A Thesis for M.D. Degree

on

ARMY PSYCHIATRY

In and Out of Battle

Its Relationship to the Soldier

and to the Service.

by

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I. INTRODUCTION.

In the dark days of 1918, so the story goes, when the fate of Britain hung perilously in the balance, Field-Marshal Lord Haig was asked if there were any possible way of stopping the war. His reply was: "Take away the medical services from both sides, and the war will stop in a week." Such is the extent to which morale is dependent on the efficiency of the medical services. From the military point of view the greatest psychiatric contribution that medical officers can make is towards the maintenance of morale.

It is the aim of these pages to review the experience with psychiatric cases of an individual medical officer during the Second World War. A number of case histories will be discussed in some detail and conclusions will be drawn from their circumstances, as well as from the results of practice among a large number of others. Factors influencing treatment will be reviewed and, finally, a small number of recommendations and suggestions will be put forward, regarding steps to be taken with a view to reducing the amount of wastage from neurotic and psychotic illness.

It is not intended to include in this summary any discussion on organic syndromes such as head injury or intracranial disease. Nor, unless in so far as they figure in the differential diagnosis, will conditions productive of psychiatric symptoms,

such as syphilis of the nervous system or vascular or endocrine disease, be dealt with. The object is rather to confine ourselves to illnesses that are essentially psychiatric in nature.

The writer served in the South African military forces from the latter part of 1940 until after the end of 1945. Broadly speaking, the first half of this period was comprised of service in the capacity of regimental medical officer in training camps at home, while the units concerned were mainly Native African and Coloured Eur-African troops, with, however, a short part of the time spent among European South African personnel. The other half of the period was spent in military hospitals, mainly in the Middle East and in Italy. This experience is again sub-divided into a term in charge of medical wards of African, Coloured and European patients; a term of work in surgical wards, where the troops were European South African, British, Yugoslav and German; and lastly, two periods in charge of psychiatric wards, where the patients were mostly European South Africans. From the varied conditions and circumstances presented by these several appointments he has endeavoured to disentangle the thread of psychoneurotic illness that runs through them all. In the psychiatric wards, naturally, abundant clinical material presented itself; in the medical and even the surgical wards it was there in fair profusion, to be seen and to be sifted by the medical officer whose eyes were open to recognise it; while in the units in camp the regimental medical officer was being constantly

called upon to form opinions and to give judgments on problems which, though covered by a thin veneer of physical infirmity, were essentially psychological in their bearing. Doubtless it was possible - and not a few doctors have made this error - to blind oneself to the psychosomatic aspects of a case, and to take the view that if a man complained of symptoms of, say, indigestion, all that was called for was to concentrate attention on the physical condition of his gastro-intestinal tract. Others, again, have been wont to regard every patient reporting sick, and in whose case there existed no manifest symptoms of disease, as being at best a neurotic and at worst a confirmed malingerer. Yet psychiatrists of experience have expressed the view that they have found malingering to be distinctly uncommon in the Services. The medical officer who is able to maintain a balanced judgment, founded upon reasonable skill and knowledge, rather than coloured by prejudice, cannot but be alive to the penetration of functional illness into every section of his medical work. So much is this the case that one is tempted to hope that in the armies of the future the real psychiatrist will be the regimental medical officer, the specialist having assumed his proper rôle as consultant and adviser and not as the person to whom may be sent those soldiers whom the unit doctor and the sergeant-major regard as being useless or incorrigible. This idea will be further developed in a later section.

It may well seem to be a disadvantage, from the point

of view of anyone wishing to draw general conclusions, to have derived his experience from work among so diverse groups, and under such varying circumstances as have been outlined. The validity of this objection notwithstanding, such variety affords enhanced opportunity to the observer to see the whole picture of his subject. He can discuss not only those patients who, following a relatively severe breakdown, have been admitted to hospital, but also those who are still at work in their units while showing symptoms. Nor are the lessons to be derived from the comparison of subjects of differing racial groups devoid of value.

After a brief note on the historical aspects of the subject, we shall proceed to discuss the clinical types and the causal factors of psychiatric illness among soldiers. The next section will be devoted to accounts of a number of illustrative cases. Thereafter something will be said of the treatment employed in cases of developed neuroses, with a note on the prognosis. A short statistical section will follow. Finally some tentative suggestions will be made, as a result of the study, that are mainly of a prophylactic nature. A short summary will conclude the paper.

II. HISTORICAL.

The absence of references to our subject in the literature suggests that in the wars previous to 1914 little serious attention was paid to the soldier as an individual by a system that saw in armies only rigidly organised machines of war, to be employed by governments for imperialistic ends. Not until the Crimean War and the advent upon the scene of Florence Nightingale were even the nursing and hospital services of armies put on a footing of humanity and decency. In the South African war we can still see the sacrifice of the soldier's comfort to the system in such regulations as those prescribing thick, tight-fitting tunics and ill-conceived items of equipment to be worn in the hot climate of the veld.

Nor are these things without reason. The sanctity of the individual, the social courtesies and the tender feelings of society were not developed in the nineteenth century to the extent to which they are among the English speaking races to-day. Even more significantly, psychiatry itself was in its infancy until the end of last century, and in the earlier phases of the 1914-1918 war there was not available to medical men that body of knowledge, then still to be built up, upon which we base our treatment of the neuroses of war to-day.

A third factor of difference between the two great wars

and the wars of last century has been the advent of conscription and the fact that service in the forces, far from being the perquisite of those who were prepared to volunteer for it, became obligatory for all and sundry who were physically fit, with scant consideration of their mental endowments or their domestic situations. In the last war, too, it became a commonplace for large numbers of troops to be away from home continuously for periods of years on end.

It was during the first great war that attention came to be paid on a large scale to psychiatric casualties, and that a military psychiatric service was brought into being. Ideas of the neuroses of battle were dominated by the conception, now outworn, of shell shock, ascribed as a shock to the nervous system occasioned by the concussion and the din of explosives. In the later stages of that war, and in the war now over, this idea has gradually given way to the view that a severe anxiety state is produced in the individual by the sheer weight and force of the stimuli of battle - the danger, the noise, the loss of sleep, the physical exhaustion, the dreadful sights and the terrifying experiences - which break down the defences of the ego, producing panic, conversion states, regressive features and conditioning to stimuli, so that every suggestive noise is followed by further accesses of anxiety.

It is appropriate here to refer to the valuable monograph entitled "War Neuroses in North Africa: The Tunisian Campaign,"

by Grinker and Spiegel.[1] This work embodies the authors' conclusions up to the middle of 1943. Interesting from the point of view of the history of the neuroses is their observation that in the First World War somatic symptoms of a cardiac nature, the "effort syndrome", were prevalent. In the years between the wars this condition seems to have been regarded by teachers of medicine as the most characteristic psycho-somatic symptom of the neuroses of war. Yet in the Second World War neuroses of gastro-intestinal coloration have been far more numerous. In explanation of this state of affairs these American authors have drawn attention to the more dependent attitude that is developed in the individual nature by these modifications in our social culture, which we have mentioned on page 5. Our generation had learned, more than any previous, to respect the sanctity of human life and liberty and to admire the cultural and material achievements of our race. An attitude more of dependence and less accustomed to aggressive outburst had thus been fostered. The stomach, as the intaking organ, is more associated with narcissistic tendency and is likely to be implicated in neurosis formation that has dependent attitudes among its causal factors than is the cardio-vascular system. Hill and Dewar have also stated that it is generally agreed that the incidence of effort syndrome has been less than in the 1914-18 war.[2]

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(1) Later published in the U.S.A. under the title: "Men under Stress, in and out of Combat."

(2) Hill and Dewar. Lancet; 1945, ii, p.161.

Craigie has noted that hysterical conditions have been less frequent in this war than in the last; and if one may venture an explanation for this, it may well be, at least in part, due to the higher standards of education and self-respect that have been fostered between the wars. The same worker has stressed the predominance of depression as a symptom, and has observed the relative infrequency of cardio-vascular symptoms.[3]

In 1921 the British Government was paying pensions to about 100,000 ex-service men for psychoneuroses.[4]

By no stretch of imagination can it be said that the British Commonwealth entered the war in 1939 in a state of preparedness. So far as the medical services were concerned, although much remained of the lessons of the last war, many had to be re-learned. The realisation of a psychiatric assessment as a necessary part of the initial medical examination had still to come. It was widely developed in the later years of the war.

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(3) Craigie. British Medical Journal; 1944, ii, p. 105.

(4) Hyland. Canadian Medical Association Journal; 1944, 51, p. 306.

III. CLINICAL TYPES AND CAUSES.

It stands to reason that Service personnel are equally liable with members of the civilian population to all the ordinary forms of mental illness. Relative exceptions to this rule will arise in such cases as the dementia of old age, involutional melancholia and arteriosclerotic cerebral degeneration, where age and sex factors and the elimination of individuals whose physical health is below standard set limits of their own.

It is not, however, intended here to deal with all the psychiatric conditions that have a place in army medicine, but rather to confine ourselves to those that have in the Service special practical applications different from or additional to those of civilian life. The clinical states of which cognisance will be taken are such as have one or more of the following characteristics:-

1. They must be conditions affecting a considerable number of personnel, and thus imposing an appreciable stress on the efficiency of the military machine.

2. They are conditions caused or aggravated by the viscissitudes of military service.

3. They are conditions the incidence of which could be eliminated or curtailed, or the severity or duration of which could be reduced by factors such as: (a) more satisfactory

initial medical examination within the limits of what can reasonably be expected from the average medical officer: (b) improved conditions of service within the limits imposed by military necessity: (c) special training of medical, and to a less extent of combatant officers, but without unduly stressing the psychological at the expense of other military considerations. (5)

A good illustration of this last point, in so far as it applies to combatant officers, arose in an instance where the medical officer of a forward engineering unit that was operating in isolation himself became a battle stress psychiatric casualty. Finding his position intolerable, he approached his commanding officer. This officer failed to understand the import of what was at stake and told his medical officer that he must carry on and that it was his business to look after himself. It was not until five days later that another medical officer, who happened to visit the unit, noticed that there was something amiss with his colleague and had him immediately sent back to the nearest psychiatric centre. In spite of prolonged treatment the patient did not recover sufficiently to be retained in foreign service, and he had to be repatriated within a year of his leaving home. Had he been evacuated five days sooner there is a good chance that his recovery would have been such as to allow of his retention

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(5) Hirsebberg has recommended instruction in psychiatry for general medical and line officers. American Jour. Med. Science, 1944, 208, p.119.

in the operational theatre for non-combatant service.

4. They are states more or less peculiar to military duty, and where the treatment assumes special characteristics, especially if these represent some advance that may be of value in post-war psychiatry.

With these considerations in mind we may set out the following as a scheme of classification of the reactions with which we shall deal in this essay.

<u>Nomenclature of Mental Diseases to be Considered.</u>

A. Mental Dullness and Mental Deficiency.

B. Common Psychotic Reactions:-
  - Manic-Depressive Psychosis.
  - Schizophrenia.
  - Paranoia.
  - Epilepsy.

C. Anxiety States.
  - Exhaustion States.
  - Acute Anxiety States, due to Battle Stress.
  - Chronic Anxiety States.

D. Hysteria.

E. Obsessional States.

F. Psychopathic Personality.

G. Alcoholism.

<u>A.</u> <u>Mental Dullness and Mental Deficiency.</u> There are good reasons for the inclusion of Mental Inadequacy (a group term to include both dullness and deficiency) in this discussion. Soldiers of this type can largely be eliminated by simple

intelligence tests and inadequacy is probably the easiest mental abnormality to detect in the medical examination of recruits. Great wastage is involved in the attempted training and employment of dullards in units to which they are unsuited. Not all the mentally inadequate are unfitted for service, but it is important that those who are retained should be placed in employment suited to their limited capacity. Disciplinary problems frequently arise, the origins of which lie in the poor mental capacities of the accused.

B. Common Psychotic Reactions. For the most part the psychotic reactions that occur in soldiers are not dissimilar to those that take place in members of the civilian population in peace time. The sex, age and physical health adjustment has already been touched upon. There is, however, one other difference as regards the incidence of psychoses. The stresses of service tend to be more severe than those of civil life, thereby constituting an enhanced exciting factor.

In discussing the treatment of psychotic states (p.76), we have referred to the frequently better prognostic outlook in cases arising acutely under conditions of war stress. Likewise Henderson and Gillespie[6] have stressed "the occurrence of dementia praecox-like conditions in a transient way and

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(6) Henderson & Gillespie. Text Book of Psychiatry; 1944 edition

apparently without residual deterioration." It seems to the present writer that such cases may be adduced as further evidence in support of the widely accepted theory that, other things being equal, patients who have broken down while subject to severe stresses enjoy a better prognosis than those whose illnesses have arisen spontaneously or in the face of only mild precipitants, whether in military or civilian life.

As regards _the manic-depressive psychosis_, it is in any event usually difficult to connect the onset of attacks with particular environmental circumstances. Nevertheless, it is reasonable to assume that the stresses of service must at times tip the balance sufficiently to produce a state of depression or mania in an individual who would otherwise have escaped it at that particular time. Depressive psychoses are not to be confused with depressed anxiety states, mainly reactive, which are common attributes of service, and which will receive consideration shortly.

Schizophrenic Reactions. In any case where a recruit is known to have suffered from schizophrenia, or to have been a mental hospital patient, his placement in the service, if he is accepted at all, must be a matter of thoughtful consideration. Conditions of service, and particularly in forward units, are such as not infrequently to precipitate schizophrenic reactions in predisposed persons. The authors already referred to have drawn attention to the dangers that schizophrenic patients may

present as members of fighting units. Lacking the normal fear reactions themselves, they may mistake the ordinary discretion of their superiors for cowardice, and may, by their ill-considered actions, expose not only themselves but also their comrades to danger.

Paranoid Reactions. Among the psychoses it is the paranoid types that probably present the greatest problem in military psychiatry. In so far as a psychotic reaction is likely to be precipitated by the conditions of service, the chances are that it will contain paranoid features. These are conditioned, in the first place, by the hostility of the battle situation. In the field of battle all the major stimuli suggest hostility. Across no man's land is the enemy, who appears as an invincible power, bent upon the destruction of the patient and of all that he holds dear. Above are his aeroplanes raining a murderous fire all about him. Even his own officers and N.C.O's appear to participate in the hostile situation, as they urge him to remain at his post or to force his way on to positions of even greater peril. In civilian life he has always been educated to respect and to conserve human life and the machines of great human achievement; here now is a situation in which he is called upon to destroy them as they are bent upon annihilating him.

Even when not exposed to great risk more tender spirits find in the military situation much that seems to represent hostility. The machine-like operation of a discipline that

is undiscriminating and from which there is no escape, the penal sanctions of the disciplinary code and the constant absence of the friendships and the comforts of his home, all bear down upon him. He develops ideas of reference, to these are added suspicions and feelings of persecution, and the picture finally resolves itself into one of systematised delusional states. In a few cases unfairness on the part of superiors or indifference to his symptoms on the part of the medical officer have existed; and these suggest ways in which the onset of paranoid states might sometimes be averted or postponed.

An officer of exemplary character, efficient, conscientious and considerate, was posted to a forward area in charge of a small technical unit. Shelling and bombing to which his area was subjected was minimal. He found, however, on arrival, that the unit had been badly administered by his predecessor, that the pressure of work was very great and that feeling on the part of the personnel was bad. His appeals for consideration and assistance, addressed to his immediate superior, were rather unsympathetically received. He soon developed a severe paranoid psychosis which gradually recovered after continuous sleep therapy. This officer was well known to the writer and there appeared to be little doubt of the precipitation of his illness by the stresses with which he was faced. A short period of normality was followed by a further brief paranoid state and he was repatriated home. For no obvious reason a third illness ensued, which

was treated with electric convulsion therapy. For many months now he has remained well and is still at work with an army formation It is fair to add that he had an attack of infectious jaundice between his first and second paranoid attacks.[7]

Epilepsy. The problems presented by epileysy in its various forms will be more apparent as individual cases are discussed in the section dealing with clinical material. On the whole it is probable that their most disruptive feature is found in the time and expense that are involved in their diagnosis and the procedure entailed by their medical boarding out of the service, and to this extent it is the sheer magnitude of their total numbers that is the worst thing about them. Greater attention to the elimination of epileptics at the time of initial medical examination will be well repaid. As in the case of the mentally inadequate, not all epileptics need be refused, but their acceptance ought to be conditional upon the existence of well-preserved personality and upon their ability to perform the tasks for which they are selected. Their medical classification must be such as will effectively prevent their employment outside their appropriate categories.

