PART II

EXPERIENCES IN GENERAL PRACTICE (1946–1949)

On entering general practice in 1946, the writer was at once impressed by the number of ex-Servicemen who had been discharged for psychiatric disorders, and by the readiness of doctors and patients to attribute symptoms to a psychological cause. Towards the end of 1946, H. M. Moran [5], an Australian surgeon, published a book, part of which was devoted to a criticism of psychiatric policy in the Army. After the book had been reviewed, the correspondence columns of the Daily Telegraph gave opportunities for a discussion of this policy.

This stimulated the writer to follow up the ex-Servicemen in his practice, who had been discharged from the Army through medical channels and thus discover the proportion with psychiatric disorders. Such a survey served a double purpose. Firstly, it would reveal whether the cases of psychiatric disorder were in fact as great in number as had been supposed, and secondly it would give an opportunity to study once more the type of case which had been posted from Army units on the recommendation of psychiatrists. This would be a fair substitute for a far more valuable follow-up which the writer had planned. It had been hoped to secure copies of “Battalion Orders” for 1943 and 1944, and from the list of men posted away from the unit select those removed on the advice of a psychiatrist. Their subsequent Army careers could then have been examined. The writer was informed that in the unlikely event of permission being granted, such records were not accessible.

The practice was in the “East End” of London and the district was typical of the industrial areas from which the bulk of the armed forces are drawn. There were 3,000 patients in the practice in 1946 increasing to 5,000 in 1949 as patients returned from the Services and the evacuation areas. Of this number, 71 had been invalided between 1940 and 1949. A small proportion
were invalided between 1945 and 1949 after the Second World War had officially ended, but as fighting continued in Palestine and Malaya and the Army was still partially mobilized, the position was the same as during the war. In nearly every case, a short medical record of each man was furnished by the Ministry of Pensions and a personal visit was paid.

The disadvantages of such a survey in the intensely personal atmosphere of a general practice became apparent immediately. It was obviously impossible to tell the patients the true nature of the visit, which was conducted under the guise of a routine examination of ex-Servicemen. As a consequence, the interrogation could not be as thorough as that carried out in a more impersonal hospital follow-up, and, as it was, some of the patients from both organic and psychiatric groups became suspicious and even resentful. It would have been instructive to examine their civilian records in some detail, and it would have been interesting to have had all the cases re-examined by an independent psychiatrist.

Among the 71 cases, causes of invaliding were as follows:

- Psychiatric causes: 30
- Gunshot wounds: 8
- Orthopedic fracture cases: 9
- Peptic ulcer: 6
- Chest disease: 6
- Ear disease: 4
- General medical disease: 4
- Eye disease: 2
- Cardiovascular disease: 2

The psychiatric cases were then examined in more detail:

- Psychoneurosis, hysteria, temperamental instability, etc.: 20
- Neurosis following experiences as prisoners of war: 3
- Psychopathic personality: 3
- Schizophrenia: 2
- Mental deficiency: 1
- Attempted suicide: 1

Psychiatric disorder was the largest single cause of invaliding in this series, constituting more than half of the total medical cases, with psychoneurosis as the most common abnormality.

An interesting comparison may be made with certain figures which were laid before the Expert Committee [2]. Examination of 118,000 psychiatric cases from all three British Services invalided between September 1939 and June 1944, revealed that they constituted between one-third and one-half of all medical invalids. Further analysis of the group revealed that the various psychiatric disorders occurred in the following proportion:

- Psychoneurosis, effort syndrome: 64.3 per cent
- Psychoses: 21.2 per cent
- Psychopathic personality: 8.1 per cent
- Mental defect: 6.4 per cent
Further study of these case histories reveals that only a minority of the psychoneurotic cases had experienced front-line service before being downgraded or invalided—only 3 cases out of 20. Brigadier James, the Consultant Psychiatrist, investigated a larger series of cases in North Africa between 1940 and 1943 [6]. At different times he examined three groups of psychoneurotic patients totalling 4,000 in all, and found that battle stress was the predisposing cause in only 35 per cent of cases.

In order to give some idea of the type of cases under discussion, relevant extracts from service documents will be quoted. This is unfortunately an inadequate method of describing psychiatric cases in which so much depends on personal contact and impressions, but it is the only available means. When discussing organic disease, the listing of physical signs, and radiological and laboratory findings, form a clear impression on the reader’s mind. In the cases to be discussed, there is only the personal opinion of a psychiatrist dealing with a subject which cannot be measured in any tangible way. Similarly, any comments on these opinions are personal, and are open to the criticism that examination of a patient in 1945 or 1950 may not reveal his mental condition in 1940. The larger psychoneurotic group will be considered first.

