WAR WOUNDS AND AIR RAID CASUALTIES

The following article is a supplement to the series of lectures on war wounds and air raid casualties printed in these columns

TREATMENT OF PSYCHOLOGICAL CASUALTIES DURING WAR

BY

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Before considering the treatment of individual psychiatric casualties there is first of all the much bigger question of policy. What policy will be adopted with regard to the position of the hospitals for these casualties, either within or fairly close to the danger zone, or further away and immune from attack? Will patients as a matter of policy, not emergency, be sent to their homes as soon as the symptoms of anxiety hysteria have been relieved or the conversion hysteria cured for the time being by whatever method, or will all except the very mildest cases be given the chance of complete rehabilitation before being sent back either to civilian life or to their unit in the combatant services? In a severely raided civilian population, where psychiatric casualties are certain to be heavy, mere pressure on bed space, either inside or without the danger zone, may make it impossible to keep any but the severest casualties in hospital. Apart from necessity, however, two more or less opposite opinions are held by psychiatrists of experience. One point of view is largely that of psychiatrists who had experience in the last war in France or other fronts; the other is held mainly by those whose main experience at any rate was in special hospitals for psychiatric casualties at home.

Choice of Treatment

The first group hold from their experience that psychiatric casualties should be treated in hospitals within the battle area. They should be treated by any methods, to be discussed later, which would render them more or less symptom-free, and then returned to their unit. The second group, to which I myself belong, would hold that there were very frequent relapses among those treated by rapid methods, and that relapsing cases were much harder to deal with than those evacuated on their first breakdown. They would hold that among those sent back too soon there was a not negligible danger of suicide, wounding by deliberate exposure to enemy fire, or of self-inflicted injury; they would believe, too, that no case of anxiety or conversion hysteria can be fully rehabilitated in a matter of days. The most serious criticism would be that, according to all modern psychotherapeutic theory, methods of treatment which stress the removal of symptoms rather than treatment of causal factors may have utilitarian value but do not make for permanent cure.

Let me say at once that I quite realize the practical value of the first method during the last war, which was waged between combatant troops and not directed mainly against the civil population. These methods did return a good number quickly to their units, and certainly some of them remained stable; but they remained stable for a certain definite reason. They were treated by methods which I should like to call the methods of authority, and they were returned to authority; they could accept it and find value in the discipline, the morale, and

camaraderie of their unit. They very possibly had a period in rest camp for further readjustment. For them their unit was just as good as, or perhaps better than, a hospital for regaining morale. The point I want to emphasize most strongly, because I believe it to be the crux of the matter, is that the situation is entirely different when we are dealing with psychiatric casualties in a civilian population. If they are treated by authoritarian methods and sent as quickly as possible to their own homes they will be removed from authority to where there is no authority to help them. They would return to homes possibly in a bombed area to a family which, even if still intact, would probably be badly shaken. Only a large body of social workers could find out whether they would return to conditions where there was any possibility of restoration of morale.

Use of Authoritarian Methods

I must now define what I mean by authoritarian methods. Let us start with the French method as described by Lhermitte. He insists first of all that the physician must be a man of strong will, that he must have the iron hand in the velvet glove; the patient must at all costs be mastered. If what he calls psychological conversations did not relieve symptoms the patient was isolated in a single room, given a diet of milk and bread, or later of bread and water if the symptoms still remained. If he relapsed he was returned to rigorous confinement. He was also kept in confinement if he refused treatment by faradization, which can be, and was in my personal experience, a very exquisite form of torture. Treatment by hypnotic suggestion, persuasion, and re-education, although not so punitive as the French method appears to have been, is, if only directed against the symptoms, an authoritarian method. The physician stands for the stern or kindly parental authority who, with the patient either in the hypnotic state or in full consciousness, insists that the symptom, whatever it is, be given up. It may be given up or, as is so often the case, changed over to another symptom, but without any true insight into the meaning of the latter. Treatment by hypnotism with abreaction of affect—that is, the revival of traumatic memories in hypnosis—undoubtedly produced dramatic relief of symptoms in many cases; but it is doubtful whether the patient gains any true insight by this method, and I have certainly seen cases where the abreaction was so violent and disturbing that further treatment would not be accepted. There is one definite danger in the use of any authoritarian method in a fairly large group of cases—they may become rebels against authority, and if they relapse are much harder to treat.