Epileptic states, until recognised as such, are also notorious for the disciplinary problems to which they give rise. They

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(7) Palmer similarly makes mention of "An acute paranoid state, with good prognosis, characterised by visual and auditory hallucinations. Lancet, 1945. ii. p. 454.

are also responsible for a number of unprovoked assaults, and these are more frequent in military than in civilian life, for the reason that the epileptic soldier sometimes attacks a superior who has given him orders, under circumstances that seldom arise under non-service conditions. The dangers inherent in the handling of arms, driving of vehicles, tanks, etc. or the operation of machines by soldiers liable to epileptic seizures are too obvious to require further mention here. The traumatic epilepsies, such as may be due to head wounds received in battle, are not discussed, being without the scope of this article.

C. Anxiety States are classified according to their duration, their severity, and as to whether they are predominantly reactive, psycho-somatic, phobic or unspecified in type.(9) For our purpose, however, it seems most useful to classify them according to the practical applications of treatment, as we have done on page Exhaustion states occur under conditions of physical and mental exhaustion. Acute anxiety states arise under similar conditions in the line of battle, or, more exceptionally, due to the non-battle stresses of service in predisposed individuals. Chronic anxiety states arise as the acute phase dies down, and in other circumstances, due to the soldier's inability to stand up to the viscissitudes of non-combatant army life. Douglas Wilson has made an important observation with regard to etiology.

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(9) D.G.M.S., U.D.F. Technical Instruction No. 28. Pretoria, 11 Jan. 45.

"Manifestations of anxiety state are now generally attributed to dysfunction of the sympathetico-adrenal reflex. Whatever its ultimate cause, there can be little doubt that the immediate cause is organic; because symptoms conform to a fixed pattern. Divergence from these patterns suggests hysteria."(8) Evidence of this kind is of value in combating any suggestion that the psychiatric casualty of battle is "lacking in moral fibre," is "yellow", or whatever may be the term of opprobrium used.

The Exhaustion State is really a state of acute anxiety superimposed upon bodily exhaustion. The practical feature of the condition is that, if immediately and energetically treated, a high proportion of patients recover completely and may be returned to their units within a day or two. The causative factors are such as the following. Lack of food and the impossibility of obtaining properly cooked or hot meals, loss of sleep and continued exposure to wet and cold or to heat and dust prepare the soil for a breakdown of the constitution. When to these are added continued exposure to danger, unremitting noise and the absence of any immediate prospect of relief, the stage is set for collapse of the personality from exhaustion and anxiety. Henderson and Gillespie would appear to deprecate the use of the term "exhaustion state" in connection with a

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(8) Douglas Wilson. Brit. Med. Journal; 1944, i, p. 413.

psychiatric condition.[6] It is, however, a convenient one, in view of the part that physical factors play in its onset, and more particularly by virtue of the circumstance that, with energetic treatment, a large proportion of these men can be returned to front line duties within a few days.

In contrast to the view taken by Henderson and Gillespie, Brigadier James has stated: "This retreat to Alamein in 1942 was the occasion which saw the birth of the diagnosis "physical exhaustion," afterwards modified to "exhaustion", for all psychiatric casualties. This administrative label has proved sound. It was much preferred by medical officers, created a hopeful therapeutic atmosphere, and led to the majority of cases returning to duty after brief treatment. The success of the label cannot fail to cause some of us to reflect on the possibility of applying some similar label to civil psychiatric breakdown in early stages. It might do much to dissolve the public prejudice against seeking early treatment, if a diagnosis of a socially acceptable kind could be found for the early phases of mental illness, especially if treatment were made possible at this stage outside the mental hospital."[10]

We may summarise the treatment of the condition as follows, although the writer did not have personal experience of dealing with cases of the syndrome. As soon as the condition is

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(10) James. Lancet; 1945, ii, p. 801

recognised, the soldier is removed from the battle area to a forward psychiatric centre. Sufficient sedation is given to ensure sleep at night. Adequate, well-cooked food is provided, and a stimulating type of psychotherapy undertaken with a view to the re-establishment of morale and appeal to the individual's sense of loyalty to the cause and of duty to his comrades. In this way a big proportion of men are fitted to return to their units after 48 or 72 hours rest.

Acute Anxiety States, due to Battle Stress. While a small number of acute and severe anxiety states occur in civilian life, and in the same way arise during military service apart from battle conditions, the vast majority are the outcome of the combat situation itself. It is with such that we are now dealing. The same causal background is generally present as has just been described for the exhaustion states. What we are now dealing with are those more severe forms, where the neurosis is of a degree that does not allow of immediate rehabilitation.

In the causation of all types of neurotic illness constitutional predisposition figures widely, and this may be observed in the cases of acute battle neuroses as elsewhere. At the same time, the stimuli of modern warfare are such that there is a limit to what any normal individual can stand.

Naturally, the main precipitating cause of our casualties was the noise, the explosions, the constant terrorising of the

bullets, bombs and shells. This was so clearly illustrated by one young soldier who in hospital, when under Pentothal and believing himself in battle, merely crouched in his slit trench (i.e. crouched into his bed), tearing at the bedclothes and howling in the most helpless terror, like a child abandoned utterly to fear.[11] Dive-bombing and machine-gunning from the air have been singularly traumatic experiences.

The death of a close friend could be a most traumatic factor. One patient, in whose case it was known that his friend had been killed by a chest-wound, re-experienced this incident under Pentothal. He shouted his friend's name, and that they (the enemy) had killed him, evincing symptoms of terror, coupled with the intensity of impotent rage. Muscles taut, face set, pupils dilated, fists clenched - an agony of the soul, an expression of compelling horror in the presence of an experience ghastly and terrible beyond any verbal description.

Yet others of our patients were affected more severely by sights of frightfulness than by the foregoing factors. The medical officer referred to on page 9 told the writer subsequently that it was not primarily the mortar fire and bombing that brought about his breakdown. What he could not face up to was the oft-repeated sights of blood covered, mutilated men who were brought to him

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(11) A few extracts are copied from my own address, printed in the South African Medical Journal of 23rd. February, 1946.

regimental aid post. So strong was the conditioned reflex that these sights produced, that even several months later, he could not bring himself to give an intravenous injection.

A further factor that sometimes operated was the distaste and repulsion that men felt at having to kill others - to kill and destroy other young men like themselves and with whom they had no personal quarrel. This feeling became turned against themselves as a moral self-accusation.

In the face of these disintegrating things the ego employs certain defensive mechanisms of its own. These reserves include inherent courage, self-respect, loyalty to and identy with the cause for which the soldier is fighting, and association with his comrades. Provided he is convinced of the rightness of his cause and of the vital urgency of the issue for which his country is fighting, and so long as he is confident in the leadership of his officers, his ego is in possession of a powerful weapon against neurotic breakdown.

The symptoms of the acute anxiety state are, in the first place, those of outspoken, uninhibited anxiety. The face assumes an expression of terror, the pupils are dilated, the muscles are taut, the pulse is accelerated and all purposeful reactions to other stimuli than that of the battle situation are in abeyance. The man may shout or cry in fear or speech may be entirely inhibited; he may run about aimlessly, may perform wild, purposeless movements, or may crouch on the ground

unable to bestir himself one iota. In other instances the reaction is less violent, and stupor, amnesia and mutism are the principal features. The soldier may wander about aimlessly and come to, hours afterwards, not knowing where he is nor able to remember what has happened. In severe cases regressions to an infantile level take place. The man lies curled up, a vacant look on his face and unresponsive to ordinary stimuli, although showing a startle reaction to loud noises and perhaps evincing fear of advances by his attendants. Course tremors are common. In bad cases he may be unable to pay proper attention to the calls of nature such as hunger and micturition. (1) (12).

As the acute stages pass off, psycho-somatic manifestations make themselves apparent in a proportion of cases. Of these the most common are the gastro-intestinal neuroses. Diarrhoea is a frequent symptom both in the acute and the sub-acute phases. Anorexia, abdominal pain, nausea and even vomiting are common. As has been noted, functional cardio-vascular syndromes are less in evidence. Headache is a common symptom, and hysterical pareses and anaesthesias add their quota to the series. Mutism, stuttering, deafness, visual defects and disorders of gait are fairly

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(1) Op. cit., by Grinker and Spiegel, from which, in addition to my own experiences, I have drawn a certain amount of descriptive material.

(12) Mulinder actually regards confused, regressed and other severe battle anxiety states as short-lived psychoses, a view to which we are, however, unable to subscribe. (Brit. Med. Journ. 1945, i, p. 733,).

frequently seen.These features will be elaborated in the sections on hysterical reactions and that dealing with clinical cases.

Battle dreams or nightmare intensity are usual, and gradually subside as improvement sets in. One of our patients suffered from acute anxiety that was characterised by mutism of such a degree that he could produce only an occasional whisper. Yet in his sleep he shouted, thrashed about in his bed, and so intense was one of his nightmares that he wrested out from the top of his bed one of those upright metal struts that support the frame. And this all in a dream while he was asleep. Insomnia, though not rare, is less marked. Depressions, mostly of a reactive rather than a psychotic coloration, are quite frequent in association with the residue of chronic anxiety. Among the activators of these, two matters are worthy of special mention. One is sorrow for lost comrades. It is probable that in these instances, in addition to the factor of mourning for a lost friend, there is a subconscious satisfaction that it was the comrade, and not the patient himself who was killed. By a psychological process of subconscious self-analysis this redounds to the disadvantage of the patient in a feeling of self-accusation.

The other matter is that not a few patients can rid themselves of the conception that their breakdown and arrival in hospital spells cowardice, and that they are "yellow" and unworthy. In the psychotherapy of these battle stress

states a good deal of attention has to be devoted to the removal of this persistent quality.

In a percentage of cases the symptomatology and diagnosis are obscured by the possible complication of concussion. Such symptoms as persistent headache and continuing lack of initiative and feeling of debility with incapacity for work, in addition, of course, to any physical neurological signs, are pointers in this direction.

Chronic Anxiety States. It is usual to classify these in the same way as the acute cases, referred to on page 17. We have, however, grouped anxiety states in general as exhaustion states, acute anxiety states and chronic anxiety states, largely on account of the strikingly different problems presented as regards treatment and disposal. These two factors, treatment and disposal, are the practical issues once the illness has set in, and they in their turn are subject to the over-riding circumstance that the interests of service efficiency should come first. The treatment of the exhaustion states was dealt with in brief on page 19 while the more involved matter of treating the acute and chronic anxiety states will follow in the section on treatment.

It will best serve our purpose if we regard the chronic anxiety states as falling into different categories according to the circumstances surrounding their onset. It is also as regards these states that the author feels he has something to

contribute by making one or two broad comparisons between different racial groups. Were we again to subdivide in accordance with the type (the D.G.M.S., U.D.F. classification, page 17) it would complicate the picture unnecessarily and to little purpose.

Chronic anxiety states, then, may be said to arise in one or other of three ways. Almost every acute anxiety state of battle must be expected on recovery to lead to a degree of chronic anxiety of indefinite duration.(※) In the second place, there are an appreciable number that arise out of battle stress, but not immediately as acute conditions. Their onset is more gradual, or they follow upon some specific circumstance, such as a period of hospitalisation due to wounds. The third group are those anxiety states that occur in service personnel apart from battle stress. These last have, in the writer's experience, conprised the greatest number, as also, they are the most difficult to treat; and it is mainly with them that we shall deal in this section.

No more need be said here of the first variety, namely, the chronic anxiety states following upon acute battle stress states. Their problem will receive consideration in the section on treatment.

The second group, those following indirectly upon battle conditions, introduce an element of confusion into our

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(※) By "anxiety state of battle" we do not here include the exhaustion states.

classification in that they, more than any others, tend to exhibit symptoms that are predominantly hysterical. It is in fact in operational areas impossible to divorce anxiety states, whether of acute or of chronic type, from hysteria. A typical instance is that of a soldier who is in hospital recovering from wounds. Whatever the man's state of mind was, his being wounded has resulted in his removal from the battle scene. As the time approaches for him to leave hospital, he must once again face the prospect of return to the battle line. However he might have carried on in the heat of the fight, it is now no easy thing to go back to it after weeks in comfort and safety. But the strength of his ago will not permit him to collapse into a condition of overt chronic anxiety. His subconscious mental processes will, therefore, more often solve his difficulty for him by producing a conversion symptom, which will effectually incapacitate him so long as it lasts, and will at the same time save his face from the strictures of his super-ego to which he would be subjected were he to admit open anxiety. It is a fact that, under circumstances of this kind, some soldiers do develop mainly anxiety, some hysteria, and others a mixture of these elements.

Attention must now be directed to our third subdivision, the large group comprising the <u>chronic anxiety states that arise apart from specific battle stress.</u> These are very

numerous and include a big percentage of all the patients who come to the inspection room of the average unit medical officer. It is superfluous to dilate upon their symptoms, which are well known to most doctors and which will, in any case, receive mention when individual cases are described in the clinical section of this paper.

It is worth while to draw attention to certain broad sets of circumstances under which these illnesses tend to appear in relatively large numbers. Certain units, because the performance of their functions does not require A 1 physique, have had to accept a large numberof lower grade personnel, and sometimes personnel known to be of lower characterological standards have been drafted to these units also. This state of affairs is prolific of chronic anxiety and chronic hysteria.

It was the writer's fortune at one time to be in medical care of a large body of South African Coloured and South African Indian troops who had just returned to South Africa after varying periods of service abroad. Among them the temptation, either sub-conscious or overt, to try to get out of the war at this juncture - the period was the latter half of 1942 - was very great. An aggravating factor was that the authorities had, just then, no stimulating service duty to which to call them and with which to fire once again their imagination. Our difficulties in maintaining their morale were not lessened by virtue of the fact that one wing of the self-same camp was already serving as a dispersal depot for men who were being discharged from the

Service, mainly on medical grounds. We had cases of mild chronic anxiety by the hundred, and such was the situation that the senior medical officer of the area accepted the position that many of them would have to be themselves discharged on psychiatric grounds.

My next experience in dealing with large accesses of chronic anxiety was when in charge of the medical wards for Coloured troops in a Middle East hospital. Most of these men had recently arrived in Egypt from their home country, and were undergoing a long period of training in the desert, but without the stimulus of being likely to make any early contribution to the fighting.

This introduces us to the question of purpose in the military effort as a factor in fortifying morale. The Non-European troops of South Africa are a subject race in their own country. They knew that they would remain so, irrespective of who won the war, and it was perhaps too much to expect them to discriminate between the state of being a subject race under British South African rule and that of becoming a slave race under German rule. Nor are their educational standards on an average anywhere near so high as the European. They could not feel that they had as much at stake as we had. As against this it is just possible that, accustomed to lower standards of comfort, they could ~~not~~ stand hardships a little better.

The value of propaganda is not to be scorned.[13] The Nazi soldier knew, or believed he knew, just what he was fighting for. The propaganda effect of enemy bombs dropped on London was bound to be greater than any half-hearted black out in Durban or Capetown could ever be. Similarly there was an impressive lack of anxiety shown by some hundreds of Yugoslav patients in our hospital in Italy.

An earlier comment of my own may be worthy of repetition.[11] "Straight away we got our convoy of Yugoslavs. Splendid types they were; men, women and children, a man over 70 and a baby in arms being included in their number; yet soldiers all, who had gone through the rigours of a war in which all the odds were against them.

