

TSUNG-YI LIN

NEURASTHENIA REVISITED:
ITS PLACE IN MODERN PSYCHIATRY

INTRODUCTION

Diseases, or at least mankind's perception and conception of diseases, have a life cycle of their own. Having an existence grounded partly in biological or behavioral reality, they are equally products of mankind's thoughts and feelings. Thus, just as any other fundamental human idea, they may spread, grow, transmute, take hold and prosper, or decline and fade away.

A case in point is neurasthenia, the subject of the special collection of articles in this volume. How has this diagnostic term, and all it connotes, taken root in most of East Asia while in the United States, the country of its origin, it has fallen into disuse, perhaps even disparagement, all within a span of roughly one hundred years? No answer is, of course, possible without reference to time and place, to history and to culture. How do these factors influence the acceptance and transformation of a disease entity such as neurasthenia?

It was George M. Beard who, in 1869, defined and then popularized the term neurasthenia as "a chronic, functional disease of the nervous system," with the characteristic symptoms of profound physical and mental exhaustion, combined with a host of other signs of functional nervous dysfunctions such as headaches, insomnia, vague pains, dyspepsia, palpitations, and flushing (Beard 1881). He interpreted these diverse symptoms as the common consequence of an excessive expenditure of nervous energy and called the condition "Nervousness." In essence, neurasthenia was conceived by Beard as resulting from a draining of the nervous energy in the face of excessive demands made upon the nervous system.

Beard claimed that this nervousness was a peculiarly American phenomenon since, in the most rapidly advancing modern society, too many psychological demands were placed on the population. In his view, neurasthenia is an illness arising out of the sociopsychological stresses which accompany a modern world uprooted from its past, adrift from traditional values, galloping forward on the twin steeds of commercialism and materialism.

It is the purpose of this paper, an introduction to the specialized articles which follow, to trace the process of neurasthenia's transplantation and transformation in four East Asian cultures: China, Japan, Taiwan and Hong Kong. My professional experience over the past more than forty years has taken me many times across the boundaries of each of these cultures, as well as those of North America and Europe. In each culture, at various times, I have encountered a

different, in many cases changing role played by neurasthenia. In this paper, I will set forth my observations, based largely on personal experience, on the role of neurasthenia in these four Asian cultures. These observations will then be placed in broader perspective, first with respect to the American psychiatric scene and the evolution since 1950 of the four editions of the American Psychiatric Association's Diagnostic and Statistical Manuals (DSM II, III and III R), and next, with respect to the world psychiatric scene and the recent revisions of the World Health Organization's International Classification of Diseases (ICD-8, -9 and -10).

Questions of history and culture loom large in this paper. The reader will, I believe, be struck, as I have been, by the divergent roles neurasthenia plays in each of the cultures treated herein. Yet, as to the four East Asian cultures, each imported the concept and the term at approximately the same time in the early part of the 20th century.

Transplantation and Transformation of Neurasthenia

The concept neurasthenia appears to have received a most sympathetic reception in other industrializing nations, such as Britain, France, and Germany, in the late 19th century. The fact that Beard singled out intellectuals, or brain-workers, as the segment of the population most vulnerable to neurasthenia apparently added a great deal of enthusiasm to the application of this concept in Europe, for brain-workers are the movers of modernity. As Max Weber pointed out, the basic ethical foundation of capitalism, consisting of such virtues as hard work, individual responsibility, sobriety, single-minded striving for material rewards, and rationality, was well accepted by the middle class (Weber 1904). The psychological demands such an ethic made upon an intellectual class of workers largely cut off from traditional patterns of living should be apparent.

Neurasthenia quickly became an illness of the upper middle class, especially the prestigious intelligentsia, and "American Nervousness" was on its way to being transformed into a Western European bourgeois illness. Many clinics, hospitals, hostels, and spas all over Europe began to specialize in treatment of these patients, whose numbers grew large enough to support commercial medicine. Many panaceas for treatment of nervous breakdowns were developed and advocated by George Beard and many other physicians whose reputations were built on the disorder and the treatment of an elite clientele. These were adopted, further expanded and elaborated on European soil. Rest cures, diets and mineral waters, massage and other physiotherapies, and hot or cold baths all made their way into such European rest spas as Baden-Baden, Karlsbad, Marienbad, Bath, Vichy, and Tepliz.

With an increase in clinical experiences, practically every great neurologist in

the 1890's wrote a major piece on neurasthenia (Drinka 1984). As a consequence, a large variety of hypotheses emerged regarding the etiology of neurasthenia, emphasizing somatic (physical), neurological or psychological causative factors. At the same time, different treatment methods were advocated and put to clinical application in various centres. The following few examples may suffice to illustrate the extent of theoretical and clinical activities aimed at refining the diagnosis and treatment of neurasthenia in Europe.¹

Jean-Martin Charcot (1889) made a fairly extensive use of the diagnosis of neurasthenia. Approximately one third of his clinical cases were given this diagnostic label. As in hysteria, he emphasized the traumatic neurotic element in its causation and employed hypnosis fairly extensively for its treatment.

Richard von Kraft-Ebing (1900) was another famous neurologist who used the diagnosis of neurasthenia frequently. He singled out the anomalies in sex life as factors mainly responsible for causing neurasthenia. For example, masturbation by the adolescent was regarded as a main cause, because it sapped his (her) nervous energy in nervous exhaustion and thus led to neurasthenia. In Kraft-Ebing's view, homosexuality and other sexual disturbances come from the same origin of excessive masturbation with neurasthenia as its forerunner.

Sigmund Freud (1895) regarded neurasthenia as physical exhaustion secondary to psychosexual problems which he attempted to treat with psychoanalysis.

It should be noted as well that constitutional or hereditary factors were emphasized by many German authors, including Kraft-Ebing, as being mainly responsible for the causation of neurasthenia.

(1) *Neurasthenia (Shinkeisuijaku in Japanese) and related disease conditions in Japan*

The transplantation of neurasthenia to Asian soil appears to have followed a similar pattern as occurred in Europe at the turn of the 20th century. It started with a phase of enthusiastic, largely uncritical reception, was followed by a second phase of critical assessment, and ended with transformation into various subcategories based on new theories (Drinka 1984; Sicherman 1977).

