Clinical and other Notes.

MINOR PSYCHOLOGICAL DISTURBANCES IN THE SERVICES.

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The common occurrence of minor psychological disorders is well known to the civilian practitioner. No criterion is available for comparison but there is reason to believe that such cases are observed even more often in the Services than in civilian practice. The Service patient, in the main, shows an increased readiness to seek medical advice; he is, moreover, subjected to enforced medical supervision. Secondly, two environmental factors tend to convert potential into clinical psychoneurotics: these are separation from families and the demand for adaptation to a new way of life.

This paper is written by one who claims no specialist knowledge of psychiatry. Its purposes are to indicate the type and frequency of these cases in the Service and to suggest that selected cases may benefit by treatment from unit medical officers. The report is based on experience of 200 cases recently sent to the out-patients' department of a static general hospital for a medical specialist's opinion. Of this number no fewer than 66, or 33 per cent, were found to have psychiatric disabilities accounting for the symptoms with which they had reported sick. Of these cases one was a schizophrenic, one a recurrent depressive, four were frank hysterics and the remainder suffered from anxiety states or anxiety states with features of hysteria. This communication is concerned only with the 60 cases in the last group.

Presenting Symptoms.—Nearly every case was referred for the investigation of organic disease. All cases had somatic manifestations as presenting symptoms except two who reported that their nervous condition was troubling them. The symptoms most frequently presented were headache, dyspncea, precordial pain, palpitation, dyspepsia, cough, frequency of micturition, hyperidrosis, "rheumatism" and "blackouts." Association of two or more symptoms was common.

Headache to most of these subjects is not so much a pain as a heavy ache or a sense of numbness, tightness or oppression. It is continuous, lasting a week or a month at a time, unremittent and little affected by extraneous factors. Others state that the headache comes on with waking in the mornings and passes off about midday. Aspirin provides at best partial and transient relief.

True functional dyspepsia is difficult to identify with certainty. In some
cases the history is compatible with peptic ulceration but in others a history such as this is given: The patient, who may be of any age, complains of vague diffuse pain the site of which is indicated by sweeping the hand across the upper abdomen. This often dates from youth, is unremittent and progressive only since entry to the Service. It is constant throughout the day but does not interrupt sleep; it is aggravated by eating and partially relieved by alkalis. Flatulence is a prominent symptom and, frequently, a history of vomiting after all meals is given. The bowels are often constipated. A family history of gastric disorders is forthcoming more often than not. On examination no recent loss of weight is found. There is diffuse upper abdominal tenderness without special localization. Aerophagy may be noted and, in hospital, vomitus is found to consist of a mouthful or two of fluid regurgitated soon after meals. Appetite, despite denial, is passably good.

Acute anxiety attacks vary from "a feeling of shaking all over" to "blackouts." Attacks simulating grand mal commonly occur and are really expressions of conversion hysteria; but their occurrence in association with anxiety states is so common that they have to be considered with this group. Onset in relation to worry and prolonged or unusual prodromal symptoms may provide some indication of the true condition. The length of the attacks and the subsequent emotional state are unreliable guides because true grand mal is frequently prolonged and followed by hysterical symptoms. The epileptic approaches the discussion of his attacks with characteristic objectivity while the reverse applies to the anxious patient. Even with a witness's account it may be impossible to reach a decision, which is then deferred till an attack is observed personally.

Neurotic Stigmata.—Much help in assessing these cases is to be had from a personal history that includes standard of education, civilian work record, employment in, and adaptation to, Army life, consumption of cigarettes and alcohol, conditions of home life and symptoms of neurosis or instability.

Enquiry about the school standard helps to identify the dull and backward. Under Service conditions it is especially important to establish the existence of illiteracy. Illiterates are usually painfully aware of their backwardness in training and are depressed about their incapacity to maintain contact with their families, being reluctant to invoke the help of others for this purpose.

Civilian work records provide a variable indicator. Some reveal their instability by admitting to having changed jobs six or eight times without adequate reason while other unstable subjects give histories of continuous employment in one job from the time of leaving school.

Histories of underlying neurotic stigmata were obtained in all cases of the present series except two who had hysterical reactions to previous organic illnesses. Amongst the common indications of neurosis and instability are: headache, sleeplessness, bedwetting beyond the years of child-
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hood, inability to concentrate and/or poor memory, depression or unaccountable mood swings, worrying about trifles and nervousness of darkness or noises.

Frequent concomitant symptoms are: Palpitation, lack of self-confidence, night blindness, fear of driving in cars, emotional lability, sweating, tremulousness under strain, frequency of micturition, dizziness, inability to wear a steel helmet, loss of interest in work or hobbies and disinclination for company.

