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DEPRESSIVE STATES IN WAR

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It is proposed to draw attention to the frequency of depressive states in war and to record the results obtained in an analysis of 88 consecutive cases admitted to the neuro-psychiatric unit of a Royal Naval auxiliary hospital.

The literature on war psychiatry might suggest (1) that the incidence of psychiatric disorders had greatly increased; (2) that this was almost entirely due to a greater incidence of "neurosis" of either anxiety or hysterical type; and (3) that the incidence of depressive illness was comparatively small, scarcely rising above that in the civilian population. Thus in a recently published book, *The Neuroses in War* (1940), which includes a survey of the literature, only a few passing references are made to depressive reactions; their differential diagnosis is not discussed, and even the term "depression" finds no place in the index.

Lewis (1934) has put forward the following definition of depressive illness: "A condition in which the clinical picture is dominated by an unpleasant affect, not transitory, without evidence of schizophrenic disorder (other than slight and subordinate) or organic disorder of the brain, and in which, moreover, the affective change appears primary, and not secondary to other symptoms of ill-health." If this definition is accepted a substantial proportion of psychiatric cases occurring in the Royal Navy must be classed as depressive states. Thus "depression" and "hysteria" as primary diagnoses have during recent months been made with almost exactly the same frequency (13%) in the cases (including the neurological) admitted to this particular neuro-psychiatric unit, whilst in the first part of 1940 the diagnosis of depression was three times as common as that of hysteria (Curran and Mallinson, 1940). However cases of depression may be classified the scarcity of reference to them in the literature is difficult to understand.

It is possible that reluctance to make the diagnosis of depression has arisen from the implication of "psychosis," which to so many suggests an illness of certifiable intensity. Experience in the Navy has confirmed the often-expressed opinion that the incidence of certifiable insanity is not greatly increased as a result of war stress. But it is unusual for psychiatrists to equate "psychosis" with certifiable insanity, although in view of the confusion which has arisen about this term there is much to be said for doing so. Probably most psychiatrists would still class as psychoses certain illnesses which never reached such intensity, and some of them would maintain that there was an essential qualitative as well as quantitative differ-

ence between psychosis and neurosis, which it was important to recognize because of the prognostic and therapeutic implications (Ross, 1923; Yellowlees, 1932). Reasons have been given elsewhere (Curran, 1937) why this last view should be regarded as false for cases met with in civilian practice, and it equally finds no confirmation in the naval psychiatric cases arising in this war, which seem quite clearly to form a continuous series.

The cases considered here were classed as depressive states because in all of them the depressive aspect predominated over such anxiety or hysterical features as were present. They ranged from cases of certifiable intensity to quite mild reactions showing excellent insight, a high degree of reactivity to their environment, and no evidence of such "endogenous" symptoms as retardation and self-reproach. Difficulties in making a satisfactory classification of depressive states are inherent in the nature of the material. For here again it is not a question of a sharp distinction between an "endogenous" or mainly constitutional illness and one which is "exogenous" or "purely psychogenic"—between a "manic-depressive" and a "reactive" or "neurotic" depression—but of varying proportions of constitutional predisposition and external stress. The following classification is not, therefore, intended to do more than roughly assess which of these two factors—constitutional predisposition and external stress—seemed to be the more important in the individual case:

1. "Endogenous depressions," which might or might not have been precipitated by external stress, mainly characterized by certain typical symptoms such as retardation, ideas of reference and self-reproach, and a "depressive content."
2. "Reactive depressions," mainly characterized by the dependence of the illness upon traumatic experiences which gave rise to a "topical content," but not showing the typical "endogenous" symptoms mentioned above with the same frequency or intensity.

In making the final decision each case was considered as a whole. Many cases fitted into the above classification well enough; a large number did not. By a strange chance each group was found to contain 44 cases, and of the total 33 were "regulars," 48 reservists, and 7 "hostilities only" recruits.

