.

NEURASTHENIA AS A BIOLOGICAL-SOMATIC INTOXICATION (1895-1910)

In 1895, Freud divides the neuroses in psychoneuroses and actual neuroses. In psychoneuroses the symptoms are the symbolic expression of an intrapsychic conflict. The symptoms of actual neuroses have, according to Freud, no psychic symbolic meaning, they are the immediate results of somatic alterations caused by sexual dysfunctioning. He classifies neurasthenia under the actual neuroses together with anxiety neurosis and hypochondriasis. In anxiety neurosis there is an accumulation of sexual energy through the incomplete orgasm during the coïtus interruptus. In neurasthenia there is a sexual depletion through chronic masturbation and frequent pollutions, which provokes directly the neurasthenic symptoms.

Ferenczi (1908) adheres more or less to the same concepts as Freud. He considers the actual neuroses as physioneuroses in opposition to the psychoneuroses. They are the result of a chronic intoxication through chemical sexual products due to a sexual excitation without orgasm (anxiety neurosis) or to chronic masturbation (neurasthenia).

In general, this conceptualization of neurasthenia closely resembled the viewpoints of other authors of that time, such as Beard (the first author, who introduced the concept of neurasthenia in 1869). The only difference is that Freud considers a sexual cause as being predominant, while other causes such as tension, disease and anxiety are supposed to be secondary. In "Hérédité et étiologie des névroses" (1896) published in French, Freud even adheres to the possibility of a neurasthenic constitution which would be at the roots of the disease.

However, Freud does not completely agree with his own theoretical statements. In "Schlusswort zur Onanie-Diskussion" (1912) he has some doubts and wonders if future research will not also show a psychic part, but he rejects after all the possibility of a psychic elaboration of the symptoms in neurasthenia. In "Selbstdarstellung" (1925) he wonders if the etiology of neurasthenia is not more complex. He concludes however that, —although he admits the presence of psychic conflicts and neurotic complexes in neurasthenia—, these symptoms are not psychologically elaborated ("psychisch determiniert") and analysable ("analytisch auflösbar") but the direct toxic result of a disturbed sexual chemistry.

According to Laplanche (1970) one may already find in Manuscript E (Freud, 1894) that Freud considers the symptoms in the actual neuroses also as an equivalent of a coïtus, giving them in this way also a symbolic meaning. Laplanche (1970) claims that, according to Freud,

the patients have an incapacity on a psychic and phantasmatic level and an absence of psychic libido necessary to elaborate the physiological sexual tension. Although this aspect may be of course somewhat present in Freud's theory, it seems to us that this theoretical point has been more developed by more recent authors.

In an interesting contribution, Krüll (1979) speculates as to why Freud did not really develop the psychic part in neurasthenic symptoms, in contrast to what he did in other neuroses. The reason might be that Freud himself was suffering from a neurasthenic neurosis and therefore, unconsciously, repressed the role of psychic factors in neurasthenia.

EARLY PSYCHODYNAMIC CONCEPTS. NEURASTHENIA AS A PREGENITAL PSYCHONEUROSIS

In the writings of other authors, the role of a psychic etiology and a psychic elaboration in the formation of the neurasthenic symptoms became more important. According to Reich (1926), the unsatisfactory masturbation is secundary to a psychic inhibition through feelings of guilt, insufficiency and anxiety. This unsatisfactory orgasm then leads to symptoms that are the immediate somatic result of the frustrated genital satisfaction without any symbolic psychic elaboration. There is an immediate somatic cause, but an indirect psychic cause might be the more determining factor. This would be the case in neurasthenia and anxiety neurosis. Exaggerated masturbation is only secondary to the remaining unsatisfied tension and not the cause of the symptoms through a sexual depletion. According to Reich, this psychic inhibition can be situated on a genital level in acute neurasthenic neurosis and on a pregenital level in chronic neurasthenic neurosis.

