MANAGEMENT OF THE PSYCHONEUROTIC SOLDIER

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THE modus operandi of a specialist unit is often an area of mystery to medical practitioners, to an extent which leaves them at a disadvantage when advising a patient on his prospects for admission, treatment, and return to a useful community living. This is particularly true of psychiatric medicine in which the training of practitioners themselves may have been fortuitous, and in which the therapeutic field is changing rapidly under the impact of the remarkable developments of the past thirty years. It taxes the leisure of practising psychiatrists themselves to keep abreast of the changes wrought by legislative, administrative, and therapeutic innovations, which as far as civilian practice is concerned have been comprehensively surveyed by Clark (1963). Even within the current wider limits of treatment, the approach at each hospital is open to considerable variation, depending on the amalgam of individual enthusiasms and the relative emphasis placed on drugs and physical methods, individual or group psychotherapy, community management, and behaviour therapy.

In passing, the British Army has had close associations with several of these developments. Occupational therapy has been in use since the First World War, and the management of acute psychiatric disorders within general military hospitals—and actually on general medical wards—has long been accepted and feasible. Maxwell Jones (1952) drew his early observations on therapeutic community management from service personnel at Mill Hill, and from ex prisoners of war at Dartford. Group psychotherapy in England owes much to the experience gained on servicemen by Bion and Rickman (1943) and by Foulkes (1948) in his admirable Northfield experiment, whilst much was learned of the application of modified insulin therapy and abreactive procedures to psychiatric battle casualties by Sargant, Slater, Shorvon and Craske (Sargant 1963).

In an attempt to improve the communications between general civilian or regimental practice on one hand and one specialist unit on the other, this paper offers an outline of the routine procedure and scope of treatment and disposal available for service personnel. It applies mainly to military psychoneurotic conditions and personality disorders, with emphasis on cases calling for admission to the Army psychiatric unit at the Royal Victoria Hospital, Netley, which functions essentially as a short stay full time psychiatric unit. Psychotic or severe dementing conditions are excluded since their supervision is the responsibility of a parallel division within the hospital, though much of the procedure is common to both divisions. The facilities are equally available for male and female ranks and officers, and their dependents, of all three services.

Admission to a psychiatric hospital, even in a contemporary social atmosphere, is rarely accepted with vigour by the patient. This applies especially to the soldier, whose arrival may be marked by strong undertones of reluctance, hostility or resignation, or by thinly disguised fear of the consequences. These are valid reactions, for at best, a return to duty may precipitate fairly rough leg-pulling and suspicion on behalf of his colleagues, or demotion, or restriction of responsibilities. Large sections of society still have outmoded conceptions of mental hospitals in terms of asylums, padded cells and straightjackets, whose primary purpose is to isolate the sad, mad, and bad.

It is generally agreed that early admission in appropriate cases brings many therapeutic and prognostic advantages, including a better response to treatment, the prevention of re-inforcement of psychopathological mechanisms and symptoms, and reduction of suffering and work inefficiency. It is logical therefore, that re-education should be designed to encourage early admission and a realistic acceptance of psychiatric treatment. One broad group of soldiers to whom these remarks apply with particular force is that characterised by the single senior n.c.o., usually with many years of valuable service behind him, living with the usual mess-life proximity and access to alcohol, often with no other outlets in life. This sector of the military population occasionally supplies the most severe and tragic cases of alcoholism, often presenting in relative disgrace with charges pending (absent without leave, larceny, misappropriation of funds), or demoted after court martial, or with desperate suicidal bids. Their case history almost always indicates that earlier action and persuasion could have forestalled these castastrophies, since there is frequently a preceding history, extending over months or years, of deteriorating work efficiency, deteriorating confidential reports, unreliability, shabby turnout failing memory, loss of the finer subtleties of personality, suspicion of being intoxicated on duty, and of being " carried " by colleagues or subordinates. Not least in this situation is the extra stress placed on their successors who inherit the disordered accounts, duties, and inventories and the thankless task of re-organising the department.

Scheme for Referral

The British Army has a comprehensive deployment of its psychiatrists either in U.K. or overseas commands, as command or area psychiatrists, or as medical staff at the Royal Victoria Hospital. The command and area psychiatrists have primarily outpatient, recruit selection and advisory functions to servicemen and their families, and are responsible for varying numbers of inpatients at the general hospitals on which they are usually based. In areas where troop and family concentrations do not justify employment of a full time army psychiatrist, these functions may be carried out by approved civilian psychiatrists (Glasgow, Birmingham), Royal Naval psychiatrists (Plymouth, Malta) or Royal Air Force psychiatrists (Aden).

Unit medical officers usually arrange outpatient consultation with the appropriate psychiatrist, and in many cases the service psychiatrist will prefer to interview the patient at his own unit. Clinical information from the medical officer is supplemented by a military report from an officer with close knowledge of the patient's character, by his conduct sheets, and by the recruit selection details and intelligence test results. These forms yield valuable information on the patient's personality, behaviour, response to training and stability.

