

## THE TREATMENT OF WAR NEUROSES \*

SIR JAMES PURVES STEWART, K.C.M.G., C.B., M.D., F.R.C.P.

Senior Physician to the Westminster Hospital; late Consulting  
Physician to H. M. Forces

LONDON

The following general maxims make no special claim to originality. They are offered, however, as a representation of the experience of the past four years of war, by one who has had the privilege of watching, in England, Malta, Gallipoli, Macedonia and Egypt, the successes and failures of various methods of treatment, both in his own hands and in those of his fellow medical officers.

The writer asks the kindly indulgence of the skilled neurologist. To such a reader, many of the remarks will appear not merely commonplace, but almost childlike in their simplicity. It may be, however, that some less expert reader will find hints of practical usefulness, when brought face to face with the class of cases here referred to.

If our treatment is to be successful, an accurate diagnosis is of fundamental importance. And therefore, before entering on any course of treatment in a case of war-neurosis, the first essential is to obtain as clear a conception as possible of the exact condition with which we have to deal.

### COMPLETE HISTORY OF GREAT VALUE

We begin by making a careful *study of the patient*. We inquire not only into his present symptoms, but particularly also as to the time and mode of onset of each of these. No detail, however trivial, should be ignored. The patient should be encouraged to tell his story at some length. If, during the process, he tends to become too long-winded, we must be careful not to betray any impatience or want of interest. The patient will feel dissatisfied if he thinks he has omitted any detail of his history. If time is becoming short, it is better to break off the consultation and to resume it again at a subsequent occasion, rather than let the patient have the feeling that he has left anything unsaid. By tactful questioning we supplement, correct and coordinate the information which the patient offers us. We should be specially careful never to give the patient the impression that we are skeptical as to the accuracy of his statements. When we have reason to suspect him of exaggerating his symptoms, or even of fabricating "decorative" details,

---

\* Submitted for publication Oct. 30, 1918.

we must not let him see that we doubt his veracity. Throughout the interview we try to form a judgment as to his degree of intelligence and culture, and also as to his habitual emotional reactions. A patient of low-grade mentality will require to be handled, as regards curative suggestions, differently from a more intellectual patient.

In addition to the history of the patient's present illness, his previous career and his family history should also be inquired into. These are points which sometimes tend to be overlooked by the inexperienced practitioner, who thinks that, if he secures a straightforward account, say, of a shell explosion, followed by certain functional symptoms, this is enough, and that he can proceed right away with a course of treatment. This is a great mistake, for, as a matter of fact, the patient's in-born hereditary tendencies, his previous career and health, his peace-time environment and his reaction to that environment, all have a profound, and sometimes a decisive, influence in determining the manner in which he subsequently responds to the more dramatic incidents of war. First of all, then, we obtain a clear, accurate and complete history.

#### SYSTEMATIC PHYSICAL STUDY REQUIRED

We next proceed to a methodical physical examination of the patient. This should never be omitted, even in cases which, from the outset, appear to be perfectly simple and straightforward. By following an invariable rule of systematic physical examination, not only do we guard against the unwisdom of accepting and, so to speak, swallowing predigested, some one else's diagnosis (which may be correct, or otherwise), but the mere process of thorough personal investigation has a beneficial suggestive effect on the patient. If we employ a well-designed routine method of investigation, this part of the examination in a case of neurosis takes up only a comparatively short time. But, now and then, it reveals new, unexpected and important clinical facts, perhaps unnoticed by the patient (for example, a hemianopia, or an extensor plantar reflex), which would otherwise have escaped observation, but which may profoundly modify our original diagnosis. A hasty or slipshod examination is always bad. It is bad for the physician, who may thereby fail to grasp some essential point of the case. It is also bad for the patient, if he thinks that the physician is not sufficiently interested in his case; moreover, it diminishes his confidence in the ability of the physician to cure his symptoms.

The interview between patient and physician should leave on the patient's mind the true and sincere impression that the patient, his symptoms, history, and treatment, are the only things in which the physician takes any interest, and that, for the time being, the physi-

cian's whole personality is being focussed on the patient, to the exclusion of everything else in the whole wide world. This ought not to be a matter of pretense or "bluff." The physician, for the time, *should* focus his whole attention on the particular patient before him. Whilst the patient William Smith is in front of him, he has no business to be thinking about the symptoms of Tom Jones who preceded him, nor about James Robinson who may be waiting to see him next. But, the moment William Smith's case is completed, and a few necessary memoranda made about it, the physician should now wipe William Smith clean out of his mind, and focus with equal concentration on James Robinson, from the very moment when Robinson comes in. This faculty of rapid and exclusive concentration on each successive case is one which can only be fully developed by practice. It constitutes one of the most valuable assets in successful diagnosis and treatment.