Method of Classification

It is now proposed to see what emerges from a comparison of the two groups and from an analysis of the findings in this series of depressive states as a whole. In order to do this the material has been summarized in

tabular form (Table I). Considerable distortion must inevitably result from the severance of particular aspects from their total and individual setting, but no other course seemed possible, for clearly we could not give full case records.

TABLE I

	Classification		Returned to Duty	Social Recovery	Reduction of Social Capacity
	Endogenous	Reactive			
No. of cases	44	44	25	40	23 (including 1 suicide)
<i>History</i>					
Average age	34	37.5	32	38	37
Family history of mental disorder	17	12	8	14	7
School record below Standard V	11	7	2	10	6
Bad work record	9	6	5	9	1
Unsatisfactory personality	7	8	5	9	1
History of a previous attack	16	9	5	18	2
Special war stress	8	19	6	14	7
Domestic misfortune	12	11	5	11	7
Physical factors	5	18	4	12	7
<i>Symptoms</i>					
Retardation	29	15	11	20	13
Ideas of reference	18	6	6	11	7
Self-reproach	27	9	8	16	12
Depersonalization	9	1	1	6	3
Somatic preoccupations	32	22	13	26	15
Depressive	37	13	14	23	13
Topical	4	27	10	13	8
Mixed	3	4	1	4	2
Anxiety	25	36	14	32	15
Reactivity	14	20	13	19	2
Hysterical prolongation	15	20	7	23	5

Past History

Family History.—Recorded only when a near relation (parent, aunt, uncle, or sibling) had been in a mental hospital, or when more than one such relation had shown unmistakable evidence of psychiatric disorder (e.g., "shell shock," or obvious psychopathy as shown by chronic alcoholism or a bad work record).

Work Record.—Recorded only when this appeared to be definitely unsatisfactory from such objective evidence as frequent changes of job.

Personality.—Recorded only when such features as well-marked hysterical or schizoid "psychopathy" or long-standing anxiety of pathological intensity were present.

Previous Attacks.—Only one patient had a previous attack of sufficient severity to necessitate mental hospital care, and in only four cases was there a history of more than one previous attack.

Special War Stress.—Recorded only when there had been a direct experience of enemy action such as torpedoing, mining, air-bombing, or immersion. The often prolonged and severe hardship and danger to which the majority of these men had been exposed has not been recorded.

Domestic Misfortunes.—All of these men had, of course, been exposed to the complications or disruption of their life entailed by active service. Details of the only factors recorded are as follows: in the endogenous group, 2 broken engagements and 6 deaths (3 mothers, 1 wife, 1 fiancée, 1 child); in the reactive group, 2 deaths (1 wife and 1 child). Justified concern over the health or behaviour of wives, the evacuation of families from bombed areas, and financial difficulties make up the remainder of the factors recorded.

Symptoms

Depression.—In all these cases the clinical picture was persistently dominated by a depressive affect as judged by general behaviour as well as by what the patients actually said.

Retardation.—Recorded only when definite and objective evidence of "slowing-up" was present; for complaints of difficulty in concentration and in making decisions were almost universal.

Ideas of Reference.—Recorded only when they went beyond what could reasonably be interpreted as heightened self-consciousness. They were seldom very persistent or intense, and it is probable that the expression of such ideas was often

checked by the natural feeling of a disciplined man that such "silliness" should not be encouraged.

Self-reproach.—Care was taken not to record such apparent expressions of self-reproach as "I've let the side down once, and I don't feel I could go back, because I might let it down again," if such statements seemed to depend upon hysterical ("escapist") motives and were more in the nature of rationalizations than genuine beliefs.

Depersonalization.—Recorded only when persistent. It was certainly more prevalent than the figures show; for its expression requires considerable powers of accurate introspection and a lucidity of exposition which many ratings do not possess. Thus it was recorded in 4 out of 13 officer patients, but in only 4 out of 75 ratings.

Somatic Preoccupations.—Recorded only when more than a transient topic of concern.