"Bright eyes theirs, in which there shone a dauntless courage that we all admired; clear eyes, where burned an implacable hatred of Nazi-ism, that evil thing that had ravished, raped and ruined their fair land; wistful eyes, in which there glowed a hope, unextinguishable, that victory and freedom would again be theirs, a conviction that there could be no surrender.

"Thin, half-starved bodies, sickly with disease, testified to what they had come through - typhus, pellagra and their wounds and an indication of the suffering, neglect and want

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(13) Several American writers have dealt with this aspect of the case. Notable Chisholm. Amer.Jour. Psychiatry; 1944, 101, p. 300.

that had for many months been their constant companions."

Out of some hundreds of these patients two were referred to the writer, one with a chronic anxiety and the other with mild hysterical symptoms.

Our South African European troops evinced a relatively high percentage of cases of chronic anxiety. Brought up, many of them, in an atmosphere of isolation - that same isolationism as played a part in United States politics - they came from homes that were not closely threatened and from a country that was never subjected to bombing. As a result, they lacked that forceful awareness of their country's stake in the conflict that enemy action impressed upon the people of Britain.

By these same standards our Native and Coloured troops ought to show an even higher rate of illness. That such was not the case is regarded as being due to the greater austerity of living to which they are accustomed in their own homes. (See Table I, p. 103).

We find as usual that the <u>major causative factor</u> as regards chronic anxiety states is the constitutional predisposition of the individual to neurotic illness. The great frequency of the symptom of ideas of reference is contributory evidence of this, as well, perhaps, as being related to factors that bring about paranoid states (page 14). In parenthesis, it was noticed by us, as well as by psychiatrists elsewhere, how high was the incidence of psychiatric casualties among medical

officers - perhaps higher than in any other branch of the Service. It is believed that the constitutional factor here is associated with the relatively sheltered lives that so many medical men lead in their earlier years, and the somewhat honoured (psychologically satisfying and comfortable) positions they occupy in our society.(14) Brigadier James often found that one-fifth of patients in officers' psychiatric wards were doctors. In one psychiatric hospital for officers 9% of all admissions were doctors.(10)

In any series of cases, whether large or small, previous neurotic trends are found to be the salient feature.

Next, probably, in importance come domestic difficulties, marital infidelity or the fear that there may be such infidelity, illness at home, the absence of news or irregular mail, financial worries and other uncertainties. Numerous authorities could be quoted as stressing the grievous effect of such stresses.(15) (16).

Other precipitating factors are the long separation from home, sexual difficulties, and the irksome demands of military life, which are apt to become grievous as their effects accumulate.

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(14) South African Magazine, "War Medicine," 1945.

(15) Sinclair. Medical Journal of Australia; 1945, ii, p.229.

(16) Torrie. British Med. Journ, 1945, ii, p.192. This excellent little article deals with stresses, and particularly the domestic infidelity factor, in the case of prisoners of war.

It was our impression that such factors operated with particular force in the case of native African and Coloured troops.

The point is illustrated by a few individual cases. Around midnight on New Year's Day, 1944, I was called to see a member of our African staff who had hanged himself from the rafters of the verandah of his sleeping quarters. He was described by those who knew him as being a solitary youngster. Another of our Africans was found, having been murdered, and his body thrown over the bridge on to the railway line outside the hospital. It was not difficult to visualise a sex factor as having operated here. Regarding a third case, an officer announced one day that he would not again dare to ask his batman for any favour. He had merely asked for another cup of hot coffee, whereupon the batman went down to a shed under the building and hanged himself. That, apparently, was actually what happened, though he was seen, cut down, and survived to be admitted to hospital and later re-patriated as a case of reactive depression.

As these incidents succeeded each other in a single unit, another batman, rather a bright African lad, was keeping his eyes open and thinking. He concluded that psychiatric illness held possibilities. But he did not hang himself; instead he wrote a letter, in which he stated that he was going to do so, and he left it where he knew it would be found. He was fortunate in that he did not have to face a disciplinary charge.

Irrelevant to the subject of chronic anxiety states, but having a bearing on the problem of mental illness among Non-European troops, was the ghastly experience of a unit in the Middle East, where an Indian trooper had suddenly run amok, firing a machine gun at point-blank range among the soldiers who were around, killing a number and inflicting terrible injuries on many more.(17) Impossible as it may be to prevent such tragedies altogether, the author cannot avoid the impression that more ought to have been done for the mental well-being of our Non-European troops than was the case. This particular lesson may not be without its application in civilian life.

The view here expressed derives support from McDougall's illustration of the running amok of the Malay, which is attributed to a pent-up feeling of grievance, which ultimately is vented in an explosive outburst of undirected revenge.(18)

D. Hysteria. In the official classification (2) hysteria is subdivided according to whether it is amnesic, motor, sensory or visceral, hysterical vomiting and enuresis being given as examples of the visceral type. In keeping, however, with the system we have adopted in the case of the anxiety states, we

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(17) The facts of this case were given to me by my colleague, Major L.J. Wigston, South African Medical Corps.

(18) McDougall. An Introduction to Social Psychology. Methuen. Twenty-eighth edition. 1946. pp. 121-122.

shall discuss hysteria as it occurs; (a) as a result of the stresses of battle; and (b) arising in other circumstances. In both instances, and particularly in the former there is a good deal of merging of the hysterical and the anxiety states into each other. One further general condition is this, that broadly speaking, hysterical reactions tend to arise in the less well educated and more labile members of society; anxiety states in those with a more satisfactory background. In the battle stress states, however, one sees a more complete merging of hysteria and anxiety, so that it is common to have both types of reaction present in the same patient, at different times or even at the same time. In discussing the anxiety states we have already touched upon hysterical symptoms that occur along with them. We shall now elaborate a few points.

Hysteria arising from battle stress. In the severe neurotic breakdowns of battle hysterical symptoms often predominate. In the most severe occur hysterical stupors that can, only with care, be differentiated from catatonic psychotic states.(12) Such have not infrequently been diagnosed as schizophrenia. The writer, on one occasion, made the reverse mistake, treating as a case of hysterical stupor, a schizophrenic patient who had escaped from the enemy lines. Amnesia, mutism, blindness and deafness are other striking features of the acute phase. These are conversion symptoms of a defensive kind. As the

patient becomes, under treatment, more distanced from the battle scene, psychomatic visceral disturbances, such as the gastric neuroses, tend to hold the hysterical field; or less acute conversion symptoms, such as paralyses and anaesthesiae, to manifest themselves.

Hysteria arising on service, but out of combat. We find little or nothing among the hysterias of non-combatant service that is different from what is customary in civilian psychiatry. The angle from which this thesis is written is that of examining war psychiatry as such, the aim being to find ways and means, if there are any, by which the impediment to the efficiency of the military machine that psychiatric breakdown presents, may be made less. It is thus unnecessary to treat of hysteria as one would do in any article relative to the neuroses of ordinary life, or in which the subject was looked at from the individual viewpoint. There are, however, two factors that are worthy of being placed on record.

The first of these relates to the large number of women now being employed in the Services. From what little we saw of the women fighters of Yugoslavia or have read of those of the forces of the U.S.S.R., it seems that they stood up to military conditions with remarkable and admirable fortitude. But among ourselves much larger numbers of women than heretofore have been subjected to stresses of war, such as bombing, shipwreck and

long separation from their homes. It looks as though service medical officers will, in the future, require to be prepared to deal with the more fluid psychic make-up that pertains to the female sex. Random examples from one's own experience are that of a nursing sister who, while suffering from a reactive depression, jumped early one morning, a full 35 feet from the upper deck of a troopship into the Mediterranean; and that of a 21-year-old married woman, who having been separated from her husband not many days after their wedding, eventually drew attention to herself by a rather clumsy attempt to drown herself in the swimming bath at a Middle East garrison.

It is interesting to read what the Director General of Medical Services (19) has to say about War Neuroses among Service women.

"The incidence of War Neuroses remains unchanged and in the Pretoria and Voortrekkerhooghte areas deteriorated considerably during the year. There were a large number of cases of uncontrollable weeping, body tremors; loss of power and concentration; failure of the faculties of attention, memory and will and utter incapacity to carry on with their work.

"Medical women in the army exercised considerable care and patience in handling cases, particularly those who seemed to have lost interest in their work, and every effort was made to rehabilitate them. It was found that after a period of rest in a happy environment, with freedom from responsibilities and

(19) D.G.M.S. Annual Report of Medical Services, U.D.F. (M.S.A.) for year ending 31st. August, 1935.

restrictions, many recovered quickly and were able to resume their posts. Others were restored by kindness and remustering to other centres of different spheres of work.

"The high incidence of War Neuroses among women in the army has been due to the long absence of husbands, sons and relatives in Italy and the Middle East and the strenuous task of doing war work and running homes for their children at the same time. The absence from home environment, the monotony and restrictions of barrack life have also affected women adversely, even though the authorities have endeavoured to make army life for women as attractive as possible."

In a later place he says that the highest number of medical boards among women have been for "Nervous Disorders."

The second factor worthy of attention is the effect upon certain meek-minded individuals of vicissitudes inseparable from military life and discipline. The patient J.C.J. (p.65) illustrates this point very well, his symptoms having become much worse following the ammunition incident and resulting disciplinary charge. This indeed, may almost be said to have given rise to a conditioned reflex of pronounced allergy to army administrative procedure. It cannot be expected that the majority of such cases can be "vetted out" at the time of the enlistment medical examination; but is it too much to ask that individuals of this type should be able to find in their regimental medical officer someone who appreciates their difficulties, and who is able to handle their cases sympathetically and wisely?

E. Obsessional States and Hypochondria. Obsessional States present no new problems to service medicine, and it is doubtful if sufferers are any worse off in the army than out of it. Indeed one has at times been tempted to feel that some such cases have received treatment more readily than might have been the case in civilian life. Naturally any obsessional tendencies coming to light in the initial medical examination deserve evaluation before the recruit is accepted for enlistment.

It is appropriate to touch upon hypochondria, which received no specific mention in the official classification referred to. It is, of course, not a true obsessional state. Nor is it a true manic-depressive psychosis, while it has features that distinguish it from the chronic anxiety state. It is mentioned here in default of a more suitable place.

Among service patients cases of hypochondria are, fortunately, uncommon, and they would hardly be worthy of mention, were it not for the fact that they involve such wastage. Once admitted to hospital a case of hypochondria may involve weeks of hospitalization, including specialists' opinions and laboratory tests, before the diagnosis can finally be made that will result in the patient's discharge as a psychiatric casualty. Further treatment will then be a pensions or civilian problem. Everything points to the strong desirability of excluding hypochondriacs at the initial medical examination, or having their cases finally

dealt with, should they come before the medical officer early in their military career.

F. Psychopathic Personalities. However much one may sympathise with the psycopath in the difficulties with which his constitution presents him, it is not too much to say that in the army he is an inveterate liability, presenting all sorts of problems of discipline, efficiency and morale. The implications regarding the enlistment of such people are only too obvious and will be discussed in the section on conclusions and suggestions. The type of practical difficulty which psychopathy presents to the executive will best appear from the discussion of a case in the clinical section of this thesis.

G. Alcoholism. It is not attempted to review the organic/toxic symptoms to which alcohol gives rise, but merely to pass a few observations on alcoholism as a condition within Service experience.

It is, in the first place, the view of the writer and not a few of his colleagues that alcohol displays certain beneficial qualities under the conditions of military service. Among these is the long-recognised features of the rum ration, or more correctly, its inhibition of psychic mechanisms such as fear and panic.

Soldiers have, inevitably, much spare time on their hands, and in this time they very frequently have many

difficulties - Service, domestic, personal - on which to brood. And as they brood, so accesses of anxiety come. It is the author's belief that alcohol, taken within reason, is of real value in allaying the stress so occasioned.

These same difficulties, reinforced by the unnatural, unisexual community that a military unit is and by certain dislikes and hostilities that develop within it, are apt to undermine the good fellowship and "esprit de corps" that are so essential in the maintenance of good morale. Time and again one has been impressed by the good effect of alcohol in assisting to dissolve the unsocial tendencies that these factors bring in their train. So far as this is so it is legitimate to claim that spirits serve a purpose of usefulness both towards the individual and as regards the Force of which he is an integral part.

From such beneficial consumption of liquor it is but a step to its abuse. Herein lies the manner in which not a few have first of all drowned their sorrows, only to swamp their own efficiency and to rot their moral qualities. A percentage of the total volume of the addiction that we observe in the Services has arisen in this way.

Yet it probably is but a small percentage. Most of those who succumb to the effects of alcohol in the army either were already given to addiction in their pre-Service days or else are persons of psychopathic personality or are mentally dull individuals.

Among such, disciplinary measures usually fail, but in a certain proportion a combination of punishment with medical guidance, and perhaps adjustments in the nature of the men's employment will effect appreciable amelioration. Where these measures fail, repatriation and eventual discharge may become necessary. With regard to this last something will be said towards the end of the section on treatment (p.100).

IV. SOME ILLUSTRATIVE CLINICAL CASES.

Case 1. A Case of Mental Subnormality. Although this man's story presented some bizarre features that at first suggested his being a schizoid psychopath, it was finally decided that his declared subnormality would explain these, and that the above diagnosis was the correct one. The facts of his case speak for themselves to indicate the unsuitability of a soldier of this type for service in a technical or fighting unit.

H.R. was, at the time of his last admission to hospital, a 33 year old sapper of the S. A. Engineer Corps. He had served in the army for almost five years from June, 1940, during virtually the whole of which time he had been employed on road construction. He was admitted to a Middle East Hospital early in 1945, with the statement from his unit that he was odd, irrational and unable to work satisfactorily. He was inconsequent and irresponsible, and subject, so it was stated, to occasional strange behaviour, such as going out at night to gape at the moon. He complained spasmodically of his stomach, having had several previous admissions to hospital on this account. From time to time he suffered from diarrhoea which generally had been

regarded as psycho-somatic in type. Yet diarrhoea was very widespread in the Mediterranean area, while an attack that the patient had later, while under the care of the writer, did not appear to be neurotic in its origin. For the most part he was cheerful, making no other complaints.

He came under our care in the U.D.F.[¥] Psychiatric Hospital, Potchefstroom, in July, 1945, remaining with us for five weeks, until discharged from the Service on psychiatric grounds. During this period he was pleasant but inconsequent, making frequent demands upon the staff for favours that were at variance with the carefully drafted regulations of this institution. He drank a little, but seldom to excess and did not occasion trouble on that score. At interview he denied having had hallucinations, ideas of reference or paranoid feelings and was able to give a reasonably good account of himself.

Physically he was a well-built, muscular individual. Routine physical examination revealed no abnormalities, except when he had a transient attack of diarrhoea with slight abdominal tenderness. A stool examination resulted in no abnormal findings. His Wassermann Test was negative.

His Intelligence Quotient was 79[¢]

(¥)Union Defence Force.

(¢) Measured by our standard tests, the average normal reading in which was computed to be 100.

For an account of his earlier history we were largely dependent upon the patient himself, and the following are among the facts that were obtained. There was said to be no history of mental illness in his family. Neither parent was living. The patient was one of a family of seven, the other members of which were married and well. Home life was happy, and on his own showing he fitted in well at school, but had to leave at the age of fifteen, after having passed Standard V., in order to work on his father's farm. After three years the farm failed and was leased to someone else, the patient entering the railway service. This episode, too, was terminated after some years, and rather abruptly, on account of his having an altercation with a colleague whom he knocked down on the line.

From the railway he went to the roads, in which work he remained until the war. The period was, however, punctuated by a bitter quarrel with his brother, in connection with some job that the patient had assisted the latter to secure in the service of the Roads Department.

From his statements life in the army seemed to have run fairly smoothly, although he made some vague generalisations against the executive. From his records, however, it appeared that his work had been, at best, indifferent.

At the age of 23 he had some neurotic illness, when he was readily startled by loud noises, but no other details of this were obtainable. On the sexual plane, too, he had had

considerable misfortune, and several girls to whom he had been engaged had let him down badly. At the age of 33 he was still unmarried.

