SCHIZOPHRENIA IN MILITARY PSYCHIATRIC PRACTICE.

By G. Tayleur Stockings, Capt. R.A.M.C.

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The object of this paper is to present a brief review of nearly five years' experience of the schizophrenic group of psychoses as found in military practice, with particular reference to its treatment, and to important new facts which have recently come to light regarding the relative values of the convulsive and insulin therapies.

Forms Commonly Encountered.

Schizophrenia in its various forms is by far the commonest psychotic condition encountered in the Army to-day. The reason for this is that the age-group of men encountered is 20–35 years, at which period of life the disease is commonest. The form of the disease does not differ from that found in civil practice, except that it is much more frequently detected in its early stages, since conduct changes which would probably go unrecognized in civil life, when they occur in a soldier are quickly detected by his officers or N.C.O.'s, and the man referred for treatment.

The most common early symptoms for which a man is referred are conduct-changes, peculiar behaviour observed by his N.C.O.'s or comrades, disciplinary offences—*e.g.*, going absent without leave, or impulsive or aggressive behaviour, failure to respond to training, or the sudden onset of acute confusional symptoms. Thus, the gradual onset of apathy, loss of interest and slovenly habits in a man who has previously been a keen and efficient soldier is often pathognomonic of the condition. It is exceptional for the man to report sick of his own accord, and he is usually referred by the officer or N.C.O. in charge of his military unit.

Acute confusion of sudden onset is one of the commonest early symptoms, in contrast to what is commonly stated in most text-books—viz., that the phenomena of schizophrenia occur most commonly in a setting of clear consciousness.

The commonest types found are the hebephrenic, with bizarre delusions and hallucinations and disorder of thought, and the depressed type, with mental confusion and hallucinosis; paranoid types and schizophrenia simplex are less common. Katatonic excitements and stupors are also commonly found.

Differential Diagnosis.

The differential diagnosis is often difficult, especially where the onset has been insidious with slight symptoms.

In the acute confusional form, the principal diagnosis is from the acute hysterical states. The presence of severe headache, absence of bizarre hallucinations, mannerisms, incontinence and degraded habits in hysterical confusional states are the most reliable diagnostic signs. The response to narco-analysis is also a reliable test.

Psychopathic personalities with acute excitement and conduct-disorder often cause difficulty; here the past history and the absence of true hallucinations and delusions should help the diagnosis.

Epileptic hallucinatory-confusional states are occasionally a source of difficulty; the history of fits and the electro-encephalogram—the latter particularly—have been found to be the most reliable guide.

Mental defect with mild hysterical or depressive features is often difficult to distinguish from the simple form of schizophrenia, particularly as the two conditions often coexist; a period of close observation for the appearance of definite psychotic symptoms is often necessary in these cases.

Acute depressive psychoses of the manic-depressive type are sometimes a source of difficulty, since a simple or hebephrenic schizophrenia in the early stages often exhibits symptoms identical with those of an acute psychotic depression. The poor

response to electro-convulsive therapy, however, and the gradual replacement of depression and anxiety by dullness, apathy and profound mental confusion, soon indicate the schizophrenic nature of the condition. In general, manic-depressive insanity is an uncommon condition in military psychiatry on account of the age-groups dealt with, and acute psychotic depressions nearly always turn out to be a manifestation of schizophrenia.

An important condition which sometimes simulates the psychosis closely is a species of acute obsessional state with mixed anxiety features, which appears to be peculiar to soldiers, and is best described by the name of " justice neurosis." These cases are usually admitted to hospital with a diagnosis of " paranoid schizophrenia"; the patient is usually tense, anxious and agitated ; he complains of unfair treatment by N.C.O.'s and officers, victimization, " not having had a square deal," bullying and being " picked on " by other men. The condition usually settles down quickly without special treatment, and true psychotic delusions and hallucinations are absent, the man's grievances always having a real basis of fact.

The last condition which may lead to difficulties is malingering. In my experience, pure malingering is very rare, contrary to what might be expected. There is almost always a strong element of psychopathic personality or feeblemindedness associated with this condition, and the diagnosis can be usually confirmed by a few days' skilled observation.

Considerations in Treatment.

We now come to the practical applications of shock-therapy in military practice. The outstanding fact which has been observed in a series of over 300 cases so treated, is that schizophrenic cases can be differentiated for practical purposes into two distinct groups—one which responds to anoxic shock, but not to insulin, and one which responds to insulin, but not to anoxic shock-therapy ; these groups can be distinguished clinically by certain distinctive symptoms.

