

## CHAPTER V

### OBSERVATION AND TREATMENT

All patients admitted to the neuropsychiatric wards received a complete physical, psychiatric, and neurological examination and, where indicated, psychological and special laboratory examinations. The following "Guide," prepared by the National Committee for Mental Hygiene, was found helpful in the psychiatric and neurological examinations:

#### GUIDE TO THE PSYCHIATRIC AND NEUROLOGICAL EXAMINATION OF PATIENTS AND THE RECORDING OF THE OBSERVATION

The following notes are designed to serve as a guide to the psychiatric and neurological examination of patients in the military hospitals of the Government in order to insure uniformity of recording.

#### PSYCHIATRIC EXAMINATION

In the guide to the psychiatric examination not only the special cases which may be encountered as a result of war, but also all the types of psychoses and neuroses which occur during peace time as well have been considered; in other words, an attempt has been made to cover all possibilities in this outline, but to do it with special reference to the needs of a hospital receiving only military patients.

The different aspects to be looked into in cases with mental symptoms (be they of the nature of definite psychoses or of psychoneuroses) are grouped under several successive headings. It is by no means necessarily the sequence which is best followed in every instance. We have to be guided in this by the condition of the patient, but it is important that all of these aspects should be covered in every case. On the other hand, it should be borne in mind that a given case may be so obviously normal in regard to some of these aspects that that part can be dismissed with a very brief examination.

The examiner should make use of his own knowledge of military life and make constant comparison between the patient's attitude toward the various phases of life in barracks, camp, or the field, and his own observations as to the attitude of other soldiers. The examiner should make the best possible use of the fact that all his patients are soldiers.

#### I. BEHAVIOR, ATTITUDE, AND EMOTIONAL STATE

Observe first the general demeanor of the patient as he enters the room (the condition of his uniform, his hair, his finger nails, etc.), and his reactions to a few simple questions of the type which a physician would naturally ask, such as questions about the patient's health, comfort, etc. Note also whether he shows evidence of loss of sleep, having been crying, bruises, suggesting fighting or rough handling. Note whether he is mindful or unmindful of the attitude of a soldier with an officer; whether his attitude toward the examiner is respectful, hostile, friendly, puerile. At the end of the examination the preliminary observations should be supplemented (in this part of the record) by a summary of the observations regarding behavior, attitude, and emotional state, which are made throughout the examination.

#### A. Accessibility.

- (1) Natural, free, alert.
- (2) With definite emotional changes.
  - (a) Depressive: Depressed, gloomy, worried, uneasy, anxious, fearful, etc.
  - (b) Elated: Satisfied, happy, exuberant, etc.More complex emotional states: Suspicious, disdainful, perplexed, etc.

## B. Inaccessibility.

- (1) Without definite emotion: Apathetic, dull, somnolent.
- (2) With more active emotional changes: Depression, anxiousness, uneasiness, tenseness, perplexity, suspiciousness, disdain, etc.

Certain reactions may at once lead naturally into questions as to what is the trouble; e. g., with an evident worry, one would ask, What is it you worry about? or, What can we do for you? and the like.

## II. MOTOR CONDITION

## A. General motility.

- (1) Normal.
- (2) Overactivity, excitement.
- (3) Diminished activity, such as slowness of motion (constant or inconstant), complete inactivity, possibly with catalepsy, resistiveness.
- (4) Queer, bizarre actions.

## B. Speech.

- (1) Normal in amount.
- (2) Increased in amount (talkative, singing, shouting, noisy).
- (3) Diminished in amount; slow speech (constant, inconstant), mutism.
- (4) Disordered (other than defects suggesting organic trouble), stuttering, "baby talk," explosive, accompanied by facial contortions, movements of hands, etc.

## III. STREAM OF THOUGHT

In spontaneous speech or answers to questions.

- (1) Clear, logical, relevant.
- (2) Jumping from topic to topic but with fairly comprehensible associations.
- (3) Retarded.
- (4) Irrelevant—incomprehensible, disconnected, with queer ideas.
- (5) Fragmentary, often disordered words, paraphasia and difficulty in word finding.

All this may be observed in the patient's spontaneous speech and in answers to questions. If he is not spontaneous, then ask further questions. In this it is best to follow the patient's lead.

