

# THE NEUROSES OF WAR

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With certain qualifications it may be said that the neuroses of war are the neuroses of peace. Nervous disorders, so prevalent among soldiers in the last war, are again a prominent feature of the present conflict and thus attract special attention and study. A wide range of clinical conditions has been included in the term war neuroses. In the last war the very acute and dramatic neurotic patterns were called "shell shock." In the current war the more benign term "combat fatigue" has been applied to the manifestations which appear to be a direct result of war experience. Other terms such as exhaustion neurosis, concussion neurosis, fright neurosis, effort syndrome, and neurocirculatory asthenia have been found to be applicable, although some of them may be outright misnomers.

British psychiatrists, who have had an opportunity to study the problem of war neuroses at first hand over a long period of time in the course of World War II, recognize four general categories of neurotic illness in military personnel: (1) preexisting, peacetime neuroses which continue unchanged; (2) prewar neuroses which become markedly aggravated in wartime; (3) disorders of personality which are not serious handicaps or glaring defects in normal civilian life, but which are manifested in gross mental disturbance under the pressure of army routine; and (4) neuroses which occur as completely new phenomena in apparently well-adjusted individuals.

This classification makes it at once evident that the factor of predisposition is the basic element in three of the four groups, and it can be argued that 75 per cent of all the psychiatric breakdowns in military service will fall in those groups where a preexisting disposition to nervous disease furnishes the ground substance on which the war neurosis is nurtured.

The proper recognition and rejection of inductees with such a predisposition is the primary step in controlling the psychiatric casualties of war. These "martial misfits," if detected at the time of induction, fall into five general categories of handicap:

**1. Mental deficiency.** This defect is the cause of the elimination of the largest number of recruits and has received more consideration by examining boards in the present war than in the last. Experience with a large group of mentally retarded soldiers demonstrates not only low efficiency in general performance and slowness and stupidity in complying with clear instructions but also a low threshold to major psychoses.

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A psychosis is easily precipitated and is usually a primitive hysterical reaction with a display of infantile behavior, pseudostupor, or wild uncontrollable panic.

**2. Psychopathic personality.** Psychopathic emotional instability is detected through a study of social behavior. Poor adaptability, little perseverance, a tendency to evade responsibility, constant shifting from one job to another, long periods of unemployment, and an instinctive desire for excitement and shallow sensual pleasure are earmarks of personality weakness. Pressure is often brought to bear by families and friends to have the individual with a psychopathic personality inducted into military service because "the discipline will make a man of him." On the contrary, the psychopath cannot profit by experience or discipline. Punishment for infraction of rules and for disobedience of orders has no value and does little to modify or improve the behavior of the psychopathic personality. His troubles are deeply constitutional, and he is a grave liability to military authorities. Under stress his usual reactions are major hysterical outbursts, excessive alcoholism, and wandering fugues with prolonged amnesias, or intermittent episodes of ugly rebellion and sullen irritability. Projection of a sense of inadequacy upon others, with delusions of reference and persecution, is another potentiality.

**3. Gross mood disorders.** These reactions are not as common in the younger soldiers, but when manifested they constitute a grievous disability and usually portend a long period of mental illness. The underlying predisposition is indicated by periods of moodiness, depression, and apathy, or by episodes of increased animation and accelerated mental and motor output extending over periods of weeks or months. Persons with a history of prolonged mood swings (cyclothymia), and particularly with a family history of major moods of melancholia or mania, are likely to follow the same reaction pattern when subjected to the vicissitudes of military life. The response to stress is usually a trend toward depression and moroseness and a sudden impulsion to commit suicide and self-injury. This psychotic reaction is observed more frequently in older men, particularly those who have been uprooted from a rather stable and fixed life routine and whose vocations in civil life are remote from what they are compelled to do as a soldier.

**4. Psychoneuroses.** Whether psychoneuroses arise from faulty heredity, maladjustment to the problems of everyday living, subconscious repressions, or excessive anxiety, they constitute a psychosomatic weakness, which is readily exacerbated or is characterized by new features when the person is threatened with any transition from a semisheltered or fixed routine. The basic personality structure of the psychoneurotic

is characterized by self-centeredness, overconscientiousness, and a poor capacity to perform tasks in practical life. In general, he creates an immediate impression of being tender-minded, sensitive, and timorous with a tendency toward feminine disposition.

