PSYCHIATRY
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(With Additions by the Editor)

The early developments in the treatment of mental disease in the Army—up to the opening of “D” Block, Royal Victoria Hospital, Netley—have been described in a recent article by Rosie. No fundamental changes were introduced until after the first World War when great advances were made in the treatment of mental illness.

Not until the recent war did Army Psychiatry as we now know it attain its present status and gain full recognition.

Prior to the War of 1914–19, and after it as well, for that matter, the Army Specialists dealt solely with the treatment of the insane and what were then known as “borderline cases.” This term included the neurotic and psychoneurotic group as well as the feeble-minded, psychopaths and the neurasthenics. Nearly all the work was done at “D” Block. Here came all the cases of mental illness in England as well as patients from overseas. Its main function was to act as a clearing centre from which patients were either, (a) discharged to the care of their relatives, (b) certified and sent to the appropriate asylums (later, mental hospitals), (c) transferred to the medical wards as “non-mental” patients, or (d) returned to duty.

None of the patients at “D” block were certified which was an advantage from many points of view, particularly as the “stigma” of certification was avoided, an important aspect from the relatives’ point of view. One of the main principles behind treatment was to enable the patient to recover sufficiently to be able to avoid certification. The officer-in-charge was allowed considerable discretion as to the length of time patients were retained under treatment. Until the war of 1914–19 the treatment of all mental patients was conservative. The now well-known forms of treatment—psychological and physical—were still in their infancy and the use of the padded room, seclusion and restraint still remained as part of the physician’s armamentarium.

In 1907 “D” Block had been enlarged by the addition of a new infirmary ward, bright, cheerful and modern, but the atmosphere still remained that of a mental hospital.

THE WAR OF 1914–19

The experience of the first Battle of the Somme when several thousand soldiers were, in a few weeks, withdrawn from the battle zone on account of “nervous disorders” made it obvious that to deal with this waste some specific
medical organization was necessary. One of the difficulties was an attitude of mind which held that it was not possible to differentiate cases of psychoneurosis from cases of "malingering."

Towards the end of 1916 a special "N.Y.D.N. Centre" was set up in each Army area for the treatment of such cases. This was largely on recommendations made by the Consulting Psychologist, C. S. Myers and the Consulting Neurologist, Gordon Holmes. At the same time a number of "neurologists" who were, in fact, "psychiatrists" were brought into the Army.

At first the tendency was to regard all these cases as "Shell Shock" postulating an organic basis (on the lines of the modern "post-concussional syndrome") and disregarding the psychological determinants which were, indeed, seldom recognized.

In a review of the position of Army psychiatry in 1920, Dr. C. S. Read—formerly officer-in-charge "D" Block—wrote as follows: "It is certain that as psychiatric medicine is having its importance more recognized in civilian life, the military authorities will have to develop their branch in the Royal Army Medical Corps, and by its scientific application do much to improve the mental status of the soldier. The sooner some officers become thoroughly trained in this specialty the better. The late war has given an enormous impetus to the necessity for active interest in psychopathic disorders and the lessons learnt should immediately instigate a line of organization by means of which the soldier's mentality can be judged accurately, so that his fitness for any particular form of service may be gauged. This would mean not only increased efficiency through elimination of the unfit but also increased efficiency by seeing that the soldier is psychologically suited for his particular work. Thorough psychiatric knowledge, too, would bring added justice in its train, as the delinquent is then seen in his right perspective. All frequent offenders, and certainly a large proportion of court-martial cases, should be mentally examined in order to get at the basis root of their anti-social acts, and so treat the offender and not the offence. This certainly has been a lack in the Service organization during the war, when organic neurologists with no psychiatric training have been called on to determine the question of responsibility of such men."