#### PERSONALITY OF THE PHYSICIAN

This is an all-important factor for successful treatment. This is no mere platitude. Neuroses, above all other diseases, are those in which one physician habitually succeeds, while another, of equal professional training and knowledge, habitually fails to obtain such good results. The successful physician (I mean the physician who succeeds, not in extracting fees, but in curing his patients) besides possessing a sound knowledge of his subject, must have a justifiable confidence in himself and in his own particular methods of treatment. This confidence he communicates to his patient, not only by words, but by his whole personality, thereby creating an atmosphere of curative suggestion. The physician should exercise authority over his patients, firmly, quietly and with imperturbable good temper. A medical man whose manners are pompous, over-bearing, blustering, or bullying, may succeed in curing a certain small proportion of cases, but these are chiefly among patients of inferior intelligence. I disapprove entirely of employing anything in the form of roughness or painful physical stimulation (practically equivalent to punishment) as a routine vehicle of curative suggestions, although measures of this sort have been carried out and with some success, chiefly in Germany, constituting Kaufmann's so-called *Ueberrumpelung*, or hustling treatment. In this, the patient, previously stripped, is subjected to intense and prolonged faradization or sinusoidal currents (being held down by several assistants, if necessary). This is combined with stern military discipline by the medical officer who "commands" the patient to move the paralyzed limb or to stop a hysterical tremor, the *séance* lasting, if necessary, for hours, until the hysterical symptom shows signs of yielding. This "curative" *séance* is followed by a night's sound sleep,

aided by a strong sedative draught. Next day gymnastic exercises are resumed, without electricity, but under the same medical officer who "cured" the patient. This kind of treatment is rarely necessary, and should be reserved for exceptionally chronic and resistant cases. Equally good results are obtainable by kindlier methods, and any feeling of antagonism between the patient and his physician is usually a serious handicap to successful treatment.

At the very outset, the physician should endeavor to secure not only the patient's confidence, but his good-will. Unless the patient is malingering, this ought not to be difficult. We should aim at securing the patient's cooperation in his own cure. As a matter of practice, it is useful, after our careful preliminary examination, to begin by explaining our diagnosis to the patient in simple, nontechnical language, and then to ask him frankly whether he will try and help in his own cure. The patient must be encouraged to feel that we are treating not an abstract disease, but a sick man with an individuality of his own. The first interview between patient and physician may thus be far-reaching and even decisive in its effects, and no effort on the part of the physician should be spared to gain an immediate tactical advantage at the outset of the campaign which is about to follow.

#### ENVIRONMENT OF GREAT IMPORTANCE

The environment in which treatment of neurotic patients is to be carried out should be carefully selected. That the patient should be withdrawn from the original surroundings under which his symptoms first developed, goes without saying. At the earliest possible moment he should be placed under the care of a trained neurologic physician, preferably in a specially arranged hospital. This should possess a specially skilled staff of medical officers, orderlies and nurses, so that curative suggestions can be concentrated on the patient as soon as possible. By this means, many a soldier who has had an emotional shock, is prevented from developing nervous symptoms, while any symptoms which may have already appeared are "nipped in the bud," and he shortly becomes able to return to his duty.

Segregation of early cases, each patient having a special tent or room to himself, away from other patients, is of special value. The patient, however, must be made to feel that he is not being imprisoned, but that he has been selected for special individual care for a limited period of time, and that meanwhile he is under constant observation by the physician, or by his skilled assistants or nurses. He is thus isolated for a time, not only from other patients, but also from well-meaning but injudicious relatives or friends, whose harmful suggestions play so important a part in the production of hysterical symptoms.

An atmosphere of cheerful, mutual confidence and optimism is essential. This should be created, as already indicated, at the first

interview between patient and physician, and must be carefully maintained. Any physical discomforts which are complained of, such as headache or sleeplessness, are to be promptly attacked by appropriate measures.

The earlier a patient comes under skilled treatment of this sort, the better are his prospects of cure. The confirmed neurotic, or "hospital-bird," who has wandered from one institution to another, gathering pearls of clinical symptomatology by the way, or, in other words, learning new tricks, is much more refractory to treatment than the recent patient who has not yet been examined or treated. The "hospital bird" tends also to have a considerable superadded element of malingering, which helps him to play his part with added gusto, whether to bored or to sympathetic audiences.

