MEDICAL PROBLEMS IN WAR

This is the last of three articles surveying the literature of neuroses in war

NEUROSES IN WAR

BY

E. WITTKOWER, M.D.

*Physician and Halley Stewart Research Fellow,
the Tavistock Clinic, London,*

AND

J. P. SPILLANE, B.Sc., M.B., B.Ch., D.P.M.

Rockefeller Research Fellow, the Tavistock Clinic

Prophylaxis

Comparatively late in the last war it was realized that the elimination from the Army of those "whose make-up was such that their behaviour would be inconsistent with military service"—that is, men with manifest psychoses and neuroses and those likely to break down—was in the interest both of the individual and of the country (P. Bailey, MacCurdy, Culpin). "I feel confident that careful weeding out of the mentally unstable will certainly greatly reduce the numbers of shell-shock cases that are bound to appear in our casualty lists" (Osler). After an expensive training many of them proved to be inefficient soldiers affecting the morale of their unit; they occupied beds needed for acute surgical cases, required prolonged medical attention, and were often finally discharged on pension. Many of them, on the other hand, while unable to adjust to military discipline, might have proved of material service in their civilian occupation. General agreement was reached concerning the rejection of manifest psychoses, but difficulties arose in the sorting out of potential breakdowns. An elaborate system for the elimination of soldiers psychologically unfit for service existed in the American Forces. The original method of examining only soldiers referred by M.O.s and company commanders proved inadequate and was supplemented by a rapid neuropsychiatric examination of all men. On the basis of a brief conversation and of observation during physical examination the recruit was passed or, if unsatisfactory, was deferred for a thorough examination. An examiner could dispose of 100 to 150 cases a day with reasonable accuracy. His recommendations were considered by a disability board composed of general medical officers and psychiatrists. The main difficulties arose from medical officers, whereas the line officers, who rated their men in terms of conduct, behaviour, and efficiency, were extremely sympathetic and co-operative. About 10 per 1,000 men were found to be unfit for service on account of neuropsychiatric disorders. Mental deficiency was most common (31 per cent.), neuroses (17 per cent.), psychoses (11 per cent.), constitutional psychopathic states and epilepsy (each 9 per cent.), organic nervous disease (10 per cent.), endocrine disorders (7 per cent.), and inebriety (6 per cent.) making up the remainder.

Further prophylactic measures advocated (MacCurdy, Tyrrell) concerned the mental hygiene of the combatant soldier and included the granting of rest, distraction, and relief from duty as frequently as the military situation would permit. Troops were not to be left too long in one sector or in a lonely position (Goodwin). Short periods of rest in those displaying prodromal symptoms often

prevented, or at least postponed, the outbreak of a neurosis, which when fully developed required prolonged treatment. The recovery rate of incipient neurotic states was given as 38 per cent. in the observations of Roussy, Brisseau, and D'Oelsnitz.

Instruction of M.O.s and talks of a suitable character to the line commanders and privates on the nature and symptoms of neuroses in war time proved to be valuable (Bailey and M. Prince).

Treatment

Treatment of neuroses in war time differs from civilian practice in so far as the aims and methods of treatment have to be adapted to the special circumstances. The necessity for the rapid restoration of man power imposes a time limit upon any therapeutic methods, so that the aims of treatment are bound to be limited to the quick removal of symptoms with little consideration for underlying difficulties. The methods of treatment employed in 1914-18 are reviewed by Crichton-Miller and others. These embraced the whole range of psychotherapy, and may be divided, according to the aim, into "covering" and "uncovering" methods, and, according to the procedure, into authoritarian and benevolent methods. The covering methods are directed towards a removal of symptoms; the uncovering methods attempt to approach the underlying causative factors. Preference was given to any of these methods according to the place of treatment, the time available, and the personality, training, and psychopathological outlook of the physician.

Place of Treatment

A graphic description of the conditions prevailing and of the emergency measures undertaken at a field hospital was given by Rhein. "The men arrived dirty, muddy, silent, trembling, tense, with drawn faces and relaxed postures, seeking resting-places at once on a bench which might be part of the scanty furniture. They seemed in the main depressed, awed, anxious, afraid they had acquired some incurable affection, that they were paralysed or were losing their minds. A careful analysis of the mental state of men under these conditions was of course out of the question. They were given a warm shower-bath, some food, and sent to bed, where they fell into a deep slumber which lasted a day or two. Then a division of cases took place." Cases of "hypermotivity" or states of tremor cleared up after a few days of rest; others in a more severe and chronic state had to be sent to the rear. General agreement exists that the place of treatment should be as near the fighting line as practicable, since by this means treatment could be reduced in time from months or weeks to days or hours (Holmes, Hart, Roussy and L'Hermitte). The details of organization are discussed elsewhere.

