THE PRISONER-OF-WAR MENTALITY ITS EFFECT AFTER REPATRIATION

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In 1919 Dr. A. L. Vischer wrote a small book entitled *Barbed-Wire Disease: A Psychological Study of the Prisoner of War*. It deals briefly with the factors producing this "disease" and with the prisoner's reaction to his environment during prison life. Dr. Vischer was a visiting doctor in German prisoner-of-war camps during the last war; he drew his conclusions not as a prisoner of war but as a psychologist studying a series of patients. His experience was vast, and his conclusions were drawn from an immense amount of data. In this short article I wish to give an impression not of a doctor examining his patients but that of a prisoner of war himself.

The number of prisoners ultimately returning to this country alone will be many hundreds of thousands, and that to countries throughout the world millions. It is quite obvious, therefore, that the organization dealing with repatriation of these people constitutes one of our more important post-war problems. The return of these prisoners will entail a flooding of our own country with men and some women who have experienced circumstances not necessarily harder but quite different from the majority of others. Those at home will welcome them as few are privileged to be welcomed, not because they have lived through worse conditions or have been more badly wounded or mutilated or have shown greater courage in facing more frightful scenes than others, but because they have lived in the valley of darkness.

During this period of enforced imprisonment they have adopted a certain mental attitude—a frame of mind compatible with camp life. Dr. Vischer has traced most carefully the origin of this mental attitude and discussed in detail its symptoms during camp life; he has not, however, described the symptoms after release from the camp. It is perfectly easy to understand the reason for a prisoner's depression while confined in a small space, crowded, and in an atmosphere of irritability. It is far less understandable that this attitude should persist on the prisoner's return to conditions to which he was normally accustomed. Broadly speaking, a prisoner's reactions in the camp are of minor importance in comparison with those which he shows on return to his normal life when he may again be beset by large responsibilities.

In medical textbooks we are familiar with what is called caisson disease. While in an underwater or compressed-air caisson such as is used in tunnelling, the bodies of the workers adapt themselves to an environment in which the atmospheric pressure is abnormally high. While working in this situation men show no abnormal symptoms, but when the caisson is raised or when they are released from it, the pressure falls back to normal and symptoms are apt to appear as a result of liberation of nitrogen bubbles from the blood. These symptoms do not always occur, but are usually the result of a too rapid fall in atmospheric pressure—that is, on a change of environment which the body finds too rapid for proper adaptation.

When a number of men are released from the same caisson, all of whom have been submitted to the same atmospheric pressure, some will show symptoms and some will not. A batch of men exposed to a high pressure for a long period will be more likely to show symptoms than a batch exposed to a low pressure for a short period. It is apparent, therefore, that the presence or intensity of these symptoms will mainly depend upon the following factors: (1) the individual himself; (2) the length of the period of immersion; (3) the pressure within the caisson. This response of a normal body to the process of recovery from exposure to an abnormal external environment is wrongly called a disease. It is the change-over from an adaptation to abnormal external influences. The

returned prisoner of war is placed in conditions which show some parallel to those who suffer from caisson disease.

If we bear this parallel in mind we may say that in the repatriated prisoner the appearance of symptoms will depend upon: (1) the individual temperament; (2) the period of time within the camp; and (3) the gravity of conditions. (By gravity of conditions is meant not necessarily the degree of physical discomfort and the occurrence of atrocities, but the intensity of factors which the prisoner feels are of psychological importance.)

The effects of internment are twofold, and can crudely be divided into physical and mental. The physical effects are easily described and easily accounted for. Their treatment after release is probably a matter of good food, elementary medicine, and pleasant conditions. It is not the object of this article to discuss these problems, which are already fully recognized and can usually be treated without difficulty. The possibilities and limitations of physical rehabilitation are common knowledge among the medical profession. Unfortunately this is not the case in mental convalescence, where, as doctors, we still tend to flounder in directing treatment. Formerly, what we call common sense was the guiding principle, and it will remain so unless some very clear and rational indication for additional methods arises. The use of individual psychological treatment for any returned prisoner of war seems to be debatable; it may carry with it a public acknowledgment of mental abnormality, which must at all costs be avoided. This will be discussed more fully later when the long-distance guidance of such cases is described.

