CASUALTIES.

ACCORDING to the casualty list received on September 22, 1941, Captain R. A. Playoust, A.A.M.C., of Mosman, New South Wales, and Captain L. P. Sapsford, A.A.M.C., of Allora, Queensland, previously reported missing, are now reported prisoners of war.

MEDICAL WAR RELIEF FUND.

THE following is a seventeenth list of contributions to the Medical War Relief Fund established by the Federal Council of the British Medical Association in Australia for the relief of distressed medical practitioners in Great Britain.

New South Wales.

£5 5s.: Dr. J. S. MacMahon, Dr. K. Kirkland, Dr. W. R. Page, Dr. R. O. Williams (second contribution).

£3 3s.: Dr. A. E. Harker, Dr. H. T. C. MacCulloch, Dr. G. T. Hunter.

£2 2s.: Dr. W. J. R. Nickson, Dr. N. McA. Gregg, Dr. C. G. Crawford, Dr. C. V. Roper, Dr. H. R. Sear, Dr. L. J. Shortland, Dr. L. H. Hughes, Dr. J. Ross.

£1 1s.: Dr. R. K. Burnett, Dr. J. A. L. Wallace, Dr. H. K. Porter, Dr. H. J. Daly.

Western Australia.

£1 1s.: Dr. W. A. Hillman.

Nominations and Elections.

THE undermentioned has applied for election as a member of the New South Wales Branch of the British Medical Association:

Duncan, Ian Lovell, M.B., B.S., 1940 (Univ. Sydney), NX35135, Captain, A.A.M.C., Headquarters, Royal Australian Engineers, 8th Australian Division, Overseas.

Obituary.

ERNEST ALBERT WHERRETT.

WE regret to announce the death of Dr. Ernest Albert Wherrett, which occurred on September 22, 1941, at Ashfield, New South Wales.

Australian Medical Board Proceedings.

NEW SOUTH WALES.

THE undermentioned have been registered, pursuant to the provisions of the *Medical Practitioners Act*, 1938-1939, as duly qualified medical practitioners:

Andrews, James Campbell, M.B., Ch.B., 1940 (Univ. Edinburgh), Lily Bank, Wauchope.

Mills, Margaret Mary, M.B., Ch.B., 1922 (Univ. Aberdeen), 10 Mackenzie Street, Lindfield.

Thomson, Charles Hutcheon, M.B., Ch.B., 1935 (Univ. Edinburgh), c.o. British Phosphate Commissioners, 16, Spring Street, Sydney.

Books Received.

"The Medical Annual: A Year Book of Treatment and Practitioner's Index", edited by H. L. Tidy, M.A., M.D., F.R.C.P., and A. R. Short, M.D., B.S., B.Sc., F.R.C.S; 1941. Bristol: John Wright and Sons Limited. Demy 8vo, pp. 561, with illustrations. Price: 20s. net.

"A Textbook on the Nursing and Diseases of Sick Children", edited by A. Moncrieff, M.D., F.R.C.P.; Third Edition; 1941. London: H. K. Lewis and Company Limited. Demy 8vo, pp. 654, with 142 illustrations. Price: 21s. net.

"Massage and Medical Gymnastics", by M. V. Lace, with a foreword by J. Mennell, M.A., M.D., B.C.; Second Edition; 1941. London: J. and A. Churchill Limited. Demy 8vo, pp. 250, with 120 illustrations. Price: 12s. 6d. net.

"The Student's Pocket Prescriber and Guide to Prescription Writing", by D. M. Macdonald, M.D., D.P.H., F.R.C.P.E.; Eleventh Edition; 1914. Edinburgh: E. and S. Livingstone. Demy 18mo, pp. 328. Price: 3s. 6d. net.

"First Aid Through Photographs", by L. S. Michaelis, M.D.; photographs by V. Elkan; 1941. London: Longmans, Green and Company. Crown 8vo, pp. 64, with illustrations. Price: 2s. net.

Diary for the Month.

