VERTIGO.

Vertigo is another common symptom amongst soldiers, and apart from the few cases due to such organic lesions as disseminated sclerosis, cerebral neurosyphilis, etc., is usually "functional" in origin. The aetiology of the so-called Ménière's syndrome is uncertain, but in the few cases I have seen, all officers, there has always been a very definite neurotic tendency. Some of these cases of vertigo are extremely difficult to "place" and the true aetiology has been a matter of doubt.

The following case illustrates this difficulty:—

A corporal, formerly a musician, was first admitted to hospital for vertigo four years ago. Physical examination proved entirely negative, his Wassermann reaction was negative, and his ears were normal. He was discharged cured after a stay of eighty-seven days in hospital. Two years later he was again admitted for vertigo complicated by otitis externa; the vertigo appeared to respond to treatment to the affected ear and he was again discharged cured. He was admitted a third time in April (1931), complaining of sore throat, fever, vertigo, marked ataxia and Rombergism, and was again discharged to duty after thirteen days' treatment. He was readmitted in May for a recurrence of vertigo, ataxia, and headache. On this last occasion the only physical sign suggesting the possibility of organic disease was well-marked and sustained double ankle clonus; the plantar responses were flexor. He was unable to stand or walk with his eyes shut, falling immediately if made to do so; with his eyes open he was able, after a little time, to walk without a stick but with a markedly reeling and drunken type of gait.

The Wassermann reactions (blood and cerebrospinal fluid) have remained negative; there are no signs of cerebellar disease (beyond the ataxia), and his discs are normal; the ears have been examined by an aurist and hearing is 100 per cent. On this last occasion, three months after admission, there has been no improvement.

In view of the frequent remissions and the definitely organic type of ankle clonus, disseminated sclerosis is, I presume, the most likely diagnosis, but I have never been able to rid myself of the idea that the whole condition may be functional in origin.

Many consider vertigo to be a vasoneurosis closely allied to epilepsy, and
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in certain cases inseparable from *petit mal*. Especially is this the case with those transient attacks labelled “faints.”

Of one thing we can be certain, namely, that the common “fainting attack” of the young soldier has nothing whatever to do with the heart, a common superstition which it is difficult to eradicate even from the minds of medical men.

**D.A.H. and Dyspepsia.**

Amongst the minor neuroses D.A.H. and dyspepsia play an important part in military medical practice.

Apart from a trifling percentage of cases due to organic disease, both the above are well-recognized symptoms of anxiety, neurotic states or neurasthenia, and they frequently occur together or alternate in the same patient.

D.A.H. is, as we know, seen in its most typical form as the cardinal symptom of the condition described by Lewis as the “Effort Syndrome,” or “Soldier’s Heart.” In these cases the heart is not primarily at fault but rather its nervous control, and the tachycardia, arrhythmia, etc., form only one group of symptoms in a condition of general nervous instability.

These patients do not improve, in fact their condition deteriorates, as a result of a long stay in bed, they are apt, too, to become rapidly hospitalized. Return to duty, or invaliding is the usual alternative.

I have learned, as a result of experience, to treat these patients as somewhat of a luxury in a ward, and like most luxuries, they can be done without. In fact, D.A.H. is a diagnosis I seldom make nowadays. In some cases a little mild psychotherapy works wonders, but on the whole they are an intractable class. In certain cases in whom unhealthy tonsils have been present, tonsillectomy has appeared greatly to improve the condition.

Some cases are undoubtedly examples of mild hyperthyroidism, a common military disease.

One should never forget to remember the possibility of pulmonary tuberculosis as a possible cause of tachycardia.

All the functional arrhythmias, extra systoles, simple tachycardia, sinus arrhythmia, paroxysmal tachycardia, etc., tend to become aggravated by residence in a hill station, while cases of organic heart disease are, as a rule, but little influenced by moderate altitude. The reason for this is partly explained by the monotony of life, especially for “other ranks,” in these hill stations.

Many cases of dyspepsia (so-called nervous dyspepsia), probably a high percentage, are also functional in origin. There is one intractable form of indigestion simulating gastric ulcer, which I have found to be especially common amongst regimental bandsmen, and which for some years I have called “bandsman’s stomach.”