All forms of psychotherapy depend to some extent upon authority. All psychiatrists know that at some time or other during treatment they may come to stand for father or mother to the patient. But there is all the difference between the parent who just forbids and says "Don't" and the parent who is trying all the time not to forbid but to explain.

During the last war in the special hospitals for psychiatric casualties authoritarian methods of some sort were used in varying degrees. In some, authority was

much too strict; in others, very definitely there was too little. It must be remembered that at that time there were very few trained psychotherapists or psychologically minded physicians, and these were generally overworked and overloaded by details of administration. Towards the end of the war, when officers had been trained at Magull in the psychological approach, conditions did improve and better work was done. It can be hoped, I believe, that conditions in the present war will be better; there will still be a shortage of trained psychiatrists, but it will not be so acute, and the whole attitude of the profession and the laity towards the genuine psychological approach to the problem of the neuroses has been revolutionized to a large extent. There will be one great difficulty in the treatment of civilian casualties—the lack of authority. Patients will be free agents, and many will clamour to go home before they are fit to go.

Treatment of Psychiatric Casualties

To come now to a brief consideration of what can be done for psychiatric casualties, and I shall refer only to the treatment of cases of anxiety and conversion hysteria. At the first-aid post probably very little can be done. Cases of simple terror should be allowed to sit quiet in some place of reasonable safety; they should be reassured and their ego ideal restored, not by urging them to be brave but by pointing out that their fear is only natural and normal, and will pass quickly because their self-control has only temporarily been weakened; a hot drink of coffee, perhaps a very mild sedative, and I believe most of them will leave of their own volition.

Anxiety hysterics will arrive of every grade of severity—the screaming uncontrolled hysteric, the mute and terror-stricken with some confusion or amnesia. They will come in mostly, I think, as stretcher cases, or, if walking, will be brought in by others, volitional control having gone. The severer cases must be evacuated as soon as possible to casualty clearing stations; an adequate dose of sedative should be given—I believe a big dose of one of the barbiturates is better than morphine for anxiety hysteria. Paraldehyde per rectum would also be valuable. Cases of hysterical stupor must of course be evacuated, and I think no attempt should be made to rouse them until they have reached the casualty clearing station and adequate nursing is available. Cases of conversion hysteria may come in, especially from places near to a serious explosion. Those patients who are seen within an hour or two and with no latency period may possibly have their functions restored by prompt persuasion and suggestion, but even if this is possible I believe they should also be evacuated because of the danger of subsequent acute anxiety or relapse.

At the casualty clearing hospital the amount that can be done must depend on the policy advocated and pressure on beds. It has been suggested that psychiatric casualties may remain at the larger casualty clearing stations for a period of days or weeks in the hope that they may recover sufficiently to be sent home. It has also been suggested that there will be at any rate a visiting psychiatrist to advise on selection and diagnosis. Treatment must, however, remain mainly on the lines of physical medicine—rest, whatever quiet is possible, isolation in severe cases because of the real danger of contagion, sedatives. From experience of very severe hysteria in peace time I believe prolonged narcosis may be valuable if adequate nursing is available, and evipan narcosis with suggestion given during return to consciousness. At both first-aid posts and casualty clearing stations any serious attempt at psychotherapy will probably be impossible.

Treatment at Special Hospitals

We now come to the question of treatment at special hospitals for psychiatric casualties. The problem of the organization and management of these hospitals, many of which will be entirely for civilian casualties, will be a very difficult one. They will be entirely different from any special hospital during the war. They will presumably be large, admitting both sexes and people of all ages, of all types, classes, and even races, if areas of maximum density of population are heavily bombed. Also, as mentioned before, it will be impossible to maintain the same discipline and authority as in a military hospital. It will be extremely difficult to establish the right sort of atmosphere for good psychotherapy. It must always be remembered that every psychoneurotic is ill in mind more than in body, whatever his symptoms, and yet retains freedom to continue or discontinue treatment. I can foresee many, but not insurmountable, difficulties.

