Alcohol and the Fighting Man—An Historical Review

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PART II

1939 to Present Time

In 1940 alcohol abuse in the French Army was the subject of a Symposium shortly before the eclipse of interest in this matter by more urgent purely military problems. Contributors stressed the importance of alcohol in military crime (Hugonot & Hazel, 1940) and its effect in increased mortality from acute infections and in the aetiology of cardiac, pulmonary and nervous disease (Giraud, 1940). Froment and Barbier (1940) discussed alcoholism as a cause of epilepsy of late onset, stating that in the French Army alcoholism accounted for one-third of the epileptics. They also incriminated alcohol excess in neurological and hepatic damage in soldiers and as a cause of "premature senility." They affirmed that a third of the medical discharges from the Service were due to the direct or indirect effects of alcohol. In the discussion on this paper a contributor said that 30% of the psychiatric admissions to a French military hospital at Villemancy were chronic alcoholics, of whom the vast majority were wine drinkers and all were reservists—"aucun n'appartenait au service actif". The problem of unrecognised alcoholism in the Army was raised; one physician stating that at least 15% of patients referred to him for gastrointestinal symptoms were alcoholics (Delore, 1940). It is interesting how close this figure is to the 13.8% of concealed alcoholics found by Nolan (1965) in 900 consecutive admissions to general medical wards. Writing after the French defeat McAdam Eccles (1942) considered that alcohol had been a significant factor in the military collapse and cited a statement from French General Headquarters in April 1940 that "alcohol poisoning was rampant among French privates, N.C.O.'s and even (not author's emphasis) certain officers". In contrast Moore (1942) comments on the victorious Germans that on active operations they "are not allowed alcoholic liquor in any form and the picked troops who invaded France in 1940 were, for the most part, men who had been on a military training regime more strict than of any football teams in our universities". However, no satisfactory evidence is given to support this statement which is probably based on the principle that "nothing succeeds like success."

The interest in alcoholism as a problem in the Bri-

tish, Commonwealth and United States armed forces in the Second World War is shown by numerous papers during this period, particularly by American authors after their country's entry into the War. A directive from the United States Surgeon General summarised the difficulties caused by alcoholics in the Army in the simplest terms.

"Chronic Alcoholism: These men are serious problems in any army. They are pathological liars, unreliable in every way, often paranoid, and when the pressure becomes great, of Absent Without Leave. In acute stages they develop hallucinations and delirium tremens. Ultimately they break down physically, mentally and ethically."

Curran and Mallinson (1940) in an analysis of the causes of psychiatric disorders in serving naval personnel in which 100 psychiatric inpatients were compared to 50 surgical inpatients report that "alcoholism was rare" although they do not comment on alcohol abuse as a contributory factor. They refer to the belief current in the First World War and discussed above (Wolfsohn, 1918) that teetotalism is a significant aetiological factor in psychoneurotic reactions and this was "excluded as too indefinite".

The difficulty of obtaining data on alcohol and drug abuse by Servicemen is mentioned (Moore, 1942a). Authors refer to the problems caused by alcoholics who had been recruited. Challman and Moore state: "One common personnel problem that is often mishandled in the company or battery is the soldier who drinks too much. Usually he stands condemned, is subjected to repeated (and futile) punishments, or he is discharged through Section VII." (Challman & Moore, 1942). In general while drinking had often increased in the Services it had started before enlistment (Harrison, 1944; Lawn, 1946).

The problem of excluding established alcoholics from enlistment received attention, mainly from American authors. This was aggravated by a tendency of alcoholics voluntarily to enlist. Thus a comparison of 669 neuropsychiatric hospital admissions with a control group showed that 30% of the alcoholics compared with 18% of the controls had enlisted voluntarily (Lemere & Greenwood, 1943). It was suggested that alcoholics volunteered with the hope that the Army would provide shelter, protection

