Critical Digest and Review

WAR NEUROSES AND PSYCHONEUROSES

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For a systematic and detailed description of the physical symptoms of the war neuroses, we turn to the French clinicians. The following résumé is abstracted from "The Psychoneuroses of War," by J. Roussy and J. Lhermitte, published in English translation by D. Appleton & Co., in Vol. II of their Medical and Surgical Therapy, 1918.

Psychoneurotic *motor symptoms*, paralyses or contractures, are among the most common and therefore most important physical symptoms of war neuroses. These motor disorders take the form of a flaccid paralysis or paralysis with contracture, when they more or less closely resemble the true organic paralyses, either flaccid or spasmodic; thus we find hemiplegias, paraplegias and monoplegias. Sometimes they defy classification and may assume the most infinite variations in type. In spite of their diversity, the psychoneuropathic motor complaints have certain common characteristics: they appear under the same etiological conditions, they exhibit specific clinical and "pathognomic" signs which permit of their differentiation from organic diseases and, lastly, they react to therapeutic measures in a similar manner.

Sometimes these conditions originate from some fairly severe trauma not entailing any grave wound, a cerebrospinal concussion from the explosion of a projectile or a mine close at hand but without any obvious bodily wound, shock from the collapse of a trench, etc. In other cases the paralysis develops without any mental or physical shock. It is not exceptional to find that these paralyses or contractures are preceded by more or less vague pains in the joints of the limbs which have been contused. Or these motor affections may develop in hospital during the course of an infectious disease contracted in the trenches.

The situation of the trauma has no bearing on the site of de-

velopment of the paralysis. A scar, proving the existence of a real initial trauma, may even be found at a great distance from the affected limb. Further, the severity of the wound bears no relation whatever to that of the paralysis; on the contrary, it appears that in most cases it is the most insignificant wound that brings about the most serious functional paralysis.

The onset of these motor affections is much the same, whatever form they may take. Sometimes they appear immediately after the trauma, as soon as the patient recovers from the emotional shock that he has just experienced; or if he has lost consciousness, at the moment he regains it in the field-ambulance or hospital. Often the hemiplegia, monoplegia or paraplegia may not become manifest until several days later, and during this period—the phase de méditation of Charcot—the soldier only exhibits vague symptoms in keeping with a physical and psychical disorder occasioned by the trauma: more or less diffuse aches and pains, vertigo and general asthenia.

Hysterical Hemiplegia.—Although much rarer than paraplegia or the monoplegias of the same nature, hysterical hemiplegia is far from a rarity. With regard to the upper extremity, it is very often more affected than the lower; hanging beside the body, it is incapable of any voluntary movement. Neither the face nor the tongue share in the paralysis, and the apparent facial paralysis sometimes met with is really due to a tonic glosso-labial spasm of the opposite side. The cutaneous and tendon reflexes are normal and muscular tone is equal on the two sides. This rule, however, has certain exceptions which it would be dangerous to ignore. Following on prolonged functional inactivity, the muscles of the paralyzed limb undergo atrophy, and this itself necessitates an inequality of the tendon and bone reflexes; the latter will be more marked on the side of the hemiplegia, without always being accompanied by true ankle clonus or patellar clonus.

Hysterical hemiplegia with contracture develops suddenly and is of two forms: (1) One characterized by an intense contracture of the upper and lower limb to such a degree that all passive movement is impossible. (2) The other, in which the hemiplegia assumes both a spastic and flaccid type; spastic as regards the contracted lower extremity, flaccid as regards the upper, which hangs absolutely inert beside the body. Vasomotor symptoms such as lowering of temperature, cyanosis of the paralyzed extremities, profuse sweating, edema, etc., are the result of functional inactivity.

Hysterical Monoplegia and Paraplegia are more frequent than

psychoneurotic manifestations of the hemiplegic type. Of the monoplegias, in the upper extremity, the flaccid type is the more common; in the lower extremity the reverse is true, there being more cases of the spastic type. Paraplegia is the most common of all these motor disturbances.

In addition to the groups just enumerated, motor affections of spastic or paralytic type, limited to a circumscribed region such as the foot, hand, shoulder, trunk, neck, or a group of muscles, are frequently observed in the neuropathology of war.

Disturbances of Gait.—These are many and diverse in form. We shall pause only to name them: Astasia-abasia, dysbasia of choreiform type, dysbasia of pseudo-tabetic type, dysbasia of pseudo-polynuritic type, various atypical forms such as tight-rope walker's gait, knock-kneed gait, walking as if on a sticky surface, bather's gait, scrubber's gait and finally a class in which fear is the predominating factor called staso-basophobia.

Tremors, Tics and Choreiform Movements.—This group of symptom is of frequent occurrence among patients suffering from the war neuroses. Considering first the tremors we may divide these into atypical and typical tremors. The atypical tremors are irregular disorderly movements not resembling in their behavior or course any tremors accompanying known maladies. The typical tremors are those which more or less resemble those seen in nervous diseases which are accompanied by tremor.