Several dreams were recounted, of which one will serve for descriptive purposes. He was half asleep, in a railway carriage, when a lady in white appeared, standing two feet off the floor. She told him of some place where a considerable sum of money could be found. He said that he had not pursued the matter, but it is a coincidence that the witch-doctor, presently to be mentioned, told him a year later the same story about this money.

The narrations about the witch-doctor are said to be not dreams, but fact, and in a country where, among the poorer classes, European superstition mingles with African magic, we can accept that. The witch-doctor persuaded a friend of the patient's to have a frog removed from his stomach. The stomach was opened by a practitioner accustomed to operating, and the frog removed from within. The patient was not present but believes the tale.[%] At a later time the patient was present at a séance where the doctor used bones that jumped in a strange manner.[¢] It was at this time that he told the patient about the money.

(%) In the author's experience a roundworm in the bowel has often been regarded, by the uninitiated, as a small snake. Africans at any rate, often believe that a patient has a snake within him. On one occasion, after careful thought, I myself operated on a man, making an abdominal incision and then sewing it up, because he was convinced that in no other way could he be cured. And he claimed to be well when I saw him a month or two later.

(¢) Suggestive of customary bone throwing by African (witch) doctors.

Another odd circumstance is that the patient, although a member of the Dutch Reformed Church, while at Premier Mine Camp gave his religion as Roman Catholic. This he did in order to avoid compulsory church parade, because, he said, the Dutch Reformed Church services in the camp were not properly conducted.

While with us in hospital this man revealed no psychotic or anti-social trends. No specific treatment was required. He obtained a job with the Roads Department of South West Africa, and was discharged from the army to take up that employment.

We briefly discussed, on page 15, the case of an acute psychotic reaction occurring in an officer on active service. The majority of such, apart from questions of precipitating causes, show little difference from similar reactions in civilian life. They tend also to have a better prognosis. The following case illustrates one of the several types of problem that can arise.

<u>Case 2,</u> regarded as manifesting a <u>schizophrenic episode,</u> followed by recovery.

K.R., a 20 year old medical orderly, was admitted to my ward in a military hospital of the Central Mediterranean Force. He said that he had, for the last 10 days, suffered from insomnia, depression and loss of appetite.

He was a well educated young man, who had given efficient service in the S.A. Medical Corps until the commencement of his illness two weeks previously. His family history

contained no record of mental or neurotic illness. His mother and his one sister were alive and well. The story of his own earlier life contained no abnormal traits, although at school he was, on the whole, reserved and somewhat shy. He passed his matriculation standard before enlisting.

At interview he was completely rational, giving a good account of his symptoms, over which he felt some concern.

Physical examination revealed no organic disease. His blood Kahn test was negative. Blood slide for malaria was negative, white cell count was 9,200, and blood sedimentation rate was 2 mm. in the first hour.

He was referred to our physician specialist, who found no evidence of organic disease in the nervous system or elsewhere.

A lumbar puncture was done and the results of examination of the cerebro-spinal fluid were within normal limits.

The further details of the man's story were the following. About two weeks before his admission he became depressed and restless and was concerned about his condition. One evening, about this time, he had an argument with someone regarding the patient's intention to settle on a communal farm in Palestine after the war. His friend said that he (K.R.) had not yet been able to make up his mind. Two or three nights later he had gastric discomfort, and vomited several times. More than once during this period, he had been unable to sleep at night and "was jumping about." Then he went on night duty in the sick bay

where he was working. He several times imagined he heard patients shouting at him, but always found on investigating that such was not the case.

Previous to the illness he had been accustomed to mix and associate well, but he now felt that he did not want to talk, or else he wanted to argue. He felt that a complete change had come over his personality in the period.

He was then referred to the senior psychiatrist in the area. This officer expressed himself as unable to give a categorical diagnosis, but regarded him, in addition to his presenting symptoms, to be showing signs of an early dementia. Testing on the Shipley-Hartford scale tended to confirm this impression.

He was in the wards for another two weeks under observation, at the end of which time he seemed to have made a complete recovery. It was, therefore, decided to allow him to return to duty.

<u>Case 3.</u> <u>This is a case of epilepsy.</u> K.C.R. was a 29 year old air mechanic. He was repatriated from a theatre of operations with the diagnosis of epilepsy. Some time previously he had had four fits within a period of about a year, but he does not seem to have been sent to hospital when any of them took place. When eventually he was admitted, still in the operational theatre, it was with a report from his commanding

officer to the effect that the patient was worried, and apparently had a great deal of domestic trouble. His wife had disposed of home and furniture and he had had no letters from her for three months. The patient had, the report went on to say, lost all interest in his work, had been drinking heavily and had lost all sense of personal cleanliness. On account of these lapses he had, a few months earlier, been reduced from the acting rank of flight-sergeant.

He stated that he had had no fits at all except the four shortly to be described. He gave no family history of fits or of mental illness, while his own earlier life story was free from anything that suggested abnormality. He left school in 1933, after passing Standard VII, and was an apprentice motor mechanic for the next five years. He then got a job in a garage in 1939. This he resigned in an effort to go to sea, but, being unsuccessful, he returned to another garage for three months, at the end of which time he joined the S.A. Air Force. While in East Africa he developed a slight alcoholic excess, which became accentuated during a later period of foreign service, as he was then upset over his domestic stresses. In the meantime he had married, but difficulties had arisen once he and his wife were separated by distance. It was under these circumstances that his efficiency began to fall off.

The descriptions of the four fits - which all took place within a period of just over a year before his admission

to hospital - were not quite convincing, but were strongly suggestive of epilepsy. Each began with a premonition, which he described as feeling like an electric shock. He gave a loud moan before at least one of them. On each of the described occasions he was seen to fall forward, to become stiff and apparently to remain unconscious for some ten minutes.

No fits took place while he was in hospital. On his return from abroad he was admitted to our hospital, where he gave a good account of himself. He was inclined to attribute his domestic difficulties to his mother-in-law, who was now living with his wife, and who, incidentally, had herself been divorced more than once. During a week-end of leave of absence from hospital he unfortunately got into a difficulty with the police for breaking a garage window. He said he was drunk at the time.

General physical examination and neurological examination were negative in their results. Examination with the electro-encephalogram was not at the time and place possible, and he was given a Phrenazol test for epilepsy, 3 ccs. of the drug being injected intravenously. A typical grand mal followed. It was felt that the diagnosis of epilepsy was now confirmed. The patient was transferred to a Red Cross Hospital, where we hoped he would be put on a stabilising system of treatment before being finally returned to civil life.

Before describing four cases of <u>acute anxiety states</u> it will be worth while to detail the technique of Pentothal narco-analysis as used by us, a technique adopted from Grinker and Spiegel's description.[1] The patient lies on a bed in a slightly darkened room. He is told that he is going to receive an injection which will, in the meantime, make him sleepy, and which, in the long run will assist in enabling him to overcome his difficulties. As the injection is given he is asked to count backwards from 100, because this requires more concentration than merely counting 1, 2, 3, etc. I have also found it an advantage to have a nurse or an orderly in the room with us at the time, the principal reason for this being that, during the time when the patient is re-enacting his battle experiences, it is, exceptionally, more than one person can do to prevent his injuring himself. The presence of the nurse is also valuable in the event of any sort of emergency, when it may not be possible for the doctor to leave the patient.

In a limited experience we found that a 0.5 gm. ampoule of pentothal was all that was required, although exceptionally up to 1.0 gm. is stated to be necessary. In the average case from 0.25 gm. to about 0.4 gm. is enough.

The patient may be told to shut his eyes as he counts, and the injection is given slowly, at the rate of about 0.1 gm. per minute (i.e. at the rate of 1 cc. per minute, assuming

that 0.5 gm. have been dissolved in 5 ccs. of distilled water). The injection is stopped before the patient falls asleep, the proper moment being gauged by great hesitancy in counting, laxity of the musculature, appearances of commencing somnolence and by the therapist's experience. (The necessity of ensuring that the needle is all the time in the vein was brought home in the case of one of our patients in whose case it had slipped, with the result that a fair volume of the drug entered the subcutaneous tissues. This patient lapsed into coma for about twenty minutes after the injection had been discontinued. Such an occurrence is not entirely without risks).

Once the injection is finished therapists keep the needle in the vein, in case a further quantity of pentothal should be required as the narco-analysis proceeds. In the writer's experience this is worth trying to do, but is extremely difficult if the patient is restless and impossible if he is violent.

The stage of somnolence reached, the patient is allowed to talk, if he commences to do so on his own. Otherwise the doctor asks him, in so many words, to describe what he <u>sees</u> of the battle scene. If this is insufficient, the doctor proceeds to tell the patient that so-and-so is happening. If he knows enough of the history, he will describe a scene that the patient had depicted in his waking hours. If not, he will draw up his own picture, saying, for example: "We are lying

in the slit trench. There's a mortar shell coming over. It's fallen beside us!" Such stimuli are enough, in severe cases, to take the patient right back to the battle scene, and from there on he will speak and act out the exact details of his talk and behaviour on the field. From his unconscious mind will be produced a detail-perfect picture of just what happened, and facts will come to light that had been withheld by amesic mechanisms when he was awake. In less severe cases he will not actually believe himself right in the combat situation, but will describe the details from memory, realising that he is no longer there. In the severe cases, however, the patient is, in phantasy, right on the battlefield, and he behaves just as he did when he was there. In such cases the therapist comes, for the time being, to be regarded as a comrade in action.

It has been necessary to introduce this explanation here in order to clarify the clinical description of cases. The implications of the narco-analysis as regards treatment and the method of its termination will be covered in the section dealing with treatment.

Case 4. This is a case of an acute anxiety state in an individual already predisposed. D.D.J. was a 20-year-old army private who was admitted to hospital in Italy in July, 1944. He had been six weeks in the line at Cassino, where he had suffered considerable battle stress, and from where he had eventually been sent back as a psychiatric casualty. Just before

being evacuated he had felt faint and vomited.

No predisposing factors in his family history were forthcoming, but constitutional loading was in evidence. Years ago he was seduced by a married woman, and this incident, which was discovered only during narcosis, had affected him to a degree that was problematical. While on service in Madagascar he and his friends had been menaced by a crocodile on the river bank. The encounter with this animal evidently set up an anxiety state that lasted at any rate for days. Later, on the coast of South-West Africa, a boating accident, which involved him and a few comrades in some danger of drowning, was followed by a much longer period of anxiety. The battle experience that brought about his admission to hospital was of a relatively minor nature. He had also suffered from periodic bouts of depression during most of his life.

Physical examination was negative on admission. While in hospital, however, he ran an occasional temperature, between 99° and (once) 104°. There were no localising signs or symptoms. Blood examination was negative for malaria on two occasions. White blood count was 11,400 and the differential count within normal limits. Laboratory examination of the urine revealed no abnormality. There was no recurrence of the temperature rise.

At interview he stuttered, was shaky, evinced a

hysterical torticollis while speaking and readily became emotional under duress of any sort. He was showing concern over his mother's health, and a fear lest he "go mad" was also in his mind.

Under pentothal he did not re-live his battle experiences, but described them, being still aware that he was in hospital. At certain points of the story he showed considerable emotion, such as when a shell exploded close to him and when he went through no man's land to collect a wounded comrade. He had been much affected by the sight of dead and wounded men and by the presence of blood in the river. In relieving himself of his emotions he said, with feeling, how he would like to go back and kill those "bloody bastards."

Psychotherapy was on the lines that will be developed in the next section, and after two weeks his condition had appreciably improved, when it remained more or less stationary. The writer's recommendation to downgrade him for return to a non-operational area was over-ruled by higher authority. He returned to the line a few months afterwards and was again sent to us as a psychiatric casualty. On this occasion it was decided to repatriate him.

Case 5, a case of acute anxiety state. S.G.J., aged 24, an army private, was admitted about the same time as D.D.J. His earlier personal history was suggestive of inadequacy

and hysteria. He had been teased at school; he was almost blind (no injury) while in Standard III; eventually he passed Standard VI, and he had suffered from headaches since a sinus operation at the age of 15. He had four sisters and one brother. His mother was in a mental hospital for some years, while his father and brother were "notably nervous".

At interview, shortly after he came to us, he was jerky, unsure of himself and stammering slightly. Battle nightmares were a prominent feature. We had great difficulty in discussing his battle experiences, both from disinclination and from the way in which any attempt to do so increased the stammer.

Physical examination revealed no abnormalities.

Under pentothal he described his battle experiences with limited emotion. The battle had apparently been successful in its outcome. There were many shells, but no enemy planes. We killed 7 Germans ...... we killed 47 Germans ...... some of them were just young boys like my young brother." He did not feel anything at the time except pride in the accomplishment, but afterwards was tormented by remorse. He was three miles out with a comrade, collecting wounded, when the enemy opened fire. They were able to get back with the wounded, but it was a severe strain.

At a subsequent straightforward interview he described being knocked off a tank by a shell that went through the turret

on which he was sitting. Thereafter he had to help a comrade to walk back, but he himself was merely responding automatically to the necessity to keep going. He vomited several times "en route", and felt uncomfortable in an indescribable way.

Later psychotherapeutic discussion dealt with (a) his battle experiences; (b) his marked concern lest he would be thought "yellow" for having left the line of battle; and (c) worry over his father's illness. He was very much attached to his father who, he said, was now suffering from cancer. This last item proved, on the whole, the most intractable to treatment. He was downgraded in medical category, for return to his native land.

Case 6, a case of acute anxiety state. R.L. is the patient whose symptoms were mentioned on page 17. He was admitted suffering from severe anxiety state, following battle experiences three weeks earlier. He was very jerky, easily upset, stammering slightly, and readily showing anger if something he disliked was suggested - e.g. the suggestion that he should have an injection. He said he did not wish to discuss his battle experiences, as it upset him too much to do so.

He had already had 3 days continuous sleep therapy at another hospital, seemingly with little benefit, and some psychotherapy which appeared to havehelped him slightly.

There was a history of temperamental instability in his family. His own early life story contained nothing of special

note. Subsequently to leaving school he had been in the Police Force, but had been invalided out on account of "fits" and some psychosomatic disorder characterised by gastric symptoms. He was married and had one child.

Physical examination was entirely negative.

Within a day or two of arrival in my ward he was given pentothal, when the whole battle experience was re-lived with the utmost drama. As the shells came over he threw himself upon the ground and dived under the bed. He described a 4-day trek up to the line, with little sleep the while. At the end of this he was affected by the sight of some fellows lying, badly cut up ..... a tank flight was going on ahead ..... a number of Italians were mown down by machine guns. After this he found he could not drive his truck as his "nerves seemed to have given in." At Pontecova he was greatly affected by the sight of two kiddies standing together against a wall, clasping each other, with their heads shot off.

Another trying experience was the sight, in a graveyard with the church still standing, of a considerable number of women and children who had been killed. He felt natural, impotent rage in the presence of this and similar experiences. There was a long period when he was heavily shelled in his bivouac, some bursts occurring right above him. This piece was vividly re-lived under the pentothal: when asked to leave the bivouac and

come to a group of comrades who were in a safer place, he cringed down against the floor, shouting: "No one will get me to leave this bivi."

That night a shell burst five yards from him ..... he does not remember what followed ..... he landed at a regimental aid post soon afterwards.

The pentothal interview was followed up by daily psychotherapeutic interviews, with considerable resulting improvement in the man's nervous state. By the end of a week he had lost the more distressing anxiety symptoms, and could discuss his battle experiences naturally and without further accesses of anxiety, while he had lost much of his feeling of rage. He had, also, come to appreciate that he was not "yellow", that he had not deserted his unit, and that the best service he could give to the war effort would be in performing more sheltered duties. He was suitably re-categorised.

<u>Case 7,</u> a case of acute anxiety state which followed a battle accident and increased while the patient was under treatment in the surgical wards. K.H., a married corporal, 25 years of age, was admitted, suffering from symptoms of acute anxiety, from a surgical ward where he had been under treatment for contusion of the sacro-spinalis, caused by a motor-cycle accident. The accident took place on 16th. June, 1944, and the patient was believed to have been unconscious for a short time after it

happened. He said that when he came to he found he was stuttering, and also that he had become "as jerky as a jack rabbit."