Barbed-wire disease, as has been said, is a misnomer. It is wrongly called a disease, and perhaps is better termed a mental attitude. This mental attitude is built up from a series of four phases through which the average internee passes. They are quite definite in occurrence but nebulous as to length and intensity. The officer prisoner of war has been chosen for discussion for two obvious reasons—first, the contrast between his normal life and his prison life is greater; and, secondly, during internment he remains unemployed and therefore has to rely on his own resources to dispose of his time.

Stage I: The Breaking-in Period

This is by far the most unpleasant of the four stages, because it is essentially the time of the acute mental stress which accompanies forcible adaptation to a lower plane of existence. The captive realizes very quickly the loss of friendly association, the loss of his own reputation and prestige, the absence of the sunshine of his own propaganda, and the power of the opposing propaganda. The lot of the man who was taken prisoner in France after three weeks of exhaustive retreat may well serve as an example. Within a month he was switched from the pleasant life of a pseudo-peacetime Army into the grip of Nazi persecution. Bewildered by the falsity of his own propaganda and disillusioned as to the might of his own country, hungry and fatigued to the extreme, he was moved into Germany. He was taken in by forced marches, given practically nothing to eat, and shot if he fell by the wayside. Lack of clothes, lack of personal belongings, and, above all, the vision of five to ten years as a prisoner of war were some of the factors which combined to make the prisoner a truly wretched creature. During this period there first arose the longing for freedom, for home, security, female society, and, above all, for sympathy. This suppressed longing for sympathy remains, and is stored up until the day of repatriation, when it crops up in different ways.

Stage II: Period of Convalescence

This is the period of recovering morale. The prisoner, having reached the depth of his depression, gradually reawakens to the life around him. He licks himself and his wounded pride, opens his eyes, and finds that far away on the horizon there is still a ray of sunlight left. Now he begins to shave, to undress when going to bed, to talk intelligently, to plan, and to organize his life. He grasps at the small things which give him pleasure and builds his life around them. At this time, typically, he gathers together what little personal belongings remain to him. He searches the camp for a piece of wood and fixes it to the wall near the head of his bed.

On this shelf he sets a photograph, a pipe, a favourite book, and anything else which represents to him a home in miniature. During the period of increasing morale the prisoner develops a sense of revenge, and is not long in realizing that revenge is impracticable. The consequent sense of frustration may easily be turned into a grudge against his own Government and higher Service officials. During this period of recovery the possibility of a reason or an object for living gradually emerges and forms itself from the all-enveloping fog of shattered values. Some find this image more quickly and visualize it more clearly than others. They are the fortunate ones, who adapt themselves more readily to prison life. Others, who find the definition of this image more difficult, remain restless, discontented, more indefinite in their prison day routine, and are liable to store up from frustrated revenge a heavy grudge against the future if it does not come up to expectations. Let it not be forgotten that many prisoners of war have not seen a friendly person outside the barbed wire for over three years. This lack of external friendliness and encouragement plays a large part in focusing the prisoner's thoughts and ideas in introspective channels.

Stage III: The Lengthy Period of Boredom

During this period we see the prisoner in his usual state. He has done his best to accommodate himself to a life in a nutshell. He has looked into the uncertainty of the future and weighed up the possibilities of his eventual home-coming. As Dr. Vischer has pointed out, this uncertainty of the duration of internment is a demoralizing factor. The criminal prisoner can plan his life to the duration of his imprisonment, the prisoner of war cannot.

