PSYCHIATRY IN BURMA.

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A CONFERENCE on Psychiatry in Forward Areas was recently held in Calcutta. A full report was forwarded to the Editor by Brigadier E. A. Bennett, *M.C.*, the Consulting Psychiatrist in India. It is regretted that space does not permit the publication of other than very brief extracts. The ones chosen are chiefly condensed versions and extracts from papers by four Divisional Psychiatrists which give some indication of the conditions under which these officers were working.

The D.D.M.S. of the 14th Army wrote: "Your specialists have been, and are, doing invaluable work, especially in the forward areas, and all formation commanders are most enthusiastic. I trust you will be able to enlarge the scope, especially as regards Indian troops. It would, I feel, be an advantage to have Psychiatrists attached to training divisions and brigades in India, if this is practicable."

Although the extracts which follow deal with Divisional Psychiatry, the conference stressed the importance of selection as a preventive measure.

PSYCHIATRY IN A DIVISION ON THE BURMA FRONT.

By Captain P. J. R. DAVIS,
Royal Army Medical Corps.

THIS Division attacked Kohima. The fighting was severe, movement was rapid, the weather appalling and casualties heavy.

It was not clear, to begin with, where a Psychiatric Centre would function most efficiently. The psychiatrist began work at the M.D.S. of a Field Ambulance, located on the outskirts of Kohima and casualties were received direct from the R.A.P.s. The noise of battle was so great, however, that it was impossible for the men to rest and relax and the dose of sedative required to give adequate sleep had to be increased beyond what was desirable. Accommodation here was limited and there was difficulty in holding cases for an adequate time. After a brief trial a Psychiatric Centre was set up 18 miles behind the actual front line at Milestone 38 on the Manipur road.

This Centre proved to be ideal. It was in a corrugated iron shed capable of holding 30 to 40 charpoys (string beds). In one of the large rooms a corner was screened off to form a ward of five beds for officers. A small room was used as a reception and consulting room and the nursing staff was accommodated in another small room. Outside were cookhouse, washhouse, latrines and a small recreation room equipped with radio, newspapers and writing material. Three 40-pounder tents were pitched, each capable of holding two stretcher cases. The Centre was adjacent to a Staging Section to which it was originally attached for rations. Eventually the Psychiatrist found it possible to look after his own rationing arrangements.

The patients, on arrival, were given a short preliminary interview, at which their condition was broadly assessed. It was important to determine at once whether the case was one in which physical fatigue was the principal factor or whether emotional causes were mainly responsible, because of the great difference in the dose of sedative required in the two groups. The Psychiatrist kept well in the battle picture and he was therefore able to judge, apart from the patient's own statement, the physical and mental stress to which he had been subjected.

As a routine the patients were next given a substantial meal with as much hot sweet tea as they could be induced to drink. A sedative was then administered, the dose depending on whether the case was considered to be predominantly exhaustive or emotional. The former required only 1 or 2 drachms of paraldehyde, while the latter often needed 5 drachms, initially, followed by 2 drachms one hour later.

Very agitated cases were accommodated, on admission, in the tents where a maximum of quietness was obtainable and where their disturbed state did not react unfavourably on recovering cases and those about to return to duty.

Sleep for a period of twelve to twenty-four hours was aimed at after which the majority showed marked improvement. Next, each man was given a bath and a change of clothes. Stocks of clothing and washing materials were held.

On the third day the soldier was given a long interview and, when necessary, this was followed by simple psychotherapy. Many improved out of all recognition with nothing more than sleep, food, a wash and a change of clothing. Abreaction, under pentothal, was not found to be a particularly useful procedure. Better results were obtained by using simple persuasion, explanation, firm encouragement and suggestion. In addition to psychotherapeutic procedures, the men were supplied with plenty of writing material and books, encouraged to use the recreation room and to listen to the wireless. The need for further resources in the way of material for diversional therapy was felt at times. Carpentry tools, for example, would have given an opportunity for manual activity.

RÉSUMÉ OF CASUALTIES FOR A PERIOD OF FIVE WEEKS.

