THE IMPORTANCE OF FAILURE OF CONCENTRATION IN THE ACUTE WAR NEUROSIS SYNDROME.

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The term acute war neurosis was applied by Sargant and Slater (1940) to a definite syndrome occurring in a number of men shortly after the evacuation of Dunkirk and consisting of the symptoms of an anxiety attack—apprehension, insomnia, terrifying dreams and a feeling of inner unrest with possibly additional hysterical features, together with those of physical exhaustion—pallor, tension or alternatively apathy of expression and a coarse tremor.

This syndrome was regarded as distinct enough to warrant description under a separate heading; it was stated by these authors to differ from any seen previously by them in peace and war although, as they imply by calling it "acute shell shock," it probably existed in the last war (1914–18). In fact a description of a similar condition after Zeppelin raids by Smith may be consulted (1916); insomnia, nightmares, apprehension and exhaustion were present and it may be noted that in some cases there resulted psychoses which needed certification. Others complained of "feeling dazed," "in a muddle" or "quite unable to do housework."

Moreover this syndrome appears very similar to conditions described by numerous witnesses whose evidence was given to the War Office Committee of Inquiry on Shell Shock. In their report (1922) cases were classed as (i) commotional, rare and actually due to exposure to blast, with or without cerebral concussion, and (ii) emotional, frequent, and due to numerous physical and, more important, mental factors, and occurring at times without any exposure to shells. It was admitted that a mild degree of commotional shock might be accompanied by emotional.

More recently Mira (1939) in a study of the War of the Spanish Intervention noted similar cases and also a more malignant type which he named psychorrhexis; and Ross (1941) and Bennet (1941) listed headache, failure of concentration, forgetfulness, insomnia and dreams.

FAILURE OF CONCENTRATION.

This symptom, it may be noted, was not mentioned specifically by Sargant and Slater and only by implication by Smith. Among the cases quoted to the War Office Inquiry it was observed that "mental inertia" was one of the symptoms in commotional states; the picture, on the other hand, of the emotional type was one of anxiety or terror and it is of course obvious that in such cases there would be inability to concentrate. Nevertheless it may be remarked that it was again not specifically mentioned by more than a few witnesses; but its presence is clearly implied by recognizing the need for the education of the power of concentration (as laid down in Appendix 3 of the report) and for adequate occupational therapy for convalescents.

An increasing loss of efficiency and alertness was noted by several witnesses to be a symptom of an impending attack; this has again been described by Blakeslee (1941) as a pre-neurotic type.

Ross and Bennet as stated above noted failure of concentration as a common enough symptom in an anxiety attack but apart from these little attention seems to have been paid to it in this connexion.

OBSERVATIONS.

In view therefore of the regular, though perhaps not great, appearance of such a symptom in the out-patients of a military psychiatrist, it seemed that it might be of interest to investigate it in slightly more detail.
Some forty cases were observed, over approximately a year, who showed failure of concentration as a major complaint; every one had a history of severe bombing and of some degree of exhaustion. These cases fell into three groups:

(1) Residual.—Those who had already, as far as could be ascertained, suffered from a full fledged acute war neurosis, as described above, which had developed rapidly after their exposure to bombing. Most of these had been treated in hospital and had been sent back to duty, apparently fit. They were now seen eight to eighteen months after the start of their original illness; the picture they showed differed from their original attack in that their principal complaint was now inability to concentrate; this was at times accompanied by mild anxiety, often apparently due to the man’s realization of his own inefficiency, an increased irritability or sensibility to criticism; sometimes by insomnia, with battle dreams and usually a coarse tremor of the outstretched hands. Some cases showed such extreme terror on hearing air-raid sirens or aeroplanes, even if friendly, that they were constrained to dive under beds although they appreciated there was no real danger; this occurred even in men whose confidence in their recovery and stability had appeared quite adequate. This condition was actually only seen in a few cases but may have been more prevalent since in the nature of things they were often not exposed even to sirens. Other cases however showed no symptoms except failure of concentration. Of twenty-four cases, fifteen showed no evidence of a previously abnormal personality.