The significance of the absence of female society as a factor in the formation of the prisoner's attitude appears to give rise to much controversy. In discussing sexual deprivation it is important to distinguish between the restricted meaning of this phrase—i.e., actual sexual intercourse—and the broader meaning—i.e., the whole sphere of association between the sexes and all that it entails. There can be little doubt that, in this broader sense of lack of affection, sexual deprivation is not only a fundamental but *the* fundamental factor in the formation of the prisoner-of-war attitude. Deeply within the prisoner, but seldom expressed, there lies the fear of becoming a forgotten man. In 1941, after a year or so of imprisonment, some two hundred and fifty officers were gathered together to listen to a newly arrived Air Force prisoner. He was giving a précis of the events in England since Dunkirk. Interesting as his talk was, nothing stirred the audience so much as when he concluded by saying, "And, chaps—the girls still love you." The acute emotional reaction after this was plainly obvious. Further proof of this need can be seen in the meticulous care with which every word of letters is read and sifted. Hours are spent in making an elaborate checking and filing system for incoming and outgoing mail, and statistics are kept of its arrival.

The importance of the absence of actual sexual intercourse probably depends a great deal on the temperament of the individual. Even although it is untrue, it is quite common for an Italian prisoner of war to believe that he will become mentally deranged without this physiological act. I have heard this view expressed also by French prisoners, but never by British or German prisoners of war. A quite unfounded fear of impotence was frequently the reason for a prisoner's seeking medical advice and reassurance.

Overcrowding, with the impossibility of ever being alone to work, was a source of irritation and a good excuse for never working at all.

Apart from all these demoralizing influences there are several aspects of this life which produce other but equally damaging results. In the camp the prisoner is relieved from the struggle of life; he no longer has to work for his living, shoulder responsibility, or worry financially. Nothing that he does within the camp can relieve any threatening situation at home, and therefore his occupations lose their significance as acts of vital importance and become merely a pastime to amuse himself and defeat his own boredom. There is no stimulation for him to work, and what he achieves matters very little to his present state. He may spend three months making a model

boat, and if he wishes he can spend six, for nobody will interfere; there is no competitive element, and time is of no importance. This attitude and this lack of responsibility tend to make him small-minded and childish. Conversation centres around small events within the sphere of the camp, events which are of no consequence to the outside world. This lack of stimulation builds up a predisposition to be unduly troubled by the everyday struggle for existence which has to be met, once again, after release.

The unemployed prisoner of war has three main ways in which he may lead a constructive life, the choice varying according to his temperament: (i) work which will be of value to him after release; (ii) welfare work among his fellow prisoners; (iii) escaping and sabotage. Most prisoners mould their occupation around one or more of these three. The minority which does not adopt any one of these seriously is building up greater difficulties at the time of readjustment following release.

Stage IV: The Repatriation Period

The returning prisoner arrives back in his home country keyed up to a high pitch and full of expectation for the pleasures to come. He is stimulated, after years of looking from the other side-of the river, into a state of exaggerated optimism and false hope. Much, for the future, will depend upon the state of his home conditions. The repatriate who finds his family and his intimates as he hoped to find them, ready to listen sympathetically and to share his experiences, however trifling they may have been, is already half-way on the road to recovery. He must regain his emotional balance before he can again assume the responsibilities of his former life. Here in the bosom of his family he may live quietly, and gradually catch up with the years that have been lost to him. Here are those who have lived these years for him and are willing to share their experiences and help him over the gap of wasted time. From this sound emotional foundation of his convalescence he will stand every chance of regaining his normal appreciation of the difference between work and relaxation and of his need for both in certain proportions. Greater difficulties are apt to beset the returned prisoner who is not so fortunate. In wartime many factors tend to upset the happy balance of affairs, and consequently grave gaps and differences are apt to appear. During this repatriation period abnormal reactions are common; in fact, probably all prisoners of long standing will present symptoms to some degree. The factors on which the occurrence of symptoms will depend are those described above, with the addition of the conditions awaiting the prisoner on return home. Briefly, these symptoms are restlessness, irritability, disrespect for discipline and authority, irresponsibility, and even dishonesty. Other symptoms that occur are the fear of enclosed spaces, especially a fear of large crowds in confined spaces, cynicism, embarrassment in society, rebellious views against any code which tends to restrict the repatriate's activities, and a tendency to quick and violent tempers.

