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ASTHENIC PERSONALITY, MYTH OR REALITY*

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SYNOPSIS

One hundred and seventy five subjects admitted to hospital for neurotic conditions were assessed as to their personality types. Forty seven percent were judged as having personality traits consistent with the diagnosis of asthenic personality disorder. Thirteen of the 138 symptom, life history and psychologial test items examined were found to be associated with the asthenic traits. Condensation of these thirteen items by factor analysis showed that two features — anxiety proneness and inability to cope with stress — together defined the disorder.

Asthenic Personality Disorder is one of the eight types of personality disorder listed in the glossary of mental disorders, published for use in Australia by the National Health and Medical Research Council. It also appears in the International Classification of Diseases, eighth version (ICD8), on which the glossary is based, and continued to be included in the new ninth version (ICD9), although it is redefined in terms similar to that of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM2). Despite its established place in psychiatric classifications, the condition receives scant mention in either American or English text books of psychiatry and does not appear to be the main focus of a single article in the literature. It is therefore proper to ask whether the condition is a definable entity, and whether it has any utility in the description of psychiatric cases.

The term features in Schneider's classification of psychopathic or abnormal personalities (Schneider, 1950). He defended the concept by saying that the "daily experience in the clinic does ask for some such category which will cover those personalities who are commonly classed as nervous individuals". The Schneiderian constructs appear to be elaborated in the three definitions which are listed below, the key concepts being italicized.

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301.6 ASTHENIC PERSONALITY DISORDER

ICD8: Characterised by *inadequate response* to intellectual, emotional, social and physical demands. Such individuals are generally *unable to adapt* to specific situations such as marriage, home life or occupation, and exhibit *lack of self confidence, indecisiveness and emotional dependence.*

ICD9: Characterised by *passive compliance* with the wishes of elders and others and a weak *inadequate response* to the demands of daily life. Lack of vigour may show itself in the intellectual or emotional spheres; there is *little capacity for enjoyment.*

Synonym: Passive, Dependent, Inadequate.

DSM2: Characterised by *easy fatigueability,* low energy, lack of enthusiasm, marked *incapacity for enjoyment,* and *over-sensitivity* to physical and emotional stress.

In DSM2 the concept of *inadequate response* to demands is included in the sub-type 301.82, Inadequate Personality Disorder.

The condition does not feature in work by English or American psychiatrists, but it is mentioned in several longitudinal studies published by European psychiatrists. Tolle (1968) conducted a 30 year follow-up study of patients with established personality disorders initially seen between 1928 and 1941. Asthenic personality was diagnosed in 25% of the cases. It was defined in terms similar to those of the classifications"
"always tired; capable of achieving little; frequent vegetative symptoms; sensitive, timid, sorry for themselves; needing someone to lean on, apathetic; difficulties are followed by depressive reactions".

These patients were reviewed during 1963-64. Some were excluded on the suspicion of various other disorders such as epilepsy, psychosis and drug addiction and the remaining 115 patients were then contacted and examined by the author. Tolle obtained a history of how they had responded to a serious life crisis and found that 70% of the asthenics suffered from depressive episodes rather than conversion reactions or psychosomatic syndromes. The percentage of hysterical, sensitive and depressive per-

sonalities showing episodes of depressive illness in a crisis were much less, the highest being 40% for depressive personalities.

Tolle rated each patient according to the degree of 'mastery of life' shown over the intervening years. This concept included stability of physical health, absence of mental illness, adaptation to family and work and participation in social life. Approximately 50% of the patients diagnosed as asthenic had functioned without requiring psychiatric help despite their personality difficulties. This is in contrast to the hysteric and the schizoid personalities of whom only 30% had not required psychiatric help. The asthenic persons coped by limiting their activities to the familiar and by guarding against events which could disturb. Tolle's efforts would have been much more substantial had he cross-checked his ratings of each patient with ratings of other psychiatrists. Agreement within a rating technique by several experienced clinicians only increases the reliability of the obtained data. However, Tolle's attempt to clarify the various personality diagnoses in terms of long-term outcome and behaviour characteristics during crisis situations is a major step for the area of personality disorder, at least within the English literature.