## IV. CONTENT OF THOUGHT

- (1) Content of any worry or anxiety regarding present and past situations, physical complaints; apprehensions about the present and future, etc.
- (2) Compulsive ideas, obsessions, phobias.
- (3) Delusions, hallucinations, peculiar mental attitudes. Some of these may have come out before. In that case it is best to summarize briefly what has been obtained thus far and then to proceed with recording the further study.

It should be remembered that it is not merely a question of recording the existence of delusions and hallucinations and the like, but a question above all of inquiring into and recording their content. Give patient's own words regarding hallucinations, etc.

If nothing has thus far been obtained and the patient makes, nevertheless, the impression of being psychotic, the following questions may bring important ideas:

- Have you had any peculiar experiences?  
 Have people said things about you?  
 Does any underhand work seem to be going on?  
 How do you fit into the company (battery, mess, wardroom)?  
 Has anyone made queer remarks? Made veiled references to you?  
 Do things seem natural or unreal?  
 Do you hear voices? Or, sometimes one may simply ask: What do they say?  
 Have people done things to you?  
 Has everyone been kind to you?  
 Have you had strange dreams?  
 Have you had visions?

Sometimes questions about certain topics bring out peculiar mental attitudes or peculiar ideas, such as:

What do you think about electricity, or magnetism, hypnotism, thought transference, wireless telegraphy? etc.

Sometimes the question, Who are you? leads to important answers.

#### V. ORIENTATION

Does the patient know the day, month and year? Does he know what place he is in, who the persons are about him; or does he understand, at any rate in a general way, the situation?

#### VI. MEMORY AND THINKING

(1) With regard to old events.

(a) Inquiry into life history before the advent of the psychosis or neurosis as regards the main data (birthday, positions, dwelling places, as well as inquiry about events since enlistment, etc.), with dates. This gives a good idea of the patient's capacity to think and correlate the different facts (look for discrepancies) as well as of his memory.

(b) Calculation—simple tasks are a matter of memory; more difficult ones test the patient's capacity for concentration and thinking.

(c) Writing—spontaneous and to dictation.

(2) With regard to recent events: Such questions as, How long have you been in this place? Where did you come from? What happened yesterday? What did you have for dinner? etc., will be found useful. (Examiner should use freely his own knowledge regarding military routine.)

Definite tests for retention, such as the remembering of a name and address for two or three or five minutes while questions are asked during the time intervening. For span of memory, test the patient's capacity to repeat series of 8, 6, or 5 digits.

#### VII. INTELLECTUAL LEVEL

If it is settled that no interference with the thought processes exists, an attempt should be made to determine the patient's intellectual level. Test especially the general information regarding the patient's habitual environment, as well as the knowledge he is supposed to have gained in his military experience. Refer also to the guide for the examination and determination of mental deficiency.

The mental tests are often of value even when the permanent intellectual level can not be obtained, since the details of functional capacity may prove of diagnostic value if successive spaced examinations are made.

#### VIII. THE PATIENT'S OWN ACCOUNT OF THE DEVELOPMENT OF HIS PSYCHOSIS OR NEUROSIS

The object here is to trace in detail the origin and development of the condition from which the patient suffers. Even if inaccurate or obviously inconsistent, the patient's account is, nevertheless, important.

In the case of mental disorders, functional or organic, due to the more specific war causes, it is especially important to inquire into:

(1) The patient's mental make-up before enlistment as regards success or failure in life; the extent to which he was able to get along with other people; his capacity for adaptation to new situations; his habitual mood; his habitual reactions to difficulties in life, responsibilities, stress, etc.; special traits, such as fear of thunderstorms, fear of going underground, sensitiveness to seeing blood; his attitude toward the suffering of others, dread of special diseases or modes of death, etc.

(2) The patient's adaptation to the life of a soldier; i. e., his attitude toward the war, his adaptation to training, his adaptation to fighting. Note his first reactions to this (fear, horror, disgust). Inquire how these first difficulties were overcome, if they were overcome. Check up patient's story by reference to officers and comrades (see disciplinary record).