How long should the neurotic patient be isolated from his fellows? The answer is, until he shows definite signs of commencing recovery. No hard-and-fast rule can be laid down. In mild cases, two or three days may be enough; in others, several weeks. Each case must be considered on its own merits. If we have a ward in which a number of convalescent neurotics are completing their cure, there is a stage of improvement at which it becomes advantageous for the patient to be released from his primary isolation, so as to have the curative suggestions reinforced by the society of other patients who are farther advanced on the road to recovery. This is toward the later stages of his cure. To congregate together a number of neurotic patients who are not improving, is bad for every one of them. And even when we are handling large numbers of patients in a hospital ward, the individual must never be lost sight of. Conversations between the patient and the physician are occasionally overheard by a neighboring patient. The skilful physician sometimes takes advantage of this to drop a Parthian shot in the form of a well-directed suggestion adapted to a patient other than the one whom he is directly addressing. And in this connection, we must be careful never to do or say anything to humiliate a patient in the presence of his fellow patients. Therefore, when conditions are such as to necessitate the treatment of a number of patients in a common ward, not only should there always be a tactful nurse, or nurses, constantly on duty to supervise treatment and maintain discipline, but a special side-room should be arranged in which private interviews with the physician can take place.

#### AFTER-TREATMENT AND SUPERVISION IMPORTANT

The return of the patient to his own home should, as a rule, be postponed until the cure is practically complete. Visits by the patient's relatives or friends, restricted to a few minutes' duration, should be

cut down to the minimum, and in most cases, after a single first meeting, should be forbidden, until a certain degree of improvement has been attained. Correspondence should also be discouraged. The patient should be reassured by the promise that any urgent home facts will be duly communicated to him, not directly but through the physician. Even when, at a later stage, visitors are allowed, each friend or relative should be scrupulously warned as to the importance of the atmosphere of encouragement, and should only be admitted to visit the patient on the clear understanding that such an atmosphere will be maintained.

The foregoing maxims are not applicable indiscriminately to every case of neurosis. Symptoms which have been produced mainly by emotional shock or by suggestion are to be treated chiefly by psychical methods; those due to physical concussion or to exhaustion chiefly by physical remedies, such as rest, massage, diet, electricity, etc. Those due to intoxications are the cases in which drugs are most likely to be of value in combating individual symptoms, such as tachycardia, insomnia, etc. Other cases may require to be transferred for treatment to a mental hospital. Hence the importance at the very outset of the careful diagnosis and accurate classification of each patient.

During his entire course of hospital treatment the patient's time must be suitably occupied. For the first few days at least, absolute rest in bed is usually advisable. Then follows a careful program of rest, recreation and work, in due proportion, planned from day to day. Exercise, whether physical or mental, should always stop short of producing exhaustion. Aimless loafing around a hospital ward, "waiting to get well," is sheer waste of time, and tends to encourage professional invalidism. Each patient, after an appropriate interval, should be made to understand that certain duties are expected of him. For a less active patient these duties may consist in assisting in the arrangement and tidying of his room and ward; later, he should be allotted some form of work which has the charm of novelty. Outdoor occupations are usually preferable, for example, gardening and various forms of farm work. Suitable games and amusements, preferably in the open air, are also added to the program. All these are best organized by a resident medical officer, rather than by a visiting physician; an ideal man for such a post should possess the qualities of the genial Father O'Flynn of "ould Donegal":

'An' yet for all ye're so gentle a soul  
'Sure, ye keep all yer flock in the grandest control.  
Checkin' the crazy ones, coaxin' un-aisy ones,  
Liftin' the lazy ones on wid yer stick!

## SPECIAL TREATMENT OF INDIVIDUAL SYNDROMES

In each case of hysteria, after careful examination and secure establishment of the diagnosis, a careful plan of treatment is to be selected for that case. The tactics of this campaign, which should be "short, sharp and decisive," will vary with each individual case, according to the patient's mentality and according to his special symptoms, for example, paralysis, contracture, tremor, etc.

The hysterical symptom was originally induced by suggestion, whether from the patient himself or from outsiders, and it has now to be removed by counter-suggestion on the part of the physician and his staff. We begin by confidently assuring the patient that he is curable, and ask him frankly whether he is willing to get well. We then promise him that his cure will begin at our very next interview. If this cannot take place immediately, it is often prudent, while awaiting the crucial moment, to isolate the patient in a room by himself, for not more than a day or two, leaving the recollection of the first interview with its careful examination and promise of cure, to incubate in his mind. In the meantime, during this preliminary period of expectation, his sleep and general bodily functions must be carefully attended to.