TABLE II.—Somatic Preoccupations

	Endogenous Cases	Reactive Cases
Headache and head sensations	12	10
Gastric complaints	7	4
Visual complaints	5	3
Bowel preoccupations	1	3
Fear of syphilis	2	1
Fear of cancer	2	0
Genital preoccupations	3	1

The remaining somatic complaints were of "weakness," pains in the limbs, and discomfort in the throat and chest. In view of the prevalence of anxiety it is a striking fact that only one patient (an "endogenous" case) complained of cardiac symptoms.

Anxiety.—Recorded only when *objective* signs were definite and pronounced.

"Reactivity."—By this was meant the response to environmental influences such as psychotherapy or occupational therapy, or the daily events in the hospital; not the degree in which the illness was consequent upon external stress.

Content.—An artificial distinction was made between those who were mainly preoccupied with traumatic experiences responsible for their breakdown and those who showed depressive preoccupations of a more generalized type. These were called "topical" and "depressive" contents, and were considered to be characteristic of the reactive and endogenous groups respectively.

"Hysterical Prolongation."—Few patients are eager to return to conditions of danger and discomfort, and consequently the depressive illnesses were often complicated or prolonged by the operation of hysterical (or "escape") mechanisms.

Aetiology

The aetiological factors may be grouped under four headings: (1) constitutional, (2) physical, (3) environmental, and (4) factors related to the personality. The last group may be regarded as the end-results of the previous interaction of constitutional and environmental influences.

1. **Constitutional.**—The importance of a constitutional predisposition is shown by the fact that 29 of the cases (17 endogenous and 12 reactive) gave a family history of mental trouble, while 25 (16 endogenous and 9 reactive) gave a history of previous attacks. A family history of mental illness necessitating mental hospital care was more common amongst the endogenous group (7 cases, as compared with 3 cases in the reactive group).

2. **Physical.**—It will be seen that physical disorders were found in 23 of the patients. It is probable that all of these (except in the cases showing symptomless urinary tuberculosis and albuminuria) had some influence in the causation and prognosis of the depressive reactions. The significance, of course, varied greatly from case to case; in a few (e.g., the cases of concussion and influenza) the physical disorder was a direct precipitating cause of the breakdown. Prognostically, arteriosclerosis and head injury were the most unfavourable of

the physical factors met with, while all three of the cases which were associated with influenza made a complete recovery and returned to duty (Table III).

TABLE III

Physical Factors	Classification		Returned to Duty	Social Recovery	Reduction of Social Capacity
	Endogenous	Reactive			
Influenza	-	3	3	-	-
Arteriosclerosis ..	1	6	-	4	3
Head injury	-	4	-	3	1
Sea-sickness	1	2	1	2	-
Syphilis (not neuro-) ..	-	1	-	1	-
Duodenal ulcer	1	-	-	-	1
Alcoholism	-	1	-	1	-
Urinary tuberculosis ..	1	-	-	-	1
Albuminuria	1	-	-	1	-
Fractured scapula ..	-	1	-	-	1
Totals	5	18	4	12	7

3. *Environmental*.—The main environmental stresses to which these men had been subjected were: (a) disruption of home life, representing in the case of many reservists the removal of a recently earned reward which has been deferred, although keenly anticipated, during their careers in the Service; (b) bereavement or other domestic misfortunes which, although hard enough to bear in peacetime, were sometimes found to be intolerable under the conditions of separation and limited leave prevailing in wartime; and (c) prolonged exposure to danger and discomfort; and in 27 cases (8 endogenous and 19 reactive) personal experience of a naval disaster, such as mining, torpedoing, and air-bombing, often involving the deaths of messmates and friends.

4. *Personality*.—It will be seen (Table I) that in only 15 cases (7 endogenous and 8 reactive) was the personality considered to be unsatisfactory or "psychopathic." Further information about the personalities of these patients is given in Table IV.

