# A CASE OF HYSTERICAL STUPOR RECOVERING AFTER CARDIAZOL TREATMENT.

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[Received May 23, 1942.]

HYSTERICAL stupor is rare, and indeed some authorities are sceptical of its existence. There are few references to it in English, either in standard text-books or papers. Oppenheim and Bleuler refer to it in passing, but with little clinical detail. Hoch's benign stupors, in spite of their name, are really psychotic reactions. He refers to invariable intellectual retardation and preoccupation with ideas of death being present, and actually a follow-up has shown that most of these cases were really schizophrenic. Millais Culpin, Hubert, and others writing of war neuroses describe hysterical stupors, but they have been the result of terrifying experiences at the front. The case described below showed features which would appear to justify a diagnosis of hysterical stupor, occurring in an individual subject to little external strain. This, in conjunction with a failure to improve over some weeks, but with rapid recovery after cardiazol treatment would seem to warrant reporting it.

*History.*—The patient, a soldier, aged 23, was one of four children, all alive and well. His mother died 18 years ago. His father was alive and well. From the patient's sister, who was the only available, but not very reliable, source of information, no history of mental or nervous disorder in relatives was obtained. Neither had she ever observed any abnormal characteristics or peculiarity of behaviour in the patient, apart from an apparently reasonless dislike for his father for some years past, which was not reciprocated, and which the sister could not explain. Details were not forthcoming. According to her he did well at school work, but disliked games. He held three jobs as hotel porter, and joined the Army as a militiaman in 1940.

He had been home on leave, and three days before this expired he was said to have hit his head against a fence in the blackout, and to have knocked down two palings. He had a headache the next day, but this improved and no other symptoms developed. On the day his leave expired the patient went out without his kit to buy cigarettes and never returned. His sister duly wrote to his C.O., and he was posted as a deserter.

Two months later he was "found wandering" by the police, though he was also, a trifle inconsequentially, reported as "unconscious at the time of apprehension." The actual facts appeared to be that he was picked up within a few miles of his home in a semi-comatose state. Stimulants were administered by the police surgeon, and he was brought to Pembury Hospital and admitted under Dr. C. S. Darke. On admission he was in a collapsed, stuporose condition, and could not be roused. He was emaciated and unkempt in appearance. His pulse was running, rapid and irregular, the heart sounds weak, the B.P. 130–100, and he was breathing shallowly. The patient's eyes were closed, and he resisted having them opened. The corneal reflexes were present. The pupils reacted to light, and the optic discs were normal.

There was no noticeable difference between the two sides of the face. There was no difference of tone on the two sides of the body; the abdominal reflexes were obtained, and the tendon reflexes were equal, though sluggish. The plantar reflexes were flexor, and there was complete anaesthesia, both to pinprick and severe pressure. Any tests requiring co-operation were impossible. He required catheterizing, and a small quantity of concentrated urine was obtained, containing no albumin or sugar, but acetone bodies.

His blood W.R. was negative; the cerebro-spinal fluid and an X-ray of the skull were both normal.

The next day he looked a little better, but did not speak. His pulse was stronger and regular, and had fallen to 80. Four days later he was reported as further physically improved, and managed "a few rather incoherent words."

A week after admission he still lay inertly, hardly ever spoke, and failed to recognize his sister. After a fortnight, the patient's condition being no different, I was asked to see him.

He exhibited the following features then, and on subsequent days. He mostly lay flat on his back in bed, and there was a complete lack of movement. He looked straight ahead, with a blank expression, but if he could be persuaded to pay any attention to the examiner, he responded by opening his eyes wide, and assuming an expression which can best be compared to that of the frightened heroine in a melodrama. He never suddenly averted his head, or shifted his gaze in the way often seen in catatonic schizophrenics. At times, however, he would pout his

lips rhythmically in a manner reminiscent of a " schnauzkrampf," though the pouting was never sustained for any long period.

It was impossible to obtain his co-operation in any tests. If one inserted one's finger into his hand he could not be persuaded to grip it, and he was still quite insensitive to pinpricks and to severe pressure on his tendo Achillis.

During the ensuing two weeks he remained in this condition, and his appearance strongly resembled that seen in deteriorated schizophrenia. There were not, however, at any time during his stay in hospital any sudden burst of activity, giggling, shrieks, or other features which often disturb the apparent tranquillity of the schizophrenic, nor did he ever behave as though he were hallucinating. Yet in spite of appearing completely stuporose, if he was left alone with a plate in one hand and the requisite cutlery in the other, he ate his own food. On several occasions I observed him from behind a screen. He ate extremely slowly and tremulously, but succeeded in eating about half of what was on his plate. Another noticeable feature was that although artificial noises (such as dropping a book behind him) did not affect him, he started violently and trembled whenever any bombs dropped even distantly. On one or two occasions he mumbled: "Aeroplanes—they are coming," looked startledly upwards, and trembled violently.

