PROMINENT FEATURES OF THE PSYCHONEUROSES IN THE WAR.

By JOHN F. W. MEAGHER, M.D., MAJOR, M.C., U.S.A.,
 NEUROPSYCHIATRIST, U. S. A. B. H. NO. 37, ENGLAND; U. S. A. B. H. NO. 214, FRANCE;
 U. S. A. GENERAL HOSPITAL NO. 30, PLATTSBURG BARRACKS, N. Y.; CLIN. ASS'T.,
 THIRD DIVISION, N. Y. NEUROLOGICAL INSTITUTE; NEUROLOGIST TO
 ST. MARY'S HOSPITAL, BROOKLYN, N. Y., ETC.

THE subject of psychoneuroses occurring in soldiers in the great World War has already a voluminous literature. It is not my intention to describe the various psychic, motor, sensory and vasomotor phenomena found in these conditions, but rather to describe some of the features of special interest.

All writers agree that the designation "shell-shock" is an unfortunate one, as it connotes an etiological condition absent in a large number of cases and not a disease entity. The term included all sorts of functional, organic and psychic conditions. Even the term "war neuroses" has no more real reason for being than had the term "railway spine," formerly much discussed in connection with railway injuries and now rarely mentioned. True, the neuroses occur in war, but fundamentally a hysteria or a neurasthenia in war and one in peace are the same, though the color of the symptoms may differ. Practically none of the phenomena observed in this war are absent in a series of cases found in civil life. So it is more correct to refer to them as the psychoneuroses found in war.

I can hardly agree with a well-known English authority when he says he has not seen a true case of neurasthenia in this war. True, hysteria in its different phases has been the much more frequent reaction-type, but neurasthenia has been quite frequent. I have seen a number of cases soon after they came from the battlefield.

I have seen hundreds of cases of neuroses in the seven months after the signing of the Armistice, and from my observations I would say that in these late cases I have found much more frequently a constitutional neuropathic or psychopathic condition than in the cases found during the active period of the War.

The term "shell-shock," first used by Myers in the *London Lancet* in February, 1915, was early objected to by Henry Head, of London, as being inappropriate, representing a mass of unallied nervous conditions. The term, of course, was meant to include only cases of the neuroses.

In my opinion the association of various endocrinopathies has been incidental in the larger proportion of cases. We know that an endocrine disturbance, as a hyperthyroidism, can be made much worse by the horrors of war, and, again, may very well be an important factor in the development of the neurosis; it may act physically, as through the cardiovascular mechanism, blood, etc., and

mentally through the irritability, irascibility, instability, etc., present in these cases. The importance of the endocrine system and the autonomie nervous system, in those cases designated as disordered action of the heart or cardiac neuroses, is of the greatest importance. The physical exhaustion was important in these cases as an etiological factor. There may be, hypothetically, certain physical and chemical secondary changes; of these we know little at the present time.

As to the frequency of the neuroses, hysteria greatly outnumbered the cases of neurasthenia. Personally, I do not accept the views of the French psychopathological school as to psychasthenia, believing that the larger number of these cases are cases of hysteria. This is the view, I think, which is held by most men of the Swiss and Austrian schools. Their interpretation is a much better one, being more analytical and therefore really more explanatory, the former being chiefly descriptive.

The underlying mechanism in the neuroses in war has been easier to study than similar neuroses in peace times, as the subconscious conflicts were much more superficial. This is true of most of the cases excepting the chronic ones, especially those occurring since the Armistice. Their neuroses were related more to peace conditions than to conditions of war.

It is, of course, important to study the soldier's make-up—that is, his ordinary and habitual way of reacting to stimuli, etc. In fact, unless one makes a study of each patient's make-up the symptoms of the disorder will mean but little to him, for the same symptom-complex in various types of personality has different meanings. It is just as important to know this as it is for a man who is building a bridge or a building to know the nature of the material which he is using.

