

**THE INADEQUATE ADOLESCENT SOLDIER**

**A THESIS SUBMITTED FOR THE DEGREE**

**of**

**DOCTOR OF MEDICINE**

**at**

**THE UNIVERSITY OF GLASGOW**

**by**

**Brigadier John McGhie, M.B., Ch.B., D.P.M.**

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## PREFACE

The fundamental purpose of the Army is that of an efficient fighting force which is capable of defending the United Kingdom and its various overseas territories. Soldiers are therefore expected to be able to fight in extreme conditions of climate and under most arduous hardships. It follows, and it has long been agreed, that soldiers must be physically fit and in first class condition. Physical standards have been laid down and those who do not come up to those high standards are rejected.

Although the principle of physical fitness has for long been accepted, it was only with the onset of the 1939 War that the importance of selecting the mentally adequate and the emotionally stable as well as the physically fit came into prominence. Such selection has been fully justified, and it is certainly even more necessary today in an era of Nuclear Warfare when the soldier must be psychologically at an absolute optimum.

Selection Procedure, which was initiated during the 1939-45 War, retains its place in peace time and the Psychiatrist is still called upon to play his part in giving professional advice and making predictions. Usually, the Psychiatrist finds himself faced by two different pressures:-

- (a) To conserve manpower and not to reject any recruits who might be potential useful soldiers

(b) To reject at intake all possible potential psychiatric casualties.

Naturally, those at the War Office concerned with manpower and recruiting hold to the first, and Unit Commanding Officers, especially those with combatant experience of the last war, adhere to the second. The Psychiatrist is therefore subjected to two almost diametrically opposing forces and he may tend to be swayed by strong pressures to follow one or other line of action. If the first, then too many soldiers will have to be discharged from the Army at a later date with all its disadvantages. If the second, then the Psychiatrist may be attempting to perform the almost impossible task of being a crystal-ball gazer.

At the present time, with the National Service soldier soon about to disappear, and with a manpower shortage almost a certainty unless there is a marked improvement in recruiting, it becomes self-evident that it is of paramount importance that every potential soldier be salvaged and utilized whenever possible.

By routine Selection Procedure, the high grade Mental Defective, the frank Psychotic, the severe Psychoneurotic and the anti-social Psychopathic Personality can be spotted. At intake they are normally rejected as being unsuitable for military service. This is almost too obvious to need repeating but occasionally one still hears the suggestion that even some in the above-mentioned categories could give useful Army Service. Without doubt, the Mental Defective has

no place and no part to play in the modern Army, although it has to be admitted that many dull men during the last war did give valuable service in the Pioneer Corps. The Psychotic soldier also is a complete liability and he should be discharged forthwith if discovered at intake. If his disability develops during service then he should be given treatment prior to his invaliding Medical Board. The severe Neurotic soldier must also be regarded as suspect and vulnerable, and he is generally a liability. This statement is made although it is agreed that in the past many neurotic soldiers have given good service and some achieved outstanding success for long periods at times when serving under strong leadership, and especially when there is good motivation and conviction. It must be accepted, however, that they always tend to be a liability and may break down profusely under particular stresses and strains. Psychopathic Personalities are rather more difficult to evaluate and occasionally, under active service conditions where aggression can be turned against the enemy, they are often brave and useful fighting soldiers at least for a limited period. The balance of all evidence strongly indicates, however, that the above four categories must need to be rejected as totally unsuited for military service.

This thesis is concerned with another group, the border-line, the vulnerable, the timid, the immature and, even more important, the "Inadequate Adolescent Soldier" taken as a group. In this category, where diagnosis may be difficult because of the different forms of

nomenclature in use, an attempt is made to determine whether such recruits, either with or without treatment, can be retained in the Service and shown to be a valuable asset rather than a mere liability.

### INTRODUCTION

Prior to 1914 every soldier was regarded as at least being capable of becoming a hero, and any soldier who showed himself to be a culpable coward was awarded the most severe penalty of the day. Two World Wars have brought changes to Army discipline and public opinion, and it is now accepted that the quality of courage varies in individuals. Some are so lacking in this quality that medical or psychiatric protection may be required. It seems to be still widely believed, however, that "the Army will make a man of you" and that every soldier carries a Field Marshal's baton in his knapsack. The Army Psychiatrist knows these to be total misconceptions and that the Army is much more likely to break than make a man.

This thesis, therefore, deals with a group of Inadequate Adolescent recruits who, usually fairly early in their military career, do not make the grade as soldiers and who are very likely to exhibit neurotic reactions or frank psychotic episodes. They appear to be unable to meet the challenge of military service for although

the stresses and strains are no different from civilian life they are perhaps of greater intensity and tempo. An equally important factor is that the recruit is for the first time leaving the sheltered atmosphere of his home and at the same time losing the support of his parents. The group is considered to include the immature, the timid, the emotionally labile and the schizoid personality. The Army Psychiatrist, predicting that such a recruit will merely produce an unsatisfactory soldier likely to be a liability rather than an asset in any unit, usually endeavours to ensure that such personnel are separated from the Army as soon as possible. This may be done in the initial routine Personnel Selection Screening or during the early weeks or months of the soldier's service. This, of course, means a certain loss of manpower, and as the need for the conservation of manpower is a principle fully appreciated by the Army Psychiatrist he is consequently alerted by any new idea which might seem to help, although only to the slightest degree, in the solving of this problem.

A paper entitled "Further Studies in Endocrine Treatment in Adolescence and Early Adult Life" by the late Dr. E. Sands in the Journal of Mental Science in January, 1954, stimulated more than a passing interest. Sands <sup>(1)</sup> stated that:-

- (a) in his cases who were under twenty-three years of age - a group of inadequate types - where some had schizoid traits and others had neurotic or

psychotic features, Dehydroisoandrosterone produced an androgenic effect in a psychological and social way, and

- (b) it produced a masculine activity, aggression and self-confidence.

Sands further stated that the drug brings the inadequate to near normal. This then was the basis for the following investigations which were carried out for the next few years into this particular problem in the Army. The stimulus was the possibility of being able to show clinical success, and the continued impetus was provided by the mirage of a possible saving in manpower. After all, the idea that Dehydroisoandrosterone might convert the low combatant temperament Corps soldier into an aggressive infantryman is no more far-fetched than the present military tacticians' belief that aerosol L.S.D. bombs will so affect the enemy that they will welcome the attacking force rather than oppose it.

The writer of this thesis is a Senior Specialist in Psychiatry in the Army and during the past few years has been in charge of the Psychiatric Centre at the Royal Victoria Hospital, Netley. His duties are mainly concerned in treatment of patients but he is also the Psychiatrist concerned in Selection Procedure at two major Units in this area. It is proposed to discuss in the first place the historical aspects of Selection Procedure and its present day status. It will be shown that even with an efficient personnel screening net psychiatric



casualties among young adolescent soldiers are still prevalent. The magnitude of the problem will be put in its proper perspective. The writer will discuss how the Inadequate soldier is uncovered during routine intake selection procedure. Charts and graphs will indicate the numbers referred by the Personnel Selection Officer to the Psychiatrist and the appropriate action taken by the Psychiatrist. The extent of the problem as shown also by the admission rate to the Royal Victoria Hospital, Netley, will be discussed. A time incidence of neurotic or psychotic symptoms in the Inadequate soldier will also be demonstrated. An account will be given of exact diagnostic procedures and of the clinical management of such cases. Resulting from little success in the clinical assessment alone, the main Section of the thesis will deal with further attempts to select suitable cases for treatment. Such investigations were of the urinary steroid secretion as measured by the total 17-Ketosteroids and their various fractions. The thyroid function was also measured. Reference will be made to the techniques used and to the "Controls" which were also investigated. This Section will include tables showing some of the results of these tests. Case records will be included. Finally, an attempt will be made to draw valid conclusions from these results and an opinion given as to the value of the investigation and whether or not the Army can make any use of the Inadequate soldier.

## HISTORICAL SURVEY OF PERSONNEL SELECTION

### AND PRESENT DAY STATUS

The basic need of any Army is manpower and, of course, the allocation of manpower in a country at war and in peace is a question of high level decision. The policy is shaped and reshaped according to the over-all picture of manpower and to the various pressing needs of the three Services and industry. It is within this framework that Service Psychiatry has the position and aim of making the best and most effective use of the human resources available. Up to and including the Crimean and South African Wars, by constant drilling and discipline, the soldier was taught to obey the word of command almost instinctively. The last thing he was taught was to think for himself and he reacted automatically. Anyone who acted contrary to this, or who showed any signs of nervousness by disobeying an order or running away, was dealt with summarily and given no opportunity of repeating his misdemeanour. It may on a rare occasion have been felt that an injustice was being done but faint-heartedness was regarded, quite rightly, as a catching complaint and therefore it could not be tolerated. It was perhaps during the 1914 War that this over-strict legal code began to be questioned. Little action was taken, however, and the soldier who could not face up to battle strain was still regarded as being fully responsible for his actions.

The American Army claims to be the first army to use Selection

Procedure during the First World War. This, however, was not true selection but a clumsy attempt to keep out the gross dullards. The first sign that the British Army might become involved in Personnel Selection was in 1922 when the Southborough Committee<sup>(2)</sup> made its report into Shell Shock. This official enquiry was set up because of the public outcry demanding to know why civilian hospitals were still cluttered up with forty-thousand psychiatric wrecks from the 1914-18 War. One of the main recommendations of this Committee was that recruits joining the Army should have a Psychiatric examination as well as a Physical examination, and that some method of Personnel Selection should also be adopted. This was because the Committee had found that a great number of men were too dull and too unstable for military service and that such men, if compelled to serve, contributed a very high proportion of the cases of Hysteria and Traumatic Neurosis, then called Shell Shock. This report was obviously well ahead of its time and, perhaps not unexpectedly under peace-time conditions, was quietly filed away.

A Memorandum<sup>(3)</sup> for the medical profession in 1939, discussing the 1914 War, states that it was considered that "the great bulk of nervous disorders noted in the field of war had been thought to have their origin in the physical effects of concussion by high explosives or of poisoning by gases. It soon became obvious that this view could not be justified but the term "shell shock" had become a catchword among troops and was welcomed by the man suffering from nervous symptoms

as he did not realize that he might be suffering from the effects of fright or terror. This catchword "shell shock" appealed to the Public imagination to such an extent that this class of case excited more general interest, attention and sympathy than almost any other - so much so it is feared it became a most desirable complaint from which to suffer."

The German Army can claim credit as being the first to use modern selection methods. In the early thirties, faced with heavy restrictions in the size of their Armed Forces, they decided to utilize such techniques to ensure that each and every man was of the highest quality. The early history and the difficulties of initiating Personnel Selection in the British Army during the 1939 War are well described by Dr. J.R. Rees<sup>(4)</sup>, who states "that there was an increasing awareness of what Psychiatry can contribute and consequently there was an ever-increasing demand for competent psychiatric advice and help." There certainly was opposition, but Psychiatrists on their own initiative began to adopt and try various Selection Procedures. Hargreaves, at the R.A.M.C. Depot at Leeds, did some valuable pioneering work and gradually evolved the Penrose Raven Progressive Matrices as a group test; with the active support of Lieut. General Sir Ronald F. Adam (then General Officer Commanding in Chief, Northern Command, and later Adjutant General) this work was accepted. Selection Procedure was bound to expand, but the medical services were unwilling

and unable to agree or accept that this function was part of their duty.

Williams<sup>(5)</sup>, reporting on the R.A.F., estimated that "almost 70% of flying personnel with psychological disorders showed predisposition to these disorders to such an extent that in Selection Procedure it could have been previously recognised." Vernon<sup>(6)</sup> relates "the difficulties and suspicions in establishing Personnel Selection in the Navy in 1941 were immense; though the Senior Service was fortunate enough to be able to reject four out of every five applicants, numerous complaints were made by entry establishments, depots, and specialist schools about the quality of trainees." He quotes as an example that among seaman torpedomen "the failure rose from the pre-war 10% to 31% in 1942, but with efficient screening was brought down to 10% again by 1944. Not only were men without necessary mechanical and other aptitudes breaking the hearts of the training staffs, but also many with excellent qualifications were wasted on relatively unskilled work." "In the Navy there were certain suspicions and senior officers were initially cautious, but gradually the various objections died down and many critics were converted. In 1946-47 far more requests for assistance, both in familiar and fresh fields, were received than the depleted staff could cope with."

A Directorate for the Selection of Personnel was set up under the Adjutant General's Branch in 1941 and the basic principles have remained the same in peace as in war, although stream-lining and

improvements have naturally followed. Penton<sup>(7)</sup> did an extensive study of the evidence upon which the psychiatric element in the selection of other ranks is based and states that the basic assumption of psychiatric selection is summed up in the ancient practical wisdom which acknowledges that "the Ethiopian cannot change his skin nor the leopard his spots." Penton concluded that the psychiatric clinical interview is partly subjective and that it cannot be standardised but in competent hands is a reliable method of selecting.

Both Ferguson Rodger<sup>(8)</sup> and Ungerson<sup>(9)</sup> emphasise the importance of Officer Selection. The former states that this is so not only because of the greater technical complexity involved in the task of selecting an officer but also because if an officer is badly chosen he is in a position to affect adversely the health, morale and fighting efficiency of those whom he is called upon to lead.

After the War a report was published in 1947 by an Expert Committee<sup>(10)</sup> on the work of Psychologists and Psychiatrists in the Army and made recommendations which have now been adopted. The report pointed out that the Psychiatrist plays a very important part by preventing the soldier from breaking down and also improving morale. It agrees that one way to do this is to have an efficient Selection Procedure, and goes on to suggest that this should be adopted and suitably trained executive officers or instructors should be employed as Personnel Selection Officers who would refer the

doubtful cases of emotional stability to the Psychiatrist for an opinion. It is obviously impracticable, and perhaps unnecessary, that the Psychiatrist should screen every recruit.

A further contribution to Selection Procedure is summarised admirably by Ahrenfeldt<sup>(11)</sup> who gives a most excellent account of its development and organization. Ahrenfeldt concludes by stating "that by a thorough scientific selection personnel fit for service should be allotted to duties in such a manner as to make the best possible use of the limited skilled manpower available so as to ensure maximum efficiency and avoid psychiatric breakdowns from inappropriate allocation." This would seem to infer, although perhaps it is not intended, that such breakdowns can, in fact, be prevented and that a niche can be found for even the inadequate soldier.

No historical survey would be complete without some reference to the American literature, and in fact it is well worth while considering their point of view. Their principle has been that a soldier must be fit for anything anywhere or he is not fit for the Army. With their almost unlimited manpower this has been relatively easy to carry out at times. The British Army Psychiatrist may have liked to accept this point of view, but with the chronic manpower shortage the principle of limited manpower service has had to be accepted. The Americans, therefore, have rather varied from the British point of view but, with typical American enthusiasm, have gone from one extreme to the other and then back again. For instance,

in the Korean War they did have, and try out, a platoon of known epileptics. Dr. William C. Menninger<sup>(12)</sup>, the American counterpart of J.R. Rees, gives a good account of Selection Procedure. He points out that Selection Procedure and screening proved to be a most complex process and the Psychiatric examinations and opinion varied extremely widely in spite of numerous efforts to standardize and supplement them with various Screening Tests. Psychiatrists often had preconceived notions re the criteria for Selection. So did Combatant Officers have definite opinions as to who could be made into good soldiers. But, by the standards of either group, the best prospects often turned out to be poor fighting men and some of the apparently poorest became heroes. Menninger also deals in some detail with the struggle of the Psychiatrists to formulate valid opinions, and of their trials, tribulations, errors, mistakes and successes. That Personnel Selection in the American Army was far from perfect can be judged from the fact that although 1,800,000 inductees were rejected on psychiatric grounds there were yet, during the war, almost 1,000,000 psychiatric casualties admitted to hospital and 500,000 were invalided from the service because of a psychiatric disability.

A further and most valuable evaluation of Selection Procedure and screening processes is to be found in a more recent publication. In 1950 General Dwight David Eisenhower established "The Conservation



of Human Resources Project" at Columbia University. This major social research programme has investigated the various facets of this problem with a thoroughness which denotes the importance placed on this subject. Three volumes have recently been published, and the writer of this thesis was given the opportunity of doing a post-publication review.

The first volume, entitled "The Lost Division", by Eli Ginzberg<sup>(13)</sup> deals almost exclusively with Selection Procedure in the American Army during the War. A very frank account is given of the methods of selection and screening processes as utilized by the American Army in World War II. By a very detailed study of a great store of military records, and subsequent statistical analysis, the author seeks to remove from the realms of speculation the true and real value of Selection Procedure. He makes no attempt to minimise the many errors, mistakes and false premises, and in fact it is only by considering these that an adequate policy for the future can be adopted. It may be almost impossible and it is certainly difficult to summarise the conclusions and the lessons from this volume in a sentence or two, but it might be said that -

- i) Too much was perhaps expected of Selection Procedure.
- ii) A higher rejection rate at intake did not necessarily imply a lower Psychiatric Breakdown rate.
- iii) The experience of World War II points to Selection Procedure even at its best as being an extremely useful but limited instrument.

This volume also pays tribute to Selection Procedure in the British Army which was said to be both more venturesome and economical in its Selection Methods. It would also be equally true to say that the pendulum never swings to the extremes in Britain.

The writer of this thesis accepts these conclusions as being valid. Selection Procedure is useful, valuable and, in fact, a necessity in the modern Army, but although the Psychiatric Breakdown rate can be diminished it can never be cut down to zero. The following section will give some facts and figures and some details in the sphere of Selection Procedure. It has to be admitted that neither the Psychologist nor the Psychiatrist has any objective test which can forecast with complete accuracy how the potential recruit will behave as a fully trained soldier. Sometimes such can only be determined by trial and error, but to suggest that the basic training period should be used for this purpose merely repeats the error of equating effectiveness under one set of circumstances, i.e. basic training, with effectiveness under quite different and more stressful conditions. Difficulties would also arise with such a plan when it became common knowledge that failure in training was rewarded with discharge from the Army. It may further be stated that if psychiatric predictions are not always valid then this is strong argument for renewed efforts to improve their accuracy and to eliminate criteria which have been found to be unreliable.

## ROUTINE PERSONNEL SELECTION PROCEDURE

Before discussing this topic in some detail it may be advisable to make brief mention of the pre-service medical examination. A Civilian Board has, in fact, examined all potential recruits before their enlistment and placed them in a medical category indicating that they are fit for military service. This Medical Board functions under the Ministry of Labour, and Civilian Consultants can be called in to give an opinion whenever necessary. An astonishing number of potential National Servicemen are considered at this stage to be medically unfit. It is stated that one in every four is placed in a low medical category and rejected for military service. Of every three of those not accepted two are rejected because of a physical disability and one because of a psychiatric disability. Regular recruits show a rather different picture and only one in every eight is found to be below medical standards, and practically without exception it is because of a physical disability. It is a sad reflection on our modern society that such large numbers of men should be found wanting when called upon by their Country to do their duty. It may be rather difficult on first sight to reconcile why a much higher percentage of National Service recruits are found to be unfit medically compared to the Regular recruits. The medical standards are the same, and in fact in certain instances a higher standard is required for the Regular. There are two reasons for this anomaly. There is a tendency for the Regular

recruit to be a more robust and a fitter man physically than the cross-section of National Servicemen. An important factor is also that the Regular recruit minimises his disabilities if he has any whereas the conscript, especially if he is unwilling, will make the most of them. Few Regulars are rejected on psychiatric grounds by the Civilian Medical Board, who appear to consider it advisable to leave even the fairly obvious inadequate, unstable, personality to the Military Psychiatrist to take the necessary appropriate action. Although the Army Psychiatrist may be willing to accept this task it may have certain rather unfortunate repercussions. It may well be that the recruit, having been found medically fit for service by the Civilian Medical Board, gives up his civilian job and joins his Army unit. Within two or three days of his arrival he may then be graded as unfit. To say the least, this may cause some confusion both in the minds of the recruit and his parents; to them it appears that there is a conflict of medical opinion, and although this may be incorrect it suggests a lack of liaison between the Civilian and Army Medical Authorities.