Disposal :		
Returned to Unit	104	
To Hospital	26	
Recategorized	23	
Posted to Rear Details	10	= TOTAL 163
Diagnoses :		
Exhaustion	62	
Acute anxiety reaction	51	
Anxiety neurosis	38	
Hysteria	15	
N.Y.D.	12	
Reactive depression	3	= TOTAL 181

It was very difficult to establish a criterion for judging which cases would relapse. At the time of writing (after three months) 12, i.e. approximately 10 per cent of those returned to their units, had relapsed. Most of them had fought well before breaking down again. Those with depression about the loss of comrades, accompanied by marked emotional instability, usually have a good prognosis and many such quickly returned to the line. The apathetic individual, with little emotional feeling, did not do well. Those of sound personality, who develop acute anxiety conditions, have a good prognosis. The timid, unaggressive individual, of solitary habits, is apt to relapse. He is less tough than the average soldier.

The low rate of psychiatric casualties in this Division is considered to be due to three causes :—

(1) Thorough selective work had been carried out during the training period. (2) There was a high standard of officers and leadership in the Division. (3) The morale of the British soldiers in the Division was high.

DIVISIONAL PSYCHIATRY.

By Captain J. W. MILLER,
Royal Army Medical Corps.

THIS Division was fighting in the Imphal area at a time when Japanese infiltration was taking place and consequently operations were "fluid."

Psychiatric casualties were seen under a variety of circumstances. From March to April the Psychiatrist was attached to an Indian Field Ambulance. This unit was located in the March defensive position or "Box." To this "Box" groups of soldiers who had become casualties made their way. The Psychiatrist made a point of seeing all British cases admitted to the Field Ambulance. Owing to the numbers it was difficult to see all the Indian cases.

In the "Box" treatment was carried out at the M.D.S. Cover from shelling was secured by digging in but there was no head cover. A splinter-proof room would have been a great asset, but it was not possible to make this. Consequently, dealing with psychiatric cases was

complex. Nevertheless, more than 50 per cent of cases returned to their units within three days.

When the position was evacuated a well-organized withdrawal in a "March Box" took place. Treatment in this was difficult but not impossible. Sedatives, explanation and rest were the chief measures employed. When the "Box" position was first occupied no one clearly knew the disposition of the troops nor the size of the "Box." There was a good deal of apprehension about the position of the Japanese and considerable nervousness was shown once or twice. The troops soon settled down and put up a remarkably good show.

The number of cases seen was 53—25 were returned to their units in Category "A," 3 in Category "C," and 25 were evacuated.

The following points, amongst others, are noted :—

(1) It is difficult to hold cases at the M.D.S.

(2) All units should know the position of the Psychiatrist.

(3) Classification of admissions quickly into the following categories : (i) Those returnable in same category ; (ii) those requiring prolonged treatment and to be evacuated ; (iii) men unfit for front-line duty but fit in a lower category.

Treatment.—In certain instances pentothal was used within the first twenty-four hours. Those selected for its use were apparently well but unwilling to return to duty or to co-operate. Paraldehyde, 4 drachms, morning and night, gradually reducing the dosage as indicated, was most useful. When barbitone-soluble was used, at least 22½ grains were given to begin with. Morphia and hyoscine were found to be of little value with battle casualties. Morphia gr. ½ and hyoscine gr. 1/50 often had little effect.

On the second day psychotherapeutic measures were used, such as superficial analysis, persuasion and suggestion and reassurance. A thorough physical examination was also made.

On the third day, if the patient was doing well, sedation could be reduced to paraldehyde, 1 or 2 drachms, night and morning. Whatever occupation was possible, such as games, reading, digging trenches and constructing dug-in wards, was encouraged.

Heavy sedation was used when evacuating those with a serious breakdown of a psychotic or psychoneurotic nature.

Psychiatry in a Division.

By Captain A. H. Williams,
Royal Army Medical Corps.

This Division was in action on the Arakan Front. When the fighting stabilized, the fighting consisted in a series of attacks on defended hill features. Exhaustion, with anxiety, was frequent after each action. These patients responded quickly to rest, sedation, good food and simple reassurance. They were seen at the M.D.S. which was close to our guns. There was also a party of Japanese about 400 yards away. The therapeutic setting consequently was not ideal. Only patients with an obviously good prognosis were retained. They were kept, on an average, for five days and then returned to duty. Gunfire was incessant and the standard of physical comfort was low. From sunset to dawn there was a constant danger of Japanese patrols. Smoking, talking and any movement were forbidden during the night. Patients were made as comfortable as possible and given good food and such other medical comforts as were available. The only sedatives used were medinal and morphia. If a patient did not respond to medinal gr. 15 t.d.s. he was evacuated. There was a shortage of other sedatives as the unit was working on a pack basis.

