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

PSYCHOLOGICAL EMERGENCIES IN WAR TIME

BY

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In any war with modern weapons of destruction, psychological emergencies, or, as they are more often called, psychiatric casualties, will be much the same in character, although the proportion of the different types of casualty may vary. During and after the great war many books were written describing the different types of psychiatric casualties both in this and in other countries. After twenty years much of this literature has fallen into oblivion, and a generation of medical men has arisen to whom war neurosis and psychiatric casualties are largely unknown. It is only the recent political situation, with the ever-present threat of war, that has brought the whole subject out of the oblivion into which it was gradually dropping. It is recognized by all thinking men and women, medical or lay, that the psychiatric casualties in the present war, of the character we are told we must envisage, may have even more far-reaching effects than physical casualties, loss of life, or material destruction. It is a problem that everyone, at any rate in our large towns, is having to face—not so much, “Shall I be killed or injured?” but “Can I face it; shall I break down; shall I keep sane or normal under the conditions I may have to endure?” There can be no question that many, perhaps most, of us cannot feel quite sure of the answer.

I think it is impossible to estimate with any certainty the number of psychiatric casualties that will have to be dealt with if any civilian population is exposed to frequent and intense aerial bombardment. During the great war psychiatric casualties occurred among disciplined troops, mainly young and to some extent at any rate selected, all of them subjected to a training which would make for the raising of morale and obedience to orders. War directed against a civilian population exempts no one, excludes no one. The morale of a civilian population is impossible to assess beforehand; it will depend on many factors—to a certain extent on class, to a greater extent on the density of the population exposed, and probably to the greatest extent on the adequacy of the protective measures and the confidence these measures inspire. The civilian population must be treated as if they were combatant troops; they must be under authority and know what to do and what to avoid doing in case of emergency. The authority also must not be remote, but, like a battalion commander, be personally known and accepted before the emergency arises.

The following attempt to classify psychiatric casualties is based on experience during the last war, both personal and communicated. Like all classifications, it must be to some extent arbitrary; types will not always be clear-cut, and exact diagnosis will often only be possible long after the case has left the casualty clearing station for special psychiatric hospitals. The classification attempts to represent the various forms of psychiatric casualties which may be admitted to first-aid posts and casualty clearing stations, and is not meant for the skilled psychiatrist, whose

services may very often not be available. It will probably be useful to try to divide the admissions into the following groups: cases of simple terror; anxiety hysteria; conversion hysteria, including hysterical stupor; concussion; and psychoses.

Simple Terror

It must always be remembered that terror is not in itself pathological; it is a normal biological response to stimuli which are felt, rightly or wrongly, to be a threat to life or are entirely foreign to all previous experience. It is, as a rule, a short-lived reaction, and passes quickly, either by getting into safer conditions or when the danger has passed. In cases of simple terror the instinct of self-preservation is in action, but not to such an extent that habituation to dangerous conditions is impossible; and, as the terror passes, purposive action in the interest of the group is again possible. It has been said that during a raid first-aid posts and casualty clearing stations will be filled with terror-stricken people. I think this is doubtful; most of those in a state of simple terror will stay where they are or go where they feel safer, and a great majority will overcome the terror and if they have a job to do will carry on.

How can we differentiate the real coward? The real coward is a coward always and all the time—in situations of danger the instinct of self-preservation is always uppermost; he will see to it beforehand that he can go at once to safety, and nothing will move him; he is not always overtly terrified. To quote what has often been said, “The brave man is afraid of feeling afraid; the coward is afraid of being brave.”

Anxiety Hysteria

In peace time the label “anxiety hysteria” is given to by far the greatest majority of neurotic maladjustments and illnesses and includes a very great variety of psychological as well as somatic disturbances which are found to be related to anxiety, and the anxiety is in perhaps most cases conditioned not so much by external conditions as by internal conflicts. As a psychological emergency in war the anxiety hysteria will resemble the severer forms of anxiety attack seen occasionally in peace time, but will, at any rate, apparently be more definitely related to the dangerous situation, whether past, present, or anticipated.