OCT. 1.—Western Australian Branch, B.M.A.: Council.
OCT. 1.—Victorian Branch, B.M.A.: Branch.
OCT. 2.—South Australian Branch, B.M.A.: Council.
OCT. 3.—New South Wales Branch, B.M.A.: Annual Meeting of Delegates.
OCT. 3.—Queensland Branch, B.M.A.: Branch (Ordinary).
OCT. 7.—New South Wales Branch, B.M.A.: Council (Quarterly).
OCT. 10.—Queensland Branch, B.M.A.: Council.
OCT. 14.—Tasmanian Branch, B.M.A.: Branch.
OCT. 15.—Western Australian Branch, B.M.A.: Branch.
OCT. 22.—Victorian Branch, B.M.A.: Council.
OCT. 24.—Queensland Branch, B.M.A.: Council.
OCT. 30.—New South Wales Branch, B.M.A.: Branch.
OCT. 30.—South Australian Branch, B.M.A.: Branch.
OCT. 31.—Tasmanian Branch, B.M.A.: Council.

Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

New South Wales Branch (Honorary Secretary, 135, Macquarie Street, Sydney): Australian Natives' Association; Ashfield and District United Friendly Societies' Dispensary; Balmain United Friendly Societies' Dispensary; Leichhardt and Petersham United Friendly Societies' Dispensary; Manchester Unity Medical and Dispensing Institute, Oxford Street, Sydney; North Sydney Friendly Societies' Dispensary Limited; People's Prudential Assurance Company Limited; Phœnix Mutual Provident Society.

Victorian Branch (Honorary Secretary, Medical Society Hall, East Melbourne): Associated Medical Services Limited; all Institutes or Medical Dispensaries; Australian Prudential Association, Proprietary, Limited; Federated Mutual Medical Benefit Society; Mutual National Provident Club; National Provident Association; Hospital or other appointments outside Victoria.

Queensland Branch (Honorary Secretary, B.M.A. House, 225, Wickham Terrace, Brisbane, B.17): Brisbane Associated Friendly Societies' Medical Institute; Bundaberg Medical Institute. Members accepting LODGE appointments and those desiring to accept appointments to any COUNTRY HOSPITAL or position outside Australia are advised, in their own interests, to submit a copy of their Agreement to the Council before signing.

South Australian Branch (Honorary Secretary, 178, North Terrace, Adelaide): All Lodge appointments in South Australia; all Contract Practice appointments in South Australia.

Western Australian Branch (Honorary Secretary, 205, Saint George's Terrace, Perth): Wiluna Hospital; all Contract Practice appointments in Western Australia.

Editorial Notices.

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THE MEDICAL JOURNAL OF AUSTRALIA

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Table of Contents.

PREVENTION OF WAR NEUROSES.[1]

By W. S. DAWSON,
Sydney.

THE subject of the present meeting would appear to be the prevention of those disabilities which can be most satisfactorily understood as having an emotional basis and in which the altered circumstances of life due to war play a major factor. Maclay and Guttmann[(1)] have described neurosis as "the expression or the result of a person's incapacity to adjust himself to or overcome a particular situation in life, very often with much internal conflict". In war, as during any other threat to the well-being and still more to the existence of the herd, there occurs an enormous intensification of emotional dispositions concerning the herd, which through mass suggestion, for example, may be the prelude to highly successful concerted action, or, on the other hand, to disruptive suicidal panic. The emotional bonds which unite the individual members of a social group we term (good) morale. That good morale is essential to successful action by the herd needs no emphasis. Napoleon said that the moral is to the physical as three to one, and a British Army publication describes moral qualities as "the soul of victory". In this war we have seen the skilful sapping of morale largely by propaganda disseminated in the first instance amongst the civilian population, upon whom rests a greater responsibility than ever for the means of ultimate victory. And this propaganda in susceptible individuals and nations tends to appeal essentially to superstition, fear and distrust. *"Omne ignotum pro terribile."* What really was, or is, Hitler's "secret weapon" except, as has been suggested, a thrust at the morale of his prospective victims? Bion[(2)] has pointed out that the Germans of today by the intensity of their propaganda, whether through loud speakers or by means of more subtle communications, have merely developed the methods used by the Germani, whom Tacitus described as uttering uncouth cries within hearing of their foes and spreading barbarous verse amongst themselves to influence their minds with the thought of victory.

