Families here probably come within the sphere of the psychiatrist much quicker than at home. In fact there is no doubt that quite a number of these cases would have been dealt with at the old general practitioner level. Such a practitioner, a trusted friend and father confessor, would listen to their tale of woe and then give his reassurance, help and advice, and probably prevent an adventure into mental illness. If the Regimental Medical Officer is taken as the counterpart of the general practitioner, then the picture is entirely different. The R.M.O. is usually young and recently qualified. Postings and transfers are frequent, and therefore he is seldom long enough there to become part and parcel of the unit. Families often feel that because of his youth he has not yet had the opportunity of facing the various problems of life, and that therefore with his lack of experience he will not be able to understand or assist them with their personal worries. They are also inclined to feel rather embarrassed to tell the intimate details of their family problems to one so young.

Superficially at least, domestic disharmony would appear to be very common among service personnel serving in this theatre. The main reason for this is probably that dirty linen has to be washed in public. At home the shaky marriage may be held together by advice or support from one or other of the parents, and, of course, psychiatric advice can always be obtained from a civilian source. If the husband and wife have too much of each other, then they can separate at least temporarily, and perhaps live with their parents for a short period. Out here there is no such privacy—a personal domestic squall is raised almost to the level of a unit problem. Another important factor is, of course, the fact that there is no stigma in living been treated by a psychiatrist in this part of the world. In fact it is fashionable—it is the done thing—the mental breakdown is easily attributed to the “terrible climate.” Admittedly, when one comes to the tropics from a more temperate zone, it is a new environment and does test our ability to adjust under a certain amount of stress and strain. But there is still too much the idea that the tropics is the white woman’s grave.
even before she leaves the United Kingdom, is given a long list, by her friends, of the various tropical diseases, both physical and mental, which are hiding round the corner; vivid imagination produces a few more. In fact, the official pamphlet’s only effect is to produce a fear or almost a true phobia about one’s poor health. Individuals, and especially the female sex, become completely hypochondriacal. In time it is hoped that just as the spine pad and the topee have quietly disappeared, so too will this over-emphasis on mental ill-health follow suit. Perhaps by then the term “tropical fatigue” will be realized to be an excuse for laziness.

During the year 1951, 102 patients were treated, 82 wives and 20 children. The Army accounted for 54 of the wives, the R.A.F. 21, and the Royal Navy only 7. Again, 51 of the patients were officers’ wives, and 31 wives of other ranks. It is difficult to determine the exact proportion of army wives in this theatre to those of the other services. It is certain that army wives are in the majority, but it is doubtful if the proportion is over 7:1 as for navy wives. As there are more other ranks’ wives than officers’ wives in this theatre, it would at first appear to be rather surprising to note that many more officers’ than other rank wives attend as patients. The reason for this will probably be more easily determined when discussing the various causative factors producing the psychiatric disability.

The main presenting symptoms given at first visits were as follows:

(a) Domestic disharmony ... ... ... ... 26 cases
(b) Headache ... ... ... ... ... 8
(c) Chronic worry and anxiety ... ... ... ... 8
(d) Sexual disharmony ... ... ... ... ... 7
(e) Excessive alcoholic consumption ... ... ... ... ... 5
(f) Delusions ... ... ... ... ... 5
(g) Depression ... ... ... ... ... 4
(h) Neurodermatological ... ... ... ... ... 4
(i) Mental instability following pregnancy ... ... ... ... ... 4
(j) Fear of suicide ... ... ... ... ... 2
(k) Fear of the dark ... ... ... ... ... 2
(l) Feeling of shyness or introversion ... ... ... ... ... 2
(m) Paresis ... ... ... ... ... 1
(n) Fear of insects ... ... ... ... ... 1
(o) Inability to swallow ... ... ... ... ... 1
(p) Aphasia ... ... ... ... ... 1
(q) Fear of pregnancy ... ... ... ... ... 1

The patients themselves sometimes realized that their symptom was only a cover for a more intimate problem, which they were perhaps only able to discuss at a later interview. In fact, the presenting symptoms at the initial interview were usually of very little importance from the psychiatric angle and were more or less ignored. The reason why rather a large number appear to report with domestic disharmony as a symptom is that they had first reported to the Medical Officer with other symptoms, and the M.O. had considered that there was
domestic disharmony with a possible psychogenic causative factor. The psychiatrist thus often finds himself being utilized as a marriage advice counsellor. It is interesting to note that not one single patient complained about her inability to withstand this tropical climate.

The constitutional aetiological precipitants of psychiatric breakdown have been discussed in Section II, and are much the same for both the sexes. But the environmental factors at play in symptom production in the families group are frequently so very different from those seen in the male, that a separate analysis is warranted. This can perhaps best be done by listing the varied precipitants, roughly in order of frequency:

(i) Frequent separations from husband and worry over husband fighting in jungle or guerilla warfare.
(ii) Financial worries—usually in people who want to take advantage of the social amenities in this tropical clime, but who are in too low a pay bracket.
(iii) Inability to accept the culture and climate of this part of the world.
(iv) Too much leisure—usually officers' wives with two or three servants and too little to occupy their interests or attention.
(v) Dislike of hotel or boarding-house life.
(vi) Intimmarital disharmony, and frank marital infidelity.
(vii) Excessive alcoholic indulgence in one or both parties.
(viii) Menopausal, pregnancy or puerperal features or fear of pregnancy.
(ix) Jealousy over a grown-up daughter or step-daughter.
(x) Inability to adjust to a tropical way of life due to personality, inadequacy or low intelligence.