- (3) Details of any fatigue-producing situations, special stress or loss of sleep, etc.
- (4) Reaction to fatigue ("jumpiness," irritability, tenseness, poor concentration, etc.).
- (5) The first symptoms of failure of adaptation, if indicated by the patient's history, such as the wish of deliverance from the situation (note the special form which such wishes took, such as the desire to be wounded, to be taken prisoner, or the desire for death or the war ending); an increase of nervousness and anxiousness about his own safety; specific fears; the development of feelings of horror about the situation (note special supersensitiveness).
- (6) Disturbing dreams (note content).
- (7) Causes which led to the definite breakdown:
  - (a) Direct injury, wind concussion, burial, "gassing," etc.
  - (b) Witnessing unusually distressing sights; or friction with superiors or refusal of leave, or distressing news from home, etc.
- (8) Onset of acute symptoms: Loss of consciousness (note duration); dazed condition; clouding of consciousness with variations in intensity, etc.
- (9) History of condition since that time.
- (10) History of treatment and its effects; also history of military management of patient's illness and the patient's attitude toward this.

In case of psychoses much regarding the development may already have been brought out, especially under the heading of content of thought. It is here gone into more thoroughly if the patient is thought capable of giving it.

#### IX. ATTITUDE TOWARD THE MENTAL OR NERVOUS DISORDER

In psychoses this refers especially to the question of whether the patient understands that he is mentally ill.

In the neuroses it refers more to the attitude in general which he takes toward his symptoms, e. g., does he think they are all due to stress or partly to his own failure in adaptation?

#### NEUROLOGICAL EXAMINATION

##### *Condition of body*

Facies, growth, abnormalities in development, glandular trophic and vasomotor phenomena, including variations in weight, growth of hair, amount of fat, asymmetries, etc.

In functional cases it is especially important to notice trophic and vasomotor phenomena such as skin eruptions, pigmentation, pallor, coolness of the skin, edema, cyanosis, increase or diminution of sweating, excessive dryness, peculiar odors and secretions, pulse rate, pain in the head, palpitation, breathlessness on exertion, precordial pains. If unusual trophic or vasomotor symptoms occur it is important to determine whether or not these are the result of the patient's own actions.

General appearance of patient as regards resemblance to some disease.

#### CRANIAL NERVES

*First nerve (olfactory).*—Anosmia, parosmia.

*Second nerve (optic).*—Acuteness of vision and, if impairment, description of same; irritating visual phenomena. Pupils, whether round or irregular; their reactions to light and to movement of eyeballs. Visual fields (note especially in shell-shock cases variations from the normal such as reversion of color fields, etc.). Ophthalmoscopic examination; exophthalmos and enophthalmos; irregular size of palpebral fissure.

*Third, fourth, and sixth nerves (ocular nerves).*—Ptosis or drooping of the upper lid, ocular palsies, description of double vision, convergence.

*Fifth nerve (motor).*—Muscles of mastication, masseters, temporals, and pterygoids. (Sensory portion.) Note disturbance of sensation for touch and pain and temperature. Pains in face. Loss or impairment of taste in anterior two-thirds of the tongue. Look for paraesthesia or perversion of taste sense in shell-shock cases.

*Seventh nerve (peripheral facial palsy).*—Inability to wrinkle forehead, shut the eye, show teeth. With central facial palsy, can wrinkle brow and shut the eye. Note loss of taste on the affected side. Electrical examination to be made if possible.

*Eighth nerve.*—Cochlear division: Determined degree of deafness by tuning fork or voice and then make a closer examination and determine whether it is due to the destruction of the nerve itself, or the middle ear, or if it is functional. Vestibular portion: Examination should be made by so-called Bárány tests either by means of a turning chair or irrigation of the external ear by water.

*Ninth nerve.*—Inability to swallow. If impaired, note degree of inability to swallow food and regurgitation of same. Loss or impairment of taste in posterior third of the tongue. Look for parageusia or perversion of taste sense in shell-shock cases.

*Tenth nerve.*—Movements of vocal cords, character of speech, and whether or not speech and breathing are interfered with.

*Eleventh nerve.*—Action of sternomastoid and trapezius muscles.

*Twelfth nerve.*—Ability to protrude the tongue and its direction and impairment of movement. Atrophy and tremor.