Amongst all this bluster Britain is safeguarded by a proud tradition, in itself a deterrent to panic so long as it is not permitted to cloak inefficiency and complacence. British phlegm, so little understood by Europeans, may well be the most valuable of all inborn or constitutional assets in the present crisis. As a profession we can do much in the course of our everyday work to promote a balanced viewpoint in regard to current events, leaving it to our elected leaders to use more public methods of fostering the urge to win.

The Soldier.

With regard to the more direct part that we can play in the prevention of neurosis, we must consider first the soldier.

Enlistment.

The history of an attack of serious mental disorder may readily be denied by the recruit, and psychopathic symptoms of a kind which render a man unsuitable for military service are apt to appear only in special circumstances. In so far as psychoneurosis is manifested under special rather than general conditions, the possibilities of its detection in the course of ordinary medical examination are correspondingly reduced. Somewhat similar problems are presented by asthmatics and dyspeptics, subjects with neuro-circulatory asthenia, and those with symptoms following concussion. Knowledge of the fact that wilful concealment of a "mental" history may render the soldier

[1] Read at a meeting of the New South Wales Branch of the British Medical Association on August 28, 1941.

liable to forfeiture of rights to pension in respect of a nervous illness contracted on service may deter a few psychopaths from joining the military forces.

In the course of his examination the medical officer will have to rely very largely on impressions in making his psychiatric assessment. The mentally subnormal subject may be detected when he is dull of aspect, slow in his replies and uncertain in his comprehension. His general appearance often betrays him, and it is a matter for surprise on the part of some of us who have to board these "nitwits" out how ever they came to be accepted. Other subnormal subjects of a more vivacious temperament easily deceive the examiner, and reveal their defects only in the course of training. Vasomotor and neuro-muscular instability are, of course, commonly associated with general psychopathic tendencies, but may be isolated features, in which case the recruit may be permitted to proceed to training "on probation". The medical examiner may well say with Falstaff: "Care I for the limb, the thews, the stature, bulk, and big assemblance of a man! Give me the spirit" (*King Henry IV*, Part II, Act 3, Scene 2).

This important component of the personality, temperament, can be assessed only superficially and intuitively, although a little time spent in general conversation with the man and inquiry into his economic, social and domestic history will provide some insight into his character, and may reveal psychological weaknesses which were denied in answer to direct questions about mental breakdowns. The severity of earlier psychoneurotic or functional disabilities may roughly be gauged by the extent of their interference with an average mode of life, the amount of time lost from work, and the period over which treatment was sought. Stalker[3] suggests that the names of patients of military age discharged from mental hospitals should be notified to the military authorities, that every recruit should present a summary of his medical history signed by his own doctor, and that psychiatrists should sit on recruiting boards. There are obvious difficulties about the first two of these suggestions. I have no doubt that in the course of brief interviews a physician with some special knowledge of psychoneurotic disorders could recognize instability and subnormality in a number of men who have been passed on general medical examination. The psychiatrist can perform an even more useful function by giving an opinion on subjects concerning whom his general medical colleague may have a doubt.

Psychometry.—By group tests of general intelligence, followed by individual tests in selected cases, the dullards can be ascertained and rejected. It will be remembered that the intelligence tests applied to the Army of the United States of America in 1917-1918 revealed some 3% of mental defectives amongst men in training, even after the more grossly affected had been rejected before enlistment. Of all recruits rejected for nervous and mental disabilities, over 30% were mental defectives. With the increasing complexity of technical devices in present-day warfare, it may safely be presumed that a man needs a mental age of at least twelve years to be able to be trained to a satisfactory standard. In the last war men were accepted in the United States Army with a mental age of eight years, but it was found that this standard was too low. The detection of superior intelligence by routine psychometry is of less value than the quick rejection of the subnormal recruits, since the good brain should assert itself. If the bright intelligence remains unexpressed, there is something wrong with the soldier's character. Unfortunately, no reliable or readily applied tests of temperament have yet been devised, and most of those in general use consist of *questionnaires*. A few questions concerning temperament and nervous instability added to the group tests of intelligence might elicit some useful information. On the other hand, questions on such topics might be answered irresponsibly, if not dishonestly, by the recruit. There is something to be said for special tests with a view to vocational selection for certain technical branches, with due regard to physique, previous experience and inclination. Clearly, general fitness for the job and capacity for any special training that may be required should tend to reduce the neurotic reaction to dissatisfaction and lack of interest. The Cambridge psychologist Bartlett[4] put the position well when he wrote: "On the whole by intelligence tests a man may safely be ruled out, but by intelligence tests alone a man cannot safely be ruled in."