These cases of bandsman’s stomach are extremely intractable, they are not improved by, or may even grow worse under, any of the strict gastric
ulcer régimes in vogue. They often vomit several times a day and give a history of having done so for years without any notable loss of flesh; although they are apt to be thin and of poor physique, they often suffer from marked hypochlorhydria or complete achylia, and they have a way of making a sudden and miraculous recovery when tired of hospital restrictions or when the subject of possible sick leave is broached.

This particular form of dyspepsia is as much a perquisite of the bandsman—it does not appear to matter what instrument he plays—although not of course entirely confined to him, as is duodenal ulcer (so-called serjeant’s stomach) a commonplace amongst the more senior non-commissioned ranks.

Apart from the above-mentioned variety of nervous dyspepsia, I have found complete or almost complete achlorhydria much more common in this country (India) than the four per cent commonly accepted as the normal proportion for this condition.

It is difficult to say if this achlorhydria is due to an actual gastritis or is simply a symptom of neurasthenia; in a large number of cases it is undoubtedly the latter.

FUNCTIONAL ALBUMINURIA.

Albuminuria which occurs as a transitory and inconstant phenomenon in many young soldiers without demonstrable renal or cardiac disease is often regarded as a functional disorder; probably also the alimentary glycosuria, which is apt to occur in somewhat older subjects, who over-eat and over-drink and lead sedentary lives, belongs to the same category. One must be careful, of course, to exclude the glycosuria associated with hyperthyroidism, also not uncommon in young soldiers.

Functional albuminuria is common in young soldiers, and is said to occur from time to time in from five to ten per cent of normal individuals. In many cases this albuminuria coincides with a heavy deposit of crystals in the urine, when it may be accompanied by transitory hæmaturia; both albuminuria and hæmaturia may be due to the mechanical irritation of the kidney substance by the sharp edges and points of these crystals.

ENURESIS.

Enuresis is another common Army complaint, especially in recruits during their probationary period at the depots, and in most cases is of course due to an underlying neurosis.

While I was at the Royal Herbert Hospital, Woolwich, a very complete set of tests was performed on these young subjects of enuresis, a special ward being set aside for their accommodation, to find out if any physical basis for the condition could be found.

The capacity of the bladder was measured; the urinary tract was
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carefully passed under review; and the sacral region was X-rayed for possible congenital abnormalities in the shape of spina-bifida.

These tests were on the whole negative; in a certain number a mild degree of spina-bifida occulta was found, but as this anomaly appears to be common in normal individuals little importance could be attached to its presence in these cases. In most cases the condition cleared up when the recruit became more in harmony with his surroundings.

One case of so-called enuresis had a tragic ending and warns us of the urgent necessity for care in diagnosing these functional conditions.

I was called to see a young soldier in the "enuresis" ward who had suddenly started intractable vomiting and was complaining of blurred vision. There was no history of previous kidney trouble but there was a previous admission for enuresis, during the course of which he was noted to have slight albuminuria, thought to be of functional origin.

On examination he was found to have a systolic blood-pressure of 250 millimetres of Hg, and there was well marked albuminuric retinitis. His urine contained albumin in quantity; his blood-urea was in the neighbourhood of 200 milligrammes per 100 cubic centimetres.

He died a few days later, and autopsy revealed far advanced congenital cystic disease of both kidneys. In this unfortunate case the frequency of chronic interstitial nephritis had been mistaken for enuresis; an excusable if tragic mistake.

ENDOCRINE DISORDERS.

Many cases of tachycardia are associated with (not necessarily caused by) mild hyperthyroidism; both of which conditions may be due to an underlying anxiety neurosis or other disorder of the functional group.

Cases of hyperthyroidism and mild Graves' disease are especially common in this country (India). There is one class of individual (she rarely becomes a patient until the disease is far advanced), a certain type of officer's wife, peculiar, in my experience, to India. Anyone acquainted with "Station" life in this country must know the type of woman to whom I refer. As a class they are unstable to a degree; uncontrolled and uncontrollable; a perfect pest to those in authority; and often a constant source of anxiety to their long-suffering husbands.