It will be important to try to differentiate the real anxiety hysteria from the attack of simple terror. It will not always be easy, but there is one difference which, although it is not invariably true, is of fairly general application. In the anxiety hysteric the emotional response to the situation has ceased to be biological and therefore to some extent useful, but has become pathological. The instinct of self-preservation has often ceased to operate; flight, or any purposive action or effort of will to overcome the terror, has become impossible. The emotional upheaval is so great and the somatic accompaniments of fear are so intense that no amount of reassurance, or removal to a place of safety, no appeal to any ego ideal of courage, elicits any response for the time being. The individual has regressed to a more primitive level; the effect of fear on the whole autonomic system has for the

time being put out of action the higher centres of volitional control.

Severe cases of anxiety hysteria will not come themselves to the casualty clearing station or first-aid post; they will be brought there, often as stretcher cases, during raids or shortly after; they may be brought in from the streets or air raid shelters, collapsed and tremulous, or wandering in a purposeless way with clouded consciousness or even amnesia; near to any severe explosion, they may be found lying apparently unconscious in the state of hysterical coma or stupor which will be referred to later. Between raids they will be brought to hospitals by their relatives, perhaps from homes close to a bombed area or from districts quite untouched—perhaps not such severe cases as those occurring actually during a raid, but quite impossible to nurse at home. There is a constant expression of terror, a coarse tremor, sweating, and tachycardia; they scream sometimes if touched, and some lie curled up under the bedclothes in the intra-uterine position. These are the severer psychiatric casualties which will most certainly occur in bombed areas. They may recover fairly quickly from their acute symptoms under hospital conditions, but evacuation is imperative, not only for the individual but because, if these cases are sent home, they will certainly relapse and become sources of "infection" to those around them who may be themselves on the verge of breakdown. I believe it to be most important to realize that many milder cases of anxiety hysteria may need to be evacuated, not so much for the sake of the individual as for the community, who may be infected by their anxiety and themselves become less tolerant of stress.

Conversion Hysteria

It may be wise even nowadays to restate what it is that is converted in conversion hysteria. It is anxiety that is unconsciously converted into some disturbance or even complete inhibition of a somatic function. This is true, and always true, not only of war conversion hysteria when the anxiety converted is the result of terrifying external situations, but also in the conversion hysteria of peace time when the anxiety is more often of endopsychic origin. The conversion hysterias are modes of dealing with and often completely inhibiting anxiety. The hysterical pareses, mutism, aphasia, deafness, blindness—all are the result of acute anxiety, but converted into the somatic disturbances and no longer felt as such. The hysterical paraplegic, the aphasic, the deaf—all of these have ceased to be anxious about the original traumatic experience, and even any anxiety about the actual symptoms seems often non-existent. It is the same mechanism in the hysterical fugues, amnesias, and stupors, many of which may be seen as psychiatric casualties.

Much has been written about what is called the period of latency, the interval that often elapses between the initial shock or production of acute anxiety and the development of conversion symptoms. It has been called the period of subconscious elaboration, or, by some French writers, the period of rumination. From some of these writers one gets the impression that they consider that in the period of rumination there is a sort of conscious attempt to avoid the anxiety by means of conversion. I do not believe this is true, the conversion symptom is not consciously willed, and whatever happens in the latency period is carried out, not in the field of consciousness but at deeper unconscious or preconscious levels. Nothing is known definitely about what does occur or how the conversion is made; we may speculate, but certainly, in my opinion, we do not know.

