

A National Service Psychiatrist's Story

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In the early 1950s male medical students nearing their finals were aware that two years National Service lay ahead. With this in mind and in an era before Pre-registration, I decided on an unusual course. Instead of taking the customary medical and surgical house jobs I spent the year in equivalent junior positions in mental hospitals. I did so in the expectation that this specialist experience would lead to an army posting in psychiatry and this proved to be so. After basic training I was posted to the home of army psychiatry, the Royal Victoria Hospital, Netley. Coming from an up to date psychiatric service in Scotland I found the clinical standards there higher than I anticipated. There were psychotic and psychoneurotic units. Most of my time was spent in the latter where I gained experience in assessment, categorisation, abreactive techniques, deep narcosis and simple psychotherapy. At that time (1953) the work of the service was much influenced by the school of Sargant and Slater [1] with particular reference to physical therapeutic methods - though this was before the arrival of chlorpromazine, tranquillisers and antidepressants.

Along with other conscripted trainees I was under surveillance as to my suitability for independent work in army commands. After three months I was posted to the Commonwealth Division in Korea where a cease-fire had just been arranged.

The troopship took 31 days to reach the Korean operational base in Japan. The allocation of medical work aboard ship was in the hands of the Senior Medical Officer. He briefly looked me over and said "Psychiatrist - bag of wind - you can be Ventilation Officer." So, nightly, in the tropics, I went round the ship with the Orderly Party deciding whether the troops slept above or below deck. Only once was I asked for psychiatric help - a report on a soldier who stabbed his mate with a penknife. The cell where I examined the offender was a triangular space - triangular because it was literally the bow of the ship. The sea being rough, the bow went up and down in a most disturbing way. I was pleased to make a "nil psychiatric" assessment and return to a less exhilarating part of the ship.

Reaching the Commonwealth base in Japan I met my predecessor as Divisional Psychiatrist. Remarkably, I knew him well as I had followed him through school, university and hospital in Scotland. His guidance and advice was particularly invaluable as the senior RAMC psychiatrist gave me little support then or later.

I quickly proceeded to Korea. I was aged twenty five. I took only one psychiatric work, Henderson and Gillespie's Textbook of Psychiatry. I was posted to 25 Canadian Field Dressing Station (FDS), the Commonwealth equivalent of an American M.A.S.H., located to the rear of the Commonwealth Division. This was a force some 20,000 strong with elements from the United Kingdom, Canada, Australia and New Zealand. American and South Korean Divisions lay to the left and right; the opposing Chinese and North Koreans to the North.

I reached the FDS in a snowstorm on Xmas Eve. I was allocated a tent. I was then given a loaded rifle and taken to the sentry box at the entrance to the FDS where I was put on sentry duty for the next three hours - to let the other ranks have their Xmas dinner. It was an unexpected start in my new role but I took comfort in the thought that my Canadian colleagues felt able to trust an unknown psychiatrist with a dangerous weapon. I was, indeed, well received and subsequently spent ten harmonious, stimulating and enjoyable months there. My psychiatric work apart I took a share in general duties such as casualty work and fitness programmes for all ranks.

In facing my new responsibilities I was aware of the importance of the cultural diversity of the division, variations in group(unit) behaviour and slight differences in military organisation which could influence my interpretation of an individual soldier's emotions and behaviour. For example, the friendly, uninhibited way a Canadian private might address an officer might be interpreted as rudeness or indiscipline in a more formal British context. At a regimental level there were interesting variations; one battalion which was held in high esteem when the fighting was on became, in my time, notable for indiscipline and high VD rates.

Six months into the ceasefire divisional morale appeared to be high. There was relief the fighting had stopped (at least temporarily). Living conditions (tented) were good. Equipment and clothing were satisfactory, rations were excellent. Although winter temperatures were mostly below zero the days were sunny and calm. Summer weather was fairly comfortable. Rest and Recuperation in Japan, alcohol and visiting entertainers all helped. There were few doubts about the rightness of the military cause. The North Koreans had initiated the conflict. Communism had to be confronted. The enemy lay ahead - not here, there and everywhere as in Vietnam and Afghanistan. Relationships with the local populace, mainly peasants, was good though there was a tendency to treat them as inferior. It was a relatively comfortable, stable, anxiety free world.