It is a curious but notable fact that many of these women suffer from quite noticeable thyroid enlargement and exophthalmos.

One particular case, an officer's wife, and a remarkably perfect example of the above-mentioned category, sought my advice for palpitations and breathlessness. I found the poor woman to be suffering from advanced Graves' disease with marked auricular fibrillation, from the effects of which she has since died.

Whether we are dealing with a primary condition of hyperthyroidism with the neurosis as a secondary phenomenon, or vice versa, must for the present remain unanswered.
Neurasthenia.

Neurasthenia, in my experience, is common amongst all ranks and at all ages.

Most military medical writers agree that it is especially common amongst the officer class, and in their case is apt to be intractable and often complicated by psychasthenic symptoms. The relatively high proportion of neurasthenics amongst officer patients was also noted during the late war.

Neurasthenia is also common amongst clerks and other sedentary workers, especially when they approach the "idle forties."

The symptoms are much the same as are met with in civil practice, having regard to the age-period and station of life from which most of our patients are drawn.

Alcohol and syphilis in these days of an almost "dry" and moral Army are not common as causative factors and the Wassermann reaction is rarely positive; unlike the Navy in this respect, in which Service, according to Surgeon Rear-Admiral Meagher, twenty-five per cent of neurasthenics are early sufferers from general paralysis.

Amongst a host of symptoms, headache, irritability, lack of concentration, loss of interest in work and play, and sleeplessness have been especially common in my series.

Reynolds [10] has thus succinctly described the headache of neurasthenia: "Headache is exceedingly common and is constant when it occurs; it may be a feeling of weight on the vertex with dragging pains up the back of the neck, sometimes coming forward to the root of the nose or round to the temples, or is like a tight band round the head, or a tight skull-cap; sometimes the skull is very irritable, at others the pain is across the brows and behind the eyes. Sometimes the pain is as if inside the brain, which is described as 'stirred up' or 'screwed up,' as if something were moving in it; or at other times as if the head felt empty."

According to the same writer, hyperesthesia of the alimentary tract, including soreness of the tongue without demonstrable lesion, is the cause of a host of symptoms from which neurasthenics suffer.

This soreness of the tongue is an important symptom in a country such as India, where sprue is common. Cases of sprue often exhibit neurasthenic symptoms. On the other hand, many neurasthenics with painful hyperesthetic tongues are, I am convinced, wrongly treated, and for prolonged periods, as cases of sprue.

"The neurasthenic is conscious" writes Tanzi [11] "of his breathing, digesting, walking, and thinking. His organic sensations, which should occupy the last place in his consciousness, spring at once to the front. By a sort of unfortunate clairvoyance, visceral functions, the work of which should be done with indifference if not actually unconsciously, become painfully conspicuous."

This attitude of mind leads to an undue solicitude in the normal
working of the various bodily functions and breeds a state of anxiety, an
anxiety neurosis, in fact; but this is very far from being the same thing as
true hypochondria, in which the patient is not apprehensive lest he be
suffering from some serious organic disease, because he is convinced of it,
and no one can shake that conviction.

Hypochondria is, when firmly seated, a most intractable disease, and it
has been suggested that, in view of the fixed delusional content of its main
symptom and lack of response to all forms of treatment, psychotherapy
included, it should be classed amongst the major psychoses rather than
the psychoneuroses.

Asthma, angio-neurotic oedema, urticaria, and the other so-called vaso­
neuroses, were at one time classed together as neurasthenic symptoms.
Modern writers, however, are leaning more and more to the theory that
some biochemical change, a metabolic dyscrasia, is responsible for many of
these disorders, although there is undoubtedly a background of neurosis to
most of them.

That many of the angio-neuroses may belong to the order of "conditioned reflexes," is an attractive hypothesis.

The diagnosis of neurasthenia is often a matter of considerable difficulty
and only arrived at by a process of exclusion.

Oppenheim [12] mentions the following objective symptoms as of some
diagnostic value, but is careful to state that one must not expect all of
them or even the greater part to be present in every case.

(1) Exaggeration of tendon reflexes.