A somewhat distinct subgroup in the psychoneurotic category is made up of the phobic individuals who are subject to obsessive ruminative states. Those who have this so-called psychasthenic neurosis are persons who are basically overrefined, excessively meticulous, and who are propelled by unreasoning fears and various compulsive rituals. Fears of commotion, crowds, open spaces and closed spaces, and a tendency to become panic-stricken easily when any situation stimulates the particular phobia distinctly disqualify them for military service. A few individuals of this group have been reported as doing well as soldiers, but they are prone to breakdown on return to civil life.

Under stress the psychoneurotic pattern is usually an anxiety tension state or a conversion hysteria. Fatigue is usually an initial symptom followed by increased sweating, slight cyanosis of the extremities, tachycardia, and eventually a conversion into some physical stigmata, which temporarily eases acute intrapsychic conflict and unconsciously serves to remove the soldier from an intolerable situation into the relatively easy environment of a hospital or rest camp. The conversion symptoms usually persist as long as they subserve their unconsciously designated function of maintaining the individual in a protected and stressless setting.

**5. Prepsychotic states.** This classification includes a large group of miscellaneous personality defects which are quite difficult to detect unless a careful psychiatric survey is made. In this miscellaneous group the most noteworthy misfit is the so-called schizoid personality. An ordinary superficial examination will hardly suffice to detect the weakness in this personality structure. In a general way it is suspected when the interview or study discloses a person who is inclined to be shy, emotionally colorless, and definitely weak in gregarious instincts. A history of poor social development with an inclination toward solitary pursuits and, above all, a lack of interest in the opposite sex is strongly indicative of the schizoid personality.

This predisposition is emphasized because experience with inductees of this schizoid cast in the early phase of military training reveals a high index of breakdown with complete disorganization of personality. Recognition of the predisposition is emphasized because a relatively benignant and otherwise stable person develops a psychosis with a poor prognosis and a tendency to a pernicious deterioration. From this group emerges the psychotic soldier who usually requires prolonged hospitalization in a mental institution.

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Somewhat related to the schizoid personality is the young person who is oversensitive and incapable of working under authority and discipline. The diathesis to mental disease is manifested in ideas of suspicion and delusions of persecution. In short, the overproud and at the same time incompetent individual is predisposed to a paranoid type of psychosis. While it is difficult to recognize the ground substance from which these two psychiatric conditions develop, it is essential that early trends be detected and that the principle of rejection at the source be followed even when there is some doubt about such possibilities.

### TRUE WAR NEUROSES

War neurosis is now designated as "combat fatigue" or "combat neurosis." The term implies that a true war neurosis is a direct reaction to war experience and that there are few or no factors of predisposition in its inception. Immediate contributing factors may include fatigue, physical or mental exhaustion, exposure to bad weather, loss of sleep, and lack of food or water. Observations indicate that the incidence of nervous breakdown is greater in rapidly trained volunteers, in fresh troops arriving at the front, in battle-tested troops after prolonged, uninterrupted camp life, and in married men over 40 years of age. The incidence rises after harrowing military operations, especially in retreating or inactive troops. Forced passivity without means of escape or retaliation appears to impose such inhibitory stress as to precipitate the greatest avalanche of acute psychic symptoms.

While these symptoms are occasionally sudden in onset, usually they have prodromata. There is fatigue, increased indulgence in alcohol or tobacco, a tendency to seclusiveness and irritability, loss of interest, and short emotional crises. The crises make their first appearance or become amplified either during periods of lull in the environment or after a terrifying experience involving great privation, danger to life and limb, or violent physical overexertion.

There are two main objective features to this acute syndrome: (1) There may be a period of violent rage reaction, which is usually followed by (2) what is commonly termed a "sham shock" or "sham death" type of collapse. In the latter phase there is immobility, violent tremor, pallor, mutism, and general collapse.

In studying these acute neurotic manifestations one can almost observe the synthesis of the neurosis, and the principle of Pavlov's conditioning elements is strongly suggested. The entire pattern of reaction can be reproduced at any time by recreating any stimulus or fraction thereof which obtained at the time of the initial shock. This fractional stimulation will induce the reactions even though the patient is aware of its

relative insignificance. The slightest noise simulating artillery fire, a commotion outside of the hospital door suggesting the tramping of many feet, a sudden rush of high wind, the roar of an airplane motor, or any such dissociated stimulus will induce the entire syndrome over and over again.