Once my psychiatric availability was recognised I saw one or two new patients a day. Most returned to their units the same day. A few were admitted to the medical ward for assessment or treatment. An infantryman not fit for frontline service was allocated to help me in lieu of a medical orderly. Though devoid of any interest in medical work he was a great help in caring for anxious, depressed or difficult patients.

Immaturity was much in evidence in British National Servicemen in particular. Across the division as a whole psychosomatic problems were prevalent and a medical specialist colleague was a great help at the assessment stage. Anxiety states were also common and the treatments here included psychotherapy and sedation, usually with barbiturates. Modified insulin non-coma therapy was employed occasionally. Deep narcosis was sometimes used in courses no longer than three days as the dangers were recognised.

As there was no fighting, the combat fatigue seen by my predecessor did not come my way. Four or five other ranks,

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older men with what was then called Traumatic Neurosis, were referred. All had had traumatic experiences in World War Two and had had depression, irritability, flashbacks and other symptoms thereafter. Korea seemed to have exacerbated their problems. I tried abreaction using sodium amytal or methedrine. The theory was that reliving the bad experiences and sharing them with a sympathetic therapist was therapeutic. Whilst this treatment may have helped patients whose traumatic experiences were recent these chronic sufferers had not benefited when I saw them at follow up. In a sense neither had I. On one occasion, as the methedrine kicked in, the patient sat bolt upright and landed an accurate, blood provoking blow on my nose.

Classic hysteria was seen from time to time. Most patients were low in intelligence and rank. The commonest manifestation was muscular weakness presenting as standing or balancing difficulties. There were none of the bizarre movement disorders that surfaced in World War One. Hypnosis worked well. French Canadian colleagues were intrigued watching two of these men come in on stretchers and return to duty on foot. They dubbed me "St Les of Uijongbu."

Schizophrenia was diagnosed infrequently - not more than three cases in my time. I admitted them for observation and, once satisfied with the diagnosis, evacuated them to Japan. One of them, sensing his own unpredictability, asked if he could be handcuffed on the flight to Japan. This was arranged. There were no antipsychotics with which to initiate treatment.

Depression was seen mostly in older men, often in association with alcohol excess. Some were admitted for rest and counselling. Sometimes barbiturates were used to help with sleep in those pre-antidepressant days. There were no suicides. A hypomanic CSM caused something of a stir. He substituted a corkscrew "Harry Lauder" walking stick for his baton. On a frosty parade ground he made his company lie down facing Mecca whilst he declaimed from the Koran. His idiosyncrasies and flight of ideas caused havoc in the regiment. So there was much relief when I sent him (plus escort) to Japan. My senior in Japan did not agree with my diagnosis and returned him to the Division to the consternation of his CO. He was as hypomanic as ever, so the CO and I consulted the ADMS who was in complete agreement with me. Arrangements were made administratively to return the patient to Canada, thereby by-passing my senior in Japan.

My limited psychiatric education had not embraced group dynamics. Yet intuitively I came to see this as of great relevance in military psychiatry. For example, I was puzzled by men who showed signs of stress when they were about to return home. American colleagues I found, termed this "The Pre-rotation Syndrome" where men were (1) distressed at leaving buddies (2) uncertain about personal and family relationships back home and (3) uneasy at the prospect of having to organise their own lives.

The most unusual group experience occurred mid-winter. The Canadian government decided to send a small orchestra to entertain the boys in Korea. At short notice a motley group of musicians was recruited and put into uniform. A regular army sergeant major bandmaster was put in charge. Their first engagement was at the Waldorf Astoria in New York, an exciting venue, where they were warmly acclaimed. Then they were sent to Korea. Mostly middle aged and militarily untrained, tent life and the bitter cold proved too much. They all manifested signs of stress - depression, psychosomatic symptoms, inability to finger their instruments, temperamental behaviour, alcoholic excess. With no foreknowledge I was summoned to an Aid Post to see them. The