After this short preliminary period of isolation and expectation—a period which in favorable cases may be omitted, especially in patients of higher grade mentality—we proceed to the crucial interview of curative counter-suggestion. This interview, which should not take place in the presence of other patients, but in a special room for the purpose, must never be allowed to end without achieving some visible improvement, demonstrated to the patient himself.

Some cases yield rapidly to counter-suggestions, others may require an hour or more. For the curative interview no hard and fast rules can be laid down. It is essentially a contest between the physician's personality and that of the hysterical patient. Each physician must wield his own personality in his own way, varying his weapons in different cases, according to the problem he has to attack. A highly intelligent patient requires more dexterous explanations than a man of coarser fiber. Delicate rapier-thrusts are lost on a rhinoceros-like mentality and we often have to supplement our explanation by an appeal to the patient's imagination, say, by electrical stimulation, which to most laymen is unfamiliar.

If the patient is suffering, say, from hysterical paralysis of a limb, the physician will explain to him in clear, nontechnical language how the weakness has been produced by undue concentration of the patient's mind on this particular limb, which, perhaps, had originally

been the site of some injury. He will show him that the apparent paralysis is not due to any real want of power, either in the muscles or nerves. This part of the explanation is usefully supplemented by brisk faradic stimulation of the affected muscles, thereby demonstrating to the patient that they really can move it. It may be further explained to the patient that, owing to his emotional shock, his brain has temporarily got out of the habit of using the affected nerves and muscles, but that now he realizes that the muscles can and do contract, for example, under the influence of faradism; his own will-power, directed to the same muscles, will also produce the same effect. We therefore "encourage" him to move the paralyzed limb, aiding him at first by faradic stimulation applied to the "motor points." Presently, when he begins to perform voluntary movements, we continue our stimulation, but no longer on the motor points, until finally we are able to demonstrate to the patient that he is performing the movements altogether independently of our electrical stimulation. Often a single interview of this sort, with energetic stimulation, is enough to restore completely the motor power which the patient had believed to be lost.

In cases of hysterical contracture, which not uncommonly accompany hysterical paralysis, during our process of explaining his case to the patient, we passively move freely the contracted joint or joints. Any adhesions which may be present are thereby broken down and the stiffened muscles are stretched and rendered more supple. Passive movements are then supplemented by electrical stimulation of the muscles, and the patient is encouraged to cooperate by voluntary efforts. In this way the patient, who has often become somewhat confused by our various manipulations and by the series of tests applied to the affected part, tends subconsciously to perform some movement of the paralyzed limb. This is the moment to be on the look-out for. As soon as we see the slightest voluntary movement, we pounce on it, call the patient's attention to its presence and show him that he has now ceased to be paralyzed. In his confusion and excitement he repeats the movement, and continues to perform it with increasing power, aided at first by electrical stimulation, until at last he can execute spontaneously all the movements which at first were only carried out passively by the physician.

Hysterical tremor, like hysterical contracture, with which it is often combined, is best treated by repeated passive movements of the affected limb, lasting half an hour, an hour, or longer, accompanied by verbal suggestions, until the muscles have become relaxed. We then encourage the patient to perform active voluntary movements, free from tremor or rigidity.



In hysterical paraplegia of contracted type, we first of all remove the muscular rigidity, and tremor if any, by passive movements and verbal suggestions to the recumbent patient. He is then encouraged to supplement the passive movements by active cooperation and later to perform them unaided. After a rest, these passive and active movements are continued with the patient sitting up. Then, after another short pause, he is persuaded to stand and walk, at first with help and finally unsupported.

Similarly in a case of flaccid hysterical paraplegia, we lift the apparently helpless patient to his feet, supporting him on both sides. We now proceed to march him up and down. Usually the patient makes some sort of feeble movement of the legs to balance himself. We watch for this first movement and point it out at once to the patient, telling him that his cure has begun. We then hustle him up and down, encouraging him all the while, and aiding him by electrical stimulation to the spine and lower limbs, until he can finally stand and walk alone.

It is of great importance to persevere with our curative séance until cure is complete, rather than break off with only a partial cure. And in any case, we must never conclude our curative interview without achieving a definite improvement which is visible to the patient himself and to his entourage.