All men returning from over-seas, and especially those who have been in isolated areas for long periods, will show these symptoms to a certain extent, but seldom to so marked a degree as in the prisoner of war who has been through conditions which are usually held to be more damaging in the psychological sense: this, too, the prisoner knows and feels. It is important that the returned prisoner of war who shows these symptoms shall not be regarded as abnormal. Some may think him peculiar, rude, objectionable, and unreliable; but they must be helped to realize that he is a normal person attempting to bridge a gap in his life, often with poor or insufficient material.

This syndrome, when it exists, should pass off after six months to one year, and thus those affected should give rise to no concern. There are two types, however, which will give cause for anxiety: (i) the repatriate with exaggerated symptoms, (ii) the repatriate with persistence of symptoms. If individual treatment of any sort is ever indicated it will be in one of these two types. The first type is associated with symptoms of severe restlessness, irritability, emotional outbursts, acute discontent, and possibly excessive alcoholism. The second type shows chronic apathy, loss of initiative, and loss of

morale and of personal drive, resulting in the inevitable appearance of more serious neurotic symptoms.

The returning prisoner of war is ill equipped for the difficult period of readjustment. He is temporarily without the sheet-anchor of his daily routine, he has laid aside his habits of recreational relaxation, and he has lost the art of working for his living. With these handicaps he must readjust himself to his return to normal life. Should domestic trouble and unemployment further burden him he may succumb to his adversities and relinquish the struggle. It is reasonable to suppose that at this point a little help from someone who understands the position may be of great assistance.

Where, when, and how to apply this aid is a difficult problem. The ex-prisoner on returning to his home country has one main object in view—to reach his home as quickly as possible. Any form of assistance which prolonged the time between disembarkation and his arrival home would be doomed to failure. It would lack a vital factor—i.e., the recipient's co-operation. Similarly, except in a special atmosphere, any massing together of the repatriates after a period of leave would become difficult as well as being in most cases unnecessary. The necessity arises for some more distant and more subtle form of control—i.e., a form of long-distance guidance, an influence of which the repatriate is only just vaguely aware in the dim background, but which he can at any time make contact with should he feel the need for its help. It must be unobtrusive, so that it does not impress the majority with their need for assistance, but it must be accessible enough to be at hand if and when its assistance is required.

An organization for the aid of returned prisoners of war must fulfil certain requirements. The following suggestions are made to this end. The organization should possess (1) a means of informing all returned prisoners of war of its existence; (2) an interested and competent staff; (3) advice centres; (4) a rehabilitation centre.

These principles might be implemented in the following way:

1. To every returned prisoner of war would be posted a pamphlet containing very simple and brief advice for him during his period of so-called convalescence and informing him of the presence of an advice organization should he require it.

2. The advice organization might be staffed by individuals, preferably medical practitioners, who understand prisoner-of-war life, and who recognize and are capable of dealing with "release" phenomena. Medical practitioners who have actually been prisoners of war would be of great value in these circumstances.

3. The establishment of a prisoner-of-war club in all large towns—e.g., over 100,000 population—where ex-prisoners may forgather and know that, should they require advice, there is someone attending each club who understands their difficulties and is willing to help them. These advice centres may also be used by relatives seeking advice in handling returned prisoners, some of whom may prove difficult at home and refuse to receive any form of help.

4. The establishment of one rehabilitation centre for the country, with consultant psychologists and a trained rehabilitation staff. The patients at the centre would consist of those recommended from advice centres and by members of the medical profession throughout the country.

Summary

The typical prisoner-of-war mental attitude is discussed.

The four phases of significance in the formation of this attitude are described—namely: Stage I, the breaking-in period; Stage II, the period of convalescence; Stage III, the lengthy period of boredom; Stage IV, the repatriation period.

Emphasis is laid on the importance of the typical mental reactions which follow release as opposed to those shown while in the camp:

The great majority of returned prisoners of war give rise to no concern, but those showing excessive mental reactions or an undue persistence of symptoms may need assistance.

A scheme for aiding such cases is outlined.