and perhaps excitement as a substitute for the escape they were seeking in drink. There was a belief among some alcoholics that the Army would reform them and among others that its way of life would entirely suit them (Berlien, 1944). Similar beliefs were often shared by the alcoholic's relations, family doctor and magistrates, producing external pressures on the alcoholic to enlist and to conceal his history in order to ensure acceptance. If he succeeded in enlistment the established alcoholic was usually rapidly discharged but accepted this without enthusiasm, often asking for "another chance" to stay in the Army. The high proportion of U.S. Navy reservists who were found to be alcoholics was noted (Stearns & Schwab, 1943). The authors considered that in most cases alcoholism had become established during service, and remark that "the (U.S.) Navy appears to have a high degree of tolerance for the drunkard. Because some men who are competent occasionally get drunk it is assumed that all drunkards are competent. Nothing could be further from the truth." Ten per cent of those rejected on neuropsychiatric grounds were chronic alcoholics. However, the pressure on medical enlistment boards was such that the total number of alcoholics was considered to be materially higher (Myerson, 1942). A minor problem associated with enlistment medical boards was the simulation of alcoholism to avoid conscription. This was distinguished by the absence of withdrawal symptoms under observation (Campbell, 1943).

The part played by alcohol in Service disciplinary offences was recognised. Clearly in a hierarchical community the disinhibiting effect of alcohol makes it particularly likely that offences will be committed. Schneider (1958) summarises this situation: "Drunkenness plays an important part and special difficulties can arise over Service discipline. Disrespect for authority and insubordination are common among such personalities especially when they have been drinking, and after some explosive upset absence without leave is a commonplace." The alcoholic is thus in danger in the Army, but he is also himself a danger to the Army because of his unreliability in crises, and especially so with the increase of complicated technical equipment. (Strecker, 1945). Abuse of alcohol, by men who were not alcoholics also played a large part in many offences such as absence without leave starting with a spree and overt exhibition of psychosexual offences which were normally repressed (Berlien 1944). The figures vary considerably: thus Wagley (1944) states that out of 500 U.S. convicted military offenders 33.2% were chronic alcoholics and 72.2% admitted alcoholic tendencies; Schneider and Lagrone also reporting on a total of 500 convicted U.S. military offenders found 27.2% chronic alcoholics; Boshes (1947) however reports only 14 chronic alcoholics in 2000 U.S. naval disciplinary cases; Weiss

(1947) found between 2.1 and 5.6% chronic alcoholics diagnosed in different military prisons; Blackman (1947) found 6.94% chronic alcoholics among 2144 prisoners. The only similar British figures available were obtained from 1000 R.N. ratings in detention; only 1.3% were considered chronic alcoholics although many had been drinking when the offence was committed (Prewer, 1944).

Alcohol abuse has been noted in the Services of Commonwealth and foreign armies. It is stated that in the First World War in the Australian Army dependence on alcohol was in the case of officers a very frequent cause of failure to make good in the field. "In the rank and file the cycle from private to sergeant and back was a quite authentic experience" (Butler, 1942). There was similar concern in articles in the Australian medical literature for the position in the Second World War. Various suggestions for improvement included the reduction of the alcoholic content of beer, rationing of spirits and prohibition of "shouting" (i.e. "treating") (Med. J. Australia, 1942; Jarvis Nye, 1942). Two authors actually suggested the punitive use of the psychiatric interview. Jarvis Nye (1942) after recommending that on the first occasion of drunkenness the young soldier is reprimanded by the unit Medical Officer, continues that on a second offence he should be sent to a psychiatrist "who should undertake a full investigation of his mental state (If possible it is desirable that this should be conducted in a mental institution)".

Bostock (1942) makes a similar proposal: "It is undoubtedly the too persistent drinker is a case for the psychiatrist. If the Army adopted the plan of sending him for a mental examination, it would go far to debunk the idea that over-drinking is a symbol of good fellowship". Eleven point six per cent of the total suicides (5450) in New South Wales for the period 1914-1937 were returned soldiers, and these 40.1% were chronic alcoholics (Minogue, 1945). In the Finnish Army, however, alcohol abuse is said to have decreased during the second World War due partly to the shortage of beer and partly to the regulation that units were "wet or dry" on the instructions of the local Commanding Officer (Karpinen, 1945).

