PSYCHIATRY IN JUNGLE WARFARE

BY

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INTRODUCTION

Psychological problems in "Exercise Medical Bamboo" are, of course, closely interwoven with general medical problems. In the exercise narrative it is emphasized that the prevention of sickness is an operational matter, not just a medical one. In a far eastern tropical theatre of war somatic sickness supersedes battle stress as the main etiological factor in psychiatric breakdown. For this reason the psychiatric services must be even more closely integrated with the general medical services than in other theatres where somatic illness is not so important.

The problems will be considered under the following headings:

(1) Prophylaxis.
(2) The type of breakdown.
(3) Organization of Psychiatric Services.

PROPHYLAXIS

Screening.—Screening is mentioned in the exercise narrative as being a necessary preliminary to posting overseas. This will have been carried out in Britain by the ordinary selection machinery of the A.B.T.U. Cases of gross instability or mental deficiency should therefore not be encountered among British personnel. West Africans, East Africans, Gurkhas and Malays will include such cases of gross instability and dullness, unless selection procedures are applied to them too. The same selection tests as for British Troops cannot be used. In West African troops the Matrix test is of limited value. According to Dembovitz, the average score is 18. In Gurkhas, according to my own experience, the score is rarely above 10. The quality of the labour units from India is important as there are likely to be gross failures in mental health among them out of all proportion to the nominal strength of the labour force.

Training.—Training is important as a prophylactic reserve. In primary training is laid down the soldier’s future attitude to the Service. Posting overseas should not be interpreted as a punishment or a banishment from the group in which the soldier has been happy and well adjusted. Good training gives a man confidence in his ability to cope with his own environment both internal and external. When formations or units are sent overseas the soldier does not change his social environment. Changes in geographical setting should be dealt with by giving the maximum amount of information about life in the
new land, how to keep fit, and of the main difficulties likely to be encountered. During the period of acclimatization and jungle training, preconceived fears about diseases, the jungle, the heat, etc., should be finally debunked, but the preliminary debunking should begin on the ship if security considerations permit. Reinforcements present social problems as they have lost their group and are likely to feel that their new unit is hostile towards them. The policy of posting reinforcements in platoons or at least sections, has a great deal to recommend it. Even a small friendly group helps the individual to adjust. In the Arakan the two British Battalions of 26 Ind. Div. differed markedly in quality and efficiency. One battalion did not bother to integrate reinforcements into the battalion. The 1st Lincolns had a special officer for the job of “Lincolnizing” reinforcements. The advantages of an undeveloped terrain, especially jungle country, should be stressed. The use of the environment as a protection instead of a hazard is an encouragement which promotes alertness and efficiency. The fact that primitive aggressive impulses can find more adequate expression in this type of warfare is important, but is better not mentioned. The inhuman qualities of the Japanese, their treatment of prisoners and difference in appearance from British troops, tend to diminish guilty feelings over the question of killing or maiming them. This is in contrast to the feelings arising over the battle with Germans and Italians.

Welfare.—Morale is best maintained by ensuring that the soldier does not have to fight a war on the domestic front as well as the battle-front. Of the two wars, that on the home front outweighs the battle against the Japanese as a factor in the etiology of psychiatric breakdown.

Good welfare organization at home and in the operational theatre are essential and adequate liaison between them must be maintained.

The exercise narrative stresses the value of a rapid turnover of mail—this is vitally important in maintaining morale.

The period of overseas service is important. Two-and-a-half years was found to be the critical time after which domestic upheavals occurred; these were either of acted-out type, such as unfaithfulness, or the type in which separation anxiety increased to such a degree that the soldier or his wife, or both, broke down with a psychoneurosis or a depression. During the first six months overseas the soldier is suggestible, and easily falls a prey to morale-raising or morale-lowering influences. After about two-and-a-half years overseas he becomes discontented and a large increase in paranoid attitudes occurs.

Leave is relatively important to British Troops but is vital to Indians and Gurkhas, though the latter are satisfied with leave every two years. Home leave of the L.I.A.P. variety is a great mistake as the soldier’s adjustment is grossly disturbed, and the fresh wound which occurs when he leaves his family and returns to the Far East is often fatal to his psychiatric adjustment.

Publicity and news, especially in the form of a Force Newspaper are morale-raising factors in that they foster group consciousness. Anything which emphasizes the links between the larger social milieu is good.
Types of Breakdown.

Anxiety States.—In British troops Anxiety States are much the commonest type of breakdown amounting to 50–60 per cent of all psychiatric cases. They may be classified into Panic States and Battle Exhaustions as well as the classical picture of acute anxiety. The first and second of these types are precipitated by acute stress, the third by chronic stress. In "Medical Bamboo" the third type is likely to predominate, except during the most intense fighting, as the stresses of climate, jungle and mountain with rapid movements against an elusive foe, tend to produce types of anxiety state more like those seen in civil life. The exhaustions and panic states have an extremely good prognosis, the classical anxiety states a somewhat less good one.

Occasionally in the absence of conscious anxiety a man is sent to the psychiatrist by his platoon commander as he has panic dreams in a forward area and constitutes a threat to his comrades by giving away the position.

Psychosomatic Illness.—Psychosomatic symptoms predominate in about 20–25 per cent of psychiatric breakdowns in British troops. Headaches, fainting attacks, dyspepsias, palpitations, dyspnœa on exertion, are the commonest symptoms. The prognosis is not so good as that of anxiety states.

Gross hysterias are quite uncommon in British Troops—amounting to only 6 per cent. The most important group in jungle warfare consists of men who complained of night-blindness, and stated that they could not participate in patrolling. The prognosis of hysterias in British personnel is not very good as the underlying personality is usually less satisfactory than the anxiety state.