In the densely populated military area covered by Southern Command during the national service days of 1958-59, the level of referrals amounted to 1.5 per 1,000 command strength per month, and 93 per cent of these were assessed and treated entirely on an outpatient basis, drawing on similar treatment and agencies available for the inpatient at Netley. When indicated, in either outpatient or inpatient, transfer to Netley is recommended by the psychiatrist, and broadly this will be to the psychoneurotic division on a basis corresponding to civilian informal admission. Disturbed, or genuinely suicidal patients can be transferred to the close supervision wards of 'P' wing on a medical order.

A small number of admissions are arranged direct to Netley from its own outpatient committment to nearby units, whilst others may be transferred from civilian hospitals, classically those who have developed amnesia, fugues or suicidal bids whilst on leave. Of 627 psychiatric admissions to Netley in 1961, 352 (56 per cent) were male other ranks admitted to psychoneurotic division, 46 percent from overseas and 54 per cent from Home commands. There were in addition 41 serving or retired officers, male and female, (6.5 per cent), 27 civilians or dependents (4.3 per cent) and 27 army or naval female other ranks (4.3 per cent). There were 180 admissions of all ranks to 'P' Wing (28.7 per cent).

Assessment and Diagnosis

The opinions of referring medical officers, commanding officers, personnel selection officers, SSAFA representatives, and the hospital psychiatric social worker are taken into consideration along with the clinical evidence both on presentation and on observation. A full psychiatric history will be recorded, to establish characteristic patterns of behaviour, neuroticism and maladaptation, these patterns often recurring in each individual in the major phases of his development, through childhood, school days, employment, service careers, and marriage. Evidence will also be sought for psychiatric illness in their parents, siblings, or children. A full physical and clinical neurological examination follows, supported by radiography of chest and skull, blood Wassermann reactions, haemoglobin values, white cell count, erythrocyte sedimentation rates, and urine testing when indicated.

This survey of the case will now have suggested other areas which will require closer investigation. Thus middle aged alcoholics will require psychological tests to assess intellectual fall-off or the extent of any memory retention defect, assessment of liver function, and electrocardiographic examination if aversion therapy is proposed. Suspected insidious schizophrenia with a pseudoneurotic foreground will require prolonged observation and full psychological testing ; dullards need detailed intelligence testing ; and cases presenting as idiopathic dementia, or showing specific neurological signs may require lumbar puncture, electroencephalogram, or air encephalograms. The hospital has an electroencephalographic department equipped to record standard and sleep tracings, and facilities for investigating suspected thyriod pathology by use of radioactive iodine uptake studies. The evidence derived from these studies will be freely discussed at all levels, and integrated with the advice and opinions of the visiting consultants in general medicine, radiology, neurology, and electroencephalography to whom patients may be presented, and with the opinion of the clinical psychologist.

In cases where a complete picture is unobtainable by virtue of pathological lying, dullness, amnesia, dissimulation, loss of insight, or dementia, or where evidence of subtle personality change or deterioration is sought, parents or wives are invited to discuss the case with medical officers. The same invitation is extended during treatment particularly in marriage problems where the views and attitudes of both partners need full and open discussion, and where advice on after-care can be offered. Psychological exploration can now be undertaken, with observation of the patient's intellectual and behavioural responses, by interviewing techniques, usually straight but frequently facilitated by abreaction or narcoanalysis, and by the set situations adopted by the clinical psychologist by use of refined tests of memory, intelligence or aptitude, or of projective techniques.

Abreaction with the use of intravenous methedrine is useful for uncovering recently suppressed or acute emotional experience, such as terrifying road accident, assault, or battle-memories, and may be helped by the use of ether by mask to heighten the emotional release. It may be said here that the mere recital of events by the patient is not enough, and that actual emotional experience must be re-lived to give full symptomatic relief, and that this may need to be repeated to " flush-out " all traces of the event. Thus, we have seen phobias initiated in the sole survivor of a terrorist ambush and forest fire who witnessed the rest of the patrol being burned to death, and the innocent man who courageously supported a colleague who had fainted on public parade at attention for 40 minutes, before being forced to release him by sheer fatigue, only to see his colleague fall onto his bayonet which pierced his neck and head.

Narcoanalysis by intravenous sodium amytal or pentothal in sub-hypnotic doses is of help in exploring chronic " atmosphere " situations of interparental—or parent-child friction, whilst hypnosis is valuable for any type of emotional trauma, amnesia, or fugue in suitable subjects.

Treatment

In dealing with psychological disorders, treatment traditionally is of three types.