The years I studied medicine and psychiatry from 1940 to 1946 in Tokyo coincided with the transitional period between the enthusiastic application and the critical assessment of the concept neurasthenia. The simple fact that a major chapter of the then standard textbook of psychiatry by Professor Koichi Miyake was devoted to this disease condition can be seen as an indication, though indirect, of the significant position neurasthenia (*Shinkeisuijaku*) occupied in psychiatry in the nineteen thirties and forties (Miyake 1932).

Certain clinical experience I had as a medical student and a trainee in psychiatry may serve to illuminate the important role this concept of neuras-

thenia played in the minds of Japanese physicians and psychiatrists at the time. I vividly remember a case of a man in his late forties whom I diagnosed as suffering from general paresis based on the presenting symptoms of advanced dementia characterized by cognitive and memory impairment, pupillary anomaly, dysarthria, and the history of syphilis in youth. Our instructor, although agreeing with the clinical diagnosis which was confirmed later by cerebrospinal fluid (CSF) findings, raised the question of why this patient had not been diagnosed earlier, and quickly pointed out that the patient had a period of “neurasthenic condition” about two years previously. He stressed, “If the patient had been seen by someone who had the knowledge that neurasthenia syndrome often appears as a prodromal or early sign of general paresis, this patient could have been treated early with a much better prognosis for recovery.”

Under the tutorship of such supervisors we, students and trainees in psychiatry in Tokyo University, all looked hard for such cardinal signs of neurasthenia as fatiguability, irritability or sensitivity in diagnosing any and all patients. It may be mentioned that a very large portion of the patients seeking psychiatric treatment at the Tokyo University Hospital – whether the patient suffered major functional psychoses, or organic brain syndrome, minor mental disorders or substance abuse – had expressed or shown “neurasthenic syndrome” at one point in their illness, and thus the attention given to this disease condition by the staff was understandably widespread and intense.

The emergence of the concept *shinkeishitsu* and a specific treatment modality called Morita therapy advocated by Shoma Morita, introduced a new perspective on neurasthenia (*Shinkeisuijaku*) in Japan (Morita 1921, 1928). In Morita’s view, a large number of neurasthenia patients should be called *shinkeishitsu*, meaning nervousness or nervous disposition, because their “neurasthenic condition” is basically a psychological reaction developed in a certain type of personality characterized by hypersensitivity, introversion, self-consciousness, perfectionism and hypochondriacal disposition. Patients with such character features tend to show anxiety about even slightly abnormal changes in their daily physical and mental functioning, e.g. slight changes in heart beat, heavy headedness, or any loss of memory or power of concentration. The anxiety over such perceived changes of function leads to elevated sensitivity which, in turn, causes more anxiety. This vicious circle between sensitivity and anxiety, which Morita termed psychic interaction, escalates to form a condition of morbid fear with which the patient is “caught” or preoccupied.

Morita therapy is a specific treatment aimed at breaking up this vicious circle of sensitivity and anxiety, by helping the patient to accept the anxiety as it is and, thus, avoid being caught or preoccupied with the morbid conditions (Morita 1974, Suzuki and Suzuki 1976, Reynolds 1976). It consists of two major phases in a hospital setting.²

In the first phase, the patient is instructed to lie in bed without engaging in any activities or contact with the outside world, such as talking, reading, watching television or listening to radio. Devoid of all possible distractions the patient is advised not to fight against feelings that come into his/her mind but to face them. The patient usually becomes very anxious on the third or fourth day, but on the fifth usually comes to terms with the anxiety and begins to have a clue about accepting it as it is.

The second phase is the work therapy, in which patients are instructed to do what they have to do despite feeling anxious. Neurotic patients tend to avoid doing necessary things and indulge in their preoccupations. Such patients are encouraged to find something to do which is appropriate and relevant to a particular situation, e.g. cleaning the house, tending the garden, working as a receptionist or kitchen helper, etc. Through this experience of being fully attentive to what they are doing in the present, they learn that they can do what they have to do, despite the fact that they still feel anxious and have symptoms.

In this phase of therapy, contacts and communication between the therapist and the patient take place through the therapist's reading of and commenting upon the patient's daily diary and the actual daily life situations the patient faces while engaged in work therapy activities. The length of stay in hospital usually lasts from forty days to ninety days, with the majority of patients showing most favourable results even after three years according to a follow-up study by Suzuki and Suzuki (1981).

Transformation of neurasthenia in Japanese psychiatry has continued following Morita. There appeared to have developed a general consensus about the concept of neurasthenia and its place in Japanese psychiatry in the early 40's. The treatise on this concept contained in Miyake's Textbook of Psychiatry (1932) is representative of that consensus. A general summary of Miyake's views on the various types of neurasthenia follows:

1. *Neurasthenia, or genuine neurasthenia*, was conceived in the original Beardian sense in terms of definition, etiology, symptomatology, diagnosis and treatment method.
2. *Reactive neurasthenia, or neurasthenic reaction* was defined as a temporary neurasthenic syndrome characterized by exhaustion, sleep disturbance, irritability in reaction to (a) physical illness such as tuberculosis, kidney diseases, infectious diseases, gastrointestinal diseases, anaemia, or (b) psychological causative factors, e.g. anxiety, fear, worries, etc. Reactive neurasthenia is a temporary condition which will remit with the removal of the underlying physical or psychological stresses.
3. *Pseudo-neurasthenia*: A typical neurasthenic condition manifests in a variety of psychiatric conditions as prodromal or early signs, or as a residual condition, e.g. general paresis, schizophrenia, manic depressive

illness, cerebral arteriosclerosis, senile dementia, organic brain damage, hydrocephalus, psychogenic psychosis, poisoning, alcoholism, etc. The presence of a neurasthenic condition should, therefore, be accompanied by an intensive diagnostic effort to rule out these above psychiatric diseases. The identification of the presence of neurasthenia was regarded helpful or even essential in determining the onset of the related or underlying illness, as illustrated previously on page 108.