(2) Exaggeration of the mechanical excitability of muscles (and less
often of the nerves).

(3) Abnormal excitability of the cardiac nervous system, palpitations,
and other objective symptoms of cardiac neurasthenia. (This, of course,
includes the effort "syndrome.")

(4) Vasomotor, secretory, and trophic disorders, and spastic and atonic
conditions in the organs with non-striped muscles.

(5) Disorders of metabolism (alimentary glycosuria, etc.).

(6) Tremor, rapid and fibrillar.

Special difficulty may be encountered in the differential diagnosis of
neurasthenia from the early psychoses, such as early dementia praecox or
manic-depressive insanity. This difficulty should be overcome, however,
if we remember that "even if he suffers from imperative ideas, the
neurasthenic is never a sufferer from mental disease, because his conscious­
ness remains unclouded and his personality intact" (Tanzi). This
distinction is, I must admit, easier to transmit to paper than to observe
when confronted with a case.

Farquhar Buzzard [13] apparently looks somewhat askance at neurasthenia as a clinical entity and classes most cases of nervous exhaustion
sent to him as suffering either from anxiety neurosis or from manic­
depressive psychosis. The distinction between these two is important,
for, as he points out, manic-depressives are apt to end their troubles by committing suicide.

During the war two types of nervous exhaustion were met with, each requiring its own treatment:—

(1) Simple Exhaustion.—In these cases there were rarely any psychic changes, nor was the patient neurasthenic in the ordinary meaning of the term; he was a more or less normal individual suffering from extreme physical and nervous exhaustion, the result of sleepless nights and harrowing experiences. Recovery usually took place in a few days amongst quiet surroundings, and no special treatment, physical or psychical, was required.

(2) Neurasthenia proper.—Usually accompanied by well-marked anxiety and psychasthenic symptoms; these were amongst the most intractable examples of psychoneurosis met with, and a relatively high proportion were invalided. It is an interesting fact that out of one large series of neurasthenics collected during the war, sixty per cent. suffered from some degree of exophthalmos.

In addition to its legitimate use as denoting a definite and well recognized disease entity, neurasthenia is also used, I regret to say, by many of us, as a convenient label for many of those border-line cases of mental disability, which, in our Sister Service, the R.A.F., are more correctly designated under such headings as anxiety neurosis, psychoneurosis, psychasthenia. This latter term is, for some reason, placed in the mental disease group in the Official Nomenclature, and cases thus diagnosed must be certified.

Most of us are loath to label a case insane unless we are moderately certain that his conduct, behaviour, and mental outlook on life are sufficiently asocial to justify such a course and that he would be a danger to himself or to others if no such precautions were taken.

I have discussed this matter with a mental specialist (military) of many years’ standing, and he is frankly in favour of “playing for safety” and certifying all doubtful cases. He argues very rightly that certification in the Army is by no means the same thing as certification in civil life, and that no stigma of insanity attaches to the patient, who has been certified by us, on his final discharge. Be that as it may, I am not convinced that “no stigma” attaches to the patient thus certified; and, in any case, the knowledge that he has been at one time considered temporarily insane and certified as such, can do no good to a man suffering from severe anxiety neurosis, for example.

For this reason the diagnosis of neurasthenia is probably justified in many of these border-line cases until such time as the Official Nomenclature is revised and its scope in respect of the psychoneurotic group widened.

The Convulsive Group.

“Fits,” like the poor, are always with us, and constitute one of the bugbears of the conscientious medical officer in charge of wards.
The fact that a man has had a fit is easily determined, although one often has to draw one's evidence from the garbled and highly coloured accounts of his room mates; to ascertain the nature and etiology of the attack is quite another matter, and frequently impossible.

It is a curious and noteworthy fact that no matter how many fits a man may have prior to admission, during his period of observation in hospital, which may run into many months, he is frequently entirely free from them; he is returned to his unit after a period of observation diagnosed N.A.D., only to have another fit on the doorstep of the barrack room as he enters it, much to the secret joy of the regimental officers, who are apt to adopt the "I told you so" attitude, and straightway drive another mental nail into the wretched medical officer's coffin.