The atypical tremors are sometimes generalized, affecting all the body muscles and sometimes localized, affecting only a limb or part of a limb. When generalized, they are usually associated with other symptoms as a part of the clinical picture of the "shell-shock syndrome." The facial expression seems to portray indescribable terror, and shares in the disorderly and irregular movements of the whole body. The tremor has been justly considered (Ballet) as the expression mimicking fear. There are also circulatory disturbances (tachycardia, flushing or pallor of the face), secretory changes (perspiratory, lachrymal, small salivary secretion, discharge of urine), all of which with the tremor are manifestations of the emotion. In these generalized tremors the patient is shaken by vibratory oscillations of variable intensity, sometimes fine and limited to the extremities, more often wide and irregular; in the latter there are extreme oscillations of the limbs reminiscent of chorea gravis, accompanied by clonic movements of the muscles of the face and neck. The patient cannot stand upright nor walk and has to be carried on a stretcher. On the slightest touch or examination these illogical

and paradoxical movements become more violent and sometimes reach a surprising intensity. Any sudden noise, such as the slamming of a door, or particularly the sound of cannon, may determine the occurrence of paroxysmal crises.

The *typical tremors* resemble, either by the actual character of the tremor or by associated signs, the definite tremorous disorders which are well known and classified in neuropathology. Various types are the pseudo-Parkinsonian type, the disseminated sclerosis type, the pseudo-cerebellar type and pseudo-choreiform types.

The Tics.—Tonic tic may be observed as a result of wounds or nervous shock in war, but is much less common than the clonic tic or spasmodic movements which make their appearance under their appearance under the same conditions as the tremors. They are usually observed in and around the head.

Psychical Disturbances of Sensation.—These occupy an important place amongst the psychoneurotic manifestations of war and may be divided into two main groups: (1) Psychopathic pains or "algias" and (2) anesthetics.

The algias are very common. They may be grouped according to anatomical location as algias of the lower limbs, of the upper limbs, of the trunk and spine, of the neck and head, and visceral algias; the latter may be gastric, visceral, renal, etc. The most frequent are those of the lower limbs. Differential diagnosis of these pains may be a matter of considerable difficulty. The following points should be considered. (1) Distribution of the pain; it is usually paradoxical in its nature and erratic in its localization. (2) Associated signs noted during examination: (a) respiratory manifestations (the dyspnea of exertion or emotional dyspnea) and the resistance shown by the patient to attempts at examination or passive movement. (b) The psychological condition of the patient who is often uncommunicative, unwilling to look the examiner in the face, always ready to turn the conversation, etc. (c) The occurrence of fresh nervous phenomena as tremor, convulsive crisis, outburst of weeping, sweating etc. (3) The absence of somatic signs is of course of great value. (4) Therapeutic tests and their results.

Anesthesia, Analgesia and Hyperesthesia.—Modifications of objective sensation are much less important than those of subjective sensation just discussed. Not being perceived by the patient they produce no loss of function. They are never a predominant or isolated sign, but are part of a symptomatic picture of functional order, during the course of which they may be discovered if they are looked for. Bobinski's method of testing sensation is worthy of note: The patient with closed or bandaged eyes, should not be asked

to say whether he feels distinctly or less distinctly a touch, prick, or warmth at some point of the body under examination; he should not be asked to say "yes" or make some sign at each touch or prick, as this will lead to his attention being drawn to the examination. He should be told to point at once with his finger to the site of the prick or touch.

Although these so-called hysterical anesthetics may present some points of interest in the neurology of the war as signaling a psychopathic condition, their diagnostic value has been grossly exaggerated. If the physician would refrain from a systematic examination of these sensory disorders, of secondary or negligible importance, or if he adopted a more rational method of conducting the tests, the frequency of these hysterical anesthetics would be, to say the least, very sensibly diminished.

Psychical Disorders of the Special Senses.—Disorders of hearing are most common, of vision next, and those of smell and taste rare. Deaf-mutism, the most frequent type, is seen in three different forms: (1) with delirious mental confusion; (2) with dull mental confusion; (3) those clearly conscious who call attention to their trouble by gestures. Deafness may occur alone but is less frequent than when associated with mutism. Mutism may also exist alone, without deafness. In some cases the nervous shock is succeeded, not by mutism but by simple *aphonia*. This sometimes exists from the first but more often follows mutism when the latter is on the way to recovery. *Stuttering* may exist alone or associated with other symptoms of shock; it occurs under similar conditions as these other disorders and is accordingly included here.

With regard to the nature of these disorders, it is quite evident that we have to deal with a psychoneurosis of emotional or concussion origin, resulting from emotional shock. They are quite on a parallel with the tremors or impotence of the limbs, the loss or disorder of speech being one of the modes of reflex outward manifestation of the emotion. As for auditory affections, it is easy to understand that the intense bombardments and the violence of modern explosives may cause auditory disorders, deafness, etc., a matter of common knowledge to all who have been under heavy fire; such factors are well calculated to produce neuropathic manifestations in predisposed individuals with an already unstable nervous system. *Disorders of vision:* These are much less frequent than those of hearing. Complete amaurosis is infrequent. Amblyopia and photophobia are common. Blepharospasm, movements of the lids or blinking are also common symptoms.

(To be continued)