In these cases, especially in the ones accompanied by anxiety, who came to us in the hospitals in France and England direct from the battlefields, we noted that distressing dreams of battle, bombing aeroplanes, etc., were very common. But we cannot agree with one well known authority who stated that the prognosis in these cases was invariably bad. It was if one refers only to their future use as combat soldiers. Most of such cases that I saw made a prompt recovery, but they were not returned to the firing line. The cases we now see in the United States do not, of course, have such terrifying nightmares. The psychological explanation is evident.

Man's ideals as to right, justice, his relations to his fellow-men, toward cruel practices, living like animals, uncleanliness, etc., had to be altered, when the objects of the War became paramount. It was necessary for them to forget many of their cultural lessons, and some of them could not do so.

That other factors besides those related to the War and their own ego must be present, is evident from the fact that nearly all

soldiers were able to go through the worst perils and privations of the war without developing any neurosis whatever. One must not, as I have seen done in England, call a simple ease of pure physical exhaustion a neurosis of the type which we are discussing. In such cases a few days' rest usually effects a cure.

In nearly all cases of the neuroses anxiety was a prominent feature, not only in pure anxiety states but in conversion hysteria, heart neurosis and cases with a marked hypochondriacal trend. In some patients the entire syndrome was centered about this morbid anxiety.

The lack of sleep, whether from the arduous work in the trenches accentuated by a state of anxiety, or from other causes, was an important factor in delaying recovery. Rest and sleep as we well know are the best means for combating fatigue, there being no direct biochemical means for curing it.

Fatigue may not only be due to physical causes but to various disturbing emotional states—distaste, disgust, resentment, fear, etc.—which are all important factors in its determination. All strong emotions result in some sort of an upheaval and the patients must have an outlet for the energy generated. If retained in the organism the emotion produces symptoms of a neurosis. A sympathetic nervous or an endocrinopathic disturbance often coexists in these cases.

In general, it might be stated, that the soldier with numerous interests recuperates much more rapidly than the man who has little or no interests. The tendency to chronicity is especially noticeable in these latter patients, especially if they were of the indifferent or asocial "shut-in" type, for they had no outlet to their pent-up energy and their introspection and ruminations made their condition worse.

A careful neuropsychiatric examination will rule out genuine cases of cerebral concussion. In speaking of cerebral concussion, I might say that in over half of the hundreds of cases of neuroses which I have seen in this War, in hospitals dealing with psychoneurotics chiefly, the question of being exposed to shell explosion did not enter at all. I have seen many such cases suffering from neuroses who never reached a position nearer the firing line than Liverpool.

In order to understand the neuroses, especially hysteria, one must realize the great dynamic value of an idea, which has intense value to the particular individual. An idea clothed with a great deal of feeling (affect) we call a complex. Hysterics react more quickly and more vividly to an idea or a situation that touches or irritates any of their complexes, than do normal individuals. By the subconscious associations operating in hysteria an idea can be transferred into a physical symptom (conversion hysteria). The history, with a careful neurological examination, will show that the condition is not organic in origin. I might add here that I have never seen a

functional paralysis in an officer, though they were moderately frequent in the men. Pure anxiety states are very frequent in officers, however.

The causes frequently given as precipitating the neurosis are often the so-called "last straw"; they are the exciting causes, but not the principal ones. The principal cause or causes one usually has to abstract from the psyche, and this takes time and necessitates a long training in psychological medicine.

One regularly notices that the patient who pays too close attention to his symptoms is thus favoring their progress and continuance. One notices this especially among the inadequate type of patients, and since the Armistice, among that class of patients who do not seem to make a very heroic effort to get well. One wonders about this, and yet there is no doubt about it. The cases of two lieutenants in the Quartermaster Corps, who broke down in France in November, 1918, who were diagnosed neurasthenia in one case and hysteria in the other, and whose conditions were supposed to be due to overwork and not to battle stress, come to memory. They were with a number of other officers whom I brought back from France in March, five months after their illness began, and in June, three months later, they still complained of trivial symptoms of no moment. To me a few factors are always in evidence in such cases.

Besides the neurosis, one nearly always finds some marked psychopathic traits, if not definite psychopathic states; their home relations, financial state, etc., are often anything but ideal; the will to get better is absent. A neurotic patient who really does not want to get better rarely does.