His early personal history and family history contained nothing of note. He was a checker on the railway. Though married and the father of five children he showed dependent attachment to his parents.

He described a motor accident that he had had in Pretoria in 1943. He felt that he ought not to have driven after this, and that he was perhaps guilty in this connection. He had served in East Africa, the Middle East and Italy, and had seen a fair amount of action fairly close to the front, but had had no breakdowns. There were two unfortunate disciplinary episodes in Egypt early in 1944, and in the second instance he had been demoted from staff-sergeant to corporal. A sense of injury over this was still preying on his mind.

On 3rd. August, two days after coming to the psychiatric ward he was noted as being "extremely jerky and scared - almost terrified." He had been waking at night with a start and had been having dreams of falling off a horse and being kicked by horses. He showed startle reaction to any loud noise.

Medical examination was negative and the contusion had healed to the satisfaction both of the surgeon and of the patient.

At interview he stated that for a few days before the motor-cycle accident he had felt afraid of driving fast,

and had been going slowly and carefully, obsessed with the idea that his family would suffer if he were killed. The major symptoms developed after the accident, and some of them only after reaching the surgical ward on 24th. June. Whereas he used to be very level-tempered, he now was often irritable and inclined to lose his temper or else to cry. He felt moody, depressed and solitary, these being qualities that previously were foreign to his nature. He often cried in bed at night. He was still stuttering considerably and was moderately depressed and anxious. I noted at the time that the stammer appeared to be a conversion sympton resulting from depression and anxiety that had been "building up" over a period.

During a pentothal interview on 7th. August he re-lived much of his experience, but rather undramatically. He believed himself to be lying on the roadside just after the accident, but was answering questions mainly relating to the past. A fair degree of emotion was produced by the suggestion that aeroplanes were overhead.

By 10th. August there was no change in his condition, although he had been for 9 days in our ward under treatment. It was, therefore, decided that he must have a period of continuous sleep-therapy. It so happened that I was just going off on a period of leave, and the medical officer who was temporarily to take over the ward had no experience of dealing with cases of this type. The patient was, therefore, transferred

to a nearby hospital and was lost sight of by us. Although we have not been able to follow his case to its conclusion, its discussion here is useful as demonstrating an acute anxiety state so persistent that its continuity must be broken by a period of continuous sleep before other methods, of which psychotherapy and occupational therapy are among the chief, can have a chance to bring about recovery.

Case 8, a case of mild anxiety arising after hospital treatment of wounds. D.M.M. was a British lance-corporal, 24 years of age, who was evacuated to our hospital a few days after being wounded. He had a shrapnel wound about 4 inches long in the right thigh, a wound three inches long in the right arm and a third penetrating shrapnel wound ½ inch long in the back of the neck on the left side. X-ray examination had shown a small piece of metal lying deep in the posterior muscles of the neck. All wounds healed satisfactorily in under three weeks and it was decided that more harm than good would be done by operating on the small piece of metal which, in any case, was symptomless.

During the last few days before his discharge the patient showed signs of anxiety, which one could sense in talking to him rather than pin down to any particular attitude or behaviour. He complained also of slight anorexia and fullness after meals. Ordinary physical examination was negative.

Discussion and questioning revealed that there was a moderate degree of latent anxiety in connection with the prospect

of return to the line. It was decided to send him to the British medical board with the recommendation that he be downgraded for base duties for a period of three montha, at the end of which time he ought to be fit. This suggestion was accepted by the board.

Case 9, a case of anxiety state of psychosomatic type. L.J.W.was a 29 year old private of the Army Postal Service. He had a long history of frequently reporting sick, mainly with abdominal complaints. Eventually he was admitted to hospital, where he complained of fullness and discomfort after meals, with occasional pain. From time to time he had, he said, suffered from diarrhoea, and infrequently had vomited. He also complained of a "cracking" in his neck when he turned his head. On account of this last symptom he was referred for opinion both to a surgeon and to a throat specialist. Both of these officers reported to the effect that they found no evidence of disease.

Clinical examination did not reveal much, the only positive finding being slight epigastric tenderness. The blood sedimentation rate, which we have often found to be a useful confirmatory test in cases of this kind, was 4 mm. in the first hour. A stool examination drew a negative report from the pathologist, and the blood Kahn test was negative.

The physician specialist was then asked to see the patient, and apart from commenting on hyperpnoea of functional type and mild epigastric tenderness, he pronounced him fit and recommended his return to duty in his present category.

Psychotherapy was attempted in the week before his discharge from hospital with a view to (a) reassurance, and (b) calling to the aid of the patient's ego the attributes of loyalty to the cause, identification with his comrades and a sense of personal duty. So far as is known no further admission to hospital became necessary.

Case 10. This is the patient J.C.J. who has been mentioned on page 68 . He was 35 years of age and married. He had not been abroad during the war and was admitted to a psychiatric hospital at the end of August, 1945.

His complaint at the time of admission was of headache, anxiety and apprehension, which were life-long but had been worse since the beginning of 1944.

Of his family history the patient told us that his father was a terror (vide infra). He described his mother as being "nervous". An uncle was given to alcoholic addiction. The patient had one sister, in good health.

His early life was entirely overshadowed by the harsh brutality of his father who thrashed him severely and often for trivial things. Eventually he became desperate and ran away from home when he was almost 14 years of age. He went to work on a farm and continued in employment of this kind until the beginning of the war, eventually buying a piece of land of his own. He was married twice, the first marriage having been spoiled, according to him, by his wife's impossible temper.

The second marriage appears to be a happy one, but there are no children.

He enlisted in 1940, being accepted in a "B" medical category on account of pes cavus. In January, 1943, he had pyelitis and in September urethritis. At the beginning of 1944 he was court-martialled on a charge of stealing ammunition, and acquitted. Apparently some person unknown had placed the ammunition in the patient's truck without his knowledge. The circumstances, however, caused the patient considerable anxiety. He said that he was popular and got along well with his comrades until shortly after this happened, when people began to say that he was acting strangely. Apparently he had been moving his arms about peculiarly and seeming dazed or very inattentive while doing clerical work. He was sent to see a psychiatrist at this time and, as a result, his work was changed. In May, 1944, he had a fracture of the left thumb and in November gastro-enteritis. There were numerous entries of all sorts in his medical history sheet, and he had been on a few minor charges in addition to the one mentioned. In July, 1945, he had some sort of fit which might have epileptic.

Ordinary physical examination was negative. An X-Ray of the head, however, showed a shadow the nature of which left some doubt in the mind of the radiologist, and on this account he was referred to the wards of the neuro-surgeon in another hospital for examination. This specialist's report was to the

effect that no signs could be found of any organic disease of the nervous system.

The eye specialist was asked to see him, and he, likewise, reported in the negative.

A leptosol test for epilepsy was done, 3 ccs. being injected intravenously without any result.

In the upshot a diagnosis was made of chronic anxiety state, reactive in type, and the war having been won, it was decided to discharge the patient on medical grounds. He was, however, retained in hospital for several weeks, when he was subjected to psychotherapy of a suggestive type and was introduced to occupational therapy. In this he co-operated well and the prospects of his rehabilitation in civil life were regarded as being bright.

Case 11, a case of mild, chronic anxiety in a somewhat inadequate individual. K.S., 23 years of age, was a motor driver in a unit attached to the Central Mediterranean Force. At the time of his coming to us he was acting as chauffeur to a senior officer, whose duties involved much travelling. He was admitted to the ward for observation. He had had an accident 4 days previously and was complaining that he felt he could no longer drive.

So far as we could gather from him both his parents, who were still alive, were soundly balanced people, nor had any

of his siblings revealed obvious neurosis. He himself had always been shy and reserved. At the age of 7 he had an accident, following which he suffered from sleep-walking and bed-wetting for a few years. Of the studious type, he had done well at school, where he passed Standard IX. He had cultivated the friendships of other boys only to a limited extent, and was attracted rather to intellectual than to physical pursuits.

Since coming abroad he had been sleeping badly,, had felt lonely and had at times been scared for no particular reason. A few weeks before coming to us he had had to take his vehicle into an area where he was exposed to shelling, to which he had reacted with a marked increase of anxiety.

Physical examination elicited no signs of illness.

It was apparent that this man was not fitted to continue with his driving duties. He was, however, keen to make his contribution and was a man of good character and education. The writer, therefore, contacted the officer in charge of postings at the Reception and Transit Depot, who kindly promised to arrange a suitable job for him.

Case 12. This case is included as an illustration of a common type of reaction which presents a problem that is administrative rather than medical, and where suitable handling may greatly affect the soldier's future efficiency.

W.A. was a 32 year-old sapper of the Engineer Corps. He was seen by the writer as an out-patient, had already given

good service to the corps of which he was a member and had won the Military Medal. The report from the medical officer who sent him stated that he was very worried about his home conditions, as a result of which he was unable to eat or sleep. The principal cause of concern was his wife's health.

His wife and he had already had one child, since whose birth she had had two miscarriages and one relatively minor gynaecological operation. She was again pregnant and the patient understood that she had heart disease. The first confinement had been abnormal and was followed by a long period in hospital. It appeared that the family doctor did not take an encouraging view of the outlook for the next, expected in less than three months' time. She had no relatives in the town where their home was and assistance from such a source seemed to be impossible to obtain.

The patient laid his cards on the table in a straightforward manner. He was obviously suffering from a mild anxiety state, associated with much worry, some loss of sleep, impairment of his powers of concentration and considerable loss of appetite. At the same time, and having regard to service requirements, there did not appear to be sufficient ground for re-categorisation.

In my report regarding him I referred to this last fact and dealt briefly with his present condition. I made the following recommendation:

"I recommend that this man make application for

compassionate leave, and that it is backed by a medical certificate, for the following reasons:

"He appears a good soldier, states that he has given in all three years service abroad and won the Military Medal. The anxiety to which he is being subjected is likely, if it continues, to result in a falling-off of his efficiency. A number of cases of this type, who have been refused leave on compassionate grounds, have deteriorated so much that medical boarding has eventually become necessary, with resulting loss of their value to the Service. It is much better, in such cases, that a man should be allowed a period of home leave, and in this way his value as an A 1 man can be ensured once his leave is completed."

Case 13, a case of hysteria. K.A.P. was a seaman serving in the Navy, who came to the writer in January, 1946, as an out-patient at a combined medical inspection room. He was a married man with two children, and had served for slightly more than 2½ years. His service had been in home waters, in the Indian Ocean and for a few weeks in the Mediterranean.

From his own account his family history and his own earlier life story contained no peculiarities.

While serving in a small ship in the Mediterranean in January, 1944, he began to feel sick and to vomit. His appetite became poor, but he had no pain. His bowels were moving twice every day, his normal being once daily. Three weeks later his

ship called at Mombassa, where he was seen by a medical officer, his symptoms having continued unchanged. When the ship called at Durban two weeks afterwards (Feb. 1944) he was sent ashore and admitted to hospital. Physical examination was virtually negative. Both a barium meal, X-Ray and a gastric analysis revealed normal findings. He was treated as a case of gastritis and given a dietary regime, olive oil and a bismuth mixture. He was downgraded for home shore duties only.

For more than a year, while taking medicine, he felt much better. In July, 1945, he began to suffer from abdominal pain of colicky type, mainly epigastric in situation. It was accompanied by vomiting but not by diarrhoea. It became worse during the next few weeks, until one week-end, when he happened to be at home, he became incoherent and then unconscious. He did not report sick, but returned to duty on the Monday. (He explained further that his wife was pregnant at the time and had some illness that made her temporarily blind.)

For the next 4½ months he remained in fair health, but he noted particularly, during this period, that excitement or being annoyed caused diarrhoea.

In December, 1945, he vomited one morning while on the way to work, and was treated at home by the district surgeon for a week. Later in the month he went to a civilian doctor who told him, so the patient stated, that his "stomach nerves were buggared up."

Early in January, 1946, he reported at the medical inspection room and was examined. A further barium meal X-ray was ordered, but the findings were negative. In the meantime the medical officer was transferred and the writer took his place.

The patient made the further complaint that he had been having nightmares for about a year and that he had lost some weight in the last few months.

He was examined on 18th. January, 1946, the day the X-Ray report was received. His pulse rate was 104, T. 97.8, R. 20. There was no evidence of disease of the heart or lungs. He had slight epigastric tenderness without other abdominal signs,

As regards the nervous system the findings were:

Cranial nerves - N.A.D.

Pupils react to light. No diplopia. Fundi - N.A.D. There was a definite anaesthesia to pin point and to tactile sensation over nearly the whole body, large areas being quite anaesthetic and bearing no relationship to anatomical considerations.

Abdominal reflexes were brisk. Cremaster reflexes were absent. Plantar responses were flexor and the deep tendon jerks of all four limbs were bilaterally equal and brisk.

There was no evidence of paralyses or of weakness and no obvious wasting.

Lumbar puncture was not done as no immediate indication for its performance was apparent.

Blood Kahn test was negative.

So far as could be ascertained the original symptoms were a conversion or escape mechanism adopted by the ego in the face of active service stress in the Mediterranean. Reassurance and a home posting removed many of the patient's difficulties and he remained fairly well for some months. The first relapse may have been aotivated by domestic worries, while towards the end of 1945 the prospect of rehabilitation in civilian life began to loom ahead. There was probably a substantial element of conditioning so that any major difficulty or worry was sufficient to bring on symptoms. The patient was co-operative and the prospects for psychotherapy good.

It was not, however, convenient to undertake the psychological treatment of a case of this kind at the medical inspection room. He was, therefore, referred to the out-patient department of a military hospital with a view to his being further stabilised before his discharge from naval service, which was due at a not very distant date.

<u>Case 14,</u> a case of hysteria. B.R.H. was an infantry sergeant, stationed in an Italian coastal town, who on a Saturday night, after several drinks, went out into the street. Within a few minutes he collapsed with abdominal pain. Taken to his unit sick bay, he was seen by the medical officer, who

diagnosed a perforation and sent him to hospital forthwith.

He was a well-built man, of muscular, athletic type. His temperature was 98°, pulse rate 100, and respiration rate 24. On first seeing him, one was impressed by rather indefinable signs that suggested a psychiatric rather than a surgical diagnosis. He complained of fairly severe abdominal pain, which had, if anything, abated in the hour or so that had elapsed since its onset. There was considerable, if not acute abdominal tenderness, worst in the epigastrium, but extending also below the umbilicus, with a high degree of "guarding". But there was no genuine rigidity.

In the routine examination of the heart, lungs, nervous system and urine no abnormalities were detected.

He was given a mild sedative and his pulse rate and temperature were recorded at frequent intervals.

The symptoms subsided gradually and within 48 hours had completely passed off. Tenderness was gone, appetite had return-ed and he felt well.

It has to be stated that this examination and the short period of observation are not sufficient finally to exclude some organic cause for the patient's acute symptoms. The occurrence ought to be well documented and the medical officer normally in charge of the patient informed of the facts. This was done. It was not considered advisable either to undertake any psycho-analytical procedure as an early return to duty was likely to be in the best

interests of the N.C.O's morale. It does, however, seem reasonable to regard the diagnosis as provisionally one of hysteria.

Case 15, a case of hysterical symptoms arising on top of organic symptoms of injury. D.J.M. was a married soldier, 43 years of age, who had been involved in a motor accident and had sustained multiple bruising of the chest wall and an injury to the right knee with tearing of the ligaments. He reached us after having spent a fortnight in another medical unit, where his right leg had been put in plaster of Paris.

The bruising of the chest wall was, by this time, virtually recovered from. The leg was still in plaster. Indeed his main complaint was now one of aphonia, in as much as he could speak only in whispers, a circumstance the onset of which was said to have been at the time of the accident.