Although these pre-service Medical Boards must indeed reject some of the inadequate personalities there are certain other factors which over-compensate for this, and it is probable, therefore, that there are still the same proportionate number of inadequate and unstable personalities as in any random sample of the civilian community. In fact, on occasions the numbers are apparently more as for many

youngsters joining the Service is the first occasion they have to stand on their own feet without the active support of their parents and relatives. Rees<sup>(14)</sup>, in fact, writing during the war time - but it might be equally true today - put it succinctly when he said that many are puzzled as to why the Army should contain such a large proportion of men who have psychiatric problems; but the reason for this is not difficult to explain. Partly, there has existed for many years a tradition that men who were immature or unsatisfactory, or whose social records were not above suspicion, could under Army discipline be made into "men". The Army in peace time has always had a good many backward and otherwise unemployable men and in the past some of them have turned out to be reasonable soldiers. Modern war demands, unfortunately, a different quality of man. A more important reason, however, why there appear to be so many in the Army is that large numbers of qualified men are reserved for industry. The Royal Navy and the Royal Air Force appear to have priority of choice, and the Civil Defence claims a great many men too. The Army comes last in the list and consequently a large proportion of what has been called the "psychopathic tenth" of the country's manpower finds its way into the Army if the mesh of the Recruiting Board is too wide.

It may well be also that, in some cases, the change in the youth's personality has been so gradual that the parents have not appreciated any real change and take it for granted that their son is normal. On joining the Army, however, his behaviour is looked upon as certainly

eccentric, if not abnormal, and closer questioning and observation soon elicits severe emotional instability and even frank neurosis. At first sight it might be considered that no Regular volunteer soldier would be the inadequate immature personality. The picture painted of the Regular soldier is often that, although perhaps rather dull, he shows confidence and aggression. However, this is by no means so, as the Inadequate Personality who finds himself unsuccessful in civil life occasionally drifts into the Army hoping to make the grade, achieve success, and find security. In some cases it will be found that the individual knows and feels that something is wrong and he will enter the Service quite voluntarily hoping to be able to sort out his problems and regain his lost confidence in himself. A recent example of this is a twenty-four year old N.C.O. who was admitted to the Royal Victoria Hospital, Netley, with a frank schizophrenic episode. He had not been in the Service very long and the initial suggestion was that the Army had been too much for him and had precipitated this crisis. On checking his medical history, however, it was found that this young N.C.O. was a University graduate. He had been a very successful student and had taken his B.Sc., but not with the honours which had been anticipated. His friends and parents were surprised when, soon after this, he joined the Army as a Private soldier. In this case it was ascertained, as the patient improved under treatment and obtained more insight, that the individual himself had known for some considerable time that something was wrong with him. At the University he gradually

felt that he was unable to cope and that his personality was disintegrating. Being unable to verbalise his various problems he had joined the Army hoping to find either some support or a means of escape.

Another much more familiar type of case is the rather timid, introverted schizoid individual who is literally forced into the Army by his parents, and occasionally even on the advice of the General Practitioner, because "it will make a man of him". Not only do Magistrates make a similar order on occasions but even the Civilian Psychiatrist also appears to consider that National Service is curative for the schizophrenic. Within the last year a case of a young National Serviceman was admitted as a frank schizophrenic. Within a few days when his parents arrived for interview and to see their son, they confessed that he had been in a Civilian Mental Hospital a few weeks prior to his call-up. As a routine procedure, a request was sent to the hospital asking for a summary or a perusal of the patient's medical documents. The latter were forwarded by return post and the last recorded entry read as follows:- "a frank Schizophrenic who is now remitting. He is due for National Service soon and he should benefit from this."

The above examples, of course, are perhaps rather extreme and isolated cases, but there is no doubt that the recruit as he arrives at his intake unit in the Army is certainly not the potential ready-made soldier. Laver<sup>(15)</sup> of the Royal Canadian Army brings out this

point well when giving the reasons why the majority of recruits wish to join the Army. These are summarized as follows:-

- (a) Dissatisfaction with civilian life and failure to obtain or hold a steady job; worry and uncertainty about the future.
- (b) The Army was viewed as an organization offering a steady job. Most thought they would be better men and more mature. They hoped to learn new trades and skills.
- (c) A deterrent, and a reason why they had not joined sooner, was fear of loss of freedom and doubts about their own ability to adjust to service conditions.

These facts are related to give conclusive evidence, if further proof is required at this stage, that some form of selection screening process of recruits is very necessary.

When a young recruit enters the Army and reports to the particular Army Unit as detailed he is likely to find that he is one of a group, which may vary in number from fifteen to two hundred, all newly arrived like himself. These recruits will include National Servicemen, Short Service Enlistments and Long Term Regular Engagements. The new recruit, in the settling-in process, has very little time for himself and he will find that, in addition to various drills and parades, he has to attend to the following: (a) obtain his new Army clothing and equipment; (b) arrange for his pay allowances;



(c) interview by his Company Officer; (d) inoculations, vaccinations and complete Medical Examination. Also during this initial phase the recruit is subjected to routine procedure of Personnel Selection. The first stage of selection comprises a group of tests given by Sergeant Testers. These include: (1) the Dominoe Test (used in lieu of the Matrix Test); (2) Mechanical Aptitude Test; (3) Arithmetic Tests; (4) Verbal Tests; (5) Instruction Tests. Following the completion of the tests the recruit is then interviewed individually by the Personnel Selection Officer (P.S.O.). The P.S.O. is usually an experienced Army Officer who, after selection for such a job, is only posted in to carry out such duties after a lengthy period of training which includes service under a Senior Personnel Selection Officer. The P.S.O.'s interview with the recruit may vary anything from twenty to sixty minutes, and his main task is to assess the recruit's potentiality and to make a recommendation for the most suitable employment available within the Unit. He attempts to sum up the recruit's personality, his intelligence rating, and his physical standards. The P.S.O. also makes an assessment as to whether the recruit is N.C.O. material or a potential Officer Cadet. The P.S.O. has been taught to refer certain recruits to the Psychiatrist as a matter of routine. These include the dullard who may be semi-illiterate, the gross hysteric with facial twitchings, the recruit with a stammer or other speech impediment, the separation anxiety state with flushed face and sweating hands. Such cases are relatively

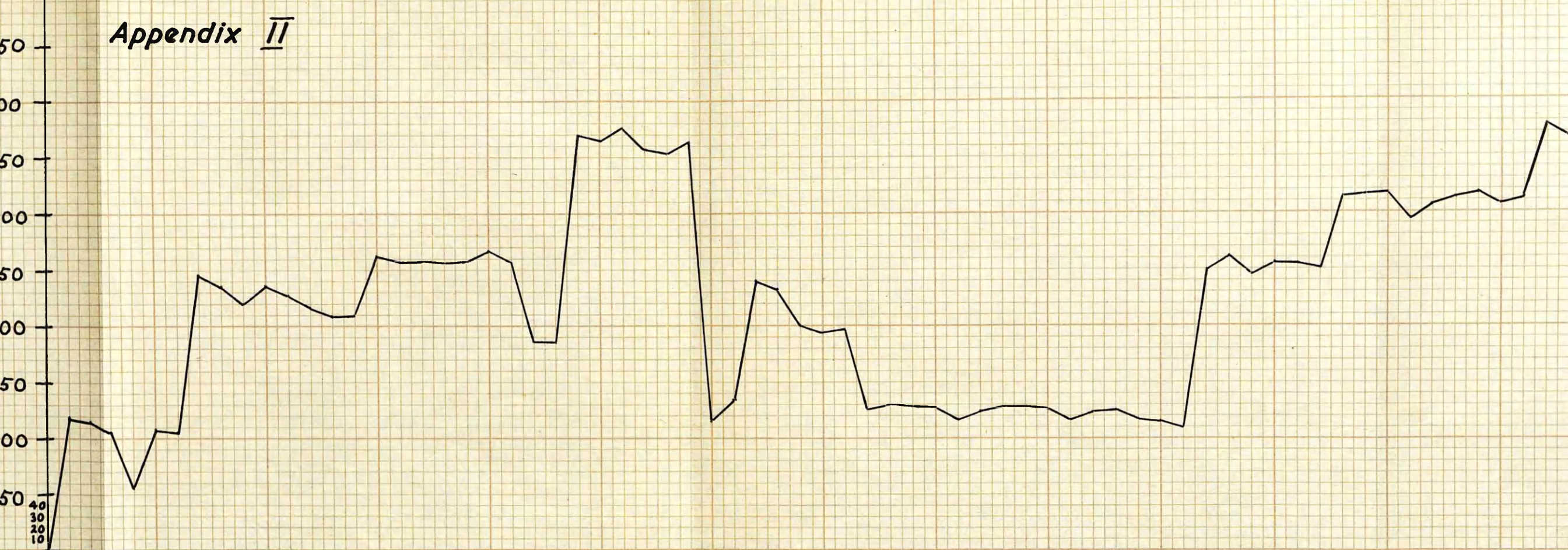


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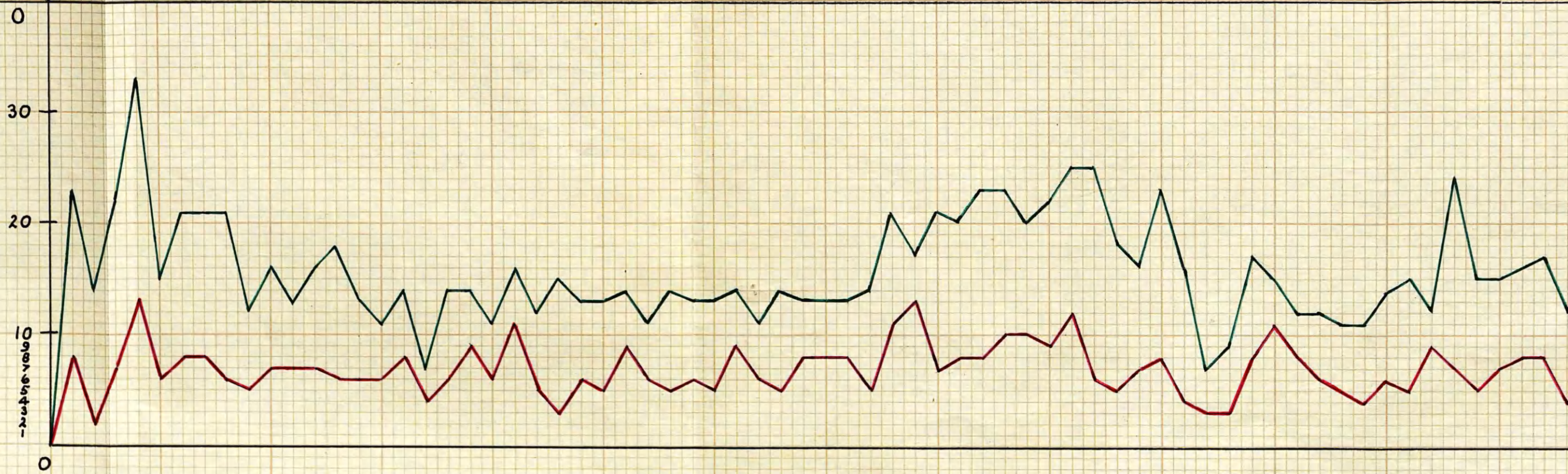
Appendix II

TOTAL  
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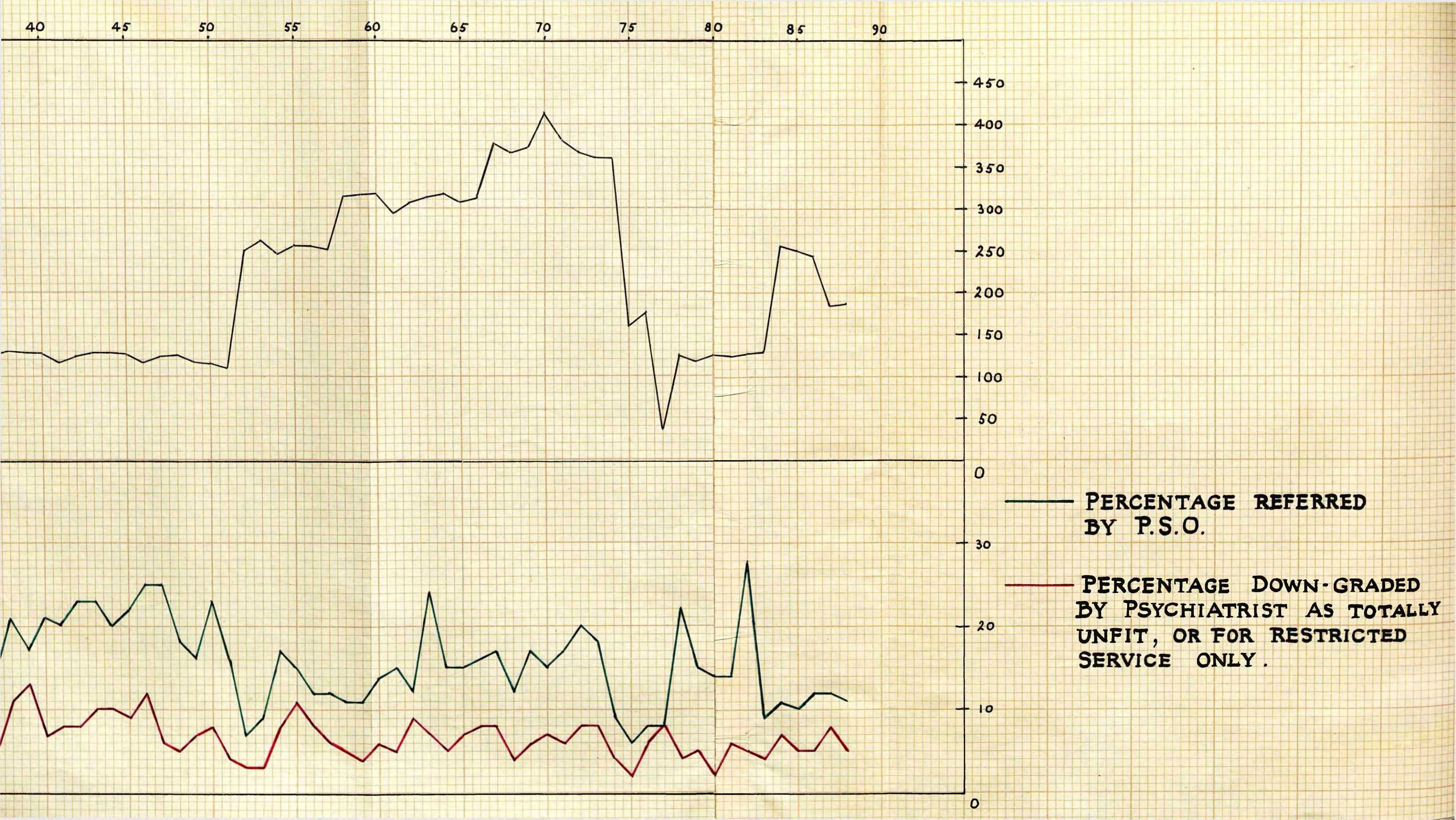
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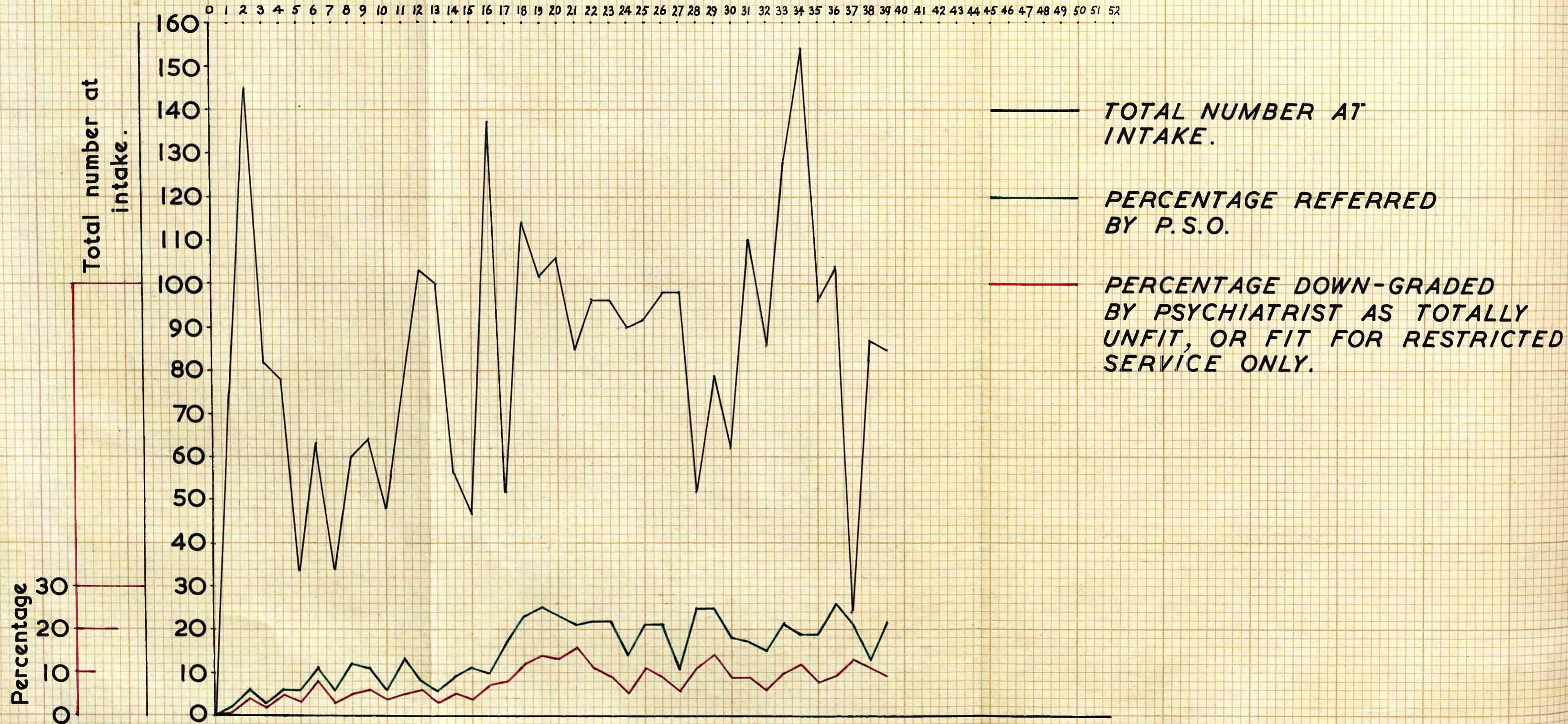






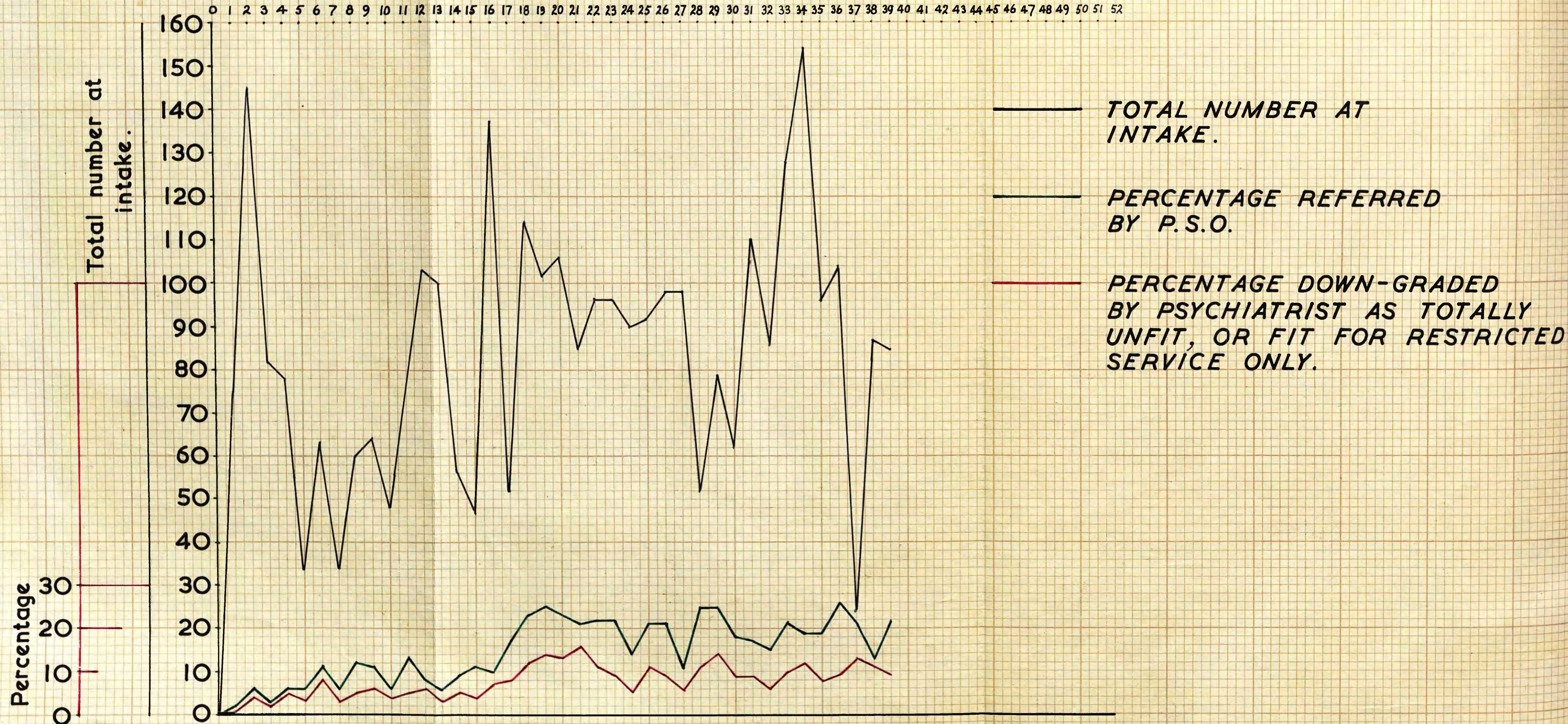


Appendix I





Appendix I





rare and when seen are fairly easily spotted, but it is the inadequate immature youth with emotional instability for whom the experienced P.S.O. is looking. Such borderline cases are only to be found by careful history taking, and the following pointers may be suggestive:-

- (a) a poor family history;
- (b) an unsettled home background;
- (c) a school record below average;
- (d) an inability to make friends, even as a schoolboy;
- (e) a constant changing from job to job without any adequate reason;
- (f) minor delinquency in adolescence.