Two symptoms which all medical men have noticed in this War have been stupor and mutism. The mechanism in these cases is usually easy to work out; the object is to shut out the surroundings and its incidents.

The mechanism and the motive for the hysteric's illness is not in awareness; but by treatment the subconscious associations were brought to the surface, and one then had the patient well in hand; the mechanism became clear to him, and the soldier then recovered. For to remain sick after one knew he understood the mechanism, or to refuse coöperation with the physician, would mean that he consciously would prefer his symptoms, and this would constitute malingering. I saw very little malingering during the war, though I observed especially for it, and was on neuropsychiatric boards in the United States before going abroad, where we examined about 105,000 troops. In the past year and a half since then my experiences have been the same. What few cases I have seen since the Armistice who might be put down as malingerers were patients who did not seem to want to get better, and who preferred their present position than to recover and go home. The signs usually mentioned to distinguish the really sick man from the malingerer—

as the drawn facies, rapid pulse, his frankness and desire for expert examination—are valuable, but the really important thing is to carefully observe his attitude and reactions.

It is better and nearer the truth—and the distinction is not unimportant—to say that a malingerer simulates a symptom, whereas in hysteria the symptom is simulated. This is another way of saying that in malingering the symptom is consciously, in hysteria unconsciously brought into being.

The distinction is fine, but there is a great difference between a conscious act, and one brought about by subconscious motives and associations of which the patient is not aware. He certainly is not aware of the relation to the symptoms. Malingerers are nearly always psychopaths. I have never seen a soldier feign insanity, with possibly one exception. This soldier was exaggerating certain hysteropathic traits and trends.

In the beginning of the War men like Frederick Mott, the noted London neuropathologist, Sir John Collie and others tried to explain too much on an anatomicopathological basis, which viewpoint later became untenable.

In some patients one saw that the antagonism to the horrors of war was at times conscious. But the important feature is this, that the patient does not realize the connection between his symptoms and the wish to get away from it all. Were the wish a conscious one, and if the patient could justify his wish—at least to himself—there is then no conflict and naturally no neurosis. The soldiers who broke down said they wanted to get better and (during the war) wanted to get back to the fight; and they did. They never consciously wanted to get out of the service.

In all of these patients I took the attitude that the same conflicts would arise again, and they would readily break down again. So in spite of their frequent remonstrances I told them I would transfer them to a non-combatant unit. I never sent one back to the United States, but told them that they would be able to serve their country in the A. E. F. The results were perfectly satisfactory to everyone. In all of them a study of their subconscious psyche, *i. e.*, a study of the content of their dreams and nightmares, the results of association tests, etc., always revealed their real subconscious desires. To tell them of these bluntly would do no good but would be promptly resented; this is especially true of officer patients. But if one brought the facts out in the proper way, they could be accepted and were accepted always without opposition, for I always showed them that it was not exactly unnatural for the instincts of the ego to predominate over the ethics of the species, that the instinct of self-preservation could not be ignored always, nor by everybody.

As in peace times the neurosis furnished a tolerable situation. In these patients a lively instinct of self-preservation, a poor con-

trol over the emotions and a poor will, with various individual subconscious factors, conflicted with their sense of honor, patriotism, duty and their conscious desire to "carry on." This brought on the military disqualifying symptom or syndrome, constituting the hysteria.

There has been a great deal of speculative theorizing on the subject of the neuroses of war which has not made the question any clearer. Thus Sir John Collie writes that most cases of "shell-shock" are due to concussion(?), but that by the time we get them the first pathological changes have disappeared. This assumption is certainly erroneous in the large majority of cases. His ideas are purely descriptive; no attempt was made to get at fundamental causes, and a pathology non-existent was declared to have been present, but was no longer in evidence. Practically none of these cases died, so the pathology is in the psyche and is not a somatic one. He would have done better had he referred to the pathology as being one of morbid anxiety.

Myers refers to certain sensory cases of what he calls "shell-shock," and says the cause might be a thalamic lesion. If there existed a thalamic lesion, it would then have been an organic case and not a neurosis. If the soldier later developed a neurosis then it would have been a secondary and not a primary one. The same criticism applies to Mott's cases, in which he described punctate hemorrhages, emboli, etc., in the medulla and elsewhere. When such conditions are found to exist postmortem, then the diagnosis should be amended and a proper anatomicopathological designation given.