*Treatment.*—After the patient had been inacessible for a month, hypno-narcosis was tried in the hope of obtaining information. 3·5 c.c. of cyclonal was given, but with no effect. The patient never flinched, but remained quite passive when the needle was inserted, and became completely comatose. At no stage during recovery from the anaesthetic could he be persuaded to speak. It was therefore decided to try the effect of cardiazol. Before administering this I deliberately spoke to students who were present of the unpleasant accompaniments of cardiazol injections, and although the patient was again insensitive to the pinprick, he trembled violently and his pulse-rate went up during my dissertation.

4 c.c. of cardiazol produced a typical convulsion. A student afterwards described his pulse as " suggestive of fibrillation " during the convulsion, but although the rate was 112, half an hour later it was quite regular. At this time the patient started repeatedly, murmuring: " Charlie is coming to see me." He said nothing else. At least nothing else was intelligible, and he could not be got to answer questions, but obeyed simple commands, such as " Put your tongue out," though carrying them out feebly.

The next day he had relapsed to his previous completely mute, unco-operative state, and the day after this was given another convulsion with 4 c.c. of cardiazol. This produced a noticeable improvement. The same day he sat up in bed and read, and talked fairly rationally, saying, among other things, that he wanted to go home to " Charlie." He again relapsed to some extent, but could now at all times be roused sufficiently to attend, though his replies tended to be incoherent. He kept on repeating "Aeroplanes "—sometimes spontaneously, and sometimes as a result of hearing them. On cross-examination he gave a disjointed account of some incident in terms which savoured of the melodramatic, although he did not altogether give an impression of play-acting. He would assume an expression of intense fear, so marked that one was reminded of an actor of the silent films " registering emotion," yet he would tremble apparently quite uncontrollably and cry out: " They're coming! They shot at me—bullets over there," and would peer from side to side. The gist of his story appeared to be that a German aeroplane had machine-gunned him in a field he was hiding in *at night*. The latter, of course, was wildly improbable, and one can only surmise that he had heard shooting.

As this improvement was maintained for three days, I hoped that a mild anaesthesia might now recapture his lost memory of what had happened since he left home, and he was again given cyclonal, but with no effect. He was therefore later given 5 c.c. of cardiazol, and had a convulsion. In view of the previous statement regarding cardiac irregularities, it was noticeable that his pulse remained quite regular.

The third convulsion was the last he needed. The next day he sat up in bed, and although speaking in a very small voice, and repeating words in a meaningless way, he was far more rational. He was orientated in time and place. He spoke of wanting to go home to live with Charlie " my brother-in-law " and his sister, that he wanted to visit them, etc. His pulse rose to 140 when speaking of his sister (why, I could not elicit), and he trembled whenever he spoke of aeroplanes.

*Progress.*—I was away for a week, and on my return the patient appeared to have made a complete recovery with no further treatment—at least, as far as his acute condition was concerned. I had a lengthy interview with him. He had

noticeably put on weight. He sat quietly, making few movements, although there was no abnormal dearth of them, His resting expression was placid, but be became animated at times. His stream of speech was normal. He answered readily, and to the point; there were none of the repetitions noted before, no difficulty in finding words, and no irrelevancies. The predominating emotion was one of anxiety, especially when he spoke about air-raids, when he became very tremulous. I noted a somewhat dubious shallowness of affect, though never amounting to incongruity. It was, however, difficult to be at all certain about this. He spoke with emotion of matters which worried him, but nevertheless, in my opinion, rather too facilely. He definitely had no ideas of reference, delusions, or hallucinations, neither did he display any secretiveness, furtiveness, evasiveness or undue suspicion. He was perfectly orientated in time and place, and gave a satisfactory account of himself until his arrival in hospital (though he worked out when this was from a knowledge of dates), but he had no memory of anything which had happened in hospital, or of any of the therapeutic procedures he underwent. His memory dated to the afternoon after his third cardiazol injection.

He gave the following account of himself: He had always been inclined to be shy and nervous, and had found reciting lessons in class and similar feats very trying. His mother died when he was quite young. He was fond of his father, and denied his sister's assertion that he disliked him, but declared he had always felt that his father was indifferent to him. He also denied being afraid of him. He was fond of his sister. After leaving school he held a job of hotel porter for some years, getting on quite well, provided he had little to do with the clients, for he was always ill at ease with people. In the Army he had been terrified of making a fool of himself on parade.

He had joined the Army in June, 1940, and in spite of his fear of ridicule and being upset by being shouted at, he declared he liked it quite well. Three weeks after entering the Army he was sent to a Thames-side hospital for a hernia. While there he was exceedingly scared by the bombing. He subsequently went home on sick leave, and it was while at home that he insists he saw and heard machine-gunning quite close and was terrified. Consequently, when the time came for returning to the Army he absconded, and, having done so, had the additional fear of punishment for desertion. He was frightened more than depressed. He declared that he hid in some woods near to his home for nearly two months, subsisting largely on apples (it was September when he decamped), though occasionally at night he managed to buy a little food in neighbouring villages, using for this purpose some savings which he had with him. He insisted that he did not go home during this time, and his sister confirmed this. As stated, she was not considered too reliable, but considering the emaciated condition he was in when found by the police, his statement would appear true.