Methods of Treatment

Most writers deprecate an oversympathetic attitude and stress the necessity for a hopeful yet military atmosphere in the wards and for complete co-operation between all members of the staff, nurses, and visitors. Where possible new cases should be received into wards containing

improved or cured cases (Nonne). The physical regime most commonly recommended consisted of rest and quiet, with hypnotics during the first few days.

For writers who looked on the cases as akin to malin-gering, treatment was a matter of punishment and included such measures as isolation, severe restriction of diet, transfer to "excited wards" (Lewandowsky), application of painful electrical currents, and prolonged baths until recovery (Weichbrodt). The chief exponent of the most rigorous form of electrotherapy was Kaufmann, whose treatment consisted of three phases: (1) suggestive preparation—the patient was told that painful electrical currents would be applied which were certain to cure his condition; (2) application of strong faradic currents for one or two hours; (3) active military exercises. The "cure" was usually completed in one sitting. This method, originally received with great enthusiasm because of the rapid recoveries, was later generally discarded when fatal cases occurred (Liebermeister, Gildemeister) and permanency of results was doubted (Binswanger).

Similar but less severe boredom and a restricted diet were advocated for the treatment of hysterical disorders by Kretschmer, who recommended the accommodation of patients in darkened rooms. The impression of inflicting punishment was to be avoided, and the patients were told that these measures were necessary "to calm their nerves." After a week or two motor phenomena like tic and tremor subsided and had often disappeared after about six weeks.

Other physicians preferred rest, good food, and firm benevolence, combined with reassuring and encouraging talks. After a simple explanation of the nature of the condition, readjustment was achieved by an appeal to patriotism and the sense of duty. In line with this an extensive use of occupational therapy was made (Mott, Adrian and Yealland, Parsons, Binswanger, Wollenberg).

Work according to personal capacities and interests rather than non-productive mechanical routine work such as mat-making, paid work rather than unpaid work, acted as a valuable incentive to recovery. The patients were employed in the policing of the hospital, in farm work and road-making, and in workshops. In the later stages of the war experimental use of these patients was made in munition factories in Germany. Various methods of suggestion were employed successfully, including the use of mild faradism, graduated exercises, and direct hypnotic suggestion. Remarkably rapid results were obtained by hypnotic suggestion in hysterical motor disorders, but the liability of the recovery was shown by Nonne, who could easily reproduce the symptoms under hypnosis after apparent restoration of function. Sham operations carried out under general anaesthesia, although successful in some cases, were generally rejected on theoretical grounds (Hurst, Rothmann, Goldstein).

Much later in the war a group of physicians arose who believed that the neuroses of war were invariably related to repressed emotion and that, for cure, this must be expressed in the form of abreaction, either in the waking state or under hypnosis. Some confined themselves to a revival and reproduction under hypnosis of the suppressed or repressed emotional incidents, for which there was a subsequent complete amnesia (Rivers, Brown, Hadfield, Brend, Sauer), whereas others (Eder, Culpin, Nicoll, Simmel), by a combination of analytical cathartic hypnosis with analytic discussion and dream interpretation, endeavoured to understand and relieve the underlying conflict situation. According to Simmel an average of two or

three sittings brought about relief of symptoms, but since abreaction in speech alone was usually insufficient in this compressed form of treatment he provided an upholstered dummy to assist the acting out of the repressed emotion.

Some instances taken from the literature illustrate the various methods of treatment.