In chronic cases the analysis of the personality and subconscious factors is of more importance than merely noting the symptoms. After one has ruled out all organic physical disease, the procedure is along the lines of analytical psychology or psychoanalysis. In the chronic cases in war and in peace the outlook differs as to whether the constitutional make-up is normal, hysterical, inadequate paranoid, etc.

Some people still refer to hysteria in the way they do to malingering. But though a vicious and unfortunate way of reacting, it certainly does not belong in the same category as malingering. We are in full accord with the remark of Wiltshire when he says that poisoning by shell gas is only exceptionally a real cause of a neurosis.

In the chronic cases and in those cases occurring since the signing of the Armistice I have been impressed by the fact that the psychopathic taint as shown by emotionally unstable and inadequate traits has been much more in evidence. In such cases certain complexes were present, preventing recovery. So we naturally feel that the diagnosis of hysteria or neurasthenia applied to a case still ill, and which developed early in the war, hardly shows the real picture. The complaints of such patients toward the end are often trivial

compared to their early symptoms. Needless to say, most of them do not feel able to resume their work in the world. It is natural that one wants to know why. They now resemble the ordinary chronic neuroses of civil life, with various psychic conflicts. Their present symptoms are often only rationalizations for their behavior and failure to get well.

The desire to avoid pain or to gain pleasure is always present even if subconscious. In these chronic cases the question to decide is to what extent the mechanism is subconscious, and needless to say to get at the complexes and to try to make an adjustment.

In many cases one is really dealing with a personality anomaly only. It is safe to say that an ordinary neurosis would not persist for seven or eight months, except for some deep-seated complexes and often a constitutional psychopathic taint. In many such cases the hysteria or fatigue neurosis was merely engrafted on the psychopathic state, so that at the end one still has a defective constitutional make-up to deal with.

TREATMENT. There are a few interesting points in reference to the treatment of the neuroses of war time to which we might call attention.

When in England I noticed that the Babinski idea of curing hysteria by persuasion was followed almost exclusively, and the method was very successful in removing the immediate symptoms. But little attempt was made to get the patients to understand the mechanism of the neurosis; however, one reason being lack of time, the other being that but few men in England have paid much attention to the study of psychoanalysis, for the subject aroused a stormy controversy in Great Britain as to its merits and otherwise.

Sir John Collie, one of the old-school neurologists, said he did not think psychoanalysis necessary. Mott said: "I do not find it necessary or even desirable." Needless to say neither of them are students of the subject. Forsythe favored it, as did Rows, Adrian and Yealand. Eder, too, must have approved of it, for he said that suggestion, especially under hypnosis, and aimed rather at the complexes than at the symptoms, was good; but to get at the complexes, he must have used psychoanalysis. Proctor used suggestion under hypnosis. Myers and Buzzard regarded hypnotism favorably.

As there has been so much doubt expressed as to the need and value of psychoanalysis, I think it would be well to say a few words about the employment of it in the neuroses of war. One realizes, of course, that in a majority of the cases a cure can be effected in much shorter ways. But psychoanalytical training helps one to understand and to treat the cases better, especially the chronic ones.

I know of no better way of presenting the psychoanalytic viewpoint than to quote some of the views on the subject as presented by Ernest Jones, probably the most eminent psychopathologist of

Great Britain. He has published a very interesting article on this question in vol. xi of the *Proceedings of the Royal Society of Medicine*, April 9, 1918.

Heredity is vague in explaining complex psychological phenomena. Suggestion merely introduces another problem.

Some factor other than stress and strain must be present to produce these conditions, for less than 1 per cent. of the soldiers developed neuroses. We all know that psychoneuroses result from unconscious mental conflicts. One can only gain access to the unconscious by some sort of psychological investigation. The etiological factors in these cases are often more complex than is usually supposed, and they are particularly individualistic. War causes an official abrogation of normal standards. The adjustment to war is very difficult for some men to make. Besides heredity and social customs, certain ideas of the early relation of the child to its parents have to be taken into consideration. In the development of his ego man comes to approve of certain standards and to disapprove of certain others. His ego-ideal is not always easily a victor, nor always fully successful.