The term Asthenic Personality was employed in a recent study of alcohol dependence, in which Lundquist (1973) analysed the personalities of 200 inpatients admitted to the University Clinic for Alcohol Diseases at Karolinska Hospital, Stockholm. All the patients were voluntary and seeking treatment for alcohol dependence. Of the 200 patients, 68% were considered to have personality disorders. Lundquist determined that 65% of these individuals with deviant personalities were asthenic and "strongly inclined toward tensions, depressive states and anxiety", a conclusion similar to that reached by Tolle.

These results suggest that alcohol dependent individuals tend to have many of the traits which define asthenic personality. Lundquist implies that the depressive, anxious nature of the asthenic is conducive to acquiring or at least influencing the course of the alcohol dependence. Without adequate comparison groups, no such conclusion can be entertained. This study does, however, illustrate how the concept of asthenic is used. Even though no clear cut description of asthenic personality is given by Lundquist, his usage of the term seems to be consistent with the previous usages.

Interested in frequency and distribution of mental disorder in Iceland, Helgason (1963) conducted a retrospective study of the mental health history of 5,395 Icelanders born at the turn of the century. Only 194 were diagnosed as having personality disorders. Helgason used Schneider's (1950) definitions of personality disorder and found asthenic personality disorder in 18% of the 194 cases. It was diagnosed in women twice as frequently as in men, but inspection of the data suggested this might be an artefact due to the classification system used. When more than one diagnosis was made in a given patient, asthenic personality was most likely to be associated with a diagnosis of neurosis or alcoholism. From these three studies it may be assumed that asthenic personality is diagnosed in Europe in a fashion similar to the descriptions in classifications used in the United States, Britain and Australia. It appears to be a common personality disorder often associated with depressive neurosis and alcoholism and often consistent with a reasonable life style.

The purpose of the present study is to examine a cohort of neurotic inpatients who were rated as to personality type by three separate psychiatrists and to determine (i) whether the term asthenic personality disorder is of value and (ii) whether it is characterised by the triad of anxiety proneness, inability to cope, and the liability to depression.

METHOD

One hundred and seventy five persons admitted to a University Hospital inpatient clinic with non-psychotic, non-organic disorders were assessed using a structured interview (Kiloh et al, 1972), the Eysenck Personality Inventory, the Cattell IPAT Scale and by Raven's Progressive Matrices. Reliability of the interview was established by tape recording the interview and discussing until the interviewer and two other judges reached consensus on the scoring decisions. Using a split half design the correlations of each interview and test variable with the criterion (judgement of asthenic personality traits as not present, mild, moderate or severe) were examined. Moderate or severe scores were consistent with the diagnosis of asthenic personality disorder.

The core features of the disorder were established by selecting those items which correlated more than 0.25, ($p < .01$) on each half *and* which correlated greater than 0.27 ($p < .001$) in the total group of subjects.

The relative importance of these core features as predictors of asthenic personality was assessed by multiple regression analysis. Finally, the core features themselves were condensed by factor analysis. Three factors were obtained. The two factors relating to anxiety were further condensed onto a common axis and correlations between factor scores and asthenic personality were computed.

RESULTS

Forty seven percent or 82 of the 175 persons with neurotic illness were judged to have moderate or severe asthenic traits consistent with the diangosis of asthenic personality disorder. Twenty six percent of the cases were judged to have normal personalities and 27% had traits descriptive of other personality disorders. Asthenic personality disorder was therefore the commonest personality type identified in this cohort of neurotic patients. There was no relationship between the asthenic diagnosis and sex, intelligence, marital status or social class. It was weakly associated ($p < .05$) with youth.

