PSYCHOTIC BATTLE CASUALTIES

BY

E. K. MULINDER, M.B., Ch.B., D.P.M.

Capt., R.A.M.C.

Neurosis arising from battle stress has been repeatedly investigated in the last five years. Psychosis precipitated in the same way is rarer but more interesting, and has largely escaped attention. The object of this article is to classify cases of psychosis induced by stress of battle, and to give examples which, though psychotic, differ from the classical types of psychosis both in their clinical forms and in their duration, which is temporary.

Cases admitted to the psychosis ward of a British psychiatric hospital in Normandy during a period of fierce fighting have been classified as follows:

	No. of Cases
1. Psychoses of classical type, unrelated to battle stress	11
2. Psychoses precipitated by battle stress, but clinically indistinguishable from Group 1	36
3. Temporary psychoses precipitated by battle stress and differing from recognized types:	
A. Reactions to stress and fear:	
(i) Showing confusion	35
(ii) Showing regression	5
(iii) Acute anxiety states	12
B. Reactions to awareness of failure to tolerate the stresses of battle	17
C. Reactions to death of comrades	22
Total	138

Discussion is confined to cases in Group 3, of which the following typical examples are given.

A. Reactions to Stress and Fear

(i) *Showing Confusion*.—Tpr., aged 29; service 4 years. The family history was negative, and the personality stable prior to Army service. He had seen much service as a tank driver in the Middle East. In 1942, after severe battle stress, he suffered from "loss of memory" for a week. On account of this and otitis media he was transferred to the fitters' workshop. In Normandy he was again employed as a tank driver. He continued duty for a month, taking part in several attacks before he broke down.

On admission he was confused and disorientated. He showed no fear, but was euphoric, irritable, easily annoyed, and was rambling and garrulous. He completely misinterpreted objects and events about him, to conform with his belief that he was still in the midst of a battle. His memory was very poor for both past and recent events. During the first week he gradually improved, becoming orientated and recovering his memory almost completely. He eventually became willing and fit to return to his earlier employment as fitter.

(ii) *Showing Regression*.—Pte., aged 25; service 9 years. This man passed down the line of evacuation and was admitted in a stuporous state, clutching a doll in his arms. He lay curled up in bed like a child, clinging to the doll as a drowning man to a straw. If approached or addressed he showed extreme terror, and tried to hide under the bedclothes. On the fifth day he became lucid and accessible. He stated that a mate who had been killed had obtained the doll for his children. The psychotic withdrawal was replaced by symptoms of an anxiety state.

(iii) *Acute Anxiety States*.—Pte., aged 27; service 9 years. This patient had had an unhappy childhood: his parents had separated, and he had been reared by a drunken foster-mother. His previous personality was stable. He had been employed as a mess waiter, but in the invasion was used as an infantryman. He had been in action for four weeks since D day, when a shell landed on the edge of his trench. He broke down into a state of terror and confusion.

On admission he was in a condition of extreme terror, believing that a Messerschmitt was after him all the time. He interpreted every sound as an approaching plane or shell. His pupils would then dilate; sometimes he tried to run away, and at other times would bury himself in abject terror beneath the bedclothes. After three days of gradual improvement he became lucid. The condition was then one of acute anxiety: he was easily startled, and complained of headache aggravated by noise.

B. Reactions to Awareness of Failure to Tolerate the Stresses of Battle

Sgt., aged 21; service 4 years. There was nothing relevant in the family or personal history. He had volunteered, and had served in Iceland. He had been in action in Normandy for five weeks. He had felt increasingly anxious, and finally became panicky and uncontrollable; he was also depressed, with a strong suicidal tendency.

On admission he gave a clear account of himself except for a period of two days when he had been in a field dressing station in a confused and depressed state. He was miserable, solitary, and self-reproachful. He asked to be left alone, as he considered himself unworthy of attention when so many better men than he had been killed. With the help of treatment he became much less depressed during the next few days, but remained in a state of moderate anxiety.

C. Reactions to Death of Comrades

Tpr., aged 20; service 2 years. There was nothing relevant in the family or personal history. He had served satisfactorily as a tank driver in Normandy for eight weeks. Then his tank, going far forward on a reconnaissance, was hit, and the tank commander was killed by an 88-mm. shell. The patient, after further severe stresses, was rescued: he was then stuporous.

On admission he was depressed and semi-stuporous, with some agitation. He was almost mute, but it could just be ascertained that he thought he was responsible for his tank commander's death, and that he could hear accusing voices. During the subsequent week he improved considerably, but remained mildly depressed. He tended still to blame himself, and lacked self-confidence.

Discussion

Cases in Group 3 do not fit readily into any established classification of psychoses. These patients are considered psychotic because they show a marked detachment from reality, together with various combinations of other typical characteristics, such as confusion, mutism, delusions, hallucinations, psychomotor retardation, flexibilitas cerea, depression, or elation.

The cases differ from the classical forms of psychosis in several ways: they usually arise in men with good family and personal backgrounds; the condition is precipitated by severe and usually prolonged stress; the prodromal symptom is a sense of increasing anxiety, but this is not always present. The content of delusions, hallucinations, or emotional disorder is derived from experience immediately before the breakdown, and is less fixed and more accessible to reasoning than in the typical psychotic. The most notable difference is in the duration: the psychotic manifestations improve steadily, and disappear with striking suddenness at the end of three to seven days. Symptoms of neurosis, usually an anxiety state, are subsequently presented, often after a lapse of a day or two, during which the patient has no complaints and appears contented. This group thus forms an interesting link between the psychoses and the neuroses.

Treatment for the first few days consisted of rest, reassurance, and just enough sedation to ensure sleep at nights. During the day, especially as improvement occurred, every effort was made to restore contact with reality and to correct misinterpretations of surroundings. In the stage of recovery the patient was encouraged to recall his battle experiences fully. Where necessary, an intravenous injection of pentothal sodium was used to facilitate this abreaction of traumatic incidents.

Summary

A series of 138 psychotic casualties arising in the Battle of Normandy have been classified.

Attention is drawn to a psychosis of short duration and distinctive clinical form which was present in 91 of these cases.

The special features of this psychosis are: (a) sudden onset after battle stress in men with good family and personal histories; (b) typical psychotic detachment from reality, with other psychotic manifestations such as confusion, delusions, and hallucinations; (c) rapid recovery from the psychotic state, usually within one week; (d) subsequent development of neurosis.

Treatment consisted initially of rest and reassurance. Later, the traumatic battle experiences were brought back into full consciousness.

I wish to thank Col. R. J. Rosie for permission to publish this report on cases seen in the hospital under his command.

C. M. Tinsley (*Arch. intern. Med.*, 1945, **75**, 82) states that pneumococcal endocarditis occurs in about 3% of all pneumococcal infections and is responsible for about 5 to 10% of deaths due to pneumococcal infections. The aortic and mitral valves are infected in 36 and 33% of the cases respectively. Purpura, splenomegaly, and infarction are less common than in subacute bacterial endocarditis. The disease is usually rapidly fatal.