The percentage of cases referred by the P.S.O. to the Psychiatrist has shown some variation during the post-war years. Immediately after the War the figure was 10% and then gradually fell to 7%. In Appendix I and II, which will be discussed later, it will be seen that approximately 18% of each intake at two Units is referred by the P.S.O. for a Psychiatric opinion. This is a rather higher figure than for the Army in general although there has been an all round increase lately, but the writer tends to encourage the P.S.O. to cast as wide a net as possible rather than to refer only a small number of cases and possibly miss the potential neurotic. The Psychiatrist's visit to Units is usually on the day following completion of the P.S.O.'s interviews - normally on the sixth or seventh day of the recruit's service. The two Units shown in Appendix I and II had a total intake amounting to 21,886 during the period in question, which was between  $3\frac{1}{2}$  to 4 years. The total number of cases referred to the Psychiatrist for a final assessment amounted to 3,275. The writer visited these two Units

once a fortnight or three weeks, or whenever required. It is obvious that the numbers and time available do not permit a full psychiatric clinical interview. As a routine, it is usually possible to see up to twelve recruits in an hour and a half, and a maximum of twenty-four in either a full forenoon or afternoon session. The Psychiatrist has available a resume of the recruit's medical history, the details of the recruit's test results and scores, and a summary of the P.S.Q.'s interviews and comments. By pertinent questioning the Psychiatrist can often fairly quickly elicit some further relevant details. It is often very difficult not to become involved with welfare problems, financial difficulties or compassionate reasons as to why the recruit is unable to serve. The Psychiatrist must not attempt to be a judge and a jury, and his only function is to give an opinion on the emotional stability of the recruit and a prediction as to whether he is fit or unfit for military service. If there are other than psychiatric indications why the recruit should not serve then the Unit must be requested to take appropriate action. The average Unit Commanding Officer dislikes discharging a recruit as being unsuitable because he considers that this is a measure of admission of his own failure. The Psychiatrist who carries out this duty regularly soon gains by experience a technique which enables him to make fairly rapid assessment. The neurotic recruit makes little attempt to hide his symptoms, and in fact as he is often poorly motivated, especially in the case of the National Serviceman, he tends to grossly exaggerate his symptoms. The Inadequate Personality

at this early stage of his Army career is still trying to cover up, and therefore he may be missed. It is a remarkable fact that the Psychotic recruit seems easily to evade routine selection screening process and is rarely spotted by the P.S.O. The Psychiatrist, after he has finished and completed his session of interviews, often has a conference with the P.S.O. and perhaps also the Company Officer in charge of the recruits' training. It is also possible to relegate doubtful or borderline cases for a further report at the next visit. This gives the unit a chance to make some observation on how the recruit is standing up to his training and the recruit the chance of settling down in his new environment. In fact, it is often quite remarkable the changes for the better which take place in a recruit as he settles down, gains confidence in himself, loses his anxiety and finds a support in comradeship.

The Psychiatrist may make any of the following recommendations:-

(a) fit for service anywhere under any conditions; (b) fit for service in a restricted capacity (home service only, clerical duties only, etc.); (c) unfit for military service. In Appendix I and II, out of a total of 21,886 recruits only 1,460 were, in the Psychiatrist's opinion, unfit for full military duties. The Psychiatrist simply places the recruit in whatever medical category he thinks is the correct one and the fit are retained and the unfit discharged on medical grounds. When a soldier is placed in a restricted medical category then what happens to him depends completely on the policy then in vogue. Until recently



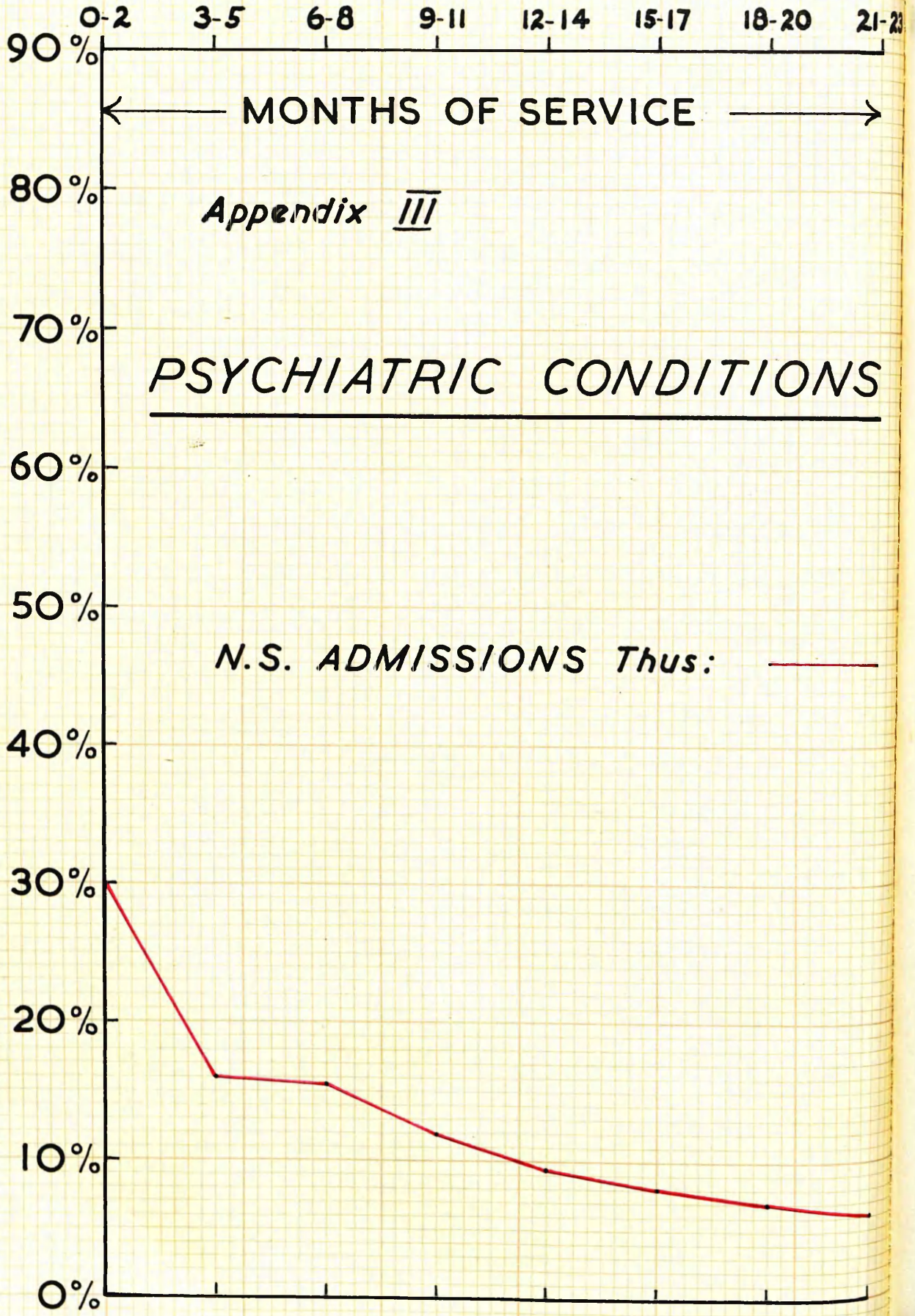
men were retained in restricted medical categories but gradually, with the running down of National Service and with the hope that the new Regular Army will be an elite, fit, fighting force, all recruits placed in restricted medical category at intake are discharged "as not being up to the required medical standard". If, on the other hand, recruiting should fall below the level of the manpower required then this may again have to be changed. Although, as seen from Appendix I and II, 8% leave the service after the psychiatric interview and recommendation either by medical board or on administrative grounds, only 1% is actually medically boarded out. A point of difference, which is possibly of theoretical interest only, is that when the recruit leaves the Army by an invaliding board he is permanently unfit for military service whereas the recruit who leaves the Army as not up to medical standards in present circumstances may be called up at any time during the period of his National Service if any emergency should develop.

The figures quoted above and given in Appendix I and II are for two major units in this area. The percentage of recruits placed in a low medical category by the Psychiatrist is higher than the average given for recruits throughout the British Army. This percentage is regarded by the writer of this thesis as an optimum. The figures are still relatively low, and therefore the Psychiatrist cannot be accused of helping recruits to evade their responsibilities of National Service or of an undue wastage of manpower. In fact, both the

Commanding Officers would prefer that a rather higher figure would be discharged by the Psychiatrist, as experience has impressed on them that the unstable and inadequate soldier is a complete liability in any unit. However, it is considered that psychiatrists would not be justified in raising the figure by attempting to predict with any degree of certainty that the borderline recruit will not make a soldier. Glass<sup>(16)</sup> has recently reported on the validity and non-validity of the psychiatric recommendation during Selection Procedure. American psychiatrists, as indicated previously, are inclined to recommend a higher separation rate than in this country, but in this particular project of Glass the borderline and neurotic individuals whom the psychiatrist recommended as unfit for service were, in fact, retained. During the next 2 years these personnel were followed up and it was found that there was a high correlation between the actual conduct of those men whom the psychiatrist had recommended as suitable for service, but there was a very poor correlation of those men whom the psychiatrist had stated were not suitable for military service. Apparently, a large number of those men in actual fact proved to be useful and good soldiers. It would therefore appear that the rejection rate during Selection Procedure must be not too high without there being a possible waste of manpower. This therefore leads to the next Section which deals with psychiatric breakdown that apparently, even with efficient Selection Procedure, must still inevitably occur.

## THE ARMY PSYCHIATRIC CASUALTY

The approximate annual average number of psychiatric cases admitted to the Royal Victoria Hospital, Netley, is 1,200. More recently there has been a slight decrease in numbers as the Army shrinks in size. The majority of psychiatric cases from the Army in the United Kingdom and overseas are admitted here if requiring treatment. Cases arrive by ambulance, car, train or by air. More Regular soldiers are admitted than National Servicemen, but no attempt should be made to draw any valid conclusion from that. The reason is that Army Psychiatrists can invalid soldiers out of the Army without admitting them to hospital and they are inclined to do this with National Servicemen, especially if they are not in need of urgent in-hospital treatment. In fact, the mere removal from an Army environment if not curative certainly often appears to alleviate their symptoms. The Psychiatric Division has two wings - Psychotic and Psychoneurotic. These terms are a link with the past, when the Psychotic Wing - "D" Block - was completely closed ward accommodation. Normally, 60% of patients are admitted to the Psychoneurotic Wing and 40% to the Psychotic Wing. The Psychoneurotic Wing has an ordinary hospital atmosphere, patients are completely independent and the emphasis is on the patient being able to return to his unit after treatment. In the Psychotic Wing, although only one small ward is now closed, patients are more dependent on the staff and the emphasis



0-2

3-5

6-8

9-11

12-14

15-17

18-20

21-23

90%

80%

70%

60%

50%

40%

30%

20%

10%

0%

MONTHS OF SERVICE

Appendix III

PSYCHIATRIC CONDITIONS

N.S. ADMISSIONS Thus:

—

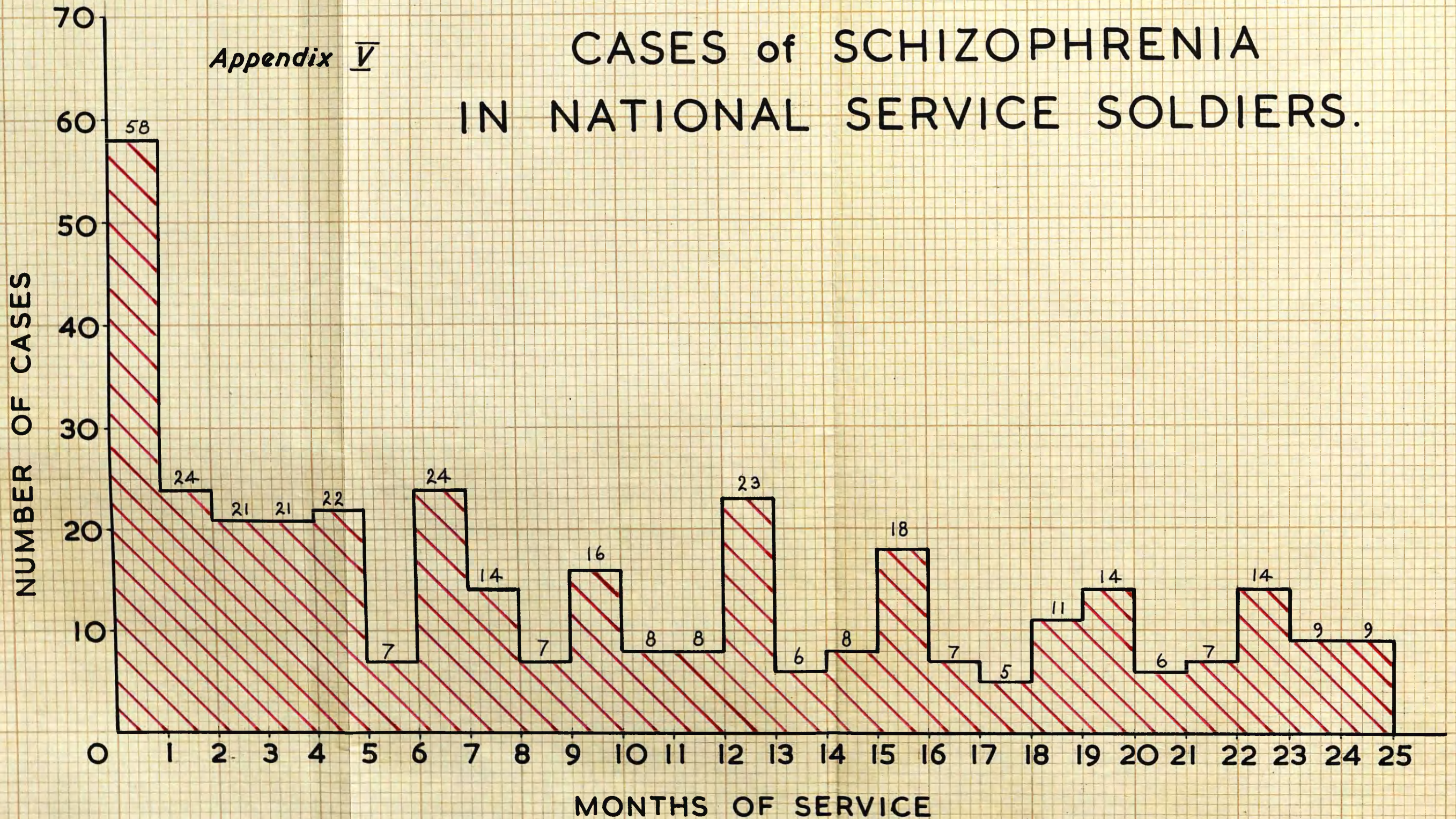
is on being able to return to civilian employment, except in certain selected cases, after treatment. Cases can be transferred, of course, between one Wing and another if it is considered to be in their best interests. Compared to the civilian mental hospital atmosphere there is always a sense of urgency as 6 months is the maximum time a patient remains in hospital on full pay and allowances. This regulation is not strictly adhered to and a few patients remain in hospital for a year or more. In spite of this short term treatment, as there is a higher Psychiatrist/patient ratio than in civilian mental hospitals, only three or four cases each year at the end of their treatment require to be admitted to a civilian mental hospital when discharged from the Army.

The writer noted that 60% of all cases admitted to hospital had under 2 years' service, and in fact 40% of all admissions had under one year's service. This seemed to be of considerable interest, and therefore medical record cards of all National Servicemen who had been admitted to hospital in one year were obtained and their particulars checked. A time incidence of their admission to hospital was then plotted on a graph against the length of service of the individual at the time. This is shown in Appendix III. This confirmed the previous suggestion that psychiatric disabilities occur very early in the military career of the National Serviceman. Figures were then obtained for National Servicemen admitted to hospital during the same



Appendix V

# CASES of SCHIZOPHRENIA IN NATIONAL SERVICE SOLDIERS.





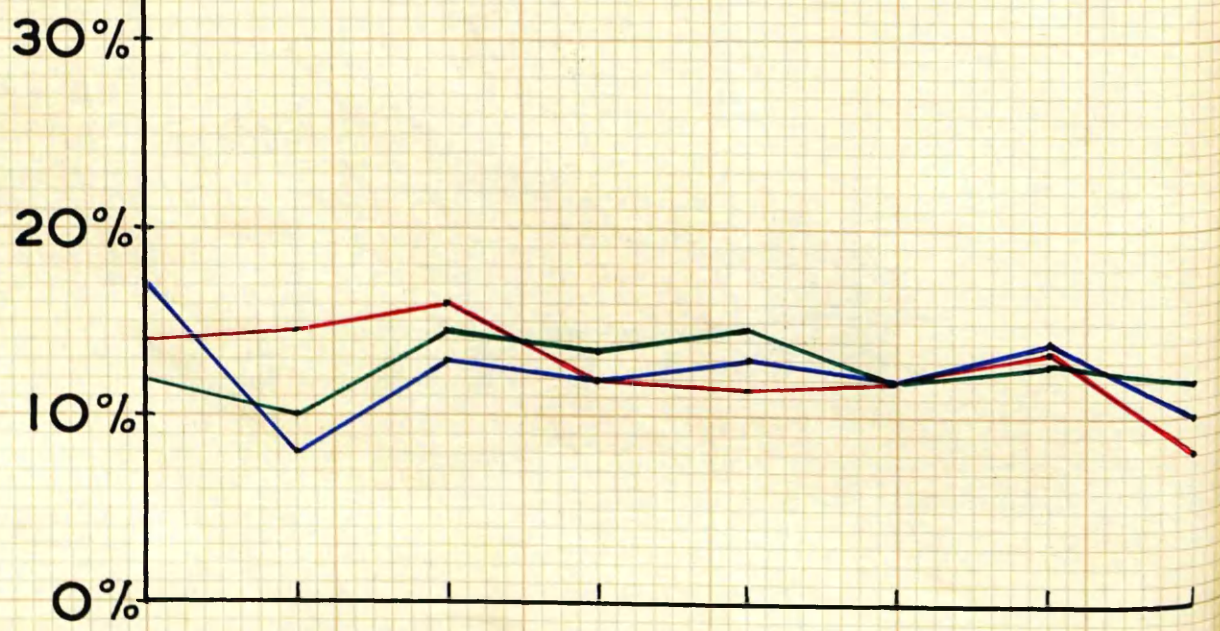
0-2    3-5    6-8    9-11    12-14    15-17    18-20    21-23

90% ← MONTHS OF SERVICE →

*Appendix IV*

*N.S. ADMISSIONS Thus :*

- ① *ASTHMA :* —
- ② *SKIN CONDITIONS :* —
- ③ *PEPTIC ULCERS :* —



year and diagnosed with so-called stress disorders, namely, peptic ulcer, asthma and skin conditions. Appendix IV indicates that in these disorders the time incidence of the disability could occur fairly equally at any time of the National Serviceman's career. Appendix V shows the time incidence of schizophrenia in National Servicemen during the  $3\frac{1}{2}$  to 4 year period under review. Here again, the first month of the recruit's period appears to be a particularly vulnerable one. What conclusions can be drawn from those interesting differences? Psychiatric casualties show a clear preponderance during the first two quarters of the service period while the other disabilities, which might have been expected to be similar, are fairly evenly distributed. Is it merely that service life picks up and focuses on a pre-existing psychiatric condition, or would the disability only have occurred because the soldier is serving in the Army? It would be wrong, of course, to attempt to give any definite answer from these figures. They may be suggestive, but no more. The writer is personally of the opinion that the former conclusion is probably the correct one. He frequently has to interview most antagonistic parents who visit the Royal Victoria Hospital, Netley, on intimation that their son has been admitted suffering from a nervous breakdown. Initially, the parents tend to be most abusive. They will allege that they are completely unable to understand how the Army has managed to turn a completely healthy young man into a complete wreck within a week or two. "The Army will have cause to regret this" and their Member of Parliament



will certainly be informed. And yet, without any particular tact and diplomacy on the part of the interviewer, the parents will soon begin to agree that their son was not too well lately. He was rather vague in his manner, his school or work record was not quite as good as it used to be, he tended to keep to himself. Perhaps at the time they had not thought anything about it or even noticed it but, on being questioned about it, the gradual change in their son's mental health now became evident. This happens so frequently that it must be more than a coincidence. In fact, the anger the parents show initially is to compensate for the guilt they feel about their son's change in behaviour which they could neither accept nor understand. It is relevant here also to note that the parents accept the explanation given to them, namely, that service in the Army has certainly not caused their son's illness, although it may have precipitated this crisis. They also accept the explanation that this acute type of illness will respond to treatment. If their son had not entered the Army then he might have remained apparently well for some considerable time, but the gradual onset of such an illness would be more likely to cause a chronic illness at a later date and would not then be so amenable to treatment.