Training.

As a practical measure only the more obviously subnormal or "nervous" are likely to be rejected on application for enlistment. Physique and intelligence can be assessed satisfactorily, but morale and temperament must come before the test of experience. In civil life we assess these qualities largely on a man's record obtained from his own statements and from such other sources as are available. Whether a man be brave or timid, steadfast or vacillating, we can know only by the way in which he has behaved in certain circumstances. We form our impressions in the course of acquaintance with a man and measure him against standards which we form in the course of years of experience. No doubt the majority of us find it difficult to formulate this largely intuitive mental operation.

The change from civil to military life is for the majority of recruits the biggest upheaval that they have ever had to face. The uprooting from a quiet routine existence, separation from home, loss of personal freedom and subjection to unexpected restrictions and authority are some of the many novel stresses which may find a weak spot in the young soldier's morale. And the man who enlists to escape from an unpleasant situation, whether it be economic, occupational or domestic, often has reason to contemplate that it is better far to

> . . . bear those ills we have
> Than fly to others that we know not of.

It is during the training period that the majority of "martial misfits" will come to light and should be dealt with. Some recruits with mild nervous instability will settle down and improve in general physique and mental efficiency. More will disclose their latent psychopathy as training proceeds. It is desirable that the same regimental medical officer should be with a unit during the whole or at least the greater part of the training period and accompany it overseas. The more often the regimental medical officer is present at field exercises and at the recreational activities of his unit, the more he will add to the knowledge of the men he has met on his sick parades an invaluable insight into the personalities of the majority of the rest of the unit. As the family practitioner of the regiment he should be approachable in regard to personal problems, fulfilling this responsibility, it is to be hoped, no less efficiently than the padre.

The detection of a psychopathic condition during training, before the troops proceed overseas, is considered so important that the Director-General of Medical Services asked a committee in New South Wales to make some recommendations. Accordingly, the following suggestions were submitted.

Recognition of Psychopathic Types and of Potential Cases of Neurosis amongst the Military Forces.

The following conditions, if persisting or becoming apparent in the course of training, call for medical examination and, if deemed advisable by the medical officer, reference to a medical board.

1. Failure to comprehend and carry out instructions and general awkwardness in drill.
2. Untidiness and lack of cleanliness in the person.
3. Lack of regard for discipline; deliberate antagonism to discipline, including persistent offenders, or indifference to it (carelessness rather than active antagonism).
4. Undue shyness, timidity and solitariness.
5. Peculiarities and oddities of behaviour and pronounced mannerisms.
6. Bed wetting.
7. Sex perversions, masturbation, homosexuality.
8. Alcoholism.
9. Irritability, tearfulness, depression.
10. Suspicion and querulousness.
11. Homesickness and worry over home affairs.
12. Boisterousness and excessive exuberance (often a "cover" for fear and lack of confidence); display of other emotions in excess.

Also:

13. The indefatigable scribe and diarist.
14. Those who are constantly "picked on" by their fellows or ridiculed or taken advantage of.
15. Those who attend sick parades frequently with trivial complaints.
16. Those complaining of undue fatigability, breathlessness and precordial distress on slight exertion.
17. Those displaying a persistent rapid pulse, often with tremors.
18. Chronic "dyspeptics".

In classes 15-18 physical disease must, of course, be excluded with reasonable confidence, while the possibility of malingering must be borne in mind. The majority of cases with "functional" symptoms will be found on further inquiry to provide other evidence of temperamental instability.