The first group, which will be referred to as the dysoxic type, is distinguished by depression of mood, slowing of cerebration, apathy, and general underactivity ; it includes psychotic depressions, paranoid schizophrenics with a depressive setting, katatonic stupors, simple schizophrenia, and some types of alcoholic hallucinosis without dementia. Anoxic shock appears to have a specific stimulating effect on these cases.

The second group, which will be referred to as the dysglycolytic type, is distinguished by the opposite symptoms of overactivity, elation, motor excitement, and rich variety of bizarre delusions and hallucinations. It comprises the acute manias, hebephrenic and katatonic excitement and paraphrenias. Insulin appears to have a specific tranquillizing effect in these cases, and directly influences the underlying thought-disorder, which does not appear to be affected by anoxic shock-therapy.

My technique in treatment does not differ in essentials from that laid down in standard works on the subject, except as regards the frequency of application in anoxic shock-therapy. It has been found that in very acute dysoxic cases—e.g. acute katatonic stupors—it is quite useless to give shock-therapy two to three times weekly ; application once daily for the first five shocks is found to be the optimum frequency, followed by application on alternate days, until a remission has been produced. In milder cases, shock-therapy on alternate days is usually sufficient. Remission is usually obtained after 7–10 shocks, and it is exceptional for more than 10 applications to be required. The course of treatment is spread over a period of approximately three weeks.

In dysglycolytic cases it is usually found that a course of 20 comas is sufficient to produce a remission. The technique used is similar to that laid down in standard works, except that the intravenous method of termination is used in all cases, followed by a high carbohydrate meal immediately on waking ; it has been found that with this method the oral glucose feed can be safely dispensed with—an important consideration in wartime where stocks of glucose are strictly rationed. The course of treatment lasts approximately six weeks.

Results Obtained.

It has been found that of all cases treated, complete remission may be expected in 70 per cent., improvement in 15 per cent., and failure in 15 per cent. The average stay in hospital is 8–10 weeks.

Prognosis.

As regards prognosis, it has been found that, generally speaking, the acute katatonic stupors with marked ideas of guilt and mental confusion have the worst prognosis, especially if occurring under the age of 20 years. They do not respond at all to insulin, and are much more resistant to shock than the other dysoxic types. It has been observed that cardiazol combined with electro-shock produces a much more marked beneficial effect in this type than does electro-therapy alone.

Typical hebephrenic and delusional schizophrenias have been found on the whole to respond very well to insulin.

Of other factors influencing the course of the disease, it has been found that a bad prognosis is not necessarily always associated with the following: a bad family history, bad prepsychotic personality, co-existing mental defect, and disorder of conceptual thinking of the hebephrenic type. A good prognosis is not necessarily associated with acute onset of the psychosis, adequate precipitating factors, good previous personality record and sound family history.

After-Treatment.

It is the general rule in the services that all patients who have had a definite psychotic breakdown, whether fully recovered or not, are invalided out of the service as permanently unfit at the termination of their treatment. Removal from the stresses and unusual situations of army life has been in the great majority of cases found to be the only effective safeguard against relapse.

The only exceptions made are in the case of men with good prepsychotic personality records, and whose breakdown has occurred under exceptional stress. In these cases, downgrading to home service category and return to duty after an adequate period of sick-leave is considered.

In the vast majority of military psychotics, who have made a full recovery, it is found that residual mild anxiety-signs with lowered morale, lack of confidence, and dread of return to duty remain; these symptoms are simply the natural after-effects of a terrible and shattering experience, and not due to any specific post-psychotic deterioration. They invariably clear up after return to civilian life.

In conclusion, emphasis should be laid on the great importance of early diagnosis and early and energetic treatment in the schizophrenic psychoses. If these desiderata can be fulfilled, and the differentiation of the dysoxic and dysglycolytic types and their appropriate treatments be clearly recognized, there is no reason why that pathetic figure, the chronic schizophrenic dement, should not soon become a pathological rarity in psychiatric hospitals.

Summary.

(1) The common clinical manifestations of schizophrenic psychosis as found in military psychiatry, and its differential diagnosis, are described.

(2) The clinical and prognostic characteristics of the two main types, dysoxic and dysglycolytic, are differentiated and described.

(3) The favourable prognosis in the majority of the cases is indicated.

(4) The importance of early and energetic therapy is emphasized.

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