A SURVEY OF SERVICE PSYCHIATRY IN THE FAR EAST DURING 1951

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In a letter written by a National Service Medical Officer and circulated by our Director-General, it was stated that the scope of Medicine in the Army was very limited, except perhaps in the field of Bacteriology, Pathology and Public Health.

We venture to suggest that psychiatry in the Army, especially in an overseas theatre, offers very much more scope and variety of clinical material than the average psychiatric civilian practice in the United Kingdom. This article is being written in an attempt to give doctors, both service and civilian, an idea of this type of psychiatric work. The clinical aspect of psychiatry is described, rather than the prophylactic psychiatric measures which, although we may appear to ignore them, we regard as important and necessary features of our work, in maintaining an adequate standard of mental hygiene.

We find it convenient to divide the article into three sections. The first deals briefly with the psychiatric administrative set-up in this theatre, and some statistical tabulations are given showing a breakdown of the cases seen in their respective categories—i.e., British Army personnel, other services, local troops, families, etc. A further break-down of these categories into the different diagnoses is made. The second section deals with all service personnel, and as we are a British Army unit, British soldiers are dealt with in greater detail. The third section is devoted exclusively to families. This large group, with such obvious differences from the bulk of service personnel in both aetiological considerations and psychotherapeutic requirements, deserves separate analysis.

SECTION I

The psychiatric set-up in this theatre consists of three psychiatrists, the senior of whom acts as consultant. His duties, in addition to those of an adviser to the Director of Medical Services in all matters pertaining to mental health, include those of visiting psychiatrist to various hospitals throughout the command. Out-patient clinics are held at these hospitals and admission of those patients requiring special treatment arranged. The second psychiatrist is in
charge of a psychiatric block in a base hospital. This block contains open wards and closed side-rooms, where all forms of psychoses and psychoneuroses are admitted and treated. In addition to the two psychiatrists in attendance, the staff consists of one Q.A.R.A.N.C. Sister, who has psychiatric training, and eleven British other-rank orderlies, more than half of whom have Army Mental Nursing Orderly qualifications. All modern forms of psychiatric therapy are carried out here, as will be detailed more fully later in this article, but it must be pointed out now that this is the only service hospital in the theatre where such therapeutic facilities are available and cases arrive by air, road, sea and rail almost daily. The third psychiatrist has a small psychiatric ward and out-patient clinics, in an isolated area, not easily reached from this base. His work and cases are not referred to in this article, other than cases he has sent to the psychiatric block for special treatment which he is not able to do with his restricted staff and equipment.

During the year 1951, a total of 861 patients attended the Psychiatric Centre, 537 as out-patients, and 324 as in-patients, (Table I).

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<th>TABLE I.—ALL IN-PATIENTS AND OUT-PATIENTS</th>
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<td>British Army personnel</td>
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<td>Families (including children)</td>
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<td>Local troops</td>
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<td>Royal Navy, R.A.F. and civilians</td>
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Table II shows the breakdown of this total by types of disease, and we have simplified the groupings by listing all the psychoses under one heading, whether they be schizophrenics, manic depressives, etc., and all the psychoneuroses under one heading, whether hysterics, anxiety neurotics, obsessional states, psychopathic personalities, etc.

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<th>TABLE II.—ALL IN-PATIENTS AND OUT-PATIENTS</th>
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Table II shows the apparently high figure of 369 patients who were found to have no gross psychiatric disability, but it must be pointed out that the majority of these patients were not referred unnecessarily and the diagnosis made did not imply that there was absolutely nothing medically wrong. Such a high incidence of patients with a "No gross psychiatric disability" diagnostic label is essential in service psychiatry. The vast majority of such cases are not malingerers or column-
dodgers, but soldiers with minor forms of psychiatric disability where maybe a single session of psychotherapy with explanations, persuasion and re-assurance is alone necessary. These soldiers go back to their units, to full combatant duty, and experience has shown that it is wise not to award a diagnosis of mild neurosis in these cases. A psychiatric label once applied has the habit of sticking to the soldier for the rest of his service.

SECTION II

Although this section deals with all three Services, we have dealt more fully with British Army personnel, and the soldier has been more in our minds, in writing this section, than the sailor and the airman.

The main aetiological factors at play in the production of psychiatric breakdown in the service personnel in this theatre may be divided conveniently into two broad categories—(a) constitutional factors and (b) environmental factors.

Prominent among the constitutional factors are such features as heavy psychiatric loading due to a bad familial history. Particularly in the psychotic group we came across cases where there is a history of insanity in one or both parents, and the soldiers themselves may have shown signs of instability in childhood or adolescence. We have come across soldiers who have actually spent periods in Mental Hospitals in their pre-service history, or have received mental specialist treatment in their own homes. We have even met re-enlisted men who were invalided from the Services on psychiatric grounds during the war and who rejoined because they were unable to make the grade in civilian life. Cases with such heavy psychiatric loading are no doubt becoming rarer nowadays, due to the effective screening at Army Basic Training Units, but the odd case will always slip through no matter how efficient the screening may be.

