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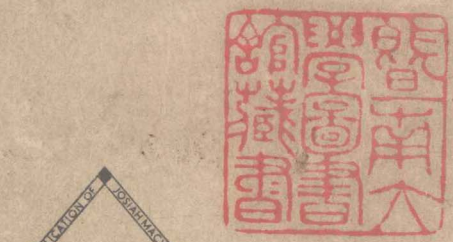
WAR NEUROSES IN NORTH AFRICA

THE TUNISIAN CAMPAIGN

(JANUARY-MAY 1943)



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FOREWORD

This preliminary report concerning the neuropsychiatric casualties encountered during the Tunisian Campaign was prepared by the authors under the stress and pressure of conditions in the theater of operations. It is reproduced with a minimum of editing in order to make the information available promptly to medical officers in all theaters.

It is believed that this document will become a milestone in psychiatric literature, not only because of its practical value in relation to the prevention and treatment of war neuroses, but also because of the richness of the case history material presented. The detailed accounts of rehabilitation of the personality under the authors' psychotherapeutic method, "narcosynthesis", are unique and of great interest from the practical and theoretical viewpoints.

We are grateful to the Josiah Macy, Jr. Foundation for making possible the reproduction and distribution of this important work.

David N. W. Grant

DAVID N. W. GRANT,
Brigadier General, USA,
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WAR NEUROSES IN NORTH AFRICA

The Tunisian Campaign*

by

Lt. Colonel Roy R. Grinker M.C. and Captain John P. Spiegel M.C.

Introduction

During World War I the incidence of neuropsychiatric casualties presented a serious problem, as well as a challenge, to the medical officers in the armed forces. During that period the erroneous implication in the term "shell shock" became recognized and the significance of psychological factors in the etiology of these cases was clearly established. Many observations made during that war and in the post-war period on chronic war neuroses contributed valuable data. Some of the earlier conclusions have been subject to re-interpreation as psychiatric and psychosomatic knowledge has progressed. Thus with the establishment of Selective Service

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*We are grateful to Col. Richard E. Elvins, surgeon of the Northwest African Air Forces, and to Lt. Col. Louis K. Pohl, surgeon of the Northwest African Air Service Command, for their cooperation in facilitating our work and its recording.

and with the entry of the United States into the present war, many psychiatrists were prepared with rational plans for selection, classification and rehabilitation. There was also considerable preparation for the understanding and therapy of war neuroses, yet actual experience with such cases in a theatre of operations disclosed that our clinical knowledge was meagre, our interpretations often erroneous and our therapy inadequate. The end of the Tunisian Campaign, like the intermission after the prologue of a play, has given us an opportunity to present what we have learned about acute war neuroses, so that those who arrive for later acts in the world tragedy may profit by our experience.

Scope and Material: We shall not discuss breakdowns at bases or camps which, although precipitated by the special conditions of army life, occur in predisposed persons and differ in no way from civilian neuroses. These cases are adequately considered in publications by psychiatrists in the zone of the interior. We shall discuss only the actual war neuroses. We cannot review the literature or cite the conclusions of other workers simply because the

necessary books and periodicals are not available.

Our experience and tentative conclusions are based on a study of psychiatric casualties which occurred during the fighting in Tunisia between January and May 1943. Among them were many who suffered from late or cumulative effects, originating during the invasion in November 1942. Many casualties developed from the severe tank and infantry battles in the mountain passes, notably at Kasserine, Kairouan and the hills before Mateur. Those occurring in the flying personnel of the Northwest African Air Forces were the product of the intense aerial warfare over Tunisia, Sicily, Sardinia and southern Italy. Some originated in non-combatant personnel subject to aerial bombardment at forward airfields. Patients were seen from all these groups after the hard fighting during retreat and in the easier period of victory; during periods when air support was weak and enemy aircraft strafed and dive-bombed unopposed, and when air coverage was adequate; during the phase of air inferiority and high air losses, and later during complete air superiority.

We were stationed at Algiers, 300 to 550 miles behind the ground front and 150 to 200 miles behind the active air bases. Therefore our patients, evacuated by air, arrived within two to five days after their breakdowns, having passed through casualty clearing stations and forward evacuation hospitals. Later casualties passed first through a British or an American general hospital to the east and those from the northern sector travelled by boat or train so that these were seen by us 7 to 10 days after the clinical onset. The facilities of a British general hospital were made available to us for work with pooled American and British patients, thanks to the splendid cooperation of Major C.R. Kenton, R.A.M.C., to whom we are greatly indebted. As neuropsychiatrists to the Air Forces and the Air Service Command and consultants to the R.A.F., we saw ambulatory members of these forces in office consultations. As members of the neuropsychiatric board, we were privileged to review cases of ground force and flying personnel with war neuroses in order to recommend appropriate disposition.

Classification: It has long been known that war neuroses do

not constitute a clinical entity with characteristic and invariable symptoms. Instead there is a wide variety of syndromes, the symptoms of which vary as greatly as the preceding personalities of the patients and fluctuate with time, with progression or regression of severity and with the distance of the patient from the zone of combat. A most pronounced characteristic of the cases seen early in their illness is the profusion with which new symptoms appear and disappear. As time goes on, without treatment, a more stabilized syndrome crystalizes. This tendency toward permutations and combinations of symptoms renders classification into types difficult and artificial, necessary only for purposes of description. In general, however, there exists a sufficient grouping of symptom complexes to permit separation of ten clinical syndromes which vary in accordance with the method by which anxiety is handled. This listing, it must be emphasized, is based on phenomenology and not psychopathology. Each variety represents a method by which the personality attempts to deal with overwhelming anxiety:

The army diagnostic classification, like all rigid systems, gives little elasticity for individual variation in degree or type of anxiety, for mixtures of clinical states and for unusual, atypical conditions. A large number of neurotics are passed through hospitals with diagnoses referable to systemic disease when they are actually suffering from psychosomatic disorders. Gastric dyspepsia and ulcer, chronic arthritis, various types of headaches and peculiar visual disturbances are among a host of diagnoses which mask the basic neurotic illness.