Conversion hysterias are true dissociations of consciousness: the hysteric has no awareness of the function which is lost, whether it is speech or some part of memory or motility. It is perhaps related to this that so many cases of conversion hysteria in war time are initiated, sometimes suddenly, without any latency period, by any momentary loss of consciousness, such as may occur in proximity to a severe explosion or on being momentarily buried under a fall of earth or debris. There is probably no true concussion, and they do not present the symptoms of cases of true concussion. One striking fact emerged during the last war and was confirmed by all observers. By far the greatest proportion of cases of conversion hysteria occurred among the men in the ranks, comparatively few among officers. There may be many reasons for this; in my own experience the true conversion hysterias often occurred among the rather naïve, simple, not very intelligent type of soldiers—often not overtly very anxious in the firing line, obeying orders, accepting authority, but avoiding any responsibility. When they broke down they did so suddenly after only a short period of acute anxiety, or after some experience of intolerable stress. Through this conversion symptom they obtained not only relief of intolerable anxiety but sanction for removal from the danger zone, which would persist so long as the symptoms remained.

It is as if the officer, with his training, his sense of responsibility, his higher ego ideal, could and did tolerate enormous amounts of anxiety before the final breakdown, but, because of his ego ideal, could not sanction the complete flight of the conversion hysteric. The man in the ranks of the type described, with no ego ideal, no sense of responsibility to anyone but himself, had nothing to inhibit the mechanism of conversion, whatever it is, which gave him so complete an escape. These views are admittedly only superficial explanations, and many other psychological determinants which would explain the difference between the two groups would emerge during treatment.

Hysterical Stupor

There is one form of hysteria that was seen fairly often during the last war and may, I think, be seen much more frequently in a future war when the brunt of the attack may be upon human material of all and every type without any selection either for mental or physical fitness; this is hysterical stupor or coma. It is important because it is not always easy to distinguish between hysterical coma and severe concussion, and the treatment and subsequent history are entirely different. These cases will be found lying apparently deeply asleep or unconscious. I use the term "asleep" advisedly, because French writers in the past have called the state "narcolepsy," although it is entirely different from the narcolepsy of modern neurology. They will generally be found somewhere near to a bombed area, generally flaccid but with no disturbance of the deep reflexes. If an attempt is made to open the eyes it is resisted by strong contraction of the orbicularis. The eyeballs are turned strongly upwards and fixed. There is sometimes, but not always, relaxation of sphincters. They may remain like this for hours or days and then recover, often with a patchy but not complete amnesia, both anterograde and retrograde. From the nursing point of view these cases are in my personal experience often most difficult and very alarming. The patients will sometimes recover consciousness quite suddenly and become very violent and uncontrolled, attacking, or more often pretending to attack, those who come near them; then after a violent period they relapse again

into coma. The attack resembles closely the somnambulisms, often intensely dramatic and alarming, which occur very frequently among anxiety hysterics in war times when in hospital.

Other Disturbances

The conversion hysterics that have generally the most definite, and often long, latency period are the paraplegias. They will frequently occur associated with a slight wound or injury but quite unrelated to the extent or even situation of the injury. They will vary endlessly in character—complete paraplegias, disturbance of gait with or without contracture, monoplegia of the arm with *main en griffe* or accoucheur hand. There will be endless cases of coarse tremor, often resembling an intention tremor and confined to one limb, or spreading to every limb when any movement is suggested. There will be tics of all kinds and many stammerers. These last two forms are nearer akin to the anxiety hysterics, and all the anxiety will not have been converted. Another group will be the so-called psychosomatic types—cardiac neuroses, respiratory neuroses, and visceral neuroses. I have seen persistent attacks of severe orthopnoea in cases which occurred through being buried. In this last group anxiety is still felt, but has shifted from the original emotional trauma to anxiety about the function that is disturbed.

