A HUNDRED YEARS AGO

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TREATMENT OF WAR NEUROSES

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SOLDIERS SUFFERING from functional nervous disorders should be quickly placed under special treatment; otherwise, they may pass from one hospital to another and become chronic. This is above all necessary in the case of hysterical disorders. There were at one time thousands of such cases in the French military hospitals, men who might, had they been properly treated, have been enabled to return to active service.

Neurasthenic patients are best treated by rest and common sense.

Hysterical cases need kindness, combined with the strictest discipline. The physician should, as Babinski puts it, assume authority. The personality of the physician counts for much; some have a kind of genius for treating these cases – a way of handling them which cannot be taught.

Much good may be done by suggestion in hysterical cases. By encouraging a patient and assuring him that he can use a paralysed limb, we may gradually bring back his control over it. Suggestion is especially useful in hysterical blindness: the patient is told that he will see, at a certain time, the exact minute being specified. Thus, Mr. Walter Jessop succeeded in curing a blind patient by getting the nurse to awake him in the middle of the night and saying to him, "Now you can see!"

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Deaf mutes are more refractory. These cases are best treated, as Dr Dunas Grant suggests, by re-educating the voice by the method adopted in institutions for the deaf.

Stammering is treated in the ordinary way.

The treatment of hysterical contractures often presents considerable difficulty. One plan is to over-correct the deformity by means of a plaster of Paris splint. Thus, in the case of equino-varus, the foot is fixed in a position of calcaneo-valgus. This treatment should be combined with the suggestion, tactfully reiterated, that all spasm will disappear on removal of the splint.

Massage and electricity should be avoided in hysterical cases.

Clinical manifestations of war neuroses

The war neuroses differ greatly in their manifestations. Most of them can be grouped under insanity, neurasthenia, psychasthenia and hysteria.

Insanity

Actual insanity is less common among soldiers invalided from the front than might have been expected. It tends to conform to the types which occur in civil life, such as dementia praecox. It is probable that in all such cases there is a strong tendency to insanity, which reveals itself under the stress and strain of war conditions.

Neurasthenia

Tachycardia, fine tremor, and nervous agitation (a combination generally met with in Graves's disease) are common features of neurasthenia. Excessive sweating, another feature of Graves's disease, is not infrequent. These neurasthenic patients are apt to be silent, and many of them seem to be agitated by persistent fear. They are probably for the most part congenital neurotics. While the fine tremors chiefly affect the hands, other parts may be similarly affected. M. Meige has described a nystagmiform tic. This physician has met with many cases of voluntary nystagmus which could be maintained for some time. Many different forms of coarse tremors are also met with.

Hysteria

Hysteria looms large. Thus we meet with paralyses (hemiplegia, paraplegia, monoplegia), contractures, tremors, anaesthesia, amnesia, blindness, and deaf-mutism – the two latter chiefly as the result of shell shock. Hysterical fits are rare among our soldiers.

Contractures are less common than paralyses. In a case of equino-varus, the varus was so marked that the external malleolus was in actual contact with the ground; the patient had hemianaesthesia (complete below the knee) on the affected side, with diminution of the superficial reflexes as is usual in such cases.

Anaesthesia, like paralysis, is generally unilateral, and often crystallizes round an injured part.

Functional blindness and deaf-mutism are practically always the result of shell shock. Blindness may affect one or both eyes. It is rarely complete; more generally there is a mere blurring of vision – smoky vision – or a concentric shrinkage of the visual field.

Deaf-mutism is much more common than functional blindness. They are capable of normal silent thought, and, indeed, are often voluminous writers. Nine-tenths recover within six weeks. Hearing almost always returns before speech. As a rule, the recovery of speech is gradual, but it may return suddenly, as the result of an outburst of laughter, or of a vivid dream.

These cases of functional deafness differ from labyrinthine deafness in three respects: the deafness is absolute; the pupils respond to the whistle; Barani's reaction cannot be elicited. Although deafness is absolute, the patients may be able to hear subconsciously, registered by a secondary personality. Such a splitting or disintegration of the personality constitutes an essential feature in the pathogeny of hysteria.

Hallucinations of hearing are common; and, as might be expected, stammering is not infrequently met with.

Epilepsy

Epilepsy may follow shell shock, but it is probable that in most of these cases the patient is congenitally predisposed to the disease. That the epileptic diathesis is consistent with heroic action is shown by the case recorded by Dr Mott of an epileptic who gained the Victoria Cross.

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