1. *Environmental manipulation and community management.*
2. *Psychotherapy, both individual and group.*
3. *Sedation and physical methods.*

In many cases, treatment will have commenced before admission—particularly in overseas hospitals, where acute symptoms call for sedation or physical treatment before the patient is fit for evacuation. Further, the only form of treatment required may be executive action producing an environmental change, as by repatriation, sick leave, return to home depot, recommendation for transfer or posting, or for discharge from the service on psychiatric, compassionate, or administrative grounds. Among the well defined groups of patients affected by such action are the new recruits who have enlisted for irrational motives (unstable civilian employment, escapism, unrealistic ideals) ; the immature and dependent personalities who are home-tied ; and the family men who have received distressing news or rumours from home.

The remaining patients are generally suitable for extensive treatment ; reactive depression, anxiety neurosis, personality disorders (immature, inadequate and psychopathic) hysteria, alcoholism and sexual disorders are the commonest diagnoses together with early and simple schizophrenic states and cyclothymic disorders. Although the diagnostic range is considerable, young psychoneurotic patients have features in common, the recognition of which forms the basis of adequate management. They will tend to have suffered a disturbed home life, emotional deprivation, have a positive family history of psychiatric breakdown and abnormal personalities, to have poorly motivated enlistment, and to have contracted complex disciplinary or domestic problems. Their personalities are marked by self-preoccupation, lack of outgoing drive or adventure, lack of group identification, or social conscience, distorted values, unrealistic ambition, undue sensitivity, and tendency to deal with stress unrealistically.

Treatment is carried out within a therapeutic community along the lines suggested by Maxwell Jones (1952), in which considerable importance is attached to staff-patient relationships, preservation of the patient's individuality and initiative, and to full occupational activity. An attempt is made to diffuse the barriers to emotional relationships inherited from general hospital practice. There is a high staff-patient ratio, few acute emergencies, and staff have more time to talk to patients and absorb and guide the emotions and attitudes which accompany treatment. These will include truculence, despair, attention-seeking, rages, obsequiousness, and dependency, and staff are trained to match these with confidence, optimism, tolerance and support. Rank discriminations are minimised, discipline is covert rather than apparent, and staff-patient mixing is encouraged, in the attemp to reduce the usual detachment and urgency associated with images of doctor, sister, and orderly.

Occupational activity is regarded as a keystone of management, and facilities are provided to fulfil as many natural impulses as possible. The intention is that some form of activity, preferably in groups, should be in progress morning and afternoon, from which any individual patient may be taken for tests, treatment or interviews. These activities are tailored to suit the need of short-term neurotics and are not as comprehensive as those supporting the rehabilitation of chronic patients. Industry is encouraged, in so far as it can be in neurotic patients, in carpentry, gardening, and a variety of short term handicrafts, in addition to normal ward chores. Exercise and competition are fostered in physical training in a well equipped gymnasium, and in inter-ward games and competitions both indoor and outdoor. Leisure and entertainments are satisfied as far as possible by a library, NAAFI canteen, indoor games, the provision of a quiet room for letter writing, or entertaining visitors, organised visits to the cinema, theatre or ballet, and an occasional concert produced by the patients themselves.

About 50 beds can be occupied in three wards for male ranks of which 30-40 are in use at any given time. Broadly, new patients will be admitted to an eight-bedded ward for the first 48 hours for initial assessment and clinical examination, and may return to this ward later should their treatment require bed rest, e.g. intercurrent infection, modified insulin therapy, or continuous narcosis. From this ward, patients are transferred early to a fully open 20 bedded unit, whilst under active treatment, and finally to a 22 bedded " finishing " unit which has even less staff supervision and where the patients exercise more responsibility for their own turnout, cleanliness, and behaviour. This latter ward, almost by natural selection usually carries a high proportion of n.c.o's. The unit has separate treatment and interviewing rooms allowing complete privacy. Other wards follows a similar pattern in the management of officers, or female patients.

Psychotherapy is used in its broad sense to include all methods of individual and group inter-action whereby the underlying personality disorder may be influenced towards the development of a socially acceptable and self sufficient end product. The emphasis is primarily on short duration, intensive treatment, with a high staff/patient ratio, and the time a patient spends with his psychiatrist compares very favourably with optimal civilian practice. Major psychotherapy such as analysis is rarely attempted, but within a span of one to three months, against the background outlined above, superficial psychotherapeutic techniques of discussion, explanation, reassurance, persuasion and suggestion are freely used. The aims are to improve insight, to influence distorted life-attitudes (suspicion, dependency, withdrawal) and to improve self control of impulsive behaviour.