4. *Shinkeishitsu* (or *Nervosität, Nervosity*): This is a neurasthenic condition basically due to constitutional factors. People with such personality traits as introversion, sensitivity, hypochondriac disposition, obsessive-compulsiveness, or sense of insecurity or inferiority, often suffer from *Shinkeishitsu* without precipitation of environmental factors. Though these personality traits may be present early in the life of *Shinkeishitsu* patients, onset of illness usually occurs in adolescence or early adulthood, and the clinical course is chronic or semi-chronic as a rule. The traditional treatment modality of rest-cure is usually ineffectual, and Morita therapy is advocated by the followers of Dr. Shoma Morita as the sole remedy of choice.

War experiences in Japan in the late 1930's and 1940's exerted extreme stresses on both military and civilian populations in all aspects of their lives. The enormous increase of war neuroses among soldiers, including "shell shock" in the battle fields far away from home country, and neuroses and neurasthenia among civilians, especially among drafted factory workers, came as a shock to the Japanese in all walks of life.

In one of the major studies of psychoneuroses among the Japanese armed forces in South East Asia, all types of acute or chronic war neuroses as reported in the Western literature were recognized, and the frequency (or prevalence) was estimated to be high, although no exact figure or prevalence rates were given (Uchimura and Akimoto 1944). The rest cure, a traditional treatment of neurasthenia, did not bring about its expected results, and the importance of genuine neurasthenia compared to other forms of psychoneurosis began to diminish. These and other observations on psychoneurosis among military personnel aroused the interest of civilian psychiatrists and administrators in the morale of factory workers, the key segment of war-supporting civilian manpower, as measured by the presence of neurasthenia and psychoneuroses among them.

Thus began a surge of interest among Japanese psychiatrists in the hitherto neglected field of psychoneuroses. This represented a new era in Japanese psychiatry in which major attention was paid to psychogenic factors in mental disorders. Attention was also increasingly paid to American and British

psychiatric literature: this represented, for Japanese psychiatry, a break from the tradition of biological or neurological psychiatry of the German school. The American domination of the post-war era in all spheres of Japanese day-to-day life surely contributed to the Anglo-American influence in Japanese psychiatry as well.

In 1979 I returned to Japan after an absence of a little more than 30 years and spent one year as visiting professor of psychiatry at Tokyo University. I made three major observations on neurasthenia:

1. Neurasthenia was no longer a major diagnostic label in use in medical or psychiatric clinical settings: only a few psychiatrists were still employing it in Beard's original meaning. Most psychiatrists I spoke to questioned the validity of such a diagnostic term in the classification of mental disorders.
2. The concept of *Shinkeishitsu* appeared to be well established and found a place in the psychiatric lexicon. Morita therapy is applied by a relatively small number of disciples of Dr. Shoma Morita to this disease condition, especially in those cases marked by *taijin kyofu* (anthropophobia), *sekimen kyofu* (erythrophobia), or claustrophobia. These phobic conditions can be regarded as culture-bound syndromes treated by Morita therapy, a culture-specific modality having Zen Buddhism as its basic philosophy (Suzuki this issue).
3. Some reported a peculiar widespread use of neurasthenia as a diagnostic label by both professionals and laymen as a camouflage for such serious mental disorders as schizophrenia or affective disorders. The frequent use of this term as a camouflage diagnosis in official medical certificates (*Shindansho*) was most puzzling: it was especially so, as these medical certificates carrying the camouflage labels were treated like all other medical certificates as legal documents and used as the basis for official statistics for health, welfare, employment, and school. They are also used as medical grounds for taking leave of absence from work or transfer of jobs (Munakata this issue).

Explaining how such an irregular practice in the use of neurasthenia as a diagnostic label has become a permissible medical *modus operandi* in Japan should pose a serious challenge to medical anthropology. In my view, it may have a few major roots in Japanese medical culture.

- (a) The physician represents an almighty father figure who is entrusted with the power and responsibility to cure and help his patient. He controls the

medical information regarding a patient, and only gives to the patient, family, or government agency, a limited amount when he sees fit. In the case of stigmatized mental disorder like schizophrenia, the majority of physicians and psychiatrists in Japan today consider it unwise or even harmful to inform the patient or his/her family about the diagnosis, "for fear of causing a shock" or to "protect the patient and the family from becoming a target of discrimination or social disgrace."³ Often it is the family, more than the patient, which is the object of the physician-psychiatrist's concern because of the fear of family stigma.

- (b) Why then does the Japanese physician-psychiatrist choose neurasthenia and not other diagnostic label for the cover-up? A number of factors may be identified as contributing to this practice. First, in Japanese medicine-psychiatry, neurasthenia was a condition which appeared in a large variety of disease conditions including a broad spectrum of psychiatric and non-psychiatric mental disorders, as seen in the previous section. It is, therefore, easily accepted when used as a diagnosis. Second, neurasthenia is classified as a neurological disease, a diagnostic label with a biological connotation which has the blessing of a socially acceptable sick role in Japan where biological psychiatry predominates. Third, the fact that hard working middle-class or upper-middle class brain-workers are more vulnerable to neurasthenia gives this diagnostic label an added flavor of having social status or even "prestige" along with its sick role. In fact, many young intellectuals in the early years of this century were regarded and publicized as neurasthenics. Fourth, neurasthenia is known to be a reversible disease condition which can be cured with rest, good environment and time, in contrast to such severe mental illnesses as schizophrenia. Thus, the label finds ready acceptance among the Japanese.

(2) *Transplantation of neurasthenia in China*

The introduction of the concept neurasthenia to China in the 1920's and 30's, coincided with a period of tremendous social upheaval:

- a. continuous political convulsions, the collapse of the Qing dynasty followed by the establishment of a new Republic, incessant power struggles and hostilities among warlords;
- b. social unrest, dislocation and internal migration of populations, coupled with poverty, starvation, and increased crimes;
- c. quest for modernization and industrialization in order to catch up with Western nations, including promotion of modernization and education of the masses as expressed in the May 4th (1919) Movement, New Life

Movement etc.;

- d. the Japanese invasion of Manchuria and the ensuing military conquest of other regions of China with overt political and economic ambition to subjugate the whole of China and Southeast Asia;
- e. the Civil War between the Kuomintang (the Nationalists) and Chinese Communist Party for many years which ended in 1949 with the Chinese Communist Party forming the one-party Revolutionary Government of the People's Republic of China on the mainland while the Kuomintang fled to Taiwan.