Following a Debate in the House of Lords in April 1922 the Southborough Committee was appointed by the War Office to survey the psychiatric problems of the war of 1914–19, and later issued its report. This Committee, having considered the evidence of combatant officers and medical witnesses, made a series of recommendations nearly all of which have the full approval of informed psychiatric opinion. The report stresses, in particular, the importance of adequate selective procedure in preventing psychiatric illness in the Armed Forces. It was emphasized that both executive and medical officers should co-operate in detecting mental instability, and that for this purpose they should receive special instruction in the management of men and in the nature of psychiatric disorder.

**BETWEEN THE WARS**

With the advent of peace "D" Block again became the collecting and dispersal centre for all Army cases. It was the only special hospital and there
were few fundamental changes in treatment to start with. However, as modern methods were introduced in civil practice they were taken up and used at “D” Block. The Army Specialists were given thorough and extensive training albeit particular stress was laid on the diagnosis and treatment of psychotic illness as well as on neurology. The specialty was not then divided.

The introduction of modern methods of treatment and a more modern approach was largely due to the initiative of such enlightened officers as Webster and Gall.

Malaria therapy for the treatment of G.P.I. was used in “D” Block about 1929 or 1930 when a very interesting series of cases was treated with, on the whole, satisfactory results. There were only a few as G.P.I. was never a very common disease in the serving soldier. One patient who, on admission, was hallucinated and deluded, recovered sufficiently to be employed as a chauffeur-gardener.

It is interesting to look back on the developments in hypnotic drugs during the last fifty years.

We were, at one time, largely dependent upon such as chloral and bromide, sulphonal, trional, tetronal, paraldehyde and morphia with or without hyoscine. As the newer hypnotics came into general use they were adopted in the Army. Recent years have seen a great change due, particularly, to the development of the barbiturates which are now used so extensively. Paraldehyde remains a stand-by in spite of its taste and smell.

One of the most recent methods of treatment is ether abreaction. Some of us had used it in the Army as long since as the war of 1914–19. The great difference was that we did not then use the word “abreaction.”

The modern approach to psychiatric problems as the result of Freud’s original work and subsequent work by Jung, Alder and the representatives of other schools of thought was not neglected but patients could not be retained long enough to justify deep analytical methods.

It must be remembered that the whole outlook on mental illness and psychiatric problems has changed in the last fifty years and a vast esoteric terminology has grown up. Amongst the simpler changes—“Lunatic Asylum” was replaced by “Mental Hospital.” “Lunacy” has been replaced by “Mental illness” while there are many young psychiatrists who, amazingly enough, do not know that they were once called “Alienists.” An outstanding change was the replacement of “Dementia praecox” by “Schizophrenia.”

While not taking certified patients “D” Block still came under the supervision of the Board of Control and was visited by them. Such visitors were invariably of very great assistance. Their interest was much appreciated.

So “D” Block remained essentially a hospital for the treatment of the psychotic soldier with which aspect of psychiatry the specialists were mainly concerned.

All the mental nursing orderlies were trained there and it was recognized as a training school for the Certificate of Mental Nursing of the R.M.P.A.

In India, which remained the only overseas station with “mental specialists” there were, at first, but two appointments, North and South. Later there was one for each of the four Commands but two of these were I.M.S. officers.
The main collecting centre was the well-known Mental Section at Deolali. The origin of the expression “Deolali Tap” is still in dispute but it is believed to ante-date the opening of the mental section. The section was chiefly a collecting centre for patients awaiting embarkation but it also took Southern Command patients for treatment. The most satisfactory form of treatment appeared to be embarkation, but more was done than that. At least three cases of G.P.I. were given malaria therapy, one with considerable success. The other two failed to take. The method used was subcutaneous, or intramuscular, the blood being taken from an infected donor—not a very satisfactory procedure.

There were small wards for mental cases at Rawalpindi, Karachi, Secunderabad and elsewhere but they were not very satisfactory. Some of the “mental wards” in the older hospitals appeared to have been designed for the detention of the more dangerous carnivora indigenous to India.