Routine examination of the heart, lungs, abdomen and urine gave negative findings. Likewise examination of the nervous system revealed no abnormalities, except that there was a large area of anaesthesia to pin point pressure over the anterior and lateral parts of the chest. This fitted into no anatomical pattern.

The throat specialist examined the patient on a couple of occasions and could find no cause for his aphonia.

The patient appeared as a rather timorous natured individual, although there was no past history of neurotic

symptoms. Nor could any other activating cause be found than the accident and, possibly, the prospect of return to further military duty. He remained in the ward for another five weeks, during which time there was a slight improvement in the aphonia, while the anaesthesia all but disappeared. During this time he was seen by the physician specialist, and his case demonstrated at a clinical meeting, without any evidence or suggestion being brought forward to disturb the diagnosis. He was eventually boarded for repatriation home, primarily owing to the long-term nature of the injury to his knee; and it was not anticipated that more than occasional psychotherapy of the suggestive type would be required.

Cases of obsessional states present virtually no problems than those of civilian life, and it does not seem necessary to include the details of a specific instance here.

Case 16, a case of psycopathic personality. R.L.D. was a youth of 21, who got into trouble while on service abroad, and was eventually sent to hospital for investigation. His mother said that in his pre-army days he had been addicted to wild and irresponsible behaviour, qualities attributed by her as being due to the effects of bad company and of alcohol. In 1939 he fell from a gantry crane suffering concussion, the ill effects of which he is inclined to blame for his subsequent irregularities of conduct. But even before that time he was subject to episodes of excitement and emotional

imbalance. There had been infrequent visual and auditory hallucinations, during which he saw a face that spoke to him suggesting suicide.

After leaving school in 1939 he went into training as an engineer apprentice. It was then that he fell off the crane and was in hospital for ten days, returning to continue his apprenticeship till 1944. At this time he got into bad company and was once or twice locked up for drunkenness. On a couple of occasions men made obscene advances to him and he knocked them down. On completion of the apprenticeship in 1944 he was "fed up" with his home town and tried to join the Navy. He was unsuccessful, but joined the Royal Durban Light Infantry a few weeks later, having given a false name in order to circumvent the wishes of the man-power board, who were desirous of retaining him in civilian employment.

In this regiment he was friendless and unhappy. At times he felt insulted and he began to think that everyone was against him. He became depressed, was worried about his mother's health, though seemingly for no good reason, and had a few further hallucinatory episodes. He explained how, after arrival in Italy he went absent without leave in April, 1945, suffering from ideas of reference and wishing to get into touch with spirits. He slept the first night among soldiers' graves, and felt contented there, believing himself close to the supernatural. His sadness, however, returning, he tried to

to get himself shot by posing to some Italian carbineri as a German. He realised afterwards that such behaviour just did not make sense, and was of opinion that his mind could not have been quite right at that stage of events. He imagined all sorts of punishments and dangers, becoming afraid and dazed. He walked many miles, being at last arrested and taken to an American Police Post, from where he was transferred to the British Police who, in turn, sent him into a military hospital. In hospital he saw a villainous face leering at him, which reminded him of Satan. Just previously, while at the police post, he had a violent outburst of temper, made an unprovoked attack on another prisoner, raved violently, and is alleged to have spoken of cutting his wrists and of attempting to escape.

Seen by a psychiatrist 18 days after this incident (July 1945), he was reported to bear an expression of worry and distraction. The report went on to say that he gave his history in a clear and lucid manner, that he was well orientated with regard to time and place, that his memory both for remote and for recent events was good, and that his attention, comprehension, cognition and ideation were sound.

Five weeks later another psychiatrist regarded him as apathetic, vague, puzzled and dull, describing ideas of reference and needing care in a closed ward. He refused food and absconded from hospital, but returned and was much improved after a brief course of insulin therapy.

He was returned to South Africa in a hospital ship and admitted to a psychiatric ward under the care of the writer, at the end of September, 1945. At this time he was very labile emotionally and complained rather bitterly of having been locked up. He was fully orientated in all spheres, had complete insight, appreciating the irrationality of his actions which he ascribed to his having been "not right in his head". He settled well to hospital routine.

Physical examination was negative. Blood Kahn gave a negative result.

Towards the end of October he was allowed leave and left hospital in his mother's care, but forsook her to visit his girl friend. Finding this young lady in the company of another man the patient lost his temper and stormed out of the house. Thence he went to a public bar, where he became involved in a scrap, as a result of which he received minor cuts and bruises and was probably rendered unconscious. What happened next is not quite clear, but he said he was too ashamed to go home. He was eventually returned to hospital by ambulance.

At interview, a few days afterwards, the patient gave examples of his earlier reactions, displaying much kindliness of temperament. How, for example, he took pity on a man who was "down and out," had a few drinks with him, getting him to tell him of his circumstances and his difficulties. Shortly afterwards, when this man was arrested on some charge, he bailed him out.

Another time he befriended a colleague in his military unit who was in need of sympathy. In this last case the picture was complicated by alcoholic episodes and the friendship ended suddenly and unpleasantly.

Late in November he was allowed out on pass. He consorted to a public house with an acquaintance, when they decided to"hitch-hike" into the city (Johannesburg), more than 70 miles away. He had, on his own showing, by this time drunk two bottles of brandy. His friend apparently got the first lift, while our patient followed in another car. His behaviour "en route" was such that he was thrown out half way. He was found later, lying on the roadside, by an influential lady who had a connection with the hospital, and who happened to be passing in her car. She took him in, but his language was so vile and his company so unpleasant, alternating between aggressiveness and amourousness, that she left him at a wayside hotel. While there he created a disturbance, on account of which a complaint was made to the police. On his return to us he was deeply under the influence of alcohol and was temporarily confined in a closed ward where, because he appeared to be trying to strangle himself, even his clothes were removed from him until he had become more sober.

It was admitted by our medical staff that treatment by psychotherapy, occupational therapy and the discipline of hospital routine had effected no betterment in his condition. The

standard apomorphine course of treatment for alcoholism had given some mildly encouraging results in our hands but, as he was insufficiently co-operative, it was deemed inadvisable to attempt it in his case. Nor was his transfer to a corrective institution for young inebriates administratively possible.

Under these circumstances an attempt was made to find suitable employment for him, and he was boarded in category "E" for discharge from the Service on psychiatric grounds as a Psychopathic Personality whose constitution was marked by Schizoid features.

Case 17. This is a résumé of a case history illustrative of re-habilitation problems among discharged soldiers. Psychopathic Personality. E. P. was an infantry private, 21 years of age. Previous to his enlistment, he had shown a tendency to drift from occupation to occupation, having been parking attendant, telegraph boy and motor mechanic (? apprentice) between the time of his leaving school and joining the army. After a period of service in the Army, he transferred to the Air Force as a trainee, but again transferred to the "Ack-Ack" section. He was boarded into category "C" (home service only) on account of bronchitis, and sent to a personnel pool.

His next attempt was when he was up-graded to category "B" and transferred to the Armoured Car Divisbon, only to serve for a few months until he was again down-graded to category "C", this time on the recommendation of the command psychiatrist.

Following this he was sent to the Central Army Training Depot, where he was once more up-graded to category "B" and included in a draft to go abroad; but two days before he was due to sail he was brought down to category "C" again.[*] In 1944 he fell asleep while on guard duty. He was referred for medical report and eventually was boarded for discharge from the Service as a psychopath.

He was placed in civilian employment in a garage. He did not, however, feel equal to this post, and was taken back on army strength, to be referred to the psychiatric military hospital where we were working. His case was found to be unsuitable for psychotherapy, nor could the attached Demobilisation Rehabilitation officer find any suitable employment for him. As a result, he was discharged to a dispersal depot to await the discovery of some niche in which he could be given a civilian billet.

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[*] Unlike all the preceding cases this one was never actually under the care of the author, although in the same hospital. The notes are an abstract from records, and it has not been possible to discover the reason for these frequent changes, nor to obtain all details of the history.

V. CONSIDERATIONS REGARDING TREATMENT.

The first aim of treatment must be to return to duty, in medical categories appropriate to their psychiatric assessment, as large a number of men as possible In the preceding section we have shown how, in individual cases, this principle has operated. Lewis and Miss Goodyear[1] have illustrated, in a carefully analysed survey, how selective posting, in appropriate medical category and to suitable types of duty, can best be done on the recommendation of the psychiatrist, influenced by the reports of skilled instructors in the occupational therapy section (20). Where such readjustment within the Service is impossible an attempt is made to set up the individual before discharge, so that he may be fitted for some form of civilian employment.

Mental Dullness and Mental Deficiency.

The treatment, in the usual sense of the term, of dull and deficient patients is not a military duty. Nevertheless, while the man, once enlisted, remains in the army, its doctors

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(1) Lewis and Miss Goodyear. Lancet. 1944, ii. p.105

are responsible for his care. Three matters call for attention. So long as the man is at work in his unit it will fall to the medical officer to deal understandingly with any ailments for which he may report sick, and these are not likely to be many. Also, in the event of disciplinary action being taken on account of any delinquencies, the medical officer may be required to adjudicate as to the degree of the soldier's responsibility in the event of the charge being proved. In the second place, cases of dullness and deficiency require both assessment and care, for which provision must be made, in military hospitals, pending their return to civil life. Lastly, on discharge, such cases require to be suitably placed. So far as this matter lies in the hands of psychiatrists in hospitals it hardly needs mention here. There are, however, a percentage of such persons who are not discharged through medical channels, and at the present time (June, 1946) both medical officers and re-employment officers at Dispersal Depots are "having headaches" (if this hackneyed army expression be permitted) when these men fail to find work or are returned to the depots having lost the jobs that were found for them. In this connection the acumen of the dispersal depot medical officers can be of great value to themselves and to their administrative colleagues.

Psychotic States. Apart from such executive matters as re-grading and disposal of patients the treatment of psychoses in the army is the same as in civilian life, and there is no need

to treat here of a subject that is fully covered in the ordinary textbooks. As regards policy, it has been our aim in the U.D.F. to provide full courses of therapy and not to return men to civilian life (or in some cases, to mental hospitals) until the greatest degree possible of recovery has been achieved. To this end psychotherapy, occupational therapy, drug therapy, electric convulsion therapy, insulin therapy and the other standard treatments have been conducted on a fair scale. Careful consideration has been given to the disposal in civilian employment or otherwise of each individual patient.

Before leaving the psychoses one hopeful feature has to be touched upon as regards prognosis. Due to the stresses of service, and particularly among front line troops, a number of acute schizophrenic reactions and of paranoid reactions are precipitated that might have been avoided in the less harassing circumstances of ordinary living. Especially where the personality is a good one and where the precipitating causes have been severe there is considerable evidence that the prognosis in such cases is distinctly good. At the time of writing we have knowledge of two medical colleagues, one being the officer whose case was mentioned on page 14 and the other a doctor who made a determined suicidal attempt while on foreign service, both of whom have since given many months of satisfactory duty while still remaining in the army.

Anxiety States.

The treatment of the exhaustion states was summarised on page 18.

Acute Anxiety States due to battle stress. The treatment of these conditions will be discussed as:

Continuous Sleep Therapy,
Pentothal Narco-analysis,
Psychotherapy,
Sedation,
Occupational Therapy,
Other methods.

Continuous sleep therapy might appear, at first sight, to be an ideal treatment of first instance for severe acute anxiety states, and we have already seen, page 62, that such sedation is at times almost an essential pre-requisite for recovery. Certain workers, for example, a group of British psychiatrists dealing with casualties following the Dunkirk evacuation,[21] have claimed good results from the method. Others, such as Grinker and Spiegel, already quoted,[1] have been disappointed with its achievement. The writers own very limited experience in Italy among patients who had already had such treatment tends to bear this out, nor did its possibilities as a routine method appear to rank high in the minds of those psychiatrists with whom he had for a time the good fortune to be associated at No. 8 Base Psychiatric Centre, Central

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(21) Reference mislaid: quoted from recollection.

Mediterranean Force. It is a method to be held in reserve for those men who seem really to need it.

The technique of <u>pentothal narco-analysis</u> has already been described (page 52) It remains to describe the method of its action. Although the patient is no longer in the battle situation the deeper strata of his mind are being constantly subjected to the effects of the overwhelming stimuli of the psychological trauma to which the ego has been subjected. Here is a vast force of pent-up emotion, to which he cannot, in his waking state give vent, and which calls for release. Under the influence of the drug free rein is given to these emotions and they are released in dramatic form (e.g. vide pp.59 & 60) The ego may indeed be said to synthesise the battle situation that it had partly forgotten and could not face. Thus the treatment has been described as narco-synthesis, rather than narco-analysis or simply narcosis. It is, at all events, a narcosis during which the psychologically traumatic situation is synthesised and in which vent is given to the emotions pent-up under pressure. There is some evidence that this alone is beneficial to the ego. Certainly it is true that an amnesia can thus be recovered from, a mutism can vanish or a hysterical symptom disappear, either temporarily or permanently in this way.

If, however, the matter is left at that, and no more done for the patient at this juncture, much of the benefit that can accrue from the treatment will fail to be realised. If the

patient is allowed to fall into sleep before he has recovered from the effect of the narcotic, part of the memory of the abreaction and of its beneficial qualities will be lost. As the patient abreacts* he is, mentally speaking, still upon the scene of the battle.** What is now necessary is that, as the effects of the drug pass off, he should be "weaned" from this phantasy to a realisation that he is there no longer; he is now in the hospital ward with the therapist. He passes almost, if not quite consciously, from the scene of battle trauma to the environment of safety, therapy and rehabilitation. Simultaneously the method of narco-analysis gradually, imperceptibility and within a space of perhaps a quarter of an hour is transformed into that of psychotherapy. In this way, as the patient becomes awake there are held before his vision the details of the battle situation in which he has just now lived and he passes with them into a scene of waking consciousness. Psychologically traumatic episodes that he could not endure and that were repressed - the pent-up activators of his anxiety - are now held before his eyes, as it were,

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* "abreacts" - if it may be presumed that this essay will be perused by any who are unversed in the terminology of psychiatry it will seem worth while to give an untechnical definition of this word. It is almost as if the deeper strata of the mind spewed up nocuous stimuli (or their effects) in the same way as the stomach vomits up noxious material. This is abreaction, a throwing out by the ego of its harmful content.

** In the rarer cases of civilian life where the method may be of value the patient would be, mentally speaking, still in the psychologically traumatic situation that had been the cause of his anxiety breakdown.

so that he may see them and realise that they are past things. His ego is in this way able to square up to them, to tackle them and eventually to overcome them. The furtherance of this object is the first duty of psychotherapy. As the patient, following narcosis, becomes conscious of his surroundings, the episode is terminated by a brief psychotherapeutic interview in which the battle situation is once more gone over and its implications discussed. Similarly, in those cases where the patient, while under pentothal, has never lost awareness of his actual situation in hospital, a psychotherapeutic interview should take place. Once this is complete he may be allowed to return to his bed in the open ward and to rest.

It may well be, however, that the action of the drug has, at least in a percentage of cases, a more specific effect of a psychophysical nature. Grinker and Spiegel[1] believe that it relieves the cerebral cortex of the bombardment of stimuli to which it is constantly being subjected by the over activated thalamic nuclei;and that in turn the cortex is enabled once more to exert its normal inhibitory effect for the time being suspended by the great access of anxiety stimuli, on thalamic function. Sergant, speaking of recovery of amnesia in casualties following Dunkirk by similar use of intra-venous sodium amytal, has stated: "It was as if changes in the autonomic system and brain metabolism produced by the

amytal were all that was necessary."[22]

A further contribution of pentothal narco-analysis is that it places at the disposal of the doctor details of the patient's experiences that would not otherwise readily be brought to light, so that these may be made use of by him in further psychotherapeutic interviews.

Psychotherapy is directed towards examining and dealing with the various aspects of the difficulty with which the ego is beset. It is a good idea, provided it can be arranged, to begin with such interviews daily. After a few days three interviews weekly and later at less frequent intervals give satisfactory results.