This symptom was, as might be expected, more common among units such as the R.A.C. where a considerable degree of concentration was normally required, or in men employed over long hours on responsible clerical work; and it was generally found that the original complaint came from the man himself, as he observed his own short-comings, and was thereafter corroborated by his superiors. Reports to the effect that “he seems to be unable to hold down his job nowadays, though he obviously tries,” “not so reliable as he used to be,” “quite unable to concentrate or take decisions,” testified to the change in the man’s abilities and, generally, to the high opinion previously held of him by his superiors—an uncommon enough finding in psychiatric cases.

Inquiry revealed the presence of a past anxiety state even in those who now showed no other symptom than failure of concentration.

This condition may be compared to a state seen in children after air-raids and described by Mons (1941) as consisting of inability to occupy themselves, fear of responsibility of making decisions, not knowing what they want.

The following may be quoted as typical examples of this condition:—

Examples:—

Case 1.—A Serjeant, aged 24, previously normal, responsible and conscientious. Severe anxiety state and gunshot wound of abdomen at Dunkirk for which he spent some six months in hospital and then returned to duty. Seen a year later with failure of concentration, irritability, insomnia and battle dreams and marked tremor. Admitted he was quite unable to get a grip on his work or to be interested for long—Boarded out.

Case 2.—A Corporal, aged 27, previously lacked self-confidence. Severely dive-bombed, with B.E.F. and developed acute anxiety state. Improved in some months. Seen a year later, continual minor inefficiencies reported at unit; irritable, lacked concentration, confidence, initiative and patience; fine tremor—Boarded out.

Case 3.—A Serjeant, aged 32, developed acute anxiety attack when bombed; seen three months later and complained of being able only to do simple jobs as he could not concentrate; memory poor; liable to be very apprehensive of air-raid sirens; irritable, tremor—improving somewhat and remains at simple job.

(2) Insidious Cases.—These showed no evidence of a previous anxiety attack but complained of failure of concentration, irritability and restlessness with mild anxiety, all gradually increasing, some months after exposure to bombing. Insomnia and battle dreams were also present in some and, at times, hysterical symptoms.

These cases were less common and it is of interest to note that, of the ten seen, three were officers and seven showed no evidence of a previously abnormal personality.
EXAMPLES:—

Case 4.—Lieutenant, aged 29, previously normal. Severely bombed; considerable over-work. After six months developed anxiety with failure of concentration and irritability so that work was impossible. Improved with three months’ rest in hospital and remained well.

Case 5.—Signalman, aged 23, previously normal. Severely bombed in France; gradually increasing difficulty in concentration; irritability and insomnia. Said to be apathetic and easily flustered. Anxiety developing from his inefficiency. Improved with reassurance and temporary light duty under supervision.

Case 6.—Lieutenant, aged 24, previously normal, anxiety and irritability gradually increasing. Some symptoms of effort syndrome; inability to concentrate which benefited from gradually increasing mental exercise. Still nervous on hearing planes but otherwise capable.

(3) Depressives.—Some men, whose symptoms began either insidiously or acutely, developed on top of these symptoms a depressive phase which included emotional instability and suicidal attempts; and it could be seen that the outbreak of this depression was generally precipitated by a minor stimulus, such as a mild reprimand, which to the patient appeared the last straw after a period of intolerable irritation.

EXAMPLES:—

Case 7.—Corporal R.A.F., aged 33, previously normal. Severely bombed and blown up in “Lancastria”—anxiety, irritability and failure of concentration increasing within a few days. Discipline and formality irksome. Mild reprimand by C.O. led to suicidal attempt in depressive phase. Recovered; returned to civil life.

Case 8.—Airman (ground staff), aged 31, always shy and reserved. Severely bombed in B.E.F.; slight injury to foot; gradually increasing anxiety with irritability, restlessness, failure to concentrate and insomnia with battle dreams. Depressive phase developed seven months later. This disappeared but irritability and inability to concentrate remained. Discharged to civil life.

Case 9.—Private R.A.S.C., previously steady and reliable. Bombed at Dunkirk; gradually increasing irritability, lack of concentration and emotional instability for five months, then absented himself. Was eventually arrested and developed reactive depression. Marked fear of bombs and tremor. Recovered slowly. Discharged to civil life.

Of ten cases five showed no evidence of a previously abnormal personality and some showed additional hysterical symptoms; the significance of this will be later discussed.