The reason for this is not far to seek. Probably some eighty to ninety per cent of all fits in soldiers are either hysterical or psychogenic in origin. The psychogenic individual "throws" a fit—genuine though it may be, epileptiform in character—to escape from the realities of an unpleasant situation, to wit, the discipline and irksomeness of barrack life, possibly with an unsympathetic N.C.O. thrown in. On admission to hospital, under the care of a sympathetic Sister, with little discipline, and far removed from the hated N.C.O., there is no further need for the fits and they stop, only to recur when he is returned to his former environmental difficulties.

This is not to say that these psychogenic fits are purely hysterical, although they are obviously psychogenic or functional in origin; the patient may lose consciousness, bite his tongue, strike his head, urinate, etc., during the course of the fit and yet not belong to the category of so-called essential or idiopathic epilepsy.

Kennedy [14] has recognized the importance of these psychogenic seizures when he writes: "It must be remembered, however, that during their first experience of a hot climate, if subjected to physical or mental stress and especially in association with over-indulgence in alcohol, young adults may exhibit fits of an epileptiform character (indistinguishable from true epilepsy) which never recur on return to this country (England). The disposal of such cases in which the diagnosis of epilepsy is open to doubt, is a matter requiring much consideration, and, for the reasons I have stated above, the diagnosis may be changed to hysteria and the man retained in the Service."

Although I am in full agreement with the main trend of Colonel Kennedy's argument, I do not consider that these psychogenic convulsive attacks should be classed as hysterical. Such symptoms as true loss of consciousness, fixed dilated pupils, tongue biting, incontinence, etc., clearly belong to the category known as "organic"; and, although one must admit that the former barriers raised between "organic" and "functional" are largely artificial, I would prefer to use some term other than hysteria to cover these psychogenic convulsive attacks, leaving the term hysteria to designate the purely hysterical seizure, characterized by much struggling,
pantomime, etc., and essentially unaccompanied by such phenomena as true loss of consciousness and fixed insensitive pupils.

Psychasthenia is probably a more apt diagnosis for the condition underlying these epileptiform attacks, but is objectionable in the present state of the Official Nomenclature which, as stated above, places psychasthenia amongst the mental diseases, which it is not.

Aldren Turner [15] has also accepted the theory of a purely psychogenic origin for some of these epileptiform attacks when he states: "To his mind there could be no doubt about the existence of a group (of epileptiform attacks) having a psychogenic origin. It was well known that emotional shock might lead to attacks in no way different from those of the so-called genuine epilepsy, and it had been contended that the psychogenic origin of a seizure should not be ignored because in the fit the patient had bitten his tongue or been incontinent."

The diagnosis between a hysterical and an epileptic convulsive attack may be very difficult and even impossible. It is open to doubt, in fact, if there is any essential difference between the two.

There are fits, we have all seen them, characterized by much pantomime, struggling, gesticulation, etc.; the eyes are usually kept tightly closed; there is often a squint due to spasm of one or other of the ocular muscles; and the pupils may be contracted or dilated, but react to light; the seizure may be followed by typical segmental anaesthesia of the stocking and glove or the unilateral variety. Fits or "struggling attacks" of this nature are of course easy to diagnose and constitute la grande hystérie of Charcot.

On the other hand, we have the habitual epileptic with his greasy skin, slow cerebration, etc., in whom the attacks recur at moderately regular intervals and often at night, and which are only to a very moderate degree influenced by external factors.¹

In these attacks, the fit follows the classic sequence of aura, tonic followed by clonic spasms with unconsciousness, and often followed by post-epileptic phenomena.

This type of fully fledged epileptic seizure, the classic major attack, is relatively uncommon in the Army. The so-called incomplete epileptic attack, or one or other of the epileptic equivalents—the latter a dangerous and a sinister group, the full range and significance of which are as yet not fully appreciated being more common.

Between these two classic extremes, la grande hystérie of Charcot and the major epileptic seizure, there is a vast hinterland of incomplete seizures of doubtful aetiology: hystero-epilepsy; psychogenetic; epileptiform; call them what you will.

In this middle stratum lie the majority of fits so common in (or rather, out of) our wards.