He also tries to explain why the neurasthenic symptoms are not further elaborated into psychogenic conversion symptoms. In acute neurasthenia the symptoms are too short living. In chronic neurasthenia no genital phantasies are present due to the pronounced pregenital fixation. Therefore, a symbolic expression in phantasy of the inhibited genital impulses is impossible. These impulses seem to be driven back in the body which reacts in its totality as an excited genital. Reich already tries to describe what more recent authors will not consider as somatic but as narcissistic. Reich thinks that some symptoms of chronic neurasthenia can be conceived of as pregenital conversion symptoms, being a symbolic expression of pregenital psychic conflicts. Also according to Reich, chronic neurasthenia is a very complex pregenital neurosis with 1. purely somatic diffuse complaints and 2. pregenital conversion symptoms.

He differentiates chronic neurasthenia from hysterical neurosis and obsessional neurosis. Both neurasthenia and hysterical neurosis are characterized by conversion symptoms; the latter however is predominantly at an oedipal level, and the former predominantly pregenital. In obsessional neurosis there is in particular a regression based

on sadistic-anal fixations, but there are also strong genital impulses. In neurasthenia there is a primary fixation on a pregenital level with foremost masochistic tendencies. A defence against pregenital impulses is more present in obsessional neurosis than in neurasthenia.

Schilder (1930-31) is the first one to consider neurasthenia as a psychoneurosis. He claims that there is no difference between actual neuroses and psychoneuroses and the causes of neurasthenia are as psychic as in any other psychoneurosis. The symptoms of neurasthenia are conversion symptoms. The psychic inhibitions are not only indirectly the cause of an accumulation of sexual toxic products after an unsatisfactory orgasm, but these psychic factors which inhibit the genital satisfaction, also result in an unsatisfactory sexual relationship entailing neurotic disturbances. In the psychoneuroses the energy of the symptoms also results from the undischarged libido and external circumstances can influence these psychoneurotic symptoms. The conversion symptoms in the hysterical neurosis would then have a genital character, whereas the conversion symptoms in neurasthenia would have a pregenital character.

In his studies about the disturbances of the body-scheme in psychogenic somatic symptoms, Schilder (1930, 1931) also describes some structural differences between hysterical and so-called pregenital conversion symptoms. Every conversion symptom is related to a disturbance in the body-scheme. In the hysterical neurosis the conversion symptoms originate in that part of the body-scheme, which is much more in relation to the personal individual experience and history. In neurasthenia the symptoms originate in a part of the body-scheme that is more common to all individuals. This would find its origin in a weakness of the body-scheme in relation to very early disturbances in the development, caused by constitutional or psychotraumatic experiences. It may also explain why the symptoms in hysteria are so different or idiographic, while the symptoms in neurasthenia are of a more general, identical form.

Schilder is also impressed by the importance in the neurasthenic neurosis of an unconscious desire for power and for punishment related to sadistic impulses. He compares neurasthenia to manic-depressive psychosis where the inhibition of sexual impulses is also less obvious.

The role of inhibition of aggression in neurasthenia is especially stressed by De Saussure (1931). He describes the somatic complaints in neurasthenia as resulting from an unconscious conflict in relation to repressed aggressive feelings. This conflict gives rise to a chronic emotional tension, which gives the same physiological changes as contained rage. The neurotic tension is not discharged through the sensorimotor nerves or the striped muscles as in hysterical conversion symptoms, but causes a chronic irritation of the sympathetic nervous system.

Fenichel (1945) synthesizes the views of his predecessors. He differentiates three forms of neurasthenia. The first one results from an external disturbance in the economy of the libido, as described in the

original concepts of Freud. The second form is a temporary neurasthenia related to internal conflicts; the symptoms are then further elaborated into a more differentiated psychoneurosis. This is also in accordance with the conceptualization of Freud that actual neurotic symptoms can be seen as starting points of many psychoneuroses. In the third form, the symptoms are the result of internal psychic conflicts and remain under a neurasthenic form. In this last form a pregenital fixation, passive-receptive desires, and narcissistic problems have a predominant role.

Considering more specifically the psychogenesis of the symptoms of neurasthenia, Fenichel explains some symptoms as the expression of an aspecific inhibition due to a weakness of the ego confronted with neurotic conflicts. The more positive symptoms are the result of undischarged excitement and affects which cause a disturbance in the chemistry of the organism, such as an abnormal quantity or quality of the hormones and other alterations in physiological functions. They present a challenge to the physiology.