We will presume that in the hospital there will be a certain number of trained psychiatrists, men and women. There will certainly not be an adequate number—there never will be except in a Utopia which none of us, at any rate, will ever live to see. I want now very briefly to state again what is the difference between the method of the modern psychiatrists and any method based entirely or largely on the use of authority. Modern psychotherapy of every school is based on a very simple premise that all and every neurotic symptom or neurotic maladjustment is the outward and visible sign of an inward and psychological disharmony, and it is a disharmony of which the patient is to a great extent unaware. The task of every psychotherapist, whatever his technique, whatever hypotheses of mental mechanism he may hold, is to try to help the patient to a solution of this disharmony; by bringing home to him the meaning of the symptoms he is made to realize that the symptom has no longer any value for any part of his personality.

All who during the last war had time and opportunity to do any kind of analytical work on the war neurotics found, as we shall find again, that the anxiety hysterics and conversion hysterics had never been completely well-adjusted people. They may not have been badly neurotic, but any full anamnesis, which is always the essential starting-point of all psychological treatment, will reveal some neurotic or character maladjustments—unduly anxious, unduly dependent, an over-strict and rigid code of morals and ethics which inhibited the expression of normal instinctive drive, either sex or aggression, or both. This is not the place to discuss different techniques of analytic approach—the aim will be the same in all. All the resources of a special psychiatric hospital will have to be directed to one end only—the mental and physical rehabilitation of the casualty; there must be carefully planned recreation and occupation, and the nursing must be of the highest order for the work. The nurse must be sympathetic towards the patient as a personality, but not express too much sympathy about the symptoms, whatever they are. The nurse must be taught that most of the patients will have regressed to a level of infantile dependence; they will tend to make mother figures of their nurses, and they must slowly be weaned from this. It was noted in the last war that most severe anxiety hysterics became sexually impotent and yet craved the presence of their womankind. In war time, I believe the psychiatrist must take his nurses, if they are good, into his confidence; he must tell them something of the problems of the patient and get their help. During the last war many nurses became invaluable helpers to the

psychotherapist; the opposite is unfortunately true, that an unwise nurse or relative may block all his efforts.

War-time Differences

There are certain very important aspects of the psychiatric casualty in war which will differentiate them from the psychoneurotic in times of peace. One outstanding feature in a large proportion of anxiety hysterics is the constant demand for security. They feel no inner sense of security or independence, and make constant demands on the outside world, their family, or their group for the security they need. In a war casualty this need for security will be enormously increased, and during war the outside world can offer the patient little or any of the security. This intense need for security will make it extremely difficult for many cases to be returned to a world when all the bulwarks of peace-time security have been broken down. Every psychoneurotic is also to a greater or less extent asocial; he may make superficial contacts, but never in any real sense identifies himself with his group or community. If he becomes a war casualty these asocial tendencies may be enormously increased. He may have seen all his world tumble about his ears—the loss of friends and relatives, as well as material losses. His world has never offered him much, but now offers him nothing at all. He may sink into complete apathy, from which it will be very difficult to rouse him. It will need all the resources not only of a psychiatric hospital but later of social workers and every kind of social organization to rehabilitate these patients and make them feel the need in themselves for life in a community.

There is one other aspect of the psychiatric casualty of war which may become a very serious one; there was some evidence of this at the end of the last war and afterwards. In every psychoneurotic there is maladjustment to the normal aggressive instinct. The acute mental sufferings of the war casualty may release this instinct of aggression in dangerous anti-social forms. He may become the complete rebel against all forms of authority and against the form of civilization which he holds responsible for his sufferings.

Conclusion

To sum up, at the first-aid post and casualty clearing station treatment will of necessity be on the lines of physical medicine. At special hospitals treatment will be mainly psychological, combined with every other aid that can be devised towards socialization and the rebuilding of a normal ego ideal. Authoritarian methods will be used again, and have a real value in many cases. It is hoped, however, that the volume of experience in psychological methods of the last twenty years may prove its net value.