The diagnostic criteria of psychiatrists vary considerably. Severe regressive states are often labelled schizophrenia, anxiety states are called hysteria, and constitutional inadequacy covers a multitude of clinical entities. Paranoid trends are overemphasized as evidence of psychosis.

One is struck by the variation in types of cases at various hospitals within the chain of our evacuation system. Mere distance from the combat zone decreases the quantity of visible anxiety so that a patient group in a base hospital far to the rear

appears calm and composed. That the underlying process often remains unchanged is evidenced by the anxiety exposed by psychological probing and by interview with the patient under the influence of pentothal. On the other hand, patients far to the rear show more dependent attitudes, and depressionsare far more frequent. These reactions are easily understood since the soldier, now adjusted to living on his reduced resources, demands help and support from his environment at the same time as he suffers the torments of his conscience for having given up the struggle.

Thus, psychiatrists in various areas from Tunis to Casablanca have received different impressions of war neuroses which will be evidenced in their future accounts and publications. There will be all variations from severe confusional, stuporous amnesias in forward areas to the psychotic and chronic anxiety states at the port of embarkation. The identical patient may have several diagnoses as he runs the gamut of the hospital system. Therefore, psychiatric reports must be analysed according to the site from which they arise, and with recognition that variations of opinions among psychiatrists, their differences in viewpoint of therapy, are due less to idiosyncracies of the physicians than

to changes in the clinical status of the patients.

From all this we may conclude that statistics regarding neuropsychiatric disorders of war will have little significance. The percentage incidence, the proportion of various clinical syndromes, the frequency of predisposing causes and certainly the recovery rate will be set forth with such a high degree of inaccuracy as to make them of little value.

Clinical Syndromes

Free-floating Anxiety States. The development of anxiety on going into battle is an almost universal experience for the normal soldier. On innumerable occasions we have heard the statement: "The man who says he is not scared is lying. Everyone is afraid". One could anticipate that the most frequent neurotic syndrome is characterized by signs of overwhelming anxiety. In truth, the patient differs from his fellows, who have been able to remain in combat, principally by the quantity of anxiety which he experiences, the concomitant reduction in ego capacity, and the persistence of the anxiety and its effects long after removal from the

original stimuli. Since quantity is the distinguishing feature, these cases in whom anxiety is the most salient symptom, can be divided on practical ground into the severe and the mild types.

Severe anxiety states result in an intensely striking, unforgettable picture. Terror-stricken, mute, and tremulous, the patients closely resemble those suffering from an acute psychosis. In fact, such patients frequently return from the front with the diagnosis of schizophrenia on their emergency medical tags. There are coarse tremors of the extremities. The facial expression may be vacuous or fearful and apprehensive. Speech is usually impossible except for a few stuttering attempts to frame an occasional word; nevertheless, patients persist in attempting to communicate with attendants and some may be able to write although unable to talk. Sudden fits of crying or laughing may occur without reason. Behavior is extremely bizarre, and attitudinizing with apparently senseless gestures alternates with periods of excessive activity, characterized by running about the ward and leaping over beds.

Any sharp or sudden noise produces a marked startle reaction and increase in tremor: the patient jumps, trembles violently, and turns toward the source of the noise with an expression of fear on his face. This sudden increase in tremor and apprehension disappears within a few moments, but reappears in a mechanical, reflex fashion on the production of any innocuous but sudden sound, ranging from the loud banging of a door to the striking of a match. A sudden motion in the direction of the patient will elicit the same reaction. The patient is actually intolerant of any but the most gentle stimuli from his environment. Even when absolute quiet reigns, he may be seized with a spasm of momentary trembling, as if shaken by some unseen stimulus. Terror is the principal theme of the patient's behavior, and because of the severe disintegration of the entire personality, and the difficulty in communicating with what remains of that personality, no data can be obtained from the patient concerning his immediate or past history. He resembles a frightened inarticulate child, with only a few persistent "islands" of his past well organized behavior. He may be able to eat, to dress himself, to smoke cigarettes. If speech is attempted, the

name of a person, presumably a friend or relative, is usually profferred in a questioning, plaintive tone. Accompanying the terror, the mutism, and the bizarre behavior, there is a child-like appeal for help and support from his attendants. There are visible although brief responses to verbal reassurance in that the patient appears momentarily calmed; but this calm succumbs to any new stimulus, and the usual train of apprehensive behavior reappears. The following case histories are representative of this type of patient:

Case 1 : A 32 yr. old infantryman was involved in the severe fighting near Sedjenane in Northern Tunisia. Nothing was known of his past history beyond the fact that his company had been subjected to heavy mortar fire and dive-bombing while attempting to take a height strongly defended by the enemy. When brought into the hospital, he was unable to speak, and presented the typical picture of severe terror. He had a coarse, persistent tremor of hands and lips and started violently when any part of his body was touched. At times he seemed about to speak, but nothing came of it except inaudible whispers. He made no effort to get out of bed or to help himself in any way but lay in a flexed posture