During this period neurasthenia was considered either as an acute and transient state of decompensation related to internal or external stress situations or as a chronic neurasthenic neurosis, based on predominantly pregenital conflicts and distinct from the hysterical and the obsessional neurosis. The symptoms of this neurasthenic neurosis are described as pregenital conversion symptoms or as somatic symptoms in which the psychogenesis occurs in a different, not yet well defined way. A relation with manic-depressive and other psychoses is assumed. The development of clear narcissistic concepts is still lacking.

NEURASTHENIA AS A PSYCHOSOMATIC DISEASE

Later on, a few authors have described neurasthenia using the model of a psychosomatic disease in relation to reactions to stress.

Alexander (1952) writes about the "fatigue state" which can be seen as equal to a neurasthenic syndrome. As underlying psychodynamic conflicts he describes the pregenital conflicts between passive wishes and reactive ambition, being present but not typical. More specific characteristics are the loss of hope to reach a cherished goal, a frustrating struggle against obstacles that are impossible to take, an absence of real interest; activities mostly with a routine-character are performed under external or internal pressure, but not on basis of personal interest. The role of anxiety may be less constant, but in some cases long lasting frustrations may result in reactive aggression provoking anxiety and a vegetative flight into activity. In some cases a feminine identification is used as a defense against aggressive ambitious impulses.

As in psychosomatic diseases the neurasthenic symptoms are caused by disturbances of the sympathetic system in reaction to stress. Alexander (1952) assumes that not only aggression and anxiety but also en-

thusiasm, zest, the wish to reach a goal have a positive influence on the orthosympathetic system. These factors may influence the orthosympathetic system in a minor way but they may have a more lasting effect. It is a well known fact that work without emotional participation is more tiring than heavy work in which one is emotionally engaged. In patients with "fatigue states", the orthosympathetic system is not stimulated, and under the influence of the emotional protest, there is a regression of the vegetative functions to a state of passivity and relaxation characterised by a domination of the parasympathetic system.

Wittkower, et al. (1941), Bastiaans (1957) and von Uexküll (1963) rather stress the difference between the neurasthenic syndrome and other specific psychosomatic diseases or psychosomatoses.

After examining patients with an effort-syndrome (a diagnosis equivalent to neurasthenia), Wittkower, et al. (1941) note the presence in these patients of psychic conflicts about aggressive feelings as can also be seen in psychosomatic patients. The authors describe then how these patients differ from other psychosomatic patients. All psychosomatic patients are overconscious and overscrupulous, but patients with a peptic ulcer seem more preoccupied with economical security, patients with a ulcerative colitis with overcleaness and overtidiness, and neurasthenic patients with problems of morality, selfrespect, religion, patriotism, sense of duty and selfsacrifice. Neurasthenic patients are considered to be somewhat less pregenitally fixated than patients with other psychosomatic diseases.

In the psychogenesis of its symptoms neurasthenia is considered by Bastiaans (1957) and von Uexküll (1963) as different from more specific psychosomatic diseases. In his survey of the reactions to internal and external stress Bastiaans (1957) views the neurasthenic syndrome as a border syndrome between alarm and adaptation, while the more complex psychoneurotic, psychopathic, psychosomatic and psychotic syndromes are characterised by their adaptive character.

According to von Uexküll (1963) the conversion neuroses are expression neuroses. The cause is a conflict between motives. The inhibited motive with its affects is expressed in action fragments, making it out of reach for the ego of the patient. There is a complete repression outside of the consciousness of the forbidden motive. The psychosomatic diseases are related to the vegetative preparation to stress. In these patients motives are not elaborated, therefore the vegetative preparations and affective tensions do not find an outlet and get a permanent character. In neurasthenia there is a conflict between motives with a strong affective charge. The ego defends itself by repressing these conflicts, but the repression is not so complete as can be seen in conversion symptoms.