The problem in the merchant marine of various countries is considerable and has interesting similarities and differences with that in the Armed Forces. An investigation of alcoholism as it affected the regular cadre of the United States Merchant Service in the Second World War, 20% of admissions to a rehabilitation centre showed a major degree of alcohol abuse (Heath, 1945). There was even a suggestion that the majority of long-service merchant seamen ultimately became alcoholics (J.I.F., 1947). Some aetiological factors such as a strong dependency need (Heath, 1945)

Rose and Glatt, 1961; Wallinga, 1956) and feelings of isolation and rejection are given both for the Merchant Service and Armed Forces (Powdermaker, 1942; Heath, 1947; Moore, 1942b). The Norwegian merchant marine, which has the special feature of providing an occupation for a high proportion of the total population at least for a short time, has had two detailed studies. Norwegian seamen have a high incidence of alcoholic psychosis, the rate of seamen being ten times greater than for officers (Ødegaard, 1956). A survey of 3500 sailors aged 20-21 years showed that those having a combination of poor education, high neurotic scores, and poor childhood home conditions were particularly likely to develop alcoholism with increasing time at sea (Brun-Gulbrandsen and Irgens-Jensen, 1964). Both studies stressed the importance of intrinsic aetiological factors and the part played by self-selection in recruitment. Kjulstad (1964) reports that 38% of 506 patients in 16 Norwegian alcoholism clinics were sailors, compared to a frequency of 18% in the country's adult male population. He too commented on self-selection by young men who were initially maladjusted and incriminated occupational stresses which included absence from home restraints, relatively high pay at an early age and the influence of older companions. He recommends more stringent selection to exclude immature youngsters with latent personality problems. Ødegaard (1956) had noted that until relatively recently recruitment of Norwegian merchant seamen had "practically no barriers of competition, of demand for special training or qualifications." Reimer (1964) discusses the relatively high suicide rate of German merchant seamen and concludes that the great frequency is because suicide by sailors often occurs when they are drunk.

The attitude of the Service authorities to alcohol has in the past been ambivalent. The classical example of this has been the naval rum ration. Until 1970 the Royal Navy continued to issue one-eighth of a pint of 95.5% proof Jamaica rum to all trained seamen over 20 years who elected to receive it at sea or in shore establishments where normal customs arrangements allowed (in general a naval establishment behind a perimeter flying the White Ensign). This amount of alcohol would have cost about ten shillings (50 new pence) on the open-market in the United Kingdom (but purchased very cheaply by the Government) and the allowance which could be drawn in place of it was three old pennies. This cash allowance had remained unchanged for 30 years and a proposal had even been made, though not effected, to reduce it by Sir Austen Chamberlain, then First Sea Lord, as an economy in the financial depression in 1931 (Skidelsky, 1968). One reason that it survived as long was that it had originally been so large that

substantial reductions could be made which still left this ample measure. It had been reduced by half in 1824 and to a gill (a quarter pint—double the ration in 1970) in 1850. Dudley (1944), then Medical Director-General of the Royal Navy, was able to remark probably accurately, on the "tremendous change for the better in the drinking habits of naval personnel, which has taken place in recent times" although he opined that this had "not been associated with a commensurate fall in the incidence of gonorrhoea". Historically a necessary measure to inure against the hardship of living conditions, it had long become an anachronism which seemed to give the approval of authority to its daily consumption (Miller & Ferguson, 1964). Nonetheless, the reaction to its belated abolition showed that this was a courageous decision as well as a wise one. The Sunday Mirror (1969) reported that 'Labour M.P. James Wellbeloved — a wartime sailor — has launched a campaign to get the Navy's rum ration restored.' He described its abolition as "an outrage," had already tabled a Commons motion attacking its discontinuance, and was seeking a Parliamentary debate. The Times (1970) describing a generally successful tour by Mr. Dennis Healey, then Minister of Defence, reported the following exchange stimulated by asking a young rating how he liked the Navy. The sailor replied:

" 'It is all right now, but it is not long till doomsday.'

'Doomsday?'

'Yes, July 29'.

Mr. Healey was baffled, "What's happening on July 29?'

