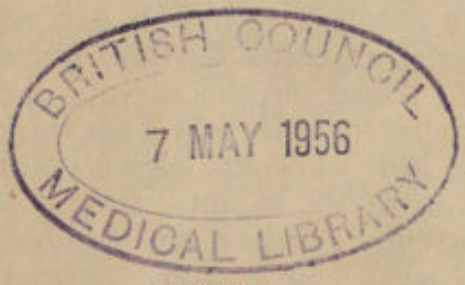
Neuroses in war-time : memorandum for the information of the medical profession / Ministry of Pensions.

MINISTRY OF PENSIONS

NEUROSES IN WAR-TIME

MEMORANDUM FOR THE INFORMATION OF THE MEDICAL PROFESSION



LONDON
PUBLISHED BY HIS MAJESTY'S STATIONERY OFFICE
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1940
(Reprinted 1941)
Price 2*d*. net

NEUROSES IN WAR-TIME

A Conference first convened by the Minister of Pensions in July, 1939, to advise the Government as to general principles for dealing with cases of nervous breakdown which may become manifest in war-time, has now reported to the Minister.

The members of the Conference were as follows—

Lord Horder (*Chairman*), Sir Hubert Bond, Sir Farquhar Buzzard, Dr. Bernard Hart, Dr. Gordon Holmes, Dr. J. H. MacDonald, Professor Mapother, Dr. Crichton Miller, Dr. T. A. Ross, Sir James Purves Stewart, Dr. Aldren Turner, together with the Directors General of Medical Services of the Navy, Army, Air Force, and the Ministry of Pensions.

Besides making other recommendations, the Conference has suggested that the following notes be circulated to all members of the medical profession :—

During the last war the occurrence of large numbers of neuroses engendered by fear, shock, exhaustion, physical and mental strain or lack of sleep, and the rapidly increasing incidence of these from 1916 onwards, caught both the Services and the Medical Profession unprepared with any organisation by which to deal with them or with any agreed method of treatment applicable to them. The result was an accumulation of a very great number of this type of "casualty" and a consequent lowering of the general morale.

These neuroses were popularly called "shell shock," a term which came into use in 1914, when it was believed that the great bulk of nervous disorders noted in the field of war had their origin in the physical effects of concussion by high explosives or of poisoning by gases. At that time this theory was widely prevalent and was even promulgated by neuro-psychiatrists of experience.

It soon became obvious that this view could not be justified since precisely similar disabilities, and in the same proportions, occurred not only amongst men who had not been subjected to any such exceptional exposure but also amongst those who had not been overseas. Moreover, the nervous disorders arising during the war differed in no material way from those well known in civil life. Again, many men who were blown up or buried to the same extent were able to return to duty without admission to hospital and without apparently suffering any durable effects.

However, the term "shell shock" soon became a catchword among the troops and was welcomed by the man suffering from nervous symptoms as he did not realise, or could not admit to himself, or to others, that he might be suffering from the effects of fright or terror. The catchword appealed to the public imagination as an excellent term by which to explain a condition which could

not easily be understood and was too often adopted by the medical profession itself as a diagnosis for any functional nervous disorder appearing in soldiers during the war. Such was the appeal of the word " shell shock " that this class of case excited more general interest, attention and sympathy than almost any other, so much so that it is feared that it became a most desirable complaint from which to suffer.

Most of these neuroses occurred either in the form of an anxiety state or as hysteria.