The same authors also describe the difference between a neurasthenic syndrome seen as a transient state of decompensation following external or internal stressful events and as a more stable neurasthenic neurosis. The neurasthenic neurotic patients are seen as somewhat less archaic

than the classical psychosomatic patients. According to von Uexküll (1963) these patients present more a neurotic than a psychosomatic conflict.

NEURASTHENIA AS A NARCISSISTIC PSYCHONEUROSIS

Today, most authors consider neurasthenia rather as a narcissistic psychoneurosis based on a defense against feelings of massive omnipotence and a high ideal ego than as a classical pregenital psychoneurosis.

In 1947 Carp already points out the narcissistic basis of neurasthenia and stresses that the feelings of impotence and insufficiency in neurasthenia are not the result but rather the cause of the neurasthenic symptoms.

Richter & Beckmann (1969) also conclude that the anxiety about somatic complaints in "Herzneurose" (which can be considered as a neurasthenic neurosis) is not the result of the disease but the cause of the complaints. These patients present severe feelings of insufficiency and are very dependent on their parents. In many cases they have been suffering from an early separation with their mother.

This conceptualization has been further elaborated by Höjer-Pederson (1956) in a more genetic-structural way and by Van Dantzig and Waage (1962) in a more psychodynamic way.

Höjer-Pederson (1956) considers that the actual neuroses are based on more regressive conflicts than the usual psychoneuroses. The symptoms are less colourful and less accessible to psychoanalysis. He thinks that these actual neuroses are mostly seen in patients with a character that is obsessional, perfectionistic and expansion-inhibited but without predominant obsessional symptoms. Such a character structure may be related to a defensive structure which is the precursor of more circumscribed defence mechanisms. It is the first barrier that is created between internal and external stimuli. The adaptive functions of this barrier are less differentiated and less flexible than the more elaborated defence mechanisms. These patients present a defence barrier consisting of a strong general inhibition of emotional and phantasy life, thought processes and psychomotoric expressions. The actual neuroses including neurasthenia appear in patients with such a character structure. When the primitive conflict is reactivated (often after an external psychotrauma), these patients do not develop the symptoms of a psychoneurosis, but the symptoms of an actual neurosis, a psychosomatic syndrome, a prepsychotic syndrome, or a psychosis.

He concludes that the actual neuroses have a specific character. They are dynamically and genetically differentiated from the psychoneuroses, they are coarctated conflict neuroses. These patients present a more regressive, more narcissistic and more rigid character. Aggression and anxiety with regard to aggression play a greater role.

Höjer-Pederson also finds that external events are often on the foreground as cause of the decompensation. He wonders if the primitive

defence barrier is directly broken or if the external factors mobilize latent conflicts in the personality. External factors often seem to be important for these patients because they are generally quiet and conformist, and present few neurotic traits. But in many cases these external stressful events are looked for in relation with intrapsychic conflicts.

The conceptions of Van Dantzig and Waage (1962) which are more centered around the psychodynamic conflicts in neurasthenic patients, complete the genetic-structural explanations of Höjer-Pederson (1956). Van Dantzig and Waage (1962) find that neurasthenic syndromes occur in patients with a so-called psychasthenic personality type. This psychasthenic personality type is characterized by perfectionistic tendencies. They react with an increased effort to keep their work on the same level when they feel less good or have suddenly more work, instead of doing it more calmly or in a less perfect way. These patients function well as long as they can maintain the illusion that they can control completely the inner and outer world. When this is no longer possible, it is felt as a subjective tormenting feeling of complete impotence, which, according to Van Dantzig and Waage, constitutes the key-symptom of the neurasthenic neurosis.

This psychasthenic character finds its origin in severe psycho-traumatic events during early childhood, resulting in a pronounced infantile feeing of impotence which has been suppressed in a massive way. When the psychasthenic defence decompensates and a neurasthenic neurosis appears there is a reactivation of the original conflict of impotence, aggression, anxiety and other intense emotions which in general remain unconscious, but can be recognized in the accompanying vegetative expressions, the vegetative symptoms of the neurasthenia.