The mind deflects his anti-ego impulses from a forbidden goal on to an ethically proper one; or their energy is repressed and a barrier is erected—so-called “defence-reaction.” In this way one who is naturally cruel may become oversensitive to painful situations, etc. But as the large majority of men were able to adjust themselves to the field of war—not a conscious adjustment only, of course—they thus permitted the inhibition of the ego-ideals against the infliction of cruelties, etc. But Jones says that in all neuroses it is important to study the relation between a current conflict and a biologically older one, the current one arousing buried and only imperfectly controlled older conflicts.

Neuroses are not, as the French psychopathologists claim, any diseases that may happen to a person, but they are unconsciously produced in the patient's mind for a definite purpose, *i. e.*, they are volitional, but not by the conscious will, nor are they deliberately purposeful. There is at the bottom of the mechanism an unconscious desire to obtain a pleasure by gratifying some repressed impulse which is out of harmony with the ego-ideal. The motive is to achieve some current end by the development of a neurosis.

The neurotic symptoms are the result of the psychic conflict; the incapacity—as a paralysis, for example—fulfils the desire, against which desire the patient has been fighting (a wish fulfilment).

But the important feature is not merely that the wish is unconscious, there being different degrees of consciousness or awareness, but that the repressed wish is against the ego-ideal and is the cause of the unawareness. Jones does not believe that a present repressed wish alone can cause a neurosis (if it could there would have been many more neuroses in this war, I believe, too). It can do so only

by reviving older repressed conflicts. Where there is a failure of adjustment we notice an introversion or a turning inward of the patient's feeling (affect). The present wish becomes associated with repressed wishes of older conflicts. Such a combination characterizes neurotic disorders; they thus differ from other ways of reacting to difficulties.

There are three factors entering into a neurosis: heredity, and "infantile fixation" during evolution, and the present or current conflict. They are all related, so that if one factor is pronounced another may need be slight to produce the neurosis. Thus with a very bad heredity an ordinary daily experience may precipitate the attack. In the neuroses of war the present conflict is of the greatest importance.

In these patients one frequently notices traits characteristic of childhood: sensitiveness to slights, being too self-centered and a desire to be helped. In the war cases the infantile repressed factor has not been sought for, yet it is very important in the chronic cases, which are hardly war neuroses any longer, but resemble peace neuroses entirely.

The reason for the greatest opposition to the psychoanalytic theory is the statement that the older infantile repressed wish is a sexual one.

In the cases we are discussing the conflict has to do with the instinct of self-preservation and the preservation of the species. But a neurosis is a disorder of the unconscious imagination. So if we say the war were the only cause, that would be equivalent to saying that the neurosis resulted from a conflict of the ego-ideal and the instinct of self-preservation, which denies the former theory.

Psychoneurotic symptoms may be developed to prevent the exhibition of fear. Fear, with causeless dread and apprehension, various phobias and bodily manifestations, is really morbid anxiety. One sees it in impending danger and evil, as in anxiety neurosis and hysteria; its characteristic feature is the disproportion between its intensity and justification. It is claimed that it stands in close relation to unsatisfied and repressed sexual libido, the morbid anxiety representing the discharge of the energy. This is a defensive reaction of the ego against the claims of the unsatisfied sexual hunger; a projection outward in the form of phobias; it is the ego's fear of the unconscious. Normal fear reacts sensibly and properly to external danger, and not like anxious dread and terror, which paralyzes choice and action. The neurotic is frightened without any external danger.

Another theory of dread—morbid anxiety—is that it is derived not from the repressed sexual hunger that is directed toward external objects, but from the narcissistic part of the sexual hunger attached to the ego. Thus it is important to distinguish object libido, *i. e.*, sexual impulses directed outward; and ego libido, *i. e.*, the narciss-

sistic portion directed inward, constituting self-love. This latter is the more primary, more extensive and the less studied of the two. It may be compared to a well from which externally directed sexuality is but an overflow. I can confirm Jones's opinion that little attention has been paid to this phase of the subject by psychopathologists in studying war cases.