Case 1.—H. J. B. Was in the Merchant Navy, and was torpedoed twice, on the second occasion being three weeks in an open boat. He suffered very severe privations during this period, and received treatment in 1946 and 1947 for anxiety state and post concussive symptoms.

Case 2.—G. H. D. Stated that during the evacuation at Dunkirk he sustained a slight gunshot wound which was followed by shaking of the limbs, headache and giddiness.

Further extracts from his history were furnished by the Ministry of Pensions. “He was a peacetime regular soldier, who suffered a trivial head injury in 1931, followed by headaches. Recurrent anxiety attacks occurred after 1935. His nerves have been worse since calling up, and he has had more sick leave than duty. He cracked up completely on coming under fire in January 1940, and had to be sent back to base.”

A specialist stated that how as mentally self-centred, hypochondriacal, and of low intelligence (50 per cent of normal), that he was a feeble, unstable personality who did not succeed in adapting to ordinary army life, but had long sick periods, and broke up completely at the first slight strain. The specialist considered he was incapable of being made into a useful soldier and the Board invalided him as a case of “Anxiety Neurosis.”

Case 3.—S. S. Was exposed to blast from a shell at Salerno in 1944 and suffered from concussion and rupture of the right ear-drum. Later in the year while serving in a reconnaissance unit, the rest of his party was killed and he received an injury to the sacrum, which was followed by persistent low back pain, headaches, and black-outs.

The Corps Psychiatrist advised transfer to a psychiatric centre or discharge, and he was discharged from the Army in 1945 with a diagnosis of “Hysteria-Sensory.”

There is little doubt that the first patient (H. J. B.) was unfit for any other form of active service, but this cannot be said for the other 2 patients. The second (G. H. D.) had presumably given useful service in peacetime otherwise he would not have been retained in his unit, and he had served at the Base in France from February to June 1940. The fact that he was described as mentally self-centred, hypochondriacal and of low intelligence should not have prevented him being employed on domestic duties at the Base—tasks requiring far less
aptitude than is needed in his normal trade of a chair maker. The danger of discharging these cases as anxiety neuroses is illustrated by subsequent events. In 1949 a letter from an official of the British Legion was received, asking for information as the man was claiming a pension on the grounds that his disability, anxiety neuroses, was either attributable to, or aggravated by, war service.

The third patient (S. S.) had suffered considerable strain, but again service at the Base should not have been beyond his powers.

Case 4.—A. E. K. The report states that on admission to hospital he was tense, tremulous and apathetic. His predominating complaint was a feeling of depersonalization in which he complained that he was unable to feel any emotion whatsoever, and felt as though he were living in a dream world. There was no evidence of delusions or hallucinations. He improved to some extent, and gained some insight into his illness. He was described as being a basically unstable, inadequate personality with short-term values, in whom a breakdown was precipitated by the death of his mother, and the loss of a girl to whom he was strongly attached. He showed mild somatic signs of anxiety (tremors, tachycardia, and rapid anxious speech), and complained of feeling of unreality and difficulty in venturing out alone.

He was considered unlikely to make further adjustment to military service, and he was discharged with a diagnosis of "anxiety state."

This patient had served in the R.A.O.C., through the whole of the N.W. Europe campaign of 1944–1945, his task being the examination of captured enemy equipment. He was never exposed to any danger, and the first point of interest is that the symptoms developed in Brussels after the war had ended. The second point of interest is that he is the only man in the series who was unable to carry on any civilian occupation after discharge. He did not resume his normal work until 1950.

Case 5.—S. A. B. Was passed fit for general service in the Territorial Army in 1936, and called up in 1939. In January 1940 he was in hospital with bronchitis and influenza. Chest X-ray normal. Sputum negative. W.R. and Kahn test negative. In April 1940 he was readmitted for investigation, and a diagnosis of "pseudo angina" was made. It was noted that he complained of pains in the chest, headache, numbness in the hands, and abdominal pain. Investigations revealed that the chest X-ray was normal, test meal normal, but the barium meal was suggestive of a gastric neoplasm. He was transferred to another hospital in May 1940, and to another in June 1940. Later in this month a diagnosis of anxiety state was made. A further chest X-ray proved normal and another barium meal revealed no evidence of neoplasm. In July 1940 he was seen by a psychiatrist who recommended discharge from the Army.