The above findings are, of course, not new, and in fact were repeatedly emphasised by various writers during the war. Mayer Gross<sup>(17)</sup> recorded " that it was tempting to reproach the Psychiatrist for providing war neurosis as just another label for human weakness

and lack of social responsibility. There must, however, be many who by their psychological make up and education are totally unacceptable."

The Lancet<sup>(18)</sup>, in a leading article right at the beginning of the last war, stated that there can be no doubt that many more have broken down with neurotic disorders under the trivial stresses of ordinary life and separation from the family than under the stresses of violent action. In this group the fundamental importance of constitutional weakness and instability is the determining factor.

Slater<sup>(19)</sup> puts it in a rather different way and he divides the war neurosis into two groups, the acute and the chronic. Many soldiers, he continues, "were burdened with neurotic symptoms before they ever became soldiers but, as life in the Army is in many ways more difficult than life as a civilian, it comes about that men who were just able to carry on in civilian life broke down sooner or later in the Army. These cases are referred to as chronic, for although obvious illness may be of fairly recent onset investigation shows that the underlying condition, which has been the cause of the illness, is of long, even life-long, duration."

Thus it would appear, though it be in an Army at war or an Army in peace time, that many men who were just able to "manage" break down soon after entry into the Service, possibly due to separation from parents, relatives and friends and their support, and possibly also due to their inability to face up to a different environment although in reality a scarcely more difficult one.

This Section has dealt with, rather briefly, the number of psychiatric cases admitted to this hospital for treatment. It should be noted that not all cases come under the title of the Inadequate Adolescent soldier. A small number of cases are of the older age group, and these are usually officers and non-commissioned officers who suffer from the typical psychiatric syndromes of the over-forties. - the manic depressive psychosis, involuntional depression, obsessional compulsion neurosis, and other such conditions as would also be seen in any modern civilian psychiatric centre. The occasional G.P.I. and chronic alcoholic are also seen. No further mention will be made of such cases and the following Sections will deal with the Inadequate Adolescent soldier as a clinical entity.

#### THE INADEQUATE SOLDIER

Usually the civilian mental hospital caters for the patient who has, at least, a reasonably severe mental illness but in the Army this is not so as the hospital tends to serve a dual function. It is the only place to send a man who is not fit to perform his duty and therefore many soldiers have to be admitted with only minor or marginal disabilities. The hospital is also used to evaluate the soldier who gives some evidence of a disability and to determine whether he is fit to return to military duty or to be discharged

from the Army. Although instructions are often issued that only soldiers requiring treatment should be admitted to the Psychiatric Centre this, unfortunately, cannot be adhered to because in the Army the soldier has no respite from the demands of his Commander except when he is under the care of his Medical Officer. In other words, the soldier is either fit for duty or he is sick and there is seldom anything in between. Hence many men seek to escape from mounting pressures by enlisting medical help.

The writer of this thesis regards these facts as being unfortunate because in the social structure of the Army the Physician, the Psychiatrist and the Hospital represent removal of a man from the military situation and invite or require his adoption of the role of "a patient". Medical or psychiatric treatment simply confirms this role. It is often very much better if the Psychiatrist is not attached to a Hospital but to such a unit as a Mental Hygiene Unit where responsibility is maintained at the periphery. This has the added advantage that preventative methods are designed to use administrative policy to provide a social milieu rather than the far too often destructive permissive hospital environment. This is recorded extremely well in Rioch's<sup>(20)</sup> description of the Inadequate American soldier when he states that "treatment should be decentralised and away from the hospital and located as close to the unit as feasible." This has apparently lead to the formation in the American Army of a Mental Hygiene Consultation Service. Rioch goes on to state that

"following the principle of decentralisation the M.H.C.S. operates in the troop area entirely (separate from the hospital and the psychiatrist spends a considerable part of his time in making and maintaining contact with military units and their Commanding Officers." This writer also gives a good description of the soldier who has been A.W.O.L., insubordinate or involved in other petty crimes and shows that "punishment given as a deterrent results in a series of repeated episodes of defiance. Eventually the soldier is conditioned and hardened by detention and a dishonourable discharge is usually the final outcome." "The Mental Hygiene Consultation Service has shown and presented to the authorities that many of these men are not tough and defiant but weak with chronic character disorders unable to cope adequately with the modern army. The definition inadequate, weak, unsuited to military service is not only descriptive but it provides an accepted course of action. But perhaps more important it evokes a response of practical attention and management of these inadequate personnel instead of a hyper-alert retaliation with the consequent tension called for by the defiance punishment transaction in our system of informal social roles."

It is most important that the term Inadequate Soldier is not confused with the Ineffective Soldier. The latter is not a psychiatric term but is used to include any man whom the Army discharges prior to his normal day of release for reasons of psychoneurosis, psychosis, defective character traits or inaptitude, all of which make him unsuitable

for military service.

There is no particular difficulty with the Psychotic soldier or the Psychoneurotic soldier. Both are admitted to hospital requiring treatment, and final disposal can be made only after further assessment. It was previously indicated that the Psychotic soldier was usually discharged from the Service but the Psychoneurotic soldier could, after treatment, frequently be retained in the Service. The Psychopathic soldier is a more difficult problem. One of the most prevalent beliefs is that the Psychopathic soldier is not motivated to fight, i.e. he is a malingerer. A second belief is the opposite view, that the ineffective psychopath is emotionally ill. The policy of the Army has inclined to be towards the latter belief and it is accepted that emotional illness is linked to mal-performance but, of course, this is an over-simplification because the relationship between emotional disturbance and performance is seldom simple and direct. The question of motivation is an extremely knotty problem and will be discussed in some detail at a later stage. The Inapt soldier is also not a psychiatric term and is applied to the soldier who has a poor performance because he is unable to make any real effort. It is a term more commonly used in the American Army than in the British Army.

Prior to the formulation of this thesis the writer had a simple definition of the Inadequate soldier, and this was as follows. The Inadequate soldier is used as a term to describe the inadequate and immature personality where no major psychiatric syndrome is present

but where there is evidence of emotional instability. It is the man whose emotional energies are so apparently drained by internal conflicts that he therefore has a vulnerable personality, especially if environmental stresses increase. The Inadequate soldier comes to the notice of the medical authorities because of -

- (a) poor performance
- (b) minor disciplinary offences
- (c) symptomatic behaviour - enuresis, fainting turns, etc.
- (d) somatic symptoms - various aches and pains, etc.

Such patients, when admitted to hospital, are more or less symptom free and may often remain so as long as their return to duty is not mooted. The following gives a summary of typical case records of four soldiers admitted to hospital and given the diagnosis of Inadequate Personality.

Case Record No.1. H.R. NS, 21 years of age

Admitted to hospital after a suicide gesture. Brought up by a rather strict father. Not allowed to go out with girls. Made to come home early at night. Got a good hiding whenever he misbehaved. Mother nervous and very dependent on father. When parents quarrelled, and this was quite often when patient was young, he felt very upset. A quiet rather timid boy at school. Usually just below the average of the 'B' stream. He did one or two jobs on a farm before joining the Army on impulse and mainly to get away from his father.

His service in the Army has been reasonable and he has been employed as a tailor. ( He has, however, disliked the Army since entry and has regretted joining. Recently, on leave, just prior to return to his Unit, he had a quarrel with his girl friend and as a result he went A.W.O.L. and swallowed thirty Aspirin and Codeine tablets. On admission to hospital he presented as a rather miserable and dejected young man. The girl friend, at interview, described him as a rather spineless individual and she wanted him out of the Army so he could settle down and prove himself. He was of average intelligence and his Unit reported that he was quiet, lacking in personality and he kept to himself. Further interviews elicited little further information. It was obvious that being rather a failure in civilian life he had joined the Army as a means of escape and was now finding that Army life was even more difficult than he had imagined. It was considered that he would only be a liability to any Unit, and certainly never an asset, and he was accordingly brought before a Medical Board and discharged from the Army.

Case Record No.2. A.D. NS, 20 years of age and 1½ months service

A shy boy who had had a happy home life. Inclined to worry easily. An average scholar who did not sit his eleven plus because he did not want to go to a Grammar School. Liked gardening so he has been working as a Corporation Gardener. Has had few friends and his present girl friend was introduced



to him by his sister. Apparently well motivated to the Army and he thought National Service would help him. Was sent first to an Infantry Unit in Ireland and after an interview was considered unsuited to the Infantry and was returned to England to join the Royal Army Service Corps. This rather upset him because he thought he had failed. He felt the odd man out, with no friends, and he just wanted to sit down and weep. Although he was allowed to work as a gardener for a short period this did not help him and he was then sent to another Unit to be trained as a clerk. He still did not like it and he then went and reported to the Orderly Officer that he thought he would run away. He was referred to the Medical Centre and was then sent to see the Psychiatrist. Arrangements were made for him to be discharged from the Army and it was considered he could hope for the next few days in his Unit until his discharge papers were confirmed. A sergeant swore at him and this upset him and he asked to be admitted to the Medical Centre. From there he was transferred to this hospital. Since admission here he has settled down, sleeping and eating well. He is rather pathetic in his effort to please. On one or two occasions he was found sitting in the ward weeping because his girl friend had written and said how lonely she was without him.

Case Record No.3. F.A. Regular, 17 years of age, 3 months service

Admitted to hospital after a suicidal attempt. No relevant

family history. Attended school from five to fifteen years of age but made poor progress. Boys used to tease him and take the mickey out of him. After leaving school had a variety of jobs usually only lasting for a few months. These jobs included clerk, painter, mechanic, farming and sheet metal worker. Various reasons for changing his job, and on one occasion was advised by his doctor to leave his job because he was run down. Joined the Army on impulse and wanted to be a Nursing Orderly in the R.A.M.C. One week later he saw an accident and he went across the road to help an injured man out of a car. When he saw the injury and the blood he panicked. This incident upset him and he imagined he had been responsible for the man's death. (This, in fact, was a fantasy because the injured man made a good recovery). He felt he no longer wanted to do nursing and he tried to explain this to the Company Officer, but he did not think that the Officer understood. He began to miss lectures and he lost some privileges for this offence. He went to see the Medical Officer but was simply advised to snap out of it. He then went A.W.O.L. to see his own civilian doctor. The doctor gave him a letter to take back to his Unit, and on the return journey he opened the letter and noted that the doctor had written to say the he doubted that he, the patient, was fit for military duty. This upset him and as he had a headache he bought a bottle of Aspirin. He took some

Aspirin, and as he felt drowsy he continued to eat the Aspirin, up to a total of between twenty and thirty. He was taken off the train, admitted to a civilian hospital in London, and then transferred here after having his stomach washed out. At interview the following day he was quiet and he had settled down to ward routine. He was still reasonably well motivated towards the Army because he felt that by staying in he might gain some of his lost confidence but he doubted if he could continue as a Nursing Orderly. The parents were interviewed, describing their son as always insecure, immature and inclined to be a drifter. He was diagnosed as an Inadequate Unstable Personality who was well motivated, but it was considered doubtful if he would ever be an efficient soldier. After two or three weeks in hospital his attitude towards further service gradually began to change and it was soon obvious that there was little hope of persuading him to make a further attempt at service. He was accordingly brought before a Medical Board and discharged from military service.

Case Record No.4. O.J. NS, 18 years of age, 3 months service

Admitted on the 7th of December; the complaint was that he felt a bundle of nerves. F.H: father alive and well. Mother a very nervous type, had a nervous breakdown during the war. Patient is an only child. A reasonably happy childhood, pampered by mother, and father tended to be over-strict. Always

rather afraid of the dark. Attended school up to fifteen years of age and was (an average scholar. Played games only because he was compelled to. After school he took a course in shorthand-typing as he wanted to work in one of the National Daily Newspapers, but was unable to get a job. He was later employed as a drapery salesman and was quite happy at this job. He had few real friends, no girl friend. Normal sex feelings, but he did not contemplate marriage. As an adolescent, prior to joining the Army, he had occasional black-outs and could not stand noise. He never went to church or the cinema because he wanted quietness. He joined the Army as a National Service recruit and he quite liked it at first, but he made poor progress as a tradesman clerk. He soon began to feel he could not stand the Army any longer. He reported sick to his Medical Officer soon after a posting to Farnborough as he could not stand the noise of the aircraft flying around. Transferred to this hospital, he was reported at initial interview as being very immature, inadequate, and a rather old-maidish schizoid youth who appeared to be mildly anxious and he also showed some hysterical features. He soon settled down to hospital routine but was occasionally mildly depressed and tense. Further interviews and psychotherapy were of little value other than to establish the fact of the soldier's complete and utter inadequacy and immaturity. He was accordingly brought before a Medical Board and discharged from military service.

## A SUGGESTED THERAPY

The above four cases are considered to be good examples of the Inadequate Adolescent soldier who appears to be unable to cope with service conditions. They are usually rather timid and non-aggressive and although they do not appear to be suffering from any gross psychiatric disability yet they are not amenable to any form of treatment. If they are made to serve in the Army for a further period of time then they will most likely become more inadequate, more ineffective and, usually, complete liabilities. It was also recognized that if pressed too hard in continued service they are quite likely to develop genuine neurotic symptoms or frank psychotic episodes. Although the latter conditions are, of course, amenable to treatment the basis of inadequacy remains untouched.

This, then, was the position in 1954 when it was noted that very many of the young soldiers being admitted to hospital did not have any gross psychiatric disability in the true sense of the word but were inadequate, immature and timid personalities of low combatant temperament, boys who had apparently been brought up in a sheltered atmosphere and who had probably never been subjected to any great stress or strain in civilian life. These boys, because of their inadequacy, were finding great difficulty in adapting themselves to service conditions. In fact, it appeared that a very large number of these cases arriving at the Royal Victoria Hospital, Netley, were

similar to the young adolescent cases who had been so successfully treated by Dr. E. Sands. ( He described his case material as a group of inadequate types where some also had schizoid trends and others had neurotic and depressive clinical features. Many showed evidence of immaturity. In this article of Sands, the cases were all under twenty-three years of age. A sentence which was of real interest to the Army Psychiatrist was that "Dehydroisoandrosterone exerts androgenic effect in a social and psychological way rather than in a physically sexual field, promoting masculine activity, aggression, self confidence and small or no increase in weight." One could almost visualise the inadequate, immature, adolescent recruit being turned into a real, mature, aggressive infantry soldier. Further on Sands states "A most important point is that the drug has proved very consistent in its action on those features of personality which lie between extreme inadequacy on the one hand and extreme aggression on the other. There is little evidence that it affects anything else." It was then stated that "It brings the inadequates to near normal." Perhaps, at last, there was going to be some truth in the statement that "the Army will make a man of you". It was accordingly decided to treat a small series of patients with Dehydroisoandrosterone and see what results were obtained. Six cases were carefully selected and treatment commenced. The daily dose of the drug varied from five to thirty milligrams, and the duration of the treatment was between two and three months. The

following is a summary from the case records of one of those cases.

Case Record No.5. T.E.T. Regular, 20 years of age, 2 years service

Having been A.W.O.L. for  $7\frac{1}{2}$  months he was brought back to face Court Martial. He felt fed up and attempted suicide by cutting his left wrist. He was admitted to a hospital in London and after suturing the wound he was returned to his Unit. The following day he cut his other wrist, using a razor blade. He was therefore transferred to the Psychiatric Centre here. On admission he was depressed and was initially in the closed ward accommodation, but within a few days he was transferred to the open Psychoneurotic Ward. No relevant family history. He was the eldest of four children and he had always been a lonely and unhappy child. At school he got on quite well with his lessons but not with the other children who teased him because of his excessive height. Prior to joining the Army he worked in the steel works in various jobs. His social activities consisted of reading and going to the cinema occasionally; he played games; and he had no girl friends. He joined the Army as a 3-year Regular because he would have been called up to do his National Service anyway and he thought an extra year would do no harm. He was posted to a Guards Unit, presumably mainly because of his height, but he soon found he could do nothing right. He had great difficulty in doing the ordinary drill movements and he was frequently being criticized in front of

his squad for dirty untidy kit. He twice went A.W.O.L. for two days during the (early part of his service and was given periods of confined to barracks. He eventually decided he could stand service life no longer and he went A.W.O.L. for a longer period. For the next  $7\frac{1}{2}$  months he worked at four different jobs in Bradford. He was eventually arrested by the Civil Police and returned to his Unit for a Court Martial. He admits that he was so fed up and so depressed that he cut his wrists to avoid trial. On examination he presented as a long lanky youth with a miserable expression and looked somewhat dejected. His depression was considered to be mild and a reaction to his constant failures. He soon settled down in the ward and ten days after admission he commenced Dehydroisoandrosterone therapy. Within a week he began to mix well with other patients and he could be persuaded to take part in football games. The following month saw very little change but he was taking an interest in occupational therapy and making a lamp in the Woodwork Department. With encouragement and supportive psychotherapy he continued to maintain a little progress. He was anxious to go on leave and this was the only real initiative he showed. When the request was turned down he expressed the opinion that he could not face going back to his Unit. He said he joined the Army to get away from civil life where he had been unsuccessful. The lack of privacy, and having to obey orders in the Army,



aggravated his misery. Allowed a pass to Southampton he came back late on both Saturday and Sunday evening. Three days later he was found missing on a routine ward check. The precincts of the hospital were searched without success but four hours later he was apprehended by the Civil Police in the outskirts of Southampton. On his return here he was again rather withdrawn and had little to say for himself. He again soon settled down and the following week he was allowed home for three days to see his parents. He continued on Dehydroisoandrosterone therapy. He returned from leave a little more cheerful and accessible. Treatment continued but it was fairly obvious that there was going to be no hope of being able to return this patient to his Unit. Finally, on the 21st of May, four months after his admission, treatment was stopped and arrangements were made to invalid him from military service.