An analysis of the diagnoses in these 82 female patients shows that 6 were suffering from some form of psychosis, 15 from a severe form of psychoneurosis, at times amounting to almost psychotic intensity, and 56 were diagnosed as mildly psychoneurotic. In 5 cases no true psychoneurosis existed. Gross domestic disharmony was present in 20 cases, but was found to be a factor in milder form in roughly half the patients seen. By gross disharmony we mean those cases where either partner wishes to leave the other, either by separation or divorce. Gross sexual disharmony was found in 12 cases, mainly due to nymphomania or sexual aberrations on the part of the husband. Minor sexual problems were encountered much more frequently and included cases of the continued practice of coitus interruptus and various grades of frigidity.

Over 50 per cent. of the cases seen were treated as in-patients, and this rather high proportion is partially explained by the fact that a number of these patients live at some distance from the psychiatric block (sometimes two to three days' travel) and thus even if intensive out-patient treatment alone is considered necessary, admission to hospital is the only means of carrying this out. In-patient treatment of female patients, although not ideal, is fairly satisfactory. Psychoneurotics are generally admitted to the ordinary families' ward. Psychotics or cases for observation are admitted to a special small ward. This small ward
adjoins the male psychiatric ward and consists of a self-contained two-bed ward with sitting-room and annexe. Burglar-proof wire netting ensures safety precautions, without giving the effect of a barred ward. When a patient is admitted to this ward, three Q.A.R.A.N.C. Nursing Sisters are made available by the Matron for duty. At least one Sister and, if possible, all three have had previous psychiatric training. In order to economize in staff as much as possible, the patient, if not considered to be a definite suicide risk, is transferred to this ward only during the hours of treatment, and remains in the ordinary families' ward for the remainder of the day and night. For example, such a patient having insulin treatment will only remain in this ward from 0700 to 1200 hours, thus requiring only one nursing Sister shift.

Psychotherapy was, of course, the main treatment; in about half the cases seen this was supplemented by at least one drug abreaction, either pentothal, ether or carbon dioxide (the latter mainly experimentally and never with very great success). Other forms of therapy employed included electroplexy, modified insulin, various forms of sedation, vitamin B and hormone therapy, marriage counselling, convalescence in a hill station, and invaliding to the United Kingdom. This latter procedure judiciously used can be a most powerful therapeutic weapon in service psychiatry in an overseas station. E.C.T. was employed mainly in the psychotic group, and two cases of puerperal psychosis so treated made uninterrupted and swift recovery. Hormones were of value, especially in the neurodermatoses. One dermatological case which had been treated by various physicians and dermatologists, service and civilian, both at home and abroad for the past thirteen years, cleared up completely after two short courses of ethisterone given prior to two consecutive menstrual periods. Marriage counselling was a therapeutic agent of real value in those cases where marital discord was due more to ignorance of marriage relationships than to incompatibility.

Twenty children were seen during the year, mainly at the out-patient clinic. These included five referred because of apparent dullness and backwardness at school, three with a stammer, two with enuresis, one with fits, and seven with behaviour disorders. In the first group, one child had to be returned to United Kingdom in order to be educated at a special school. An hydrocephalic was brought to the clinic because the parents had been informed soon after the child's birth that an operation might be necessary to alleviate the condition. They had put off this decision for almost six years, and were now very guilty and worried that it might be too late. In many cases it was necessary to treat the parents rather than the child. The usual story was the only child with over-anxious and over-fussy parents.

In addition to seeing children at the out-patient clinics, Army Service Schools were regularly visited. The aim was to visit local schools at least once per term and schools at out-stations at least once per year. These visits were entirely informal. Generally the headmistress would refer six to eight children per visit, and to ensure that the interviews were considered entirely routine, one bright child and one average child were included in the list. During the short interview, the child was always tested for an I.Q. by the Herring revision of the
Binet-Simon test. It was interesting to note that the results obtained in this way after ten to fifteen minutes were almost identical with the results obtained in the Moray House test, in those children who had taken the latter. After the interview, the teacher was advised how to deal with the child's particular problem, and occasionally an interview had to be requested with the parents. Some interesting clinical material was discovered at these school interviews, including two cases of crossed laterals, both in the same class at the same school, both producing problems to their teachers and parents.

**Summary**

A survey of service psychiatry during 1951, in the Far East theatre, has been attempted.

Facts and figures have been produced, and etiology, diagnosis and treatment of service men, their wives and children have been discussed.

The article has been confined to discussion of clinical rather than preventive psychiatry.

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**AN INSULIN COMA THERAPY UNIT IN A MILITARY PSYCHIATRIC DIVISION**

**BY**

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*Royal Army Medical Corps*

The unit described is at the Royal Victoria Hospital, Netley, and the period reviewed is the year 1951. The unit, in a somewhat similar form, was in operation for almost two years in Banstead Military Wing prior to its move to Netley. It is hoped that this account will be of some assistance to any medical officer in the Services who may in the future be given the task of setting up such a unit.

**Lay-out of Unit**

The accommodation occupied is part of the psychotic wing of the Psychiatric Division and is itself "closed" accommodation. It consists of a ward of 16 beds which serves as a dormitory at night and a treatment ward during the day, a day room, a sister's room, a sterilizing room, a food preparation room, annexes, three side wards with single beds, a padded cell and a medical officer's consulting room. Certain modifications are near completion which will greatly facilitate treatment, by converting a space just off the treatment room into a sterilizing room.
A Survey of Service Psychiatry in the Far East in 1951

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