Anxiety states reveal a common characteristic—the constant presence of fear or anxiety accompanied by vasomotor and visceral concomitants to a greater or lesser extent. Some are cases of mild type in which the anxiety is simply a prolongation and exaggeration of the natural anxiety experienced by everyone when exposed to war conditions. The feeling of fear is the normal reaction to threatened danger when the impulses activated by the instinct of self preservation are aroused, but these impulses have to be kept under control if an exhibition of cowardice is to be avoided. The source of this anxiety is very commonly the fear of being found afraid and the fear that control of these natural impulses, which are regarded as shameful, will not be forthcoming when the occasion arises. In some instances natural anxiety is aroused by the fears connected with loss of business and other financial and domestic worries caused by the dislocating effects of war. In cases of more severe type the condition is induced by morbid anxiety in which there is no apparent logical connection between war experiences and the symptoms of anxiety. In such cases the anxiety is out of all proportion to the apparent exciting cause or it may appear to have no obvious cause at all, though rationalisation on the sufferer's part may seem to account for it. In most of such cases it is experienced as a diffuse state of emotional tension undirected to any specific object or situation and causes a state of fearful expectation, the patients being described as " anxious " and " apprehensive." In a few predisposed cases the anxiety reaction is characterised by the development of phobias, or the anxiety may be transferred from its original object to some other situation which appears to the patient to afford reasonable grounds for apprehension, or to preoccupations of a hypochondriacal type. It may be accompanied at the outset by some degree of depression, or depression may be a secondary development after the anxiety has been concentrated on the symptoms themselves and a vicious circle has been set up.

Hysteria, more than any other form of mental reaction, provides the clearest example of the onset of neurosis due to failure of adaptation as the result of conflict between individual needs and social requirements. Suggestion is the most important factor as a cause for the symptoms. Physical manifestations of severe emotional disturbance such as mutism and tremors, or the effects of a minor physical injury producing some temporary loss of power in the limbs, are readily perpetuated as hysterical symptoms by means of

suggestion in men who have been subjected to physical or mental stress. Suggestions by medical officers or other attendants, in the course of examination and treatment, may have serious results and are often responsible for the onset of such symptoms.

Underlying the process of suggestion is a conflict between the instinct of self preservation on the one hand and ideas of duty and self respect on the other. The development of the symptom satisfies the patient's ethical requirements, provides an escape from duty on ground of physical incapacity and at the same time it gives effect to his individual needs by removing him from an intolerable situation. In a sense hysteria is thus an unwitting purposive or defence reaction, the patient being unaware of any such motivation. This unconscious motive is a factor of the first importance because, not only is it responsible for the onset of the neurosis, but it helps to perpetuate it until such time as the conflict is solved by other means. It is aggravated by popular misconceptions as to the nature of the neurosis, by public opinion, by the sympathy of friends and acquaintances, and if it achieves its aim, viz., invaliding from the battle-field or the Service, the bad influence exercised is shown by an increase in the incidence of these neuroses. Further, if it should lead to any economic gain treatment becomes extremely difficult and often useless.

In 1920 the Army Council appointed a Committee to collate the expert knowledge derived by the Service Medical Authorities and Medical Profession from the experience of the war with a view to recording for future use the ascertained facts as to the origin, nature and remedial treatment of " shell shock." This Committee issued a report in 1922 (Report of the War Office Committee of Inquiry into Shell Shock, H.M. Stationery Office, 1922). The Committee reported :—

(1) The term " shell shock " has been a gross and costly misnomer and the term should be eliminated from our nomenclature. It is a catchword which reacts unfavourably on the patients and on others.

(2) The war produced no new nervous disorders and those which occurred had previously been recognised in civil medical practice. The cases divided themselves into three main classes :

(*a*) genuine concussion without visible wound as a result of shell explosions ; this formed a relatively small proportion—5–10 per cent. of all the cases of shell shock.

(*b*) emotional shock, either acute in men with a neuropathic predisposition or developing slowly as a result of prolonged strain and terrifying experience, the final breakdown being sometimes brought about by some relatively trivial cause ; these formed 80 per cent. of all cases.

(*c*) nervous and mental exhaustion, the result of prolonged strain and hardship.

(3) Authorities are agreed that in the great majority of (chronic) cases of war neuroses there already existed a congenital or acquired predisposition to excessive and therefore pathological reaction in the individual concerned, and that this constitutional factor was of vast importance. It appears equally certain that the neuroses of war may manifest themselves even in those of sound nervous constitution provided stress be sufficiently severe and/or prolonged.

(4) No cases of psycho-neurosis or of mental breakdown, even when attributed to shell explosion or the effects thereof, should be classified as a battle casualty any more than sickness or disease is so recorded.