Hysterical amnesias will be fairly often seen as psychiatric casualties, and must be differentiated from post-concussion amnesias—not always very easy, especially if there is a history of proximity to a severe explosion with the possibility of a momentary true loss of consciousness. They are frequently very patchy, both retrograde and anterograde, and in the patchy amnesias there is often still some anxiety and some confusion. The man remembers nothing since, for example, he was in a training camp in England, but feels that something dreadful happened after this. Other rarer cases are complete amnesias for all the past. One patient I remember very well was exactly like a child, but with no memory of his parents or home; until he recovered he had to be taught again how to feed himself, to read, and to write. The true hysterical fugues—the cases where men are found wandering with a complete retrograde amnesia, going back either for days or months—are not, in my experience, so common. A fugue is so often the easiest form of true malingering and not always the easiest to detect. I have myself worked at a fugue case for many months in a very intelligent man of the officer class, only to find out in the end that he was a true malingerer with no loss of memory at all. Others are quite easy to detect after a little questioning, and are often associated with the end of leave. True fugues do exist, of course, but they are much easier to simulate than the patchy amnesias associated with more or less anxiety.

Concussion

Here we are on debatable ground. Cases of true concussion may be considered as neurological rather than psychological casualties; but they will certainly often be regarded as psychiatric casualties, because they will be found unconscious without any sign of physical injury. It is also debatable ground because in much of the literature on war neuroses cases are included under concussion when, although there may have been transient loss of consciousness, there are marked symptoms of anxiety hysteria, or even of conversion, immediately or shortly after the traumatic episode.

In true concussion the period of unconsciousness may be extremely short, or deep and prolonged. In the slighter

forms the man may recover and carry on with what he was doing, apparently little the worse. In all cases, however, of true concussion I believe there is one significant feature—a retrograde amnesia which, short or long, is always clear-cut and definite, and an amnesia which is permanent; there may also be a varying anterograde amnesia, not so clear-cut as it emerges into full consciousness, but also permanent. Concussion patients as they recover may be confused often for a long period, but there is not the same amount of anxiety as in the hysterical cases; the complete retrograde amnesia has also cut out all recollection of any anxiety or emotion felt just before the traumatic incident. All the concussion cases are, in my experience, more serious than the anxiety hysterics; in severe cases the ultimate prognosis is very uncertain, and some deteriorate into a permanent condition of mental hebetude and depression. A severe case of concussion brought in unconscious should be fairly easily differentiated from hysterical stupor. The patient is profoundly unconscious, deep reflexes are abolished, muscles are hypotonic, pupils are often unequal, and there may be ophthalmoplegia or ptosis.

The Psychoses

In any civilian population there are a fairly large number of psychopathic personalities, mild manic-depressives, schizophrenics in remission, and superior mental defectives. All of these will stand the strain of war conditions badly and will become psychiatric casualties. In the last war cases of katatonic stupor were found in casualty clearing stations; mildly depressed men became acutely maniacal; cases of mild hypomania became acutely depressed. The problem of the effect of war on high-grade defectives is in war time often more a social than a medical problem. In the last war some of this type managed or were compelled to enlist, even obtained commissions. Many drifted into military prisons or were sent into special hospitals for observation and report for various delinquencies, character disorders, or anti-social acts. There will probably be more of these in any war on civilian populations.

I have said nothing about the effect of war conditions on the obsessional neurotic, of whom there are very many. I have done this deliberately because, in my opinion, the true obsessional stands war conditions as well as or better than most; when he does break down he will become for the time being an acute hysteric with similar symptoms. It will only be when under treatment that the obsessional character will again emerge and present a definite problem.

Neither have I said anything about the more specific effects on women and children; here much could be written, but it must be, and I hope may remain, speculative.

I have given a classification in which any psychiatrist, including myself, could pick as many holes as are in a sieve. I have only attempted one which may have some practical value.

A revised edition of the pamphlet *Physical Aspects of Radium and Radon Therapy*, by Dr. C. E. Eddy and Mr. T. H. Oddie of Melbourne, has been issued by the Health Department of the Australian Commonwealth, Canberra. Copies are being distributed to radiologists and physicists in Australia to assist in attaining accuracy and careful application of radium and radon in treatment, and to foster co-operation between radiologists and physicists. The first edition was noted with approval in our issue of September 18, 1937 (p. 589).