Of the 138 interview and test items, 13 fulfilled the criteria of core features (Table 1). Five items were from the

TABLE 1

Correlations of 13 items related ($p<.001$) to asthentic personality. Items examined = 138, subjects n = 175

lack of ability to cope	.66
nervous as a child	.41
school underachievement	.40
IPAT trait anxiety	.38
IPAT C, emotionality	.36
work underachievement	.35
EPI neuroticism	.35
IPAT 0, insecure	.35
premorbid anxiety traits	.34
IPAT Q3, lack of self control	.34
fears of what might happen	.33
suicidal ideas present	.30
worried by little things	.28

psychological inventories: EPI neuroticism, Cattell IPAT trait anxiety and the subscales of C (emotionality), O (insecurity) and Q3 (passivity and poor self control). Three items were related to the present neurotic illness — complaints of 'fears of what might happen', 'suicidal ideas', and being 'worried by little things'. Five items related to the premorbid history — lack of ability to cope with previous stresses, school under-achievement, work under-achievement, being nervous as a child and premorbid anxiety traits.

A multiple regression analysis of these 13 predictors (core features) of asthenic personality was performed and the result of the first analysis is presented in Table 2. Lack of ability to cope accounted for 44% of the variance, while this and an additional 3 items, nervous as a child, suicidal ideas and 'being worried by little things' together accounted for 51% of the variance. The addition of other items produced little further gain. The psychological tests associated with the diagnosis were overshadowed by the clinical variables. As clinical judgement of personality characteristics may not be consistent between psychiatrists

TABLE 2

Results of multiple regression analysis of 13 variables as predictors of asthenic personality traits

	multiple r	variance r^2
(a) 13 clinical and test variables		
lack of ability to cope	.664	44%
nervous as a child	.691	48%
idea of suicide present	.704	50%
worried by little things	.715	51%
school underachievement	.719	52%
fears of what might happen	.723	52%
IPAT C, emotionality	.724	52%
work underachievement	.724	53%
premorbid anxiety traits	.725	53%
EPI neuroticism	.725	53%
IPAT trait anxiety	.726	53%
IPAT O, insecure	.727	53%
IPAT Q3, lack of self control	.727	53%

	multiple r	variance r^2
(b) 5 psychological test variables analysed separately		
IPAT trait anxiety	.379	14%
IPAT C, emotionality	.396	16%
EPI neuroticism	.403	16%
IPAT Q3, lack of self control	.410	17%
IPAT O, insecure	.411	17%

of differing orientations it was deemed important to examine the degree to which the psychological test variables could predict the disorder. Multiple regression analysis of the five test variables was performed and together they accounted for only 17% of the variance (see Table 2b).

TABLE 3

Principle component factor analysis of 13 variables associated with asthenic personality traits

	Factor 1 Test Anxiety	Factor 2 Clinical Anxiety	Factor 3 Coping
lack of ability to cope	.13	.38	.72
nervous as a child	.30	.50	.38
ideas of suicide present	.58	−.13	.23
worried by little things	.31	.66	−.16
school underachievement	.16	.02	.80
fears of what might happen	.16	.63	.14
IPAT C, emotionality	.76	.20	.20
work underachievement	.10	−.03	.82
premorbid anxiety traits	.12	.84	.12
EPI neuroticism	.74	.41	.01
IPAT trait anxiety	.90	.32	.11
IPAT O, insecure	.86	.29	.05
IPAT Q3	.77	.26	.14
Correlation with asthenic personality traits	.26	.35	.49
Correlation of asthenic personality traits with sum of anxiety factors (factor 1 + factor 2)		.43	

A principle component factor analysis with varimax rotation of the 13 core features was then performed. Three factors were obtained. These factors are displayed in Table 3. Correlations between the factor scores and the rating of asthenic personality traits were derived and showed that Factor 3, the coping factor, was more closely related to this judgement than were either Factor 1 or Factor 2, the anxiety factors. The two anxiety factors were collapsed onto a common axis in order to gather some idea of the relative importance of these two concepts, anxiety proneness and poor coping, to the judgement of asthenic traits. The correlation between the conjoint anxiety factor scores and the judgement was found to be 0.45.