In the *Statistical Year-Book of the League of Nations*—which has appeared regularly since 1927, and of which a new edition has now been issued—the Economic Intelligence Service provides statistical information of interest both to specialists and to the general public. The yearbook deals with a large number of subjects. The statistical tables, carefully kept up to date, relating to the territories and populations of all countries in the world and to the natural movement of those populations, are of general interest. The 1938-9 edition contains new tables relating to the number of survivors as shown by life tables, and to the changes which have occurred in the structure of the population according to the main age groups—namely, the young (under 15), persons of productive age (15-64), old people (65 and over), and women of child-bearing age (15-49). A large amount of information, part of it hitherto unpublished, is provided concerning mortality rates according to age, the fertility of women, and gross and net rates of reproduction. This information throws light on the probable future trend of the population of each country.

Reports of Societies

SULPHONAMIDE THERAPY

At a meeting of the committee of assistant medical officers of the London County Council, held under the auspices of the Metropolitan Counties Branch of the British Medical Association at B.M.A. House recently, a discussion on experiences in the clinical use of drugs of the sulphonamide group was opened by Dr. J. H. SIMMONS. Dr. W. ALLEN DALEY was in the chair.

Dr. Simmons described how eighty-four cases of pneumonia in adults were treated with sulphapyridine. Two-thirds of the cases were of lobar pneumonia, while the remainder were cases of bronchopneumonia or of febrile bronchitis. There were fifteen deaths in the series, of which eleven were due to pneumonia. Three of these eleven patients had had sulphapyridine administered for less than twenty-four hours before death, and in only three of the remainder did the sulphapyridine appear to have no effect. The dosage employed was 1 gramme four-hourly for forty-eight hours, followed by 1 gramme three times a day for three days; an average of 20 to 24 grammes was given in each case. If there was no response to treatment in five days it was useless to continue, and indeed it was usually found that the diagnosis had been incorrect. "Failures" of this type were later found to be cases of tuberculous bronchopneumonia, empyema, and primary lung abscess. In the majority of cases the condition terminated by crisis in twenty-four hours, irrespective of the day of disease on which the treatment was begun, and in 80 per cent. the temperature became normal in forty-eight hours. In eight cases there was a relapse on terminating the treatment, which was controlled by repeating the administration of sulphapyridine. The drug appeared to be just as effective whatever the type of the pneumococcus. Vomiting and cyanosis were not uncommon complications, but were of little significance. The former was often overcome by powdering the tablets or by giving an intramuscular injection of the sodium salt. Dr. L. J. M. LAURENT said that individual idiosyncrasy to these drugs was more important than toxicity. In streptococcal infections sulphapyridine and sulphanilamide were of equal value. In cases of erysipelas failure to improve under treatment with these drugs made the diagnosis questionable; all local treatment and all anti-sera had been rendered obsolete by the introduction of these new compounds. Sulphanilamide was useless in the treatment of the toxæmia of scarlet fever. When it was given alone, to prevent complications, the results were inconclusive; better results were obtained if antitoxin was injected at the same time. Late otitis media and late adenitis ran a milder and shorter course under treatment with sulphanilamide, but if mastoiditis existed it was dangerous to delay operation even if the patient seemed well. Nephritis was no contraindication to the administration of sulphanilamide if serious septic complications were present. Acute streptococcal tonsillitis responded well to sulphanilamide therapy, but acute rheumatism and carditis were not prevented.

In cerebrospinal fever sulphapyridine was superior to sulphanilamide. Eleven cases had been treated with one of these drugs and with meningococcal antitoxin, with two deaths. The recoveries were much more rapid than with serum alone. In proved pneumococcal infections only sulphapyridine had been used. As good recoveries were seen in post-influenzal pneumonia as in primary lobar pneumonia. Many relapses were observed after stopping the drug, one as late as fourteen days after. Four of these relapsing cases which came to necropsy showed small foci of suppuration in the lungs or pleura. The same type of organism was found in the relapses as in the original attacks. The general impression was that these drugs were most effective against an organism invading