Among environmental factors there is a diversity of features, one or more of which are seen to act as a precipitant in mental breakdown.

The following commonly recurring factors are: (a) separation from home; (b) domestic disharmony or worry over wife, family or financial matters; (c) dislike of the Army, regret at having signed on for a regular engagement, discontent at present employment, or disappointment over lack of promotion; (d) poor adjustment in the Army—for example, a soldier belonging to an older age group posted to a unit consisting mainly of young National Service men, some of whom may be senior to him in rank; (e) marriage just before embarking on an overseas tour—quite a common occurrence; (f) poor education or intellectual dullness with employment beyond mental capacity; (g) anti-social and anti-Army bias, due to faulty early life environment—for example, the institution child or the soldier with a previous history of psychopathy, with perhaps a probation, approved school, Borstal or even civilian prison record; (h) postponement of Army release due to the emergency; (i) traumatic battle experience; (j) boredom because of inactivity in a base installation; (k) dislike of the tropics, the people or the climate; (l) previous P.O.W. experiences.

So much for the main precipitants of mental breakdown in British Service men in this theatre.
A point of interest with perhaps a relevant bearing on army morale is the abnormally large number of psychiatric referrals from Regular soldiers as compared with National Service men. Of the 477 British Army personnel seen at the psychiatric block during the year, no fewer than 433 (92 per cent.) were Regular soldiers. This striking contrast may perhaps lose some of its significance when the numerical preponderance of Regular over National Service soldiers in this part of the world is considered, but we believe that the inference can still be drawn from these contrasting figures that, in general, the National Service soldier has a higher standard of mental health than his Regular comrade. It is not difficult to find reasons for this. Hardly any of the constitutional factors at play in symptom production apply to the young National Service man. Personnel selection and psychiatric screening at intake usually ensure that the preneurotic, potentially psychotic and mentally backward recruits are quickly detected, and either rejected from service altogether or allocated to restricted employment well within their mental capacity. Again, few of the environmental precipitants of psychiatric breakdown apply in the case of the National Service man. He is, naturally, of a younger age group, and, being young, has an adventurous spirit, is seeing the great wide world for the first time, and the glamour of the tropics is still sufficiently novel to prevent him from becoming disgruntled and bored, unlike his Regular Service comrade, the hardened old campaigner who has seen it all before. The National Service man, furthermore, is usually a single man, and consequently has a minimum of domestic, financial or accommodation worries. He is a young boy, many thousands of miles away from home, it is true, but his separation-anxiety has usually resolved itself during his basic training, long before he embarks on overseas duty, and in any case his tour of duty overseas is so short, usually just over one year, that it lies well within his capacity to abide the time of his home coming, without resorting to symptoms of neurosis.

The Regular soldier, of course, being usually older, is more likely to be married. Because of the exigencies of the Service, it may be necessary for him to be separated from his wife and family for an indefinite period, perhaps for three years. If his wife remains in the United Kingdom, he frequently gets disturbing letters from home, where his wife, due to the prevailing financial stringency and austerity, may be finding it difficult to cope. Before the war the Regular soldier was prepared to take the rough with the smooth, and knew that he might be separated from home for long periods on campaign duties—he was prepared for this, and accepted it as part of a soldier’s life. Today, when he sees his National Service comrade going home after a short tour, in the highest possible state of morale, it is not surprising perhaps that he finds it difficult at times to adjust himself happily to his army career. If there is any underlying instability in his personality, he is likely to become a psychiatric casualty—and this type of psychiatric disability is one not at all easy to cure. However, much can be done to help him, with the aid of Red Cross, Welfare and S.S.A.F.A. organizations, and occasionally leave or Home postings on compassionate grounds. Invaliding to the United Kingdom in this type of case is only resorted to when the psychiatric breakdown is really severe. A common-sense approach is necessary, for
if every soldier with home worries was sent home on medical or compassionate grounds, we would soon find ourselves out here without an army at all.

Another interesting feature encountered during the year with almost monotonous frequency was the number of patients referred for assessment with some form of suicidal tag attached to the case histories. Eight per cent. of all cases seen, 70 patients out of the over-all total of 861, were referred with a suicidal tag, whether genuine or hysterical, pseudo-suicidal attempts or merely suicidal gestures or ideas. We feel that this percentage is abnormally high, in an essentially healthy young adult population, and as these cases are time-consuming and require a considerable degree of experience and responsibility in making correct diagnosis and disposal, a more detailed analysis may be of interest.