The man was astonished. 'You mean you don't know?'

'That's the day you're ending the rum ration.'".

The surprised Minister made a reasoned and eloquent but unsuccessful attempt at conversion.

The rum ration was issued mixed with two parts of water (that is, as "grog") to those below Petty Officer rank who had to drink it immediately. Petty Officers and Chief Petty Officers drew through their messes. Although storage was prohibited by regulations, in practice senior rates were allowed to take it undiluted and to store it. In addition ratings drew one to two half-pint cans of beer when at sea. The regulations prohibited giving the ration of rum or beer away but this was open to local variations affected by the state of discipline and morale. The rum ration was not issued to commissioned naval officers who can, however, buy alcohol duty free at sea. A view held by many ship's captains is that "an officer's wine account is his own responsibility unless he makes it mine". In many ships an "unwritten law" restricts the consumption but often at a fairly generous level. Submarines are dry at sea (but not in port)

and officers on flying duties in carriers are abstinent.

There are other examples of this ambivalent attitude. In overseas military stations alcohol tends to be cheap while Service pay is usually marginally higher than in the United Kingdom; alcohol thus becomes very cheap in relation to income. Pozner (1961) cites occupational Service factors and considers that if following long conditioning a moderate drinker develops into an alcoholic it is expedient for authority to claim that the fault is in the individual and not in the system. Wallis (1964) similarly emphasises the environmental pressures in the Royal Navy. Authors refer to a similar situation in the United States Armed Forces. West mentions a military tradition of heavy drinking, a general acceptance of a high basic consumption of alcohol in military society and its use in many social contacts (West & Swegan, 1956; Ginsburg, 1962). A diagnosis of alcoholism however involves in the United States forces discharge without honour, no official provision for treatment, and no pay during hospitalisation. This combination of unofficial tolerance of heavy drinking with strongly punitive official policies encourages concealed incidence (West & Swegan, 1956). Some authors have suggested a useful role for alcohol. Its use in the Pacific war theatre is mentioned as a method of self-medication producing tension release after operational missions in an abreactive manner and for similar tensions built up at sea from close contact with a small number of men, fatigue, nostalgia and restrictions due to necessarily strict discipline (Harrison, 1944). In the U.S. drinking is confined to leave ashore as United States Naval ships are "dry." Henderson and Moore (1944) in a study of the first 200 psychiatric patients "admitted to a hospital of the United States Armed Forces somewhere in the South Pacific" considered that many of the patients when on leave, particularly the first one after returning from active operations, drank too much, but they continue that "on the whole, the part alcohol seemed to play was a beneficial one. It was generally used as a releasing agent, for purposes of recreation—usually in a social setting—and to relieve or ameliorate the tension and frustrations of war."

In the past British and North American authors have varied in their approach to the treatment of alcoholism within the Armed Forces: At one extreme is the view that the soldier who succumbs to alcoholism does so independently of environmental pressures because he is the type of vulnerable personality who would do so in civil life. The Service is not responsible for him and he is a danger to the Service and should be discharged as rapidly as possible (Berlien, 1944, Strecker, 1945). Monsour suggests that "some men with basic psychopathic traits made good war-time soldiers". He continues however that the peace-

time United States Army is an unsuitable environment for the retention of treated alcoholics (Monsour, 1948). The view that alcoholics should rapidly be discharged without treatment is given mainly in papers published during the Second World War and immediate post-War period; the pressures of these times render this policy understandable and possibly unavoidable. An interesting exception is the description of a method of treating alcoholics who continued on duty in a United States Navy camp but were segregated in a special section. Treatment aimed at rehabilitations and restoration of self-respect, and full use was made of Alcoholics Anonymous (Nunan, 1944). In the less militarily urgent peacetime setting increasing attention has been directed towards treatment. Lawn describes a programme based on psychotherapy at a Rehabilitation Centre (Lawn, 1946).