TABLE IV

Recorded in Table I

Endogenous Group	Reactive Group
3 hysterical psychopaths	7 hysterical psychopaths
2 schizoid psychopaths (one of them described by a colleague as "a schizoid sour grape")	1 constitutional inferior
1 reformed alcoholic	
1 chronic hypochondriac	
Not Recorded in Table I	
10 excellent personalities	11 excellent personalities
6 conscientious personalities (3 of them also "dull")	5 conscientious personalities
12 simple or "dull" personalities (3 of them also conscientious)	11 simple or "dull" personalities (5 of them also conscientious)
6 of a sensitive worrying type	10 of a sensitive worrying type (5 of them also conscientious)

The majority were worthy, strikingly conscientious, self-disciplined men of a rather dull, unimaginative, plodding type, who had previously stood up well to their responsibilities and the demands made upon them by their lives. But they were not men who were highly endowed with initiative and enterprise, and those very qualities which had made them trustworthy workers of a routine type made it difficult for them to adapt themselves to the altered conditions entailed by active service in wartime, away from their homes and the set ways which meant much to them. Moreover, in 18 cases (11 endogenous and 7 reactive) a significant degree of mental backwardness tended to increase their difficulty in adaptation. Finally, the average age of the group was notably high, and, presumably owing to their hard life, ratings are often old for their years.

In Table V the age incidence of these depressive cases is contrasted with that in a parallel series of 63 hysterics.

TABLE V

	No. of Cases	Under 25	25-35	35-45	Over 45	Total Under 35	Total Over 35	Average Age
Depression	88	12.5%	25.0%	46.5%	16.0%	37.5%	62.5%	36
Hysteria ..	63	43.0%	27.0%	28.5%	1.5%	70.0%	30.0%	29

The difference in the categories, as well as in the age incidence, is also informative, for only 7 of the depressive cases were "hostilities only" recruits, compared with 20 "hostilities only" recruits in the hysterical series. Again, 13 of the depressive cases were officers, and only 1 of the hysterics. In summary it seems reasonable to conclude that the depressive cases were for the most part excellent men, who finally broke down not through any deficiency in morale but largely owing to certain deficiencies in adaptability, due to a number of causes—their age, their temperament, and, in quite a high proportion, mental backwardness or arteriosclerosis.

Results

The results obtained are given in Table VI. It will be seen that approximately 28% returned to duty and that only 26% showed on discharge any significant reduction in their previous social capacity, not more than five cases needing further hospital care. When it is considered that the duration of stay hardly ever exceeded three months and that most of the cases were in hospital for a shorter period, these results are very good. Nor can this be wholly attributed to mildness, for the majority showed a reaction which at some time was of considerable severity. The "reactivity" of these cases was therefore a very striking phenomenon.

TABLE VI

	Endogenous	Reactive	Average Duration of Illness (excluding 2 Patients with Illness of 7 Years)
Duty	12	13	4.1 months
Recovery with little or no reduction of social capacity ..	19	21	6.9 "
Improvement with some reduction of social capacity ..	7	10	6.7 "
Certified	4	0	
Voluntary patient	1	0	
Suicide	1	0	

Prognosis

The aetiological considerations mentioned above may help to explain the prognostic findings. In attempting to assess prognosis each case must of course be studied individually: the remarks which follow can only be regarded as broad generalizations.

The patients who returned to duty tended to show (Table I) those attributes which are associated with adaptability, such as relative youth, intelligence, and, above all, a plastic and resilient temperament. (This last attribute does not lend itself to a tabular record and hence has not been shown.) Thus it is not merely a coincidence that the proportion of officer patients who returned to duty was high (8 out of 13 cases). Indications of stability, such as a steady work record and "conscientious character," had some prognostic value, but were too apt to be combined with that rigidity and deficiency in adaptability already described. Turning to the illness itself, a duration of less than six months (Table VI) and symptoms of relatively mild intensity (especially if following some physical illness such as influenza) were favourable signs, but the most valuable of all seemed to be the degree of rapid "reactivity" that was shown.