Amongst the points mentioned are :—

(1) During the monsoon, malaria increased, and with it was seen a marked rise in toxic psychosis.

(2) Physical investigations often revealed anæmia, splenic enlargement and infestation with worms. When the physical conditions were remedied, the psychiatric symptoms often faded.

(3) Morale amongst Indian other ranks depended on good leadership and administration. When the men are well fed, given regular leave and when their religious scruples are respected,

they will do anything and go anywhere. Morale in British other ranks depended on their knowing what they were expected to do, unit *esprit de corps* and sound tactical leadership.

A Note on Psychiatry in Indian Troops.

By Major J. Matas,
Royal Canadian Army Medical Corps.

The following short extract from a paper on Psychiatry in an Indian Corps by Major Matas, is given. He raises an important point when he refers to the use of the blood sedimentation rate to exclude active organic disease.

Indian Other Ranks.—It was noted how frequently physical factors caused or contributed to their psychological symptoms. It was often difficult to make an exact diagnosis as usually they could not be kept long enough at the Corps Centre for the physical illness to be treated.

The I.O.R. is subject to hysteria, commonly in the form of " fits." Under acute stress, gross hysterical symptoms, such as deafness, blindness and tremors, were frequent. In most instances these patients responded to simple suggestive measures while conscious or under the influence of pentothal. The I.O.R. was very difficult to deal with if he developed an anæsthesia or paralysis following a slight wound. Patients who complained of weakness, dizziness, vague aches and pains, and even of psychotic symptoms, often had a physical illness, commonly chronic malaria, amœbic dysentery or hookworm infection. The blood sedimentation rate was done, as a routine, in all cases of doubtful ætiology.

In spite of the larger number of I.O.R.s in this Corps they suffered less, proportionately, then the B.O.R.s from psychoneurotic illness. Psychosis, on the other hand, was commoner. In 7 of the last 11 I.O.R.s admitted as psychotic, toxic factors were found. Suspected S.I.W.s were very much more common in the I.O.R.s than in the B.O.R.s.

Delirium, as a symptom of a toxic psychosis, was rare amongst I.O.R.s. More often the psychosis was of the stuporous type, and the patient was mute, self-absorbed, inactive, indifferent, neglected food and soiled himself. Sometimes a mood of fearfulness, related to the alleged presence of the enemy, appeared in a psychotic setting.

The I.O.R. is liable to short psychotic episodes of the manic-depressive and schizophrenic types. If prolonged, the clinical picture is likely to change rapidly from week to week, e.g. the patient with mild anomalies of behaviour becomes " crazy " in the lay sense of the term, shortly to revert to his former behaviour.

Viceroy Commissioned officers and officers of Indian birth, developed psychoneurosis of the same type and, for the same causes, as the B.O.R. In I.O.R.s it was difficult to assess the level of intelligence except clinically, as tests used on B.O.R.s are unreliable for I.O.R.s and no others were available. In the illiterate I.O.R., such simple tests as remembering six numbers, or counting backwards from 10, were found to be beyond the capacity of even quite the competent sepoy.

To determine the intellectual level of the I.O.R. is less important than with the B.O.R. In the B.O.R. the dull and backward break down in action. In the hardships and dangers of active service he has nothing to support him except a vague desire to do his bit. Sentiments such as patriotism, appreciation of the alternative to winning the war, tradition, and other complex ideas which keep up the morale of the average man, are beyond his grasp. In addition, he has been brought up with one set of ideas which can be summarized as the Christian attitude, and he lacks the capacity to adjust to what is, in many respects, the antithesis of this attitude. The I.O.R., however, is accustomed to a lower standard of living, and he finds the hardships less onerous. In addition, he is living in his own country and can go home periodically, and, most important of all, the I.O.R. infantry soldier comes from a martial race, and being at war requires no re-orientation of attitude.

The Gurkhas, on this front, produced very few cases, either psychotic or psychoneurotic. The average Gurkha starts with better physical health than the I.O.R., is perfectly adapted to fighting and accustomed to the jungle.