Difficulty in mental concentration is usually ascribed to the mind wandering or to "many thoughts crowding out the thing that I am trying to think of." Depression and swings of mood are admitted in these terms: "I seem to be up in the air one moment and in the depths of depression for no reason the next." Relatives' observation on temperament are valuable: "My wife has scolded me for being so moody." Confession to worrying about trifles is typically associated with good insight: "I know that it's silly but I just can't help worrying about little things."

The importance of a carefully taken family history can hardly be overemphasized. In more than half the cases a history of psychiatric disabilities in close relations is obtainable. The patient is not always explicit: "My aunt has always been nervous" may be followed, on further questioning, by the revelation that she has spent the last twenty years in a hospital for mental diseases.

Precipitating Factors.—The psychogenesis of these conditions is important both for the establishment of diagnosis and for treatment. In some cases no precipitating factor can be elicited while in others it can be clearly defined. The factor can commonly be established in patients with somatic symptoms in a system previously the site of organic disease. Examples are headaches following trivial head injuries, where insanity or serious damage to the brain may be feared, and cough or breathlessness in the patient who has had bronchitis and who fears tuberculosis. Fears of organic disease also arise without previous involvement of the parts concerned but here a suggesting influence, such as family history of the disease, can usually be discovered.

Other precipitating factors that have been encountered in this series are family worries; concern about money or business; experiences in concentration camps; prolonged training associated with the desire to serve overseas and concern about responsibilities of an N.C.O. Separation from families has a particularly marked effect on some dull and backward patients who miss the advice of their wives to whom they have always previously turned for a decision when in doubt or difficulty.

Less frequent factors, usually discovered after repeated interviews when the writer was a unit medical officer, were fear of insanity; fear of discovery of bedwetting by companions; doubt, usually based on circumstantial rumours, about fidelity of wives; fear of consequences of long-past sexual adventures; fear of breaking down on active service; and self-conscious-
ness about homosexual habits. A limited experience of the last group suggests that they are unsuited to Service conditions, community life tending to increase awareness of the aberration. Rather unexpectedly, only one case of the so-called "compensation neurosis" was clearly established in the series and this dated from civilian employment. It seems probable, however, that many of the neurotic states arising after illness or accident in the Service may be partly determined by the conviction that compensation should be paid by the Government.

Where specific factors cannot be elicited, onset and exacerbation of symptoms may, nevertheless, be proved to have been related to periods of mental stress.

Treatment.—The submission is made that cases of mild anxiety state should be treated by the unit medical officer rather than by the specialist at hospital. The unit officer has the advantage of being able to assess the condition and progress of the patient by repeated personal observation and by enlisting the co-operation of officers and N.C.O.s. If the patient is admitted to hospital he must re-adapt himself to the environment of the Service on his return, while treatment can be undertaken in the unit without ever detaching the patient from that environment. Even a visit as an outpatient to a hospital tends to confirm the belief of the impressionable that theirs is an unusual or serious condition, whereas treatment in the unit is accepted by most as a matter of course. The exception to this principle is the man who is convinced that he has some specific condition which can be denied by the impressive investigations that can be made in hospitals: a negative barium meal result may have a valuable therapeutic effect on the patient who is determined that he has a peptic ulcer.

The method adopted by the writer as unit medical officer was to take a complete history and to examine the patient fully in every system. No further examination is then necessary in the absence of new symptoms; nor is it advisable, as re-examination tends to renew doubts in the patient's mind about his condition and leads him to question the efficiency of his doctor who has reassured him categorically after the initial negative examination. Where doubt exists the patient is referred to the appropriate specialist before reassurance is undertaken. The only types referred initially to the psychiatrist are the grossly dull and backward and those neurotics whose condition is so well established that general treatment is unlikely to prove effective.

Some cases, especially those with fears of organic disease, require no further treatment after one interview. In such cases a detailed examination greatly enhances the value of the subsequent reassurance by creating in the patient's mind confidence that his condition has been carefully considered. Other cases need to be seen more than once. It helps these patients simply to know that the advice of the medical officer is always available to them.

The consultations are best undertaken alone with the patient and not during the morning sick parade. A willingness to listen while the patient
talks freely, sympathy and a tone of firm reassurance are called for. Repeated
talks of this sort not only increase the patient’s confidence in his doctor and
therefore in the reassurance that is conveyed in them: they also bring to
light troubles of which the patient has hesitated to speak at the first inter­
view. This, of course, makes further treatment easier, adequate psycho­
therapy depending, as it does, on a full understanding of the mechanism
by which the symptoms are produced.

