A STUDY OF ACUTE NEUROTIC DEPRESSION AS SEEN IN MILITARY PSYCHIATRY AND ITS DIFFERENTIAL DIAGNOSIS FROM THE DEPRESSIVE PSYCHOSES.

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Depression or dysphoria in its various forms is probably the commonest single symptom encountered in military psychiatry, and its differential diagnosis is often a matter of extreme difficulty. The author's observations, based on three years' experience as psychiatrist in a military psychiatric hospital, have shown that of a large number of cases admitted with a diagnosis of "depressive psychosis," by far the greater proportion are not psychotic at all, but are cases of an acute reactive neurotic disturbance, characterized by a variety of mixed anxiety, hysterical and psychopathic features, and combined with a marked disturbance in the sphere of affect and personality.

This syndrome in its fully developed form is rarely met with in civilian practice, and appears to be almost peculiar to military conditions; it presents a twofold problem, both in diagnosis and in therapeutics, because the treatment differs radically from that of the psychotic depressions, and the prognosis is invariably good.

The condition consists essentially of a failure to adapt to the radical change of life imposed by military service, and a high proportion of cases show evidence of previous mental instability. The personality types which most commonly develop this reaction are those with mild degrees of mental defect, psychopaths of the emotionally inadequate and antisocial types, the hysterical, and the anxious, worrying over-conscientious type.

Clinically the condition consists essentially of a severe depressive affective reaction, in combination with mixed acute hysterical, anxiety, or sometimes obsessional features in a variety of combinations, but with absence of psychotic features. The outstanding and constant feature, which overshadows all the other symptoms, is the dysphoria. Under it may be included all those conditions which have been described under the labels of "acute psychopathic state," "paranoid state," "paranoid hysteria," "reactive depression," "personality-disorder," and "anxiety hysteria."

The Clinical Picture.

The patient is usually admitted with clinical features predominantly those of an acute depressive state, and is invariably labelled with a diagnosis of "psychotic depression." The clinical signs may be either those of a state of depressed and sullen apathy, or of an agitated state with marked apprehension and increased mental tension.

In the first type the patient is the picture of abject misery. The expression is dejected, mask-like, and miserable, and the conjunctivae often injected as if the eyes were red with weeping. There is often a strong impression of sullenness and deliberate conscious exaggeration and dramatization; the patient exhibits a hostile and unco-operative attitude, and answers to questions are hesitant, monosyllabic, and have to be literally dragged out of him.

Apathy and motor anergia are often so marked as to amount to a condition of semi-stupor, the patient lying curled up in bed and paying no attention to his surroundings. Careful examination, however, reveals that this is due to intense emotional tension and preoccupation, and not to true cerebral retardation, as in the case of psychotic depression. In the second type, acute anxiety and agitation

are much more marked, and sullenness, non-co-operation and pseudo-retardation absent, the condition approximating more nearly to a typical acute anxiety-reaction. The depression and its characteristic features will be more fully described when the differential diagnosis is considered.

Conduct-disorders are often found in the form of emotional and impulsive outbursts, transitory episodes of violence, and suicidal attempts; the last mentioned being nearly always impulsive, dramatic, and ineffectual, with none of the calculated deliberation of the melancholic.

In the sensory sphere headache is invariably a prominent symptom; it is always of the pressure-type, symmetrical and diffuse, and associated with intense mental distress and emotional tension. Functional gastric and visual disturbances are common, and insomnia is the rule, but the appetite is not usually affected.

Gross hysterical and anxiety signs are commonly found in both types, of which the commonest are tremors, tics, astasia-abasia, tachycardia, vasomotor disturbances, and hyperidrosis, with functional pains and paraesthesias. Motor paralyses and anaesthesias of the gross hysterical type are not usually found.

Disorientation in time and space, memory-defects for recent events, fugue-states and amnesias are common; these are most likely to be found in cases with a psychopathic history, and often the " amnesia " is not completely genuine, with a strong element of conscious malingering and exaggeration.

Subjective Symptoms.

The subjective symptoms of which the patient commonly complains are the headache, as already described; depression, usually described as a feeling of " being browned off," " fed up," " miserable," etc.; loss of confidence and feelings of insufficiency and inadequacy; morbid inferiority-feelings, such as that of " not being wanted," " laughed at," or regarded as " queer " by his comrades—i.e. a general feeling of heightened and intensified self-consciousness; inability to think clearly and concentrate; impaired memory and transient periods of confusion, usually described as " turns " or " blackouts," and feelings of acute and constant unpleasant mental tension, commonly described as " worry," or " always worrying," which may be diffuse, or attached to some particular problem, such as domestic and marital difficulties. A variety of phobias are often found, such as fear of crowds, bombing, guns, handling live ammunition, or air-raids. Irritability and intolerance to noise, with transient emotional outbursts of temper and violence for which amnesia is often alleged, are also common symptoms. Subjective complaints of insomnia, frequently exaggerated, are the rule.