An excess of sexual hunger may cause suffering. There results first a discharge in the form of morbid anxiety. A perfectly normal man is free from morbid dread at all times. This war has proved that. The intolerance of narcissistic sexual hunger, with dread in the face of danger, results in an accumulated tension.

Many of the symptoms of the neuroses of war corroborate this view of wounded self-love, as lack of sociability, lack of affection for relatives and friends, the feeling that their personality has been wounded or neglected and their importance not recognized, etc. So too in such patients their unconscious idea of death is a reduction of essential vital activity, or else a state of calm, in which the ego survives, but is freed from the disturbances of the outer world.

It will be very interesting to investigate our cases with these views in mind. It was my good fortune to meet Jones in London recently, and the views of England's most eminent psychopathologist furnish food for reflection.

All will agree that psychoanalysis takes time. In the large hospitals devoted especially to this class of cases, where we admitted hundreds of patients per month, we could not go into the psychological mechanism in all the cases. One observation which I would like to make, however, is the relatively large number of married neurotic soldiers who gave a history of severe marital upsets, as unhappiness, separation, divorce.

I think we will all agree that hypnotism alone is bad on psychological grounds, as it does not remove the causes. The same applies to suggestion but not to psychoanalysis.

Mott disclaimed hypnosis, claiming that it was undesirable. Mott, however, being a neuropathologist, his opinion in these matters does not carry the weight that it would were he speaking of organic conditions. We might add here also that neither suggestion nor hypnosis alters the state of the patient's mind.

In treating these patients one should lighten their burdens and protect them from unsympathetic surroundings, but should not foster their symptoms by misplaced sympathy. In many of the emotional patients I secured good results in the acute stage of their illness by complete isolation. First rule out any organic or metabolic disorder; then the treatment is individualistic and essentially psychobiological. Rest is the best aid in the acute stages, both mental and physical rest. In order for them to secure mental rest, however, their conflicts must be brought to light and an adjustment made.

Later in the course of the disorder, too much rest or lounging, and

a failure to provide productive occupations help to keep up the symptoms. I have seen hysterical paraplegics who had been bed-ridden in surgical wards for a couple of months, chop down trees a few days after coming to the neuropsychiatric wards. The will to work is very important. It is self-evident that the loss of the work habit is disastrous. The wish to be cured is essential. A careful and systematic examination makes an impression on these patients; it therefore has therapeutic value. The patient must be made to realize his obligations. Any asocial tendencies, as well as hypochondriacal trends, must be combated. Do not allow the patient to develop an attitude of chronic invalidism. Treat the patient and his disordered personality: they are of greater importance than the symptoms.

The reëducation of the patient must not be confined to a mere restoration of his lost physical function, but must also include the correction of any defects of feeling, will or intellect.

Electricity and massage are used almost entirely for their suggestive influence. Any concomitant physical disorder must be treated according to the dictates of rational medicine.

A very important point to remember is that one's self-assurance of success has greater effect on the patient than any direct reasoning one may employ. This is nothing new, but physicians often disregard this dictum, and we see neurotic patients frequently going to various frauds and quacks who succeed just because they apply this point with emphasis. The hypersuggestible patients have full faith in the assurances.

The neuroses of war have taught us but little that is new. But because of their frequency and the widespread interest that has been taken in them they will probably stimulate physicians in the future to take a greater interest in the neuroses of civil life.

LOCALIZATION OF TUMOR METASTASES.

By G. E. ARMSTRONG, C.M.G., M.D., LL.D. (Queens),
D.Sc. (Liverpool),

CHIEF SURGEON, ROYAL VICTORIA HOSPITAL,

AND

H. OERTEL, M.D.,

PATHOLOGIST, ROYAL VICTORIA HOSPITAL, MONTREAL, CANADA.

THE term metastasis as applied to tumors is generally held to mean generalization of a growth by formation of secondary deposits throughout various tissues and organs of the body and not directly connected with each other. But this is really not an all-embracing