Despite the enthusiasm of the Therapist, none of the cases showed any measurable signs of improvement and, in fact, they all had to be invalided from the Service. After a personal communication from Dr. E. Sands, it was considered that the cases were possibly not being properly selected. The writer of this thesis, Dr. Sands and the Psychiatrist from Southern Command, agreed to visit various Units in Aldershot District to interview some of the recruits soon after intake and attempt to formulate criteria for the selection of the Inadequate

Adolescent Soldier, especially those who might benefit from treatment, and an opportunity would (also be taken to interview certain Commanding Officers to gain some idea of their impression of the Inadequate soldier.

Before, however, discussing the results and conclusions which were arrived at after those visits, it seems appropriate to record in some detail some facts and opinions extracted from a fairly comprehensive review of the literature relating to the Inadequate Personality, especially concerning the soldier, whether in peace or war.

In reviewing the various available articles on this topic one is first struck by the fact that the "Inadequate Personality" is very seldom mentioned, but then one soon realizes that the reason for this is that there is no common nomenclature and that terminology varies from time to time according to fashion and from country to country. Sim<sup>(21)</sup> goes so far as to say "the accurate diagnosis of psychiatric conditions has always been a difficult problem and to meet it various systems of nomenclature have been devised. These have been based on aetiological, symptomatological and even prognostic factors, yet in the practice of Psychiatry in the Army none of the systems in current use have been particularly satisfactory and the task of fitting things into the official nomenclature has been very difficult indeed. Very often one meets conditions which do not

conform to official nomenclatures and yet have to be pigeon holed into it. This means that the label given to the disease in many instances bears very little resemblance to the disease it was supposed to indicate." Sim then attempts to use numbers to describe the quantitative element in Psychiatric diagnosis and thus tries to give a more accurate picture of a soldier's mental state. While one possibly does not agree with Sim's solution to the problem, it is undoubtedly true that the present nomenclature in use either in the Service or in civilian life often tends to confuse the issue.

If one attempts to review the literature by first considering some of the descriptions in one or two text books, then Noyes<sup>(22)</sup> gives a reasonably good description of the various Personality Disorders, and he divides those into three main groups:

1. Disturbances of Personality Pattern
2. Disturbances of Personality Traits
3. Sociopathic Personality Disturbances

The Inadequate Personality is a sub-division of the first group. He, Noyes, describes individuals of Inadequate Personality as persons who "in spite of average education and other opportunities and of normal intelligence as measured by psychometric tests, fail in emotional, economic, occupational and social adjustments. They are often good-natured and easy going but are inept, ineffective and unconcerned. Their judgment is defective, they lack ambition and initiative, and they tend to be dreamy. They seem to lack

physical and emotional stamina. When it is clear that effort will be rewarded they lack sufficient perseverance to achieve the results already in sight. The pleasure of the moment satisfies; they can neither work, nor wait for deferred pleasure or reward. As a result they are improvident and shiftless. Many of the near-do-wells belong to this group. They are defective in a sense of responsibility to themselves and society."

Further sub-divisions in this main group, according to Noyes, are the Schizoid Personality, the Cyclothmic Personality, and the Paranoid Personality.

In the second main group, namely, Disturbances of Personality Traits, a sub-grouping is the Emotionally Unstable Personality. "Individuals of this type of Personality are characterised by the explosive intensity of their emotions in reaction to slight external stimuli. Between their outbursts they are usually outgoing and friendly, happy and likeable. Their relationship to other people, however, is continuously subject to fluctuating emotional attitudes, because of strong and poorly-controlled hostility, guilt and anxiety. Their emotional tension is usually at a rather high pitch and may suddenly and unexpectedly burst out in uncontrolled anger or other disproportionate emotional display. At these times such persons may shout, bluster, threaten, or even become destructive and assaultive. In some the excitability may be manifested in outbursts of despair, silky irritability or obstinate inaccessability. Suicide attempts

in response to frustration or as effort to relieve a situation regarded as intolerable are not rare. Jealousy and quarrels with those of the opposite sex are common. Far from being the desired evidence of vigor and strength of personality the outbursts of excitement are often poorly concealed attempts to disguise an inherent weakness. Such reactions, characterised by fluctuating emotional attitudes, unstable and explosive feelings and undependable judgement, are to be regarded as expression of an immaturity of personality."

Masserman<sup>(23)</sup> discusses Constitutional Inferiority in some detail and states "this term denotes a presumption that the patient's difficulties in behaviour are due to congenital defects or an inferiority of physical make up, established so early in life as to justify the term 'constitutional'. The term personality has an interesting derivation from the Latin persona - the mask - through which an actor speaks. Etymologically then, personality connotes not the real individuality of the subject, but the external appearances he assumes, and the role he rehearses and plays. 'Inadequate Personality' has fewer organic connotations than 'constitutional inferiority', but it is scarcely more meaning-ful from the descriptive point of view. It is generally applied to individuals who, whether or not they consider themselves well adapted or content, have not achieved a degree of familial, educational, sexual, social or occupational success considered adequate by a diagnostician with

\* No: person is derived from persona  
personality comes from persona  
See Sh. Conf. 3rd

self-consciously 'normal' accomplishments and standards.

As may be anticipated, 'Inadequate Personality' has often been used glibly and sometimes with not altogether unconscious smugness to describe the irresponsible vagabond, the harmless ne-er-do-well, the untroubled Bohemian, the impoverished, the unproductive but happy minor artist and other such folk, not overtly concerned about either the opinions or the officiousness of the social order, but who manage to remain relatively serene - to some observers annoyingly so - in their chosen role. More objectively employed, the term has some usefulness in denoting patients who because of motivational, intellectual, or other adaptational deficiencies, fail to achieve success as desired by or for them; even in this connection, however, it must be remembered that their 'inadequacy' is often relative to the levels of achievement set for them, and that if the standards were to be revised their psychiatric difficulties would disappear. 'Infantile', and 'Puerile' Personality, are terms describing behaviour difficulties parallel to those mentioned, and ascribed to 'emotional immaturity' in adult individuals, who have remained fixed at or have regressed to the narcissistic dependent and aggressive patterns of childhood."

Curran and Guttman<sup>(24)</sup> give an excellent and simple classification of "anomalies of personality". The nearest to the Inadequate Adolescent Soldier is the Vulnerable Personality. They state that "these form a more or less clear-cut group; they are potentially unstable people liable to breakdown in various ways and in different

ways at different times. Handicapped by constitutional loading, they have a small margin (of reserve, and when pinched by circumstances are liable to develop various neurotic reactions as well as 'short circuit' uncontrolled or explosive outbursts. They may show one sort of reaction at one time, and another at a later one; or, if lucky, they may pass through life without overt symptoms. In general, they are inadequate.

The first thing to consider is the prevention of breakdown and this must depend on the degree of vulnerability and therefore the degree of shelter from the buffets of life that such a personality may require. The practical value of preventing breakdown by trying to fit pegs into more or less appropriate holes was shown very clearly in the last War. When breakdown has actually occurred, the treatment must be symptomatic in the first instance, with removal from the precipitating situation if the state is sufficiently severe to call for it. This may be followed by trying to make readjustment in the personality by better use of the assets, re-education of unsound attitudes and an environment re-arrangement designed to minimise the risk of further breakdown."

Finally, Curran points out that "vulnerable personalities, though in varying degrees inadequate, may yet possess certain worthwhile qualities. They are by no means necessarily to be sneezed at, for they may have much value within their limitations."

On reading Mayer Gross<sup>(25)</sup> one wonders if the term Inadequate Personality is another name for the rather old-fashioned illness of

Neurasthenia. He describes this in some detail, and states that "although the basis is considered by most authorities to be purely emotional other workers suggest that there is also a physiological basis." It is further stated that "there are many men, who are consistently anergic, easily dismayed, and discouraged, who have less than the average power of persistence. Men of this type were common neurotic casualties in the last war. It was shown that patients suffering from anxiety states, effort syndrome, and related conditions when tested with ergography felt exhausted at a time when estimation of the blood lactic acid and other physiological tests showed that they had as yet suffered little ill effect from the physical effort they had expended. In some, it was likely that the state of fatigue was a hysterical conversion symptom determined by the special situation, and the wish to escape from further service, but in others this appeared to be more a lasting feebleness of conative powers of will and purpose." Mayer Gross goes on to point out that "although the picture of pure neurasthenia has now almost completely disappeared there are often those who are restless in an aimless fidgety manner, oversensitive to noise and light and easily irritated. They avoid company and tend to live a solitary life and are incapable of following a regular occupation."



A review of the literature on the problem of the Inadequate Soldier and those who break down easily could be most expansive. The following gives a wide variety of opinions and this is set out as far as possible in chronological order.

Berg<sup>(26)</sup>, after giving details of certain specific cases, "suggests that war neurosis is not a specific entity but merely the precipitation of a latent state of psychoneurosis or psychosis in an individual already potentially ill and only resisting breakdown in the absence of exceptional stress."

This is a fairly typical view whether it be referring to war-time neurosis or to the recruit who is finding difficulty in settling down during his training in peace time.

Lauderheimer<sup>(27)</sup>, writing of his experiences as Consulting Specialist for Mental Disease and Neurosis to an Army Corps in 1915-1918, states that in almost every case he detected predisposition. While agreeing that he is "not of the opinion that even manifest neurosis is in itself an impediment to the subject becoming a good front line Soldier" he points out that "there are certain groups who should not be sent to the front, or if so, removed as soon as possible, for military reasons as well as in their own interests. Without touching the babel of psychiatric nomenclature I think it is related to the group called 'anxiety hysteria'. They are mostly nice and decent people, unobtrusive or shy, over cautious but irresolute, easily put out and inclined to 'hypochondriac fears'. They are in

no way malingerers but they seek to find unconscious escape into illness as an excuse for (their nervous insufficiency." This group would easily qualify under the heading of Inadequate Personality.

Sutherland<sup>(28)</sup> states "There is little doubt that the psychoneurotic can be valuable in military service as in other spheres, yet often his greatest liability, to panic, is a constant menace to the morale of any fighting Unit. Of a series of one hundred cases 80 of them showed definite traits indicating previous emotional instability, 36 gave a history of previous psychoneurosis, 33 showed a degree of temperamental instability. This series contained the over anxious, over conscientious, the poorly adjusted socially and a number of weak personalities who had never been a success in civilian life."

Discussing the psychopathology of the group, Sutherland suggests "the outstanding feature appears to be a basically insecure attitude towards the outside world. This attitude was manifested in many ways particularly in this excessive dependence upon these figures with whom security was felt - namely, their families. It was as though these men had always unconsciously dreaded the assertion of their independence as a dangerous, aggressive process. There can be no minimising the importance of this symptom anxiety and psychopathologically it is most important. This is the greatest factor governing the pronounced negative therapeutic reaction of these cases compared with the neurosis among civilians in peace time. They accept treatment gratefully and initially with relief of these symptoms until the threat of continuing the separation by a return to duty became a menace to the patient.

Then the desire to leave the Service became explicit." This separation anxiety, of course, is an important factor when the new recruit joins the Service even in peace time.

Kennedy<sup>(29)</sup> comes nearer to the description of the Inadequate Personality - "given health, rest and good leadership the average man can adapt himself adequately, if not always happily, to all but the most extreme hardships, physical or psychological of modern war. If however his resistance has been reduced by injury, exhaustion or discouragement or if he is constitutionally vulnerable to the particular stress to which he is exposed, he may have recourse to mental mechanism which result in functional incapacity. Under normal conditions the flight into illness is seen either in patients who have broken down under a complicated series of disasters and anxieties or in that large group of individuals who by reason of inborn inferiority or adverse experience in early life are unable to adapt themselves to a new environment. Experience has already shown that this constitutionally inferior group forms a large proportion of all cases of War Hysteria."

Fairbairn<sup>(30)</sup> suggests that War Neurosis is a wrong term and ought to be "Neurosis in Wartime". He considers that there are no distinctive features differentiating it from peace time. He too, as other writers, believes that "a war traumatic experience is one which serves to precipitate a psychopathological reaction through the activation of pre-existing but hitherto latent psychopathological

factors." Writing on psychopathology, Fairbairn states that "there is always a relationship between war neurosis and infantile dependence and not only is separation anxiety invariably present in war neurosis but it is the only single symptom which is invariably present. In other words, the neurotic soldier craves to go home and he is ill because he craves to go home." He further explains that "this is a much more important factor than being exposed to situations of danger. The latter view ignores the frequency of suicidal feelings and also the fact that war neurosis develops in places where danger is at a minimum, e.g. Shetland Islands. The desire to return home is most marked in the psychotic and may be seen as a compulsion to return home. It is to the symptom of separation anxiety that we must look for the real significance of war neurosis. It is towards a return to his home and his loved ones, rather than an escape from the dangers of the battlefield that the neurotic soldier is orientated."

This is an extremely interesting postulation and, if accepted, throws further light on the reasons and causes of the adolescent inadequate recruit breaking down so early in his career, even in the semi-sheltered environment of a peace-time Army.

Farnkilm<sup>(31)</sup>, in discussing a survey of neuropsychiatric casualties in the American Army, states that "patients often give

various reasons or excuses for their breakdowns, but on investigation these are found only to be a smoke screen to hide basic personality inadequacies."

Stearns<sup>(32)</sup>, in his description of Naval Inductees, states that "the term Psychopathic Personality stigmatises an individual so much" that he prefers to use the term Inadequate Personality because it simply means that there is a personality problem which is less prejudicial to the individual.

Pearce<sup>(33)</sup> is one of the few authors writing during the War who actually wrote of the Inadequate Personality. His views are therefore worth recording in some detail. He begins by pointing out that "in 1888 Koch described a condition which he named constitutional psychopathic personality. Although this label has fallen out of favour the essence of this individual is an inferior quality. Psychopathic Personality is divided into three main groups, viz. the predominantly creative, the predominantly aggressive and the predominantly inadequate or passive." Pearce was mainly concerned with the Inadequate or Passive and states "It is quite the largest group and constitutes a formidable man-power problem." He records that "these are men who are not actually ill but have always reacted inadequately to the demands of life and who are frightened and ineffective in action. Most of them are placid, suggestible, submissive, lacking in initiative, always taking the line of least resistance, expecting others to look after them and their troubles. Certainly many, but by no means all, find

their way to the Army Psychiatrist. Be that as it may, most of this group are quite honest and are merely inadequately and inferiorly endowed men. It is well to remember the old old adage that one cannot make a silk purse out of a sow's ear. Many patients referred to the Psychiatrist as Psychoneurotic have no true Neurosis but are Inadequate Personalities or in a state of self pitying hypochondriasis."

Pearce's description of the Inadequate Personality in a Field Force is also worth repeating. "They were frightened and ineffective in action. They often disappeared at the onset of an action to reappear later. They display a remarkable compassion in their eagerness to assist a wounded man to the R.A.P. or further. With commendable vigour they dig deep slit trenches wherein they remain until the battle is over. If on a line of communication of base unit their Officers complain bitterly of their inadequacy and uselessness. In point of fact they are a constant nuisance to everyone, just as they have always been in civil life."

Ekblad<sup>(34)</sup> wrote along somewhat similar lines but here the literal translation tends to make the terminology even more difficult to comprehend. Ekblad brings out the difficulty of establishing a definite diagnosis of the term psychopath and gives a good descriptive classification of his own cases under investigation. He first mentions that Wollenberg, after the 1914-1918 War, divided his psychopaths on the basis of their reaction to military life into two

main groups, viz. the "disturbers" and the "failures". From the point of view of their value to the forces he, Wollenberg, considered the "disturber" group to be the more important since on the individuals in this group the insufficiency reactions manifest themselves in an immediate objection to military discipline and they thus become useless to military services. Those belonging to the "failure" group are still to a certain extent usable in spite of their insufficiency reactions. Ekblad states that in the studies he has endeavoured to follow Schneider's system of classification. Difficulties are admitted, such as different fundamental personality disturbances being present in the same individual. Ekblad's classification is as follows:-

1. Asthenic psychopaths:- an important group - in this class belong the constitutional neurasthenics and those who put too much attention on their body. Among these we find some who when exposed to extraordinary stress soon show signs of palpitations, psychosomatic symptoms, abdominal pains, headache and insomnia and such mental symptoms as loss of memory, poor concentration, etc.
2. Unstable psychopaths:- they are the many cases who have shown asocial tendencies even in civilian life and in general could not adjust themselves to military life. They show a certain amount of self assurance and fearlessness but at the same time they are weak willed and easily swayed

by temporary emotional moods and outside influences.

They tend to lack persistence and they are unreliable.

3. Hysterical psychopaths:- those who display affective instability and showed a liability to unusual and dramatic behaviour under mental stress and conflict. They often display demonstrative harmless efforts at suicide gestures or attempts.
4. Explosive psychopaths:- those showing marked irascibility and at the same time often other traits.
5. Dysthymic psychopaths:- those with depressive symptoms, either constant or periodical.
6. Sensitive psychopaths:- the insecure type.

Ekblad goes on to say that he "placed in this latter category those which with another terminology would have been designated as Schizoid Psychopaths. Those displaying queer stereotyped behaviour and who are day dreamers were classified as 'suspected schizophrenics' ". One of Ekblad's conclusions was that "the above type of individuals showed maladjustment during a long period of military training during peace time. Severe cases should be exempted from military training. In the milder cases for the sake of morale among conscripts in general the men in question should complete their compulsory training in spite of their mental abnormality and their minor insufficiency reactions."

Singer<sup>(35)</sup> stated that "the truly Inadequate Personality must not be confused with the so called Passive Aggressive Personality,



the chronic complainer who shows angry reluctance and calculated inefficiency. This individual has a sincere conviction that he is incapacitated by some illness such as headaches and blackouts. If the medical officer adopts the line of least resistance and refers him for further opinion then this can go on indefinitely. On the other hand if the Medical Officer has the courage of his clinical convictions and firmly insists that he returns to duty the Passive aggressive personality will accept defeat and respond reasonably well to work and duty once he realizes that he has been found out."

Gibbs (36), in his description of mental abnormality and military delinquency, tends to classify his Inadequate and Neurotic Personalities as "those men who could not face the rigid institutional demands of the Army; men with continuing histories of social failure, and non adaptive reactions to stress who may present psychosomatic symptoms in conjunction with delinquency." He further classified "the immature as adolescents without strong identifications, and their reactions are basically childish." He indicates "that much of their external tough behaviour is a facade concealing feelings of insecurity, and inferiority. The insecurity of these psychologically under-developed youths, may often be related to early emotional deprivations, and a subsequent failure to introject mature standards of authority and discipline."

Monro (37) discusses the term Inadequate Personality as a clinical

entity and agrees that "in a sense almost all mentally disordered behaviours occur in Inadequate Personalities." He suggests that when the term of Inadequate Personality is used it should exclude all recognized syndromes of mental illness and mental deficiency.

Knox<sup>(38)</sup> describes a number of prisoners as Inadequate Psychopaths or "Constitutional Psychic Inferiors". He describes the average inadequate person as timid and fearful and goes on to say that "there is an hysterical and hypochondriacal tendency in such persons which requires a good deal of attention." He further notes that "among the inadequate prisoners one in twenty-five were markedly schizoid. Many had noticeable depressive phases and there were quite a number who were for long periods in an excitable hypomanic state."

McGrath<sup>(39)</sup> writing a report on the Mental Health of troops in Northern Command during 1960 states that "the commonest factor leading to an apparent nervous breakdown in troops is when there has been definite evidence of Inadequate Immature Personality. Emotional overdependence and poor stress tolerance are the common traits found in the Immature and Inadequate Personality and they are often associated with a history of childhood neurotic traits. Environmental stress in the absence of constitutional predisposition is never by itself sufficient to result in nervous breakdown. In the Army the clearly recognisable stresses are separation from home, shouting N.C.Os, the rough and tumble of Army life on parade. If the anxiety which follows cannot be abreacted then it may be converted into

somatic symptoms with a consequent development of secondary anxiety."