This case illustrates the danger of over-hospitalization and over-enthusiastic investigations. The patient was a Cook-Serjeant and could surely have carried on in this trade.

Case 6.—A. B. Joined the Army in 1943, and was employed in Normandy in 1944, driving vehicles and replacements up to the front line. After the fighting had ceased, he had two road accidents. He was never unconscious but complained of headaches and giddiness. He was invalided and described as "a poor inadequate personality, of low average intelligence. Neurotic symptoms throughout and a neuropathic family history." Diagnosis—hysteria (sensory).
Case 7.—C. W. B. Stated he was concussed in a motor accident in July 1947, and since then suffered from headaches, vertigo, black-outs and faintings. A neurologist reported that there was no evidence of organic abnormality. A psychiatrist found that the man was depressed, worried and anxious that his intelligence was below average, and that he was an inadequate unstable type.

A diagnosis of “Hysteria (sensory)” was made, and the psychiatrist considered he was unlikely to render further useful service, as he was “preoccupied with personal problems to the exclusion of other interests.” He felt that treatment in hospital would be unlikely to assist the man.

These 2 cases raise the question of whether the presence of symptoms which do not respond to treatment should lead to the patient being discharged from the services. It is probable that these 2 patients could have been found employment, though not as drivers. Neither of them have complained of their symptoms since their release from the Forces, and it would appear that the situation is comparable with that which arises after industrial accidents—the one set of symptoms being relieved by release from the Services, and the other symptoms being relieved by a financial settlement.

Case 8.—H. F. T. Complained of pain and weakness in the left arm in October 1941. The psychiatrist found he had always suffered from depressed moods and had not been a good mixer. He married in August 1939 and showed an unduly profound attachment for his wife as a compensation for his feeling of lack of intimate emotional contact previously. In hospital he was described as being “intellectually superior.” He remained depressed and disgruntled, with hysterical weakness and anesthesia in the left arm. The weakness was modifiable by suggestion, but despite this he was recommended for discharge in January 1942. After discharge he stayed with one firm for five years, and is now working in the offices of a voluntary hospital.

Hysterical paralyses were rare in the Second World War, and with reference to the treatment and disposal of this case one may quote Sir Arthur Hurst [7]. “Even now in 1944 it is not invariably recognized that a diagnosis of hysteria carries with it the obligation to cure the patient, and that this can almost invariably be done at once, and with great rapidity.”

Case 9.—A. S. An extract from his records states that “on returning from Christmas leave he became unduly depressed, worried and anxious. He had considerable domestic worries.”

An R.A.F. neuropsychiatrist stated at the time: “He is still showing marked emotional liability—it is recommended that he be invalided on the grounds that he is temperamentally unstable.”

Case 10.—G. A. N. The extract from the R.A.F. records merely states that he was invalided for (1) temperamental instability, manifesting itself in headaches and insomnia; and (2) chronic suppurative otitis media.

These 2 cases have been considered together because the disability—temperamental instability—was the same in each case. In Case 9, it is perhaps unfair to dwell unduly on what is probably one paragraph from a long report. Many people must have experienced similar symptoms on returning from leave, and it is significant in this case that the neuropsychiatrist had only been qualified for three years. G. A. N. stated that he had joined the R.A.F. in 1940, and had volunteered for air crew duties. He is an intelligent and able man who,
when examined, was in charge of a settlement in the East End of London. Some suitable duties could surely have been found for him in the R.A.F.

_case 11._—T. H. The extract from the notes indicate that this airman had developed typical anxiety symptoms (headaches, giddiness, sleeplessness, etc.) as a reaction to a difficult domestic situation. A diagnosis of anxiety state was made and invaliding recommended.

This patient was on non-flying duties in Ceylon and such symptoms as were present could probably have been ameliorated by compassionate leave, or even a special release.

_case 12._—E. C. C. Had rheumatic fever when a child, but denied this when he had his medical examination in 1941 as he wanted to join the Army. He served as an anti-aircraft gunner in the Orkneys and was discharged in 1944 with “psychoneurosis” and “rheumatism.” The psychiatrist reported that he was agitated and nervous, and that he belonged to a dull and backward group of individuals, and that on the basis of poor intelligence there rested a large hysterical, hypochondriacal superstructure.