It had long been a rule that patients were detained in their Stations until sent for embarkation. This was gradually ignored and, whenever possible, patients were transferred to Hill stations from the Plains during the hot weather.

In 1933 the mental section at Deolali was transferred to the Military Hospital at Colaba, Bombay. This was a more convenient centre for embarkation. There were also more clinical facilities and the services of other specialists were more readily available for consultation. Parenthetically, the Specialist found it a more pleasant place in which to live and a more convenient place from which to tour. He and his predecessors had acquired an unholy familiarity with the railway station waiting room at Kalyan.

At Colaba all patients were put through a thorough investigation as to their physical condition. All were X-rayed to exclude cysticercosis and impacted wisdom teeth; W.R. and Kahn tests were done on blood and C.S.F.; stools were examined for cysts, etc.; blood films were examined and complete blood counts done in most cases. An attempt was made to introduce occupational therapy and, whenever possible, patients were treated in the medical wards free from restraint of any kind.

It had been well appreciated by the specialists in India that changes in the approach to mental illness were becoming more definite. They all realized that prevention was better than cure and it was felt that physical and mental hygiene were inseparable. About 1936 a scheme was submitted for the reorganization of the Mental Services in India laying stress on the importance of prevention. It was also proposed that an up-to-date mental hospital should be built at Poona and that there should be an Adviser to the D.M.S. on all matters concerned with mental health and the treatment of mental illness. However, for various reasons, amongst which finance loomed largely, things remained as they were.

It had, however, been possible, at least in the Southern Command, to establish a close relationship with the J.A.G.’s Branch in dealing with court-martial cases. This was proving its value and would have been extended had not the war intervened.

Some investigations had brought to notice the comparatively large proportion of young soldiers—in relation to the total numbers of mental cases—who broke down after a comparatively short time in India. This afforded an argu-
ment for the introduction of some form of selection before sending troops overseas. The wisdom of sending "boys" to India at all was questioned.

In the United Kingdom some form of selective intake had been advocated shortly after the first World War. It seemed, more than once, to have been accepted in principle but nothing practical emerged. At the outbreak of the second World War the situation remained still far from satisfactory.

The Army had a few competent specialists and a limited number of trained mental nursing orderlies. For accommodation there was "D" Block at Netley. Overseas there were no specialists outside India.

The War of 1939-45

This saw a very dramatic advance. At first psychiatry was greeted with some suspicion and mistrust. The very word "psychiatry" was new to the Army where the attitude towards mental illness was still tinged, all too often, by the "looney bin" mentality.

It was clear enough, even before the commencement of the war, that the prophylactic approach to the problem of "war neurosis" was by far the most important, and that the scientific selection and placing of men would do more than anything else to avoid the development of widespread psychiatric disabili­

Unfortunately, it was not until much later that adequate measures were instituted. Despite the unequivocal conclusions and recommendations of the Southborough Committee, a pre-war attempt, in March 1939, to initiate the introduction of selection testing into the Army, met with failure.

A consulting psychiatrist, J. R. Rees, was appointed shortly before the commencement of hostilities and, after the outbreak of war, a psychiatric consultant, Henry Yellowlees, was also appointed for the Army in France. To commence with, military psychiatric cases, other than gross psychoses, were treated in the E.M.S. Hospitals and, towards the end of 1940, in No. 41 General Hospital in Somerset.

From April 1940 onwards, the Psychiatric Service was established on a Command basis with, in each Command, from three to ten area psychiatrists working under the Command Psychiatrist. A comprehensive out-patient service was built up and the whole system of in-patient treatment reorganized by the opening of military hospitals for military patients. Later there developed special Army hospitals for the treatment of the psychoneuroses.

In April 1942 a Directorate of Army Psychiatry was set up with H. A. Sandiford as Director. From then the Army psychiatrists dealt with such problems as: Psychiatric aspects of morale, discipline, training and equipment. Psychiatric aspects of recruiting, selection, grading, allocation and transfer of officers and other ranks. Clinics, hospitals, invaliding and liaison with the Ministry of Pensions, Ministry of Health and Boards of Control.