¹It has been noted by those in charge of epileptic colonies that even amongst confirmed epileptics emotional and mental factors play an important part in the causation of the individual fits.
As suggested above, the majority of the victims of these attacks are individuals cursed by some inherent instability of character, who have been unable to make the necessary mental adjustment to their new environment.

If the environment can be so altered as to be more in sympathy with their outlook, and if the external or exogenous factors play a more important part in their causation than do the endogenous or personal factors of inherent defect of character, they may be cured by the removal of the unpleasant situation or experience, whatever it may be; or possibly taught to overcome it and thus rise superior to their environment instead of being dominated by it; on the other hand, if the personal factor looms large, especially if there is a bad heredity, the prognosis is so much the worse.

These psychogenic fits are apt to occur in infantry soldiers who have been detailed for transport duties which entail being in charge of mules or horses (which, on interrogation, it is found they are frightened of or unable to manage); or in cavalry or gunner recruits during their early riding-school days. In these cases the fits may often be brought to an abrupt end by transferring the transport driver to his former "foot-slogging" duties, or the cavalry recruit to an unmounted branch of the Service. A better method, of course, is to explain quietly to a patient the reason for his seizures, and to encourage him to overcome his repugnance for this, to him unpleasant, duty.

It is, of course, with something of the same idea that the pilot of an aeroplane, who has just crashed, is made to make another ascent forthwith to prevent the formation of a "phobia" for piloting aeroplanes; in other words, to prevent him from "losing his nerve."

Mention has been made already of the difficult and dangerous category of the epileptic equivalent. From a medico-legal standpoint we are here on debatable ground, and a diminishing few still deny their occurrence, and refuse to accept this plea as an excuse for crime, even if the individual is an epileptic and the crime has been shown to have been unpunmeditated and committed for no apparent reason. Most neurologists and alienists agree, however, that certain of the unpunmeditated crimes of violence, especially those with a grossly sexual basis, that figure so prominently in our newspapers of to-day, may be the result of epilepsy in one of its protean forms.

For the same reason, it is possible that certain of those individuals who, from time to time, are brought into our mental wards under guard, for observation as to the state of their minds, having committed some such crime as striking an officer or N.C.O., or committed a sexual assault, may be similarly afflicted. It behoves us, therefore, in all such cases, to make a careful inquiry as to a past history of fits or of fainting attacks (petit mal).

Unfortunately, the victims of this, as of other forms of epilepsy, are as a general rule perfectly normal between the attacks and may be, and often
are, discharged, with some such diagnosis as N.A.D., only to commit some more serious crime when once their liberty has been regained.

If only for this reason it is always advisable to have the "backing" of a second opinion (even if a Board be thought unnecessary), before discharging a case who had been admitted for observation on account of some peculiarity of conduct or behaviour.

**Border-Line Cases.**

The more aggravated types of psychoneurosis, the severe anxiety and compulsory neuroses, phobias, hypochondria, etc., as well as, of course, the definite psychoses, come more under the purview of the mental than of the medical specialist.

There is one form of psychosis which appears to be prevalent in our Army, and partly accounts for the high recovery rate from mental disease, namely, the so-called psychogenetic psychoses.

These cases constitute the mental equivalent, so to speak, of psychogenic epilepsy, a reference to which has already been made.

This psychosis, an eminently curable, or rather recoverable, condition in most cases, is apt to occur in individuals of marked mental instability who are suddenly confronted by overwhelming environmental difficulties to which they temporarily succumb, their downfall being exteriorized as a psychosis of a temporary nature, recovery taking place when the environment is changed, or, more rarely, when and if they can be made to overcome the difficulty without change of environment.

Major Webster [16], in an interesting article calls attention to the frequent occurrence of this form of psychosis in the Army and stresses the good prognosis in a high percentage of cases. He describes the salient features of a simple case in this group as follows:

(1) The reaction of the patient to life is, in a general way, normal before the onset of the psychosis.

(2) The illness is directly the result of a difficult or disagreeable situation.

(3) The delusional content, if any, is related to the experience which caused it.