#### *Motor symptoms*

Station and gait. Deformities and contractures. Convulsions, local spasms, ties, tremors (coarse or fibrillary), myokymias, etc.

Limbs: Determination of strength by grip and movements, both voluntary and against resistance. Tonicity, atrophy, or hypertrophy, coordination of extremities and trunk (ataxia), cerebellar asynergy.

#### *Reflexes*

*Cutaneous.*—Conjunctival, corneal, epigastric, cremasteric, plantar, Babinski, defense.

*Tendon.*—Biceps, triceps, wrist, patellar, Achilles.

*Muscle reflexes.*—Clonus: Wrist, patellar, ankle. Special: Kernig, Trousseau.

#### *Electrical examination*

Faradic response.

Galvanic response and nature of the reaction.

#### *Speech disturbances (organic functional)*

*Organic.*—Motor aphasia: Patient knows what he wants to say, understands what is said to him, can read, but is unable to express himself either wholly or in part in spoken words or by writing.

Sensory aphasia: Patient can talk and can write, but neither his speech nor his writing make sense because he is word deaf; that is, he does not understand the meaning of the sound of words.

Sensory motor aphasia: A combination of motor and sensory aphasia, the extent of the disturbance depending upon the completeness of the lesion.

*Functional.*—In functional or shell-shock cases, look for various forms of speech defects such as mutism, stammering, stuttering, and verbal repetition.

Hearing may be lost often with speech. Hyperacusis or extreme sensibility to sound is very common.

#### *Sensation*

Studied in head, trunk, upper and lower extremities with finger tip, cotton-wool, camel's-hair brush, esthesiometers, hot and cold test tubes, etc.

*Epicritic sensibility.*—Superficial touch, light pressure, warmth, coolness, tickling (hairy surfaces), tactile localization, and tactile discrimination.

*Protopathic sensibility.*—Pain sense, extreme heat, extreme cold.

*Deep sensibility.*—Muscular, tendinous, arthroal.

Sense of position and passive movement, deep pressure. Astereognosis. Asymbolia. Vesical, rectal, and sexual functions.

#### *Lumbar puncture*

Cell count and Wassermann.

*Physical examination*

This should be a general physical examination including condition of the heart, lungs, blood pressure, blood for Wassermann, etc.

Active treatment as contrasted with custodial care was emphasized in all neuropsychiatric wards and hospitals. Diagnosis was not considered an end in itself. Individualization of the patient was insisted upon. Patients, in so far as possible, were not permitted to be idle. From the day of his entrance into the hospital an effort was made to see that the patient was kept occupied. In this important procedure the occupational therapy worker was invaluable.

In most of the hospitals the neuropsychiatric staff met daily to consider difficult cases, to discuss the advisability of discharging certain patients, and to review the results of the examination of recently admitted patients. In some of the hospitals a weekly conference was held, to which all the medical officers of the hospital were invited. At these conferences papers on such psychiatric subjects as might be of interest or benefit to the general medical officer were read and patients were presented and discussed. These conferences frequently aroused much interest and were well attended. A further opportunity to familiarize the general medical officer with psychiatric case studies was presented by the regular hospital staff conferences. The neuropsychiatrists took their turn in presenting to the entire staff of the hospital interesting psychiatric material.

The experience of those responsible for the neuropsychiatric work at Walter Reed General Hospital, Washington, D. C., is more or less typical of the experiences elsewhere and is worth recording.

Prior to the World War mental patients at Walter Reed General Hospital were cared for in the basement of the administration building along with the military prisoners. The place was wholly unsuited for prisoners, let alone patients. But the feature which evidently recommended it was that, having been built for prisoners, it was heavily barred and guarded and the insane could not get out. Treatment was impossible and the care in all respects, except possibly food, was about the equal of the county asylum of the old type. Before the end of 1917, however, psychiatry at Walter Reed General Hospital had improved materially. Five neuropsychiatric wards, of wooden construction, were opened. The first ward was built in accordance with the building plan of the neuropsychiatric wards of the base hospitals; that is, a ward divided into three sections so as to provide a better classification of patients. The other wards were dormitory wards similar to the general medical wards. As it was planned to use a section of the first ward for disturbed patients, the rear portion of this ward was screened with iron-wire mesh. The screening was never completed and a part of what had been put up was later taken down.

