



Neurasthenia, subjective health complaints and sensitization

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Received 29 November 2004; received in revised form 10 April 2005; accepted 21 April 2005

KEYWORDS

Neurasthenia;
Subjective health complaints;
Pseudoneurology;
Musculoskeletal complaints;
Fatigue

Abstract Patients ($n=997$) visiting general practitioners in an area in Western Norway completed a battery of questionnaires related to subjective health complaints and fatigue. An additional 78 patients were referred directly to the hospital for neurasthenia. After screening the questionnaires and interviews with a selected sample, a total of 73 patients were finally accepted as 'neurasthenia' patients satisfying the ICD-10 diagnosis. These patients were compared with the remaining 1002 patients. Patients with neurasthenia had more prevalent and more severe subjective health complaints, particularly pseudoneurological and musculoskeletal complaints than the reference population of patients. They reported low levels of instrumental coping and poorer physical fitness, in spite of a comparable level of self reported physical activity and exercise. Women were over-represented in this group. This overall higher score on subjective complaints from all organ systems is in accordance with the hypothesis of an overall and general sensitization to the afferent inputs from their psychophysiological systems.

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1. Introduction

Neurasthenia has a centennial history of rise and fall (Hickie, 1997; Luthra and Wessely, 2004). Recently the concept has regained interest in psychiatry and psychology. Is 'neurasthenia' still a useful concept in contemporary medical care? Is this a specific condition or just part of a syndrome of subjective and ill defined complaints?

Complaining of being tired is one of the most common health complaints in the general population. About half the general population in Norway report that they have been bothered by feelings of tiredness over the last 30 days (Ihlebaek et al., 2002). To qualify as chronic fatigue syndrome or neurasthenia, the condition requires a combination of persistent and disabling fatigue and neuropsychological and neuromuscular symptoms, with a high degree of disability (Fukuda et al., 1994; Lloyd, 1998). In ICD-10, neurasthenia is defined as a long-lasting condition with low threshold for fatigue

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reactions and exhaustion after minor physical and mental efforts (World Health Organization, 1992).

Other somatic and psychological complaints are common. This comorbidity is one reason to question whether this condition is specific, or part of a general syndrome. There are also other questions as to the validity of the diagnosis (Bankier et al., 2000). The controversy and the identification of general weakness and fatigability as a specific condition has a long history (Shorter, 1992). In 1869, the American neurologist George M. Beard coined the term 'neurasthenia', and described the condition as a somatic disorder, with emphasis on physical complaints and fatigability. The somatic explanation offered was 'nerve weakness' based on a 'hypersensitivity' of the nervous system, in accordance with the contemporary neurological state-of-knowledge (Beard, 1869). The diagnosis of neurasthenia became popular, and through the last decades of the 1800's neurasthenia expanded into a wide spectrum of ill-defined and medically unexplained complaints and conditions, losing much of its original meaning of hypersensitivity to physical and mental efforts. Eventually, the use of the diagnosis faded and other concepts became more popular (Chatel and Peele, 1970).

During the last decades, the illnesses of general weakness have reappeared with new labels and categories: postviral fatigue, myalgic encephalomyelitis (ME), chronic fatigue syndrome. (Wessely, 1990). Also, the terms burn-out and exhaustion depression are used for conditions where fatigue is prominent. One common paradigm for the new recognition of the concept of chronic fatigue syndrome and ME has been the notion of an infectious cause, most likely by a virus, and a consequent immunological reaction and dysfunction, causing fatigue and the various accompanying complaints (Farrar et al., 1995; Lane et al., 2003). Despite new theories and explanatory models, there are no consistent medical findings or markers, and the magnitude and variety of complaints and disabilities to accompany the condition is still not fully explained (Afari and Buchwald, 2003).

The comorbidity of psychological and physical symptoms makes the stringent diagnosis of neurasthenia or chronic fatigue syndrome difficult. Since tiredness is so common, and since many of the comorbid complaints (muscle pain, gastrointestinal complaints) also are common complaints, one mechanism may be sensitization to ordinary health complaints, leading to a vicious circle (Eriksen and Ursin, 2004). Sensitization is defined as an increased reactivity to stimuli, and is recognized at the synaptic level of spinal neurones, as well as for populations of nerve cells. It is also a concept

that may be used for more complex cognitive functioning (Brosschot, 2002; Overmier, 2002). It has been suggested that sensitization is the neurobiological mechanism for generalized and non-specific muscle pain, for 'functional' gastrointestinal problems (Wilhelmsen, 2002), and for multiple chemical sensitivity (Bell et al., 1992). Sensitization has also been suggested as the underlying mechanism for somatization in general, and for other disorders such as major depression, panic disorder, phobic disorder, irritable bowel syndrome, ovarian cysts and anxiety (Bell et al., 1992, 1998).

Fatigue, and fatigability in particular, with low thresholds for fatigue reactions after minor physical or mental efforts, may well be regarded as a condition of sensitive physiological responses, possibly as a result of sensitization. The sensitization process may start with an infection, causing immunological dysfunctions and post-infectious fatigue, but may also be precipitated by overstrain, stress or psychological trauma. The resulting condition is usually characterized by a general subjective experience of illness, somatic complaints and vital exhaustion, with no evident medical signs or pathology (Afari and Buchwald, 2003). The issue, then, is how specific this sensitization is. Does it affect only one psychobiological process, or does it affect many afferent systems, explaining the high degree of comorbidity?

To elucidate this question, we have screened both the 'neurasthenia' patients and the general help-seeking population in general practice for all their complaints by the use of a standardized questionnaire for subjective health complaints (SHC) (Eriksen and Ihlebaek, 2002). We have examined whether there were differences between these two populations in the prevalence of subjective health complaints, sickness leave and coping, and whether any such differences related to demographic variables, life style, physical fitness and coping.

2. Method

2.1. Material

1075 patients filled in questionnaires on subjective health complaints, neurasthenia, coping strategies, together with demographic information, illness history and lifestyle. The questionnaires were followed by written information about the study, and all participants taking part in further interviews gave written consent for contact and interviews.

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