In all these cases the type of failure of concentration was very similar and may be described as an early tiring of attention. Thus the patient would have no difficulty in starting his day’s work but became slow, tired and unreliable by afternoon. On some test such as the R.E.C.I. Matrices he would start quickly and correctly but would unduly soon complain that he was unable to collect his thoughts or to make a decision and become somewhat confused, anxious or impetuous. After a while he could carry on where he had given up and go on moderately well, particularly if some other topic had meanwhile been introduced. The patient’s self-confidence began correspondingly to fail but it was noteworthy that in most a high degree of conscientiousness was seen.

ÆTILOGY.

The ætiology of the acute war neurosis was discussed in some detail by Sargant and Slater, who pointed out that men of reasonably sound personality might break down under a severe enough strain. Although constitutional factors were occasionally present, many cases existed whose soundness had at least been adequate to adapt to civil life and enlistment in the Army. They stressed the importance of the co-ordination of physical and mental strain in which must be remembered not only the sights of war but the continued frustration of retreat.

In this connexion it may be remarked that Marshal Ney, whose bravery was a proverb, did appear to suffer from the effects of the retreat from Moscow which had demaded—and obtained from him—an incredible degree of physical and mental effort; his later symp-
toms of irritability, indecision and failure to concentrate had a profound influence on his master's final campaigns. So that it is perhaps reasonable to agree that every individual has his breaking point. The reason why some break in situations where others survive is probably to be found in the argument that identical conditions may appear entirely different to two different men and that their importance, as Benton (1921) has stated, lies rather in the individual's conception of them than in the reality.

The views of the War Office Committee were that, while the commotional shell shock was due to explosion, the emotional type was brought about by a great variety of causes; the exciting factor being physical and mental exhaustion and some definite disturbance. The predisposing causes included inherent instability, previous illness or injury such as concussion, racial characteristics, education and social conditions.

The connexion of bad morale with the outbreak of emotional "shell shock" was stressed by many witnesses as a matter of experience and agreed on by the Committee.

It was again recently re-emphasized by Ross while Bennett pointed out that boredom in particular was responsible as a potent cause of low morale for the production of all types of neurotic symptoms.

The importance of physical factors (especially of hunger in the Spanish civil war) was again demonstrated by Mira.

The production of this failure of concentration does not seem to have been much discussed. Several points are significant. Firstly, as has been pointed out by Sargent and Slater, the proportion of cases showing previous psychological abnormality (which could be detected) was considerably smaller than the proportion of similar cases among the emotional "shell shock" mentioned in the War Office Inquiry; a point which is incidentally supported by the cases quoted here.

Secondly, a large proportion had been heavily dive-bombed. The comparison of the proportion of these with the last war's shell shock is of course difficult, since it was readily admitted that prolonged exposure to gunfire played a large, but not the greatest, part in the onset of emotional shell shock.

Thirdly, it must be remembered that commotional shock was marked in the last war to have been associated as might be expected with inability to concentrate.

Fourthly, as has been observed in the cases here under study, that the inability to concentrate was in no way associated with lowered morale. The cases quoted and their officers' reports illustrate this. The earlier history of these men, while in their acute phase, was not always available in great detail but, as far as it could be obtained, it suggested that this point could also be made at that stage.

It is then possible that one explanation may be found for all these points, namely that many cases are entirely or largely due to commotional shock; other physical factors were also perhaps of more than usual importance, though it was shown by Ross and by Hubert (1941) that those suffering principally from the effects of these recovered surprisingly quickly with adequate food and rest.

If the commotional type is more common it might well be expected that inability to concentrate would be a prominent feature. It may of course be overshadowed at the time by other symptoms but will reveal itself as they pass. This was particularly noticeable in those whose morale was considered high.

If this be so, it would be expected that cases should occur at random rather than, like "emotional shell shock," in epidemics from bad units. Insufficient evidence is available to say if this is so or why these men broke under bombing which was practically speaking the same for many of their comrades.