Some other authors have been calling more attention for the difference between the neurasthenic psychoneurosis and the depressive and anxiety neurosis, considered also as narcissistic-based psychoneuroses. In comparison to depression there are less guilt feelings, because through a mechanism of projection, all responsibility is attributed to external forces (Simenauer, 1967; Laughlin, 1967). Attention is also more focused on somatic than on emotional problems. Secondary gain is more likely because it is socially more acceptable to be tired than to be depressed. The somatic symptoms are more diffuse than in hysterical conversion symptoms and the link of symbolisation, repression and bodily expression is lacking. It seems more a regression to an archaic state with diffuse bodily sensations (Caïn, 1967), i.e. a very early state of development when the relationship with the mother is the only experienced relationship and when all what happens can only be felt on a very diffuse physical level. The neurasthenic symptoms restore these primitive oral relationships. They protect and repair the essential defective relationships of the subject, preventing manifest depression and anxiety. However, anxiety is always present latently. Neurasthenia is a flight for fight, a passive and regressive attitude of the personality, an archaic defence mechanism that prevents from a more severe

decompensation. The feeling of fatigue, which is a key symptom in neurasthenia, appears in childhood at about ± 2 years of age either as a limitation of the feelings of omnipotence on the surrounding world and other people or as a barrier against aggressive and libidinal impulses (Bugard, 1967).

Eicke (1976) considers the symptoms of neurasthenia as a perversion of normal fatigue. According to this author, fatigue is a drive characterized by a tendency to sleep; frustration follows when it is not satisfied. In his first theory Freud would have classified fatigue under the selfprotecting drives. These selfprotective drives are closely related to the later concepts on aggressive drives.

SOME EMPIRICAL PERSONALITY STUDIES OF NEURASTHENIC PATIENTS

The relation of neurasthenia with depression and anxiety, with psychosomatic diseases and psychotic tendencies, the importance of obsessoïd character-traits, eventually narcissistic tendencies and the massive inhibition of feelings is confirmed by several more empirical personality studies.

Birket-Smith (1960) examined 99 patients with a chronic asthenic syndrome (75 can be considered as neurasthenic, 11 as asthenic combined with a concomitant disease) and a control group of 50 non-asthenic persons. In the neurasthenics he finds neurotic and obsessional character-traits, a tendency to give few answers on the Rorschach and a depressive mood without manifest depression. Many of these patients have been subjected to great stress during early childhood.

Duc et al. (1967) compared 19 patients, presenting an asthenia of psychic origin with 19 patients presenting an asthenia from organic origin, on the MMPI and the Rorschach. They describe the following results as typical for the patients with an asthenia of psychic origin. On the MMPI there was an increase of the neurotic triad (D, HS, HY); D was higher than HS and HY. PA was clearly increased, the Ego-strength was diminished, the anxiety index was increased and there were signs of falsifications of the profile in a pathological sense possibly in relation to masochistic tendencies. In 3 cases there were profiles typical of psychosomatic patients. The Rorschach was characterized by the small number of answers and a mean reaction time of more than one minute. There were signs of anxiety and meticulosity.

Winter (1971) compared a group of 30 patients with neurocirculatory asthenia (a diagnosis equivalent to neurasthenia) with 30 healthy persons and 20 asthmatic patients. In comparison to the healthy group, he found in the neurasthenic group an increase of the neuroticism score measured with 24 items of the Eysenck's Maudsley Personality Inventory and an increase of the anxiety score measured with the Taylor's Manifest Anxiety Scale. There were no differences with the asthmatic psychosomatic group. Examining the presence of a conflict of aggression versus dependency wishes with the Draw-a-Person test and the Gottschalk-Kaplan test, he found an increase of this conflict in patients

with neurocirculatory asthenia in comparison to the control groups (as well the healthy as the asthmatic patients).

Verhaest (1976) found that neurasthenia in general was related to character-traits typical of obsessionality and anal fixation in psychoanalytic terms. This was more the case for chronic than for acute neurasthenic patients. In chronic neurasthenia there seems also to be an increased relation to a character-trait, measuring the need to feel omnipotent and assessing more narcissistic tendencies.