After discharge from the Army this man stayed at one job for four years and did not report sick in this period. He himself stated that some of his symptoms were due to the lonely and depressing conditions in the Orkneys and in fact one man in a nearby unit committed suicide. Though both Cases 11 and 12 may have possessed certain signs and symptoms, it is doubtful if they constituted a true psychoneurosis.

_case 13._—G. C. F. Was in the Royal Artillery and served in N. Africa and Persia but did not experience active service. Just before his unit embarked for Italy in 1943 he developed violent shaking in the limbs and headaches and was posted to another unit. On 14.8.45 he was described as a chronic neurotic who broke down under the strain of overseas training and domestic worry. The psychiatrist considered he had been slightly improved by treatment in hospital but was unfit for further service as he had an anxiety state.

It seems surprising that this man was invalided, for he must have served at the base from the onset of symptoms in 1943 until the summer of 1945 when he would be due for release with his “age and service” group.

_case 14._—R. E. Was a keen soldier, but following an accident in which he killed his best friend he developed the symptoms of an anxiety state. The symptoms did not respond to treatment.

_case 15._—S. J. The notes merely state that he was a timid immature youth of low intelligence, who was unduly depressed. He had been absent without leave on several occasions and had deserted once. He was invalided with a diagnosis of “Anxiety State, Chronic.”

This case would appear to be one for disciplinary action and the best disposal would have been a dishonourable discharge, rather than an honourable release through medical channels.

_case 16._—L. D. A. When examined on 26.12.41 he was described as “nervous, anxious, with apparently subnormal mentality. There is difficulty in starting a sentence but he continues easily once the sentence is started. He is unable to speak for several seconds if addressed sharply.” The specialist reported that he complained of bad nerves, difficulty in getting words out, and fear of the dark. The patient did quite well at school and had a fair employment history.
It was concluded that he was of average intelligence and had a timid, inadequate, over-protected personality. He had a fairly severe degree of speech block which he attempted to overcome by rubbing his nose and other mannerisms. In July 1941 a psychiatrist advised that he be kept under observation. A diagnosis of psychoneurosis (hysterical) group was made, and it was recommended that he be discharged as he was reported to be no use as a soldier and frequently sick.

This patient was in the Pioneer Corps and his speech disorder need not have prevented him doing the simple manual work performed by this Corps.

**Case 17.—H. A. M.** Was discharged with "effort syndrome" and the psychiatrist's report stated: "This man is definitely immature for his years and a poor physical specimen. Quite intelligent. Poor personality. Constitutional neuropath. Emotionally unstable. Poor physical and mental make up. Unlikely to make an efficient soldier."

This case is of interest for several reasons. Firstly, effort syndrome was comparatively rare in the Second World War. Secondly, the report illustrates the vague terminology used by psychiatrists. Thirdly, this man though rather immature and undeveloped would have made a useful nursing orderly in the R.A.M.C. where he was posted in the first place, and where he would not have had to be "an efficient soldier."

**Case 18.—G. A. R.** Joined the Army in 1941 and served as a batman in a light Anti-Aircraft Regiment in England. In 1944, he began to suffer from insomnia, because he was worrying about his wife and two children who were exposed to air raids. In 1945, he was sent to a psychiatrist and discharged from the Army as a psychopathic personality with emotional abnormality. The psychiatrist described him as "A poor dull, miserable looking man with a long list of symptoms. He is emotionally unstable and of low intelligence."

This man returned to his trade as a veneer repairer and has remained there since. He has attended the surgery on a few occasions for minor complaints. He had performed useful domestic duties as a batman and there seems to have been little reason for removing him from these duties.

**Case 19.—D. B.** Volunteered for the R.A.F. in November 1943 and was discharged in January 1944. The records have unfortunately been lost, but the man states he suffered from "nerves."

**Case 20.—H. W. H.** Volunteered for the Army and concealed the fact that he had received treatment at Neurological Departments in 1935 and 1936. (Examination had revealed choroido-retinal atrophy on the right side, deafness in the left ear and aural vertigo.)

He was invalided from the Army with a diagnosis of (1) retinitis pigmentosa, (2) mitral regurgitation, and (3) low mental state (neurosis).

Re-examination revealed that his heart and mental state were both within normal limits.