If anxiety is present as well, it may be supposed that this tends to perpetuate the failure of concentration for several reasons. Firstly, the occurrence of symptoms in any one is likely to produce anxiety over his health; and Ross even stated that all his patients with insomnia and failure of concentration developed a fear of insanity; thus a vicious circle of anxiety and further inability to concentrate are set up. Even if this is not so, it is probable
that the patient’s fear of losing his job or his rank, his prestige or his pay, will set up a similar anxiety and so increase his inefficiency.

Secondly, anxiety may produce failure of concentration by merely excluding from attention topics other than the cause of the anxiety.

Thirdly, there were cases in whom it was observed that morale was low and who showed evidence of a good previous personality. In these it appeared possible that various symptoms, including failure of concentration, developed under exposure. Many remain later as hysterical symptoms, like aphonia or stammering, with the object of preventing the return of their owners to the Army or to any future exposure. It was noted that in some cases other hysterical symptoms were associated.

The production of insidious cases is perhaps due to a gradual increase in the patient’s consideration and imagination of past and future exposure, so that the stress gradually mounts.

As was noted a high proportion of the few cases seen were officers who were also intelligent and imaginative.

TREATMENT.

As has been mentioned, the need for rapid removal of anxiety as soon as possible by adequate explanation and reassurance has been generally emphasized. In particular the need for discussion of the symptoms was stressed by Rivers (1917) who condemned the advice so often given to the patient to forget his symptoms as a frank impossibility and substituted the suggestion that they should instead be viewed in as matter-of-fact a light as possible.

Such treatment in the early stages will undoubtedly go far to diminish anxiety and so the failure of concentration; but in some cases it would seem that a moderately long period is bound to elapse before concentration will be at its original capacity.

It thus becomes extremely important for the physician to decide the extent and the cause of the symptoms. The quick return to duty advocated, partly for disciplinary reasons and partly for the patient’s sake, must be supposed either not to have dealt with cases who had little lack of concentration nor with situations where much concentration was required.

It is felt however that many cases do exist where a rapid return to duty will produce harm rather than good both to the patient himself, because he realizes his own inefficiency, and to his comrades, perhaps paradoxically enough, because they do not do so. Such a contention is supported by the cases seen relapsing soon after their return to duty.

It will thus be very important to diagnose between the causes of the failure of concentration and to differentiate the type where rest is required; it is suggested that this may be done by an assessment of the previous personality and an investigation as to the morale, the presence or absence of hysterical symptoms and the amount of failure of concentration. Cases regarded as hysterical may be returned as soon as possible, provided they are not in positions of dangerous responsibility, but it is highly important that the others should be recognized as unfit, temporarily, for prolonged or complicated brain work. Unfortunately the organization of the Army still finds the employment of partially fit men difficult, particularly if their symptoms are of a psychological nature, and the gradual increase of the work for such men needs elastic arrangement, but it should be possible with sufficient supervision from unit M.O.s and adequate co-operation from the patient’s superiors. It is as fatal surely to his self-respect and self-confidence that he should do too little as too much.

In view of the patient’s susceptibility to air raids, it has been suggested that efforts should be made to “decondition” him; but so far the only deconditioning process used would seem to be the employment of time although on some scale E.M.S. Centres have attempted the use of artificial noise to the patient’s reactions. In this connexion too the course in use at Battle Schools to accustom men to fearsome sounds and thoughts may be regarded as prophylaxis.

Another kind of prophylaxis has been suggested by Bion (1940) who stressed the import-
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ance of impressing on the soldier and civilian, in training, the exact details of the job to be done as soon as they become exposed to hostile action.

The relief resulting from actual manipulative work was stressed by Rivers especially in evidence to the War Office Inquiry.

SUMMARY.

(1) Attention is drawn to the importance of the symptom of failure of concentration in acute war neurosis.

(2) Cases showing this symptom do so either as residual from a typical syndrome or as part of an insidious subacute war neurosis. Either may develop depressive features.

(3) The production of this symptom is discussed and it is held that an assessment must be made of its importance in each case so that men unable to concentrate are not returned to exacting duty. This assessment must be made by an investigation of the previous personality and the amount of concentration power lost, the morale and the presence of hysterical symptoms.

REFERENCES.

Blakeslee, G. A. (1941). N.Y. State, Journ. of Medicine, 1, 1241.
W.O. Committee of Enquiry into Shell Shock (1922) passim.