Most of us can, on reflection, I think, recall cases, puzzling at the time, which fulfil the above diagnostic criteria, and which, contrary to our expectation based on textbook accounts, have completely recovered.

The differential diagnosis between these psychogenic psychoses and dementia praecox may be extremely difficult and depends more on the lasting nature of the delusional content in the latter—especially if the delusions persist after removal of the patient from the surroundings or individuals which precipitated the psychosis—than on any essential difference between the symptoms of the two conditions. A bad family history naturally, and I think rightly, prejudices one in favour of the more serious condition.

To make the diagnosis even more difficult it must be remembered that
long remissions are by no means uncommon in dementia praecox during which it requires an expert alienist (or a member of his family in close daily contact with the patient) to recognize that there is anything mentally wrong with him.

In spite of the essential curability of many of these psychogenetic cases if removed from the provoking environment, Major Webster considers that they should be treated as temporarily insane—as indeed they are—and be invalided.

Regulations of course also demand this course, as no soldier is allowed to continue to serve if he has once shown signs of mental disease, even if he be completely cured.

There is one form of temporary psychosis which should, and in my practice does, form an exception to the above hard-and-fast rule—namely, the exhaustion of toxic psychoses, usually of confusional type, with little or no fixed delusional content. Examples of the toxic psychoses are not uncommon in India and are especially liable to follow prolonged fevers of the typhoid group. In my experience, the prognosis is uniformly good in these cases with no tendency to relapse, and they should not be invalided, except for a period of convalescence in England.

In spite of statements to the contrary malaria is not, in my experience, a cause of psychotic disease.

There is one possible exception to the generalization concerning the rarity of true and persistent mental disease in the Army. Sir Farquhar Buzzard has pointed out that manic-depressive psychosis is far more common than is generally believed.

A large number of chronic and incurable alcoholics are, he states, manic-depressives, and are alcoholics because they are manic-depressives; he also mentions the important practical fact that most cases of suicide occur amongst the manic-depressive class.

This form of psychosis, a somewhat elusive one in the early stages with no very definite or characteristic symptoms, is apt to escape our notice if we are not on the look out for it; and partly for this reason is probably not commonly diagnosed in military practice, at least not before the case comes under the care of a mental specialist.

In view, therefore, of the likelihood of these patients ending their own lives—the only suggestive symptom being a state of mild depression—it behoves us to be specially careful in our disposal of these depressed patients.

Those individuals that have been sent into hospital, often under arrest, for observation on account of some peculiarity of conduct, or, as often happens, after some act of violence to a N.C.O., or for having beaten a native, are amongst the most difficult class of case to deal with. Their symptoms, if there be any on admission, usually clear up in a few days, and their disposal becomes a matter of difficulty and of anxiety.

My only comment is: Do not be rushed into a hasty and ill-considered
diagnosis, and an equally rash disposal of the case, by the importunity of
the man's regimental officers. In most cases it is advisable to await the
decision of the Medical Board which by regulations is bound to sit on all
such cases after a month's observation in hospital. We are lucky, of
course, if we have the services of a mental specialist at our disposal.

If, however, there is clearly nothing wrong with the man beyond the
fact that the unit wish to rid themselves of an inefficient soldier and are
attempting to do so by the comparatively easy method—to them—of a
Medical Board—the man should be returned to his unit with the suggestion
that he be got rid of under regimental arrangements if this be considered
advisable in the interests of the Service.

A few cases of general paralysis are admitted to the mental wards each
year, but this is a relatively rare diagnosis, and the Wassermann
reaction—which should of course be taken in all cases showing mental
symptoms—is consistently negative.

In this respect it must be pointed out that the presence of a positive
Wassermann reaction in a patient showing symptoms of mental
disability, does not necessarily mean that he is suffering from G.P.I.
Syphilitic neurasthenia is a very real disease and is often accompanied by
psychasthenic symptoms, especially of a hypochondriacal nature.

TREATMENT.

With regard to the treatment of the various psychoneurotics with their
kaleidoscopic ailments who help to fill our wards, I am unable to make any
authoritative or even very helpful statement.