(5) The following factors are generally regarded as tending to increase the incidence and severity of mental and nervous disorders in time of war.

(*a*) All those factors by which a soldier, or even a potential soldier, is encouraged to believe that the weakening or loss of mental control provides an honourable avenue of escape from military service at whatever period of his service.

(*b*) The ignorance of the general community, both civil and military, together with a lack of interest evinced by the medical profession before the war regarding the origin, nature and significance of mental, and especially emotional, disorders.

(*c*) All those preventable conditions which undermine a man's mental and physical health and lower the power of resistance, e.g., bad sanitation, bad accommodation, abuse of alcohol and drugs, venereal disease, etc. In promoting and maintaining morale, good food, good housing, recreational relaxation and attention to the comfort and well-being of the soldier are of the greatest service.

(*d*) The introduction and perpetuation of the term "shell shock."

(*e*) The employment of such terms as "N.Y.D.N.", "D.A.H." or other designation which may become catchwords and thereby lead to an increase in the number of cases.

Diagnosis of Concussion and Emotional Shock

It is important that cases of concussion should be differentiated from cases of acute emotional shock not only because inappropriate treatment of the latter in the early stages retards recovery but also because incapacity certificates for physical injuries under the Personal Injuries (Emergency Provisions) Act apply to cases of

concussion. The diagnosis of concussion should be made only when the history or clinical symptoms leave no reasonable doubt that the patient has suffered physical injury by the direct explosion of a shell, by being knocked over by it, or by being buried under debris of a building or shelter. The concussed patient becomes immediately unconscious or is at least severely dazed or stunned. This loss of consciousness may last for a few minutes to several days. When the immediate effect passes off there is complete amnesia for a period immediately before and after the injury. The patient is consequently unable to say what happened to him and it is not possible to restore his memory by any therapeutic measures. Patients suffering from emotional shock also frequently state that they became unconscious after the incident to which they attribute their symptoms, but by careful questioning it is usually found that they can recall eventually most of their experiences.

Evidence of Physical Injury

Evidences of direct physical injury are often associated with concussion, such as rupture of the tympanic membranes, epistaxis, contusions and, more rarely, signs of organic injury of the nervous system. The symptoms vary with the severity of the condition and with the interval between the injury and the day on which the patient is examined. The early symptoms seen as the patient is regaining consciousness can rarely be mistaken, but those of later periods are often misinterpreted. These are neither invariable nor constant, but the most characteristic are headache, pain and stiffness of the neck, vertigo, mental and physical inertia with drowsiness and heavy sleep, which is rarely disturbed by dreams or nightmare. The pupils may be irregular and their reaction to light may be sluggish. In the early stages the tendon jerks are usually depressed but later generally become brisk or exaggerated. There may be fine tremors of the limbs but the coarse tremulousness of the limbs and head which is so common in the neuroses does not develop in concussion. The headache of concussion is usually better in the morning and early part of the day and increases from fatigue as the day advances. As distinct from the neuroses there is an absence of emotional instability.

Emotional Shock

Acute emotional shock may develop independently of any close exposure to the place of explosion. The fact of being subjected to bombardment or air raid or seeing horrifying sights may suffice to precipitate it. An avalanche of emotion seems to overwhelm the patient's consciousness, releasing primitive reactions. The clinical picture in the more severe cases may be one of terror, stark panic and confusion or one of physical and mental collapse. In the former type the tendency is to hyper-activity—aimless running, inco-ordination, incoherence, screaming and disorientation. In the latter type the reverse condition of stupor of greater or less

degree may occur. In this state it is difficult to gain the patient's attention and it may be impossible to elicit information. The patient may sit, or lie, about in an apathetic state and may be shaken with violent tremors. In such cases there may be a cataleptic state for a considerable time. In milder cases of this type, stupor is less profound, and the patient may carry out simple actions but in a slow and hesitating way. They present a dazed or confused appearance, are easily startled and take little notice of what is going on around them. The stupor may last from a few hours to several days and then pass off suddenly or gradually.