In Gurkhas, gross hysterias predominate—aphoria and deafness being the commonest type of symptom. Hysterias in both Indians and Gurkhas do well as a rule. The total percentage of breakdowns in Gurkhas is likely to be very small. West Africans and East Africans are prone to develop hysterical conditions and in Gurkhas, Indians and Africans anxiety states are uncommon. Such anxiety states are in the more intelligent and educated Gurkhas, Indians and Africans.

Depressions occur in British Troops, Indian Troops and Gurkhas—feelings of unworthiness are prominent and suicidal attempts are common. The cases are evacuated to the Advance base centre and given E.C.T.

Panic states occur most commonly in young British Officers and in Gurkhas. There is no future for them in the operational theatre but the prognosis at base is good.

Schizophrenia is uncommon in British Troops but quite common in Gurkhas, Indians, West and East Africans. In the Africans, violence—even homicide is not rare. The schizophrenias of Indian and Gurkha troops seem to be considerably less serious from a prognostic viewpoint than similar states in British Troops. Many resolve within a few weeks at the corps exhaustion Centre and the majority recover after E.C.T. at the advance base treatment Centre.

Toxic psychosis is common in Indians, Gurkhas and Africans. It has a seasonal incidence as might be expected, being maximal during and just after
the Monsoon when malaria and water-borne diseases are most common. The ultimate prognosis is good but the cases may be written off as far as the campaign is concerned.

**Organization of Psychiatric Services**

Divisional psychiatrists are essential in a campaign such as that envisaged in "Medical Bamboo" where communications are poor and divisions are often far from each other in time if not in space. The divisional psychiatrist is posted to Div. H.Q. under the aegis of the A.D.M.S. When active operations are not going on, the divisional psychiatrist should carry out further selection and morale investigations and should give lectures and talks on mental hygiene to R.M.O.s and combatant officers. He should get to know the fighting units as well as possible so that in action their particular problems will be understood.

In action he should set up a Divisional Exhaustion Centre of 20 beds with, or close to, an A.D.S. The best site is in the A.D.S. where the psychiatrist is likely to miss only a few cases. It is realized that a field ambulance is an evacuation unit and the policy of holding a score of psychiatric cases may present a problem to the field ambulance commander. This problem is best dealt with by giving the psychiatrist an establishment, so that he is not parasitic for nursing help and equipment, and by demonstrating that it is just as important to hold a psychiatric battle casualty well forward as it is to evacuate a serious surgical casualty. In some way the battle neurotics deteriorate as they proceed to base and their prognosis worsens. This is due to three factors; firstly, the battle neuroses are best treated before they have had time to become fixed and static, when the patient is suggestible. Secondly, it is important to keep a soldier in his own social group in which his morale recovers most readily. Thirdly, with each hour's journey towards the base the secondary gains from the neurotic symptoms increase.

The divisional psychiatrist carries out simple therapeutic procedures such as sedation, narcosis, narco-analysis, hypnosis and brief interpretive psychotherapy. Group treatment is desirable both from the viewpoint of saving time and because it reduces the isolating effect of neurotic illness. Good food and vitamins are powerful adjuncts to treatment. About 75 per cent of all cases can be returned to duty from divisional level. The relapse rate is about 10 per cent but even if one month's fighting is sustained, the therapeutic effort has been worth while.

**The Corps Psychiatric Centre.**—At Corps level there is a corps psychiatrist whose duties are to co-ordinate the work of the divisional psychiatrists and to organize a corps exhaustion centre, usually attached to a C.C.S. where more elaborate treatment can be given to the cases evacuated from Div. level and also to the breakdowns in Corps troops and L. of C. visits. Because of the dual role of the corps psychiatrist, it is desirable for him to have the help of a trainee or a graded psychiatrist who can take charge of the exhaustion centre while he goes on tour or is employed by the D.D.M.S. on specific projects.

At Army H.Q. there should be an adviser in psychiatry, who, under the direction of the Army Commander and the D.D.M.S. Army, should give help
on all questions of morale as well as advice regarding the psychiatric organization for the campaign. At the Advance Base Centre, either as a wing of a general hospital or on its own, should be an Advance Base Treatment Centre where cases evacuated from the Corps Centre can be held for treatment up to three months provided that the prognosis is thought to be favourable and a return to unit is expected.

Close to this Treatment Centre there should be an Army Selection Centre in which re-categorization and re-allocation can be carried out so as to conserve manpower as efficiently as possible.

**DISCUSSION**

In the discussion which followed, Brigadier Rosie, Director of Army Psychiatry, said that he believed that the Far Eastern Theatre was the only theatre in which Divisional Psychiatrists were used. He stressed the importance of early psychiatric treatment.

He thought that "morale" was a very misused term—quite a few people being under the impression that it meant recreational activities and facilities and other amenities. Morale, he said, did not depend on these things at all, the main ingredients of high morale being the group or team spirit.

*Col. Officer* thought that all Divisional Psychiatrists should have experience as Regimental Medical Officers before taking on their duties at divisional level.

*General Dowse* did not think Major Williams had laid enough stress on his talks to R.M.O.s. In his opinion they were extremely important people and as they were the men on the spot, could do much to check psychiatric cases at the outset.

He mentioned the Intelligence Tests for West Africans and said that he thought they were quite unsuited to their mentality. He also said that he thought that a large number of officers posted to these West African units were quite unsuitable and in some cases could not even speak their language. He thought that all officers and N.C.O.s posted to these units should be specially selected.

*Col. O’Dwyer* mentioned an experience in Delhi where a group of young officers, having been warned too vividly of the prevalence of disease, developed psychoneurosis.

In conclusion, the *Director-General* said that the late C.I.G.S. had expressed a wish that only specially selected personnel should be posted for service with West African units.
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