Conversely, few returned to duty who had a poor school record or an illness lasting more than six months, especially if of a severe character. It will also be observed that a large number of those who, although unable to return to duty, made a good social recovery showed symptoms of hysterical prolongation; the early appearance of such symptoms makes an ultimate return to duty less likely. They often diminished or disappeared when the man knew he would be invalided.

The family history, special war stress, and domestic misfortune seemed to have less influence upon the prognosis than might have been expected. Nor did the presence of somatic preoccupations appear to make much difference, unless of a gross depressive type (e.g., "testes rotting") or associated with other symptoms indicating an illness of severity.

In the tabular records few differences can be seen between those cases which made a good social recovery and those which did not, with the striking exception of the lack of "reactivity" shown by the latter group. In dealing with war cases, which typically respond so rapidly, persistent unresponsiveness to environmental influences should therefore lead to prognostic reserve. It is sometimes possible, however, from a more detailed knowledge of the individual case, to suspect the reasons for an unsatisfactory social outcome. Thus some active service ratings (or "regulars") find themselves in a psychological impasse: they cannot face a return to duty, while invaliding leads to the termination of their careers. Again, it is embarrassing for a proud man to be invalided from the Service if he has no symptoms to show for it when he goes home. Finally, prolonged illness may occur, just as in peacetime (especially when arteriosclerosis is present).

Treatment

The same general principles must be applied to the treatment of these cases as are employed in all depressive states. They need not be recapitulated: an excellent account will be found in Diethelm's book (1936). Brief mention will only be made here of two aspects.

1. *Continuous Narcosis*.—The onset in these cases had usually been insidious. This is not surprising in view of the type of personality which has been found to be characteristic, and which is perhaps one of the conditions of their development. For individuals lacking the same conscientiousness or of a less robust temperament tend either to succumb to affective reactions at an earlier stage, before the more definite symptoms of depression become manifest, or escape by the development of hysterical illnesses before affective symptoms become manifest at all. Only one patient (the captain of a ship which was sunk by enemy action, not included in this series) has so far come under observation who, previously free from symptoms, developed a profound self-reproachful depression almost overnight after the catastrophe. It can therefore scarcely be expected that continuous narcosis should have the same value as in certain acute reactions of recent origin, like those described by Sargant and Slater (1940) in soldiers after Dunkirk. More restricted claims must be made for its value in depressive states and all results be reviewed in the light of the fact that these cases do very well without it. It would, however, be foolish to deny its value for more recent cases with much anxiety. The same arguments apply to the various forms of "shock therapy," which are further complicated by the possibility of fractures and dementia (Tooth and Blackburn, 1939).

2. *Psychological Treatment*.—The two main ways in which these cases differ from those met with in civilian practice are: (a) their "reactivity," and (b) the strong incentive that is present to hold back from complete recovery, which with few exceptions means a return to those conditions of stress responsible for the breakdown; for it is unusual to encounter a patient whose illness is totally unconnected, either directly or indirectly, with war service.

The first point—the reactivity—provides ample scope for psychological treatment, meaning by this both psychotherapy and individual psychological management within the framework of a regime of "occupational therapy" organized on the lines recently so well described by Cameron (1940). Skill is required in planning the patient's day according to his needs and capacity, and attention to apparently minor points, such as what patients should be in neighbouring beds, can make an important contribution. Mapother (1936), speaking of the acute anxiety states in the last war, has said that, without

glorification as heroes, such patients needed and deserved all the sympathy and reassurance that could be given to them. The same holds true in equal measure for these states of depression. Perhaps the essence of psychotherapy in all affective reactions is to induce the patient to accept and to interpret his symptoms as evidence of illness entailing both restrictions and responsibilities, and those who suppose that the psychotherapy of depressions can be summarized in the formula of "simple reassurance" make a profound mistake.