19. Cases with "fits". Whilst it is important to make an accurate diagnosis, the hysteric is as unsuited for military service as the epileptic.
20. A man's statement that he has been treated before for psychoneurosis or psychosis by his own doctor, or in a general or special hospital should, if possible, be supported by a certificate. The severity of the nervous disorder may be gauged by its effect on his social and economic adaptations (e.g., amount of time lost from work).

A man who has had a definite "nervous breakdown" or who develops psychopathic symptoms such as those mentioned above, should not be sent overseas. If useful in any military capacity he may be retained on home service. For example, some defectives who are quite untrainable as soldiers prove diligent and useful kitchen helps and general camp "rouseabouts".

When a presumed psychopath is referred to a medical board for decision as to disposal, the regimental medical officer should indicate clearly in Part II of D2 not only the symptoms of nervous instability displayed by the patient, but also the ways in which he has shown himself to be unsuited for military life. Such information is indispensable to a medical board when a man displays few or no signs of nervous instability at the time of examination.

Although the medical officer in the course of his various duties with his unit will observe some cases, many more will be brought to his notice if the other officers in the unit know what to look for. The regimental medical officer should use these notes as a basis for lectures to the officers and senior N.C.O.'s of his unit on the subject of the prevention and ascertainment of nervous disabilities in soldiers.

On Active Service.

With regard to the preservation of morale amongst the troops, I propose to touch on a few aspects only which concern us from a medical standpoint. Moreover, upon us devolves the responsibility of formulating our attitude towards the whole problem of the disposal of men who become temporarily or permanently unfit for further service by reason of a nervous or mental disability. We have to bear in mind that the medical attitude will ultimately be reflected in the policy adopted by the administration. Most of us can recall the wide and indiscriminate application of the term "shell shock" to all sorts and conditions of psychoneurotic disability in the army during the greater part of the last war; this, in the words of the "Report of the Committee of Inquiry",[5] was a "gross and costly misnomer" which "should be eliminated from our nomenclature. It is a catchword which reacts unfavourably on the patients and on others." It was estimated that genuine concussion as a result of exposure to shell explosions, but without any external wound, accounted for between 5% and 10% of all the cases in which the diagnosis of shell shock was made. To quote again from the report, 80% of the "shell shocks" were "emotional shock, either acute in men with a neuropathic predisposition or developing slowly as a result of prolonged strain and terrifying experience, the final breakdown being sometimes brought about by some relatively trivial cause". The committee recommended that psychoneurosis, even if shell explosion was deemed to be a factor, should not be classified as a battle casualty any more than ordinary sickness.

Among the conditions stressed by the committee as "tending to increase the incidence and severity of mental and nervous disorders in time of war" and, we may add, amongst all classes in time of peace in regard to their responsibilities, are the following:

All those factors by which a soldier or even a potential soldier is encouraged to believe that the weakening or loss of mental control provides an honourable avenue of escape from military service at whatever period of his service.

That the general comfort and well-being of the troops, control of infectious disease (especially venereal disease) and adequate recreation will promote efficiency, needs no emphasis here. The detection and treatment of psychoneurosis should be attempted as early as possible with even more enthusiasm and perseverance than in civilian practice. The regimental medical officer has the advantage which he did not enjoy as a civilian doctor of having his panel of patients not only under close observation but also under control. He should be on the lookout for such symptoms as fatigability, irritability and jumpiness, insomnia, loss of appetite, and such more obvious exhibitions of emotional instability as anxiety attacks, crises of weeping, unsociability, disinterestedness and depression. Alcohol and tobacco may be sought as a means of relief with the craving of an addict. Company commanders and others will no doubt send men exhibiting these features to the medical officer.

Amongst the many stresses that the soldier has to endure there is one which he may from time to time have to share with the civilian in these days of "total warfare", and that is the more or less passive endurance of attack by land and by air. It may in some instances be a good policy to send a man who is becoming unsettled out with a patrol or raiding party, to provide him with some other means of working off his pent-up nervous energy. Allied to what may be termed the syndrome of suppressed voluntary activity are the anxiety symptoms of anticipation states before battle, in which, as in the keyed-up states preceding an athletic contest, there occurs a vigorous mobilization of the biochemical mechanisms concerned in the preparation for fight or flight. Until voluntary action takes place the mental state is one of acute uneasiness. Further reference will be made to this aspect of psychopathology in the section dealing with civilians. Unfortunately, as the war continues there is to be anticipated an increasing amount of psychoneurosis as the capacity to withstand shock, and more particularly stress over a prolonged period, gradually wears out. The incidence of neurosis is said to be higher in technical branches exposed to great danger, such as machine-gun, engineering and tank units.