SYNTHESIS

After this rather chronological survey of the opinions about neurasthenia, it might be worthwhile to summarize these different viewpoints with regard to the symptomatic diagnostic position of neurasthenic syndromes, the difference between an acute and a chronic form, the developmental level, the psychic elaboration of the symptoms, the character-structure in these patients and the major psychodynamic conflicts and defence mechanisms.

On the *symptomatic level*, neurasthenia is characterized by a feeling of impotence, exhaustion, a series of vegetative symptoms as headache, heart complaints, digestive symptoms, etc. and symptoms of psychic lability as emotional instability, feelings of tension, difficulty to concentrate, etc. It will not always be easy to differentiate neurasthenia from a depression because the mood in neurasthenia is generally somewhat depressive but the depression does not dominate the symptomatic tableau. The differentiation with anxiety neurosis is even sometimes impossible when there is an anxiety attack where the diffuse anxiety of anxiety neurosis is replaced by somatic anxiety equivalents. The presence of exhaustion and feelings of impotence can be helpful in the differentiation. The differentiation with a phobia, a conversion hysteria — wherein the symptoms are more circumscribed and have a clearer latent communicative value — and a hypochondriasis — where the morbid examination of the symptoms is more pronounced, is easier. This is also the case with a psychosis and a clear cut psychosomatic disease.

The neurasthenic syndrome can be *acute and short living* or take a more *chronic course*. The acute form is described as a temporary decompensation caused by an actual real disturbance in the economy of the libido (Reich, 1926; Fenichel, 1945) although feelings of guilt may play a role (Reich, 1926). This acute neurasthenia is also considered as a temporary psychophysiological reaction to internal or external stress (Bastiaans, 1957). It can disappear or can be the starting point of a more complex psychoneurotic, psychopathic, psychosomatic or psychotic syndrome (Bastiaans, 1957; Fenichel, 1945) or the symptoms can remain under a neurasthenic form. This last form can then be considered as a syndrome we would tend to call a neurasthenic neurosis although many authors do not differentiate between the two forms.

Even in this chronic form the role of external factors in the etiology of the decompensation seems quite important when we compare this to other neurotic syndromes. This could however result from the fact that, in general, the neurasthenic patients live a very quiet life so that the external factors are more clearly perceived than in other neuroses (Höjer-Pederson, 1956).

Considering the *developmental level*, the authors differentiate beween the more classical psychoneuroses — as hysteric and obsessional neurosis — and the actual neuroses — containing neurasthenic neurosis next to anxiety neurosis and hypochondriasis. According to Freud (1895) and Ferenczi (1908) actual neurosis is based on actual real disturbances in the sexual functioning resulting in a physiological intoxication or depletion, and not on a symbolic eaboration of an intrapsychic conflict. Schilder (1931) and Reich (1926) think of neurasthenia as a kind of a pregenital neurosis combining the intrapsychic conflicts of an obsessional neurosis and the symptoms of an hysterical neurosis. Most authors write about the importance of conflicts on a narcissistic developmental level in neurasthenia. This is especially stressed by Carp (1947), Van Dantzig and Waage (1962) and the fact that older authors write about an absence of a psychic elaboration (Freud, 1895; Reich, 1926) and the relation with a manicdepressive psychosis (Schilder, 1931) points also in the direction of a very regressive narcissistic developmental level, although these opinions are still not so clear as the views of the other later authors. This narcissistic fixation is considered as less severe than in real psychosomatic diseases and psychoses (Wittkower et al., 1941; Bastiaans, 1957 and von Uexküll, 1963). On a developmental level neurasthenia is very much related to depression and anxiety neurosis (Simenauer, 1967; Laughlin, 1967; Caïn, 1967; Bugard, 1967), which have also strong narcissistic roots.

The *elaboration of the symptoms* in neurasthenia is rather typical and can be differentiated from what happens in a psychoneurosis and a psychosomatosis. Freud (1895) and Ferenczi (1908) claim that the symptoms are the result directly from a somatic sexual intoxication. Sometimes Freud also admits the role of psychic conflicts (Freud, 1911, 1925; Krüll, 1979) but always maintains his view of an incapacity of a psychic elaboration in neurasthenic patients (Laplanche, 1970). Reich (1926) thinks that part of the symptoms remain as such because there are no genital phantasms, which makes a psychic elaboration impossible and that part of the symptoms are a symbolic genital expression of pregenital conflicts.