As a result of visits made to various units, the following points were noted:-

1. Such Inadequate Personalities were present in many Units but that perhaps the failure to satisfy Army standards was too broad a basis for selection.
2. The more treatable cases will show up from Units where more aggression is normally required.
3. It has to be remembered that of all the Inadequates found only a percentage of these would respond to "Diandrone" or, in fact, to any other known treatment.
4. It was agreed that cases should not be accepted too soon and possibly not before nine to fourteen weeks of service.
5. That inadequacy would often be accompanied by at least borderline Neurotic, Depressive, Schizoid or even frank Psychotic Schizophrenic symptoms.

The next stage was to issue to the Psychiatrists in Southern Command criteria for the selection of Inadequate Personalities apparently suitable for treatment. Psychiatrists were requested to send a number of such cases to the Royal Victoria Hospital, Netley, for investigation and treatment. These instructions were approved by Dr. Sands prior to issue.

## INADEQUATE PERSONALITIES

It is suggested that Inadequate Personalities suitable for the research project should have the following basic characteristics:-

1. They are immature socially, emotionally, sexually, physically, and possibly intellectually also (to avoid complicating the issue with the question of mental defect it is suggested that known dullards be left out at this stage).
2. These cases since early childhood have been of the follower rather than the leader type. They tend to be teased and bullied. They tend to avoid difficulties wherever possible and may compensate for their failure by antisocial activities.
3. Various signs of maladaptation, e.g. anxiety, behaviour disorders, etc., appear in response to the normal stresses of childhood, such as schooling, rivalry with siblings, etc.
4. They tend to be over-dominated by parents. Inferiority feelings are marked. They are aware of these feelings and resent them. They tend to express such resentment antisocially.
5. As they reach puberty there is failure to show the usual increase in masculinity and the greater confidence, wider range of activities, and interest in the opposite sex usual at this stage; in fact, girls tend to be avoided because they cannot make the expected rapport with them. They may feel attracted but may take little action as a result.

6. They never make real friends, just one or two or none at all.  
If the friends are lost replacement is difficult for them to achieve. They may, however, make various acquaintances.
7. Unusual indecision is shown over selection of career. They show lack of persistence, and failure without adequate cause is often seen in a series of jobs. They fail to qualify for promotion, and may even regress in the quality of the occupation they are able to undertake. Responsibility is avoided. They are unable to learn from experience.
8. The more active sports are ignored, or just suffered to avoid censure from others.
9. They tend to look younger than their years. There may be some delay in development of secondary sex characters, and at times the testes are undescended. Occasionally feminine distribution of pubic hair is seen.

In practice, Inadequate Personalities might be considered to fall into two main groups which, in fact, merge into each other without any definite line of separation:-

- (a) The predominantly constitutional or endogenous, having a very limited capacity for adaptation to environmental stresses even though these be of a minor degree.
- (b) The predominantly reactive, possessing less constitutional limitation, but with inadequacy in adaptation to more stressful environmental changes, even though such may be

easily accommodated by the majority of the more normal population.

Group (a) will show many of the above-numbered features and will fail with minimal Army stress, whereas those of the (b) type will show much less failure in civil life and in the Army will fail in Units where a fair degree of aggressiveness is needed to satisfy training requirements. The latter should be more amenable to treatment and carry a better prognosis. Naturally, the majority of cases will lie somewhere between these two extremes.

Accordingly, a further six cases were selected most carefully and were admitted to the hospital on the recommendation of the Psychiatrist at the hospital, and a summary of their case notes was sent to Dr. Sands for approval. It was only after universal agreement that treatment with Dehydroisoandrosterone commenced. The following is a summary of the case notes of one such typical case.

Case Record No.6. K.P. NS, 18 years of age, 3 weeks service

Referred by the Area Psychiatrist after he had threatened suicide as he could not stand the Army. "This Army ..... I cannot stand it ..... I hate everything about it ..... I knew I should." No relevant family history. A fairly happy home but a very lonely child. Very attached to his mother. Attended school up to fifteen years of age.

Got on well with his teachers but had difficulty with the other school-children. Felt they took no notice of him. Was bored with organized games. After school worked as a counter assistant in an aunt's small sweet shop. Then worked as an assistant in an out-fitters, salary £3.15.0. per week. He had few social attributes but he joined a tennis club and he became quite a competent player. Does not drink or smoke. Goes to the cinema on occasions but never dancing. Used to be a regular church-goer and he was a choir boy and bell boy for some time. States he is neutral re girls and sex. Before he was called up he knew he would not like Army life. Prior to his enlistment he felt so despondent one day that he took a quantity of Aspirin, but nothing happened and he told no one about it. When he was due to report he did nothing at all but his mother discovered that he had not reported and he was made to report three weeks late. As soon as he commenced training he began to feel that it was getting him down. He hated the noise and the bustle. He loathed the lack of privacy and the silly boring conversation of the other recruits. He began to feel ill, weak, and all washed out. He reported sick saying that if he was made to carry on he would commit suicide. He was admitted to this hospital and presented as a tall, asthenic, bespectacled youth of

of unprepossessing appearance. He soon settled down to ward routine. At further interviews he showed a willingness to confide spontaneously. Polite and respectful, and eager to please as if he were seeking to earn the favour of his medical discharge. He was placed on Dehydroandrosterone therapy but showed very little change. He stated he did not feel suicidal about the hospital but if he had to return to his Unit he made no bones about his intentions at making a genuine effort to end it all. He would say all this in the most unemotional way. Again psychotherapy and drug therapy were continued for over two months but the Therapist again realised he was fighting a losing battle and that no change at all was apparent in the patient's condition. He was regarded as a typical Inadequate Personality and a complete liability to military service, and accordingly he was brought before a Medical Board and discharged.

In brief, no more success can be claimed for this group of patients than for the previous one. Some difficulty was experienced on occasions in deciding whether the patient was objectively any better. Subjectively, of course, they would never admit to any improvement at all. On occasions a patient would appear to be perhaps more aggressive, and show better beard growth with some



deepening of the voice, but these were only slight and transient. The Malamud Rating Scale was used but was considered to be most unsatisfactory. A self-assessment scale adapted from the Tavistock Clinic M.M.F.I. by the hospital Psychologist was found to be of more value, but even this was not entirely satisfactory. The main object of the treatment was to enable patients to be returned to their Units as reasonably useful soldiers, and therefore the chief criteria as to improvement was whether or not the patient showed any semblance of improvement which would warrant or justify the possibility of a return to Unit as an effective soldier. During the treatment of this latter group of patients they were all informed during the course of their treatment that they were not to be returned to their Units but that treatment was being given in order that they would be more confident on their return to civilian life, which would be as soon as their treatment was completed. This was to try and ensure, if at all possible, that the question of motivation did not enter into the success or otherwise of treatment. However, even this promise did not seem to make any difference. It is, of course, possible that the patients may have had some doubt whether in actual fact they were going to be discharged from the Army, and they may have considered that if they did show any signs of improvement then, in spite of the previous promise, they might still have been retained.

The point was that up to date the project had proved completely unsuccessful. Various possibilities were considered:-

- a) Perhaps a military hospital setting was not the proper environment for such patients.
- b) Perhaps only cases with endocrine changes, specially those with low beta-ketosteroid secretion, should be treated. As a corollary to this, if a patient was treated with Dehydroisoandrosterone and his beta-ketosteroids returned to normal, could it be assumed that the patient's mental condition would also improve? If the beta-ketosteroids returned to normal and there was no concomitant mental improvement, did this mean that the patient was unwilling rather than unable?
- c) Was lack of motivation the main reason why, up to date, no success had been noted?

The latter two possibilities will be dealt with in later sections and a discussion of the former will complete this section.

Accordingly, another group of six patients was carefully selected. These were admitted to the Psychiatric Centre for initial investigation and their case records completed. These case notes were sent to Dr. Sands and only on his approval were the patients transferred to St. Ebba's Hospital for treatment. Patients were not sent as a group but one or two at a time. They were all volunteers for treatment, which had been discussed with them in detail, and they were all made

to understand in no uncertain terms that this modern treatment was being offered to them to help them to overcome their lack of confidence and to make them less nervous and, therefore, to ensure their success on return to civilian life. One or two only may have felt that they might be returned to their Army Units for a period but all others certainly fully understood that they were to be invalided out of the Service at the conclusion of their treatment.

The following is a summary of the case notes of a typical example of one of those cases transferred to St.Ebba's Hospital:-

Case Record No.7. L.M.M. N.S. 18 years of age, 5 months service

Referred to the Psychiatrist because he cannot stand things, he felt a restlessness, an inability to enjoy life or to maintain an interest in anything for long. The relevant family history is that the mother is neurotic and suffers from ulcerative colitis. He has five young siblings, one who is a problem child. As the eldest child he felt his mother was against him. She told him he was no good and he began to develop an inferiority complex. At school he was rather above average; although he liked his lessons he tended to remain solitary. After school he worked in a Jewish tailor's shop. He was nearly sacked three times but as the owner was a friend of his father he stayed on. Few social contacts; no girl friends and no interest in sport. At first on joining the Service he quite liked it, but he soon changed his mind as he

found it was "brutal and unfair". He felt that life was so terrible that he must get away from it all. He reported sick and was referred by the Medical Officer to the Psychiatrist and admitted here. He presented as a pale-faced youth of small stature and asthenic build; he was mildly depressed but more resentful. "I cannot stand the Army, it will drive me mad", "The Army will not do any good". He appeared to be rather immature, schizoid, hypochondriacal and introspective. He was very loquacious but talked quite coherently. He admitted that in civilian life he could slack whenever he liked. There appeared to be some flattening of affect and an incipient schizophrenic illness was considered a possibility. He soon, however, settled down to ward routine and neither psychometric testing nor further interviews confirmed this diagnosis. After nearly four weeks in hospital the diagnosis of an Inadequate Immature Personality was agreed on and he was transferred to St. Ebba's hospital. He remained there for over two months treatment. He was then re-transferred back to this hospital with the remarks that "Patient never settled down in hospital nor managed to fit in with hospital routine." "His conduct appeared to be that of a Psychopath compensating for inadequacy and immaturity." He was accordingly brought before a Medical Board and discharged from military service.

Up to date, therefore, the project was still completely unsuccessful. It had been assured that the cases had been properly selected and also that they were being properly treated. The question of lack of motivation to get well was discussed and seemed a possibility. The line between unwilling and unable is obviously a very thin one and merits further discussion later.

It had also been suggested that prior to treating patients with Dehydroandrosterone the ketosteroids should be fully investigated and that the drug should only be given if there was a low beta fraction. A series of cases should thus be investigated both clinically and by ketosteroid estimation, and only if the latter results showed an abnormality would treatment be given. It was further agreed to widen the scope of the endocrine investigation to try to establish if there was any apparent relationship between endocrine activity and mental illness and also to determine if there was a return to endocrine normality as the patient improved. In this particular part of the project the patient who had developed a genuine neurotic illness or a frank psychotic episode would also be investigated.

In fact, young schizophrenic patients could be selected, and the main reason for this was that the measurement of improvement of the schizophrenic could be so much more objectively assessed. At this stage, however, it was not appreciated what other difficulties would arise.

## PSYCHO-ENDOCRINE STUDIES

Although in Dr. E. Sands' article on "Further Studies of Endocrine Treatment in Adolescent and Early Adult Life" cases had been selected and treated on a purely clinical assessment, in a previous paper by Strauss<sup>(40)</sup> cases of Schizophrenia and Schizoid Personalities had only been treated with Dehydroisoandrosterone when there was an abnormal 17-ketosteroid excretion. Both Lamb<sup>(41)</sup> and Serra<sup>(42)</sup>, however, had also relied purely on a clinical assessment prior to giving Dehydroisoandrosterone, and this was probably because at the time when Sands initially gave this drug precise methods of endocrine investigation had not then been available. In the past, of course, many attempts have been made to relate biochemical and endocrinological disturbances to mental illness but the results of these have, in the main, often been completely inconclusive. This may have been because too unreliable and crude methods of technique have been the only means available for investigation. More recently, however, it had been stated that modern laboratory methods had been developed which would enable the investigator to detect intermediate and borderline endocrine changes either preceding, accompanying, or following psychological changes. The use of isotopes and such improved chemical methods permit quantitative measurements of some hormones in a much more accurate way than hitherto. On the basic assumption, therefore, that if Dehydroisoandrosterone is a hormone - when given to psychiatrically

ill patients appears to improve their condition, then it is possible that some endocrinological abnormality could be discovered prior to that treatment, and it was decided to continue with this project. It was realised that if any endocrine disturbance in the psychiatric patient was present then it might only be casual and not causative. But it was considered that even to establish this would be of some value. The next stage was to select another group of cases for treatment with Dehydroisoandrosterone where an abnormal 17-ketosteroid excretion - usually low beta fraction - had been demonstrated. The initial laboratory investigations were carried out at other hospitals, and during this interim period an opportunity was taken to obtain the necessary laboratory equipment and also to ensure that the hospital technicians here were attached for short periods to civilian laboratories to gain experience in techniques which they would be required to use. Such investigations were to be confined to simple estimation of steroid hormone excretion and a measurement of the thyroid function.

Another series of six cases of Inadequate Personalities were carefully selected, and when the laboratory tests demonstrated a low beta steroid excretion they were accordingly treated with Dehydroisoandrosterone. Two typical case records were as follows.

Case Record No.9. D.B.J. NS, 18 years of age, 6 days service

Referred to this hospital after he had attempted suicide by cutting his wrists; no relevant family history; at school

he was above average and he quite liked it although he was often bullied. Intellectually his school career was successful and as he was good at modern languages, especially Spanish, he obtained a State Scholarship to Oxford University. He has always been regarded as a nervous individual and one year ago he was referred to a civilian Psychiatrist for over-studying and tending to fall asleep during lectures. He had no outside interests other than reading. He entered the Army as a National Serviceman on the 16th of September, and right from the start he regarded the Army as a nightmare. On the 22nd of September he attempted suicide by cutting his wrists. He stated that he would have liked to have stuck a knife into his eyeballs, but he could not bring himself to do this. He was admitted to a civilian local hospital and then transferred to this centre. At interview he presented as a thin, round-shouldered adolescent with acne on his face. He was rather restless and ill-at-ease and tended to fidget about continuously. He expressed some anxiety as he did not know whether he would be boarded out of the Army or whether he would be required to face a Court Martial. He threatened to repeat the suicide attempt if returned to his Unit. After further interviews he was given a diagnosis of a very Inadequate Schizoid Personality with some hysterical features. The laboratory investigation showed that the total 17-ketosteroids were within



normal limits. The total 17-ketos were 12.0 and 11.7 mg in each of two successive 24-hour specimens. The fractionation of the 17-ketosteroids showed the following abnormalities: Dehydroisoandrosterone 0.8 and 0.6 mg (normal 5 mg) in 24 hours, and this expressed as a percentage of the total 17-ketosteroids was Dehydroisoandrosterone 7% and 5% (normal 17%), and the total beta-ketosteroids 11% and 12% (normal 10-35%). This patient was therefore treated with Dehydroisoandrosterone and during treatment, for the next 2 to 3 weeks, the laboratory investigation showed that the excretion of Dehydroisoandrosterone had been raised from 0.8 and 0.6 mg to 5.6 mg excreted in 24 hours. There was, however, no concomitant improvement in his mental condition. At the end of a month's treatment, Dehydroisoandrosterone excreted had fallen to 1.2 mg excreted in 24 hours. The patient's mental condition still showed no improvement and, in fact, he was now rather tense and became mildly agitated by minor frustrations. On one occasion he was found to be missing from the hospital and while a search was being conducted around the hospital precincts he rang up from an outside telephone to say that the hospital staff should not be worried about him as he was not intending to commit suicide. He eventually returned voluntarily 36 hours later saying that he just could not stand being in hospital any longer. He also produced a long letter, written with many childish references to suicide and self-mutilation, and a fair amount of

bizarre material typical of the Schizoid Personality. It was eventually decided that he was neither amenable to either psychotherapy or drug therapy and the diagnosis was made of an Inadequate Schizoid Personality verging on a frank schizophrenic episode. He was eventually, condition unchanged, invalided from the Army on medical grounds.

Case Record No.10. B.A. NS, 20 years of age, 11 months service

Admitted to hospital because of dirty and untidy habits, and it was alleged that he thought people were continually getting at him. There was no relevant family history. At school he had always been looked upon as inclined to be rather backward, and he was considered to be quiet, shy and he kept to himself. He left school having failed various examinations, and prior to enlisting in the Service he had worked at various jobs with little success. During his few months of service he had been on various charges for petty offences, such as dirty equipment, untidiness, improperly dressed, late for parade. He had eventually been referred by his Company Commander who was convinced that this man would never be a soldier as he seemed unable to cope even with the simplest of duties. He presented as a dirty, rather untidy adolescent youth of stunted growth, thick beard and acne on his face. At interview he appeared to be rather sensitive, self-pitying, apathetic and a morose adolescent who showed very little interest in his person or surroundings. Intellectually he was below average but by no means

a dullard. There was no evidence of thought disorder, hallucinations or delusions. Again a diagnosis was made of an Inadequate Personality, and laboratory investigations gave the following figures. The total 17-ketosteroids excreted were low - 5.2 and 6.2 mg in two successive 24-hour specimens. The fractionation of the 17-ketosteroids showed that the Dehydroisoandrosterone was 0.25 and 0.2 mg in 24 hours, and the Dehydroisoandrosterone expressed as a percentage of the fractionation of 17-ketosteroids was 5% and 4%, and the total beta-ketosteroids 9% and 9%. He was therefore treated with Dehydroisoandrosterone and though after two months' treatment the total 17-ketosteroids rose to 15.3 mg in 24 hours and Dehydroisoandrosterone to 1.2 mg in 24 hours, and this expressed in a percentage rose to 8% and the total betas rose to 13%, absolutely no clinical improvement at all was noted. He remained in hospital for some time still on treatment, and although he was taken on the staff as a temporary measure to give him a chance of an occupation it was eventually agreed that there was no alternative but to bring him before a Medical Board and invalid him from the Army.

#### PSYCHO-ENDOCRINE INVESTIGATION

Having reached no success with the use of Dehydroisoandrosterone in the treatment of the Inadequate soldier, even when such cases were selected on the basis of endocrine abnormality, it was decided to go

ahead and widen the project to see if it was possible to establish any endocrine abnormality in the young psychiatrically ill soldier, not only an Inadequate Personality but also those showing acute symptomatology, including the Schizophrenic. No special difficulties were envisaged. In fact, with the abundance of clinical material of the right age group, the Psychiatric Centre at the Royal Victoria Hospital, Netley, appeared to be an ideal place for such a project. Controls would also be easily available, or so it was thought. There were, of course, some disadvantages such as, for instance, the fact that in any Army Unit the Junior staff, laboratory technicians, etc., are all too frequently posted to another Unit. Care had to be used in the use of the word "research" as the general public was still rather "anti" the Army and any suggestion that patients or controls were being given injections of radio-active isotopes, at least in the early stages, would certainly have brought headlines in the National Newspapers, if not indeed a "Question in the House". The small research laboratory which was set up was therefore given the rather grandiose term of the "Biochemical Clinic". At the same time, for similar reasons, it had to be laid down very firmly that at no time would a patient ever have any necessary treatment withheld because of the current investigations. This was considered to be so important that a large number of patients, in the midst of the investigations, were withdrawn from the project on the merest whisper by any member of the Junior Medical Staff or the Senior Nursing Staff that the patient

was deteriorating or requiring treatment. This may be considered to be rather unnecessary, but it was considered the safest course to adopt. The following simple routine investigations were carried out under two main headings.

### Investigation of Steroid Hormones

Severe mental disturbances have, in the past, been associated with tumours of the adrenal cortex and also in Addison's Disease. More recent methods of assessing the adrenocortical functions by estimation of the 24-hour urine excretion rate of total 17-ketosteroids and their fractionation have indicated the presence of hitherto clinically unsuspected marginal endocrinological disturbances in mental patients. Reiss<sup>(43)</sup> has investigated the urinary steroid excretion in a case of Manic Depressive Psychosis and showed that the onset of the depression appeared to be accompanied by the excretion of a high proportion of the beta fraction of the 17-ketosteroids and a low cortin excretion rate while the reverse took place in the manic phase. These findings appear to be confirmed by Bryson<sup>(44)</sup>, and Hemphill<sup>(45)</sup> has found evidence of abnormal adrenal response in Schizophrenia.