The major question now is whether or not the man is going to become fit for further front line service. The decision ought to be taken as early as possible. If it is to the effect that he will require down-grading for base duties or for repatriation, the patient should be informed of the fact, as this knowledge removes one of the greatest obstacles to recovery from his anxiety. The further details of his disposal (or in civilian cases, any modification of his environment) are left for future decision in the light of events.

The first object to which psychotherapy has to be

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(22) Journal of Mental Science. 1944. XC. p.528.

directed is that of bringing into full consciousness the repressed or partly repressed material that is activating the illness. This has been done initially during the pentothal interview and a good deal of the patient's resistance thereby overcome, while the therapist has, at the same time, been acquainted with the details of this material. In many instances the patient will still feel real difficulty in relating the circumstances in the waking state. This, however, is precisely what he is required to do. He must repeatedly recount his traumatic experiences: in this way he comes to accept their reality, to face their implications and eventually to overcome their terrors. In doing so he is aided by encouragement and by explanation from the doctor, towards whom he develops a state of transference as in any psycho-analytic procedure.

Psychotherapy must next take cognisance of any overt symptoms, such as stammering, regressive phenomena, hysterical manifestations, nightmares and others. So far as these remain after the pentothal interview they must gradually be dissolved by analysis (discussion) and re-education.

There remain the fixed attitudes we touched upon on pp. 23 to 25. On the whole, the chief of these is apt to be that comprised of a sense of failure, an obsession with the idea that he has let down his comrades, that he is yellow and no more of any use. It is with such strictures that the super-ego taunts and afflicts the ego, already weakened and striving to recover

its equanimity. It has been our custom, in psychotherapy, to lay emphasis upon the fact that a sufficiency of battle stimuli will cause a breakdown in anyone; that the patient has received a psychological wound just as surely as a physical one is sustained by a soldier struck by a shall fragment; and that the therapist knows the truth that the psychological wound is even harder to bear. It is pointed out to the patient that there are many of his colleagues, among whom indeed are numbered the personnel of the hospital services, who are doing useful and essential work, but only behind the lines. The patient, in fact, has served his turn, and if his symptons are such as to make inadvisable his return to the front, then the greatest service he can give to the cause is to try to get well quickly and return to perform a job of work at the base. Repeated reassurance is often necessary along these lines.

Feelings that have been brought to light, such as the horror experienced at the death of close friends, the revulsion felt in the presence of sights of destruction and carnage and the intensely acute distaste that is sometimes entertained when contemplating one's own part in killing other men - all these require full and frank exposition in a reassuring type of psychotherapy. To the individual doctor it falls to bring his highest intellectual and moral qualities to bear upon these problems.

It is unnecessary to dwell upon the details of <u>sedation</u>

methods in acute anxiety states, as these follow usual textbook lines. The writer's prejudice, for what it may be worth, was in favour of paraldehyde as a principal standby, but the administration of several common sedatives such as sodium amytal, medinal and luminal, having regard to the merits of each particular case, is to be commended. It was, again, our practice, in cases of doubt to give rather than withhold a sedative; and where one had not been specifically ordered, the night sister was almost always given a free rein in her discretion to give a standard dose to any who required it. At the same time, we naturally were ruled by the view that sedation should be temporary and that once the acute stages of the illness were past its use should gradually be discontinued.

Occupational therapy is a matter of great importance, and where numbers justify it, it is desirable to have a suitably stocked department, staffed by trained personnel. A big consideration in military cases, and probably not without some application in civilian ones also, is that where possible the work done should have obvious value in relation to the war effort (in civilian cases the public good) and the ingenuity of members of the medical staff expended in the effort to arrange such work is not time wasted. In our own case we had typed copies of a circular letter, which was sent to every department of the hospital, explaining the position and asking that any department able usefully to employ patients should communicate

with us. Instances of patients thus employed with benefit are a man who did map drawing and mounting work for the educational officer: another who typed for a recording department and one who assisted in cleaning jobs in the kitchen.

Other methods of treatment include Group Therapy, which is the application of psychotherapy to a whole group of patients together, such as the discussion of problems of a type that are common to many. My limited experience of it has emphasised not so much its ready usefulness as its disadvantages, and the perseverence required to bring it to success. But it has one great recommendation in that it is enormously time-saving, a number of patients being subjected to it at once; and in theory at least it ought to do something to revive a corporate spirit and to disperse the mental atmosphere in which ideas of reference and suspicion thrive, besides providing opportunities for self-expression and thus fostering confidence.

Of group therapy Hirsebberg says that: "There is general agreement in the literature that individual psycho-analytic procedures do not fulfil all the therapeutic needs of the patient; all those problems and conflicts which come roughly within the domain of the social super-ego do not seem to get properly worked out. One of the main distinctions in treatment implied in group therapy is the introduction of a didactic element."(23)

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(23) Hirsebberg. American Journal of Mental Science; 1944, 208, p.199.

Foulkes, on the other hand, has given a useful summary of one form of group thrtapy in which the therapist keeps as much as poasible in the background and where the didactic element appears to be virtually absent.[24] It is probably true to say that neither argument does justice to this promising line of treatment, but that pride of place must be accorded to those methods that tend to develop spontaneity and initiative among the patients. Whiles has stressed the value of group therapy for ex-prisoners of war.[25]

Hypnotism has some value as a means of removing persistent symptoms but, as an analytical method, it falls short, at least in ease of application, of the chemical method described.

In psychoneurotic depressed states electric convulsion therapy has sometimes proved its value.

As regards the treatment of chronic anxiety states it will be apparent that much of what has just been said about the treatment of acute states really applies only after they have passed the acute phase. Where chronic anxiety states that have arisen in base areas or in home camps have been such as to call for hospital treatment, they have been afforded this on lines similar to those just described, with suitable modifications in the case of psychotherapy. In as far as they have arisen from

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(24) Foulkes. Lancet; 1946, i, p303.

(25) Whiles. British Medical Journal; 1945, ii, p. 697.

factors that were less traumatic they have tended to occur in persons even more heavily predisposed. To this extent they are more prolonged illnesses with a rather less favourable prognosis. Even so, the prognosis of a military psychoneurosis is "mutatis mutandis", at least as good as that of the average civilian case.

While there is no essential difference between the treatment of an anxiety state occurring in a soldier and one from which a civilian suffers, so that therapy will proceed according to the ordinary recognised principles, there are one or two points that have special application to the Service.

A large proportion of mild cases can and ought to be dealt with by the regimental medical officers, to whom also, a close rapprochement with the Service specialist psychiatrist will bring great benefit. A stimulating type of brief psychotherapy will often be all that is required, while in selected cases amelioration may be effected by change of environment, such as transfer to another station or to more suitable work. More often than not it is inadvisable to embark upon anything like a psycho-analysis of such patients. (vide page 74, case 14).

An illustration of the contrary state of affairs, namely, the neglect of patients, was seen in a couple of patients, both of whom were admitted to my ward in Italy almost on the same day. Both suffered from anxiety states that had initially been of the usual, rather chronic type, but which had become acute.

The senior psychiatrist of the area, an officer of the British Forces, was asked to see them and to give his opinion. In conversation he afterwards stated that he never had seen, in his experience in the British Army, cases of anxiety that had been allowed to get into such a nervous state.

The treatment of hysterical symptoms was briefly referred to when discussing cases and in connection with battle stress anxiety states. There are few differences from what obtains in civilian practice, so that the matter need not be further dealt with. Nor is it necessary, within the scope of this article, to detail the treatment of obsessional states or of psychopathic personality. In our case the same general policy was pursued in regard to them as was adopted in the case of psychotic serving personnel. That is to say, it was our aim to provide reasonably full courses of therapy, and not to regard our responsibilities towards these patients to have been discharged until an optimum degree of recovery had been achieved. In a country like South Africa, where facilities for the treatment of civilian psychoneuroses are meagre, there are reasons for believing that Service patients were at an advantage in this respect as compared with their non-serving brethren.

Physical examination and Differential Diagnosis.

Lastly, every patient, or virtually every one, should have a competent physical examination, the doctor who performs it

being the judge as to the necessary scope of the examination. Adherence to this principle will not eliminate all possible mistakes, but it will avoid most. Where a symptom is supposedly hysterical, careful examination to exclude organic damage is the foundation of treatment. If the doctor has not attended to this matter he cannot expect the patient to accept his assurance that the symptom is psychogenic. Where anxiety is the presenting factor it is useful to remember the possible effect of glandular dysfunction or of mild febrile illness. In the acute neuroses of battle the ever present possibility of concussion or of cerebral injury is not to be forgotten, although even careful rxamination of the nervous system has sometimes failed to elicit signs. In the psychotic reactions of middle age the Kahn or Wassermann test is a useful guide to the possible existence of early general paralysis. These are but a few pointers. The patient-doctor relationship within the Service is only too apt to differ somewhat from its civilian counterpart, and it is important that the medical officer, when treating his patient, not only should understand him, but should have a clear idea of how far, if at all, physical illness is complicating the clinical picture.

In differential diagnosis there are, further, a number of toxic factors that play a relatively bigger part than is usual in most civilian practices. One is alcohol. Of the diseases associated with warm climates cerebral malaria is usually the

most important, while the prophylactic use of atebrin has itself been responsible for a small number of confusional states. Among the syndromes in this field are also a few psychotic or confusional reactions that are due to the noxious effects of certain chemical substances, of which lead compounds and carbon disulphide are examples. With the great expansion of mechanical industry that took place during the War, an enhanced number of persons were employed in workshops. In areas abroad these often included large numbers of native inhabitants who lacked the mechanical-mindedness that citizens of more industrialised countries possess. An instance was afforded by the numerous Egyptian workers in the military workshops in Alexandria. The moral here is that the Service medical officer will be best equipped to deal with an acute mental reaction (as well as with many medical ones) if he can obtain an idea of the circumstances of the patient's employment and if there is present in his own mind the possibility that one or other of these less common activators may be at the root of the trouble.

There was even an instance at a hospital where we were stationed in which a patient was transferred to the mental wards, but whose case proved on post-mortem examination to have been one of undiagnosed typhus.

Under this head there falls one further matter with which the writer had not intended to deal specifically in this thesis. However, since these pages were written it has again cropped up in conversation with an ex-service medical man. It has, therefore, been decided to pay some attention to it.

Only too often have medical officers expressed the view that almost anyone can obtain a down-grading in medical category, provided he is able to gain access to a military psychiatrist and is prepared to rehearse before him with sufficient plausibility a catalogue of woes. It is as though these doctors thought the psychiatrist were entirely dependent upon what the patient said in the matter of making a diagnosis. Statements of this sort are fair to no-one and they can do much to bring psychiatry into disrepute.

It is, in the first place, supremely difficult for a malingerer or an individual who is 'lacking in moral fibre' to simulate a true anxiety state, hysteria, psychosis or other psychiatric illness. A real neurotic illness is as much a technical entity as a physical one. The careful psychiatrist is not going to diagnose such an illness unless he is satisfied of the existence of the symptomatology and sign-formation that are appropriate to it.

In forming his opinion the psychiatrist is going to be guided, not only by what the patient tells him, but also by reports received from the unit medical officer and from others. His experience and training have taught him to evaluate not only

what the patient says but also what he does and to discern the consistency or otherwise between these two factors. He has, further, at his disposal the advantage, where it is deemed advisable, of prolonged or repeated observation; and the use of uncovering techniques such as narco-analysis, or the tests devised to distinguish simulated from genuine symptoms.

Undoubtedly, the greater the co-operation he receives from his medical colleagues the higher will be the percentage of accuracy among his assessments; because, while one generally can detect the faulty nature of an inaccurate report, there is at least an initial tendency to be misled thereby. This maxim has a bearing, not only in the Services, but in civilian life also. Examples, to mention only two, are industrial psychology and medico-legal work.

Rehabilitation on Discharge from Service.

In touching upon the treatment of mental defect and of psychopathy we mentioned the difficulties that are now confronting those who handle, at the dispersal depots, personnel who come under these categories and under that of alcoholism. In view of the magnitude and continuing nature of this problem it may not be out of place to refer to a couple of typical case extracts in point. They were culled from a report on "Rehabilitation of Neuro-Psychiatric Problem Personalities."

(a) Ex-Volunteer, Psychopathic Personality, aged 27 years. He had, apparently, attested for service on no less than four occasions and been discharged on each occasion after varying periods in the ranks. He claimed to have had no employment except in the army. Several civil charges (the record does not say if they were convictions) and at least one prison sentence were noted against him, while he had repeatedly been admitted to mental hospital as a voluntary patient, or sent to magistrates for observation. He had a hysterical fit, after discharge from the army, in 1944, and was admitted to a military hospital as an Ex-Service man. He constantly demanded passes, withheld all cooperation in investigation, and finally persuaded the Governor General's Fund to pay his fare to another part of the country. Thus he left with no solution of his employment problem having been found.

(b) G. T. was an ex-sergeant, 30 years of age, an Alcoholic Addict. He had seen foreign service in East Africa, in Nairobi only. Pre-war he had been employed in gold mining, but there is no further record of this. After return from Kenya he served in several base camps, he was conspicuously addicted to drunkenness and eventually was sent to hospital for treatment. He received electric convulsive therapy and an Apomorphine course,[26] but relapsed. Finally, in December, 1943, he was boarded category "E" for discharge. Thereafter he worked for a few months, but repeatedly broke down, ultimately being returned to an army psychisatric hospital for treatment. Clearly this is a rehabilitation rather than a treatment problem.

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(26) The procedure adopted by us was that outlined in "Anxiety and Its Treatment" by Dent.

VI. A FEW STATISTICS.

In any review of Service medical problems a statistical background is valuable as giving a wider view than clinical experience ordinarily does of the bearing that the medical matters have upon Service requirements.

The writer was invited to pay a visit to the Statistical Department of the Director-General of Medical Services in Pretoria. For various reasons it was not possible to obtain as much information as one would have desired, but the following tables were drawn up from information placed at his disposal. Despite the above limitation they afford an objective, if not altogether comprehensive view of the place of psychiatry within army medicine.ø

ø Statistical compilation is not yet complete, but the hope was held out that it might be possible at a later date to add to the number and variety of these tables.

TABLE I.

Troops: Racial group	1940 -41		1941 -42		1942 -43		1943 -44		1944 -45		1940-1945	
	Admissions		Admissions		Admissions		Admissions		Admissions		Admissions	
	per 1000	% of total	per 1000	% of total	per 1000	% of total	per 1000	% of total	per 1000	% of total	per 1000	% of total
South African European Males	29.4	2.9	29.0	3.1	33.9	4.8	33.7	5.6	33.3	6.7	31.9	4.6
Coloured, including Indians	15.4	2.1	21.8	2.7	26.5	3.2	23.3	3.0	24.3	3.6	22.3	2.9
Native Africans	6.1	1.3	15.4	1.9	14.7	2.0	13.3	2.2	11.9	2.1	12.3	1.9
South African European Females	23.6	2.3	24.6	2.6	34.8	3.8	44.3	6.1	42.4	7.0	33.9	4.4
Royal Air Force	11.0	1.7	11.1	1.7	14.3	2.5	11.4	2.5	11.3	2.7	11.8	2.2
Enemy Prisoners of War	2.2	1.3	4.8	2.7	8.5	4.2	10.8	4.4	10.5	4.2	7.4	3.4

TABLE OF ADMISSIONS TO HOSPITAL OF TROOPS IN SOUTH AFRICA, DURING THE RESPECTIVE PERIODS, FOR DISEASES OF THE NERVOUS SYSTEM.

As no classification was given for functional, as distinct from organic diseases, it is probably reasonable to presume that from 90 to 95 per cent. represent functional illnesses.

TABLE II.

Analysis of Discharges from the Service on Medical Grounds during the Year September, 1944 to August, 1945.