DISCUSSION

The 175 neurotic patients formed part of a study of depressive illness and during the interview and testing there was no particular focus on or interest in the concept of asthenic personality. These patients were a random selection of non-psychotic admissions to a University clinic inpatient service, chosen only on the basis that they complained of depression as a symptom. This neutrality to the idea of asthenic personality and the split half design used initially ensures that the core features of asthenic personality are unlikely to be artefactual. Nearly half the patients had personality traits consistent with asthenic personality disorder. If Tolle and Linquist are correct, this figure will be artificially inflated in the present material by the emphasis on depressive illness used in admitting patients to the study. Still, as depressive symptoms are very common in persons requiring admission for neurotic illness, it may be concluded that asthenic personality is a frequent associate of neurotic breakdown.

It is therefore important that the full characteristics of this personality type be examined. The definitions suggest that this personality type is associated with anxiety, inability to cope and the liability to depression. The design of the study, permeated as the cases were with depressive symptoms, would not have allowed the third feature, depression, to emerge as a significant feature of asthenic personality. The first two features emerged strongly and there were no other contaminating features associated with the diagnosis.

According to the definitions, inability to cope or adapt is the principle feature of the disorder. In the present material, inability to cope evidenced throughout life is a cardinal feature of the disorder. It remains paramount whether assessed by correlation, multiple regression analysis or factor analysis.

According to the hypothesis erected on the basis of the classifications and the literature review, another feature of the disorder is the presence of anxiousness (poor self confidence, passivity, dependence, easy fatigueability and anxiety proneness). In the present material the anxiety proneness is evident in the childhood history, and is indicated by the Eysenck Neuroticism score and the Cattell Trait Anxiety factor score. The Cattell subscales on which the asthenic subjects scored highly have a component traits poor self confidence (O+), passivity and dependence (Q3—) and easy fatigueability (C—).

It may be claimed that the features associated with the clinical diagnosis are very similar to those suggested by the definitions of the disorder. As the condition appears to be a definable entity, what are the clinical implications? Tolle suggested that persons suffering from this disorder could function adequately if protected from environmental stress. These persons, then, are liable to experience anxiety in response to a given external stress and in addition, quickly find that this anxiety debilitates their attempts to cope. This proposition would be simple to examine in terms of the experimental paradigm relating skilled performance to rising anxiety.

The clinical management of such persons would appear to revolve around them avoiding change in their life status, being content to be dependent and passive, and relying on the efforts of others to insulate them from adversity. There is no information to suggest that their anxiety proneness can be reduced by drugs, relaxation or meditation. Nor is there information to suggest that from psychotherapy or counselling can they learn to cope maturely rather than by the immature strategies of passivity and dependence. But then for some people, life has to be made easy.

REFERENCES

American Psychiatric Association. (1968). *Diagnostic and Statistical Manual of Mental Disorders,* (2nd Edition) American Psychiatric Association, Washington.

Helgason, T. (1964). Epidemiology of mental disorders in Iceland. *Acta Psychiatrica Scandinavica Supplement,* **40:** 1.

Kiloh, L.G., Andrews, G. Bianchi, G.N. and Neilson, M. (1972). On studying depression. *Australian and New Zealand Journal of Psychiatry,* **6:** 85.

Lundquist, G.A. (1973). Alcohol dependence. *Acta Psychiatrica Scandinavica,* **49:** 332.

World Health Organization. (1977). *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death,* (9th Edition, Vol. 1) World Health Organisation, Geneva.

National Health and Medical Research Council. (1972). *Index and Glossary of Mental Disorders,* Australian Government Publishing Service, Canberra.

Schneider, K. (1959). *Clinical Psychopathology,* Grune and Stratton, New York.

Tolle, R. (1968). The mastery of life by psychopathic personalities. *Psychiatrica Clinica,* **1:** 1.

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