TREATMENT

The immediate treatment of patients exhibiting nervous symptoms due to fear, anxiety and other mental factors during and after air raids is extremely important as if they are neglected the morale of the population suffers seriously.

Such terms as "shell shock," which may suggest that these nervous symptoms have a physical basis, or are due directly to injury, must be rigidly avoided.

The following is an extract from the Emergency Medical Service Memorandum issued by the Ministry of Health dealing with the treatment of neuroses :—

"The first essential in the handling of these patients when they arrive at an aid post is to convince them that their symptoms indicate no serious injury and that they will soon disappear. This necessitates reassurance and the re-establishment of self-confidence combined with such methods as may lead to even temporary disappearance or abatement of the symptoms. This requires a firm and authoritative but sympathetic attitude on the part of the Medical Officers and their Assistants.

In patients who are simply frightened and in emotional cases reassurance combined with an appeal to personal and patriotic pride and a large dose of bromide will be usually sufficient. The patients should then be sent to their homes.

When confusion, excitement, loss of memory or disorientation are the chief symptoms, rest, warmth, hot drinks with plenty of sugar or a dose of bromide (gr. xx-xxx) or pheno-barbitone (gr. i) will be necessary. When patients are restless or excited, a hypodermic injection of morphia (gr. $\frac{1}{4}$) or preferably an intramuscular injection of sodium pheno-barbitone (gr. $1\frac{1}{2}$) combined with hyocine hydrobromide (gr. 1/100) may be required. The latter is provided in tablets which are easily soluble.

It may not be possible to retain these patients for long in aid posts and smaller medical establishments, but every effort should be made to return them to their homes if they improve sufficiently to do so with safety.

When hysterical symptoms predominate an attempt should be made at once to influence or remove them by suggestion, for instance

by showing the patient that a powerless limb is not paralysed or anæsthetic, or by making a speechless patient phonate by coughing and then utter a single sound as "Ah." Hysterical tremor can be usually arrested by making the patient relax his muscles.

It is of fundamental importance for Medical Officers to understand that as the incidence of neurosis is determined by psychological factors, the severity and duration of the disorder and its extension to other individuals depends in many cases on the treatment which it receives at the onset. If patients in whom such a step is not absolutely necessary are transferred to hospital, the conditions from which they are suffering may be accentuated or prolonged, and the extent of neurotic disorder in the population may be greatly increased.

Every effort must therefore be made after the preliminary treatment and whenever it is possible to do so to send such patients back to their own homes, under escort if necessary. It will, however, be necessary in many cases to provide for sending these cases home, and consequently the question of transport and escorts will have to be considered by those responsible for organising the aid posts. Such arrangements are not likely to be difficult where the patients reside in the area where the raid occurs, but in the case of patients occupied in the vicinity but living in the outer area some difficulty may be experienced, and therefore it is a contingency which should be borne in mind in advance. The services of some organisation which is arranging to send other patients to their homes from hospital might be made available, see Emergency Medical Service Memorandum No. 2, paragraph 29.

As it will rarely, if ever, be possible for a Specialist to visit an aid post it will be necessary for the Medical Officer to evacuate those whom it has not been found practicable to send home to a "Casualty" hospital.

Again, it cannot be hoped that there will even be a Specialist on the staff of every casualty hospital and therefore the Medical Officer of the aid post should ascertain which of the "Casualty" Hospitals nearest to his aid post is so provided. This will avoid unnecessary delay in getting the needs of the case decided. The desirability cannot be over-stressed however that in circumstances that may be expected in a future state of emergency every patient suffering from a neurosis unless the symptoms are so severe or prolonged as to make this course impossible, should be sent home. General practitioners should not send cases arising in their private work to first aid posts but direct to the special clinics which will be set up in connection with casualty and intermediate hospitals."

Printed under the authority of HIS MAJESTY'S STATIONERY OFFICE
by Percy Lund, Humphries & Co. Ltd.

(3930) Wt. 2173/—/P.S.3470. 1,000. 10/41. P.L.H. & Co. LTD. G.943.