Consolidation of the Chinese Communist Party brought about a number of fundamental changes in medicine and public health as an integral part of a new political philosophy and social order. A most outstanding feature of the revolution lies in the unprecedented emphasis on health as a priority national interest (Lin & Wegman 1973). The targeting of health as a policy priority came about not only because the reconstruction of China heavily relied on a healthy work force, but the political ideology of the Communist Party spoke of the need to transform the once uneducated and neglected mass of people into liberated, dignified citizens of a modern socialist state who are both consumers of, and participants in, the health services (Chin 1973). The fact that attention, albeit minimal, was given to the problem of mental illness at the First All-China Conference of Health Workers in 1950, immediately after the establishment of the People's Republic of China, deserves special notice, a fact pointing to the role of the political philosophy of the revolutionary government which considered "health of the people" as a priority target of political commitment (Lin 1985: 8).

Introduction of Soviet ideology and developmental models as the sole dominant force in modernizing Chinese political, social, and scientific reconstruction, encouraged, or rather demanded, Chinese psychiatry to adopt Pavlovian theory as the sole fundamental theory on which to build theories and clinical skills. In the course of the adoption of the Soviet model, concepts and techniques from Western countries such as the U.S., Britain, and France had to be relegated to a secondary position or given no place at all in the hierarchy of science. For instance, sociology and psychology were banned in 1952, depriving psychiatry of the contribution of the behavioral sciences (Lin 1985).

The strong and lasting influence of Soviet psychiatry can still be seen in three major aspects of Chinese psychiatry today: the theoretical orientation of psychiatrists; clinical practices; and administrative psychiatry. It appears that Pavlovian theory has affected every aspect of psychiatric thought in the last twenty-five years, as seen in most Chinese textbooks. As Young (1984) notes, it is "like the situation in the United States up until recent years where the Freudian psychoanalysis or psychodynamic approach has knowingly, or

unknowingly, permeated into every corner of American psychiatry.”

Soviet psychiatry prevailed in almost every aspect of Chinese clinical practice, ranging from the banning of psychodynamic psychotherapy and psychosurgery to the promotion of such preferred treatment modalities as prolonged sleep treatment and artificial hibernation treatment. In addition, psychiatrists were bestowed with all-inclusive rights to treat the patient, including decisions on admission and discharge, choice of treatment modality, and the structuring and operation of hospital routines and administrative procedures. Furthermore, the Soviet model of the primary health care system has had a profound and far-reaching effect on the health care delivery system in post-liberation China. Primary care has become the virtual backbone of the public health system intermeshed with different levels of community, social and political organizations and their activities.

Psychiatry in China in the early 50's not only weathered the political storm, but also managed to develop into an increasingly respectable medical discipline with a position roughly equal, at least in theory, to other medical sciences and health professions. The First National Conference of Psychiatric Specialists was convened in 1958 to summarize the accomplishments of the first 10 years after Liberation and to assess the nation's future mental health needs as contained in the First Five Year Plan in Mental Health (1958-62) (Wu 1962).

Neurasthenia or *Shenjingshuairou* (“weakness of nerves”) assumed an extraordinary significance in this First Five Year Plan: a grand scale national campaign against neurasthenia was initiated (Editorial, Chinese Journal of Neurology and Psychiatry 1966). This campaign was aimed at controlling the rapidly increasing problem of neurasthenia, believed to be rampant all over China, especially among “mind or brain (intellectual) workers,” a category including bureaucrats, office workers, teachers, and students. It was also found to a lesser extent among laborers and in the armed forces. Starting in the 1950's, many schools complained of absenteeism among teachers and students, and factories suffered from reduced productivity, all of which were attributed to neurasthenia. Thus neurasthenia became one of the three priority targets of the First Five-Year Plan in Mental Health (1958-62).

Lin (1985) hypothesized that the marked increase in neurasthenia and the extraordinary national attention it provoked suggest the presence of a deep-seated tension in the revolutionary development of the People's Republic of China in the 1950's. “It appears that during the Great Leap Forward the vitality, productivity, and optimism which marked post-Liberation reconstruction between 1950 and 1958 encountered a sudden reversal. Yet workers and the masses generally were still laboring under the same political exhortation and suffering from extreme material, physical, and psychological hardships without any means of venting their frustration or political views” (Lin 1985: 13-14). Starting in the 1950's, medical or neurology clinics were reporting the great

majority of their outpatients, sometimes 80 to 90 percent, as suffering from neurasthenia. The predominance of intellectuals among the neurasthenic patient population suggests the difficult adjustment they were experiencing under such adverse political and social conditions.

An ingenious therapeutic model called the Intensive Comprehensive Group Treatment or Speedy Synthetic Method (Chen 1955, Kuan 1960, Sichuan Medical College Dept. of Psychiatry 1960) was developed; it proved effective and soon became the treatment of choice nationally. It involved group therapy lasting for four to eight weeks, emphasizing re-education of the patient to develop "correct ideas and attitudes to work and socialist life, especially in fostering the proper relationship of the self to the society, the Communist Party, and the nation." It was obviously a highly politicized treatment modality. Medication, usually including sedatives or Chinese herbal medicines, was generally used as an adjunct to the group therapy. The role of psychiatrists in these sessions appears to have been more along the line of authoritarian teachers than therapists or psychotherapists in the Western sense. The results of the Intensive Comprehensive Group Treatment for neurasthenia were reported as good in general, with successful outcomes ranging from 60 to 85 percent (Peking Medical College, Department of Psychiatry 1960).

The fact that among the Chinese population neurasthenia became the vehicle to express extreme political, social and physical stresses in the late 1950's deserves special attention. It can be interpreted as due to the Chinese preference for using somatic symptoms to express their stresses (somatization), which also is consonant with the sick role of traditional Chinese culture (Kleinman and Kleinman 1985). One cannot, however, overlook the influence of Soviet psychiatry in this context. Pavlovian psychophysiological theories dominated the medical thought of the time, and thus many of the neurotic symptoms manifested by the Chinese were given a Pavlovian explanation (Li et al 1960). The combined use of group method characterized by political indoctrination with the conventional "rest cure" for neurasthenics also reflected the politico-social reality of the time in China. Thus these three factors – somatization, Pavlovian theory and political persuasion – are not only responsible for the prevalence, modes of manifestation and choice of treatment modalities, they also helped to popularize and perpetuate neurasthenia up until the time of my visits to China in the 1980's, long after the conclusion of Great Leap Forward.