bandmaster gave me a good account of what had happened and expressed his frustration managing such an unmilitary group. I then saw all eight bandmen individually. None of them, in my view, merited psychiatric attention or evacuation from Korea. I suggested to the senior officers they should be given more support and better accommodation. My concern at this time was not with the official "patients" but with the bandmaster in immediate charge. He was tense, had a bad tremor and clearly had been drinking. He spoke in an uneasy way about his charges and said he wondered if they were out to get him. I put it to him that as he seemed stressed he might come down to the FDS for a short break and to this he agreed. I then sent him off. When I got back myself a few hours later I found he had gone berserk and started to break down the plywood walls of the Operating Room, thereby disconcerting the surgeon at work within. My colleagues had sedated him with paraldehyde. He was evacuated to Japan and then to Canada. An NCO with a good record he made a quick recovery and returned to duty but not to Korea. The rest of the band proved to be a flop as entertainers and soon returned to Canada.

One hot summer's day I was summoned to the Field Detention Barracks (FDB), a unit with a notorious record for harsh discipline. Offenders found life at the front line infinitely better. The FDB staff told me they had a madman in their midst. He was a large New Zealand Maori with a truculent manner that had been put on a 12 hour punishment routine climbing and re-climbing a small hill wearing full kit and in tropical heat. When dismissed at the end of 12 hours he politely asked if he could go up the hill again. Shocked, the warders felt he must be psychotic. In interview I found no evidence of mental illness. Asked to explain his behaviour he told me "*I spent the day going up and down for those bastards - I wanted to go up once for myself*" I told the bemused CO the man was quite sane. I did not tell him of my admiration for the triumph of the human spirit.

The Americans had a Psychiatric Holding Company near Seoul where they organised a monthly get-together for divisional psychiatrists. There were case presentations and general discussions. On one occasion the meeting focussed on group identity which can become so important in stress situations. Admiration was expressed for the British system wherein regiments with their history, local connections and traditions helped soldiers know who they were and how to behave.

The only other non-American psychiatrist was the senior medical officer of the Turkish Brigade. He informed me he had few psychiatric problems - three or four schizophrenics in the course of a year. What did this mean? A psychiatric culture that did not recognise non-psychotic states?

My Korean year over and with several months National Service still to do I was shipped to the Malayan Theatre where I joined the psychiatric unit at BMH Singapore. Living in this more formal, well ordered and very British world I missed the relaxed, rough and ready camaraderie of Korea. At the same time I appreciated and enjoyed working in an efficient and well run department under the leadership of a first rate, cultured and knowledgeable colonel psychiatrist. I was in day to day charge of the psychiatric ward.

We saw a wide spectrum of problems. The Insurgency was coming to an end and we did not encounter exhaustion or traumatic syndromes. We had several Ghurkas with schizophrenia and they received ECT, the only treatment available to us in those pre-chlorpromazine days. Soldiers to the core, they often marched smartly into the ECT room, saluted us therapists and stretched themselves out on the couch in the attention position.

Discharging these men for repatriation to Nepal troubled us. We were led to understand they would be returned to their village communities, where, once their mental illness was recognised, they would be cast out.

We also had a number of Ghurka wives with clear cut post-natal depression. Lacking the support of their families and in a strange land these young mothers were very vulnerable. The infants were sometimes at risk and nursing vigilance was essential. Without antidepressants treatment was difficult. The frankly psychotic received ECT.

These young women came to my mind some thirty years later in the course of a mental health survey in a Karachi(Pakistan)

slum. How was it that some desperately poor mothers could care for and nourish their infants adequately while others, at the same income level, failed, and their infants were malnourished? I felt post-natal depression was a factor.

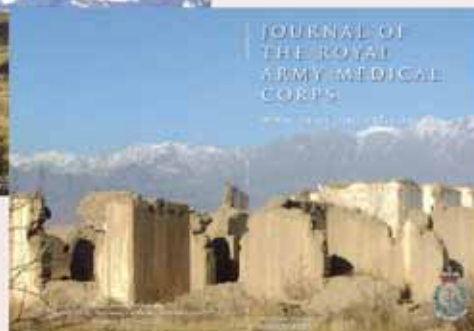
Twenty of my twenty four months service were spent abroad. On returning to the everyday world I felt that army life, far from impeding my medical career, got me off to a surprisingly fruitful start.

Reference

1. Sargent W and Slater E, Physical Methods of Treatment in Psychiatry 1951;

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