Reiss<sup>(46)</sup> has also carried out investigations of the fractionation of the 17-ketosteroids in normal controls and chronic schizophrenics, and has found a significant difference. A further article by Batt<sup>(47)</sup> gives details of endocrine concomitants in Schizophrenia. This

author shows "a distribution of frequency of values in schizophrenics and non-schizophrenics. ( Values may be results of single determinations of any parameter, e.g., circulation time, body temperature, basal metabolic rate, blood chemistry, thyroid activity, or excretion rate of adrenal cortical hormones. Although schizophrenics and normals may share a common mean value of these parameters the scatter of values is much wider in the schizophrenic." He draws no conclusions other than to say that "this seems a profitable field for further study."

Werbin<sup>(48)</sup> also writes on this subject. He used a 48-hour specimen of urine from an equal number of Psychotic patients and normal controls. In chromatographic fractionation he was able to demonstrate marked differences, especially in Parts III and IV, between patients and controls. He recorded that in his opinion "there may be considerable differences between 17-ketosteroid excretion patterns of the Psychotic and the normal individual."

In the investigations carried out at Netley, in the main total 17-ketosteroid excretion rate was the measurement repeatedly assessed, but on occasion fractionation of the ketosteroids was also measured. The method used was that described by Callow, Callow and Emerson, 1938. It is generally accepted that the excretion rate of the total 17-ketosteroids fluctuates daily a great deal, but the accepted normal range is from 7-18 mg/24 hours in the average male.

## Investigation of Thyroid Function

Mental disturbances, often severe, have been recognised for many years in gross disturbances of the thyroid gland. In Myxoedema, for instance, various forms of psychosis occur and sometimes this is the early prevalent symptom. The Psychiatrist occasionally also comes across an isolated case of an acute Anxiety state or Hypomania, where it becomes soon evident that gross thyroid over-activity is a basic factor. It is only recently that the development of radio-active tracer methods has seemed to make it possible to detect minimal thyroid dysfunction. This is again well described by Reiss & Haigh<sup>(49)</sup> who, by using  $I^{131}$  and a suitably adapted method, screened the thyroid activity of a large number of mental hospital patients and, on an average, showed that about 20% of those patients had values outside the normal range.

It would therefore seem possible that, by this method, borderline thyroid disturbances would be shown in patients who did not show any clinical signs of thyroid dysfunction. It was also reported that the thyroid activity of almost 400 patients who were investigated before and after treatment showed a highly significant correlation between normal thyroid activity after treatment and mental improvement.

The method used in the investigation at this centre was as described by Dr. Max Reiss and, in fact, some of the equipment was initially on loan from his laboratory.

It was decided to carry out both ketosteroid investigations and thyroid tracer measurements in a relatively large group of controls. While it was appreciated that valid normals were available for the former, it was considered that it should be done as it would give some useful experience to the laboratory technicians and ensure that their methods and techniques were correct. With the thyroid tracer measurement it was felt that as large a number as possible of controls should be done, as although figures for normals were available they were not for the same age group as the Adolescent Soldiers who were to be the patients under investigation. Although it was initially considered that controls would be extremely easy to obtain in the Army, snags and difficulties soon became apparent. At first, it was hoped that the controls would be a random sample of troops in a large garrison town, but while it was easy to arrange to take such things as blood pressures, or even specimens of blood, from troops while on duty, to collect full 24-hour specimens of urine was in a quite different category. When this project commenced the Hospital also had a large Convalescent Wing. Patients here were convalescing from various wounds, injuries, accidents or operations, and during the process of rehabilitation went through a routine of graduated physical exercises and training until they were considered fit for full duty in their Units. They seemed to be a reasonably good random sample of troops and accordingly routine investigations commenced, but it was soon pointed out that such convalescents could scarcely be regarded



as true endocrine normals as the stress of their particular accident, injury or operation could easily have caused reaction in their endocrine system. If this were so, then obviously any results would be completely invalid, and as soon as this was appreciated it was decided not to investigate such personnel as controls and any figures already obtained were discarded. After further discussion, it was finally accepted that the only controls available were Unit staff and accordingly volunteers were called for and accepted. At that time, and now, the writer of this thesis has felt rather unwilling to accept them as a true random sample. Two workers in this Hospital have recently found that volunteer subjects are by no means a random sample even of the group available. Volunteers tend to be extroverts and hysterics rather than introverts and dysthymics. The latter, as would be expected, tend to remain in the background.

This is further confirmed by Lasagna<sup>(50)</sup> who, when using volunteers for certain drug tests, found that almost 50% of them had a severe psychological maladjustment and had various reasons for volunteering for such tests.

Pollin<sup>(51)</sup> also noted that in one series fifteen out of thirty controls showed significant psychopathology. He considers that "there are various groups and sub-groups and it is suggested that the volunteer's psychiatric status is an additional variable that needs to be taken into account in biological as well as psychiatric studies."

The Other Rank in the Royal Army Medical Corps, and especially

the National Service recruit, tends to be a rather timid non-aggressive type of personality and not really a typical aggressive soldier.

However, as there appeared to be no other alternative, these personnel had to be accepted as the only normal controls available. Having decided who to use as controls, the next step was how to use them.

There appeared to be two possible alternatives:-

- (i) To allow the controls to carry on with their normal duties as far as possible
- (ii) To submit the controls to an environment as near as possible to that of the patients.

Firstly, attempts were made to carry out the specific investigations with the soldier still on duty. This gave rise to no great difficulty in the thyroid measurement but when attempts were made to collect full 24-hour specimens of urine then obvious difficulties were soon apparent. The question arose whether the volunteer should carry his Winchester bottle about with him throughout the day, including visits to his barracks, wards, NAAFI, etc., or whether individual labelled Winchester bottles should be placed at such strategic sites as were considered necessary. Apart from the fact that this was too difficult it was felt that they would be so ridiculed by their mates that volunteers would soon become rather scarce. The above suggested methods of collection of urine were therefore abandoned at a very early stage. The second alternative was considered to be the most feasible, and arrangements were made to detail the volunteer staff

in a ward specially "rigged up" for this purpose. The controls would live in almost similar conditions as the patients, i.e. closed or semi-closed accommodation. Facilities available to the volunteers and to the patients were more or less the same. The volunteers would remain there for 2 to 4 days, depending on the time required to collect urine and complete the thyroid tracer investigations. It should be noted here that not all controls had both investigations as quite a large number of volunteers would agree to only 48 hours restriction and therefore only one investigation could be done. At no time, either with patients or controls, were both investigations carried out at one and exactly the same time. It may be felt that it was not a good thing to have had the controls living in this rather artificial atmosphere akin to ward routine, and this again might have given rise to false results. Psychologically it did not appear to affect the controls in the least and, in fact, they seemed to rather enjoy relaxing and having a lazy time. In addition, each control was given a 24-hour pass for every 48 hours he was required for this investigation.

Following the investigation of controls, patients were then selected. The thyroid function measurement did not give rise to any particular difficulty. The patients were all of the same age-group as the controls and included the Inadequate Personality, anxiety state, hysteria, schizoid personality and schizophrenia. As far as possible, the initial estimation was done before the patient

had any treatment; in fact, patients were taken off all drugs, including sedatives and (tranquillisers, for at least 48 hours prior to the test. No particular difficulty was noted in carrying out this test. The occasional acute anxiety state was rather frightened, but it was usually relatively easy to calm him down, and very rarely an acute schizophrenic was so disturbed that it was not possible to obtain his co-operation in carrying out the test. No repeat of the test was done for a minimum period of 14 days and in fact, if possible, not until 21 days had elapsed.

If no particular difficulties were encountered in carrying out thyroid assessment of either control or patient the collection of a 24-hour specimen of urine was found not to be quite so easy. A small number of controls were done, however, relatively easily with the staff, as previously indicated, in the restricted ward atmosphere. But when this was attempted with patients various difficulties arose. Problems were created by the Inadequate Personality, the anxiety state, etc., who would forget, and in due course when the young acute schizophrenic was being investigated difficulties became almost unsurmountable. One was constantly amazed by the number of things that could happen to a sample of urine when secreted by the kidney until the time it reached the laboratory bench. Thus, assuming that even the laboratory techniques were absolutely reliable, false results could easily be obtained by incomplete 24-hour specimens. Various methods of collecting urine samples were tried, and a final decision

on how and where it was done was only arrived at after trial and error. Initially, patients had urine collected while under normal ward routine in their own particular wards. At a later date patients were confined to bed in their own wards when urine collection was being tried out; later still it was agreed that only one or two patients per ward would have their urine collected at any or the same time. It was eventually decided that the most reliable method was to have one small ward equipped and staffed for this purpose. Patients were therefore transferred to this ward for the two or four days that urine collection was required. Complete and very detailed instructions were given to the ward staff, and every nursing orderly was made to realize the importance of his job in seeing that a urine collection was a complete 24-hour cycle.

Even with detailed written instructions and following verbal talks it was rather surprising how a relatively intelligent staff did, apparently, continue to make mistakes. The fact that on the first day the specimen of urine taken at 7 a.m. was thrown away seemed to cause a regular misunderstanding. The 7 a.m. specimen on the second day should, of course, be included in the first Winchester bottle to complete the first 24 hours. Towards the beginning of the investigation this specimen of urine, i.e., the 7 a.m. specimen, had an equal chance of being thrown away or put in the second bottle. At one stage it was seriously considered that a 48-hour specimen should be collected, then the figure for the estimation of the

24-hour 17-ketosteroids would be found by dividing such results by two. The following is (a list of some possible fallacies and difficulties in collecting a complete 24-hour sample of urine:-

(1) Patient forgets to pass urine into urine bottle or Winchester bottle; (2) Patient passes urine correctly but in transferring into the Winchester bottle some is lost; (3) Patient deliberately passes urine into some other patient's Winchester bottle; (4) By error the urine from the urine bottle is transferred into the wrong Winchester bottle; (5) Patient passes urine direct into the Winchester bottle and some is lost by going over the side; (6) Patient may be at occupational therapy or some other department when he voids urine; (7) Patient passes urine when he is passing stool and urine is lost; (8) Patient is incontinent; (9) Winchester bottles are apparently easily broken, either when standing in toilet or in transit to laboratory.

These are only some of the possible errors and give an indication why a very strict and precise detailed written instruction was absolutely necessary. It is agreed, however, that the strict routine imposed on patients under investigation may have caused them some psychogenic stress. Patients did not want to be separated from their friends in their own ward, nor did they particularly like to be kept in bed or restricted in any way. One or two of the schizophrenics were apparently under the impression that they were being subjected to this particular restriction because of some possible wrong which they had done. The writer was also surprised by the

diversity in the amounts of urine collected from schizophrenic patients even when it was reliably reported and they were complete specimens. However, on one occasion it was discovered that two schizophrenics were having an individual contest by drinking excessive amounts of water in order to attempt to pass more than two complete Winchester bottles in 24 hours.

There had been adequate reasons for switching the investigation at this stage from the purely inadequate personality to the acute schizophrenic, namely, that (a) the latter was a diagnosis in which there was no difference of opinion, and (b) it was also a condition where the measurement of success or improvement after treatment could be objectively measured without fear of contradiction. However, it was soon discovered that such acute cases were unfortunately too often completely unco-operative, and it looked simply as if the project had jumped from the frying-pan into the fire and the disadvantages probably outweighed the advantages. In spite of the difficulties, however, during the period under review this endocrinological investigation as described was carried out in as many patients as possible.

#### Results of Thyroid Investigation

The agent used was  $I^{131}$ .

- (i) K = the normalized slope, and the figures accepted as normal are 1.3 to 4.

(ii)  $R/C$  = the absolute value of the radio-active iodine accumulated in the thyroid as a percentage of the total injected measured 24 hours after injection.

The normal figure for this is 25 to 50%.

(iii)  $I_t$  = Index of thyroid activity in arbitrary units.

The normal figure for this is given as 1.7 to 8.0.

In the following results the  $I_t$  reading was taken as the important value and the normality or otherwise of the thyroid was therefore assessed accordingly by this reading.

Number of controls investigated	...	...	...	...	99
Number of repeat investigations	...	...	...	...	19
Total number of controls investigated	...	...	...	...	118
Number of controls who gave readings outside normal	...	...	...	...	24 or 20.2%
Number of patients investigated	...	...	...	...	639
Number of repeat investigations	...	...	...	...	238
Total number of patients investigated	...	...	...	...	877
Number of patients giving readings outside normal	...	...	...	...	144 i.e. 16.5%

Thus a higher percentage of the controls than patients were apparently outside the figure quoted as normal.

If, however, the figures were broken down further then of the 16.5% of patients outside normal 14.3% had a higher figure than normal and 2.2% only were below the normal limit. Of the 20.2% of controls who were outside the normal limit 12.7% were above the normal limit and 7.5% were below the normal limit. Expressed another way, 87% of the patients who had abnormal results were above the normal limit and for



the controls the figure was 62.5%. Similarly, 13% of the patients outside the normal limit had a low reading and for the controls the figure was 37.5%.

This would suggest that in the present series there is a shift of the so-called 'norms', or if the previous 'norms' are accepted then 23.7% of the controls more than patients were below the normal limit. If the present series of controls were utilized to find the 'norms', then a much higher percentage of patients would be outside the normal limit than the 20% quoted by M. Reiss and other workers.

Statistically, figures can be made to prove anything, and if the  $I_t$  reading is not what had been hoped for then the K or the R/C% may be more amenable to prove whatever is required. This is not intended to belittle the accuracy of the Thyroid Tracer estimations, which are certainly a tremendous advance from taking Basal Metabolic Rate estimations, but in the early stages the equipment in use was almost as temperamental as the patients. More recently, better equipment, techniques and methods have been brought into use. The 24-hour and 48-hour urine excretion rate can now also be measured and in most laboratories it is also essential to measure the protein bound iodine in the blood.

To summarize the work and results during this project, it could be said that, in general, patients tended to show a rather high indication of thyroid activity. It could also be said that the methods used were still relatively crude and not nearly as precise as had been hoped.

## Results of Urine Investigation

Twenty-five controls had at least two successive 24-hour specimens examined for total 17-ketosteroids only. The main objective of this was not to establish 'norms' which have been accepted and confirmed but to check techniques of the laboratory assistants who had not much experience in this type of work. These results came within the generally accepted range, which is 8 to 20 mg in 24 hours in a young healthy adolescent male.

A total of 595 patients had urinary ketosteroid estimation and a number of these included fractionation. A total of 3,528 urines were examined, which gives an average of 5 urines for each patient. But of course this was not so as many patients had a single ketosteroid within 48 hours of admission but only a limited number were accepted for further assessment. The laboratory had certain limitations on the number it could handle efficiently, and certain patients had to be taken off because they required treatment. Some would not, or could not, co-operate. With the initial enthusiasm all types of cases were investigated, including the Inadequate Personality, Hysterics, Anxiety States and Homosexuals. Finally, as indicated previously, the ketosteroid investigation tended to be focussed on the acute Schizophrenic. Some patients had as many as thirty specimens of urine examined. It is difficult to quote facts and figures, but the following table gives some details of a series of 100 Schizophrenic cases who had urinary ketosteroid examination in some detail. The results as shown are for the total 17-ketosteroids.

Total number of cases ... .. 100

Category

1. Patients with normal 17-ketosteroids on admission to hospital	... ..	34
2. Patients with an initially abnormal 17-ketosteroids	...	66
<u>Patients with normal 17-ketosteroids on admission to hospital</u>		<u>34</u>
(a) Spontaneous improvement and ketosteroid remained normal	...	8
(b) Improved with treatment and ketosteroid remained normal	...	21
(c) Spontaneous improvement with ketosteroid becoming normal	..	Nil
(d) Improvement with treatment with ketosteroid becoming normal		4
(e) Did not improve and ketosteroids remained normal	... ..	Nil
(f) Did not improve and ketosteroids became abnormal	... ..	1
<u>Patients with an initially abnormal ketosteroid secretion</u>		<u>66</u>
(a) Patients who remitted spontaneously and ketosteroid became normal	... ..	5
(b) Patients who remitted with treatment and ketosteroid became normal	... ..	25
(c) Patients who remitted spontaneously but still showed abnormal ketosteroid excretion	... ..	9
(d) Patients who remitted with treatment but had abnormal ketosteroid excretion	... ..	20
(e) Patients who did not improve either spontaneously or with treatment and whose ketosteroid remained abnormal	..	5
(f) Patients who did not improve either spontaneously or with treatment but where the initial ketosteroid secretion changed to normal	... ..	2

To summarize this latter work, it would obviously be unwise to attempt to draw any valid conclusions from such a small number of cases and no attempt is made, therefore, to make any tentative formulation.

It is possible that statistical analysis would show significant differences, but the collection of full 24-hour specimens of urine is considered to be an unsurmountable difficulty. Even accepting that the laboratory technique is completely accurate, a faulty collection of urine may render results completely false. Initially, urine tended to be suspect if under 500 cc or over 3,000 cc in 24 hours. Numbers of such urines or results were initially discarded but it was established that the amount of urine of the Schizophrenic patient did vary frequently and by large amounts. Similarly, if the creatinine was below 0.5 mg the urine was initially discarded, but again there seems to be some doubt if this can be accepted as the low norm for a Schizophrenic. It is appreciated that the biochemists regard the excretion of creatinine as being relatively stable and that this can be calculated per kilogram of body weight and the amount of creatinine can therefore be predicted. If the predicted amount is greatly in excess of the amount of creatinine actually found in the 24-hour specimen of urine collected and examined, then this would signify that the specimen of urine is incomplete. But the biochemists are referring to the psychologically normal individual and no figures are given to suggest that, for instance, the Catatonic Schizophrenic will secrete normal amounts of creatinine.

To conclude this section, it can be said that the relatively still crude method of thyroid estimation which was used did not give any significant results. Also, although it is agreed that the

excretion of urinary steroids gives a good indication of adrenal activity, the inability to obtain a complete and accurate 24-hour specimen of urine from the mentally ill made the results questionable.

It can certainly be said without fear of contradiction that our laboratory tests had not given any assistance or support that Dehydroisoandrosterone, or any other hormone, would be of value in the treatment of the Inadequate Adolescent Soldier or even in the Psychotic Episode.

### DISCUSSION

This thesis has set out to demonstrate the concept of the Inadequate Adolescent Soldier, and to show that even with an efficient Selection Service such personnel at present arrive in the Army in sufficient numbers as to create a problem. This warrants the necessity for some attempt to treat them in an effort to minimise the loss of manpower as far as possible.

Although it is difficult to generalise, if an attempt were made to present a composite picture of the Inadequate Soldier then it would be as follows. He is usually noticed fairly early in his career, and is usually a rather immature, timid, adolescent youth who has come into the Army either -

- (a) because of lack of success in civilian life, and with the hope of finding a solution to his problems, or

(b) as the rather unwilling National Service soldier who was able to manage by going his own way in civilian life, and who may possibly be facing a financial loss by being compelled to do military service.

Whether he be Regular or National Service, a common factor to both is that he tends to be timid, dependent, and lacking in confidence and aggression. Such an Inadequate Personality soon finds service conditions too much for him, and certainly not to his liking. He may complain of service conditions, and state that they are completely intolerable, of the noise, of the constant shouting of the N.C.Os, of the rigid strict discipline, of the lack of privacy, and of the poor food. Usually the complaints are rather vague and indefinite. This is so especially if he is asked to substantiate his various allegations. Such an individual is often reported by the N.C.O. or Officer as being apparently so lacking in moral fibre as to be unable to cope even with ordinary routine tasks. Very soon this is followed by the Inadequate Personality either reporting sick, going absent without leave, or being involved in some minor disciplinary offence. Frequently, suicide threats, gestures, or attempts are made. For various reasons, such an individual often is admitted to hospital. He then appears to be tense, rather anxious, and symptoms of depression or hysteria which may be present tend gradually to disappear. Father and Mother usually visit the hospital to see their son as soon as possible. Both appear concerned about their son's health. Mother is often weeping.

Father gives the impression that although he blames the Army he had half expected that this would happen. The Inadequate Soldier, having then presented himself to the Psychiatrist and his parents as being emotionally ill, soon settles down in the hospital Ward, and as long as no attempt is made to broach the subject of a return to Unit the patient remains happy and contented. It is usually, however, fairly obvious that such an individual is lacking in material necessary to be an effective and efficient soldier.