The routine treatment of hysterics in base hospitals of the American Expeditionary Force (Schwab and Fenton) started with a simple explanation of the hysterical mechanism of the symptoms. The patient was assured of its unconscious nature and of rapid disappearance of symptoms provided he gave his co-operation. Then followed the use of one of the many methods of suggestive symptomatic treatment. Finally, due emphasis was laid on the fact that the symptoms had disappeared and on the mechanism of their disappearance. For hysterical amnesias associative exercises leading back to the events concerned were advocated. In contrast to cases of conversion hysteria, which rapidly responded to practically any form of treatment, great difficulties were met in the treatment of anxiety states. "A modified psycho-analytic procedure, adapted to a war-born condition, divorced from a good deal of the technical complications of the method used in peace time," was employed to relieve the patient from the ill effects of repression; he was encouraged to talk freely about his experiences, to go over the emotional states that accompanied them, and to examine himself as critically as he could. His chief current conflicts were analysed out in this way.

In cases of conversion hysteria a process of re-education on similar lines was practised by MacCurdy. In a simple explanatory talk the patient was reassured that his legs, for instance, were not really paralysed, but that he had forgotten how to use them and that he must learn to do so over again. Suggestion or hypnosis then served to demonstrate that the function which was lost or disturbed was not vitally affected. The recovery of function was attributed to the patient's efforts and not to those of the physician. Various tricks were used to demonstrate the presence of the capacity which seemed to have gone, such as a sudden sound, with jumping, in hysterical deafness, and the demonstration of response to electrical stimulation in paralysed limbs. Active movements were then gradually encouraged. In cases of incomplete dissociation patients are vaguely aware of the psychic origin of the symptoms and are apt to develop a fear of insanity. A friendly relationship with the physician allays their morbid fears and diminishes the difficulties over authority which are a source of neurotic manifestations. "Any physician who has a reasonable fund of common sense and a natural interest in his patients is bound to be successful in the treatment of many of these cases."

Based on the concept of a conflict between a desire to get away from the firing line and a sense of duty, MacCurdy recommends the removal of anxiety neurotics to a quiet environment, absolute rest for the first few days, and a Weir-Mitchell type of diet to combat the sense of fatigue. Isolation is harmful in patients subject to the fear of being left alone. The use of hypnotics and sedatives, unavoidable in the first few days, is deprecated later on, and may be substituted by hydrotherapy or suggestion. More active measures are practised once the patient gets over his initial stage of fatigue. For the treatment of his most obvious subjective difficulties—the fear of war and the thought of its horrors—distraction in one form or another proved helpful. In a common-sense conversation the patient was reassured that he was going to get well, and this recovery would be greatly facilitated by his active co-operation. An effort was made to produce a state of mind wherein he was willing for the time being to forget the war without fostering the idea that he was out of it for good. Occupational therapy, adapted to individual requirements, was invariably given. Temporary absence from the military atmosphere, granting of leave, and feminine companionship proved beneficial. In most patients the symptoms cleared up under symptomatic treatment of this nature. In some, conversations explaining the underlying conflict assisted in the final adjustment.

No fixed rules in the treatment of war neurotics were adopted by Culpin. "If the paraplegic or the mute can be made to walk or speak by half an hour spent in explanation and persuasion—to act on that principle is plainly a matter of common sense." More often than not anxiety states do not respond to rest and quiet. For them, for hysterical patients refractory to simple methods, and for obsessionals a modified psycho-analytical method was recommended.

Prognosis

As in peace time, the prognosis of neurosis in war time depends on the age and intelligence of the patient and on the duration, nature, and severity of the disorder. Actual breakdowns or pronounced character difficulties before enlistment, and a preponderance of endogenous over exogenous factors, were of bad prognostic significance. Under severe stress almost anyone may break down. The significance of a positive family history is debated. Cases beginning on home service, on leave, or during discharge were unfavourable. Early treatment and the place and nature of treatment are important factors. Premature discharge often led to a recurrence of symptoms. Not infrequently during the last war the announcement of imminent discharge from hospital produced a return of symptoms. If in spite of this the patient was discharged to his unit the symptoms were aggravated during the transport; when he finally rejoined his regiment he was often in such a state that immediate readmission to hospital was unavoidable. Thereafter he occupied hospital beds for weeks or months, and relapsed after discharge. It is generally held that the prognosis is favourable in regard to the removal of symptoms, doubtful in regard to complete recovery, and, once the patient has been removed to the base, almost hopeless so far as permanent fitness for front-line service is concerned.