Multidirectional therapy including Antabuse for selected cases is described (Brown & Knoblock, 1951; Genes, de, 1954; West & Swegan, 1956; Swegan, 1957; Catanzaro, 1964). Wiseman's treatment programme included a follow-up in which, out of 105 questionnaires sent to the Commanding Officers of the soldiers' units, 90 were returned. The results appeared good but the follow-up period was relatively short (Wiseman, 1959). An Alcoholic Unit has been established at the British Army and Navy Psychiatric Centre at the Royal Victoria Hospital; the approach is multidirectional with emphasis on group psychotherapy (Miller and Ferguson, 1964). Other authors discuss methods of early counselling in cases of alcohol abuse. A United States Division psychiatrist in Korea established a method for treatment of problem drinkers in forward areas by general duty medical officers and general physicians. The methods were mainly physical, including Antabuse, but there was great emphasis on the doctor-patient relationship (Ginsburg, 1962). The particularly favourable position of the unit medical officer from his local knowledge of the soldier and the unit is emphasised. Such knowledge is particularly valuable where heavy drinking is reactive to local stresses and advice on situational manipulation is appropriate (Selesnick, 1955). In an interesting paper which discusses the special pressures on French soldiers in the protracted war in Algeria, Bernard Galixy and Bercoviei (1963) comment that "the propaganda against alcohol has not yet had its full effect, in the same way as residence in Algeria, where the removal from the family environment added to the moral and physical climate incites people to aggravate this tendency." Alcohol was the cause of death of 13% (25 patients) of all patients dying from medical conditions in 1960 and 1961. Of these three young soldiers died of acute alcoholic poisoning. The great majority of the remainder which included three captains and 17 non-commissioned officers were

alcoholics of long standing who died either from delirium tremens or hepatic cirrhosis. The authors consider that these soldiers, of whom the majority were not giving useful service and six had an unsatisfactory professional rating ("rendement professionnel"), for several years, should never have been sent to that theatre where it was foreseen that psychological factors would affect them adversely.

Wallis (1968) with some justice criticised the British Service medical contributions to alcoholism should qualify as a condition for alteration in patients' military medical category and that "these arguments are often rather meaningless because the disorder can be expressed either as a personality defect or a neurosis, so that the psychiatrist can within limits chose the diagnosis which best fits the directives of the Service to which the patient belongs for the disposal he thinks most appropriate." This situation has now changed. In April 1970 a symposium of 'Alcohol as a Problem in the Armed Forces' was opened by the Director-General of the Army Medical Services at the Royal Army Medical College. Jenkins (1970) described a well-established and successful alcoholic treatment group at the Princess Alexandra's Royal Air Force Hospital at Wroughton. The author of this thesis presented preliminary findings of the section of the survey relating

to concealed alcoholism in general medical patients admitted to military hospitals (Miller, 1970). Later in the same year a series of papers with discussions under the chairmanship of the Director of Army Psychiatry was given at the Third International Conference on Alcoholism and Addiction at Cardiff. O'Connor (1970) in a paper subsequently published discussed special pressures on aircrew which included sleep difficulties related to the economic necessity of obtaining the maximum use of expensive aircraft and airfields, fatigue after flight and the positioning of aircrew in isolated airfields overseas where alcohol is cheap. He considered that alcoholism was rare in both service and civilian pilots but that "the true incidence may be somewhat higher because of the natural disinclination to face up to the reality of dependence upon alcohol by patient and employer alike." A previous Director of Army Psychiatry discussed current problems of addiction in the United States Armed Forces (Phillipson, 1970). He cited the evidence of a senior American medical officer (Colonel H. Kolmer) to a Senatorial Sub-committee in 1969 that he estimated from the results of a study he had carried out by a questionnaire to those in medical charge of six large military installations that the incidence of alcoholism in the United States Army was between 2.7 and 3.2%.

PROPHYLAXIS OF HEPATITIS A WITH IMMUNE GLOBULIN

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The Editor regrets that this article, in which the author considered the military implications of Hepatitis A, included a diagram whose original source was unknown to the author and which appeared without acknowledgement, and other material the reference for which was incorrect.

The correct attribution should have been:
MORTIMER P P, Hepatitis A and its virus. In Recent Advances in Clinical Virology (Ed A P Waterston) London: Churchill Livingstone, 1980.