Previous sections have described attempts to treat such personnel with Dehydroisoandrosterone, firstly after clinical assessment only, and as this met with no success treatment was tried where cases had been selected by prior endocrine investigation. In those examples, too, treatment did not meet with any real response. Nor was it possible to demonstrate any endocrine abnormality in the young Adolescent Soldier who had developed an acute psychotic illness. The question then arises as to why treatment was not successful. Why is it that, apparently by merely donning Service uniform, the mild Inadequate Personality in civilian life is converted into such a definite Inadequate Personality and Soldier that he is completely unable to cope with service conditions and shows no response to a recognised form of treatment?

No other reference will be made here to the psycho-endocrine investigation other than that results are considered to be still rather unreliable. The thyroid tracer tests depended on temperamental but most expensive equipment. In the type of tests which were used in this series of cases, Iodine  $I^{131}$  was used, but it may be that in the future, where the tests can be repeated within 24 hours or twice in the same day if necessary,  $I^{152}$  will prove a more reliable method. Cramer<sup>(52)</sup>, using Iodine  $I^{152}$ , was able to make repeated daily tests of the thyroid function, but even with this short-life iodine isotope he was unable to establish any significant differences in thyroid activity between manic and stuporose phases in a cyclical patient. The estimation of the ketosteroids was considered to depend far too much on an accurate collection of full 24-hour specimens of urine. This, however, is regarded as being something which is extremely difficult to do, and in fact almost impossible with such cases as acute Schizophrenics. More recently a more accurate and acceptable procedure is to express the ratio of ketosteroids to creatinine which is also calculated per kilo of body weight. This may be more accurate but still does not surmount the difficulty of urine collection. Recent investigations also seem to throw some doubt on the belief that the daily amount of creatinine is relatively steady. Schwartz<sup>(53)</sup>, in examining a number of normal medical students subjected to the stress of a final medical examination, noticed a rise and fall in creatinine excretion but correlation with estimates of tension was poor. He



states that "theoretically the rise in the Creatinine excretion could have resulted from the accelerated release of the substance from the muscles, possibly due to heightened muscular tension or from increased renal clearance." If this is so, then it is probable that the frankly catatonic Schizophrenic, or merely the slowed down Schizophrenic, would excrete a less than normal amount of creatinine. If this theory is correct, then it follows that the creatinine estimation would be an unreliable indicator as to whether a full 24-hour specimen of urine had been collected or not.

It would appear appropriate, when considering the answer to the question posed earlier, to search either in the Service Environment or in the Individual Personality, and perhaps in fact the answer will be found to be partially attributable to both.

1. ENVIRONMENT

If one is to believe the comments of some of those Inadequate Adolescent Soldiers, then there must be something radically wrong with even a peace-time Service Environment. Some of the comments made by soldiers referred to in the previous case medical records were "the cruel and unfair Army", "I just can't stand it", "It's terrible", "the bullying and shouting N.C.Os". Certainly, most of these remarks sound rather dramatic and hysterionic, and a short discussion on suicide gestures might be of value at this stage.

## Suicide gestures

Of the nine case records which are given in some detail in earlier sections, six of those cases had made suicide gestures or attempts. This, to the uninitiated, might suggest either that service conditions and environment were really intolerable or that the individual was severely psychiatrically ill. It certainly appeared that suicidal gestures had been made in a rather high percentage of cases, and accordingly facts and figures for all cases admitted to the hospital for one complete year, i.e. first year of this project, were obtained. Twelve hundred cases were admitted and, of those, 280 patients were admitted because of suicidal threats, gestures or attempts. In other words, of all admissions to the Psychiatric Wards of the Royal Victoria Hospital, Netley, in one year almost 25% had been considered necessary because of the fear of suicide. A further breakdown of those figures shows that 18 cases were Officers and 262 were other ranks. It was also noted that 179 of these cases were either threats or gestures, while 90 had made what was considered to be either a moderate or serious attempt. It is not relevant here to give details of the methods used except to mention that 64 had taken aspirin (the number alleged varied from 9 to 200 tablets), 27 had made various attempts at cutting their wrists (usually superficial). A perhaps surprisingly high number - in fact 21 - had attempted to commit suicide by hanging themselves. The explanation of this was that most of the latter had done so

while in the Unit Guardroom where knives, poisons, etc., were obviously not readily available. Attempts at hanging need not be considered to be serious attempts at suicide as in most of the cases recorded the individual apparently made sufficient noise to attract the attention of the Guard Commander. Human nature appears to be most trusting, and on one occasion the writer of this thesis happened to visit a Guardroom to interview a prisoner undergoing detention when the cell door was opened and the prisoner was found hanging from a rope with his toes just off the ground. It was obvious that the incident had happened just a few seconds prior to the door being opened. No action was taken for a brief period in order to see if the prisoner had intended, or was able, to take action on his own. However, before he became completely anoxic, he had to be cut down and resuscitated.

On further investigation of those cases which had been admitted to hospital because of suicidal gestures, 54 were considered to be either Schizophrenic or suffering from severe depression, while 185 were diagnosed as Inadequate Personalities, Hysterics, Anxiety States, or Psychopathic Personalities. In fact, 35 were considered to have no psychiatric disability at all. The small number other than those were epileptics, alcoholics, toxic psychosis, post-traumatic, etc. It can therefore be seen that a high number of cases who had made suicide gestures were not suffering from one of the major psychiatric disorders but were the inadequate type of soldier under discussion in this thesis. Further facts are that

28 cases had under one month's service in the Army, and a total of 135 had under one year's service. It is also interesting to note that of the 280 cases sent to the hospital because of suicidal attempts, over 50% were considered to be such slight suicide risks that they were admitted to the ordinary open wards and not to closed accommodation.

Although at first it might be considered that the Army environment must have been very severe to precipitate such suicidal attempts, this is not the case. In fact, the Inadequate Personality makes his suicidal gesture in an attempt to manipulate the environment to meet his own ends. It is not that the Inadequate Personality makes a suicidal attempt because of the stress of the environment, but it is an attempt by him to put pressure on his Commander Officer, his Medical Officer and, of course, to persuade his parents of what difficulties and arduous conditions he has been submitted to. There is no doubt that the Unit Command is usually rather afraid of the successful suicide as this would obviously bring unwanted publicity and undue criticism, and consequently the Unit Command may, in turn, submit the Medical Officer to a certain amount of pressure to ensure that the individual is removed from the Unit and transferred to hospital. The Psychiatrist, understanding the position more fully, is less concerned but appreciates that even the occasional suicidal gesture might by mistake prove fatal; but he must be prepared to take certain risks. Offenkrantz<sup>(54)</sup> gives a very lucid account of how to deal

with the threat, gesture, or attempt at suicide in the non-Psychiatric patient. He states that the patient is told that he will not be admitted to hospital, nor will he be discharged from the Army or given a change of job or Unit. The soldier is told that only he can stop himself from committing suicide if he really intends to commit suicide. He is informed that if he succeeds in committing suicide then it will be regarded as a sane act thus allowing no material benefits to his family as a result of his death. It is also pointed out that the result of an unsuccessful suicide will be a court martial. Offenkrantz admitted none of those individuals to hospital, nor did he see them for a second interview. There is no doubt that this firm but courageous handling of such cases pays dividends. If the non-Psychiatric threat at suicide wins, by blackmail, then it is made so much easier for others to follow.

To summarise this, it can be stated that with the Inadequate Personality the suicidal gesture is little more than an attempt to gain discharge from the Army and should be considered to be of little significance. The writer of this thesis was reminded of this by a recent R.M.P.A. lecture given by Doctor M. Sim of Birmingham, who stated that a woman with an unwanted pregnancy may make suicidal gestures and attempts in order to intimidate or frighten her family, her General Practitioner, or perhaps a Psychiatrist in order to force medical opinion into recommending that an abortion is advisable. Sim was able to show from a large number of cases followed up over

a number of years that, in fact, none of these women did make successful suicidal attempts, even though their pregnancy was not terminated. He was also able to show from the records of the Coroner over a 6-year period that not one single case of death by suicide had occurred in pregnant women. There is certainly a similarity between such behaviour and that of the Inadequate Adolescent Soldier, i.e. to gain an objective.

The present day Army environment can, in no circumstances, be termed intolerable, and certainly especially under peace-time conditions in the United Kingdom. None of the patients referred to in this thesis was at any time in active service conditions, nor were they required to serve even in the unfriendly and hostile attitude of an enemy population in an overseas theatre.

To many of the recruits the food and lodging provided by the Army are at least comparable to and often better than what they had been accustomed to in civilian life. The Army Catering Service, for instance, now bears no relationship to the cooking in Army camps in the past. But, of course, musical-hall jokes die hard and the Army cookhouse is still something to make fun of. In this Unit, for example, there is a wide variety of choice of menu's which is at least on a par with many civilian restaurants. The kitchen is up to the standard of many London hotels which would qualify for

mention in a motorist guide book. The Master Cook or Chef has for his convenience all modern kitchen equipment, including potato-peeling machines, fish friers, etc. The staff and patients' Dining Rooms are decorated in pastel shades, with flowers and pictures on the walls. Food is served in the Cafeteria system, and tables are set with clean linen and cutlery. Gone are the days when soldiers were required to carry their plates, mug, knife and fork with them to and fro between their barrack room and dining room. Waitresses assist in the dining room, clean the tables and remove the empty plates. In fact, although the Cook and his Assistants are all Army personnel, others involved in such menial tasks as cleaning the kitchen, washing up pots and pans, vegetable preparation, scrubbing of floors, washing up of crockery, etc., are all civilians, and normally no soldier is required to do such duties.

The modern barrack rooms provided for the troops are much more modern than previously and a tremendous improvement has been seen since the War. Admittedly, although they can be described as clean and tidy, there is always a certain lack of privacy in any barrack room, but by judicious use of wardrobes and other furniture a bare barrack room can be divided up and made to look reasonably congenial. In fact, it can be said truthfully that the modern Army is becoming so acclimatized to peace-time conditions, and comfort and welfare take such a high priority, that sometimes it may be forgotten that the basic reason for becoming a soldier is to be trained and equipped to

fight an enemy in the field. Yet with all these improvements there has been apparently very little effect on the young soldier recruit. Why should this be so? Kardiner<sup>(55)</sup>, who wrote the first edition of War Stress and Neurotic Illness on Anticipation of a Major War and then a revised edition in 1943, discusses this problem in some detail. Although he is mainly concerned with wartime neurosis, he points out that similar conditions are seen in peace time. Referring to the new recruit, he says "Once in the Army the soldier begins to live and function in a social organisation that has little resemblance to the one from which he came. He has to live in a non-familiar hierarchy made up exclusively of men. While in training he is subjected to hardships, physical and emotional in which all his weaknesses come home to roost. His capacities to endure, to take the initiative, to be at once subordinate, and a leader, to co-operate, to form attachments to others, to carry responsibility - all these are put to great strain. Heretofore the soldier has lived in a democracy which meant that he had a wide range of choice as regards activity. His personal failures did not necessarily count against him for he could find a place where he could function within his limitations; or with the aid of social ties he could function within his family or outside it. The recruit's life is particularly difficult for the men who have led protected lives - whose parents have assumed every responsibility for them." It would therefore appear as if the Army environment -



and this is to be expected - can rarely hope to replace that of the home and family.

At the present time, in Intake Units the newly joined recruit is certainly kept busy, but in no circumstances could this be described even as arduous. Company Officers and N.C.Os of such Units are constantly being reminded that the new recruit must be handled with care, understanding and tact. But, just as in any boarding school, the timid first-termer may be ragged by the other boys, so too the Inadequate recruit may have to tolerate his leg being pulled by his more aggressive companions. In short, the Army has gone out of its way to make service conditions easy and tolerable for the new recruit.

These latter remarks do not refer to or include the conditions under which Officer Cadets are required to serve. Here the premise is that such individuals should be able to perform reasonably onerous tasks under a graduated stressful environment. This is so arranged that the average Officer Cadet finds no particular difficulty in coping with such an environment. If, however, an Officer Cadet should break down then it is considered that such individuals do not have the maturity and stability required by an individual expected to reach the status of an Officer and a Leader. It is certainly preferable that such vulnerable personalities are found at this early stage rather than that they be allowed to become Officers and perhaps break down in an emergency.

The conclusion can therefore be reached that, in normal circumstances, the service environment at present cannot be described as intolerable or cruel. It can hardly be regarded as the positive factor in suicidal gestures in a normal individual. If such should happen, then it would appear that the basic reason must be found not in the environment but in the personality.

## 2. PERSONALITY

Although it is appreciated that to attempt to divorce personality from environment is completely artificial, it is perhaps appropriate here to give an indication of what one is referring to when one uses the term "Personality". Personality includes such diverse assets as the individual's intelligence, acquired skills, competence, emotional stability, his value, his worth, and his tolerance to stress. In civilian life his ability to remain competent may be to some extent determined by his physical stamina, his technical skill, and his basic emotional stability. The latter may be re-inforced by support from his parents, his wife, friends or mates. His beliefs, convictions and sense of responsibility all play a part.

When a recruit elects or is compelled to join the Army, he is put through a fairly rigorous examination. It is relatively easy for the Army to put the recruit through a series of physical tests to determine if he is physically fit and that he has no such obvious

defects as poor eyesight, cardiac trouble or other major disabilities. It is also quite simple for the Army to ascertain the level of the man's educational achievements, but perhaps it is rather more difficult to discover what the man's capacity to learn actually is. But seeking to predict how a soldier will respond to military service in general, and to the severe stress of battle, is a problem which is almost impossible to assess except where there are obvious gross psychiatric disabilities or severe personality defects. A willingness to invest heavily in selection processes does not guarantee that all selected personnel will prove satisfactory, nor does it mean that those not accepted for military service would have proved complete failures.

When discussing personality, the factor of motivation must be considered, and Guttmacher<sup>(56)</sup>, in describing motivation, states that "it plays a most important part in the adjustment of the individual and there are few psychological elements which are more difficult to evaluate either through tests or interviews."

Unable to cope, or unwilling to make the effort - the dividing line between these two is sometimes very fine, and on occasion there is considerable difficulty in determining which is which. Combatant Officers have varied in their approach to this question. Initially, the most prevalent view was the belief that the principal defect of most ineffective soldiers is that they are poorly motivated - they are malingerers or, in other words, they are unwilling to make the effort although capable of doing so. A second belief is exactly the

opposite view, namely that all soldiers who are ineffective are emotionally ill. There has been a tendency recently for the pendulum to swing from the former to the latter, which is at present in vogue. As previously indicated, however, this is an oversimplification and to attempt to separate the emotionally disabled from the inadequately motivated presents some real problems. It can be said that there are three types characterized by low motivation:-

- (a) There is the Psychopath who will do what he wants and likes and not what he is ordered to do.
- (b) There is the Malingerer, who quite deliberately refuses to meet the demands made upon him because he calculates that he will be better off by going his own way.
- (c) Finally, there is the individual with whom this thesis is concerned, and that is the Inadequate Personality who appears to be unable to put forth any real sustained effort to perform efficiently as a soldier.

The Malingerer, and even the Psychopath, the Army might deal with and force into some semblance of reasonable behaviour, but it is very doubtful - especially with a Psychopath - if this is worth the time and energy required. It should be pointed out however, that just as some men become ineffective in the Army because they

are not well motivated, others with quite severe handicaps are able to tip the balance in their favour because of their determination not to fail. This, of course, does not refer to the true Inadequate Soldier whose weakness of character in this sphere, as in other spheres, is so large that motivation, though perhaps not negative, is hardly ever sufficiently positive to tip the balance in favour of success.

A most important fact, and possibly the basic reason why the attempted treatment in this thesis led to no success, may well be that because the Army makes it easier for men to be discharged it indirectly encourages large numbers of men, who have previously been trying to meet its demands, to slacken their efforts. This fundamental fact is of tremendous importance and is one reason why the Inadequate Personality and, in fact, other psychoneurotic patients in Service Military Hospitals, are so difficult to treat - these patients know that if they get well they are returned to Unit whereas if their illness persists they will be discharged from the Service. In fact, there is a similarity here to the compensation case in civilian life who will not get well until his case is settled in his favour. In the Army the neurotic tends to hold on to his illness until he is discharged from the Service. Lewis<sup>(57)</sup> points to an almost similar picture in war time. He states that "the success of treatment must be judged by the proportion of those treated who are able to resume and continue military duties. Neurotic illness is

so dependent on circumstances and especially of stresses of the soldier's life, from some of which he is free while in hospital, that his improved condition after some weeks of treatment in this relatively sheltered place is not an indication of his fitness."

Considering the Inadequate Soldier in this respect, he may basically be determined in his own rather ineffective way to attempt to soldier on and he has possibly made some rather half-hearted efforts to overcome his difficulties and to face up to his problems. Being in the hospital environment, where he sees the Psychotic and the Psychoneurotic obtaining medical discharge from the Army because of their disability, and seeing the Psychopath and perhaps even the Delinquent leave the Service because they are liabilities rather than assets, then the Inadequate Personality, with his typical lack of character, is incapable of making any real effort and he succumbs to taking the easier path of clinging to his disability. It must be understood that if the diagnosis of the Inadequate Personality is a correct one then it is an inability to get well and not an unwillingness to recover.

### 3. PERSONALITY AND ENVIRONMENT

As can be seen from the discussion on Personality and Environment, these two must in reality be considered as an entity. The Inadequate Personality may have appeared to be able to cope in civilian life with the support of his parents and friends, but coming into the Army he loses this support and until he has been integrated

into the Unit structure and has found his mates, his chums and leadership, there is a void period which is just beyond his capabilities of coping. The truly Inadequate Soldier, however, is regarded as being so inadequate that even first-rate comradeship and first-class leadership do not prove sufficient to bolster up the weakness in the personality.

If one attempts to consider the concept of the Inadequate Personality in terms which a layman would understand, then it is not concerned with the grossly psychiatrically or mentally ill but with those personnel who give evidence of emotional difficulties and vulnerability of personality which suggest that they will be liabilities and not assets as far as the Army is concerned, and that they will probably break down under the stress of mere routine military life.

It would appear that there is no place in the modern Army for the Inadequate Personality, and up to date treatment seems to be of little avail for such personnel. The writer of this thesis considers that the concept of the Inadequate Personality is of real value and certainly much more, than has been suggested, than an ingenuous excuse for a relative failure in the diagnosis, prognosis or treatment.

Finally, to put this problem in its proper perspective, it is only fair to point out that the Psychiatrist tends to obtain a rather

one-sided picture as he is continually dealing for the greater part of his time with the neurotics, and misfits and the inadequate. It must be remembered that this only relates to a very small number in the Army. Perhaps in fairness to the Regular soldier the following quotation is worth recording. Benvenuti<sup>(58)</sup>, the Secretary General of the European Committee on Crime Problems, presents a most excellent report showing how the young adolescent has reacted in all European countries, whether victorious, vanquished or neutral. As he says, "lack of a stable background, faster change, greater need for adaptability - these are the social characteristics of our times; and they are the general background against which delinquency must be viewed. On the whole, youth does well in these difficult times. When the gap between the generations is becoming so pronounced and there are so many complaints against youth and so much sharp condemnation of young people, it is as well to remember from time to time how many work hard, behave sensibly - and therefore fail to make headlines."

In other words, there are some "Inadequates" in the Army, but the vast majority of soldiers are mature and stable individuals who have chosen this career for a variety of reasons and are determined to make a success of it.



## SUMMARY

The concept of the "Inadequate Personality" or "Inadequate Adolescent Soldier" is described. Methods of Selection Procedure are discussed in some detail and it is shown that even with an efficient Selection Service the Inadequate Personality, the border-line Psychoneurotic and the occasional near Psychotic, gains access into the Army.

As such individuals have soon to be discharged from the Army, with a consequent loss in manpower, the concept of the Inadequate Personality as a clinical entity amenable to treatment is discussed as a possibility.

The clinical assessment of the Inadequate Adolescent Soldier is fully described, and some case records are given. Attempts at treatment with Dehydroisoandrosterone are described and, as this did not prove successful, detailed routine Psycho-endocrine investigations which were next attempted are given in some detail.

Finally, reasons for lack of success in this sphere are discussed and some indication given as to the relative importance of personality, environment and motivation.

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