A reminder may not be out of place that psychoneurosis may be covered by a diagnosis of rheumatism, dyspepsia and debility. It may happen in military as in civilian hospitals that the general medical wards hold more psychological problems than even the psychiatric annexes. Another point which has engaged the authorities in Great Britain and here, is the prevention of boredom and nervous invalidism among men undergoing lengthy treatment for injuries to the limbs. In such cases the value of well-organized occupation and recreation, prescribed and regulated as part of treatment, is established beyond question. Some words of warning by the late Dr. A. W. Campbell[6] concerning the treatment of psychoneuroties, especially during the process of evacuation, are well worth repetition:

> To save resistive cases from acquiring the invalid habit, the shorter their stay in hospital the better. It cannot be too plainly indicated that strongest measures should be formulated for dealing with them on transports, on disembarkation and prior to discharge. This is a continuous critical period, during which they must be guarded with the utmost tact and circumspection against themselves and their friends and a grateful country.

The Civilian.

The civilian in total war may be exposed to danger equally with the soldier; but, being unable to retaliate directly, has to endure and to find a substitute response for the natural impulse to revenge. In so far as the

civilian lacks adequate organization and training, his morale is apt to suffer. The deeply rooted and even instinctive loyalties of the average man are to his family, the social sense being far less keen in regard to the contacts of the workshop and other groups. In a time of emergency the civilian may be called upon to protect lives and property with whatever group he may find himself. As Rickman[7] has pointed out, the morale of each individual is strengthened by being a member of a group and by having a task and a responsibility for the safety and welfare of others. The dangers which threaten the morale of the individual who is not satisfactorily engaged in some form of national service, were emphasized by Trotter,[8] and his words apply with an even greater force today:

> It must surely be clear that in a nation engaged in an urgent struggle for existence the presence of a large class who are as sensitive as any to the call of the herd, and yet cannot respond in any active way, contains very grave possibilities. The only response to that relentless calling that can give peace is in service; if that be denied, restlessness, uneasiness and anxiety must necessarily follow. To such a mental state are very easily added impatience, discontent, exaggerated fears, pessimism and irritability.

The guiding principle for the preservation of morale in an emergency should be: "Everyone to a job and a job for everyone."

Here the members of National Emergency Services can assist bodies with recognized authority, such as the police and fire brigade, in educating the general (non-corporate) public beforehand and exercising control and direction during an emergency.

In so far as the disposal of civilian psychoneurotic casualties may have some effect on the morale of the general population and its proneness to emotional crises, it may be noted that Mira,[9] basing his views on his experiences in Barcelona, has stated that "when a man did not return to his post after a nervous breakdown his comrades were quick to notice it and there was a tendency for more neuroses to appear", and "it was our experience that you can always fill your psychiatric beds no matter how many you decide to have; the supply creates the demand". In the "Memorandum on Neuroses in War Time"[10] it is advised that while intensive treatment should be applied to psychoneurotic casualties, such patients should be sent to their homes afterwards whenever possible.

If patients in whom such a step is not absolutely necessary are transferred to hospital the conditions from which they are suffering may be accentuated or prolonged and the extent of neurotic disorder in the population may be greatly increased.

The Factory Worker.

Whilst the factory worker shares the general risks of present-day warfare with the rest of the civilian population, he is also exposed to psychological dangers connected with the special conditions of his occupation. The output of unusual effort over a prolonged period under the stimulus of enthusiasm and higher wages is likely to precipitate a breakdown in impulsive, emotional and "nervous" individuals. The exhausting effect of longer hours of work may be intensified by insufficient or unwise recreation. General education on these points and supervision and advice by trained welfare officers might have preventive results of real economic and social value. In the factory worker such symptoms as increasing fatigability, defective concentration, waning interest, irritability and discontent, to say nothing of loss of physical condition and a host of somatic symptoms lacking any clear physical basis, indicate that the breaking point has been reached. So far psychoneurosis amongst the civilian population in the United Kingdom is reported to be negligible. The medical officer of health of Coventry referred to calm defiance after the air raids and a decrease in the numbers attending the psychiatric out-patient departments, although some people seemed to be temporarily stunned after their terrifying experiences. On the other hand, a lay social investigator[11] found numerous persons in quieter districts who had left the great centres after being subjected to bombing and who exhibited intense depression and retreat. Many had taken to their beds and remained there for weeks.