A. B. Newman (*Amer. J. Dis. Child.*, 1942, **64**, 649), who reviews the literature and records 6 personal cases in children aged from 4½ to 12 years, states that peptic ulcer is comparatively rare in childhood: according to Hirsch the incidence is between 0.3% and 1%, and is equal among boys and girls. The diagnosis is more difficult in younger than in older children, in whom the disease tends to conform to the adult pattern. The importance of x-ray examination in obscure abdominal symptoms in children is emphasized.

A CASE OF ASPIRIN POISONING

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Records of aspirin poisoning are uncommon enough to warrant publication of a further case.

Clinical History

The patient was a European woman, aged 46, living in Kenya Colony. She had been worried about domestic trouble, and had suggested in a letter to a friend that she was about to commit suicide. On Nov. 24, 1939, she took 30 gr. of médinal, but awoke from its effects at 8 p.m. On Nov. 25, at 2 a.m., she swallowed 750 gr. of acetylsalicylic acid (150 5-gr. tablets of Howard's aspirin). The time of taking the drug was ascertained by the patient's personal admission after her recovery, and the exact dosage was proved by counting the remaining (350) tablets out of a previously unopened (500-tablet) bottle. There was no vomiting.

I was called to see the patient 14 hours after she had taken the drug. She was sitting in a chair. She was drowsy and disorientated for time, repeatedly mistaking the day of the week. She complained of tinnitus, requesting that the kettle be removed from the fire. Her respirations were rapid (40 a minute) and deep. Her pulse was 130 and the volume small. She was sweating and complained of the heat, in spite of the fact that the day was cold. She was not cyanosed and had no rash. Her pupils were small and reacted to light. Her reflexes were normal. An examination of the heart and lungs revealed no abnormality. Her tongue was clean.

A catheter specimen of her urine was of normal colour and had an odour of acetone. Its specific gravity was 1030. The reaction was very acid, the pH ranging from 4 to 4.3. The addition of perchloride of iron produced a deep violet colour. Rothera's nitroprusside test for acetone bodies was strongly positive. Gmelin's test for bile pigments gave a positive result. A moderate cloud of albumin was present on boiling. There was a marked reduction of Fehling's and a slight reduction of Benedict's solution. The yeast fermentation test was positive. After 16 hours of yeast fermentation the specimen was again examined for reducing substances, when it was found that, while still producing the same pronounced reduction of Fehling's solution, it was now negative to Benedict's test. This proved that, whereas the reduction of the copper solutions before fermentation had resulted mainly from the presence of salicylic acid, there had also been a trace of glucose. Microscopical examination revealed the presence of several red blood corpuscles and pus cells, but no casts. In order to test the antiseptic action of the drug, a nutrient agar slope was inoculated with a sample (not a catheter specimen) of her urine. No colonies resulted after incubation.

There was a steady improvement in the patient's condition. Her progress is summed up in the following table:

Table of Progress

	1st Day	2nd Day	3rd Day	4th Day	5th Day
Temperature	Up to 99.4°	Up to 99.2°	Normal		
Pulse	130 and small	66; normal tension and volume	Normal		
Respiration	40 and deep	28	24; varies in rate	Normal	
Mental condition ..	Disorientation and drowsiness	Orientation normal; still drowsy	Still drowsy	Not drowsy	
Liver	Not palpable	Not palpable	Not palpable	Not palpable	Palpable but not tender
Urine:					
Rothera's test ..	++	++	—		
Reduction of Fehling's solution ..	++	++	—		
Reduction of Benedict's solution ..	+	+	—		
Ferric chloride test for aspirin ..	++	++	++	++	*Faint violet
Volume	Oliguria for 27 hours, during which, apart from one catheter specimen, there was no passage of urine				

* Further specimens unobtainable owing to recovery and discharge from hospital.

Differential Diagnosis

Apart from cases of idiosyncrasy, such a large dose of aspirin is required to produce toxic symptoms that poisoning by this drug is nearly always the result of attempted suicide, which may be accompanied by an effort to conceal the cause of the illness. In this particular case the evidence of witnesses, combined with the presence of the aspirin bottle at the bedside, greatly aided the