Schilder (1931) considers the neurasthenic symptoms as pregenital conversion symptoms. However he links them to earlier disturbances in the bodyscheme than in conversion hysteria. Therefore, the symptoms do not differ much from one patient to another as in hysteria; but they are of a more general, identical kind. Caïn (1967) thinks that the symptoms differ from neurotic conversion symptoms. The link of symbolisation, repression and bodily expression is lacking and the symptom formation happens more through a regression to an archaic

state where only diffuse bodily sensations can be experienced. Eicke (1967) even considers the neurasthenic symptoms as equivalent of a perversion of normal fatigue.

Other authors consider the symptoms as the result of a chronic irritation of the sympathetic nervous system (De Saussure, 1931), especially of the parasympathic system which prepares for rest when action is necessary (Alexander, 1952). This resembles the symptom formation in psychosomatic diseases. von Uexküll (1966) however considers that the symptom formation in neurasthenia differs from the symptom formation in psychosomatic diseases. In psychosomatic diseases the symptoms are the result of a pathological physiological preparation of the sympathetic system in relation to stress. In neurasthenia, however, these vegetative symptoms are, much more than in neuroses, the expression of a conflict of repressed motives. This repression is less severe than in conversion symptoms.

The neurasthenic patients show a typical *character* that is obsessoïd but without clear obsessional traits. This character is the expression of a very early defensive organization with more archaic defence mechanisms than in psychoneurosis. This defensive organization would be caused by very early psychotraumatic experiences resulting in severe narcissistic injuries and defences against feelings of massive impotence (Van Danzig & Waage, 1962; Höjer-Pederson, 1956; Verhaest, 1976). According to Wittkower et al. (1941) this character would be less regressive than in a true psychosomatic disease.

The *psychodynamic conflicts* are not centered around genital sexuality but rather around pregenital (Fenichel, 1945), sadistic wishes (Schilder, 1930-31; Verhaest, 1976), masochistic tendencies (Reich, 1926), problems about aggression (De Saussure, 1931; Wittkower et al., 1941), problems about dependency (Winter, 1971), passive receptive desires (Fenichel, 1945), the loss of the hope to reach a cherished goal (Alexander, 1952), and feelings of massive omnipotence on a narcissistic level (Carp, 1947; Van Dantzig & Waage, 1962; Fenichel, 1945; Verhaest, 1976; Höjer-Pederson, 1956). As defence mechanisms the isolation of affects and emotions (Höjer-Pederson, 1956) and the tendency to project are regularly cited (Simenauer, 1967; Laughlin, 1967; Duc et al., 1967).

CONCLUSION

Many authors do not consider neurasthenia just as a purely constitutional deficiency, but as a differentiated neurotic syndrome corresponding to a typical constellation of psychodynamic forces.

The neurasthenic neurosis is more regressive than the classical psychoneuroses, but less regressive than psychosomatic or psychotic cases and is very much related to the depressive and anxiety neurosis.

The somatic symptoms, although having a psychic origin, must be differentiated from conversion symptoms and symptoms of psychosomatic diseases. Even if the neurasthenic symptoms have a symbolic

meaning this symbolic expression is of a more primitive nature and is less influenced by the specific history of the patient than in conversion symptoms. In psychosomatic diseases the role of reactions and preparation to stress seem more important than the symbolic expression of psychic conflicts, as in neurasthenic symptoms. In relation to depressive and diffuse anxiety symptoms, the neurasthenic symptoms seem to have a function as a regressive defence against these painful affects.

Psychodynamic conflicts are centered predominantly on aggressive drives. Masochistic and narcissistic tendencies have an important part.

This neurasthenic neurotic syndrome tends to occur in patients with a personality type characterized by a general inhibition of affects and emotions and presenting itself, clinically, as obsessoïd without predominant obsessional symptoms.

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