Analysis of the figures available reveals that in spite of an apparent lack of uniformity the prognosis as regards return to duty bears a close relation to the place of treatment and the nature of the disorder. Concussion exhaustion, and "hyperemotivity" head the list of percentages of those returned to duty; conversion hysteria, gas neurosis, and "neurasthenia" follow, in that order; while anxiety states are even less favourable, and obsessional states and effort syndromes are at the bottom of the scale. Officer patients present less favourable material for return to duty: 25 per cent. returned, as compared with 51 per cent. of men (United States Army Report). The number of those returned to duty is in inverse proportion to the distance of the place of treatment from the firing line. This may be due in part to the sorting-out process whereby mild cases are successfully dealt with at advanced posts and never reach the base. Ninety-one per cent. of those treated at a French (Leri), 66 per cent. at a British (W. Brown), and 65 per cent. at an American casualty clearing station were returned to front-line duty after a few days' treatment. Accurate assessment of the incidence of relapses was made difficult by the movement of divisions, since the men did not return to the same centre. Tentative assessments vary between 4 per cent. (American) and 10 per cent. (Holmes). The average figure of those returned to duty from British "N.Y.D. neurological" centres situated in France was 75 per cent., while from corresponding American neurological hospitals it was 55 per cent. Conformity is lacking in regard to the results obtained in base hospitals in this country: 21 per cent. of cases discharged from Maghull Red Cross Special Military Hospital and 60 per cent. from the Canadian General Base Hospital at Ramsgate were returned to duty. The official statistics failed to indicate the number

returned to front-line duty. According to Salmon, whose authoritative opinion was based on a wide survey, it was very low. Only 1.1 and 1.7 per cent. of cases treated in German base hospitals returned to front-line duty (Willmans, Stern). On this account it has been doubted if a return to front-line duty should invariably be the aim. It has been argued that the few "shell-shocked" soldiers returned to front-line duty, often inefficient and unreliable, hardly balance the large number of mental invalids in receipt of a pension. Early discharge, after rapid removal of their symptoms, to civilian occupation in which they can render greater services to the country has been suggested (MacCurdy, Gaupp).

Nearly 66,000 cases were accepted for pension by the Ministry of Pensions on account of functional disorders of the nervous system alone; 29,000 of these still drew pensions in 1938. Wounds and amputations apart, functional nervous disorders ran second in the incidence of disorders for which pensions were being paid. If functional diseases of the heart are included they rank first, even exceeding tuberculosis.

The most comprehensive survey of readjustment to civilian life was made in the psychiatric service of the American Army. A follow-up of 830 cases of typical war neuroses was undertaken in 1919–20 and 1924–5. The earlier survey showed that concussion and gas cases rank very high in the percentage of successful readaptation, while cases with a strong constitutional element such as hypochondriasis, psychasthenia, and timorousness did not readjust themselves nearly so well. It is pointed out that "many of the men who never saw action have a more serious aftermath in symptoms than those who were actually in the thick of it." In the 1919 survey a majority of hysterics were having difficulty in getting along in civil life and displayed numerous neurotic residues: little more than one-half of them were able to earn their living. A great number of anxiety and effort syndrome cases tended to be permanently affected. The clerical and professional groups made the best readjustment, those in agriculture the poorest. In 1924 practically all the diagnostic group showed a higher percentage of readaptation, but gas neurosis and effort syndrome remained unchanged.

[This and the preceding two articles are printed in the Journal by permission of Messrs. Macmillan and will be included in a book shortly to be published by them under the title of "Neuroses in Wartime," in which full references to the literature will be given.]

War-time nursery centres are to be established in reception areas to provide evacuated children under the age of 5 with social training and occupation during the day. A circular issued by the Board of Education and Ministry of Health states that for children under 2 a simple day nursery or crèche will be sufficient. Children between 2 and 5 years should meet at centres in groups of ten to twenty for sessions corresponding to those in ordinary infants' schools. Each centre should be within easy walking distance of the children's billets, and the children should return for their midday meal unless communal meals are provided. Single empty rooms would provide the necessary accommodation provided that each child had a minimum floor space of 15 sq. ft. The children should be under the charge of a warden, not necessarily a qualified teacher but someone specially selected for her suitability for the work, who, in many cases, would undertake this work as a form of national service without payment. A superintendent who should be a trained and experienced nursery school or infants' teacher must be appointed to supervise the work of the wardens. An appendix to the circular contains detailed advice on premises, equipment, and the conduct of the centres.