Overseas, G. W. B. James had become Consulting Psychiatrist in the Middle East where he did notable work. He was later Consulting Psychiatrist to the Army at Home.

E. A. Bennett became Consultant in India where he was responsible for building up a very fine team of psychiatrists who worked with the Army in
Burma. It was here that the remarkably successful system of Divisional Psychiatrists working in forward areas, was introduced. The value of prompt, efficient early treatment was made very manifest.

Very fine work was done by psychiatrists in the Field in North Africa, Italy and, later, in North-West Europe but their story may be read elsewhere.

From June 1941, the Directorate of Selection of Personnel came into being and worked in very close collaboration with the Directorate of Psychiatry. When War Office Selection Boards were set up one or two psychiatrists were included in the establishment of each W.O.S.B.

Much specialized work of very great value was carried out by Army psychiatrists in such matters as the psychiatric aspects of discipline and morale, psychological warfare and the psychology of the enemy, psychosomatic disorders and the rehabilitation of the physically disabled as well as the civil resettlement of repatriated ex-prisoners of war. In passing, their best-known patient was, probably, Rudolph Hess.

All forms of modern treatment were used extensively: Continuous narcosis, analysis, narco-analysis, abreaction, suggestion, electric convulsive therapy, insulin and modified insulin. Early sedation in forward areas proved very valuable. The great value of constructive occupational therapy, as distinguished from merely diversional therapy, was fully appreciated and highly developed.

One very successful innovation was the organization of the Military Hospital at Northfield. This contained 200 beds for hospital treatment and 600 beds as a "training wing" where the rehabilitation of soldiers suffering from psychoneurosis could be carried out prior to their return to duty. This had been advocated as the result of experience in No. 41 General Hospital where it was felt that too lengthy hospitalization of psychoneurotic patients was definitely harmful.

Great importance was also attached to the question of responsibility and there developed a very close liaison with the J.A.G.'s Department. It is now the almost invariable practice to have psychiatric reports on all soldiers charged with serious offences.

It seems not inappropriate to conclude with a few remarks on the attitude adopted by the Army toward psychiatry. It was not to be expected that the Army would react to psychiatry and its implications in a manner very different from the civilian community and civil medicine. Thus, in the Army, from the very beginning of military psychiatry, "the Commanding Officer and the Regimental medical officer were the first to realize the possibilities of this aspect of medicine. Difficulties, however, there certainly were; and many of them will be commemorated in the half-friendly, half-doubtful nickname of 'trick-cyclists', which was bestowed on psychiatrists at an early date!" In the more detailed account which follows, some of these difficulties will be too apparent. The position has been well summarized by J. R. Rees (1945): "Earlier in this present war we were often told that psychiatrists were the fifth-columnists of the Army, and this because they were advising the discharge of men who were obviously too dull or too unstable to soldier. The administrator who has to produce the "bodies" and is quite out of contact with real live men is critical, and much
opprobrium has come to Army psychiatrists because there has necessarily been a high discharge rate from psychiatric causes. The fighting soldier is in no doubt at all as to what kind of man he wishes to have with him. The further you get away from the front line the tougher become the comments, the more hints there are that everyone is trying to evade service, and that is and always has been a common experience of armies. . . . Any suggestion of change may arouse anxiety and so aggression, which the psychiatrist has to appreciate and counter, treating the situation clinically. Patience, tolerance, infiltration-tactics, and skill in counter-attack, which psychiatrists learn through conditions like these, are of some value for the future. We cannot tolerate the retention of sickness and inefficiency in society just because we wish to avoid tiresome opposition and criticism of ourselves. It is very striking how few of the really intelligent and valuable leaders fail to appreciate the contribution of psychiatry, but we have to beware of those who become ‘converts’ and thus lose their capacity to help us with real criticism.”