The patient remained in hospital until he was boarded out of the Army. He was inclined to be solitary, and was usually to be found on his own. His voice was generally tremulous when I spoke to him, and he was always terrified if any aeroplanes were about, so much so that I took it on myself to tell him I was sure he would not be required for active service. However, there was still the court-martial hanging over his head, but after some weeks it was possible to tell him that it had been rescinded. (I had recommended this after consultation with the A.D.M.S. on the grounds of "severe temperamental instability.") This news, however, appeared to make little difference to him. It may have been that he thought all along he would not be punished, but my impression was that he was so genuinely preoccupied by his fear of bombing that the fear of the court-martial played a smaller part than might have been expected.

## Discussion.

Before considering the positive evidence for diagnosing hysteria in this case, the grounds for excluding organic disorder and psychosis require mention.

*Negative evidence.*—(1) *Organic stupor:* There was no clinical or pathological evidence to support such a diagnosis. Admittedly there was a history regarding a head injury three days before, but to knock palings out of a fence with no other consequences than a transitory headache seems to point to the fragility of the fence more than anything else. In any event the stupor (lasting four weeks) did not resemble that following head injury, nor would cardiazol clear up the latter.

*Psychosis.*—That the attack may have been preceded by depression is possible, and undeterminable. There was no evidence that the depression was psychotic in nature. The more important question, because of the prognostic implications, is whether the patient was schizophrenic. In regard to the stupor itself, the pros and cons of this diagnosis have already been discussed. In any case, in psychiatry especially, the total picture is necessary for making a diagnosis. Other evidence in favour of schizophrenia could be the past personality of the patient, his sudden and unexplained dislike of his father, and the very slight shallowness of affect observed after his recovery. On the other hand, as pointed out, his thought processes appeared perfectly intact. There were none of the sudden irrelevancies or tangential flight of ideas which occur in this disorder. There were no peculiar mannerisms, no evasiveness or evidence of ideas of reference or hallucinations. In the absence of any such findings over a period of six weeks, when the patient was seen regularly, it hardly seems justifiable to construe the other symptoms (which are quite compatible with a psychoneurosis) as meaning schizophrenia.

*Positive evidence.*—On the other hand, there is ample evidence that the patient was terrified of bombing and aeroplanes, and found the conditions of military service very difficult to cope with. Wandering away in response to such difficulties is typical of a hysterical fugue, though I am not suggesting that this was a fugue, which to my way of thinking are always very suspect reactions. It may be that the patient absconded in an effort to overcome his dilemma; he was a little dazed from his knock on the head, and possibly he used this slight injury as an excuse to himself. What is clear is that there was no question of his malingering when he was admitted to hospital, nor in his condition afterwards. It would be interesting to know how far hunger played a part in his condition. Hunger does tend to make some persons drowsy, and this may have helped to bring about the stupor. No abnormalities in the sugar tolerance curve were noted whilst he was in hospital.

Finally the case raises certain points in regard to the concept of hysteria generally and indeed of the whole question of purposiveness in psychological explanations. The current views of hysteria are summarized by Mapother and Lewis as follows: "Symptoms of illness are represented by the patient for some advantage without his being fully conscious of the motive." This means that the patient's symptoms are of a kind which can be brought about deliberately, or that the patient is exaggerating or making use of symptoms already there, but not necessarily of a kind which he could consciously produce. But a third type of syndrome is frequently labelled hysterical, because there are psychological precipitating factors, and the personality is of the hysterical type; the overbreathing epilepsies are an example. But a little consideration will show that these really far more resemble types of disorder like asthma where a psychological stimulus sets off a physiological mechanism. Kretschmer meets this difficulty by speaking of hysterical symptoms under the control of the central nervous system, and those under the control of the autonomic. But in regard to the latter it would appear wrong to speak of true motivation, which leads on to a tendency to confuse two aspects of purposiveness in modern psychological writings. For there is a difference between ascribing a motive to an action, and observing that it has a purpose. For example, we eat because we are hungry, and we eat to live. But whereas the first reason for eating is a motivated response (to feeling hungry), the second statement is a deduction founded on a large series of observations. But if we regard the second in the same light as the first it will lead to inaccurate and therapeutically confusing statements. For example, in this case the patient might be told that he had become stuporose in order to avoid military service. But although the stupor served this purpose, it is difficult to imagine that however strong the desire, profound stupor could be brought about, or indeed even simulated. At most one could imagine that the patient did not resist it. To take an analogous instance, a sufficient degree of worry or fear may so far reduce resistance that influenza may be contracted, but it would hardly be tenable to say that, for example, an accompanying pulmonary consolidation was psychogenic.

Therefore the case described here is one which was not psychotic, at least on the facts available at the time, but is hysterical in the generally accepted sense of the term.

The rapid recovery on cardiazol is a matter of some therapeutic interest.