These cases invariably give cause for a certain amount of anxiety, and rightly so, for when a patient under psychiatric treatment actually commits suicide, the layman's attitude of awarding a black mark to the unfortunate therapist is sometimes quite unjust. Some people can commit suicide—the cultural racial practices of the ancient Romans or the modern Japanese are examples, if examples are needed, and it sometimes happens that the half-hearted pseudo-suicidal hysterical attempt is more successful than the unfortunate victim intended. But the psychiatrist is not a fortune teller or a seer; he may predict but he cannot foretell the future with certainty. He can only assess the mental state of the possible suicidal patient and act on this assessment. Only 8 of the 70 suicidal patients were in fact diagnosed as psychotics, and few were placed on Special Suicidal Precaution Cards, apart from an initial period of 24 to 48 hours' observation which is always advisable before making a firm diagnosis in these cases. Forty out of the total of 70 were found to have no gross psychiatric disability. They were usually psychopathic types who required firm handling; they were invariably returned to the unit guard room with a minimum of delay, and at the same time disciplinary action was recommended.

One National Service man held the record for hospital admissions because of pseudo-suicidal attempts. On one occasion he took an overdose of aspirin tablets, and on two occasions he slashed his arms and wrists with a razor blade. No psychiatric disorder was discovered and he was awarded 18 months' detention at a subsequent court-martial, where he was charged with self-inflicted injuries, rendering himself unfit for duty. Twenty-two of these suicidal patients were found to be suffering from acute anxiety, reactive (non-psychotic) depression, hysteria or just puerile immaturity. Although the majority made sufficient recovery to return to duty, perhaps in a lower medical category and in restricted employment where they could periodically attend conveniently for out-patient psychotherapy, a few required invaliding home.

Out of the 70 suicidal patients, 26 made suicidal or pseudo-suicidal attempts of one sort or another. Attempting to hang themselves headed the list with a total of 8 cases—some were genuine enough, others showed that the patient went to some pains to attract attention before starting the attempt. This was closely followed by body, arm or wrist slashing with knife or razor blade (7 cases). Most of these were obviously hysterical in nature; the incisions were usually
multiple but superficial, and the patient was often the inmate of a guard room or detention cell. Swallowing some noxious substance came next (4 cases), followed by attempted drowning (3 cases), jumping from balcony (2 cases), hunger strike (1 case) and cut throat (1 case).

The single case of cut throat was of interest, in that it was deliberate and genuine, and was probably not successful in the end through lack of courage. The injuries were quite severe. The patient was a warrant officer with a very good army record, who had just been recommended for a commission. His depression was of a reactive nature, and as his difficulties were fairly easily sorted out he made a rapid recovery.

In spite of this mixed bag of suicidal patients—i.e., psychotics, neurotics, psychopaths, and the wide variation of disposal (invaliding, out-patient therapy, court-martial), none of the 70 suicidal patients encountered during the year was successful in his suicidal efforts.

An interesting sideline to service psychiatry is the amount of medico-legal work encountered. Out of the total of 477 army personnel, 67 were medico-legal cases. Forty-one were referred before trial, and a report in the form of a disciplinary pro forma was submitted after due examination. This pro forma report embodies the McNaghton rules, and from it the Convening Officer of a court-martial is able to see whether, on medical grounds, the accused soldier is adjudged sane or insane, fit or unfit to plead, knows or does not know the difference between right and wrong, and whether, if he does know the difference, he knows that in committing the offence he is doing wrong. In this pro forma, which has been designed to obviate the necessity for medical men to appear personally in court in every disciplinary case, the psychiatrist is asked to express an opinion on legal as well as medical insanity.

Of the 41 cases seen before trial, only one was considered unfit to plead, and he was ultimately invalided to the United Kingdom, without trial, suffering from an acute psychosis. Five cases required admission to hospital, for a further period of observation, before a firm diagnosis could be established, but these cases were all subsequently discharged to units to await trial.

The remaining 26 medico-legal cases were soldiers under sentence, and of these, three soldiers were found unfit on psychiatric grounds to continue sentence, and they were invalided home after medical board action.

Occasionally one encounters the psychopathic soldier under sentence who decides he has done enough punishment, and is determined to become a nuisance. He refuses food, smashes up his prison cell, becomes aggressive, violent and almost unmanageable. These cases may require admission to hospital for a period of observation, but they are usually feigning insanity and are fairly easily found out.

Not only is there a wide range of clinical material in service psychiatry, but in this theatre particularly there is plenty of variety as far as the cultural milieu, racial origins and language differences of our patients are concerned. There have been times when a stranger, walking through the wards of the psychiatric block, might have thought, and with good reasons, that he was visiting a miniature
Tower of Babel. During the year we have had to deal with psychotic Turks, Greeks, Danes, Dutch, French, Indians, Gurkhas, Malayans, and one wild man from Borneo, who, luckily for us all, was not in any head-hunting mood during his sojourn here. Language differences present a great problem, and even with a good interpreter—an unusual event—it is difficult to get across even basic psychotherapy in psychoneurotic cases.