In common with the majority of my medical colleagues of the older
school, I have had little or no training in psychological methods of treat-
ment, which were a trifle démodé when I was a student. In this respect,
I would suggest, therefore, that medical specialists, at least, receive a
grounding in psychotherapy (not necessarily in psycho-analysis, which has
yet to prove its worth). Without this equipment one is sadly handicapped
in dealing with this large and ever-increasing body of psychogenic disorders.
Personally, I greatly feel the need of such expert knowledge.

It would appear that there are four main lines of psychotherapeutic
attack:—

(1) Suggestion or Persuasion.—A method popularized by the French
school and particularly successful in the treatment of the conversion
neuroses (hysteria). This method has been further modernized by the
"Coué" school of auto-suggestion.

(2) Abreaction, by which the patient is encouraged to "let out" the
underlying emotion.

(3) Re-education.—The patient is encouraged to re-direct his energy
from the more primitive to the more civilized form of reaction.

(4) Psycho-analysis.—The patient is encouraged to delve down into
the recesses of his forgotten or subconscious childish memories for the
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"psychic (sexual) trauma" underlying his present neurosis. Freud, the originator of the system, and his two former collaborators Jung and Adler, have each developed their own schools of psycho-analytical technique.1

All the above methods were exploited during the late war in the treatment of the war neuroses; and in evidence before the Government Shell Shock Committee witnesses expressed no very decided opinion as to which was the best; most witnesses were agreed, however, that anything like full psycho-analysis was too involved and laborious a proceeding for military war-time practice.

Whilst all the above lines of psychological treatment have their uses—in the hands of those with the necessary psychological equipment—in the treatment of specially selected cases, that of suggestion or persuasion is most generally useful and requires less specialized knowledge on the part of the operator. Psycho-analysis is time-absorbing and requires a special technique and mental equipment not possessed by many of us.

Re-educational methods have also claimed many successes when properly applied.

CONCLUSIONS.

In conclusion, some explanation is due for having included in my review certain conditions which might appear to lie outside the scope of the functional nervous disorders.

My excuse must be that the term "functional" as applied to a disease group is difficult to define, and probably, for the reasons given above, undefinable.

My endeavour has been to include only those conditions which are generally considered to be "psychic" rather than "physical" in origin; although there is still a body of expert opinion that considers that physical factors play an important part in their causation and perpetuation.

When it is realized that probably fifty per cent of our patients are to some extent psychoneurotic, and that nearly a hundred per cent suffer from some degree of anxiety neurosis in addition to their more tangible ailments, the importance of the group must be admitted.

Finally, I would call attention to the marked divergences of opinion (often amounting to flat contradiction) expressed as to the etiology, diagnosis, nomenclature and treatment of the whole group of psychoneuroses by the leading neurologists and psychiatrists the whole world over.

While this is a healthy sign showing universal interest in the subject with its promise of progress, and shows that many active minds are intensively engaged on the many problems provided, it may truly be said that the whole subject is in a state of fluidity, and finality is very far from being reached.

1 Strictly speaking Freud is the only one of the three who makes use of psycho-analysis; the methods used by Jung and Adler being psychological but not psycho-analytical.
Under such conditions it is difficult for the medical "man in the street" to know what lead to follow.

"Mediis tranquillus in undis" should, I think, be our motto, and we should endeavour to steer a safe and middle course between all the conflicting doctrines, taking care not to be unduly influenced by extremists on either side, until such time as the true worth of one or other of them has been fully proved, not only to the satisfaction of the doctrines, but to our own satisfaction as well.

There is one further point I would stress in conclusion. It is a notable fact that certain diseases are disproportionately prevalent in certain units—I could quote many instances—and usually a reason for this can be found; it is equally true that certain units furnish an undue proportion of psychoneurotics and border-line cases; and again there is usually a reason for this if we can only find it.

Disharmonies in regimental domestic life are just as prone to produce—or more accurately, provoke—a neurosis as are similar conditions in family life.

REFERENCES.


[2] Text Book of Nervous Diseases, Oppenheim. (Translated by Alex. Bruce.)


[4] Text Book of Mental Diseases, Tanzi. (Translated by W. Ford Robertson, M.D., C.M.)


[16] See Ref. 7.