Unreality and depersonalization symptoms are found in a number of cases, and in the author's experience this symptom is much more typical of a neurotic than a psychotic reaction.

Differential Diagnosis from Psychotic Depression.

It will become evident from the above description that the condition with which the acute depressive neurosis may be most easily confounded is an acute psychotic depression.

Indeed, the profound emotional and personality disorder in the former condition often invest it with a superficial resemblance to a depressive psychosis, which renders correct diagnosis a matter of extreme difficulty. The main features which differentiate the two conditions will now be briefly indicated and discussed.

It should be emphasized in the first place that the true manic-depressive psychosis is a rare condition in military psychiatry. The reason for this is that this condition, as do also the involutional depressions of later life, does not usually manifest itself until after the age of 30 years; and the age-group most commonly dealt with in military psychiatry is that of 18–30 years.

Psychotic depressions occurring under the age of 30 years are, in the author's experience, nearly always disguised schizophrenic episodes, and, if observed for a sufficient period, eventually reveal themselves in their true nature by the appearance of suggestively schizophrenic symptoms, rendering diagnosis relatively easy.

Taking the symptoms individually, the depression of acute neurotic states is found to have features which readily distinguish it from that of melancholia or

depressive schizophrenia. Although profound, it is always strongly appropriate, and in nearly all cases a precipitating cause is present in consciousness. Such causes are commonly domestic, especially marital, troubles consequent on enforced separation from home; inability to adapt to military conditions—the so-called "martial misfits"—found especially in mental defectives and psychopaths of the constitutionally inadequate type; long and strenuous hours of duty with excessive responsibility, especially in the case of men of the over-scrupulous worrying type; and repeated failure to achieve promotion, with resulting feelings of grievance, inadequacy and frustration—the so-called "justice neurosis."

There is often a strongly psychopathic history, in the form of delinquency, chronic absenteeism, episodes of aggressiveness and violence, or drunkenness; the sullen and apathetic type of reaction is the kind most likely to develop in these psychopaths.

In the depressive psychotic, however, the prepsychotic history and personality are often excellent; he has usually been a keen and efficient soldier or N.C.O., a good mixer, popular, and with a strong liking for Army life; the history is usually of an insidious and causeless onset of depression "out of the blue," with no adequate precipitating factors. In psychotics, again, hopelessness and apathy, rather than acute anxiety and tension is the rule; true cerebral retardation rather than sullenness, persecutory delusions and auditory hallucinations of accusatory type are usually concomitant symptoms; these are not found in the acute neurotic reaction. In agitated depressives the agitation is stereotyped, and usually associated directly with the delusional and hallucinatory features rather than with the symptoms of acute anxiety, and there is always a distinct element of the bizarre and unnatural which is never found in the acutely depressed neurotic.

Acute hysterical headache, somatic anxiety signs, tremors, tics, amnesias and fugue states are much more typical of the acute neurotic depressions. True hallucinations and delusions are never found with the neurotic depressions. These cases are often admitted with a psychiatric report of having been "acutely deluded and aurally hallucinated." Careful examination, however, always reveals that the hallucinations are either entirely of the hypnagogic type, or else merely nightmares; or, if they have occurred in a setting of clear consciousness, have been of the elementary or simple type—i.e. "buzzing" in the ears, "singing in the head," etc. Such sensations are never interpreted in the bizarre manner of psychotics. In cases with acute hysterical fugues or twilight states, the commonest form is that of terrifying noises, usually of guns, bombs, aeroplanes, etc., associated with vivid recurring phantasies of terrifying battle or "blitz" experiences.

The alleged "delusions" are usually found to be merely feelings of inferiority, inadequacy or morbid self-consciousness, which have been wrongly interpreted, and clinical evidence of true projection and dissociation is never found. A common example encountered is that of the depressed and anxious mental defective who has been the butt and laughing-stock of his comrades, or the victim of a bullying N.C.O., and whose "delusions of reference and persecution" are only too well founded on fact.

Other points which distinguish the neurotic-depressive syndrome are the relative frequency of minor degrees of mental defect shown by cases of this condition, as compared with the manic-depressives; the greater day-to-day variation in the intensity of the symptoms, which often become much less pronounced if the patient thinks he is unobserved, and are modified to a much greater extent by outside influences (visits of relatives, promise of release from service, etc.); and the fact that they very often tend to show a rapid and spontaneous improvement within a few days of admission to hospital, without any special treatment.