We have already referred briefly to the forms of treatment carried out in the psychiatric block at the base hospital. Some facts and figures may perhaps give a picture of the scope of the work here.

During 1951, 122 sessions of electroplexy were given, mainly for catatonic and other unmanageable schizophrenics, but this form of therapy was also employed for reactive and endogenous depressions and the occasional case of hysteria. The diphasic type of shock using a McPhail and Strauss machine was found to give more valuable results than the monophasic, and this type of electroplexy is now solely employed.

Fifteen patients were treated with modified insulin therapy, and courses of between three and four weeks were usually sufficient and effective. Mild neurotic breakdown in a soldier with a good premorbid personality responded well to this form of therapy, and excellent results were also obtained in two cases suffering from post-traumatic mental deterioration. The carefully selected patients who were given modified insulin were ultimately all returned to full duty, and follow-up reports showed that improvement was fully maintained. There has been no relapse so far. Deep insulin shock therapy was rarely employed and never carried to completion, as patients requiring this treatment, being long-term, were medically boarded and, if European, evacuated to the United Kingdom without delay, or if local soldiers, transferred to their local mental hospitals.

Continuous narcosis and lesser variations ranging from heavy and deep to mild sedation were actively employed in selected cases. Results were at times quite striking, especially with soldiers with a good service record who had cracked up suddenly with symptoms of acute anxiety. The salvage rate in this group was quite high, and the majority were ultimately able to go back to full duty, without reduction in medical category. We usually limited the drugs employed on continuous narcosis and other forms of sedation to three basic types—(a) barbiturates, usually sodium amytal and phenobarbitone, (b) chloral hydrate, and (c) paraldehyde. We found 10 c.c. of pure paraldehyde given intramuscularly of real value in dealing with violent and maniacal patients. We encountered no local complications using paraldehyde in this way, and we have employed this method in emergency for some years now. We have, of course, long since removed such relics of the past as rubber rooms and strait-jackets from our equipment. We found it a valuable procedure, in cases of acute psychiatric emergency where force and immediate sedation were necessary, and intravenous pentothal was not possible, to administer an ordinary rag-and-bottle ether light anaesthetic, as a preliminary to intramuscular paraldehyde.

Various abreactive techniques, using sodium pentothal, ether and carbon dioxide, were employed during the year. Altogether 128 sessions of narco-
analysis, using pentothal, were employed. This method of treatment was, of course, of especial value in dealing with neuroses associated with traumatic battle experiences, and dramatic results were sometimes obtained. Good results were also obtained by the use of intramuscular vitamin B therapy, especially with nicotinic acid and thiamin. Two examples of Korsakow's syndrome showed excellent improvement of their mental symptoms with intensive vitamin B therapy. Methedrine, myanesin, thyroid, dexedrine and epanutin were other therapeutic agents employed in selected cases. Methedrine, however, on the whole, was disappointing, and we felt it could not be considered an alternative to E.C.T., as we had hoped. Myanesin, given by mouth, in the form of an elixir (Elixir Myanesin B.D.H.) in cases where the somatic features of anxiety were prominent, occasionally worked like a charm, especially when combined with strong suggestion and psychotherapy. Basic superficial psychotherapy remained the sheet anchor in the therapeutic approach to psychoneurotic patients, especially at the many out-patient interviews, and for in-patients it was combined with energetic occupational therapy and sessions of group therapy.

The results of treatment may perhaps best be studied by a short analysis of the final disposal of the 477 British Army male personnel seen during the year. These figures are chosen, as, being army, they can be accurately and conveniently estimated from our quarterly returns.

(a) 351 (75 per cent.) were returned to full duty. These consisted of cases which had recovered from neurotic disability after treatment, or cases where no gross psychiatric disability, or only minor forms of neurosis, existed.

(b) 57 (12 per cent.) were down-graded to a lower medical category (M2, S3) and returned to units with a recommendation for re-allocation to new employment in a non-front-line installation. These cases were ultimately seen by a Personnel Selection Officer who, taking into account their educational and intellectual endowments, arranged their transfer to new employment within their capacity.

(c) 21 (4 per cent.) were down-graded in medical category (M2, S3) but returned to units without P.S.O. recommendation.

(d) 45 (9 per cent.) required medical board action and invaliding to the United Kingdom. This total was made up of 23 psychotics (mainly schizophrenics) and 22 psychoneurotics (mainly grossly unstable soldiers with suggestive prepsychotic traits in their personality profile).

(e) Three soldiers were recommended for discharge on non-medical grounds as psychopathic delinquents.

(To be continued)