The Child.

If the emphasis which has been laid in recent years on the enduring effects of impressions received in our early years is in any way justified, it follows that children need special consideration in our schemes for the prevention of psychoneurosis. Fortunately, impressionability and plasticity are the natural qualities of the young nervous system. The memory of unpleasant experiences, however severe, provided that they are of fairly brief duration, tends to be crowded out by more pleasurable later impressions. Long-continued uneasiness and tension are far more noxious to emotional stability than intense single shocks. Accordingly the view has been expressed in England that distressing experiences of air raids have left comparatively little aftermath of emotional upset in children, whereas evacuation involving a disruption of home life and separation from the parents and brothers and sisters has a far more disturbing effect. The abrupt breaking up of habits is tolerated badly at either end of the age scale. The need for security and a settled mode of life is greatest in childhood, although coveted by all ages. The most common psychoneurotic symptoms which have been noted in "evacuated" children are enuresis, somnambulism, depression and anxiety, especially anxiety for members of the family left behind in the danger zones. Interference with home discipline and with schooling may well cause a rising tide of delinquency. Long hours in crowded and ill-equipped shelters with a minimum of privacy have exposed children and adolescents to physically unhygienic conditions and to moral risks, the consequences of which have yet to be appreciated. For a smaller number of city children whose upbringing lacked system, if it did not qualify them for the title of neglected, removal to the care of the right sort of foster parents in safer areas has been of the greatest benefit, both physical and mental. Such are a few of the problems of childhood in wartime which we may unhappily have to face, but in regard to which a definite policy will be difficult to attain.

References.

(1) W. S. Maclay and E. Guttmann: "The War as an Ætiological Factor in Psychiatric Conditions", *The British Medical Journal*, Volume II, September 21, 1940, page 381.
(2) W. R. Bion: "Neuroses in War", 1940.
(3) H. Stalker: "Rejection of Psychiatrically Unfit Recruits", *The Lancet*, Volume I, April 26, 1941, page 535.
(4) H. Bartlett: "Psychology and the Soldier", 1927.
(5) "Report of the War Office Committee of Inquiry into Shell Shock", 1922.
(6) A. W. Campbell: "Remarks on Some Neuroses and Psychoneuroses in War", THE MEDICAL JOURNAL OF AUSTRALIA, Volume I, April 15, 1916, page 319.
(7) J. Rickman: "War Wounds and Air Raid Casualties", *The British Medical Journal*, Volume II, August 26, 1939, page 457.
(8) W. Trotter: "Instincts of the Herd in Peace and War", 1916.
(9) E. Mira: "Psychiatric Experience in the Spanish War", *The British Medical Journal*, Volume I, June 17, 1939, page 1217.
(10) "Neuroses in War Time. Memorandum for the Medical Profession", *The British Medical Journal*, Volume II, December 16, 1939, page 1199.
(11) T. Harrison: *The British Medical Journal*, Volume I, April 12, 1941, page 573.

PSYCHIATRIC PRACTICE AND CLINICAL MEDICINE.[1]

By N. V. YOUNGMAN,
Brisbane.

IN any specialty new methods and new ideas on the causation, diagnosis and treatment of disease are being continually evolved. There is often a tendency to associate these advances with the specialty in which they were first noted. When such views are brought forward at such meetings as this, the discussion not infrequently remains confined to a limited sphere. For instance, if hæmatemesis is being considered, the discussion centres round that problem rather than round the search for allied conditions which might provoke a comparable disturbance of physiological processes.

[1] Read at a meeting of the Queensland Branch of the British Medical Association on July 4, 1941.