The second point—namely, the danger of hysterical developments and prolongations—makes treatment even more difficult. These developments are natural enough in a man who has been severely ill, has rightly been reassured that he has been ill, has interpreted this as in some sense a moral absolution, and knows very well that a full recovery will mean a return to conditions of danger and stress. It is difficult, but most important, to try to judge when a psychobiological reaction of depressive type is being replaced by hysterical manifestations, and to reinforce sympathy with the firmness that is then called for. The dangers of retention in hospital must therefore be balanced against those of a premature discharge, but it is perhaps better to risk the relapse which may follow too rapid a return to duty, or to civilian life after invaliding, than the invalidism that may follow prolonged hospitalization. Nothing can be worse for some patients than uncertainty as to whether they will be invalided or not, and it is well to make as rapid a decision as possible.

Discussion and Conclusions

The facts put forward do not reveal any fundamental and clear-cut distinction between the endogenous and reactive groups, and had it been possible to demonstrate the cases, or even to give full case records, it could have been shown more convincingly that these depressive states formed a continuous series. The point is of some importance, for it is still often supposed that the question, "Is this case of depression of a psychotic or neurotic type?" necessarily permits of a categorical answer with important and definite prognostic and therapeutic implications (the "psychotic" depression being essentially a constitutionally determined reaction which runs its predestined course to ultimate recovery unaffected by any environmental influences, including psychotherapy; the "neurotic" depression, on the other hand, being essentially psychogenic and unlikely to recover without psychotherapeutic intervention). This is not so. Certain cases at each end of the endogenous-exogenous scale do more or less fulfil these criteria; such cases, however, are not separated by a sharp borderline but by a wide borderland. In brief, it is held that the classification adopted possesses meaning only as indicating towards which end of a continuous series (the extreme ends of which certainly differ widely) a given case belongs.

Similarly, there is an indeterminate zone where the question whether a given case should be classed as a depressive state with anxiety features or an anxiety state with depressive features is merely a matter of taste. Such mixed reactions shade off into "pure" anxiety states without any obvious features of depression at all.

A distinction which is justified on clinical and therapeutic grounds can, however, be made between "affective disorders," comprising cases in which either the mental and physical symptoms of anxiety or depression is the main feature, and hysterical reactions, in which "mental and physical symptoms not of organic origin are produced and maintained by motives, never fully conscious, directed at some real or fancied gain to be derived from these symptoms." (M.R.C. Report of Committee on Head Injuries—private information, unpublished.) The symptoms in the affective group are reactions of the whole organism in a way in which hysterical reactions are not. Thus physical symptoms the involuntary accompaniments of emotional disturbance, such as loss of weight and tachycardia, are to

be found. Some of these symptoms may be *biologically* purposive, but they are of a type which cannot be imitated voluntarily, have acquired a certain autonomy of their own which cannot be abruptly terminated by changes in the environment, and, as some might say, are outside the patient's control.

To suppose that all affective reactions (i.e., states of anxiety and depression) are of an "escape" type and *personally* purposive would be both to overvalue psychogenesis and to confuse it with hysteria. It is of course true that the two types of reaction—*affective* and *hysterical*—may coexist: the readiness with which a given patient will succumb to or will utilize in a hysterical way the symptoms of an affective disorder will vary. Certainly many patients do so; or are not able or willing to put up with an affective reaction—especially the visceral components, which in themselves are not more severe than those experienced by other men who do not succumb. These are, no doubt, the causes of the incapacity produced by many so-called "organ neuroses," such as certain of the "functional dyspepsias" so common in the Services.

On the whole, therefore, it would seem more important to try to determine the presence and assess the intensity of genuine affective symptoms and to contrast this with the presence or absence of hysterical features rather than to contrast neurosis and psychosis. For the treatment of a predominantly affective reaction does differ fundamentally from that of hysteria, as does the type of personality that tends to be affected.