Special splints or supports, which have sometimes been employed for the correction of hysterical paralyzes and contractures, should be avoided altogether in hysteria. Not only are they unnecessary, but they are positively harmful, since they tend to perpetuate in the patient's mind the suggestion of disability. It should also be borne in mind that splints and other apparatus, originally applied for the maintenance of correct posture in a limb which has some *bona fide* organic lesion of nerves or other structures, may subsequently come to exercise a baneful suggestive effect, so that by the time the surgical injury is healed, the patient has lost the habit of using his muscles. In other words, a hysterical paralysis has become superimposed on an organic injury. In these cases the supporting apparatus is now a hindrance to complete recovery and the patient will carry about his crutch or splint indefinitely, until by counter-suggestion and reeducation, he learns that it is useless. He then discards it, whether on the floor of the physician's consulting room or on the wall of some patron saint's chapel, as the case may be. The importance of motor reeducation in organic injuries is appreciated by every medical officer who has had the opportunity of watching the beneficial results attained in the "curative workshops" attached to our military orthopedic hospital centers.

## HYPNOTIC SUGGESTIONS

Hypnotism is rarely necessary and has been discarded by most neurologists. It is open to the objection that the phenomena of the hypnotic trance are themselves essentially hysterical in character, so that by hypnotizing a hysterical patient we are merely replacing one hysterical condition by another. To this it may be answered that it is better for a patient to be hypnotically capable of movement than hysterically paralyzed. As a matter of clinical experience, however, we find that waking suggestions are just as efficacious as those achieved by hypnosis, and their effects are more likely to be permanent.

In cases of obstinate motor disability, and in hysterical mutism, it is sometimes advantageous to give the patient a general anesthetic, to the extent of producing a transient mental confusion. During this stage of intoxication the patient often begins to talk or moves energetically his previously paralyzed limb. As he comes around from the anesthetic, we continue to talk briskly to him and make him go on moving the limb, until, when he finally wakes up to full consciousness, he finds himself carrying out free voluntary movements which were previously impossible. Hysterical deafness is often similarly cured by a general anesthetic, associated with vigorous conversation with the patient as he is coming round, perhaps combined with a touch behind the pinna with a hot Paquelin cautery, so as to concentrate his attention on the affected ear. Hysterical stammering is more difficult to cure than mutism. A considerable proportion of cases give a history of stammering in childhood. To eradicate it, prolonged treatment may be necessary, since the stammer in such patients is merely one of the stigmata of a congenital psychasthenia. Hysterical blindness is often cured by the familiar device of placing a plane lens in front of the alleged blind eye and a strong *plus* lens in front of the good eye, so strong that the patient cannot possibly see through it; or we may drop a mydriatic such as homatropin into the sound eye. We then ask the patient to read. He succeeds in doing so, unconscious of the fact that he is now reading with his supposed blind eye. Once he realizes this fact, cure rapidly ensues.

## TREATMENT OF OTHER NEUROSES

Neurathesia, or simple nerve exhaustion, with its excessive fatigue on exertion, be it physical or mental, and its other clinical phenomena, cannot be relieved by suggestion alone, although encouraging suggestions will hasten the process of convalescence. For the treatment of neurasthenia we prescribe rest in bed for a month or longer, combined, in severe cases, with isolation, and in all cases with an abundant diet and with general massage, just as in the ordinary "rest cure" of peace

time. Later on, graduated open-air exercises are added. As a rule, six weeks or longer must be devoted to the cure, if we hope to secure permanent results. Neurasthenic patients of lower grade mentality or of neuropathic heredity are less satisfactory as regards results of treatment than the intelligent patient, free from hereditary taint, and are usually unfit for further military service, except at the base.

Dysthyroidism, with its tachycardia, relative lymphocytosis, etc., may occur either as a pure clinical picture, or it may be complicated by neurasthenic symptoms. But even those patients with well-marked tachycardia progress favorably under graduated open-air exercises under an intelligent instructor and, in time, become fit for ordinary exertion. They tend, however, to remain permanently hypersensitive to emotional stimuli.

Anxiety-neuroses following incidents of war require careful study, with analysis of each individual case. They are best treated by isolation, rest in bed, attention to sleep, psychical analysis (not in the narrow freudian sense) and by encouraging suggestions and reeducation for the stress of every-day life. In such patients analysis of the mental content, inclusive sometimes of dream-analysis, may require long and patient conversations, in which various threads of association in the patient's mind are followed up. Such analyses often have their beneficial effect not merely owing to the "mental katharsis" on which the freudian school lays so much stress, but still more from the self-knowledge which the patient thus attains, a self-knowledge which brings with it self-control.

In all war-neuroses, an atmosphere of confidence and cheerfulness on the part of the medical officer and his staff exercises a profound and beneficial influence on the patient. This is effected not merely by the conscious suggestions imprinted on the patient, but by the development of a happy, "emotional" feeling-tone, entirely reflex and subconscious, exercised through the vegetative nervous system and the endocrine glands.

94 Harley Street, W.I., London.