It is difficult to comment upon the other 10 cases in the series for a diagnosis of schizophrenia or psychopathic personality stigmatizes a man far more than does a diagnosis of psychoneurosis.

Not all psychiatrists are agreed that such cases should be discharged. Indeed Mayer-Gross [44] has stated:

"Schizophrenics remitted after a first attack have been excellent subordinates thanks to their loss of spontaneity and even have shown unselfish recklessness in
action thanks to the shallowness of their emotions. Similarly, many high-grade mental defectives make good soldiers for some time on account of their docile subordination and dull gregariousness.”

After their experiences in the Royal Navy, Curran and Mallinson [45] observed:

“Some patients, particularly psychopaths and hysterics, would benefit from a labour corps or rehabilitation camp where all kinds of manual labour could be done under modified naval discipline.”

Two case histories are of interest:

C. G. R. His records state that soon after he joined the Army his wife deserted him. He repeatedly deserted or went absent without leave. A psychiatrist diagnosed chronic anxiety in an inadequate personality, and he was discharged as a case of “psychopathic delinquency.”

In an interview in 1947, this man stated that he wished to join the Royal Engineers, but was sent to the Royal Army Medical Corps. He did not make satisfactory progress as the lectures at the Corps Depot sent him to sleep—a state which overtook many medical officers who attended the same lectures.

A. L. Enlisted on 3.8.44, but was unable to master rifle drill and worried about this. On 10.8.44 he was sent to York Military Hospital and was transferred to another hospital on 18.8.44. He was discharged from the Army on 24.8.44 as a case of “neurosis.” Later in the same year he was admitted to a Mental Hospital and considered to be an early case of schizophrenia. He carried on in civilian life until the end of 1946, when he was readmitted to this hospital, and given insulin shock therapy.

At this time, he was seen by a Consulting Neurologist who considered that the patient had a grade two mental capacity, and was being worried by work that was far beyond his ability. One wonders whether some simple employment could have been found for him in the Army.

The cases of neurosis following experience in captivity have not been considered since these men had rendered useful military service. The man who had attempted suicide was not visited for obvious reasons.

**Discussion**

In the discussion of his war experience, the writer observed that the majority of cases were referred to psychiatrists before reaching first-line units. The series quoted above confirms this view. There can be no doubt that some of them showed greater psychological abnormality than the cases seen in the battalion. Just as the battalion cases could have proceeded on active service, so the majority of the second series could have served at the base, and invaliding would seem to have been unnecessary. The writer has pointed out that in a front-line battalion, some duties are much more hazardous than others. The gulf between the man in the battalion and the man at the base is many times wider. In all seriousness the writer considers that if a man cannot perform one of the many, simple domestic duties required of a soldier at the base, it would hardly seem fair to allow him to face the difficulties of civilian life.
One argument advanced for invaliding these men is that if they cannot face the strain of Service life, they will be more useful to the country and themselves in civilian life. Of the Service cases quoted in the second series some at least lived in pleasant surroundings in the country or at the sea, all were fed, clothed and housed, and all had allowances paid to their families. After discharge they were sent back to an industrial area to face the perpetual danger of bombing, and to live on less adequate rations in squalid houses, or dirty air-raid shelters. Despite full employment, life was a struggle. One wonders if Army life really was a greater strain.

In 3 of the cases the phrase “unlikely to make an efficient soldier” was used. It is true that these men were unlikely to make efficient fighting soldiers, but as only a small proportion of soldiers do fight, and as the higher commands of all Services are lavish in the establishment of Base and other non-fighting units, alternative employment could surely have been found.

The writer considers that many of these recommendations for invaliding and down-grading resulted from rigidity of thought. Some individuals with varicose veins and flat feet are unable to march, and during the First World War anyone with these conditions was downgraded, and was not allowed to serve in a front-line unit. Consequently many enthusiastic men (and many lazy ones) were prevented from serving to their full capacity. It seems that a similar attitude of mind prevailed in the Second World War with regard to the disposal of psychiatric cases. Some men with psychoneurosis are unfit even to serve at the Base, but to discharge every man who admits to, or is found to have a psychoneurotic symptom is far too sweeping. When discussing another aspect of military medicine, Marriott remarked that “An Army exists to fight—not to go to hospital” [42]. Psychiatric policy should have been directed to fitting men for the fight, rather than to finding and creating posts for them at the base.

(To be continued)