Regrettably no reliable objective epidemiological or clinical research data have been made available regarding the situation of neurasthenia during the Cultural Revolution. Although perceived as less prevalent than during the near-epidemic situation in the late 50's and early 60's, neurasthenia persisted as a major mental health concern of psychiatrists and public health officials throughout the political and social turmoil, and still constitutes an important mental health problem today, as the reader will see from the ensuing articles in

this volume.

(3) *Neurasthenia in Taiwan and Hong Kong*

Taiwan inherited the Japanese tradition as the foundation for developing its psychiatry during the Japanese occupation, and continuing after World War II through my return to my homeland as the only Taiwanese psychiatrist trained in Japan (Lin 1953, 1961). As far as neurasthenia is concerned, it was still regarded as a clinical entity applicable to a fair number of patients who exhibit the typical symptom complexes identified by Beard. In addition, neurasthenia was also considered a syndrome, called either a reactive neurasthenia or pseudoneurasthenia, which manifests in a number of functional or organic psychiatric conditions at different states of various diseases. *Shinkeishitsu* came up sporadically from 1946 to 1950 as a diagnosis given to certain patients of "constitutional neurasthenia" with the triad of obsessive and introverted personality traits and socio-phobic symptoms, *taijin Kyofu* [anthropophobia] or *sekimen Kyofu* [erythrophobia]. It must be added that the number of such patients was extremely small compared to Japan, probably not more than five cases a year among the more than two thousand psychiatric patients seen at the National Taiwan University Hospital. It gradually became clear that most of these patients could be classified as phobic or anxiety neuroses or even as paranoid personality disorders in a few cases, in contrast to Japan where large numbers of *shinkeishitsu* patients manifest a consistent clinical picture. It is quite possible that *shinkeishitsu* should be recognized as a culture bound syndrome (Kasahara 1970, Uchinuma 1983).

My own increasing contact with Western psychiatry and my two years of clinical experience in Boston (1950–52) with attendant extensive exposure to American psychiatry and behavioral sciences, gave substantial stimuli to new directions in both theoretical and clinical work in Taiwan. The result was a broadening of the foundation and scope of perspectives in Taiwanese psychiatry. Prominent among the changes in the nomenclature and taxonomy was the decline of the usage of neurasthenia, a result of American influence, discussed below.

The decline of interest in neurasthenia on the part of Western-trained doctors in Taiwan contrasted sharply with a rapid rise of its popularity among the traditional Chinese doctors and the lay public. Newspaper advertisements with stories of miraculous cures of neurasthenia by a certain traditional remedy, a specific herb or a combination of herbs were quite common. Further, ads for neurasthenic remedies or herbs began to clutter the billboards of many busy streets in the old section of Taipei city. Many Western-trained doctors shook their heads in disbelief at the sight of such a neurasthenia boom. The popularity

and attendant commercial benefits of neurasthenia in Chinese traditional medicine continued to grow in spite of the fact that modernization and Westernization started to pick up its momentum only from the 1960's in Taiwan.

A number of reasons explain this development. Foremost among them was the resurgence of Chinese traditional medicine in Taiwan. It can perhaps be called a rebound phenomenon, a reaction of the Taiwanese general public to the long suppression of the Chinese traditional and folkloric medicine by the Japanese colonial government, which had ruled Taiwan from 1895 to 1945. It may also be seen as a reaction against an even deeper level of Japanese suppression, the Japanese antipathy to or overt prohibition of anything Chinese, especially toward the end of the colonial control of the island of Taiwan in the 30's and 40's. The revival of Chinese traditional medicine hand-in-hand with that of indigenous religious activities clearly attested to this rebound phenomenon. The public championed popularized traditional Chinese medicine, including the remedies it advocated for neurasthenia.

It must be added that a few practical situational problems related to medical care did contribute to the revival of Chinese traditional medicine and folk healing in Taiwan. The breakdown of the medical care system during and after the War, especially due to the changeover of the government after the Japanese defeat, made quality medical care unavailable or too costly to the majority of the populace, especially the poor and farmers. Traditional Chinese medicine and folk healing filled this gap and thus became popular. Furthermore, the Chinese Nationalist government supported and encouraged the proliferation of traditional Chinese medicine as it had on the mainland, promoting it as a symbol of Chinese cultural heritage. It was in this kind of social and medical climate that neurasthenia established itself as a major disease in the minds of the Taiwan public in the late 1940's and early 1950's.

Neurasthenia fared similarly in Hong Kong as in Taiwan, except that the Western-trained doctors there had received British training which paid less attention to neurasthenia than in Japan or Taiwan. On the other hand, Chinese traditional medicine had been widely accepted by all segments of the population for years, which legitimized the use of the term "neurasthenia" as a diagnostic label among traditional Chinese doctors and the lay public.

As noted above, the popularity of the concept neurasthenia among the practitioners of traditional Chinese medicine and the general population is widespread and deep-rooted in all three Chinese cultures – on the mainland and in Hong Kong and Taiwan. In a sense, neurasthenia, which originated in the United States as "American Nervousness," has been transformed into a Chinese concept and "indigenized" in Chinese culture, especially in the subculture where traditional Chinese medicine dominates both theory and practice. A detailed discussion of this specific aspect of indigenization is presented by Fanny Cheung in this Special Issue (Cheung 1989).

*Transformation of Neurasthenia in the U.S. and its Place
in International Psychiatry*

The study of the transplantation and transformation of neurasthenia in the soil of four Asian countries requires looking at the process of transformation in its birthplace, the United States, and also at the broader international scene as viewed through the lens of the World Health Organization.

In the U.S. the beginning of the decline of Beard's concept of neurasthenia was noted as early as the turn of the century (Dana 1904, Blumer 1906). It was widely used in World War I, but showed a rapid decline in popularity in post-war years and largely diminished by the 1930's (Chatel and Peele 1970). In the 1940's and 1950's neurasthenia experienced a dramatic fall in popularity as a respectable and scientifically legitimate disease entity.