The five wards at Walter Reed were open wards without bars or mesh, and were comparable in every way with the general medical wards of the hospital. As a matter of fact, it was possible, in showing visitors through the hospital, to take them from the medical to the neuropsychiatric wards without their knowledge of when they had made the change. The same lack of restraint was to be found at Hospital No. 2, Baltimore—no bars, no bolts, no mesh. The ward physically was no different from any other ward in the hospital, except

the ward for military prisoners. The psychiatrist's difficulty in conducting this kind of a ward was not so much in keeping patients in as keeping patients out. The ward in the early days of the hospital was so much more attractive than the other wards that it was at times difficult to keep other patients from coming over to visit, play the piano, listen to the victrola, or work in the shop.

The standards were equally high at Fort Benjamin Harrison, Fort Sheridan, the Letterman General Hospital, Fort McPherson, Fort Sam Houston, and Fort Des Moines. Each differed somewhat from the others, depending upon local conditions. None were as free of bars and mesh as Walter Reed General Hospital or General Hospital No. 2, at Fort McHenry, Md., but in each these evidences of incarceration were much reduced and further reduction was contemplated, the chiefs of the service being convinced that the bars and the mesh were not only unnecessary but that treatment could be carried out much better without them. As a matter of fact, many wards that had originally been barred or meshed in order to relieve the anxiety of a commanding officer became open wards, with doors unlocked and patients given much freedom.

That the open-ward system was successful there can be no question. The success depended upon a number of things. The spirit of the wards was important. The spirit was distinctly that of a hospital, not that of a jail. The patient was not constantly reminded of his situation by the sight of bars; he realized that at least some one considered him sick and that for that reason he had been brought to a hospital where he was under no greater confinement than other patients in the hospital; at no time was he stung with the humiliation of imprisonment. Incentive to escape was reduced to a minimum; the patient came to regard himself possibly as sick; his ingenuity was not aroused to out-trick his jailers or to create out of nothing instruments to remove bolts and bars. The importance of careful classification of patients was kept constantly in mind.

#### CARE OF CASES OF NERVOUS DISEASES

The treatment of organic diseases of the nervous system, under which heading epilepsy is classed at this point for convenience, was of little military importance, as these conditions, almost without exception, disqualified for service. Few of them were susceptible of any great degree of amelioration by such treatment as was afforded in our military hospitals.

The hospital history of all the cases of this general class was that they were retained in the service for antisyphilitic treatment, for tonic treatment, or for operation, as the case might be, and then were discharged from the Army. They showed no differences in symptoms, course, or indications for treatment in the military service from similar cases in civil life.

One of the important demonstrations of the war was the great number of men from all walks of life who were conditioned in their practical usefulness by functional nervous disorders of some kind. These came in for dramatic prominence as cases of shell-shock, developing in both front and base sections in France; but still larger numbers were refused entrance into the Army, and many were discharged from the camps on surgeon's certificate of disability.

The number of neuropsychiatric cases rejected or discharged at home may be divided into two general classes—the psychasthenic, or neurasthenic, and the hysterical. In the former the patient was concerned with a chain of mental difficulties, and was constantly provided with long explanations as to why he did not successfully carry on his military duties. These explanations referred to various purely subjective symptoms, which might come to light when the man was reported as a patient. Under such circumstances he could be found in any of the various medical services, as the symptoms might be referred to any organic system. These cases were especially found in connection with the “effort syndrome,” and with the whole group of cardiovascular conditions. Symptoms referable to the stomach and intestines were particularly frequent.

The cases called hysterical were apt to be associated with more definite symptoms, such as paralysis, contractures, abnormal gaits, etc. In this hysterical group, suggestion as a factor in determining the type of symptom was much more evident than in the psychasthenic group; also these patients were frequently noticed to be less intelligent.

The cases returned as neuroses from overseas were so similar to the home cases in their symptoms that it can be said that there appeared to be no fundamental clinical differences between neuroses developing in actual warfare and those which developed in the training period. The probability is also great that there is slight difference, with the exception of some war coloring, between the neuroses of war and those of civil life.