Broadly speaking, it may be said that the better type of individual, with a high sense of duty and morale, if he develops an illness as a result of war stress, will tend to develop an affective reaction. It is significant that many of these men did not report sick but were sent sick. The severity of the total psychobiological reaction to a given stress is presumably dependent mainly upon the constitutional predisposition, and severe depressive illness will only occur in the predisposed. On the other hand, men with a less strict sense of duty and lower morale tend to escape by the development of "pure" hysterical reactions or succumb to "affective" symptoms of relatively minor intensity. Consequently, assessment of the relative proportions of affective and hysterical features is of great importance in determining how much firmness should be shown, the possibility of a good response to semi-disciplinary measures, and whether a man should be kept at duty or not.

The group of cases that have been studied lie towards the depressive end of the scale of affective disorders. The type of personality in which these depressive reactions commonly arise and the constitutional, environmental, and physical factors which contributed to their development have been described. It has been noted that the majority of the patients, although showing symptoms of a constitutional or "endogenous" type, responded rapidly to environmental influences in hospital. This reactivity, although valuable from the point of view of therapy and a rapid recovery by civilian standards, increases the likelihood of relapse on return to active service. It does, however, serve to belie the attitude of therapeutic nihilism which is so often adopted towards patients who are wrongly thought to show a "purely endogenous illness."

Summary

Attention is drawn to the frequency of depressive states in war, which during the latter part of 1940 formed 13% of all admissions to a naval neuro-psychiatric unit.

The results obtained from the analysis of a series of 88 consecutive cases are recorded. No justification for a sharp and clearly cut division into "neurotic" and "psychotic" types could be found.

It is put forward that a more fundamental distinction would be between "affective disorders" (cases in which the mental and physical symptoms of either anxiety or depression, or both combined, are the main features) and hysterical reactions (in which the "escape" element predominates). Consequently it is more valuable to try to determine the presence and assess the intensity of genuine affective symptoms, and to contrast this with the presence or absence of hysterical features, than to contrast neurosis and psychosis. This is because the treatment of a predominantly affective reaction does differ fundamentally from that of hysteria, as does the type of personality that tends to be affected. As has been pointed out, the proportion of firmness to sympathy should vary in direct relation to the hysteria that is present in war cases; and, conversely, it is senseless to try to "keep in the firing line" genuine and severe affective states.

It was found in this series of cases that men of a fine type and excellent morale, but who for various reasons were deficient in adaptability, were, as the result of prolonged stress, prone to develop reactions which lay at the depressive end of the affective series. These depressions differed from those met with in civilian life by their rapid reactivity and better outcome. Thus, after a brief period of treatment, 25 patients (29%) were able to return to duty, and only 5 cases (6%) needed further hospital care. The prognosis and treatment of depressive states in wartime are discussed.

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GENERAL PRINCIPLES OF TREATMENT OF AIR-RAID CASUALTIES *

BY

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I must confess to a feeling of diffidence in dealing with the subject of the treatment of air-raid casualties, as owing to my administrative Army work I have had little opportunity of first-hand experience except during the period I was in Norway. I have, however, discussed the subject very fully with many colleagues from various hospitals who have considerable experience as surgeons under the E.M.S. in London and elsewhere, and am largely indebted to them for what I have to tell you.

Before proceeding to discuss the principles of treatment it is well to consider certain facts arising from experience in air raids on our cities, and the first and most outstanding fact is the small number of casualties compared with what was anticipated. Again, it is noteworthy that though the proportion of killed to wounded (I think seriously wounded only) is high—approximately one to two—the vast majority of those wounded suffer from very slight multiple wounds requiring no skilled surgical intervention, while of the seriously injured many are too ill to be helped by surgical skill. Thus the scope of surgery in air-raid casualties is very limited, though where it is justifiable it is often life-saving.

Head wounds are but seldom met with, though there is a most distressing, and all too frequently not fatal, injury—knocking away of part or even the whole of the face by bomb fragments owing to the victims not having

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