Since my contacts with American psychiatry have occurred in distinct phases, my views on the vicissitudes of neurasthenia in American psychiatry will be presented according to the following phases of my own experience:

- a. My initial contact with American psychiatry in 1950–52 coinciding with the publication of DSM-I.
- b. Work in WHO, Geneva, 1965–1969, as a medical officer responsible for epidemiological and social psychiatric research, coinciding with the finalization of ICD-8 and tangentially related to the work on DSM-II.
- c. Work in the U.S. and Canada from 1969 up to the present as a clinician and researcher, and also involved in international mental health, coinciding with the publication of DSM-III and ICD-9 and ICD-10 (Draft).

(a) In 1950 when I made my first visit to the U.S., I was perplexed at the infrequent use of the term neurasthenia either as a syndrome or a diagnostic entity. Soon it became increasingly clear to me that the prevailing school of psychiatric thought of the time, dynamic psychiatry, played an important role in causing this change (Ellenberger 1970). As early as 1894, Freud advocated the separation from neurasthenia of a particular syndrome called the anxiety neurosis. He considered "morbid anxiety" with "anxious expectation" or free floating anxiety and anxiety attacks as its nuclear symptoms. Freud went further to speculate that the psychosexual process of anxiety neurosis was distinguishable from neurasthenia (1895). It was presumed that anxiety neurosis had gradually usurped a greater role in the family of neurotic disorders, relative to neurasthenia, especially because anxiety is common or ubiquitous in most psychiatric syndromes. Many cases which would have been diagnosed as neurasthenia by me or my Asian colleagues then, were labelled as anxiety states or anxiety neuroses by our American colleagues. I found myself often perplexed and overwhelmed by the arguments of my articulate American colleagues,

particularly so, when seemingly convincing dynamic formulations of the disease process, including psychosexual interpretations, were presented time and time again. Such experiences were powerful enough to convince me, a novice in American psychiatry, of the need to abandon the “fallacy of neurasthenia as a diagnostic entity.” This “conversion” in 1950–52 in Boston had important short- and long-term effects on the theoretical and practical clinical work of this writer and his colleagues in Taiwan. And doubtless similar exposure occurred to many other Asian psychiatrists throughout the U.S.

The Diagnostic and Statistical Manual of Mental Disorders, First Edition (DSM-I), published in 1952 (APA 1952), gives no formal recognition to neurasthenia. In its place, under the title of “psychophysiologic nervous system reaction,” a footnote is attached to indicate what is to be done to place those cases diagnosed as neurasthenia: “009–580 Psychophysiologic nervous system reaction.” This category includes psychophysiologic asthenic reaction, in which general fatigue is the predominating complaint. There may be associated visceral complaints. The term includes many cases formerly called “neurasthenia.” In some instances, an asthenic reaction may represent a conversion: if so, it will be so classified, with asthenia as a manifestation. In other instances, it may be a manifestation of anxiety reaction and should be recorded as such.

Being strongly influenced by American psychiatry, I did not then find this handling of neurasthenia unreasonable. The only observation I made was that the language or diagnostic terms used in DSM-I were largely Meyerian, i.e. of the psychobiological school. The question raised then is why both dynamic psychiatry and psychobiology in the U.S. in the first half of the 20th century paid attention to anxiety as a dominant factor in psychopathology, especially in neurotic disorders? I, for one, am without a clear answer.

(b) The DSM-II, published in 1968 by the American Psychiatric Association, accorded neurasthenia a formal diagnostic entity as a subtype of neuroses (APA 1968). The text of the section on 300.5, Neurasthenic Neuroses (neurasthenia), reads as follows: “This condition is characterized by complaints of chronic weakness, easy fatigability, and sometimes exhaustion. Unlike hysterical neurosis, the patient’s complaints are genuinely distressing to him and there is no evidence of secondary gain. It differs from *anxiety neurosis* and from the *psychophysiologic* disorder in the nature of the predominant complaint. It differs from *depressive neurosis* in the moderateness of the depression and the chronicity of its course. (In DSM-I this condition was called ‘Psychophysiologic nervous system reaction’.)” The inclusion of neurasthenia in DSM-II in 1968, however, should not be taken as an indication of the renewed interest of American psychiatry in this disease condition or disease criteria, as no signs of increased clinical or popular usage of the term were observed.

In my view, the listing of neurasthenia in the American classification of DSM-II came about primarily due to the effort of the APA Committee on Nomenclature and Statistics which took the stance of making the DSM-II compatible with the International Classification of Disease 8th Edition (ICD-8). As Ernest Gruenberg wrote in *The Introduction of DSM-II* (APA 1968):

This second edition of *The Diagnostic and Statistical Manual of Mental Disorder* (DSM-II) reflects the growth of the concept that the people of all nations live in one world. With the increasing success of the World Health Organization in promoting the uniform International Classification of Diseases, already used in many countries, the time came for psychiatrists of the United States to collaborate in preparing and using the new Eighth Revision of that classification (ICD-8) as approved by the WHO in 1966, to become effective in 1968. The rapid integration of psychiatry with the rest of medicine also helped create a need to have psychiatry nomenclature and classification closely integrated with those of other medical practitioners. In the United States, such classification has for some years followed closely the International Classification of Disease.

In this connection, I recall the interesting discussions and conversations in and out of the meetings in 1965 and 1966 in WHO, Geneva, before finalization of the ICD-8 Section V (Mental Disorders), in which international cooperation on mental health statistics and mental health research constituted an important focus. The emphasis on internationalism among mental health leaders around the world since the end of World War II seemed to have gained momentum and direction in the early 60's, as manifest in the effort to standardize taxonomy bilaterally (e.g., the U.S. – U.K. diagnostic study [Cooper et al 1972]) and internationally (e.g., WHO's social psychiatry program [Lin 1967], which included ICD revision and development of the International Pilot Study of Schizophrenia [WHO 1973]). My involvement in the WHO as the responsible medical officer for the social psychiatry program gave me an opportunity to be involved, albeit tangentially, in bringing about the compatibility of DSM-II with ICD-8 through E. Gruenberg and M. Kramer of the U.S., among others. In short, it was primarily the "Zeitgeist" of internationalism in mental health in the 60's that brought neurasthenia into DSM-II in line with ICD-8.