When circumstances permit group psychotherapy is used in which groups of seven to ten patients of either similar or mixed diagnoses are encouraged to discuss their problems, to talk out their attitudes, and to adopt relative roles within the group under the guidance of a therapist. In this setting, the patient may show facets never suspected in the individual interview, and is open to a wide range of verbalised or non-verbalised social influences. This form of treatment has found wide application in all fields of psychiatry, and is the current method of choice in many specialised units in England, dealing with neurosis, alcoholism and psychopathic personalities. An extension of this which has been very valuable to service alcoholics is regular attendance at the Southampton Alcoholics Anonymous group, the civilian members of which have been extremely helpful.

On a larger scale the ward conference is used as the occasion demands in which all the staff and patients meet formally, with minutes taken by a patient secretary. At these conferences all changes affecting the wards are announced together with the reasons for them, future projects are discussed and suggestions and offers of help are invited and encouraged from the patient body. This simple method helps to forestall a great deal of discontent and misunderstanding, and mobilises social talents. Finally, another type of meeting which is held regularly and which has considerable influence on the therapeutic atmosphere is the staff conference in which medical officers present details of each new admission or interesting case in outline and encourage discussion amongst all the staff who attend. By this method, the staff learn to appreciate the difficulties of differential diagnosis and are guided in their observation and management of the patients, for groups of whom they assume personal responsibility.

The remaining area of treatment is that of sedation and physical methods. Drugs are used for symptomatic relief as in the use of barbiturates and tranquillisers ; for vitamin replacement, particularly with alcoholics and in states of pathological anorexia ; as specific protective drugs in alcoholism, such as Antabuse or Dipsan ; and the occasional use of hormones in states of physical immaturity, in the control of nocturnal enuresis, or in libido control. Most of the depressive states admitted to this department will respond to anti-depressive drugs of the Imipramine or monoamine oxidase inhibitor group ; and electroconvulsant therapy can be used for the occasional drug-resistant depression. States of severe anxiety with weight loss, or pathological anorexia, often show improvement on modified insulin therapy both in the relief of anxiety and in weight gain, whilst continuous narcosis is used in simple form for the early management of severe acute reactive neurosis. Techniques derived from Eysenkian behaviour therapy have been used for the treatment of stammering, tics, and nocturnal enuresis, or for aversion from alcoholism, homosexuality, and other sexual abnormalities, in most cases with initial success.

Disposal

The ideal disposal for treated neurotics would be to return to duty in their parent unit or an alternative regiment, or a home based depot, usually with a protective PULHEEMS downgrading of temporary or permanent duration, with outpatient reviews at increasing intervals. In fact, this situation arises less frequently than one hopes, and applies mainly to good previous personalities who have been exposed to severe strain, or who have had a reversible endogenous illness. As a generalisation,

better results will be obtained with the career-motivated senior n.c.o. and officer than in the young soldier with less than two years service, or in females.

In practice therapeutic aims must recognise the hard facts of experience, that the grossly abnormal personality or chronic psychoneurotic tends to perform badly within the demands of a service framework, and to develop restrictive dependencies on others or on hospitals. Despite the immense care and attention devoted to problems of welfare, accommodation and discipline by regimental officers in most units, there is a point of balance beyond which further retention of the chronic neurotic is economically and militarily indefensible. Such a patient is precipitated into his maladaptive and time-consuming responses of repeated absence without leave, fugues and amnesias, heavy drinking, assault, or suicidal bids by common events, and even when treatment achieves symptomatic relief and gain in insight, the risk of relapse is considerable.

The disposal figures for psychoneurotic division, Netley, 1961, indicate that the direct invaliding expectation rate for officers is about 16 per cent, for male other ranks 30 per cent and for female other ranks about 66 per cent. The total discharge (from the Army) for male O.R's is higher however, since among those returned to unit will be a proportion whose recommended grade places them below current standards for retention, and who are therefore liable to administrative discharge. Others will be discharged on compassionate or disciplinary grounds, and their ultimate discharge rate will be in the order of 40 per cent. It is clear that a considerable part of the therapeutic effort is therefore directed towards civilian resettlement, and noteworthy that the Army Medical Directorate encourages and provides facilities for any form of treatment which a medical officer believes to hold promise.

Breakdown of durations of hospital stay in 1961 show that 30 per cent male O.R's were discharged from hospital within two weeks, 59 per cent within four weeks, 67 per cent within six weeks, whilst 8 per cent were treated for ten or more weeks. Every patient who is recommended for discharge from the service on psychiatric grounds is interviewed by a disablement rehabilitation officer armed with medical summaries, and provisions are made to ensure reasonable employment or training within the scope of the Disabled Persons (Employment) Act, 1944.

Summary

A survey is presented of the psychiatric services currently available to Army personnel, with emphasis on psychoneurotic disorders, and in particular the minority requiring admission to psychoneurotic division, Royal Victoria Hospital, Netley.

Reference is made to the schemes for admission, facilities for diagnosis, assessment and treatment, crude invaliding rates and duration of stay in the period 1961-1962, in relation to the division's function as a short stay, intensive full time neurosis centre.

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