The most reliable diagnostic test, however, which has been found by the author to be almost specific, is the response to electro-convulsive therapy. In the depressive or depressive-schizophrenic, the application of three or four shocks nearly always produces a dramatic improvement; in the neurotic-depressive no improvement at all is produced, and some cases—the agitated and anxious type particularly—may actually become worse following the treatment. Further reference will be made to this in discussing the treatment of these conditions.

The response to narco-analysis in the depressed neurotic is always dramatic, with strong abreaction and abolition of inhibition and stuporose features, and the acute features can often be cleared up completely in a single session.

In psychotic depression the relief obtained is always transitory, and the general response is not nearly so good.

The other conditions for which an acute neurotic depression may be mistaken are simple schizophrenia, depressive-paranoid psychosis, and organic conditions, such as general paralysis with depressive symptoms. Schizophrenia simplex sometimes has an onset deceptively like that of the depressive neurosis, with depression, feelings of inadequacy, and emotional outbursts, the bizarre features with apathy and personality-deterioration being absent in the early stages. The diagnostic pointers are the earlier age of onset, absence of adequate causal factors, and the appearance, sooner or later, of typically bizarre and psychotic features; the response to anoxic-shock-therapy in the early stages is also a reliable test.

As already indicated, the neurosis may be easily mistaken for a paranoid-schizophrenic episode, particularly in cases where the principal complaints are of frustration, unfair treatment, and " victimization," and there is a strong sense of grievance against authority. In these cases careful inquiry always reveals that the " paranoid ideas " have a real basis of fact, genuine hallucinations and delusions are absent, and the condition rapidly settles down after admission to hospital without recourse to shock therapy.

General paresis with symptoms of depression and loss of efficiency should offer little difficulty. The later age of onset, evidences of organic nervous disease and serological changes should easily settle the diagnosis.

Course and Prognosis.

As already indicated, the course of these disorders is one of rapid spontaneous improvement, and the prognosis for complete recovery invariably good. Within a day or two of admission to hospital the acute depression, apathy and other gross features begin to clear up, and the patient rapidly becomes brighter and more interested and co-operative. Removal from active service conditions to a hospital ward is by itself often effective in producing a remission. The underlying psychopathic traits, however, remain unchanged, and the prognosis for return to duty is poor. The outlook is better in those who have broken down under stress of front-line service overseas; in these cases, downgrading to home service category and return to duty under more sheltered conditions can usually be considered, particularly where the history shows a good pre-neurotic personality. The military prognosis in those where the precipitating factor is domestic or marital maladjustment is generally poor.

Treatment.

In view of the tendency to spontaneous improvement and absence of any specific therapy, treatment is for the most part symptomatic. As already stated, shock therapy is generally ineffective in these cases. For one particular symptom, however, acute hysterical headache, it has been found to be of value; it has been found that this, one of the most distressing and otherwise intractable symptoms, can in nearly all cases be promptly and effectively relieved by three or four applications. It should be reserved for those cases where the headache is the most prominent and distressing symptom.

For cases with acute stupor, gross inhibition with emotional tension, amnesias and general unco-operativeness, narco-analysis with pentothal or amytal has been found to be the treatment of choice. Abolition of these symptoms can usually be effected by a single injection.

Benzedrine sulphate in doses of 10–20 mgm. twice daily has been tried by the author, but the results have not been striking. It does not affect the headache or the depression, and is contra-indicated in cases where there is much tension, insomnia and anxiety. It is, however, of value in some of the milder cases where the principal symptoms are mild depression with subjective feelings of asthenia and loss of energy. For cases with pronounced tension, anxiety and emotional instability, a sedative mixture *t.d.s.* containing full doses of bromide with chloral hydrate gr. ij–iij is often effective. Alternatively, for cases with much evidence of sympathetic overaction, carbachol (carbaminoyl-choline) 2 mgm. two to three times daily has been found to be effective. Insomnia and nocturnal restlessness are best treated by hypnotics in full dosage.

As regards general measures, rest and occupation are particularly beneficial; the simpler forms of psychotherapy are also employed, but these have a strictly limited application, particularly in the mental defectives, psychopaths, and in cases where the precipitating factors are the common ones of chronic marital maladjustment and conscious desire for discharge from the service.

Summary.

(1) The syndrome of acute neurotic depression and its clinical features as found in military psychiatry are described.

(2) The differential diagnosis from psychotic conditions with depressive features is discussed.

(3) The use of electro-convulsive therapy as a diagnostic test and its relative ineffectiveness as a therapeutic measure in these conditions is indicated.

(4) The rarity of manic-depressive psychosis in military psychiatric patients is emphasized.

(5) The close association of the neurotic-depressive syndrome with mental deficiency and psychopathic personality is indicated.

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