(c) The impact of DSM-III (APA 1979) and later DSM-III-R (APA 1987) on clinicians and researchers in American psychiatry has been positive and far reaching, even extending beyond the borders of the U.S. The ripples DSM-III caused in China with respect to the diagnosis of neurasthenia are worth attention.

The fact that neurasthenia is given no place in the DSM-III and DSM-III-R has created considerable response, mostly negative, from among Chinese psychiatrists. For example, Young Derson of the Hunan Medical College, called it a "flip-flop" of American psychiatry and said, "One cannot help feeling that changes of symptoms of diagnosis does not always mean progress of mental

science; it sometimes only means going around and around" (Young 1989). Indeed, neurasthenia was only listed in the subject index at the end of the DSM-III-R "Neurasthenia p.230 and 232" to refer the reader to Dysthymic Disorders on those two pages as suggested: one finds that the definition or description of dysthymic disorder in DSM-III-R has little resemblance to what is known as neurasthenia to the Chinese psychiatrists. "It is nothing but a subtype of chronic depressive state, having little to do with neurasthenia," one Chinese colleague recently ventured his view to me (Hu 1988).

Another important study in this area deserves special mention: Arthur Kleinman's 1980 study in Hunan of 100 patients diagnosed as suffering neurasthenia (Kleinman 1982). Using the Schedule of Affective Disorders and Schizophrenia (SADS) and the diagnostic criteria of DSM-III, both adapted for use with Chinese patients, he reported 87 percent as suffering from various forms of clinical depression. This finding, understandably, created a great deal of interest – and some controversy – among psychiatrists in and out of China. The Chinese responses can be divided into three categories, based on my personal discussions with Chinese psychiatrists during successive visits to China since 1982.

First, outright fury has been expressed by a few diehard conservatives who dismissed the study as of no scientific value, as "it was done by an American who doesn't know Chinese medical thoughts and Chinese culture well enough to make such a study." This kind of response may be regarded as similar to the common initial reaction frequently encountered in other areas of cross-cultural psychiatry when a new finding or theory is presented, contrary to a traditional view or practice. Such reaction usually gives way to more rational, deliberate reasoning later, as a rule, when full facts or detailed theoretical viewpoints are revealed.

In Kleinman's case the above criticism hardly applies, as he has spent almost a quarter of a century working in Chinese language and culture, and furthermore, his research assistants for the study were all young Chinese psychiatrists.

The strong response of the Chinese psychiatrists may reflect their misreading of Kleinman's work as implying that Chinese psychiatrists could not diagnose depression. The resistance of the Chinese psychiatrists may be in part based on their fear that the prevalent and pernicious stigma attached to depression as a form of mental illness might interfere with the treatment of those "neurasthenic" patients if rediagnosed according to DSM-III (Chang Ming-yuan 1989).

A second form of response has been an increased interest in solidifying the theoretical foundation of and/or consolidating clinical observations on neurasthenia while taking a close critical view of the American approach, of DSM-III in particular, to neurasthenia (Young 1989, Yan 1989).

Third, there has been an increased perception of need for experimental scientific enquiry into the possible reasons for a discrepancy in diagnostic

practices between the U.S. and China (Zang Ming-yuan 1989).

The application of DSM-III depression criteria to cases of neurasthenia in Hunan carried out by Kleinman did rekindle the interest of many Chinese psychiatrists in re-establishing neurasthenia as a disease entity in Chinese nomenclature of mental disorders both from the viewpoints of theory and clinical practice. For myself, I wish that Kleinman had gone one step further to include ICD-9, along with DSM-III, in his experimental or theoretical examination of the place of neurasthenia in psychiatric classification. Kleinman himself clearly has taken away an important lesson from his research, and has consulted WHO on maintaining neurasthenia in ICD-10 (Kleinman 1988).

Kleinman's study (1982) raised major theoretical issues concerning somatization and depression among the Chinese. Of the 100 Chinese neurasthenia patients, the great majority presented predominantly somatic, or autonomic nervous system and neuroendocrine, symptoms. For example, of the chief complaints, headaches were present in 90%, insomnia in 78%, dizziness in 73%, and various pains in 48.5% of the cases, in contrast to only 9% of patients giving depression as one of their chief complaints. These and other observations, together with research findings of other investigators (Marsella 1979), have focused on the psychobiological significance of somatization and depression as playing "a fundamental relationship between an individual and society" (Kleinman and Kleinman 1985).

My involvement in the finalization of ICD-8 and in the initiation and execution of the plan for ICD-9 gave me a great deal of insight into the complications of developing a cross-cultural scheme of diagnosis and classification of mental disorders at the highest level of deliberation and negotiation in WHO. The intensity of national pride, the preoccupation of each delegate with his or her own school of psychiatry, the weight of tradition in medicine and psychiatry, the delicate cultural barriers and language difficulties despite the help from the best possible simultaneous interpreters, were hard to overcome within a given limited time of the expert committee meetings.

This experience with ICD-8 led me to propose a ten year plan to develop a universally more acceptable and practicable ICD-9 with a glossary (Lin 1967). The seven annual seminars of the ten year plan starting from 1965 did much to raise and resolve many important issues for clarification before arriving at a text for ICD-9 (1978) which further developed into ICD-10 (Draft) (W.H.O. 1988).

Although it met with some opposition from certain quarters, neurasthenia was adopted to stay as a subtype of neurosis in ICD-8, mainly supported by European and Soviet participants. The U.S. went along with it conceivably for the sake of developing a compatible worldwide schema.

Neurasthenia is listed in ICD-10 (Draft) as F48.0 Neurasthenia (fatigue syndrome), which has three main features: (a) persistent complaints of increased fatigability after mental effort, (b) persistent complaints of bodily weakness and

exhaustion after minimal effort accompanied by unpleasant physical sensations and inability to relax, and (c) the absence of anxiety or depression. It is noteworthy that ICD-10 (Draft) emphasizes the exclusion of depressive disorder or anxiety disorder as a condition for making the diagnosis of neurasthenia, which in essence supports the original concept of neurasthenia.