Disease	Sept., 1944					Oct. 1944					Nov. 1944				
	Eur. M.	Eur. F.	C	N	Total	Eur. M	Eur. F	C	N	Total	Eur. M	Eur. F	C	N	Total
War Neuroses	10	-	-	-	10	19	-	-	1	20	8	-	-	-	8
Mental Disorder	8	2	5	5	20	32	1	2	16	51	21	1	4	4	30
Epilepsy	4	-	-	2	6	9	-	2	6	17	11	-	1	2	14
Alcoholism	1	-	-	-	1	3	-	-	-	3	2	-	-	-	2
Other Neuroses	50	15	7	3	75	65	14	6	2	87	85	15	2	3	105
Total Psychoses and Neuroses	73	17	12	10	112	128	15	10	25	178	127	16	7	9	159
Total Boards All Diseases	231	47	44	74	396	289	37	46	91	463	334	43	39	48	464
% P/T	31.6	36.2	27.3	13.5	28.2	44.3	40.5	21.7	27.5	38.4	38.0	37.2	18.0	18.7	34.3

Eur. M - European Males

Eur. F - European Females

C - Coloured Troops

N - Native Troops (Africans)

% P/T - Percentage of Psychiatric Grounds to Total of all Grounds for Medical Discharge.

Table continued on next page.

Disease	Dec. 1944					Jan., 1945					Feb., 1945.				
	Eur. M	Eur. F	C	N	Total	Eur. M	Eur. F	C	N	Total	Eur. M	Eur. F	C	N	Total
War Neuroses	9	-	-	-	9	10	-	-	-	10	9	-	1	-	10
Mental Disorders	18	-	1	6	25	30	2	3	2	37	3	-	-	6	9
Epilepsy	10	-	3	3	16	19	2	4	4	29	11	-	-	2	13
Alcoholism	-	-	-	-	-	1	-	-	-	1	-	-	-	-	-
Other Neuroses	83	10	2	2	97	88	6	3	4	101	75	10	1	1	87
Total Psychoses and Neuroses	120	10	6	11	147	148	10	10	10	178	98	10	2	9	119
Total Boards All Diseases	304	28	30	58	420	384	32	45	70	531	320	32	21	65	438
% P/T	39.5	35.7	20.0	19.0	35.0	38.5	31.2	22.2	14.3	33.5	30.6	31.2	9.5	13.8	27.2

Disease	March, 1945					April, 1945					May, 1945.				
	Eur. M	Eur. F	C	N	Total	Eur. M	Eur. F	C	N	Total	Eur. M	Eur. F	C	N	Total
War Neuroses	7	-	4	-	11	3	-	2	-	5	7	-	5	-	12
Mental Disorders	12	2	3	8	25	4	2	2	4	12	4	-	1	2	7
Epilepsy	8	1	3	5	17	5	-	3	2	10	11	-	3	3	17
Alcoholism	1	-	-	-	1	1	-	-	-	1	1	-	-	-	1
Other Neuroses	93	9	13	3	118	63	8	1	3	75	19	2	1	1	23
Total Psychoses and Neuroses	121	12	23	16	172	76	10	8	9	103	42	2	10	6	60
Total Boards All Diseases	398	38	77	71	584	311	30	58	83	482	259	11	64	51	385
% P/T	30.4	31.6	29.9	22.5	29.5	24.4	33.3	13.8	10.8	21.4	16.2	18.2	15.6	11.8	15.6

Disease	June, 1945					July, 1945					Aug., 1945.				
	Eur. M.	Eur. F	C	N	Total	Eur. M	Eur. F	C	N	Total	Eur. M	Eur. F	C	N	Total
War Neuroses	5	-	1	-	6	4	-	2	-	6	3	-	-	-	3
Mental Disorders	-	-	-	3	3	-	-	2	1	3	1	1	-	1	3
Epilepsy	3	-	2	-	5	5	2	-	3	10	5	1	1	2	9
Alcoholism	-	-	-	-	-	2	-	-	-	2	-	-	-	-	-
Other Neuroses	27	6	2	1	36	16	10	3	1	30	16	4	1	-	21
Total Psychoses and Neuroses	35	6	5	4	50	27	12	7	5	51	25	6	2	3	36
Total Boards All Diseases	283	24	43	43	393	266	32	27	41	366	228	29	40	42	339
% P/T	12.4	25.0	11.6	9.3	12.7	10.2	37.5	25.9	12.2	13.9	11.0	20.7	5.0	7.1	10.6

	Sep. 44 - Aug. 45	
	Eur. M	Eur. F
Total Psychoses & Neuroses	1020	1365
Total Boards All Diseases	3607	5261
% P/T	28.3	25.9

TABLE II. A.

Summary of totals for the whole year in the case of

(a) Male Europeans, and

(b) Total Personnel.

Table I relates to Diseases of the Nervous System (of which it is probably correct to assume that nearly 95 per cent are either neuroses or psychoses) which were severe enough to require hospital admission. It deals with troops who were, at least for the time being, not in an operational theatre of war. It indicates that a small but substantial percentage of hospital admissions are for functional conditions. Were it possible to obtain figures for those who, time and again, report sick at medical inspection rooms for the same reason, the totals would be considerably enhanced.

It is significant that, as the war progressed, the ratio of nervous admissions tended to show an increase in the case of all racial groups. In the case of admissions per 1,000 personnel this increase was not so consistent.

Table II bears out the same broad differences between the different racial groups. For some reason that is not obvious the percentage of medical boards (i.e. discharges from the Service on medical or surgical grounds) in which the disability was of a psychotic or neurotic nature was much less during the second half of the period under review. In the first six months one third of all the discharges by medical board were for such conditions: by the last month it had fallen away to just over 10 per cent. Even so, throughout the year (Table II A) more than a quarter of all the discharges from the

Service on medical and surgical grounds were due to psychoses or neuroses.

It is further the writer's impression, from work among many thousands of Coloured (Eur-African) troops who were under his medical care in camp, that the actual percentage of neuroses among them was substantially higher than those figures would suggest. Besides which, not a few, both of these and of soldiers generally, who are admitted to hospital, pass under diagnoses such as gastritis, rheumatism and D.A.H. (disordered action of the heart) although in fact a neurotic condition lies at the root of their symptoms.

Table III, on the following page, analyses a series of admissions to the Military Psychiatric Hospital in the Transvaal of patients evacuated by hospital ship from the Mediterranean Area. The relative incidence of different psychiatric disorders among 250 consecutive admissions is shown.

TABLE III.

Type of Syndrome	Number of cases	Percentage of total.
Neuroses (Anxiety States and Hysteria)	90	36
Psychopathic Personality	50	20
Psychoses	34	13
Mental Dullness	24	10
Alcoholic Addiction	20	8
Epilepsy	15	6
Others	17	7
Total Psychiatric cases in series	250	100

This is a limited series of admissions within a period of three months at the end of 1944 and the beginning of 1945. If the personnel concerned, and who were an unselected group, may be regarded as representing an average sample of psychiatric cases from a foreign theatre of war, then the most interesting feature revealed is the high percentage of cases of Psychopathic Personality, Alcoholism and Mental Dullness. These three groups together comprise 38 per cent. of the whole. The special interest resides in the fact that a large proportion of such are probably capable of detection at the time of the initial medical examination or during the early months of their service.

VII. SOME SUGGESTIONS AND RECOMMENDATIONS.

It is the natural tendency, when a prolonged and terrible war has ended and a spirit of sober thankfulness has descended upon a strife-weary population, while remembering its gigantic losses, to forget many of its lessons. The time appears unauspicious for pronouncements on the organisation of wartime medical services. Yet if this not done now the lessons that Service conditions have taught us will not be only forgotten but lost. And who can say, despite the best will in the world to maintain a United Nations' Organisation that will ensure lasting peace, that we are not, indeed, heading in the direction of future wars? Nor, looking only to the more immediate future, is it too late to apply some of the principles of the up-to-date psychiatric outlook to the problems confronting the personnel of the large forces still to be maintained both at home and abroad. It is our first contention that military psychiatry should continue to be regarded as one of the subjects in the syllabus of psychological, if not indeed of all medical education. The chapters dealing with it ought not to be deleted from new editions of textbooks.

There are two reasons for this. The first is the obvious one that it would be unwise to regard the mission of the

army psychiatrist as being, so far as any foreseeable future is concerned, over and done with. There is, however, a further reason. War psychiatry has taught us something of the genesis and pathology of mental reactions, we have seen neurotic and even psychotic breakdowns in a simpler, purer form than is usual among civilian patients, with the result that even the student of the future, who has not himself had this experience, may benefit from a study of the principles that workers in the field have enunciated.

As regards detailed suggestions, the desirability of including a rough psychiatric assessment within the scope of medical examination of recruits is now widely recognised. In this country it was undertaken, during the last year of the war, with encouraging results. How far it will be possible in the event of any future large scale recruitment remains to be seen, but its expediency should not meanwhile be forgotten. Were all medical examiners even invited, by a directive in the syllabus of medical examination, to refer for such assessment any doubtful cases, we should have gone some way towards achieving the ideal. From this it follows that recruits who are accepted, but subject to a psychiatrist's qualifying report, should be placed and employed only in the light of that recommendation. If the man proves himself he can later be up-graded for general duties.

Early in 1945 we met in a Middle East hospital a man,

22 years of age, who complained of symptoms of mild chronic anxiety among the causal factors of which were the circumstances of his army employment. He was a private in a base unit, whose work consisted of rather menial and unintellectual tasks. Yet he had completed about two years of a university course for a degree in psychology. He was a person of somewhat tender mental qualities, and it may be that he would ill have stood up to severe forms of stress; yet it struck us at the time that his intellectual and moral standards were high and that, if suitably placed, he could have given excellent service as an officer.

More attention should be given to the suitable placement of medical officers. It ought to be a prime consideration on the part of those mainly responsible for the posting of medical officers to be "au fait" with the qualifications, capacities and propensities of the individual medical officers concerned and to judge appointments accordingly. For instance, the selection of a doctor for an administrative post, for a dangerous post or for an irksome but important tour of duty has too often been done by rule of thumb or has depended upon sentimental considerations. Furthermore, an officer in medical care of troops should, where possible, remain long enough in that particular place to make his mark felt. "Per contra" a reasonable turnover ought to be encouraged in those forms of medical work that are by their nature unsatisfying. It was on one occasion the writer's experience to be superseded in a job of reorganisation

for which he had been promised several weeks longer. It later transpired that the appointing authority had forgotten that they had already posted him. Hence they sent someone else.

One of the most debated issues relates to the standing as between the regimental officer and his men (vide a number of recent letters in the correspondence columns of the "British Medical Journal." Whatever feelings professional status may engender his first duty is to maintain morale and to foster a high standard of physical and mental hygiene among the men. He cannot afford to allow the slacker to "get away with it," and if any question of malingering is in real doubt, the benefit of that doubt should generally be given to Service interests. The man should be told, after say, a couple of examinations have been made, that nothing can be found wrong with him and that a continuance of his reporting sick will be followed by disciplinary measures.

On the other hand, the medical officer is, for the time being, the man's private doctor, and he owes to him the obligations that that status implies. To this extent he ought first of all to know his men. The senior medical officer of a newly formed division put out an instruction that medical officers should endeavour to interview every man under their care and to discuss outstanding problems right at the outset of the division's corporate life. A beginning of this kind ought to augur well for the future.

Medical officers have sometimes complained that there is a type of patient who will come, asking for an interview with the psychiatrist, before even submitting to medical examination. So far as this is an attempt at malingering it calls for suitable measures. On the other hand, unless the medical officer has the confidence of his men as one by whom they will be given a fair hearing, he need not be surprised if an occasional attempt is made to by-pass him.

Very important is the relationship that exists between the medical officer of a regiment and its executive officers. Not only will a warm rapprochment here facilitate the former's performance of his duties relative to hygiene and general health, but it will often enable the medical officer to arrange adjustments in the interest of individual members of the unit who have sought his help. Once or twice the writer has noted the fact that some junior medical officers have tried to adopt an attitude of independence and even of superiority where their executive higher officers are concerned, which, to say the least of it, is unjustified and serves no good purpose.

One is tempted here to pass a stricture on certain superior officers of the medical services, who have not shown towards their militarily subordinate medical officers that degree of cooperation and trust that ordinary social standards would have forced upon them had they been outside the army. In this way the work that the medical officer is doing for his patients is rendered less easy and efficiency suffers.

It is a definite recommendation that the rudiments of military psychiatry should be made available to as large a proportion of medical officers as possible.

A few general suggestions are brought to mind. The value of propaganda is not to be ignored. Witness the brilliant success that attended Field-Marshall Montgomery's methods in the Middle East and later on the West European front. The greater the extent to which soldiers can be made to feel their own interests to be identified with the military object in view the higher will be their morale. The more they are taken into the confidence of their leaders in operational matters the better is their cooperation likely to be.

A channel for the ventilation of legitimate regimental grievances and a degree of democracy within the service unit, so far as these are compatible with military exigency, are factors likely to improve the tone of feeling in most units. One commanding officer well-known to me adopted the plan of having a weekly public discussion of affairs in the battalion of Coloured troops of which he was in command. I am unable to speak of the general results achieved, although I do know that the medical officer was exposed to considerable criticism by the men.

Restrictions that are quite unnecessary are best avoided. Little advantage can accrue from curtailing leave merely to impress upon personnel that they are in the army and are no

longer free agents. Hard work and efficiency go along well with fairly general casual leave privileges, the over-riding factor being, as always, Service requirements. Where irksome restrictions are necessary the men should, unless such considerations as military secrecy preclude it, be told why these are being imposed.

A recent example of this was quoted in the case of British personnel attached to West African units, who were detained abroad, after the end of the war, longer than appeared to be necessary. The reason was that shipping was not available to take the African troops to their own country, and it was considered inadvisable to deplete the units of their European staff. Dissatisfaction was expressed, the European members of the units not having been told why it was they were being retained abroad. Burdon has placed on record his opinion that: "More explaining of intentions (by the higher authorities) would do good, so far as this can be done."(27)

One has seen a good deal of hardship arise in individual cases from the non-fulfilment of promises that had been made rashly, and of others that were made in all good faith but which could not later be implemented by those who made them. In the Service it is well to promise only what lies within one's own power to carry out.

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(27) Burdon. Jour. Ment. Science. 1944. xc. p. 727.

Again and again we were impressed by the fact that in every country where our troops were stationed relatively little (and sometimes very little) provision was made for the comfort and entertainment of Non-European personnel. If this state of affairs has its origin in racial prejudices that are natural, that is perhaps all the more reason why the more enlightened sections of military opinion should move towards its amelioration.

One matter that has received no mention in these pages is that of disciplinary action against personnel accused of cowardice in the face of the enemy and of charges of a serious nature. It is desirable that the influence of the psychiatrist should be increasingly felt in the drafting of regulations pertaining to, and in dealing with, cases of this kind. Even more use than has hitherto been the custom could with advantage be made of psychiatric examinations, when charges of this nature and certain other charges are under consideration.

War is inevitably a vicious and catastrophic business, in which the individual suffers. Some are killed, some maimed, some bereaved and some subjected to stresses and strains the severity of which taxes their resources to the utmost. It is not our business to design a new and better army. Our task is to build up and to maintain the resistance of the soldier, to rehabilitate those who have succumbed, and by our influence to guide but not coerce the executive in matters that pertain to hygiene, morale and health.

SUMMARY.

1. Until the early years of the Great War of 1914-1918 Military Psychiatry as an entity had little place within the scheme of medical care of troops. Since then it has developed into a subject of increasing scope and importance.

2. The various types of Neurotic and Psychotic reaction that are found in medical practice among troops in wartime are discussed, but the organic reactions are not dealt with in this paper. The causative factors are studied and differences among various racial groupings receive comment. The symptomatology is briefly outlined.

3. Seventeen clinical cases are discussed in some detail.

4. The treatment of the various reactions is discussed, but it is detailed only in so far as it bears particularly on the Service aspects of the case. A few prognostic indications are touched upon.

5. Three statistical tables are included, it having been impossible to date to obtain complete statistical information.

6. A few suggestions and recommendations are made with regard to the future of military psychiatry, the examining and placing of recruits, the training of medical officers and one or two matters of general application.

Cape Town, S.A., June, 1946.