Experiences in dreams provoke the same reaction, and therefore nightmares of a terrifying nature are a common sequence to the original experience. This fractional stimulation by minor and incidental experiences is commonly called the "alarm" or "startle" reaction.

If the neurosis has been acutely and recently synthesized or conditioned into being, it follows that early reconditioning offers a hope of recovery and improvement. On this basis the experiences in the Italian campaign have been very encouraging. The patient is quickly put to rest and treated symptomatically, but is maintained near the combat zone in a setting where the stimuli are still active so that he can be desensitized. It has been established, furthermore, that if a patient with such a neurosis is withdrawn to a distant rehabilitation area and protected by utter seclusion, reconditioning becomes progressively less possible, and the neurosis may become chronic. The number of those returned to duty is found to be in inverse ratio to the distance of the rehabilitation zone from the zone of combat.

Front line experience for the soldier is characterized by the exclusion of individuality, complete inhibition of natural instinctive fears, and complete absorption in and devotion to a common cause. Violent outbursts of a neurotic nature furnish an emotional outlet.

The prognosis of the neuroses of war, as of the neuroses of peace, depends on the age and intelligence of the soldier and on the duration and complexity of the nervous disorder. Early treatment is essential. Anxiety states offer a poorer prognosis than does hysteria or concussion exhaustion. Obsessional states, true to type, are most unfavorable.

Short periods of rest for those with prodromal symptoms often prevent a pernicious neurosis, and in military practice the aim should be to effect a quick removal of topical symptoms with less consideration for the basic disturbance. Most writers emphasize the necessity for a semi-military atmosphere and believe that new patients should be distributed amongst those who are improved or convalescent. Good food, rest suggestion, encouragement, and some form of remunerative work act as valuable incentives to recovery. Under hypnosis or in the waking state psychotherapy can be applied for the purpose of reviving the suppressed or repressed emotional incidents, thereby relieving the underlying situation of conflict.

However heroic, dramatic, or pragmatic the treatment may be, the necessity for an organized approach to the treatment of war neuroses is obvious. The task is indeed a colossal one, for the number of neurotic soldiers will be legion, and it is the duty of the medical profession to have available every device which will cure or palliate disability and reduce the postwar liabilities which a neurosis imposes upon the individual and upon the community.

## STATUS ASTHMATICUS ASSOCIATED WITH OTHER ALLERGIES

### *Report of a Case*

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Asthmatic symptoms may be divided into two types: (1) bronchial asthma, which usually responds to the routine measures for symptomatic relief, including ephedrine or epinephrine, and (2) status asthmaticus, the more severe form or shock type, which is characterized by extreme exhaustion and severe dyspnea bordering on collapse.

In the case reported severe status asthmaticus was recurrent and was complicated by sinus infections, drug allergy, and dermatitis medicamentosa due to neoarsphenamine. The case illustrates the complicated management of recurrent attacks of asthmatic bronchitis and episodes of status asthmaticus requiring heroic measures for the control of symptoms. On several occasions it was doubtful whether the patient would recover from the attacks of status asthmaticus.

### CASE REPORT

**History.** A housewife, aged 38, was first seen at the Clinic on March 18, 1940. In May and June for twenty years she had rose fever with sneezing and rhinorrhea. In 1939 her symptoms began in March during the tree hay fever season and were associated with wheezing. The following September she had several attacks of asthma, and a month later she began to have attacks of coughing and wheezing every night. Since the onset of the nocturnal attacks she had lost five pounds and had become irritable and nervous. During the winter months she had a chronic postnasal drip. She noted that damp weather made her symptoms worse.

Aspirin and phenacetin made her wheeze, and codeine was thought to cause trouble also. She suspected that ham, cabbage, and milk caused water brash and nausea. Chocolate and eggs were also incriminated. She took ephedrine by mouth to control her asthma. The only other drug used regularly was mineral oil for a mild constipation.

One sister had a history of hay fever.

**Physical Examination.** The physical examination revealed an asthenic and underweight person. Her chest was symmetrical; the lungs were normal to percussion,