Searching for the Place of Neurasthenia in Modern Psychiatry

The subtitle of this paper, "its (neurasthenia's) place in modern psychiatry," begs a more fundamental question: Does neurasthenia have a place in modern psychiatry? This question has been frequently raised to me by many North American psychiatric colleagues who know my neurasthenia project. Many suggest that neurasthenia is an obsolete term or that it is a misnomer for anxiety states or depression, and not a subject for serious study.

The simplest and most direct response is that the term neurasthenia is in use by perhaps half of the population living on this globe in a variety of medical and psychosocial contexts. The formal listing of neurasthenia diagnostic entity in ICD-10 (Draft) (1988) bespeaks recognition of that fact. It also demands that all national classifications consider according neurasthenia a legitimate place to insure compatibility of classification and statistics of all medical disorders from all member nations. The importance of maintaining compatible taxonomy and statistics cannot be too strongly emphasized; it is an essential prerequisite for all international cooperative ventures both in theory and practical health measures. Future investigation of the nature and clinical practice of neurasthenia clearly requires international cooperative effort.

In reviewing the state of affairs concerning neurasthenia, I am impressed by the wealth of research opportunities and topics it raises for students of cross-cultural psychiatry. I would suggest the following questions as merely a few examples.

1. Are there patients in the U.S. or Canada who fit the criteria of neurasthenia as specified in ICD-10? If so, how are they being diagnosed and classified, and on what grounds? How are they being treated? It would seem most desirable to have a joint diagnostic exercise like the U.S. – U.K. Diagnostic Exercise (Cooper et al 1972) or a reverse of the Kleinman study of neurasthenia patients in Hunan by having Chinese psychiatrists rediagnose American depressives or neurotics. The WHO Diagnostic Exercise which involved psychiatrists of multiple nations or schools of psychiatry viewing videotaped interviews of patients or case vignettes to provide diagnostic labels, and offering responses to a systematic questionnaire could also be considered for this purpose (Shepherd et al 1968).

Such studies would also help to clarify some of the questions regarding the boundaries of various forms of neurotic disorders, and would foster development of internationally compatible criteria for the classification of neurasthenia and other neurotic and depressive disorders, the so-called minor mental disorders, with well defined research methodologies. With the results of such research and the research instruments developed, epidemiological studies of various populations should be attempted across the Pacific, U.S. or Canada vs China and Japan.

2. Much has been said about the role played by Pavlovian theory on the etiological views of neurasthenia in Chinese psychiatry (Li et al 1960, Young 1989). To my knowledge, however, there has not been convincing demonstration of this thesis using systematic clinical or experimental research data. There is an urgent need for our Chinese or Soviet colleagues to enlighten psychiatrists in other cultures on this very important theoretical issue.
3. The problem of using neurasthenia as a camouflage diagnosis for schizophrenia and other psychotic conditions appears to be widespread and widely known in Asian culture, especially in Japan. Nevertheless, there exists an extreme paucity of data or reports available for studying its clinical, sociological or administrative significance. Perhaps the absence of objective information on this uniquely Japanese phenomenon is in itself part of the problem. My view, which appears to be in line with Munakata's (1989), is that this practice is deeply rooted in the Japanese cultural tradition relative to the concept of mental illness and the family attitude and social stigma attached to the mentally ill. It is this very cultural tradition that appears to constitute the major obstacle to changing the long-established pattern of hospital-centered mental health service to one of community centered care. Thus, research into the practice of camouflage diagnosis – its extent, nature and psychosocial effects on the family and the patient – would greatly facilitate the study of patterns of mental health service in Japan, and other Asian cultures as well.
4. Indigenization of neurasthenia in Hong Kong and Taiwan offers not only a splendid case for investigating the concepts of, and approaches to, mental health among Chinese, but also illustrates the integration of traditional and Western medicine (Cheung 1989). One should not lose sight of the important fact that a similar process is taking place on a much larger scale on the Chinese mainland. To my observations, albeit casual and limited, a large majority of neurasthenics seek help from traditional medicine doctors or barefoot (farm or factory) doctors who constitute the backbone of the primary health care system. Here appears to lie a hidden treasure for research into primary mental health care in China aimed at learning about the magnitude and kinds of mental health problems, the social-environmen-

tal strains, and the modalities of treatment. I still vividly remember my own shock when told during my earlier visit in 1982 by a barefoot doctor (farm doctor), that "about 35% of our patients suffered from neurasthenia at the time of the Cultural Revolution, but it is about 10% now." The gold mine of information buried in the enormous primary care systems of China should be dug out for scientific study, and most important of all, used at the basis for future mental health planning (Lin & Eisenberg 1985).

Finally, I would like to remind readers that the views expressed in the nine papers of this Special Issue only represent those of each author, and not of any school of psychiatry, although each of these authors is a nationally recognized expert on the topic of neurasthenia and (related) psychiatric disorders. It is hoped that this Special Issue will contribute to further discussions of this area, a crucial focal point in international psychiatry involving, as the reader will see, a variety of themes and issues which we, as scholars and students, will have to elaborate and resolve in the years to come.

*Suite 1503, 805 West Broadway
Vancouver, B.C.
Canada V5Z 1K1*

NOTES

¹ For a detailed account which is beyond the scope of this paper the reader is referred to Drinka (1984) and Sichenman (1977).

² The following brief outline of Morita therapy is largely based on the paper "The Concept of Neurasthenia and its Treatment in Japan" by Dr. Tomonori Suzuki (this issue).

³ There exist numerous and significant legal impediments to the rehabilitation of the mentally ill in Japan. Those diagnosed as suffering from any form of mental disorder, especially those hospitalized, face the threat of losing their jobs and disqualification from eligibility for innumerable jobs as specified by relevant laws (Tahara 1988). These mental illnesses include schizophrenia, affective disorders, and all forms of psychotic disorders. The number of jobs deemed ineligible for the mentally ill has been increasing and now covers a wide range of occupations amounting to over several hundred including hair dresser, taxi driver, physician and all categories of health profession, pilot, any business dealing with chemicals or fire arms, police, government employees of all levels, accountant, lawyer, etc. It appears that only a few non-skilled jobs are available for the mentally ill. Furthermore, the mentally ill are deprived of certain rights which are essential for a citizen in modern society, e.g. voting rights, rights to seeking elective office, to hold a driving licence, etc.

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