Insight and improvement can be obtained in some cases where neurotic
symptoms are prominent by indicating the relationship of their onset and
aggravation to worry. It can be pointed out that reactions to stress differ;
involuntary micturition in association with fear and headache with worry
can be quoted as examples. This demonstrates the non-organic nature of
the symptoms while implying that they are real to the patient. The condi­
tion is often aggravated by the suggestion from laymen that the patient is
malingering and no opportunity to correct his misconception should be
missed.

A number of cases, especially those whose condition is largely hysterical,
do not respond and their resentful comment remains: “Something must
be causing all this.” A much firmer tone is adopted where hysterical symp­
toms are evident; but this is not always successful and these and other
failures are sent to the psychiatrist.

Differential Diagnosis.—The first step in dealing with minor psycho­
logical disorders is the exclusion of organic disease or, if this is present, the
assessment of its influence on the patient’s condition. With the diagnosis
established it has to be borne in mind that the neurotic is no less liable
than anyone else to intercurrent organic disease.

A most difficult group is constituted by those cases of anxiety state
who wilfully exaggerate their disability. These are forwarded to the psychiatrist,
wherever possible, with an account of observed performance in relation to
symptoms.

In the diagnosis of these disabilities a constant watch must be kept for
the rare malingerer. He selects a psychiatric disability because he thinks
that no physical sign is necessary for the corroboration of his story. The
differentiation of hysteria and malingering is regarded as a matter for the
psychiatric specialist. But where neurotic symptoms are presented some
guidance may be had from the patient’s way of telling his story, his attitude
and his behaviour. Few cases of neurosis volunteer the relevant symptoms
which have to be obtained by questioning. Recently, a case was seen who
related in fine detail, and without prompting, a classical story of compulsive
obsessive neurosis. He was despatched to the psychiatrist labelled with this
diagnosis. The specialist, however, noted this unusual facility of speech
and sent the patient to a special centre for observation. The neurotic is
usually tense, anxious, tremulous, emotionally labile, taciturn or irrelevantly
talkative, often sweating during examination. He sits erect in his chair,
ever relaxing. The malingerer, on the other hand, sits back and relates
his story with relish as if in the knowledge of a lesson well learned. Observation of behaviour is open only to unit medical officers and to officers with charge of in-patients. For this reason a report of observed performance sent to the psychiatrist may be of great value in reaching a diagnosis. The difficulty of maintaining a pose over a long period usually defeats the ends of the malingerer. Moreover he can seldom keep his secret. As the charge, if proved, is serious, it is reasonable to impart suspicions to the man’s officer, who may furnish information that leads to a definite diagnosis.

I wish to express my thanks to Colonel M. J. Williamson, M.C., for allowing me to report on cases seen in the hospital under his command and for permission to submit this paper for publication.

A CASE OF RAT-BITE FEVER.

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ALTHOUGH many cases of rat-bite fever have been reported, especially in America, few cases have come to light in this country. It has therefore been thought worthwhile to record the following case:—

Private C. was a rat-catcher before the war and has been carrying out this work at a Military Hospital since his enlistment two years ago. He has caught thousands of rats and has been bitten about a dozen times with no untoward result but, on August 6, 1942, he was admitted to hospital with the following history:—

Fourteen days previously he had been bitten by a rat on the dorsum of the left hand in the region of the second metacarpophalangeal joint. The wound had been cauterized with silver nitrate and dressed with antiseptics. There had been a little local inflammation but this was subsiding when, on the day before admission, the area became painful and swollen and malaise, headache and anorexia occurred. On admission the temperature was 101° F., pulse 88, there was an inflamed indurated swelling in the region of the wound presenting a bluish-red appearance and discharging a little serum from its centre; there was lymphangitis of the forearm and axillary adenitis. On admission the temperature was 101° F., pulse 88, there was an inflamed indurated swelling in the region of the wound presenting a bluish-red appearance and discharging a little serum from its centre; there was lymphangitis of the forearm and axillary adenitis. During the next few days the temperature rose to 103° F., and the patient looked pale and toxic; there was no rash neither was there any arthritis. The pyrexia continued for four or five days and then the symptoms and signs abated. The hand showed no signs of abscess formation. A culture of the serous discharge from the wound grew staphylococcus aureus. The Wassermann reaction was not performed. There was no relapse of the fever but, although the local condition cleared up fairly quickly, convalescence was slow and the patient’s general condition was poor. Treatment consisted of sulphanilamide by the mouth with local applications of heat to the wound. No injections of arsenic were given.

On the fourth day after admission, an axillary gland was aspirated and the culture of the fluid obtained grew streptobacillus moniliformis. The following is a detailed account of the laboratory examination: The blood-
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